IMSANZ
INTERNAL MEDICINE SOCIETY *of Australia & New Zealand*

Secretariat
145 Macquarie Street
Sydney NSW 2000
AUSTRALIA

Telephone
+ 61 2 9256 9630

Facsimile
+ 61 2 9247 7214

Email
imsanz@racp.edu.au

Website
www.racp.edu.au/imsanz

From the President...

Dear IMSANZ Members,

The last three months have been interesting times in college politics as far as IMSANZ is concerned.

Aftermath of the General Medicine Forum

In January we saw the release of the long awaited college report from the General Medicine Forum held in March 2003, the main points of which are discussed later in this issue. At about the same time, the college Workforce Taskforce presented its interim report to college council outlining current shortfalls in physician supply and suggestions as to what the college should do in response. Both reports are notable in that while both refer to the option of training more general physicians to redress undersupply of physicians in regional and rural areas, both shy away from stating an unequivocal resolution that the college mandates the establishment of general medicine units in all teaching hospitals and commits itself, by reforming the training program, to graduating more general physicians.

Resurrecting general medicine in Sydney teaching hospitals

At the Specialties Board meeting of December 2003, when the General Medicine Forum draft report was being considered, I proposed that the Board unanimously endorse the resolution of resurrecting departments of internal medicine in all teaching hospitals in Sydney (which currently have none). I regret to report that this motion failed, although there were pockets of support. Replies ranged from the politically sanguine: "There are alternative models of providing acute care in general medicine" (if so, what are they and could they also apply to other subspecialties?) to the more provocative: "Is there any evidence to suggest that care has worsened since the general physicians left?"

I would suggest that a reading of the recent NSW Health Care Complaints Commission (HCCC) inquiry into poor care at Camden and Campbelltown hospitals in outer Sydney (available at www.health.nsw.gov.au/pubs/i/pdf/invstign_hccc_2.pdf) indicates what happens when general services in medicine, surgery, emergency care and intensive care are not properly supported in secondary referral hospitals by both colleges and health authorities. Lack of properly qualified full-time specialist staff, combined with poor supervision of junior staff, paucity of protocols and standardised procedures, absence of peer

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support and referral capacity involving neighbouring tertiary hospitals, and hospital management obsessed with budgetary bottom lines were the key factors for the appalling lapses in care revealed by investigation of 47 separate incidents from 1999 to 2002.

Substituting sub-specialists for general physicians in Sydney hospitals

The situation in Sydney in regards to general medicine is precarious and getting no better. IMSANZ is reliably informed that subspecialists with little or no post-FRACP practice in general medicine are being appointed to general medicine consultant positions in teaching hospitals, with college letters attesting to their having an FRACP. It is argued that, in most cases, no general physicians applied for these positions, but one wonders to what extent the past history and current professional cultures existing in these institutions are strong disincentives to general physicians applying. No-one wants to work in an institution that makes you feel unwelcomed. These appointments also demonstrate a double standard in that the converse would never be allowed i.e. a general physician with an interest and procedural skills in, say, cardiology being appointed to a position in cardiology. I have written to the NSW Director-General of Health expressing our concern at these appointments and inviting discussion, and am currently awaiting her reply.

Reforming the College education and training program

The next big event has been the release of the 111-page Education Strategy discussion document related to improving the current college training and CPD program. Despite the verboseness of the obligatory mission statement, rationale, principles and philosophy, the specific areas of training that need change, and the action plans developed to bring this about, are worthy of careful consideration. My reading of this document, and one shared by others on IMSANZ Council, is that the central issue of how these changes will impact on workforce, in particular ensuring the graduation of more general physicians, has not been clearly articulated. Also, the timelines for achieving certain reforms seem very ambitious and it is difficult to see how everything proposed can be done without major input of man-hours and resources from the college and special societies. However I should add that as a society IMSANZ is prepared to be a constructive player rather than a disengaged critic. IMSANZ has convened a Curriculum Writing Group (described elsewhere in this issue) which aims to define the particular knowledge, skills and attributes needed of a trainee to practise general medicine.

The case for dual training and dual certification

Both the General Medicine Forum and the Education Strategy documents place emphasis on the concept of upgrading generalist skills of all physicians regardless of primary specialty, of nurturing 'the physician within.' While IMSANZ regards this concept as worth exploring, it will not grant it legitimacy in the absence of a training program that promotes dual training and certification in general medicine and a subspecialty – a program in which the training component in general medicine has depth and rigour sufficient to ensure that trainees acquire the skills and competencies necessary for independent practice as a general physician.

We will not accept tokenism in this regard. UK trainees receive separate accreditation in both their speciality and general medicine. This ensures a minimum standard of competency. Australia and New Zealand must do the same and require certification of all those who wish to practise as general physicians which confirms the trainee has fulfilled specified requirements of training in general medicine. This will prevent subspecialists practising or locuming in general medicine when they are not competent to do so. Accordingly, subspecialist trainees aiming to practise in general medicine must be assessed not only by their subspecialty SAC but also by the SAC in General Medicine.

Watered-down 'optional extra' approaches whereby a trainee can practice as a "subologist and general physician" following a program where the majority of time in advanced training is still reserved for a single subspecialty, but which includes a brief (6-12 month) period spent in one or two 'related specialties,' will not be acceptable. If you are to be certified as capable of providing services as a general physician, then you will need to undergo the proper level of training in our discipline, and the view of IMSANZ on this is non-negotiable.

The ability of the college and, more particularly, the Specialties Board to endorse and operationalise a dual training program will be the litmus test of the sincerity of their professed claims to redress the decline in general medicine and accord it equal status among the specialties. Moreover, the ideas of training more general physicians versus nurturing 'the physician within' all subspecialties should not be seen as mutually exclusive options for correcting our workforce shortages. Giving dominance to the latter runs the risk of marginalising those who seek to ensure that adequate numbers of truly generalist physicians are provided to meet the needs of regional and rural communities. Having said this, IMSANZ is keen to avoid any perception of a 'them and us' struggle in our interactions with our specialty colleagues and acknowledge the need for collective debate and action.

Reforming relationships between RACP and Special Societies

Finally, there was a special meeting of Special Society presidents and RACP executive office-holders on March 3 this year at which a no-holds barred discussion occurred as to how working relationships between the college and the SS could be enhanced, and how this better working relationship could then be used to engage the SS in designing and operationalising the Education Strategy. Let there be no mistake about the urgency of this matter. The college is being required by the Australian Medical Council to have in place, by November this year, a program for reforming its training and education program according to AMC standards, or face the prospect of being disaccredited as the training and certifying body for specialist physicians. Some of the suggestions discussed at this meeting regarding college governance and training programs were truly radical and provide IMSANZ with unparalleled opportunities to in uence college policy and decision-making. The resolutions arising from this workshop are detailed later in this issue. I have outlined some of our policy perspectives in a recent article in RACP News.

2004 is shaping up to be a watershed year in the history of both the RACP and our society. There will be much to ponder at our next AGM and I look forward to seeing as many of you as possible at the May meeting in Canberra.

IAN SCOTT
President, IMSANZ

Despite the loss of drug sponsorship, this years IMSANZ meeting proved to be as enjoyable as previous years. Drug sponsorship rules in this country have apparently been revised and it may be difficult, in future years, to attract sponsorship. Despite the implied, almost hypnotic in uence drug companies are meant to have on doctors; it was pleasing to see that those present were quite capable of independent thought. Where the sponsorship has been sorely missed is the time saving for the clinician whose responsibility it is to organise the meeting.

Thanks go to Bruce King and his colleagues in Nelson for their efforts. The academic programme was more varied than previous years and I believe the better for it.

Vincent Crump led the controversies section, challenging our views on immunotherapy, especially, in the treatment of certain subgroups of asthmatics. He was followed by Bob Lodge, our token Australian this year, with a workshop an anaesthetic risk in the post MI period.

The afternoon was taken up with varied presentations on aspects of physician workload.

Yes, you do need your sleep I'm afraid. The meeting was unanimous on the benefits of an afternoon siesta as an OSH requirement. I only wish!

Below are some Internet sites that may be of interest regarding physician workloads:

- ama.com.au has established a code regarding appropriate workloads
- osh.doc.govt.nz
- sleepwake.massey.ac.nz

L to R: Reg Quinn (Rotorua) talking with Anthony Burton and Matt Hills from Timaru.

Bob Lodge (centre) was the sole Australian attendee, but seemed right at home talking with John Henley (Auckland, left) and Sisira Jayathissa (Wellington, right).

Malcolm Clark's work on workloads was excellent and reminiscent of similar work by Brendon Rae in Dunedin. You would be well advised to contact either, if you are struggling to convince your management of the need to expand services.

Andrew Bowers and Phillippa Poole updated us on the enormous task of reshaping the pre and post exam years of training in general medicine so the sub-specialty is not one of a default position. The session was more of a workshop format, challenging those present to address the issue of curriculum development. Not that easy!

The IMSANZ dinner was held at Flax Restaurant, northwest of Nelson and well worth a compulsory stop when visiting the region.

As many of you will know the college meeting is likely to be in Wellington next year and will likely encompass the IMSANZ meeting we traditionally have at this time of the year.

Don't forget RACP/IMSANZ in Christchurch this year; hope to see you there.

Again thanks to Bruce King and his Nelson Colleagues for a great meeting.

MATTHEW HILLS
Timaru

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ALICANTE REPORT

Photo taken at the Alicante Gala Dinner - from left Sarah Lynn, Andrew Wesseldine, Jaime Merino, Chris Davison.

We attended the 6th European School of Medicine in October 2003. This is an annual event held in Alicante, Spain, run by the European Federation of Internal Medicine. It is attended by trainees in Internal Medicine from around Europe and IMSANZ sponsors two members currently training in General Medicine. The aim of the school is twofold. It primarily provides a forum for trainees to meet, share ideas and experiences and establish contacts. The educational component provides updates in areas of Internal Medicine.

This year there were 60 doctors from 19 European countries, including representatives from a number of Eastern European countries. We were welcomed as an 'addition' to Europe for the duration of the meeting. Despite not being part of the European Union our experiences and opinions were appreciated. The Europeans were interested to hear about Australia and New Zealand, though many were overawed about the distance and time required to travel 'down-under'. The school is open to trainees at any stage in their Internal Medicine training. All sessions were held in English making us feel fairly inadequate about our inability to communicate, let alone present, in a second language.

