IMSANZ

INTERNAL MEDICINE SOCIETY *of Australia & New Zealand*

NOVEMBER 2003

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From the President...

Dear IMSANZ Members

It gives me great pleasure to recount the many activities undertaken by the IMSANZ Council over the last 6 months and which are discussed in more detail in accompanying articles in this issue of the newsletter. Such achievements are testament to the energy and vision that this society holds for the practice of general internal medicine (GIM) and I thank all councillors for their contributions.

New Look IMSANZ Council:

The Council has endorsed a new internal committee structure, which aims to enhance its productivity and responsiveness by allowing each of its councillors to assume a personal portfolio of activities and interests (see page 3). From my position as president this new operational framework is already yielding dividends in new ideas and projects.

RACP ASM Canberra 2004:

The IMSANZ – RACP Annual Scientific Meeting Program Group under the leadership of Les Bolitho (Vic) and Mary-Ann Ryall (ACT) is well progressed in organising a fantastic meeting for May 2004, in Canberra. This promises to be even better than the very successful meeting in Hobart this year (see *summary report* on page 7).

Diarise this event now and note the closing date for abstracts for presentations at the IMSANZ presentations session, which also attracts awards for best papers (see insert). Phillippa Poole (Auckland) and colleagues from New Zealand are already planning activities for the 2005 meeting in Wellington.

Education and Training Review:

Following on from the Forum on General Medicine (the official college report of this will be available as we go to print) which supported greater access of general trainees to subspecialty training, many members of Council participated in a recent teleconference with Winnie Wade, the education consultant from the Royal College of Physicians in the UK, who has been contracted by RACP to provide recommendations about reforming the college training and education program. Ms Wade agreed with much of what IMSANZ was proposing and regarded the need for specialty societies to embrace the need for more generalist training and to be more exible in their training requirements, as the greatest challenge facing the path to change. Discussions I have had with the college CEO, Craig Patterson, and his liaison officer, Gary

(continued on page 2)

As you turn the pages...

PRESIDENT'S REPORT

November 2003

Disher, have centred on convening a Training and Education Workshop later this year or early next year, at which design and operationalisation of a new curriculum for advanced trainees – and one with greater emphasis on generalism - would be the principal objective. More on this in the next newsletter.

Registrar rotations to non-metropolitan hospitals:

The critical issues of workforce needs and shortages in internal medicine in rural areas has been given greater prominence by the recent efforts of David Russell (Vic). David has written to the Victorian Minister of Human Services outlining the need for an equitable system of seconding registrars from Melbourne hospitals to rural hospitals if closure of beds at these sites is to be avoided. As a result, the CEOs of Melbourne hospitals and government officials have met to work out a mutually agreed plan of secondment which has implications for other states.

Training and career opportunities for general trainees:

Nationally, IMSANZ is proposing zonal or regional registrar workforce schemes to alleviate problems of recruitment in rural hospitals, and which involve career paths over 2-3 years rather than simple annual appointments. As a local example, I have been able to persuade administrators in my own institution, Princess Alexandra Hospital in Brisbane, to increase the number of secondment registrars to general hospitals in the Southern Health Zone of Queensland from 7 to 11 for the start of 2004, with plans to increase this by another 2 in 2005. IMSANZ is also building a national database of training and career opportunities for trainees in GIM as a means of attracting trainees to non-tertiary settings and we ask you, our members, for your help in this initiative (see *Building a national database on training opportunities* on page 7).

Rural Physician Networks:

Kenneth Ng (WA) and Diane Howard (NT) are working to set up a Rural Physicians Network in their respective States to provide professional support to their isolated colleagues (see *Ken's letter* on page 11). IMSANZ Council recently held discussions with the chair of the college Rural Physicians Taskforce, Rick McLean, on how IMSANZ can work with the college in replicating such networks across all states. Readers' thoughts and ideas on this are most welcome and we will provide a progress report in the next newsletter.

IMSANZ Awards and Scholarships:

IMSANZ Council recently endorsed the establishment of several new awards for which IMSANZ is now calling for applications. Successful applicants will be announced at our AGM in Canberra next year (see *Awards and Scholarships* on page 15). These awards confirm our intentions to promote and reward the pursuit of academic excellence on the part of IMSANZ members. Please consider whether you or any of your colleagues may be eligible for any of these awards and, if so, contact the IMSANZ secretary for an application kit.

Quality improvement:

Bruce King (Nelson, NZ) and I attended the 3rd Asia-Pacific Forum on Quality Improvement in Health Care, in Auckland, in early September. This featured international speakers such as Don Berwick, Brent James, Bruce Barraclough, Sir John Oldham and Rod Jackson. It was a most interesting meeting and some of the highlights, from our perspective, are detailed on page…

Let me close by asking all readers to think again about what each of us can do as clinicians, scholars, researchers, communicators, and leaders, to advance the cause of general internal medicine. I offer some personal re ections in a subsequent article (see *IMSANZ needs* you on page 13) and invite you to share your views, as has Professor Edward Janus on page 19. I would also recommend Prof Zajac's recent article in the Medical Journal of Australia (2003; 179: 250-252) regarding the role of general medicine in the hospital of the future. Good reading and best wishes for the Festive Season!

IAN SCOTT
President, IMSANZ

IMSANZ Secretariat

The Secretariat office has moved from Phillip Street into 145 Macquarie Street, Sydney and as such the phone and fax numbers have changed. Please make a note of the new numbers.

Phone: 61 2 9256 9630 | Fax: 61 2 9247 7214

LOOKING TOWARDS THE FUTURE

A New Vision & Structure for IMSANZ Council

At a teleconference on 14 August 2003, IMSANZ Council ratified a 5-year strategic plan for the Society, which included a far-reaching restructuring of Council operations and functions in the form of a new committee structure. This aims to make Council policy-making more inclusive and participatory, and to share the increasing workload of the Council more evenly among its members, in a way that aligns individual councillors with areas of work best suited to their interests and skills. This allows Council to be even more productive and responsive in meeting the challenges facing our discipline.

Each committee will address specific issues and aim to achieve several objectives outlined in the strategic plan using various strategies. At regular teleconferences and at the AGM, the chair of each committee will be asked to provide a progress report to Council on the activities undertaken by that committee. The new structure is described below.

Council Executive comprises the President, Ian Scott; Vice-president Australia, Di Howard; Vice-president New Zealand, Phillippa Poole; past President, Les Bolitho; Treasurer, Mary-Ann Ryall; and Secretary, Simon Dimmitt.

The Executive will be responsible for providing executive leadership, governance and policy-making on behalf of Council, and for facilitating enactment of the recommendations agreed to by Council.

Membership Committee: Simon Dimmitt (Chair), Wilton Braund, Kenneth Ng, Mary-Ann Ryall, David Russell, Les Bolitho, Ian Scott, and Briar Peat.

This committee will address issues relating to membership and recruitment.

Objective: To increase IMSANZ membership by 25% within 12 months, 50% within 2 years, and 75% within 4 years.

Strategies: Comprehensive membership campaign at national, state and local levels using an advertising campaign, an invitation to all new advanced trainees to join, and a request to existing members to assist in recruitment.

Development of a package of membership services for members, which includes:

- A directory of vacancies for general physicians throughout Australia and New Zealand;
- A directory of training positions for advanced trainees in general medicine, with focus on regional appointments with exposure to subspecialty rotations;
- A directory of advanced trainees or fellows who are willing to provide locum services to regional centres;
- A directory of education and skill development resources of special interest to general physicians (clinical practice guidelines, CME courses, upskilling workshops, scientific meetings, etc).

Professional Development and Research Committee: Phillippa Poole (Chair), Ian Scott, Bruce King, Aiden Foy, Les Bolitho, David Hamill, and Briar Peat.

This committee will focus on education and research issues, MOPS affairs, and organisation of scientific meetings and other professional development activities.

Professional Development

Objective 1: To maintain and further strengthen the profile and in uence of IMSANZ in organising the RACP annual scientific meeting.

Objective 2: To lobby for, and assist in the establishment of, tertiary hospital based upskilling courses for regional general physicians.

Objective 3: To develop an annual calendar of IMSANZ scientific meetings, comprising three major events: the RACP ASM; the New Zealand college ASM; and a regional IMSANZ meeting in both Australia and New Zealand (and which might include an off-shore Asia-Pacific destination).

Objective 4: To establish an Education Account within IMSANZ for the purposes of raising funds with which to support IMSANZ-sponsored educational and professional development activities, including activities undertaken in partnership with other societies, government departments, non-government organisations, universities, or NHMRC.

Objective 5: To implement a structure of regionally based educational meetings and forums for local groups or networks of fellows and advanced trainees in general medicine.

Objective 6: To establish an annual Travelling Scholarship to the value of $5,000 for advanced trainees or fellows of less than 5 years in general medicine to attend international meetings relevant to general internal medicine.

Objective 7: To continue to actively support the RACP in procuring the ICIM meeting in 2010 and to assist in the organisation of the scientific program.

Objective 8: To assist members in undertaking MOPS activities e.g. providing audit tools or other aids for practice evaluation, which are of relevance to physicians practising general medicine.

Research

Objective 1: To establish the IMSANZ Research Fellowship worth $10,000, to be awarded to an advanced trainee or fellow (of less than 5 years duration) in general medicine who wishes to pursue research qualifications (at Masters or PhD level) in clinical epidemiology, health services research, quality improvement or a related field.

Objective 2: To establish an IMSANZ Award for Best Scientific Publication in Internal Medicine, to be awarded to any IMSANZ member who publishes a key article relevant to internal medicine in a high-profile peer-reviewed clinical journal.

Objective 3: To develop a directory of involvement of IMSANZ members in health services research and clinical trials.

Training Committee: Leonie Callaway (Chair), Phillippa Poole,

Graeme Dickson, Simon Dimmitt, Aiden Foy, David Russell, Thein Htut, Kenneth Ng, Mark Morton, and Ian Scott.

This committee deals with issues of basic and advanced training, mentorship, and assessment.

Objective 1: To ensure provision of an appropriate and accredited training program that meets the needs of trainees wishing to practice as general physicians in regional areas.

Objective 2: To strengthen professional development and mentoring processes for advanced trainees in general medicine.

Objective 3: To introduce state or regional systems for general medicine trainee appointments in hospitals, that entail career paths over 2-3 years and which provide exposure of trainees to rural/regional general medicine and subspecialty medicine.

Welcome to New Members

IMSANZ would like to welcome the following New Members:

- Prof Dawn De Witt (Shepperton, Vic)
- Dr Ciara O'Sullivan (Alice Springs, NT)
- Dr Natacha Sorour (Toowoomba, Qld)
- Dr Zoya Volobueva (Toowoomba, Qld)

A warm welcome is also extended to our new Associate Members:

- Dr Niranjan Arachchi (Lower Hutt, NZ)
- Dr Jennifer Butler (Christchurch, NZ
- Dr Sheila Cook (Stafford, Qld)
- Dr Leon Fisher (Caulfield North, Vic)
- Dr Robert Gibson (Newcastle, NSW)
- Dr Patrick Gladding (Onehunga, NZ)
- Dr Fraser Mackenzie (Brisbane, Qld)
- Dr Anne Maloney (Invercargill, NZ)
- Dr Spencer Toombes (Cairns,Qld)
- Dr Hla San Tha (Auckland, NZ)

The President would also like to congratulate Dr Sarah Lynn and Dr Andrew Wesseldine as the IMSANZ sponsored candidates who attended the ESIM in Alicante, Spain in October 2003.

Finance Committee: Mary-Ann Ryall (Chair), Phillippa Poole, Ian Scott, Wilton Braund, Les Bolitho, David Hamill, Rob Nightingale, and Justin La Brooy.

Objective 1: To increase income ow into IMSANZ accounts to ensure adequate cash reserves in the event of extraordinary one-off outlays, and the granting of awards and scholarships.

Objective 2: To seek sponsorship from external sources (government, pharmaceutical companies, non-pharmaceutical medicine-related companies) for education and research related activities undertaken by IMSANZ Council and members.

Health Policy Committee: Aiden Foy (Chair), Diane Howard, Bruce King, Simon Dimmitt, Justin La Brooy, and Ian Scott.

This committee looks at health policy and public health issues, input into RACP social and public health policies, and external relations of IMSANZ with other official bodies.

Objective 1: To develop a number of key health care and public health policies and statements that confer a public and medicopolitical voice to issues of direct concern to general internal medicine.

Objective 2: To raise the profile of IMSANZ as the representative body for GIM, which specialist societies and healthcare organisations should consult in seeking endorsement of guidelines, service frameworks, policy statements and other public documents that are relevant to the practice of general physicians.

Objective 3: To engage the RACP and its agencies (eg Health Policy Unit) in contributing to, and supporting, an agenda for reform in meeting the needs of GIM in Australasia.

Objective 4: To build alliances with other colleges and societies and to engage the AMA in mounting initiatives that address the need for more general physicians, especially in rural and remote areas of Australia and New Zealand.

Communications Committee: David Russell (Chair), Bruce King, Kenneth Ng, Aiden Foy, and Ian Scott (Tom Thompson, Michele Levinson – ex officio members).

Objective 1: To strengthen the IMSANZ newsletter as the chief organ of news and communication for IMSANZ members by increasing the frequency of publication to 3 times a year, as from the July 2003 issue, with the aim of increasing to 4 times a year, if feasible.

Objective 2: To revamp the IMSANZ website, increase its content, and improve its appeal and interest to potential users.

Objective 3: To encourage IMSANZ members to submit articles outlining their perspective on issues of relevance to GIM to both the IMSANZ newsletter and RACP News.

Objective 4: To review methods for enhancing electronic messaging to IMSANZ members.

IMSANZ COUNCIL
14/08/03

3RD ASIA-PACIFIC FORUM REPORT

Quality Improvement in Health Care, Auckland, Sept 2003

The authors recently attended the 3rd Asia-Pacific Forum on Quality Improvement in Health Care held in Auckland. In this article they share some of their experiences.

This meeting is held annually and is supported by the BMJ Publishing Group and the Boston-based Institute for Healthcare Improvement. Support for the 2003 meeting came from the New Zealand Ministry of Health, the Accident Compensation Corporation, and Standards New Zealand.

The general focus was on methods of quality improvement in healthcare services and systems, with a parallel theme on healthcare for indigenous peoples. The wide multidisciplinary and international representation amongst the delegates, especially from the Asian Pacific rim, provided a unique breadth of perspective. The meeting structure included a plenary session, usually as the first event, then a selection of small group workshops of 90 minutes duration, which focused on specific components of quality improvement processes. These ranged from issues quite specific to Maori health and the Treaty of Waitangi, to the details of use of clinical indicators, evidence-based practice, and disease specific examples of successful changes in service delivery.

Issues of quality measurement and how to incorporate such measurements into clinical practice, to change delivery of healthcare to individual patients, were covered in three sessions delivered by Brent James, executive director, Institute for Healthcare Research at InterMountain Health Care (IHC), Salt Lake City, Utah. He used examples from IHC to show how such an approach resulted in substantial improvements in both the quality and cost-efficiency of healthcare . The presentation described the use of a detailed costing analysis, which identified disease and process-of-care priorities, combined with development of clinical pathways linked to systems for measuring pathway variances. Most pathways were disease and setting specific e.g. diabetes mellitus in primary care, with some procedural items such as extubation in the intensive care unit, infection prophylaxis in surgery and adverse drug event prevention across hospital and primary services. The repeated message was the importance of spending time in developing evidence based pathways, and pragmatic measures of pathway-mandated care processes that could be used in everyday care (see: www.ihc.com/xp/ihc/facilities/institute).