There were many highlights during the week long program. For us the best part of attending the school was meeting trainees from around the world and comparing our training and health systems. It reinforced for us that medicine is the same the world round. Despite some differences in training, the knowledge and attitudes amongst the group were fairly similar. As most of you will know the system in Europe is very different to the UK or Australasia. Physician trainees in Europe all train in Internal Medicine for 4 to 6 years depending on the country and many physicians then work solely as Internists. One can then choose to specialise by doing, on average, an additional two years in a specialty area. In some countries it is very competitive to obtain one of these spots. No countries, other than Australia and New Zealand, have the option of dual training in general medicine and a specialty. The assessments required during training vary. Turkey appears to have it the toughest with an examination at entry level and year two along with further examinations and a thesis at completion. We are one of the few countries, along with the UK, Spain and the Netherlands with no formal exit assessments.

The most popular educational sessions were case presentations given by a representative from each country. There was a strong theme of infectious diseases, especially mycobacterium infections which provided many learning points for us. The cases promoted a great deal of discussion amongst the group and demonstrated the benefits of the Internal Physician in handling non-specific presentations and multi-organ diseases. We were also treated to an excellent CPC session which really demonstrated how to do this well. Updates were given on a range of topics, including malignant lymphoma, hepatitis C and diastolic heart failure. Not all the presentations were on clinical topics with a session on Quality Assessment. It surprised us to see that this is not a large part of practice in many countries. In fact many of the delegates did not know what a clinical audit was and it was mainly the Australasians and British who had worked in hospitals that had an active audit program.

An afternoon session was devoted to ethics and medical professionalism. The European Federation of Internal Medicine has been involved with several other Internal Medicine societies from Europe and North America to develop a charter on medical professionalism. Our session was based on this charter which was published in the Annals of Internal Medicine and the Lancet in February 2002. It became clear that there still exist a number of differences between Eastern and Western European countries. Doctors working in Estonia, Poland and Slovakia are held in high regard by the community but are poorly paid. They still have a less transparent relationship with patients and are able to act quite autonomously without any fear of litigation.

The other obvious highlight was that the school is held in Spain and although the weather in October was not fantastic we had plenty of opportunities to enjoy the Mediterranean lifestyle. The Spanish delegates along with Dr Jaime Merino, the director of ESIM, were excellent as hosts and tour guides. Alicante is a town of 300,000 and is best known as a popular tourist town in summer. It is possible to y into Alicante, though it is only a three hour train trip from Barcelona for those who wish to experience the joys of Gaudi and Picasso. Although the week was quite busy the organisers were able to fit in some social activities which included a performance from local Andalucian dancers, a guided visit to Alicante's castle 'Santa Barbara' and an afternoon tour of the area. We visited a small town called Orihuela which is famous for its good quality shoes, no further excuse was needed! All the essential Spanish food was sampled with the assistance of our new Spanish friends.

We would strongly encourage IMSANZ to maintain this link with our European colleagues and to continue to sponsor trainees to attend the ESIM. The contacts made and the knowledge gained about Internal Medicine in other parts of the world was invaluable. We found the case presentations and clinicopathological sessions the most instructive and organisers of future IMSANZ meetings may like to consider including these in the educational program. We would like to thank IMSANZ for their support and the organisers of the school, Jaime Merino and Chris Davison.

SARAH LYNN & ANDREW WESSELDINE
sarahlynn@optusnet.com.au
awesseldine@hotmail.com

THE AFTERMATH OF THE GENERAL MEDICINE FORUM

In our e-mail message in February, we alerted members to the release of the college report on the General Medicine Forum held in March 2003. The Forum was a response to the concern of the college to the decline in general medicine services and the diminishing number of general physicians and general medicine trainees. The overall purpose of the Forum was 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. Training programs relevant to general physician trainees were also discussed and inevitably became intertwined with the demands of the college review of training in general that was being undertaken by the Education Strategy Taskforce.

The Forum was attended by 48 delegates, mostly Fellows and trainees from Australia and New Zealand, but also including representatives of the Commonwealth Department of Health and Ageing, the NSW and Queensland Health Departments, the Victorian Department of Human Services, the Australian Medical Workforce Advisory Committee, the Medical Training Education Council of NSW, and the Hunter Area Health Services.

The full report has been e-mailed to IMSANZ members, and can also be accessed at the college website (www.racp.edu.au). A number of background papers were presented by IMSANZ councillors at the Forum which have been published in previous IMSANZ newsletters and which can also be accessed at either the college or IMSANZ websites. It is not intended to summarise all the Forum presentations in this report, but to review the key recommendations contained in the Forum report and to consider its implications for IMSANZ and how we as a society should respond.

Forum recommendations and statements of support

The recommendations of the Forum which have been endorsed by the RACP Adult Medicine Divisional Committee and IMSANZ were as follows:

1. The College will continue to affirm the importance of general medicine. This support is for general medicine training at basic training level and for general medicine as a subspecialty at advanced training level, as well as its continued existence as a subspecialty of internal medicine.
2. The College will continue to support the concept that general medicine has an important and cost-effective role in the provision of internal medicine health services in the Australian environment, both in metropolitan and in regional/rural areas.
3. The College believes that academic general medicine units have an important role in sustaining and promoting general medicine and that an academic environment in which good role models exist is important for the future training of specialists in general medicine.
4. The College will work with relevant external agencies, particularly the Commonwealth Department of Health and Ageing, State Health Departments and area health authorities, to address issues which are seen to impact negatively on the future of general medicine. These include issues such as rebates for cognitive work, the maintenance of general medicine units in tertiary hospitals, maintenance of and support for medical registrar positions in regional hospitals, and working conditions in rural and regional locales.
5. The College endorses the concept of 'The Physician Within.' The concept has two elements:
   a. The first is that basic training includes training across the breadth of the subspecialties in internal medicine, including general medicine.
   b. The second is that practising subspecialty Fellows (and advanced trainees) are frequently dealing with diseases and/or complications that are outside the organ-based area of their subspecialty training. Therefore all physicians and advanced trainees have or should have the ability to practise more broadly than their subspecialty, although the extent of this practice will depend on the primary subspecialty, the location of practice and personal interest.
6. The concept of 'The Physician Within' has important ramifications for advanced training, continuing professional development (CPD) and physician practice. In particular, advanced training outside the trainee's primary subspecialty should be fostered and encouraged, as should CPD outside the physician's subspecialty, and support should be given to a more broad practice, particularly at key stages in the physician's career.

   In an environment in which all Fellows and trainees are being encouraged to acquire and maintain skills outside their subspecialty area, the specialty of general medicine should be recognised as being a provider of such skills and continue to be supported as a subspecialty in its own right. This will involve considerable attitudinal and philosophical change within the College but it is realised that the College has a particular responsibility to ensure that the product of its training is appropriate for the healthcare needs of Australasia.
7. In relation to advanced training, the College will work with the specialist advisory committees (SACs) and specialty societies to ensure that:
   a. Trainees in general medicine have access to a range of rotations, including those that include procedural skills that are appropriate and necessary for general physicians, particularly in regional and rural areas; and
   b. Trainees in other subspecialties are made aware of the benefits of elective training being undertaken outside the primary subspecialty area, either in a related or an unrelated subspecialty.

Other issues which were considered and attracted a position statement were as follows:

1. **Achieving collaboration between generalists and subspecialists:** It is suggested that review of the current training program, the development of shared curricula, and the adoption of the 'Physician Within' concept may well reduce the divisions between these two groups and break down the prevailing 'silo mentality.'
2. **The interface between emergency departments and general physicians:** There was a role for the college in the interaction between these two groups of physicians. It was agreed that once a decision had been made to admit a patient, care should be led by the acute care physician and his/her team. There was diversity of opinion on whether the acute care physician should be working in the emergency department, although it was pointed out in New Zealand, the physician works in the same workplace as the emergency specialist. There was also support for the establishment of acute assessment units, to which patients could be transferred after assessment, or the provision of acute clinics, combined with early and appropriate referral to subspecialty medical units.
3. **The interface of aged care services and general medicine:** It was agreed that these two areas are complementary and work well together. It was recommended that the College undertake further promotion of combined general medicine/ geriatrics training.
4. **Remuneration issues:** Funding for general medicine consultations and the need for more full-time positions were thought to be relevant. Also discussed were lifestyle issues, and it was recognized that general physicians in more isolated sites work long hours away from families and that better renumeration and locum support were needed.
5. **Role of general medicine in the continuum of care between hospital and community:** There was recognition of the role of the general physician in community-based ambulatory care. Concern was expressed about the lack of awareness of many trainees about community expectations outside the hospital. It was thought the college could play a role in remedying this situation.
6. **Place and role of academic general medicine:** There was difficulty in reaching agreement on the definition of 'academic general medicine' and what comprised an academic unit. IMSANZ had proposed minimum criteria for defining a teaching general medicine unit as follows: a full-time general physician; acute on-take across the spectrum of internal medicine; expertise in chosen 'niche' areas (such as perioperative medicine, obstetric medicine, or addiction medicine); working relationships with one or more regional centres in supporting clinical services and teaching; and involvement in programs aimed at improving organisation and delivery of care. It was proposed that a formally structured research program led by general physicians with university affiliations would also need to exist to qualify for the label of an academic unit. However, a 'bricks and mortar' research facility was not thought necessary, nor was it considered mandatory to have full-time research staff undertaking post-graduate degrees. The fields of cardiovascular medicine, perioperative medicine, health services research, evidence-based medicine and clinical education were nominated as examples of clinical activity amenable to research by general medicine units.

   Clinical services, research, teaching and administration were all relevant but it was agreed that a physician in an academic General medicine unit would need time off clinical services. The model would vary depending on whether the location was Australia or New Zealand, metropolitan or rural. It was acknowledged that the issues of funding and protected time for teaching and research were not being adequately recognised by universities and health services.
7. **Composition of a general medicine department:** It was thought that a GIM department would comprise a portfolio of administration, research and clinical services, both in-patient and out-patient. A minimum inpatient caseload of 20-30 patients combined with at least 2 outpatient clinics per week were proposed, combined with adequate administrative and logistical support, and close liaison with emergency and intensive care departments.
8. **Dual training for advanced trainees:** There was considerable support for the concept of dual training, now being extensively practised in New Zealand. IMSANZ proposed that the entire training program remain at the current duration of six years but instead comprise a '2+2+2' format. The first 2 years (PGY2 & 3) would comprise basic training, the next 2 years advanced training in a 'general medicine' curriculum (which could include a mixture of training in general medicine units, subspecialty units, and other disciplines such as public health or occupational health), and the last 2 years in a designated subspecialty. This change in training could be aimed at dual certification in general medicine and a subspecialty.
9. **Rural/regional components in training:** There was support for the mandatory rotation of basic trainees to regional and rural training posts for periods of no more than 6 months. Advanced trainees who were interested in pursuing careers as non-metropolitan general physicians would also be strongly encouraged to undertake such rotations. Trainees at the Forum spoke of the educational and experiential benefits of rotating through regional hospitals that provided appropriate levels of supervision and training support.
10. **Determining and maintaining competence of general physicians:** It was acknowledged that while it would not be possible for general physicians to maintain competence in all areas of medicine, it was felt feasible that competence could be upheld in regards to commonly encountered problems within their major areas of practice: cardiovascular and respiratory medicine, endocrinology, gastroenterology and renal medicine. Knowing what they do not know and knowing when to refer were seen as important. These issues could be assisted by the provision of decision support and CPD resources from relevant subspecialty societies (such as guidelines, upskilling programs, presentations at educational meetings) and ready access to subspecialist advice when needed. Peer review, practice-specific CME activities, and clinical audit were proposed methods for maintaining professional standards.

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IMSANZ response to Forum recommendations

A year has elapsed since the Forum was held and members are entitled to ask what's happened – how are the recommendations being implemented and what is being done to advance the issues that attracted statements of support? In truth no operational plan has been devised to date for putting the words into action, but IMSANZ is currently working on such a document which will offer specific actions, timelines and performance criteria. A draft will be distributed to all members in late April for comment and it is hoped that the final document will be ratified by IMSANZ Council at its next meeting in mid-May. It will also be discussed as an agenda item at the next AGM. Members are asked to take an active interest in this matter and to voice their strong support for the agreed action plan when it is publicly released.

IAN SCOTT

DEVELOPING A TRAINING CURRICULUM IN GENERAL INTERNAL MEDICINE

One of the outcomes to date of the college Education Strategy Taskforce is a request to all specialty societies to develop a curriculum that adequately defines the key knowledge, skills, and attitudes of that discipline, and the educational strategies that will be used to impart those skills to trainees and maintain and augment them in fellows. In undertaking this task, the Royal College of Physicians in the UK has recommended that where several societies share common ground or overlap in terms of curriculum content (eg oncology and palliative care; general medicine and geriatric medicine; cardiology and renal medicine), the societies involved should form 'natural alliances' and develop a shared curriculum in an effort to maximise use of time, effort and resources. Also, wherever possible, curricula that have already been developed by other colleges around the world should be retrieved and adapted for use by RACP rather than require every society to 're-invent the wheel.'

In assisting societies with these tasks, the College and the Education Development Unit (EDU) have convened curriculum writing workshops (first one held on Mar 16) and are providing educationalist overview of draft curricula. To date, curricula are well advanced for oncology, palliative care, and neurology, and to a lesser extent for endocrinology and geriatric medicine.

It is vital that IMSANZ now sets to the task of developing a curriculum in General Medicine that is relevant to advanced trainees and practising fellows. I should stress that this task is separate to the writing of a basic and generic curriculum which will include professional skills common to all specialties and which are relevant to both basic and advanced training. Associate Professor Phillippa Poole from Auckland who is current IMSANZ vice-president will chair the IMSANZ Curriculum Writing Group (CWG), whose other current members include Ian Scott, Les Bolitho, Briar Peat, Andrew Bowers, Aidan Foy, Graeme Dickson, David Russell, Simon Dimmitt, Diane Howard, Peter Greenberg, Llew Davies, Julia Lowe, Mark Morton and Leonie Callaway.

The themes that the group has identified to date as being essential elements of a generalist curriculum are: management of acute undifferentiated disease, chronic care of multi-organ disease, and peri-operative medicine. Communication, history taking and physical examination, critical reasoning and evidence appraisal, teamwork, quality/safety improvement, health services analysis, health informatics, and medication use feature as themes in the basic and generic curriculum.

IMSANZ has also entered into discussion with the Australian Society of Geriatric Medicine in collaborating on writing those curricular elements in which our two societies share common interest: acute geriatric care, geriatric assessment and rehabilitation, and community care in regards to the elderly. There may also be opportunity for IMSANZ to liaise with other groups in developing curriculum in areas such as obstetric medicine, adolescent health, and hospitalist care.

The work of the CWG will be conducted mostly by e-mail and teleconference with occasional face-to-face meetings. Travel and accommodation costs incurred in attending meetings will be reimbursed by the college. The work needs to progress quickly as we are requested to have a draft curriculum document ready by June 30. The Group welcomes suggestions for other themes from IMSANZ members and is keen to enlist the help of any member who can give some of his/her time to this task. Please contact the IMSANZ secretary to register your interest.

IAN SCOTT

IMSANZ ANNUAL GENERAL MEETING

The IMSANZ Annual General Meeting will be held on Monday, 17 May 2004 at 5.30 pm in the Nicholls Theatrette at the National Convention Centre, Canberra.

A COUNTRY JOURNEY

General Medicine to Academia

Dr Llew Davies FRACP was awarded the Medal of the Order of Australia this year for his services to internal medicine and clinical education. Here he traces his professional journey as a member of the first generation of rural physicians in northern Queensland.

After twenty six years as a general physician, I muse over the fortuitous intern roster that took me to a vocation I still find to be exciting, and full of potential to better the lot of patients. My impression of internal medicine as a student was of an impossibly large, dry, and slow-moving discipline. Life changed in my junior resident year with a chance placement to Dr Tom Ferrier's medical unit at the Royal Brisbane Hospital. Under Dr Ferrier's exhilarating tutelage every patient became a fascinating exercise in mental gymnastics. The production of a diagnosis by combining detective-like histories with skilful examination rapidly became the source of endorphin-like highs, and my lifelong addiction to searching the literature was set in train. Why general medicine? Even now it seems to me that every facet of medicine is interesting. I am desolate at the idea of not addressing if I can, the whole patient, whatever their medical presentation.

Despite being a Brisbane boy I had links to the country through grandparents, my wife Marian, and an early internship rotation to Mackay. Early in training I also became seized by the potential range of country general medicine. RBH and Prince Charles Hospitals gave me great experiences with a wide range of specialist supervisors. Happily they were keen to equip me with intellectual and technical skills needed to survive far away from tertiary centres. It is hard to select only one name from many luminaries, though the meticulous cardiology of Dr Rupert Graff at PCH gave me a lifelong model of physicianly behaviour. I suspect that it is now more difficult for general trainees to access such open-handed assistance, at least from metropolitan specialty units.

With two year old and two month old daughters and a new FRACP diploma, we moved to Mackay in 1978. Country town medicine was slowly leaving a period in which GPs provided definitive, often good care, for everything from infarcts to colon cancer. New physicians required diplomacy as much as medical skill. One's ability to pull occasional patients out of critical situations, to nail a diagnosis without smugness, and with enthusiasm to return the patient to the GP's care, were pivotal to the acceptance of a physician's role. The teamwork between physicians and hard-pressed GPs, and the continuity provided by local specialist physicians became important to the community. Dr Maureen Duke, Mackay's first physician, who sadly passed away in 1986, was a gracious and cooperative colleague. Together I think we raised internal medicine to being a respected and valued local professional discipline.

One of the great challenges of country medicine is to be the ultimately responsible for the care of a very sick patient. Evacuation to the next level of care required either a 400 km trip to Townsville or 1000km trip to Brisbane – neither option being easy, particularly two decades ago. Imaging and laboratory services were limited and one had to develop a good knowledge base plus a wide variety of procedural skills. Inevitably a single country physician managed multi-system problems which, in the metropolis, would have involved several specialists. Was this safe? With a network of colleagues available by phone, voracious consumption of the literature, and insight into one's skills and limitations, I think it was. Our stamping grounds, the Mackay Mater and Base Hospitals, were highly professional and big enough to support our specialized care, but also small enough to be free of many bureaucratic nightmares plaguing tertiary institutions.

Dr Llew Davies OAM.

One of the pleasures of country medicine is to feel a useful part of a discrete community, caring often for multiple members of extended families. I learned much for example about the Maltese and South Sea Islander communities in Mackay, and about the sugar industry which is the town's lifeblood. A physician's professionalism also becomes very focussed, by frequent encounters with one's patients outside the medical sphere. In Mackay the volume of work on offer continuously exceeded the capacity of the local physician workforce, but I was never able to bring myself to short-change patients in terms of consultation time. The essence of good physician practice is to be thorough. One will be forgiven for many things but not for excessive haste and poor communication.

For the literature-hungry country physician, the advent of information technology has been an enormous boon. Libraries were almost nonexistent in the 1970s, but now with a few keystrokes, one can be as literature-savvy as the gurus of tertiary hospitals. Indeed the case-based literature-searching in which country physicians are vigorously engaged, is insufficiently recognized as valuable research with high beneficial outcome for patients. Scholarly learning for country physicians can be further rounded out through conferences and networking, but the acquisition of new procedures is problematical, particularly where accelerated training courses are unavailable or unfunded.

I am unashamed, after many disappointments in recruiting country physicians, of a passion to remedy our workforce shortages. Apart from civil conscription, only two corrective measures are likely to work: affirmative action in student selection, and training medical students in the country. Creative arithmetic by the large medical schools minimises the benefit of rural student selection, and the results of short term country rotations are dubious. However with dedicated Commonwealth funds, the recent establishment of Rural Clinical Schools has enabled long term and highly effective country training. The new schools need staff, and without exaggerating our importance as general physicians, it is difficult to suggest more suitable teachers of undergraduate internal medicine. Name the topic and the experienced country generalist will be able to teach on it from copious personal experience.