Prof Rod Jackson, epidemiologist from the Auckland University Department of Community Health, discussed a prediction tool for estimating future risk of cardiovascular events (based on multiple risk variables) and providing decision support and guidelines for individualised intervention using a web based format. This was a fabulous talk and Rod has posted this presentation and some very useful EBM resources on his website (see: www.health.auckland.ac.nz/comhealth/epiq/epiq.htm).

IMSANZ president Dr Ian Scott speaking with Dr Sue Rudge, President of New Zealand Rheumatology Association. (The NZRA/RACP/IMSANZ Meeting at Rotorua, Sept 3-6, 2003).

Helen Bevan (UK) and Paul Plsek (US) gave entertaining insights into the quality improvement transformation of the NHS in the UK over the last decade, led by the NHS Modernisation Agency. While this has been associated with a significant amount of new funding, this was conditional on fundholders achieving fundamental redesign and increased productivity of the healthcare system. Numerous case examples of practice improvement that derived from this outcome driven approach were provided, together with illustration of the organisational psychology and sociology underpinning change in large health care systems (see: www.modernnhs.nhs.uk/scripts/default.asp?site_id=10).

In the closing plenary, Don Berwick showcased relatively simple healthcare innovations in resource-poor countries such as Colombia, India and Russia, which had significantly improved the quality of care of common ailments such as hypertension and pneumonia, for millions of people. He emphasised that if the developed world was to emulate such successes, we needed to display the same level of clinical leadership and determination shown by those less fortunate than ourselves (see: www.ihi.org).

Prof Bruce Barraclough from the Australian Council for Safety and Quality in Healthcare led a workshop outlining the theory and practical application of open disclosure to patients of the occurrence and causes of adverse events related to healthcare, and what health professionals intended to do to prevent recurrence and help the harmed patient towards recovery (see: www.safetyandquality.org/ and click on “Open Disclosure Final Standard”).

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IMSANZ President Dr Ian Scott with Dr Rinki Singh, winner of IMSANZ Young Investigator Prize for her presentation on "Lifetime risk of carpal tunnel syndrome in Type 1 diabetes." (The NZRA/RACP/IMSANZ Meeting at Rotorua, Sept 3-6, 2003).

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There was discussion of a Victorian ICU Collaborative, describing the development and utilisation of trigger tools for detailed clinical review, which included haemoglobin fall of greater than 4 g/L in less than 24 hours; positive blood cultures 48 hours after hospital admission; blood glucose levels less than 3 mmol/l; and absence of bowel motions after 4 days of ICU admission. These tools are at an early phase but appear promising in providing useful benchmarking information across Intensive Care Units throughout Victoria.

Other presentations, which the authors attended, included:

- The methods and outcomes of the activities of the Brisbane Cardiac Consortium (part of the RACP-auspiced Clinical Support Systems Program [CSSP]), which targeted care of patients with congestive heart failure (see: www.health.qld.gov.au/bcc).
- An overview of the theory and applications of evidence-based practice and continuous practice improvement which underpinned the various CSSP projects throughout Australia, and the lessons learnt for informing design of future projects (see: www.racp.edu.au/cssp).
- Innovations to mortality and morbidity meetings, primarily re ecting surgical practice where a "surgeon only" meeting was rapidly changed to a multi disciplinary meeting.
- Description of both the strengths and weaknesses of the application of evidence based medicine principles to quality of care systems, particularly in the presence of an uncertain or deficient evidence base.
- A systematic review of differing methods for improving the quality of care of patients hospitalised with acute coronary syndromes, which showed that practice audit and feedback, compared with guidelines, pathways and process analysis, constituted the most consistently effective stimulus for practice change.
- A collaborative hospital study of the attitudes and barriers to incident reporting, showing that for nurses it was fear of reprimand while for doctors it was reluctance to be caught up in a bureaucratic process which compromised clinical autonomy.
- The efficacy of an on-line, small-group education program, which covers evidence-based practice and clinical guideline development, developed by Queensland Health and accessible to all 30,000 clinical staff.

The meeting was excellent and provided many ideas which could be readily applied to quality improvement processes within departments of internal medicine. Printed proceedings of the meeting should be available shortly and readers will be notified. Attendance at the 2004 Asia-Pacific Forum, which will be held in Canberra, is strongly recommended to all general physicians.

From an IMSANZ perspective, we might like to promote dedicated forums where successes or failures in quality improvement and system change, experienced by IMSANZ members, can be openly discussed. As asides, Bruce recently attended the Australia and New Zealand Society of Nephrology Meeting, which featured an excellent CPC presentation with clinical presentation, moderator and discussant, while Ian attended the last day of the Rotorua NZ-IMSANZ meeting at which Dr Andrew Bowers from Dunedin gave a provocative, step-by-step, evidence-based debate about how to manage transient ischaemic attacks, with vigorous audience participation. Both used a format which would work very well in future IMSANZ meetings.

There is great professional satisfaction and personal pleasure in envisaging better practice and then achieving it on a scale one would not have imagined possible. Please join us in these efforts and by doing so translate our individual achievements into mass action.

BRUCE KING
Nelson, New Zealand

IAN SCOTT
Brisbane, Australia

The RACP ASM 2004 Adult Medicine Scientific Program will provide an excellent opportunity for interaction between general and sub-specialist physicians from all areas of medicine in Australia and New Zealand. The program has been designed to provide the opportunity to present the current hot topics in controversial issues in each Society.

The greatest challenge for the individual at the ASM will be time management – how to maximize the opportunities to attend diverse sessions and obtain the greatest benefit. The stimulating program will expand the ability of each of us to be more confident in addressing the clinical issues faced by our patients and encourage us all to expand and nourish the "physician within".

The program will include issues in acute stroke medicine, indigenous health, heart failure, toxicology, addiction medicine, cognitive decline, sexual health and perioperative medicine.

Symposiums will be conducted by the specialist Societies covering topics relevant to their particular expertise - the Endocrine and Diabetes Society of Australia will cover diabetes, obesity and lipid disorders; the Cardiac Society will address hypertension, acute coronary syndromes and rhythm disturbances; the Haematology Society will address anticoagulation, neutropaenia and chronic anaemia; the Human Genetics Society of Australasia will expand on the challenges in genomic medicine; the Gastroenterology Society will consider liver disease and GI bleeding; and the Australian Society for Geriatric Medicine will discuss the needs of our ageing population. Infectious diseases, palliative care medicine, pain management, adolescent health issues, and renal disease and its metabolic complications will also be addressed. Issues such as medical assessment and planning units, and current controversies in health delivery will be discussed by IMSANZ and the HPU.

Clinical examination remains the cornerstone of diagnostic skill and the art of good medicine calls for a discerning eye. Do you want to know how good you are in Rapid Fire Clinical Diagnosis? The Clinical Quiz is a multi-disciplinary session to test your skills and will be a session not to miss! Attractive Prizes to be won.

The Annual Dinner will be held at the spectacular National Museum in Canberra. Dr Karl Kruszelnicki, the Julius Sumner-Miller Professor of Science in Sydney, will address the meeting. Dr Kruszelnicki is the Australian Father of the Year 2003 in recognition of his family pursuits, and his endeavours to popularise science in media presentations on radio and television are well recognised. He has promised to provide a witty address challenging many of our long-held beliefs

The Royal Australasian College of Physicians will be submitting a bid at the International Congress of Internal Medicine in Grenada in September 2004 to hold the ICIM 2010 in Melbourne on 15th – 20th March 2010.

Guest speakers at the Canberra 2004 meeting will be Professor Rolf Streuli, Secretary-General of ISIM (International Society of Internal Medicine) and Dr Charles Hind, President of ISIM, who will address the global issues of Internal Medicine.

We look forward to your attendance at the RACP ASM 2004, Canberra.

LES E BOLITHO
Member RACP & IMSANZ ASM Canberra 2004 Committee
IMSANZ ASM Adult Medicine Co-ordinating Committee

HELP WANTED!

Towards a National Database of Training and Career Opportunities for Trainees in General Internal Medicine

A number of advanced trainees have expressed their frustration at not knowing which hospitals out there are able to offer attractive training opportunities in GIM, especially in regards to subspecialty exposure. "I want to go to another hospital where I can get some hands-on training in doing this or that. But which one? How can I be sure it will be accredited? How good are the facilities and who's providing the supervision? What's the after-hours roster like? Have any other trainees spent time there and what did they think of it? Could spending time at this hospital give me a chance at establishing a career in the future if the area needs another general physician?" Fellows likewise complain: "If only our trainees knew what we could offer them and how we would support them if they wanted to come back as consultants and set up practice here."

In providing such information, IMSANZ is building a national database of hospitals which offer training opportunities for advanced trainees in GIM. We are inviting resident physicians to submit a profile of their local hospital using the following template adapted from that kindly provided by the Australian Society of Geriatric Medicine. Already, we have profiles on almost all tertiary and secondary referral hospitals in Queensland, as well as several from NSW, Victoria and New Zealand. Many thanks to those who provided this information. But we want national coverage on both sides of the Tasman.

We, therefore, invite all fellows outside Queensland to complete the **attached profile** and forward it to the IMSANZ secretary, Mary Fitzgerald, at 145 Macquarie Street, Sydney 2000 (fax 02-9247 7214) or e-mail her at imsanz@racp.edu.au if you prefer to submit the electronic version. A **sample copy** of the profile for Princess Alexandra Hospital in Brisbane is provided to assist you.

We hope to collate all profiles into folders and CD discs, for distribution at the Trainee Skills Day and the IMSANZ Jobs Expo that will be part of next year's RACP Annual Scientific Meeting in Canberra. With recent changes to college training requirements, that mandate basic trainees spending 6 months of their 12 months of core general training in a non-tertiary hospital, and gaining exposure to subspecialty rotations in their second 12 months, there is now the best opportunity, to date, for general physicians to attract basic trainees into their hospitals and show them the benefits of a career in GIM.

We urge you to support this initiative. State and NZ councillors will be in contact with members over coming weeks to ensure that all are aware of this project and to provide any assistance.

IAN SCOTT
On behalf of IMSANZ Council

Career Opportunities/Vacancies for Consultant Physicians in Internal Medicine

(Please forward completed form to The Secretary, IMSANZ, c/- RACP, 145 Macquarie Street, Sydney NSW 2000)

PRACTICE LOCATION
Details of Contact Person:
Address:
Phone:
Fax:
Email:
Description of vacancy/career opportunity (eg. type of practice; essential and preferred qualifications/skills/interest; patient load; rostering/AH cover/locum support; hospital appointments; junior staff support; income; CPD opportunities):
Description of living environment (eg population; geography; cultural, educational and recreational amenities):
Other information:

TRAINING SITES FOR ADVANCED TRAINEES IN INTERNAL MEDICINE

TRAINING SITE **NAME:**	
Head of Unit ***Contact Details:*** Phone: Fax: Email: Website:	Number of Training Positions: Duration of Accredited Advanced Training: Date of Most Recent Survey: Date of Next Survey:
Description of Service	
ORGANISATION: **Staff** - **Units** -	
DEMOGRAPHICS:	
Internal Medicine (IM) Beds:	**IM Specialty Interests/Special Units:**
IM Inpatient activity:	
IM Outpatient clinics:	
FORMAL TRAINING	
Lectures:	**Journal Club:**
Grand Rounds:	**Consult Rounds:**
Specialty Rotations:	
Research:	**Quality Improvement:**
TRAINEE RESPONSIBILITIES in Internal Medicine	
Coverage Roster:	**Workload in Internal Medicine units:**
Teaching responsibilities:	**Research/presentations:**
INFRASTRUCTURE	
Library: **Personal Email:** **Facilities:**	**IT:** **Director Physician Training:**

TRAINING SITES FOR ADVANCED TRAINEES IN INTERNAL MEDICINE

TRAINING SITE
NAME: Department of Internal Medicine, Princess Alexandra Hospital, Brisbane

Head of Unit
Dr Ian Scott FRACP MHA MEd

Contact Details:
Phone: 07-3240 7355
Fax: 07-3240 7131
Email: ian_scott@health.qld.gov.au
Website: N/A

Number of Training Positions: 6
Duration of Accredited Advanced Training: 3 years
Date of Most Recent Survey: 2000
Date of Next Survey: 2004

Description of Service

ORGANISATION:
Staff - 1 full-time director; 2 part-time specialists; 3 visiting medical officers
Units - 6 medical units of 12-15 beds each staffed by consultant, registrar and resident

DEMOGRAPHICS:
600 bed tertiary teaching hospital in southern Brisbane incorporating University of Queensland Southern Clinical School. Southbank Parklands, Convention Centre and Performing Arts complex nearby

Internal Medicine (IM) Beds:
80 beds (24% of all Div Med beds)

IM Inpatient activity:
3800 separations pa

IM Outpatient clinics:
5700 occasions of service pa

IM Specialty Interests/Special Units:
Clinical pharmacology
Acute stroke medicine (Acute Stroke Unit)
Geriatric medicine
Clinical epidemiology and health services research
(Clinical Services Evaluation Unit is affiliated with department and headed by unit director)

FORMAL TRAINING

Lectures: Specialty units have weekly tutorial program

Journal Club: Weekly

Grand Rounds: Weekly

Consult Rounds: 2 per week; daily informal contact

Specialty Rotations: 3-6 month rotations negotiable in:
Vascular Medicine, Hypertension, Renal medicine, Neurology, Infectious Diseases, Cardiology, Respiratory Medicine (with bronchoscopy experience)
Trainees in general medical units also participate in OPD clinics in Respiratory Medicine and Hypertension

Research: Active research program in health services research, evidence-based medicine, quality improvement science

Quality Improvement: Fortnightly mortality and morbidity meetings; monthly unit business meetings; weekly case conferences; extended care program for high-risk patients; nurse clinical facilitators

TRAINEE RESPONSIBILITIES in Internal Medicine

Coverage Roster: 1 in 4 to 1 in 6 after hours evening roster (4.30-10.30pm); single 8-hour week-end shift; no night duty

Workload in Internal Medicine units:
One 24-hour admission on-take per week with one in 4 week-end 24-hour on-take
2 ward rounds and 2 OPD sessions per week

Teaching responsibilities:
Yes, to junior staff/nursing/RMO/students

Research/presentations:
Bi-annual clinical audits; Grand Rounds presentation every 6 months

INFRASTRUCTURE

Library: Yes
Personal Email: Yes
Facilities: Registrar's room with security lockers

IT: 2 computer workstations, 1 PACS workstation in each 26 bed ward
Director Physician Training: Yes

SHOULD THERE BE RURAL PHYSICIAN NETWORKS?

A chance to "belong" and not just be a bunch of lone rangers!

The reasons for networking include:

1. facilitating postgraduate educational activities relevant to rural physicians;
2. offering a forum for informal communication between equals - sounding board, sharing of information or experiences, advice;
3. creating a numerically viable body to in uence policy direction and resource allocation;
4. giving identity and recognition that we exist, do good work, require support, and can contribute to relevant regional views in the rural debate over staffing, training, fund allocation, service coverage and best use of human resources;
5. giving a voice to the need for general medicine to be supported in rural practice - whether by recognition, upskilling or training opportunities, and by being centres of rotation from metropolitan hospitals;
6. giving us a chance to "belong" and not just be a bunch of lone rangers!

In April 2002 the Rural Forum convened by the RACP was held in Shepparton, Victoria. In March 2003 the General Medical Forum was convened by the RACP and was held in Sydney.