On being offered an academic post in the UQ Rural Clinical Division (RCD) at Rockhampton, I soul-searched about leaving patients and friends. The challenge however, of at last doing something to raise and educate a new generation of country doctors, decided the move. Two years later, we are succeeding in producing a new cohort of doctors enthusiastic about country medicine. Numbers are likely to increase as their positive experiences filter back to preclinical city colleagues. Our teachers, though keen, are in limited supply, and there are challenges in integrating the RCD program with our parent school 700 km away. My hope is that one day some of our students will form the nucleus of the much-needed new generation of country physicians.

LLEW DAVIES

(From Page 8)

GENERAL INTERNAL MEDICINE IN SYDNEY HOSPITALS: A WAY FORWARD?

Many of the readership will be aware of the almost complete disappearance of General Units from tertiary hospitals and the appointment of non-general physicians to general appointments in peripheral hospitals in Sydney.

The reasons are long and complex, and will not be expanded upon in this short article. It goes without saying that the ow-on effects are considerable within the health system, and with respect to attracting and retaining trainees who see non-generalists appointed to general positions and those appointed simply cross-referring anything outside their area. As one registrar once put it, "on passing the exam, there is no more General Medicine".

There may be some hope for change. The former Minister for Health established the Greater Metropolitan Transition Task Force (GMTT) chaired by Kerry Goulston, formerly Professor of Medicine, Northern Clinical School. The GMTT has the job of ascertaining from clinicians recommendations and visions for the future for medical services in the designated area. The GMTT has allocated a considerable amount of money to areas such as Burns and Stroke units. Details of its success may be found on its website (http://www.health.nsw.gov.au/policy/gap/gmt2/). General Medicine now has a presence within GMTT with major presentations and submissions to relevant committees.

At the recent "Metro Hospitals Forum" conducted by GMTT and attended by the Minister for Health, Director General of Health and IMSANZ representatives, much was said and written about the place of General Medicine and the role it should have in the overall scheme of patient care in the hospital setting.

For General Medicine to move forward in Sydney, it needs at least the following:

1. re-establishment of general medical units in tertiary hospitals
2. high profile general physicians in large numbers affirming the career path
3. appointment committees must appoint fully trained general physicians to general medical positions. The 'excuse' of a generalist with an interest should not be used to appoint a subspecialist with little interest in general medicine.
4. the college must ensure that it uses its representation on appointments committees to correctly identify general physicians if requested.
5. general physicians must apply for advertised jobs! This may seem surprising to some but it seems that 'no suitable applicants' is the excuse used to appoint the semi-skilled.
6. ensuring the survival of general medical units still functioning in smaller hospitals.

Further representations are being made to GMTT which hopefully will in uence outcome in these areas.

The role of the generalist is changing. Many achieve competence in procedural skills such as endoscopy and echocardiography. Advanced diagnostic imaging including teleradiology expands the role of smaller hospitals. Our surgical colleagues constantly request physicians with peri-operative skills. However, it remains imperative that anyone appointed to the general medicine roster must remain fully competent to care for all acute admissions which are not in immediate need of tertiary subspecialist care.

IMSANZ and the College must ensure that a large number of fully trained general physicians are available to fill positions. Such action will then leave true tertiary problems to the subspecialist. This is not the present situation.

MICHAEL KENNEDY
Consultant Physician, Manly NSW

NEW ZEALAND VICE PRESIDENT'S REPORT

IMSANZ (NZ) Meeting Nelson (April 1-3, 2004)

This year has been another important, and successful one for IMSANZ. Progress has been made particularly in the promotion of general medicine, both within the RACP and in the health care system as a whole, and in defining the skills of generalists. A third major area of focus has been the general medicine workforce, particularly in rural/regional areas. General information on these and other initiatives is provided in the RACP News and the IMSANZ newsletter, as well as on the RACP website.

I would like to highlight a few specific areas to the New Zealand branch members:

1. Physician Training	The RACP has outlined an educational strategy, which is now being implemented. A key part of this is to develop a general medical (GM) advanced training curriculum. IMSANZ and the SAC are leading this, with the assistance of the RACP education development unit. Other projects include development of basic training and generic curricula for all trainees, and determination of the structure of basic, advanced and dual training. Continuing education for fellows is also a focus, and a revamp of the MOPS programme is inevitable. These matters will be discussed further during the curriculum workshop at this meeting.
2. Meetings	**RACP ASM, Canberra, May 16-19 2004** IMSANZ has planned a very stimulating adult medicine programme for general physicians. For those of you who are attending, Ramesh Naggapan's clinical quiz is highly recommended (take a spare suitcase for the prizes)! **RACP (NZ) / IMSANZ / TSANZ / ID Christchurch, August 3-6 2004** Another very interesting programme with major themes of PE and community acquired pneumonia. David Jardine and John Thwaites are coordinating the programme for IMSANZ. There will be a $500 prize for an AT presentation. **RACP ASM New Zealand 2005** Wellington has been chosen as the venue for the RACP ASM New Zealand 2005. We should be prepared for IMSANZ to coordinate the adult programme for the Adult Division of the RACP. IMSANZ is represented on the overall ASM Scientific Programme Committee, led by Fred Khafagi. The IMSANZ organising group model that worked well this year for Canberra includes Les Bolitho, Ian Scott, a local member and myself. Sisira Jayathissa and colleagues in Wellington have been primed to consider topics, local expertise, and possible speakers for IMSANZ. It is very much hoped that Wellington will be confirmed as the venue, and that this group plus any others who are keen to be involved can start to work on a programme outline in April. The ideas will then be taken to a meeting between the Faculties/Divisions and IMSANZ in Canberra in May prior to the upcoming RACP ASM. With respect to topics, some have already been suggested, however other ideas for the programme and general medicine keynote speakers and local experts are welcomed. **IMSANZ meeting latter part of 2005** It is hoped that we may schedule a meeting with our Australian IMSANZ colleagues in Australia, outside of a major centre.
3. Workforce Issues / Vacancies	There continues to be workforce shortages both at trainee and consultant level. In 2004, Australian medical schools increased places by over 250 and those in NZ by 40 (for students from a rural background), but these will take years to ow through. Concern remains that while there are fewer graduates than registrar training places, specialties in metropolitan centres will be preferred by trainees. Initiatives such as rural networks, alliances between metropolitan and provincial centres, and compulsory registrar rotations to regional hospitals are working to promote rural and regional rotations in Australia, and should be considered here.
	A brief survey late last year of general medicine vacancies in NZ showed that there are still problems with getting a stable GM consultant workforce, as well as NZ trained registrars. The new Waitakere Hospital will be opening in West Auckland in early 2005. This will increase demand for GM consultants and registrars. This survey data has been collated, but is, as yet, incomplete. Please take the opportunity at this meeting to correct / add your hospital data. In the last newsletter, Ian Scott asked for completion of templates outlining the environment for GM trainees at each hospital. These templates will be kept at the IMSANZ office and on the website so that potential trainees can see what options are available and who to contact. The word is out there in Australia that NZ provides good training, so detailing your positions should be beneficial to you.
4. Reports	On your behalf, IMSANZ submissions have been provided to the following: ACC medical misadventure review, Pharmac tender process review, CTA workforce strategy consultation document, MOH draft strategy for response to major disease outbreaks (e.g SARS). These responses are usually done in consultation with the NZ executive. There is currently a consultation document on scopes of practice for nursing. If anyone is interested in assisting with this or other responses, please let me know.
5. SACs	There has been some discussion on the joining of some NZ and Australian SACs. Your executive remains strongly against such a proposal for general medicine, given (a) the relative strengths of general medicine in NZ, in part due to the collegial relationship between the SAC and trainees in New Zealand, and (b) the differences in the health systems between the two countries.
6. Advanced Trainee Issues	Graeme Dickson has provided a very thoughtful and comprehensive report (see below). Despite the numbers of general medical ATs there are only 11 IMSANZ AT associate members. Graeme is stepping down as the NZ AT rep on council, and a replacement is required. There are no ATs at this meeting despite Graeme's encouragement.
7. Members	There are currently 95 NZ members (incl. 11 trainees)
8. Your NZ Executive	This is currently: Phillippa Poole, Bruce King, Andrew Bowers, Briar Peat, Brandon Wong, Neil Graham (ex officio), Advanced trainee (vacant)

I would like to thank particularly Bruce King, Andrew Bowers, Briar Peat, Graeme Dickson, Brandon Wong, Neil Graham, Tom Thompson, Paul Reeve, David Jardine, John Thwaites, Sisira Jayathissa and many others of you who contributed to advance your society in 2003-4. It has been my pleasure to be your VP this year, and I look forward immensely to the next 12 months. There are considerable challenges ahead, but these will hopefully lead IMSANZ to an even stronger role at forefront of medicine in New Zealand and Australia.

PHILLIPPA POOLE
p.poole@auckland.ac.nz
General Medicine, Auckland City Hospital,
and University of Auckland

EUROPEAN SCHOOL OF INTERNAL MEDICINE

(ESIM VII) - *Saturday 16th - Friday 22nd October, 2004*

The title for 2004 of this annual refresher course held in Alicante, Spain is **Hot Topics in Internal Medicine**. A provisional list of topics is shown below. In addition to the course, attendees will enjoy a half free day visit to a nearby tourist or cultural destination. The final price is 965 € and includes full board at the hotel, social events, material for the course and subscription to Eur J Intern Med.

Registration forms are available from the IMSANZ secretary and must be returned by **10th September**. Advanced trainees in general medicine can apply for the IMSANZ Travelling Scholarship valued at $5000 to assist with travel and accommodation costs. Application forms are available from the IMSANZ secretary.

Suggested Topics:

RESPIRATORY DISEASES

1. Tuberculosis and Anti TNF drug
2. Pulmonary hypertension: new treatments and outcomes
3. Smoking habit cessation
4. New pathogens in respiratory infections: SARS and avian in uenza
5. Lung cancer screening

NEPHROLOGY

1. Microalbuminuria and proteinuria: pharmacological control

ONCOLOGY - HAEMATOLOGY

1. New markers in cancer diagnosis and prognosis
2. Targeted therapy of hematological malignant diseases
3. Proteomics in Oncology

ENDOCRINOLOGY-METABOLISM

1. The use of stem cells in diabetes treatment
2. New Insulins
3. Statin effects: beyond their hypercholesterolaemic effects

CARDIOVASCULAR DISEASES

1. The interest of BNP measurements
2. Anti-oxidant vitamins: their effect on morbidity and mortality in cardiovascular diseases
3. Current approaches in atrial fibrillation management
4. How to treat a hypertensive patient in 2004
5. Anti-thrombotic therapy in cardiovascular diseases
6. Peripheral arterial insufficiency, a common problem not always well managed.
7. Anti-in ammatory markers in cardiovascular diseases.
8. New approaches to patients with cardiovascular risk.

GASTROENTEROLOGY

1. Barrett oesophagus: should it be more extensively screened ?
2. Latest information about Helicobacter pylori related diseases
3. Treatment of in ammatory bowel diseases

CRITICAL CARE

1. What is new on sepsis and septic shock ?
2. The validity of hyperbaric oxygen treatments.

ALLERGY

1. What is the best choice for asthma treatment ?

GERIATRICS

1. How better to prevent and treat osteoporosis ?
2. The controversial use of hormonal replacements therapy or an update on hormone replacement therapy.
3. The role of statins and anti-hypertensive drugs in the older population.

NEUROLOGY

1) An update on Parkinson's disease
2) What are the advances in diagnosis and treatment of patients with dementia ?
3) Advances in diabetic neuropathy

MISCELLANY (Several topics)

1) Validity and safety of herbal Medicine
2) Exercise: real validity and for whom ?
3) Micro array chips in medicine.
4) Guidelines: arguments for/against

INFECTIOUS DISEASES

1) The new faces of old infectious diseases
2) Multi-resistant infections
3) Anisakiasis

RHEUMATOLOGY-SYSTEMIC DISEASES

1. Crystal induced arthritis
2. Anti-phospholipid syndrome: Clinical implication and management
3. Syndromes with pitting oedema

REGIONAL TRAINING IN GENERAL MEDICINE IN THE HUNTER

In the Hunter region of NSW there exists an informal consortium of hospitals comprising the Mater, John Hunter, Belmont, and Maitland hospitals. We also have an association with Tamworth and soon hope to have a remote area attachment with Alice Springs (see below). This means that within this consortium we can provide:

- Experience in acute general medicine in a metropolitan and a regional setting.
- Training in endoscopy, echocardiography, and bronchoscopy.
- Training in some key disciplines: infectious diseases, ICU, high risk diabetes, addiction, obstetric medicine, and perioperative medicine.
- Exposure to a number of relevant academic disciplines such as clinical pharmacology and epidemiology.

We can therefore assemble a package covering three years for accreditation in General Medicine or four years for General Medicine plus another discipline which can be varied to meet an individual's needs.

We have suggested to the College that this would allow a trainee to complete their training within one group of hospitals rather than have to transfer to somewhere else for part of the time which has been the normal pattern. Katherine McGrath (then CEO of the Hunter Area Health Service), Bob Batey, Julia Lowe and I, met Rick McLean, Peggy Sanders and Tim Bohane in November last year and we found them very positive and encouraging. The College was encouraging more regional schemes such as ours but we were the first with a detailed proposal. It was felt that the relevant SAC's would be happy with the arrangement.

The second element of our proposal was that rather than individual units/departments or the Area Health Service being funded to provide positions in this training program, the trainees themselves would be funded directly such that the funding was tied to the trainee, not the position. This would allow us, for example, to approach the cardiologists to take a trainee on for six months to learn echocardiography without their having to sacrifice one of their existing positions, or pay to set up an additional position. Rick McLean was again helpful here by suggesting that we seek funding from the Outer Metropolitan Regional Scheme and we have been advised that we could receive funding for up to four positions.

This is all very promising, but I believe it has important ramifications. If we can put a scheme like this together, so can others. In south-east Queensland, a formal network of 5 community hospitals affiliated with a tertiary hospital (Princess Alexandra Hospital) has been established which fosters a regional training program. Our model is not necessarily the only one possible or the best possible, and others should be considered. In the meantime, IMSANZ fully supports what we are doing, and seeks to assist in developing and co-ordinating a nationwide network of training programs in both Australia and New Zealand.

The opportunities we have been waiting for in developing General Medicine are now starting to come along. We are close to consensus on the role of the general physician and the criteria training programs should meet (see later this issue); we have created some innovative and attractive training opportunities; and we have positioned ourselves to take advantage of the current political climate to provide services which are desperately needed and which only we can provide.

AIDAN FOY
Newcastle

Welcome to New Members...

IMSANZ would like to welcome the following New Members:

- Dr Mahesan Anpalahan (Melbourne VIC)
- Dr Martin Brigden (Atherton, QLD)
- Dr William Burke (Deakin, ACT)
- Dr Syed Hasan (Gisborne, NZ)
- Dr Jacquelyn Martin (Roleystone, WA)
- Dr Tim Matthews (Masterton, NZ)

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

- Dr Andrei Catanchin (Geelong, VIC)
- Dr Rupert Handy (Auckland, NZ)
- Dr Terry Mitchell (Auckland, NZ)
- Dr Mitzi Nisbet (Auckland, NZ)
- Dr Peter Robinson (Brisbane, QLD)
- Dr Marjoree Sehu (Mt Waverley, VIC)

FORTHCOMING MEETINGS

2004

2004

April to May	**Falls Workshops** For more information visit the website: www.fallsprevention.org.au
May	**RACP Annual Scientific Meeting** *May 17-19 ~ National Convention Centre, Canberra, ACT* Website: www.racp.edu.au/asm/index.htm **IMSANZ Annual General Meeting** *May 17 at 5.30pm ~ Nicholls Theatrette, National Convention Centre, Canberra* **Society of General Internal Medicine Annual Meeting** *May 12-15 ~ Sheraton Chicago Hotel and Towers, Chicago* Website: www.sgim.org/meetings.cfm
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 Telephone: 613-730-6244 Fax: 613-730-1116 Email: csim@rcpsc.edu Website: http://csim.medical.org **National Heart Failure Forum - Improving outcomes in chronic care** *June 7-8 ~ Canberra, ACT* For further information visit: www.heartfailureforum2004.com.au
August	**RACP New Zealand Annual Scientific Meeting** *August 3-6 ~ Christchurch, New Zealand* In conjunction with IMSANZ, the Thoracic Society and the Infectious Diseases Society Contact conference organiser: Amanda Graham (amanda@sixhats.co.nz)
September	**International Congress of Internal Medicine (ICIM)** *September 26 - October 1 ~ Granada, Spain* For further information visit: www.acponline.org/isim or www.granada2004.com/frame-principal.htm
November	**XIth International Congress on Antiphospholipid Antibodies** *November 14-18 ~ Sofitel Wentworth Hotel, Sydney* Abstract deadline: May 25, 2004 Visit the website: www.xith-icaa2004.unsw.edu.au/sydney/index.html Email: s.krilis@unsw.edu.au

REPORT ON WORKSHOP

To examine the relationship between the College & Specialty Societies

Following is a summary of this workshop held in Sydney on March 3, 2004 written by Dr John Kolbe, Chairman, Specialties Board.

A meeting between the representatives of the Specialties Board and the Adult Medicine Divisional Committee (AMDC) was convened to discuss the above issue. This is a crucial time for the relationship because of a high level of frustration and dissatisfaction expressed by the Presidents and representatives of Specialty Societies at previous Specialty Board meetings, the limited success of previous endeavours to engage Specialty Societies, the recent release of the draft Education Strategy which has profound implications for Specialty Societies, and the external in uences of the Australian Medical Council (AMC) and Australian Companies and Consumers Commission (ACCC).

A free and frank exchange of ideas took place at the meeting, and there was a remarkable consistency in the issues identified by the representatives of the Specialties Societies with respect to their relationship with the College. I would hope to maintain the momentum that has been generated and present the agreed-upon resolutions at the AMDC meeting on 1 April.

Some important issues identified with the current relationship included:

- That most Fellows identified the Specialty Societies rather than the College.
- Most Fellows did not believe that they receive "value for money" from the College, particularly when the subscriptions for the College are compared with those for the Specialty Society.
- The current College structure is perceived to be complex, poorly understood and resistant to change.
- The current structure of the College was perceived to be non-representative and the view was expressed that Chapters and Faculties had representation within the College and were resourced to an extent that was out of proportion to their membership.
- Specialty Societies perceived that they had no defined role within the College and had no effective mechanism to in uence College decisions or policy-making.
- A broad and high level of dissatisfaction with the current functioning of Specialty Advisory Committees (SAC) was expressed.
- The functioning and relevance of the Specialties Board was again questioned.
- Specialty Societies representatives clearly felt that the advanced training was being delivered by the Specialty Societies and they wanted "ownership" of this training.
- The College was considered to have a poor record in the provision of CPD, and the current system of accumulation of MOPS points was not considered to be meaningful or relevant to most physicians.
- A number of issues about the content of the RACP ASM and Specialty Society involvement were raised.

However, the "critical inter-dependence" of the College and Specialty Societies was acknowledged, and the Specialty Societies expressed a desire to improve upon the current relationship. None of the Specialty Societies are planning to "go their separate way" at the present time.

A number of issues were raised which were of considerable importance generally but needed to be addressed at other levels within the College. There is an acknowledgement that the governance structure of the College needs an overhaul to accommodate the new Educational Strategy and to facilitate more effective decision-making and allocation of responsibility within the College. There are planned changes to processes around financial planning and budgeting.

The workshop focused on a number of key issues directly relevant to Specialty Societies in order to develop resolutions to be considered by all Specialty Societies and then by the AMDC on 1 April 2004.

Resolution 1: ***Specialty Society representation on AMDC***

That Specialty Society representation on the AMDC be increased to facilitate a more effective and meaningful role for Specialty Societies in the functioning of the College.

There are a number of potential models for such representation. However, any model needs to avoid marginalisation of smaller Specialty Societies. One model that was discussed had larger Specialty Societies (or an amalgam of Specialty Societies) having permanent representation on AMDC, while smaller Specialty Societies would have rotating membership of AMDC. There are a number of issues which would arise from such a development and which would require further discussion.

Resolution 2: ***Future of Specialties Board***

If the Specialties Board was to continue to exist, then its role should be to facilitate "horizontal" communication between Specialty Societies, specifically in the area of collaborations with the College, eg. All aspects of advanced training, provision of CPD, etc.