Out of both meetings came an understanding:

1. that all physicians, whether in single system/organ specialities or general medicine, should embrace the "physician within" and not become solely experts in a limited field;
2. that rural Australia is woefully undermanned;
3. that a lot of places depend on overseas staffing because potential local candidates opt for urban positions because of putative disadvantages in embracing the rural rather than the tertiary institution, lack of rural resources, and active discouragement from "disappearing" into the country and out of the eyes of major metropolitan hospital grand rounds and university Department of Medicine meetings;
4. that apart from the VRPN (Victorian Rural Physicians Network) most states lack a practical network of rural physicians to maintain a sense of cohesiveness, offer any corporate or collegial existence or to enable co-ordination of cost-effective programmes for support, post-graduate education, and sharing of information and experiences;
5. that the RACP needed to give more than lip-service to the issue of "rurality" - hence the revamping of the rural task force to task oriented work.

The first job is to increase our awareness of other rural physicians and our shared issues.

The second is to connect all physicians in all States, by a rural newsletter.

Thirdly, to offer you all the opportunity to tell us how we are to "get together" and what each of you want of the network or if you want one at all.

And lastly, the VRPN should speak to us all, as to the benefits of grouping ourselves - this is not yet another committee or organisation but rather RACP fellows linked by a common need.

Please think about this, and any ideas you have would be much appreciated.

KENNETH NG
Kalgoorlie, WA

IMPORTANT NOTICE

There has been a **change** in the timing and venue for the **2004 RACP Joint Meeting** with TSANZ, IMSANZ, and ASID in Christchurch.

The revised dates are **3-6 August 2004** and the venue will now be the **Hotel Grand Chancellor Christchurch**.

This is different from what was previously promoted.

If you are planning to attend please make sure you change the date in your diaries.

We would like to see as many of you there as possible.

ICIM 2010

The RACP and IMSANZ will be submitting the bid to hold the ICIM 2010 in Australia to the ISIM Congress in Granada in September 2004.

Les Bolitho met with Prof Jaime Merino, President of European Federation of Internal Medicine in Alicante. EFIM has 35,000 members who are general internists / physicians in 28 European countries - the subscription fee is only 1 Euro each!

Les also met with the Director of the Granada Congress Centre, Luis Candal, and Prof Blas Gil Extremera, President of the Spanish Internal Medicine Society, and Chair of the ICIM 2004 in Granada.

Granada is an exciting place with many interesting areas including the Alhambra, Albayzin and Sacremonte, and it is close to the Sierra Nevada and Mediterranean coast. The Granada meeting should be most interesting and IMSANZ members are encouraged to attend.

FORTHCOMING MEETINGS

2004

2004

March	**Cardiac Intervention and Wilderness Medicine** *March 2-12 ~ On board 'The Peregrine Mariner' in Antarctica* Information: http://www.peregrine.net.au/pdfs/MEDICAL_CONF.pdf
April	**IMSANZ New Zealand Meeting** *April 8-10 ~ Nelson*
May	**Society of General Internal Medicine Annual Meeting** May 12-15 ~ Sheraton Chicago Hotel and Towers, Chicago
	RACP Annual Scientific Meeting *May 17-19 ~ National Convention Centre, Canberra, ACT* Website: http://www.racp.edu.au/asm/index.htm
	The Greek Conference 2004 *May 23-29 ~ Rethymna Beach Hotel and Resort, Crete, Greece* The Greek Conference will have a strong medical theme, with participation from Professor Peter Doherty, the 1996 co-winner of the Nobel Prize; Professor Spyros Marketos, past president of the World Hippocratic Society of Kos; Emeritus Professor Gabriel Kune, IVF pioneer Dr John McBain, cardiac surgeon Jim Tatoulis and others. For further details, please visit the website at www.greekconference.com.au or contact our Conference Secretariat on www.ospreyconsulting.com.au
June	**ASMs of the Canadian Society of Internal Medicine and the Association of Internal Medicine Specialists of Quebec** *June 2-5 ~ Hilton, Quebec City, QC* Information: Canadian Society of Internal Medicine 774 Echo Drive, Ottawa, ON K1S 5N8 Tel: 613-730-6244; Fax: 613-730-1116 Email: csim@rcpsc.edu Website: http://csim.medical.org
August	**RACP New Zealand Annual Scientific Meeting** *August 3-6 ~ Christchurch* In conjunction with IMSANZ, the Thoracic Society and the Infectious Diseases Society
September	**International Congress of Internal Medicine (ICIM)** *September 26 - October 1 ~ Granada, Spain*

IMSANZ NEEDS YOU IN ENSURING A BETTER FUTURE FOR GENERAL INTERNAL MEDICINE

"Who or what is IMSANZ and what does it do?"

I hear this question not infrequently when I move among my colleagues, including some I thought would already know the answer. As general physicians, we sometimes encounter confusion in the minds of other health care professionals, government bureaucrats, and the public as to what it is we actually do. People seem to be more certain of what a cardiologist or gastroenterologist does, and are more likely to have heard of the Cardiac or GE Society.

The voice of general medicine is at last being heard...

Since its inception in 1992, IMSANZ has put considerable effort into defining and publicising the role and attributes of the general physician, and advocating the cause of General Internal Medicine (GIM) in the corridors of power in both government and college circles. Many recent events indicate that the voice of general medicine is at last being heard - the convening by the college of the General Medicine Forum earlier this year, the RACP invitation to IMSANZ to plan and organise the annual scientific meetings in 2003 and 2004, the public admission by the college president Robin Mortimer that general physician care was being lost, to the detriment of patients (RACP News From the President 2003), and the current review of the college training program with a view to including more general medicine in the advance training program of all specialties.

In supporting these moves and in strengthening our voice in setting the future agenda, we need, now more than ever, to marshall the full resources of a large, vibrant and committed community of general physicians. There are approximately 4,500 fellows in the college, of whom almost 1 in 3 indicate in workforce surveys that they practice, at least partly, general medicine. General physicians comprise one of the five largest specialty groups within the college fellowship. In contrast, the current membership of IMSANZ is only 420, or roughly a third of all those who practice GIM. This compares with other specialist societies, which boast coverage of more than 80% of eligible members.

Why such a low membership rate? Possible reasons include: ignorance of IMSANZ; disenchantment with the activities or philosophy of IMSANZ; uncertainty as to what IMSANZ has to offer; and reluctance to pay yet another membership fee (particularly after paying your indemnity premium, AMA fees, college fees and any other specialty society fees!). Whatever the reasons, we need to reverse them, and in doing this, I am asking you, our valued current members, to do what you can to reach out, engage and recruit all those with an interest in general medicine who might share our vision. In doing this we stand to enrich ourselves in the process.

I respectfully offer some suggestions:

1. Speak to your colleagues. Identify those who are not members, and ask them - have they thought of joining IMSANZ? If no, then please recount your own reasons for joining and your view of the ensuing benefits; if yes then ask them why they refrained from doing so, and feedback the reasons to us (anonymously if you prefer) so we can try to reform whatever may be seen as obstacles. Of course please feel free in such instances to persuade your colleague to reconsider if you feel he/she has been misinformed, or has developed erroneous perceptions, of the functions of IMSANZ. In this issue of the newsletter I enclose a yer and a revamped application form that you may like to use to entice your colleague to join. (Please feel free to make photocopies or e-mail Mary Fitzgerald at imsanz@racp.edu.au for more hard copies).
2. Convene local or regional networks of general physicians. Meet, teleconference or e-mail regularly; discuss both clinical and professional issues; perhaps start a local journal club or 'case of the week' chat group; organise occasional workshops or symposia; strike up a partnership with leaders in general practice and the general community. The rural physician networks that exist in Victoria and NSW and which are currently being formed in SA, NT and WA, together with the North Queensland Physicians Group, are great examples of the value of this form of professional (and social) interaction. If you live in southern Queensland, Tasmania or the ACT, talk to your state councillors about getting one going?
3. Look at how your network could act in, assist in local community health policy-making or collaborative research projects; advertise job vacancies that might be available and help IMSANZ build a national register of professional opportunities; assist your local hospital in gaining as much accredited time for basic and advanced physician training as possible; welcome trainees to local meetings and social events and discuss with them the advantages of being a general physician.
4. Finally, demonstrate the passion you have for your craft and let us hear your voice (even if you think we may not want to hear it!). Pen that letter to the editor you've been meaning to send for the last 12 months, contact me or any of the councillors about issues you feel strongly about, share with us innovative changes in practice (even those that did not work as well as you might have liked) or those occasional pearls of wisdom that beg wider application.