After presentation and overview of the draft Education Strategy, the potential roles of the Specialty Societies in the Education Strategy were discussed with reference to the chapter "Partnership with Specialty Societies" in the draft report. There was a broad support for Specialty Society involvement in the area of Education, particularly advanced training but also CPD.

(Continued Page 16)

Dear colleagues and friends,

It is a great honour for me to welcome all of you to the 27th World Congress of Internal Medicine which will be the highlight of Spanish medicine. The Organizing Committee and our Society will offer you a most exciting event not only scientifically, but also socially and culturally, giving our guests and visitors the opportunity to enjoy the pleasant and magnificent legacy of our historical country -culture, folk, landscape, gastronomy, music, and the warmth and friendliness of our people.

On this occasion, the Organizing Committee of 27th World Congress of Internal Medicine is pleased to announce this important event to be held in the city of Granada (Spain).

The Internal Medicine of the new millennium will face many challenges, and seek innovative approaches to prevention and management of many diseases. The congress will include a number of scientific activities and give you the opportunity to share this knowledge through plenary sessions, lectures, workshops, satellite symposia, continuous medical education, poster sessions, pharmaceutical and technical exhibits, etc. The scientific sessions will be held in the modern Granada Exhibition and Congress Centre, the most modern in Spain and one of the best in Europe.

An attractive social and visitors' programme is designed to give you the opportunity to enjoy the historical and cultural beauties of Granada and Andalucía. The city of Granada offers you a magnificent array of monuments, entertainment, accommodation, museums in beautiful southern Spain, including the ski resort of "Sierra Nevada" and Mediterranean Sea only forty minutes drive away.

Don´t miss Granada 2004: We look forward to welcoming you here.

PROF DR B GIL-EXTREMERA
President of the Organising Committe

(From Page 15)

Resolution 3: ***Specialty Society involvement in Education***

That several Speciality Societies, in collaboration with the College, would undertake an "initial implementation" strategy in relation to advanced training in their sub-speciality.

In line with commitment of Specialty Societies to advanced training, and in order to begin the process of cooperation and collaboration for the provision of education within the framework of the Education Strategy, it was proposed that several Specialty Societies would embark upon "initial implementation" programs to deliver advanced training. In doing so, all aspects of the delivery of advanced training would be reviewed. It is anticipated that the Specialty Societies would have a major role in areas such as curriculum development and assessment, selection and supervision of trainees, and accreditation of training sites, but all in partnership with the College. The College would have a major role in formulating and engineering guidelines/templates, facilitating consistency of programs between Specialty Societies, setting standards and audit, but these will be undertaken in partnership with Specialty Societies. It is appreciated that such an initiative will need to develop processes to address complex and contentious issues such as transfer of resources between Specialty Societies and the College. The results of these "pilot" projects will be used to develop the final strategies for the provision of advanced training.

Resolution 4: ***Provision of advanced training***

That several Speciality Societies would trial education provision initiatives for advanced training that are in line with the concept of the "physician within."

As discussed at previous Speciality Board meetings and as outlined in the Education Strategy Taskforce draft document, there is the potential for Speciality Societies to take a much greater role in the provision of post-FRACP education in partnership with the College, both to their own members but also to physicians generally. Speciality Societies will "trial" various strategies for this education provision.

Both of these initiatives provide the opportunity for the College and Speciality Societies to undertake research into the provision of education. There have already been very strong expressions of interest in being involved in these initiatives by Speciality Societies who were represented at the above meeting **(I have indicated that IMSANZ is willing to participate in these pilot projects: Ian Scott)**.

JOHN KOLBE
March19th, 2004

What skills does a physician in the Pacific require?

This question has been exercising our minds considerably recently, because our training program for specialist physicians has now been in place for nearly 6 years, and we are looking to see if it is really serving our needs.

Obviously there are similarities between a physician practicing in a country area in Oz or NZ, and in a Pacific Island nation. So we have looked to the training of rural physicians for guidance. Despite the differences (for instance, a physician in the Pacific will have much less access to subspecialists than in rural Oz or NZ, evacuation is much more complex in the Pacific for very sick patients, and one physician in the Pacific is likely to be responsible for 100,000 – 200,000 people rather than 10,000 – 20,000 people as in Oz or NZ), in both cases physicians must largely be a Jack of all trades. They must be able to deal with acutely ill patients with a wide variety of problems, and must also be able to manage rare and/or complex patients over a long period of time. They must also be the local expert on many different diseases, and be prepared to be on call for long periods of time.

So, should we train a physician in the Pacific in much the same way as general physicians are trained in Oz or NZ? Some say yes, arguing that the diseases suffered by the population are basically the same, and the role of the physician in diagnosing and managing those diseases is not fundamentally different. However, some say no, arguing in particular that a physician in a Pacific island nation must be even more of a Jack of all trades than one in rural Oz or NZ. They also point to the number of specialists in the Pacific who gravitate into administration – many of the senior health administrators come from the specialist ranks – and argue that formal administration qualifications should be a compulsory and significant component of training. Some also argue that the training of rural physicians in Oz and NZ is by no means perfect, and does not necessarily provide a good model for the Pacific to emulate. Indeed it is even hinted that Oz and NZ might have more to learn from training in the Pacific than vice versa.

So far, the emulators have largely carried the day. That is, there has been a general acceptance that the end product should be reasonably similar in the Pacific to that in Oz and NZ. However, the method of getting there is considerably different, in that our training program has been much more formalized. All candidates must undertake a series of modules in all the major subspecialities over a period of three years, and the final written examinations are based on the material covered in those modules. Clinical skills are assessed by long cases (in the first year), and short cases and a viva (in the later years), which are very similar to those undertaken in Oz and NZ. However in addition, all students must also formally undertake training in gastroscopy and echocardiography. These two procedures have been singled out as the two most important skills required for a physician in the Pacific. However, it has also been decided that a student can still pass the program without gaining accreditation in these skills. In other words, it has been decided that, highly desirable though those skills may be, it is possible to be a physician in the Pacific without having mastered those skills and the attainment of those skills should not be compulsory.

Last, a compulsory research project has also been included in our program. The argument in favour of this has been that specialist physicians should be the leaders in developing a research capability in the Pacific. In addition, there has also been a structural argument in that the qualification is a Masters degree (rather than a College Fellowship), and that all Masters degrees should have at least some research component. There is still some disagreement on how major a project this should be, some arguing that "mickey – mouse" research projects can do more harm than good by "devaluing the currency". Others have argued that too strong an emphasis on a research project will distract students from the clinical aspects of the program, which are after all the most important aspects. At the moment we seem to be resting about midway between these two extremes, but neither "camp" has given up trying to shift the point of equilibrium.

So what we have at the moment for our training of physicians is a bit of a hotchpotch – aiming to produce much the same product as the training system in Oz and NZ, but doing it in a different way. I would be very interested in the views of IMSANZ members, particularly those practicing in rural environments, on what they see as the essential components of a training program best suited to equip graduates to undertake the different roles which will be expected of them in their future careers.

Now let me turn to another matter exercising our minds here recently - that is what we should be doing about the large numbers of patients we have in Fiji dying from end-stage renal failure. Estimates vary, but it is likely that 100 or so patients die of ESRF each year, most of whom are relatively young and otherwise well.

Obviously prevention is important, but even the best preventive programs won't stop some patients reaching ESRF, and at the moment a policy decision has been made in Fiji that it doesn't have the resources to undertake a renal replacement program, either by dialysis or by transplant services.

Dialysis and transplantation had just commenced in Oz when I did my training, so I have personally never before had to look after a young person dying of ESRF without any form of renal replacement therapy. It is a very harrowing experience, particularly when both they and their families know full well that life saving treatment could be provided, and it is only financial considerations that are denying them that treatment. I have also become more experienced than I would like to be at judging when regular morphine should take over from ACE inhibitors, phosphate binders, etc.

It is interesting to note that at various times, chronic dialysis services have been available in both Suva and Lautoka (I'm ashamed to admit I don't know what the situation has been in other Pacific island countries). But they have depended on the presence of both enthusiastic clinicians and money, both of which come and go - over the last 10 years or so, neither seem to have been present.

In the last few months some prominent members of the community, several of whom have had transplants and/or been on long term dialysis in Oz or NZ, have banded together to form a Fiji Kidney Foundation. This has the express purpose of instituting chronic dialysis services and facilitating transfer to Oz or NZ for transplants. These enthusiasts argue that Fiji can in fact afford such services (although they seem to have a relationship with a provider of dialysis uids that must engender some suspicion).

Obviously there is a concern that lobbying by in uential people is not the best way to determine priorities in the provision of health services. The Public Health people in particular are concerned that investing in such costly "curative" services will divert funding from much more valuable (in their eyes) preventive services. However, it would obviously also be wrong to deny members of the community a voice in what they see as the best way to spend the health dollar, and, as I have already said, it is particularly harrowing and wasteful to the community to have otherwise well and productive people dying of a potentially curable condition.

It will be interesting to see how the matter progresses – my own personal view is that we are probably not quite ready yet for such services in Fiji. However, I will certainly embrace with enthusiasm the provision of such services if they do eventuate, and I know my physician colleagues over here will join me in heaving a sigh of relief if we are spared the awful task of explaining to patients and their families that there is nothing more we can do for them because the services which could save their lives are not available in Fiji.

Well, that is about all for now - except to point out that the Fiji School of Medicine position in internal medicine in Lautoka has as yet not been filled. So if any of you are still interested but haven't summoned up the enthusiasm to enquire further, a wonderful opportunity is still available to experience internal medicine in a way which I can (almost) guarantee will be uniquely satisfying and enjoyable.

Vinaka vakalevu and moce mada

ROB MOULDS

TOWARDS BETTER DELIVERY OF SPECIALIST PHYSICIAN SERVICES IN REMOTE AREAS.

In this feature, four IMSANZ members describe some of their experiences in regards to providing outreach physician services to rural and remote communities.

AIDAN FOY

Newcastle

I have just returned from Central Australia where I was participating in the Medical Specialist Outreach Assistance Program (MSOAP). This is a federal funded program which pays for specialists to visit remote communities to provide both secondary medical care and education of local clinical staff.

Remote communities are ideal for the practice of General Medicine. In fact, specialist care in Internal Medicine can only be provided by general physicians. The majority of patients have metabolic syndrome in its various manifestations, whilst others present with a wide variety of problems such as dilated cardiomyopathy, respiratory failure, vasculitis, mixed connective tissue disease and the various manifestations of liver disease just to mention a few of the conditions I have seen personally.

Almost no patient will present with disease in one organ system only, and all are much sicker than anyone we would encounter in outpatients or rooms in metropolitan centres. Referral to other disciplines is possible, but you need to be selective because of the travel involved and other logistic problems. Most of these referrals will be for tertiary procedures, although in some cases, such as the mobile echocardiography service provided by Warren Walsh from Prince of Wales, the tertiary service comes to the patient.

Therefore, when faced with a patient with diabetes, hypertension, and deteriorating renal function 400kms from the nearest hospital, the visiting specialist must just get on with it and formulate and execute a management plan. The patient may not see another doctor of any kind for several more months.

This is a very challenging environment and one in which I have learnt a great deal about the gaps in my own practice. It is also an extremely enriching training experience as we found during our previous attempt at a clinical attachment to the Nganampa Health Council situated in the Pitjantjatjara Lands in South Australia. That project failed because of lack of infrastructure but we did demonstrate that we could provide a good clinical service and unforgettable education for our registrars. The MSOAP program does have substantial infrastructure and political support and lends itself nicely to incorporating training modules in the various aspects of Internal Medicine that are exemplified in these locations.

At the moment, Ciara O'Sullivan, who is the only fulltime physician with the program, is trying to provide services for an enormous area (approximately 1.2m sq. kms), to recruit others, and to coordinate their activities. She does have the committed support of the Department of Medicine at Alice Springs Hospital which makes things a bit easier, but it is a huge task. I can make a small contribution by taking responsibility for six visits a year to a small group of related communities, but much more is needed. I would like to build up to the point at which we at Newcastle had a specialist and a registrar out there for most of the year and we can probably get to that point if we work at building the relationship.

If we can get involved to this extent, so perhaps can others. I realise that many people have tried similar things, and that there are a number of outreach programs in various parts of the country, with physicians making significant personal sacrifices to keep them running. If however, every major tertiary and secondary centre took responsibility for a group of remote communities under the auspices of MSOAP or some other scheme, it should be possible not only to provide specialist care in Internal Medicine to the whole of remote Australia but also incorporate Remote Area Health into every training program in General Medicine in the country.

DIANNE HOWARD

Darwin

I have been involved in providing outreach services from RDH for over 20 years, as is the case for every physician, regardless of primary specialty, who is appointed to RDH. While I welcome any attempt to provide outreach services that meet a pressing clinical need, and realise there are many different ways of doing this, most of us who work in the Bush would offer the following perspectives.

Fly-in, y-out (FIFO) specialists are nowhere near as valuable as people who live in the region doing their own outreach and who become highly knowledgeable of local exigencies. Despite my longstanding participation in doing bush clinics in the northern region, last year I started doing clinics in the Barkly region [about 700 km further south around Tennant Creek] and while the diseases I treat are the same, the people, the problems and the solutions are different. Thus I'm learning all the time.

People who live in remote communities will always need FIFO and drive specialists, but they should be specialists from a local hub. Providing specialist services with projects such as MSOAP using specialists from elsewhere are of limited effect in improving the basic health infrastructure or resources in the regions. Despite best intentions, it is a bandaid solution in the short term and indeed often adds to the workload for primary health carers when specialty services are provided by people without local knowledge.

We would prefer that physicians wanting to practise rural medicine come and live here and throw in their lot with us. That's real commitment and does not run the risk that local resources are being used to simply enlarge the training programs of distant hospitals. As we have experienced first hand, the value of the outreach specialist is not just in the act of consultation. Indeed, it is often only a minor part of the contribution. The local physician comes to "belong" i.e owned by the communities he/she services and in turn becomes their advocate and facilitator in the regional hub, and helps them unravel hitches in the health care system, which is something a remote FIFO specialist can never do, quite apart from issues such as local knowledge.

Another frustration is that when we are trying to run programmes for our own registrars, most of whom are here because they want the remote experience, we often can't take them bush with us because there is no cover at the base hospital and/or no travel funding to do so. That's why I am not keen on having remote FIFOs using our positions for their own registrar training, which seems at odds with the intention of MSAOP funding.

After thinking long and hard about how our colleagues on the seaboard can best contribute to services for remote and regional Australians, some of my thoughts include:

- Reliever terms [leave cover, 'sabbaticals' and "backfill"] to allow some of us to take holidays, do more bush trips, write up papers and undertake even a bit of local research. Our heads are brimming full of ideas, theories and observations, but we never get a chance to express or develop them.
- Job swaps to enable remote folk to refresh/acquire new knowledge/techniques, or even just experience some contact with colleagues and the intellectual challenge of working in top institutions for 1-3 months. This could be a valid use of MSOAP funds.
- Videoconferencing education sessions, grand rounds, journal clubs and other CME activities to rural and remote locations, which would be a 2-way process. For example, Steve Brady in Alice Springs could present a case to Grand Rounds at St Elsewhere's which could be very educational for all concerned!
- Establishment of conjoint or reciprocal registrar training programmes with a tertiary centre, wherein, for example, we take one of their registrars for 12 months and they take one of ours for the following 12 months.
- Establishment of regional hubs further and further a field. As we have observed here in the NT, outreach services from afar can actually impede the development of good local hub services, by taking pressure off the local health authority to do something. As an example, the development of a top level renal service in Darwin was delayed for 15 years because of well meaning outreach from SA.

People in remote Australia have worse health outcomes for just about every disease that's been surveyed, and the more remote you are, the worse the outcomes. If you are aboriginal, the outcomes are appalling. Not surprisingly, the NT and WA are the worst off, although I suspect that the outcomes for far west Qld and NSW are just as bad, but obscured in the rest of the data from those states. There is an urgent need to increase the supply of specialist services to remote communities and I urge members of IMSANZ to consider how they could offer to help us in addressing this pressing problem.

STEPHEN BRADY

Alice Springs

Outreach services should occur from the local hub whenever possible. However a critical mass of specialists in an area is required to provide this. This has successfully occurred in some areas e.g Cairns, Darwin but not in others e.g Kalgoorlie, Alice Springs.

Hospital care in these areas is also extremely challenging and intense and requires sustainable numbers of physicians. I have seen either 1) shortage of hospital physicians leading to reduced/no outreach services; 2) physicians continuing outreach whilst hospital patients had a poor level of care and poor outcomes; or 3) physician burn out as he/she tries to do everything.

PUBLICISING RESEARCH EFFORTS OF GENERAL PHYSICIANS

IMSANZ would like to list research publications of members on the new "Resource" pages of its website. This aims to convey some idea of the extent and diversity of research undertaken by general physicians to other fellows, trainees and the wider public.

We invite members to submit citations of any articles they have authored or co-authored and which have been published in a peer-reviewed journal since January 2000. We would ask that you use the Vancouver system of citations and Medline journal indexing format (eg Bloggs J, … (to 3 authors followed by 'et al' if more than 3), title, journal (eg N Engl J Med), year, vol, pages. Could you also underline your name in the author list.

IMSANZ website editors may not be able to list all submitted citations due to space limitations, and we will choose those that are likely to be of interest to the majority of general physicians and general medicine trainees.

Please forward your citations to the IMSANZ secretariat by E-mail: imsanz@racp.edu.au *or* by Fax: 02 9247 7214

The ideal is to build a sustainable number of physicians in a region. However this has not occurred to date in many areas, partly due to lack of political will and money, partly due to few suitable physicians, and partly because not everyone wishes to live in "remote areas" (although I am not sure why).

Until we achieve a Utopia of physician saturation in outback Australia I think we will continue to have a need for "FIFO specialists" to augment local services. The challenge is to manage this in a way that maximises outcomes and provides a service that is much better than no service at all (which is often the alternative).

To do this I feel a FIFO service should be built in collaboration with the local service providers, appropriate cultural and clinical orientation should occur, and close clinical collaboration should be ongoing.

Providers need to have an appropriate skill mix (e.g be able to actively manage advanced chronic renal failure) and be committed to provide a continuing service. The benefits of this are in providing remote providers with relief, together with support and links to major centres. Physicians from major centres get to provide real medicine and understand what occurs in the "bush".

To provide an appropriate workforce for the future to work in such areas we need to continue to provide good general medical training both in tertiary centres and in remote centres, and expose more trainees to both the breadth of clinical experience and the good roles models working out bush. In the end, a few more may join us!!!

KENNETH NG

Kalgoorlie

My experience of providing outreach to the Goldfields on a day to day basis is that the varied patient populations and the challenges posed by isolation and scarce local resources means I have had to practice differently depending on where I am. While the care I give does not vary, the logistics of delivering it has to accommodate issues of cost and levels of intrusion of my visits into the day to day life of my patients. It costs over $1,000 to y a patient from the central desert to Kalgoorlie and accommodate them and y them back. It's much cheaper if I go to them.

Such outreach services have been going on well before MSOAP even existed in anyone's mind. From 1994 I have visited Cosmo-Newbury, Warburton, Wingellina, and Warakurna to name a few communities as a personal service commitment. They are all on the WA side of the central desert communities which comprise the Ngyanjatjarra, Tjuntjunjarra, Patjarr and Wongutha Communities. The travelling was by hitching rides with the RFDS or hiring planes, the latter involving ACAT visits at the same time, which was a means of generating some funding. But it was all self generated work and therefore not recognised.

However, with the advent of MSOAP and its administrative needs, I was obliged to travel to Alice Springs and go from there. Unfortunately I did not have the time to travel from Perth to Alice, sometimes via Adelaide, so now I only go to Tjuntjunjarra and Coonana as I can hitch a ride with the RFDS clinics and am not constrained by the bureaucratic requirements of the Alice office. These visits are in addition to my other MSOAP commitments to Esperance and Norseman. David Henshaw does Southern Cross, Menzies, Leonora, and Laverton. Between the two of us, we cover 1,000,000 sq km containing over 20 widely separated communities. So you can appreciate we find it difficult to do all of this plus provide a consultant practice locally.