This is a critical time for IMSANZ and for general medicine, and I thank you for any support you can provide. Let me finish with this quotation slightly paraphrased from that of a famous figure in history: "Ask not what your society (IMSANZ) can do for you but what you can do for your society."

IAN SCOTT

FROM YOUR PACIFIC CORRESPONDENT

Bula Vinaka from Fiji

This letter, and the ones following (if they eventuate), arose from a conversation I had with Peter Greenberg at the recent College meeting in Hobart, the program for which, of course, was largely put together by IMSANZ.

Not surprisingly, he asked how things were going in Fiji, and I immediately launched into my usual spiel about what a fulfilling combination it was of fascinating clinical medicine and teaching of enthusiastic undergraduate and postgraduate students. I then also mentioned that, like all good things, it also has its down sides. But before I got the chance to go any further, he said "Why don't you write about it for the IMSANZ newsletter?" It seemed like a good idea at the time, as the saying goes. And it still seems like a sufficiently good idea that here is my first go at trying, albeit from a privileged academic viewpoint, to give IMSANZ members a feel for the fascinations, and frustrations, of practicing and teaching internal medicine in Fiji.

There are two issues at present particularly exercising our minds, so it is logical to commence with them.

The first is that we are constantly losing our good graduates to make up the shortfall of well trained doctors in rural Australia. So much so, that a sign recently mysteriously appeared outside the Fiji School of Medicine saying "Welcome to Australia's off shore School of Medicine." Perhaps it could also have said "A donation from Fiji and the Pacific Islands to the poor people of rural Australia."

When one considers that the GDP per head of population in Australia or New Zealand is more than ten times that of Fiji, and Fiji is the most prosperous of the small Pacific Island countries, it seems obscene for such rich countries to be actively recruiting the few professionals the poor countries are able to train. Yet what right do we have to hinder the aspirations of our graduates to better themselves financially? Particularly when it is rumoured that some of the Pacific Island governments actually want their medical graduates to work in Australia or New Zealand because the money they repatriate is a major source of foreign exchange.

There are important curriculum questions arising from this brain drain - at both an undergraduate and a postgraduate level. For instance, should we deliberately develop a curriculum which will make our graduates less attractive to overseas employers? The Fiji School of Medicine curriculum, quite appropriately, already strongly emphasizes Pacific Island public health issues, and formal public health teaching takes up much more time than in most, if not all, medical schools in Australia or New Zealand. However it has been suggested we should deliberately expand this emphasis on public health, at the expense of generic clinical skills. The case has largely been argued on the need for practitioners in Pacific Island countries to have increased public health skills. However a "hidden agenda", albeit perhaps an unconscious one, is undoubtedly also to reduce the clinical skills of our graduates, thus making them less attractive to overseas employers.

Some of us have argued against such a cynical approach, but there is no doubt we are in a nasty Catch 22 situation - the better we clinically train our graduates and postgraduates, the more attractive they become to embattled medical directors of country hospitals in Australia and New Zealand desperately trying to fill essential resident and registrar positions.

There is obviously no clear solution to this problem. However a few facts are clear. Fiji and other Pacific Island countries will never be able to compete financially for medical graduates with Australia or New Zealand. Also, even if Australia and New Zealand were to increase immediately their training of sufficient doctors to meet their future needs (which seems unlikely), they will need to attract doctors from overseas for at least the next 10 years to meet their shortfalls. So Pacific Island countries will have to devise other attractions to keep their graduates.

Unfortunately there is not the political will in the Pacific at the moment to really tackle the problem. Politicians bemoan the loss of doctors (and other health professionals), but their answer is to appeal to their sense of patriotism and duty, rather than to look at ways of making them feel they are really wanted and needed. Doctors are public servants in the Pacific, and they are still treated as such – at the beck and call of the Ministry – and it will require a sea change of thinking for doctors to be treated differently. Perhaps the politicians should visit Rockhampton, or Shepparton, and talk to the medical administrators there. Then they might get a better idea of how to go about trying to develop packages which doctors will find attractive.

Thinking of attractive packages leads me on to the second issue at present exercising our minds over here. And that is how to fill the FSM senior lecturer position in internal medicine at Lautoka, which will become vacant at the beginning of next year. It is at present filled by John Hunt, who has taken long service leave from Western Hospital in Melbourne and from his private practice in respiratory medicine. However, John has to return to Melbourne at the end of the year, so we are looking for a replacement.

The position is one of only two in internal medicine at Lautoka, which is rather frightening, considering that Lautoka hospital is the main hospital for the west of Fiji. So it serves a population of about 250,000, including most of the tourist resorts. However, that is also one of the great attractions, in that the clinical experience is second to none. There are no subspecialists in internal medicine at all in Fiji, so the physicians have to look after all medical problems, from acute leukaemia, to myocardial infarction, to TB meningitis. And all this without a CT scanner (the only scanner in Fiji is in Suva), or many other diagnostic supports. Yet peer support is available in Suva, and the essential drug list contains nearly all the drugs required to care more than adequately for most patients.

The academic component of the position is to be responsible for, and supervise, the internal medicine rotation of the 6th

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AWARDS AND SCHOLARSHIPS

2004

IMSANZ Travelling Scholarship

Purpose: To contribute towards the cost of airfares, registration and expenses to attend a major international meeting relevant to the discipline of Internal Medicine. Examples include: 1) annual scientific meetings or schools of the European Federation of Internal Medicine, Canadian Society of Internal Medicine and Society of General Internal Medicine (US); 2) Asia-Pacific or European Forum on Quality Improvement in Healthcare; 3) Scientific Basis of Health Services Meeting or Cochrane Colloquium; 4) annual meetings of the International Society of Heath Technology Assessment or Association of Health Services Research.

Value: $A5,000

Eligibility: Advanced trainee or fellow of the Royal Australasian College of Physicians of less than 5 years duration, who is a member of IMSANZ. Successful applicants will be required to explain how attendance at this meeting will be used to enhance the practice of Internal Medicine and to provide a 1,000 word summary of the meeting attended for publication in the IMSANZ newsletter.

IMSANZ Research Fellowship

Purpose: To provide support for an advanced trainee or younger fellow to undertake a higher research degree (Masters, MD or PhD) in clinical epidemiology, health services research, quality improvement science, or a related field.

Value: $A10,000. The fellowship is a total amount that is paid on a pro rata basis for the duration of enrolment in the research degree.

Eligibility: Advanced trainee or fellow of the Royal Australasian College of Physicians of less than 5 years duration; membership of IMSANZ; and enrolment in a higher research degree at a University in Australia or New Zealand.

IMSANZ Award for Best Scientific Publication in Internal Medicine

Purpose: To recognise and promote the undertaking and publication in a peer-reviewed journal of original research relevant to the practice of Internal Medicine.

Value: $A2,000

Eligibility: Advanced trainee or fellow of the Royal Australasian College of Physicians; membership of IMSANZ; and publication of research in one of a list of selected peer-reviewed clinical journals.

IMSANZ Excellence in Clinical Education Award

Purpose: To recognise and promote excellence in clinical teaching and education.