At the moment, Ciara O'Sullivan looks after the NT side while nobody is holding down this side of the central desert communities, given that I will shortly be departing Kalgoorlie for a new job in Caloundra/Cooroy after working here for more than 10 years. But there is one solution I would offer to all IMSANZ members and that is for everybody to volunteer for at least 1 trip a year to these places and therefore not only help Ciara out in NT but also provide cover to communities in WA as well. You might find the clinical work, and the opportunity to sample life in a desert town, a refreshing experience. The person to contact is Carol Muir at cmuir@cyllene.uwa.edu.au from the West Australian College of Rural and Remote Medicine who administer the MSOAP.

WHAT IS MEANT BY 'NURTURING THE PHYSICIAN WITHIN'?

The recently released General Medicine Forum report introduces the notion of nurturing 'the physician within' as one means for improving access of the population to physicians competent in providing specialist care across the spectrum of internal medicine. But what does the phrase mean exactly? Les Bolitho explains:

The 'Physician Within' promotes two or more concepts.

The first concept is to support Subologists who need confidence in handling general medicine (GM) issues outside their specialty. Most have GM training but have become deskilled. General physicians can play an important role in promoting this upskilling.

The second concept is to reach out to Subologists in Ology Units and attempt to promote the concept of 'cross-ology' sharing of management and experience, and encouraging trainees to maintain their GM skills, as well as providing GM trainees with opportunities for training in specific subspecialties or procedural areas.

The short term aim of increasing the number of already trained physicians to expand their management skill base and alleviate the immediate shortage in general physician services can only be achieved by encouraging our fellow Ologists to include more GM in their workload. In order for this to happen, our colleagues must receive appropriate training in GM.

LES BOLITHO

CRITICALLY APPRAISED TOPICS (CATS)

Atrial Fibrillation (AF): Rate or Rhythm, Rhyme or Reason?

Rate control is just as effective as rhythm control in preventing death and stroke for patients with AF, and results in fewer hospital admissions.

Citation: The AFFIRM investigators. A comparison of rate control and rhythm control in patients with atrial fibrillation. N Engl J Med 2002; 347:1825-1833.

Three-part Clinical Question: Is rhythm control better than rate control in preventing death or stroke or other adverse outcomes including hospital admission in patients with AF?

The Study: Non-blinded randomised controlled trial with intention-to-treat analysis. Randomisation stratified to one of 213 treatment sites.

Patients: Age>65years. Eligible for anticoagulants. AF deemed by their physician as both likely to recur and to contribute to morbidity/mortality. Hypertension: 71%. CHD: 38%. Left atrial enlargement: 65%. LV dysfunction: 26%. Mean age: 69.7 years. Women:39%. Ethnic minority group: 11%.

Control group (N = 2027; 2027 analysed). Rate control: aim for resting heart rate of < 80/min and post-six minute walk heart rate < 110 /min. Rate control achieved with beta blockers and/or non-dihydropyridine calcium channel antagonists and/or digoxin.

Experimental group (N = 2033; 2033 analysed): Rhythm control: drugs and/or cardioversion at the discretion of the treating physician.

Withdrawal and Follow-up: 71 patients withdrew and 26 were lost to follow up. Mean follow-up was 3.5 years. Maximum was 6 years.

The Evidence: event rates derived from figures quoted in the publication. These were derived by Kaplan-Meier estimation.

Outcome	Time to Outcome	CER	EER	RRR*	ARR*	NNH
death from any cause	**5 yrs**	**0.259**	**0.267**	**NS***	**NS***	**NS***
composite endpoint:death, disabling stroke, anoxic encephalopathy, major bleeding, cardiac arrest	**5 yrs**	**0.327**	**0.320**	**NS***	**NS***	**NS***
admission to hospital	**5 yrs**	**0.73**	**0.80**	**-9 (95% CI: -6 to -12)**	**-0.07**	**14 (95% CI: 10-23)**

*** CER: control event rate | EER: experimental event rate | RRR: relative risk reduction | ARR: absolute risk reduction**
NNH: number needed to treat for one to be harmed
NS: not significant(ie at least 95% chance that there is no difference between the groups)

Ischaemic stroke at 5 years: (NS)
Rate control: 6%
Rhythm control: 7%

Patients in sinus rhythm:	**1 year**	**3 years**	**5 years**
Rate control:			35% (80% had adequate rate control)
Rhythm control:	82%	73%	63%

Anticoagulation:
62% of INR values between 2-3 at follow up. >85% rate-control group and 70% of patients overall continued warfarin throughout

"Crossovers":	1 year	3 years	5 years
Rate to rhythm:	8%	12%	14%
Rhythm to rate:	17%	27%	38%

Comments:

- the only significant difference between the groups was admission to hospital, however, the mortality endpoint approached statistical significance in favour of a survival advantage with rate control (p value of 0.08 derived from the log-rank statistic).
- more "torsade de pointes" (12/2033 v 2/2027. P=0.007) in the rhythm compared to the rate control group
- 70% of the strokes in both groups occurred in patients who had stopped taking anticoagulant therapy or who had INR <2.0, highlighting the requirement for anticoagulation
- surprisingly high prevalence of sinus rhythm in the rate control group may be a consequence of 36% of trial patients having only one episode of AF at the time of recruitment
- sub-group analysis: patients > 65 years and (curiously) patients with no cardiac failure, showed significantly lower mortality with rate control
- amiodarone was the most commonly used drug for rhythm control (63%) followed by sotalol and propafenone. Dofetilide became available during the study
- these patients were >65 years. Younger, symptomatic patients could benefit from rhythm control

WHAT'S IN THE JOURNALS?

General Internal Medicine

Outlined below are recent publications of relevance to General Internal Medicine. Please send along additional publications and/or comments.

The public hospital of the future.
Zajac JD. MJA 2003; 179:250-252

Professor Zajac discusses the evolution of public hospitals. He considers that relationships between general and subspecialty clinicians are likely to improve as "pure" general physicians are replaced by subspecialist physicians with an interest in general medicine. In a letter responding this (Walpole BG. MJA 2004;180:47), Brian Walpole, an emergency physician reports his views on such relationships. In response, Professor Zajac discusses the important of physicians cooperating to give up "territorial imperative in full ight".

Integrated critical care: an approach to specialist cover for critical care in the rural setting.
Hore CT et al. MJA 2003; 179:95-97.

The requirements for rural critical care can be addressed through multi skilled critical-care specialists, who are "empowered to work beyond the perceived traditional boundaries", according to the authors. This paper was followed by a number of letters (MJA 2003;179:510-512).

Specialists need general training.
Batey RG. RACP News. August 2003. 14.

A request to the RACP to ensure that advanced training in the various specialties includes rotations through general medical terms and afterhours general medical experience. Also see "General Medicine", the report on the forum hosted by the RACP in Mar 03, which is published on the RACP website.

American internal medicine in the 21st century. Can an Oslerian generalism survive?
Huddle TS et al. J Gen Intern Med 2003; 18:764-767.

The history of general internal medicine in the USA is outlined, along with the particular threats posed by the development of "managed care".

The future of general internal medicine. Report and recommendations from the Society of General Internal Medicine (SGIM) Task Force on the domain of general internal medicine.
Larson EB et al. J Gen Intern Med 2004; 19:69-77.

A task force was commissioned to redefine the domain of general internal medicine. The report includes statement of core values and competencies, especially those that distinguish general internal medicine, and 8 specific recommendations for the future. In an accompanying editorial (Challenges and opportunities for general internal medicine. Shapiro MF. J Gen Intern Med 2004;19:95-96), further comments are made about the role of general internal medicine, particularly in the USA, and the challenges raised in Larson's report.

A rural ethical dilemma.
Komesaroff P. RACP News. December 2003:14-15.

Dr Komesaroff, RACP ethics convenor, discusses the ethical issues around a request to the RACP Rural Taskforce for "input into a proposal by a major health company to provide a one-off significant grant in the form of relocation expenses to a young physician who had moved to a country town in which the company has a private hospital. The conditions imposed by the company that the doctor would apply for admitting rights to the hospital and would stay in the town for a minimum of one year". Grant Phelps and James Hurley responded in RACP News February 2004:15-16.

Evidence-based guide to slowing the progression of early renal insufficiency.
Johnson DW et al. Intern Med J 2004; 34:50-57.

David Johnson presented some of this material in an outstanding session at an IMSANZ ASM. A recent editorial in the BMJ (Sims RJA, Cassidy MJD, Masud T. The increasing number of older patients with renal disease. BMJ 2003;327:463-464) suggests that nephrology trainees should enhance their geriatric skills, and the same could be argued here.

Thoughts for new medical students at a new medical school. Smith R. BMJ 2003;327:1430-1433.

This issue of the BMJ was the Christmas edition for 2003. It is worth perusing the table of contents, which includes many treasures (bmj.com). For this paper Richard Smith, BMJ Editor, consulted with members of his Editorial Board. The result is this informative, entertaining and at times provocative paper. It is illustrated with relevant quotations and images, which are available as a "powerpoint" presentation at www.bmj.com/talks. Mandatory reading for us all!

Notes of a surgeon on washing hands.
A Gawande New England J Med 2004; 350: p1283-6

PETER GREENBERG
Melbourne

(From Page 22)

See also Van Gelder IC et al. A comparison of rate control and rhythm control in patients with recurrent persistent atrial fibrillation. N Engl J Med 2002; 347: 1834-1841. This was a smaller trial with similar methods and results, but with only a composite end-point; Hohnloser SH, Kuck KH, Lilienthal J. Rhythm or rate control in atrial fibrillation—Pharmacological Intervention in Atrial Fibrillation (PIAF): a randomised trial. Lancet. 2000;356:1789-94; Falk RH. Management of atrial fibrillation-radical reform or modest modification? (editorial) N Eng J Med 2002; 347: 1883-1884.

Appraised by: Simon Chatfield, Royal Melbourne Hospital, March 2004
Email address: Simon.Chatfield@mh.org.au
Kill or Update by: March 2005

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:

Tom Thompson - tomt@ghw.co.nz OR thomfam@clear.net.nz
Michele Levinson - michelel@bigpond.net.au

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

Dr Tom Thompson
Wanganui Hospital
Private Bag 3003
Wanganui, New Zealand

Phone: (06) 348 1234
Fax: (06) 348 1206
Email: tomt@ghw.co.nz

Dr Michele Levinson
Cabrini Hospital
183 Wattletree Road
Malvern, Victoria, Australia 3144

Phone: (03) 9576-0643
Fax: (03) 9824-8531
Email: michelel@bigpond.net.au