Value: $A1,000

Eligibility: Advanced trainee or fellow of the Royal Australasian College of Physicians; membership of IMSANZ; and nominated by peers to receive award.

Application Process

Applications or nominations for these awards will be sought 6 months prior to the annual general meeting of IMSANZ in the year the awards are to be granted. Whether any particular award will be offered in any particular year will be at the discretion of IMSANZ Council in terms of quality of applications and/or availability of funds. Guidelines for applications will be available from the IMSANZ secretary and will be in accordance with those issued by the RACP Research Advisory Committee. All applicants will be required to: have IMSANZ membership; provide referee contact details; be available for interview if required; and list relevant academic record, publications and appointments.

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(final) year medical students doing their student internships at the Lautoka hospital. The students spend half of their final year (ie 18 weeks) at Lautoka hospital rotating through the major disciplines of internal medicine, surgery, paediatrics, and obstetrics and gynaecology. A senior lecturer is responsible for each of these rotations.

The cost of living is relatively low in Lautoka, so the salary, although low by Australian or New Zealand standards, is well sufficient to maintain a reasonably comfortable life style. Facilities like internet connections (provided through the School of Medicine) are quite reasonable, and the weather in the west of Fiji is fantastic – it is no coincidence that the tourist resorts are mostly nearby. The contract is for three years, but can be varied if necessary, as it was for John Hunt. So, how about it IMSANZ members? Think about it!

Anyone interested can contact either me or John Hunt, and I'm sure Mike Lowe, who preceded John over there, and is now at the Darwin Hospital, would be happy to talk to anyone who might be interested in the position. John and my e-mail addresses are j.hunt@fsm.ac.fj and r.moulds@fsm.ac.fj respectively. My phone number at FSM is (679) 3311700, ext 1907.

So that brings me to the end of my first letter from Fiji. I hope it has given you a taste of what the life of an IMSANZ member is like over here, and might even have whetted your appetite for more.

Vinaka vakalevu and moce mada.

ROB MOULDS

CALL FOR ABSTRACTS

Guidelines

IMSANZ Scientific Presentations
RACP Annual Scientific Meeting
Tuesday 18th May, 2004 - 11.00 am to 12.30 pm
National Convention Centre, Canberra

Abstracts are invited from fellows and advanced trainees to present at the IMSANZ Scientific Presentation session of the 2004 RACP ASM. This is a great opportunity to present a paper and for advanced trainees to be considered for the IMSANZ/Roche Advanced Trainee Award of $1,000 for the best advanced trainee presentation. The presentation will also be an asset to your CV/portfolio.

If you are interested in submitting an abstract, please adhere to the following guidelines. Oral presentations should be timed to be no more than 12 mins with 3 mins discussion.

Abstract Guidelines

Abstracts should be original research. Case reports may be acceptable although the onus is on the author to demonstrate the significance of the report.

- Maximum 300 words - word count should include:
  Title
  Authors/Presenters
  Institution/City/State/Country
  Body of Abstract
- Text should be single spaced with justified margins
- Arial or Helvetica font, 11 point
- Your abstract should contain the following:

1. *Title* - Upper and lower case and bold.
2. *Authors/Presenters* - Upper and lower case. Show surname and then initials only. Title, degrees and awards should not be included. The name of the presenter should be indicated by an asterix.
3. *Institution/City/State/Country* - Upper and lower case, italics. (Authors from outside Australia and New Zealand are requested to include country.) Note: Leave one line space before the next item.
4. *Body of abstract* - Upper and lower case. Text only, no graphics, diagrams or illustrations. Analytic studies should include the following headings, in bold:

   Introduction, including the study hypothesis
   Method statement
   Results, including statistics
   Conclusions reached and their significance. It is not satisfactory to state, "results will be discussed" or "data will be presented".

- Abbreviations may be used but must be spelt out in full at the first mention and followed by the abbreviation in parentheses.
- References (maximum of four).
- Abstracts must be saved as Microsoft Word documents

For a sample of an abstract please refer to the 'sample abstract' at: www.racp.edu.au/asm/abstracts/regulat.htm.

Abstracts should be forwarded to either Dr Ian Scott (ian_scott@health.qld.gov.au) or Dr Phillippa Poole (p.poole@auckland.ac.nz)

Closing dates for abstracts is Monday 23rd February, 2004

Successful applicants will be notified by return e-mail or surface mail (ensure you enclose a return address) and will be required to register to attend the conference (day registrations are available).

We look forward to receiving your abstract.

IAN SCOTT
President IMSANZ

PHILLIPPA POOLE
Vice-president IMSANZ

Secretariat Changes

Cherie McCune retired from the IMSANZ Secretariat at the end of June 2003. **We wish Cherie a very happy retirement**.

Mary Fitzgerald has replaced Cherie at the Secretariat.
A warm welcome is extended to Mary.

REFLECTIONS AFTER A KIWI'S HOLIDAY IN VICTORIA

Snow gums in Kosciusko National Park (Courtesy of Phillippa Poole).

After a busy few months and a long dreary winter, the promise of a good break was very appealing as husband Paul, daughter Sarah, and I left Auckland for eleven days in Victoria. The itinerary included participation in several major orienteering events, with the prospects of exploring the national parks at Mts Kosciusko and Buffalo, in between. Orienteering (the "thought sport") requires expert and fast navigation over all types of terrain, with races designed to be won in 60 minutes or less. To win requires a combination of physical fitness and mental skills, particularly map interpretation, giving the opportunity for the more cunning and slower of us to at least be competitive! Novel challenges of the Australian bush, for Kiwis, are granite boulders, termite mounds, sprawling gully/spur terrain and, at times, the wildlife.

Cultural immersions in Melbourne, at each end of the trip, were separated by stays at Bendigo, Beechworth, Jindabyne and Bright. We particularly liked Echuca and Beechworth. Neither have an airport (pity, as this may limit their consideration as sites of a future IMSANZ meeting), but both have a historic Beechworth Bakery! Echuca has the Murray River paddle steamer culture and some good eateries; Beechworth houses a stunning collection of old historic sandstone buildings. Highly recommended, is a stay in the gorgeous grounds of the old lunatic asylum, now the La Trobe University hotel school.

We were a little ambitious after a race in the rocks of Mt Kooyoora - heading east with the aim of reaching Jindabyne through Dead Horse Gap by nightfall. It was, after all, only about 600km, and Kiwis believe all Aussie roads are straight and fast. Our Melbourne-based friends looked at us as if we were mad. We should have listened to them!

Seemingly endless at wheat-fields were punctuated by bright yellow fields of canola; a lattice of roads and small towns led to surprisingly big centres such as Shepparton (pop 45,000), the home of the University of Melbourne Rural Clinical School. The Hume Highway snaked into Ned Kelly country, and we passed the Wangaratta exit with a mental wave to Les Bolitho. Although it was now dark, we saw the sign stating that Corryong was the town where they buried the Man from Snowy River. A sign at Khancoban indicated that chains were required, but the shop was now closed. "Never mind" we reassured ourselves, "if it snows we will turn back". In NZ the road would be closed, or else cowboys come and fit chains for you at an exorbitant price!

We slowly climbed, seeing two other cars in two hours. Snowdrifts lined the side of the road, but there was clear tarmac ahead and, fortunately, no black ice. The tense feeling in the car indicated that we had all underestimated the Australian Alps. With relief, we made it over Dead Horse Gap, and the tension dissolved into squeals of delight as a wombat ambled down the road in front of us. Down past Thredbo and safely into our cabin at Jindabyne by 10pm. Three cm of snow fell that night, creating an impressive contrast with the many hectares of trees blackened from the recent fires.

The orienteering was great; however, we didn't beat the Aussies this time (we never do on their home ground). There were some personal highs, if not medals, and an easy summit of a snowy Mt Kosciusko. As we ew home across the "ditch", the medical wards on which I work were being moved into the new Auckland City Hospital - allegedly now the largest hospital in the Southern Hemisphere. A new roster of 12 full general medical teams was being rolled out, as was John Henley's new state of the art 45 bed Admission and Planning Unit. Minor teething problems excepted, the new hospital is quite amazing. What a welcome home!

So how does my holiday relate to IMSANZ?

As most of you know IMSANZ was formed from the respective national bodies in 1997 to serve the needs of general physicians in Australia and New Zealand, both urban and rural. My anecdotes, and more objective comparisons between Victoria and New Zealand, provide a context for considering the similarities and variations that IMSANZ has to keep in mind as we continue to develop.

The population of Victoria is 4.7 million compared with New Zealand's four, but New Zealand is slightly larger in area (268,000 versus 227,000 km2). Like Victoria, New Zealand has one huge city (Auckland) with a series of smaller ones, and there are two medical schools. Australia is wealthier - borne out by the 2003 GDP figures (all AUD) of $34,000 per capita in Australia versus $29,000 in NZ. The differences in health funding models make direct comparisons difficult, but the gap in health spending is even greater than in the GDP. One recent comparison (in AUD) has Australia spending $2,430 and New Zealand, $1,648 (figures from www.nationmaster.com) per person per year.

However, we all know that money isn't everything where general medicine is concerned, and that lifestyle, partner's jobs, kids schooling and the likelihood of locum relief are very important. Rural Victoria, and NZ, are still pretty idyllic places to live and bring up kids, yet we still both have difficulty with recruitment and retention of physicians. Both countries are addressing this problem with an increase in rural origin students accepted into medical schools, and in more undergraduate rural attachments, two measures shown to improve rural workforce numbers. To

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IMSANZ New Zealand Meeting

NELSON, April 8-10, 2004

First Announcement

INTERNAL MEDICINE SOCIETY OF AUSTRALIA & NEW ZEALAND
IMSANZ
"All Systems Go"

Thursday 8 to Saturday 10 April 2004

- Program Proposal
- Beating the Bugs – Chemistry and trickery
- Workload symposium – how much is too much?
- Acute care - selected topics
- Controversies - (this may mean YOU)
- Members free papers include Quality improvement activities
- Young Investigator presentations Annual meeting IMSANZ NZ
- Cocktails at W.O.W!
- Imsanz dinner

Plus opportunity for much more –

- Kayak the Abel Tasman
- Bike in the Nelson ranges
- Fish the local streams for trout
- Sample the extensive range of high quality local wines
- Please come and stay the week-end.
- Bruce King for the local team.

- This meeting will be the first without the organisational and fiscal support of GSK who have withdrawn from sponsorship relationship with IMSANZ. As a result there may be a similar registration fee to previous meetings for less or a higher fee dependant on levels of other sponsorship.
- As always there is intent to involve local staff and members as presenters with options in Controversies and Members presentations including Quality improvement activities. We are all involved in the latter and can learn from successes and failures of others!
- There will also be a greater emphasis on individual responsibility in ights and accommodation. I hope to have links to facilitate this and to provide for recreational bookings to fill the remainder of the weekend.
- Please book the time now and come and participate.

bruce.king@nmhs.govt.nz

REFLECTIONS OF A SENIOR GENERAL PHYSICIAN

I am a rural general physician with ongoing academic and research activities both local and international. I still frequently travel overseas as an invited speaker. I have worked in New Zealand, Australia, England and Hong Kong, and took up rural medicine as a deliberate challenge 4 years ago after returning to Australia from a period as professor at Hong Kong University. As I have a somewhat different background and perspective to many general physicians I felt I should contribute.

The biggest problem where I work is who will replace me when I retire from rural practice (within 2-3 years). We need general physicians in rural cities and if they have a special interest, as I have, that is fine. I have worked in a very narrow subspecialty as well as in general medicine and I am concerned how narrow some of my subspecialist expertise is already.

We need more General Physicians urgently!

We need to have most registrars, during their basic training, rotating through our rural hospitals. They would get excellent experience. In Victoria, only St Vincent's and Royal Melbourne contribute substantially to rural medical registrar rotations and they are concerned that this may deter registrars from applying to their hospitals.

We get by with overseas trained doctors as registrars. A few would be capable of undertaking RACP training programs but the immigration and registration systems beat them so they become GPs. One I had recently was top of her class in Iraq. We should see if we can recruit these individuals into our RACP training and make this clear to government as need be. I know of some excellent overseas trained surgeons in the same catch 22.

Other overseas trained medical registrars have no interest in learning or do only the minimum to satisfy the immigration authorities, so the consultant ends up doing a lot of the work the registrar should do. The challenge and interactive education obtained from having an RACP trainee is lost in that case. For me, and my recently arrived physician colleague, this may be what will make us leave our present positions, which we otherwise enjoy.

Continuing professional development is laudable, but remember that after working long hours, especially in rural areas, we need evenings and weekends to recharge and for life outside medicine. We are overburdened from every angle by government and regulatory bodies already, and the college must not add excessively to this burden. Our junior colleagues are already working restricted hours while older specialists rarely have this possibility. We are reaching the point where the straw will break the camel's back.

Finally, each specialist, including the rural specialist, has quite different individual ongoing professional development needs and often has particular interests outside their obvious duties. These activities often sustain them, as work can be repetitive.

I hope IMSANZ members find these comments useful, and I look forward to future discussions.

EDWARD JANUS
Horsham, Victoria

(From Page 17)

date, there have not been rural clinical schools established in NZ as there have been in Australia. We watch with interest such initiatives as the recent $6 million boost to the funding of the Rural Clinical School at Shepparton, to see whether they deliver.

Despite (because of?) New Zealand's relative poverty, general medicine as a specialty remains well established in most major centres. The vast majority of advanced trainees complete at least 12 months of general medicine during basic training. There are over 70 advanced trainees in general medicine, representing almost 40% of all New Zealand advanced trainees. A large subset of the advanced trainees are dual training by choice. IMSANZ (NZ) mounts at least 2 meetings per year (in addition to the full college RACP ASM). In recent years, one of these has been a joint meeting with RACP (NZ). There is, however, increasing difficulty in attracting sponsorship for these, because companies are withdrawing because of the government's stringent medicine funding policies.

IMSANZ is now at a critical juncture. The momentum from the efforts of the original leaders and the 2003 General Medicine Forum must be consolidated and sustained. In addition, there are two very big challenges in front of us right now – namely, to effectively lead the RACP annual scientific meetings, and to inform the RACP training debate. We are currently thin on the ground in terms of people with passion, skills and time to do this, and have only Mary Fitzgerald in the secretariat. Because of this, we need to ensure that initiatives undertaken are well evaluated, so that we neither overextend ourselves with unsustainable commitments nor erode fragile gains already made. Efforts on behalf of the whole college must be recognised by the RACP.

Particular strengths of IMSANZ include our diversity, enthusiasm, broad-mindedness, and responsiveness to change. Harnessing these and moving forward requires a sense of collectiveness that can only be developed through communication and ongoing debate with members on both sides of the Tasman, whether urban or rural. However, that collectiveness and any solutions must respect the range of training, work and life experiences of the whole membership. Specific solutions for one region may not fit all, no matter how appealing this approach may be.

Enough philosophising - I'd love an opportunity to come back to rural Victoria - perhaps in the context of a combined Australia / New Zealand IMSANZ meeting in late 2005, or who knows - even to locum some day? I know the holiday was just what the doctor ordered.

Best wishes,

PHILLIPPA POOLE
New Zealand Vice President IMSANZ

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 three times a year - in April, August and December.

We welcome contributions from physicians and advanced trainees.

Job vacancies and advertisements for locums can be published.

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

Tell us what you want!!

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

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

Submissions should be sent to either:

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Michele Levinson - michelel@bigpond.net.au

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

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