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From the President...

Dear IMSANZ Members,

Conjoint Committee proposal

As many would know, the Specialties Board has recently invited expressions of interest (EOI) from Specialty Societies to develop and trial pilot conjoint committees between an individual society and the college. These pilots were recommended by a special Specialties Board workshop which we reported on in the last newsletter (April 2004, pp. 15-16). These committees would work through the detail of sharing responsibilities between the society and the college across a spectrum of activities including training, education, and accreditation, finances and resources, and policy and communications. The 8 page EOI form indicated that applicant societies would need to commit heavily in time and manpower to achieving the desired outcomes. Unfortunately the time between notification and closing of submissions was less than 3 weeks (and over the school holidays!). This issue was considered by Council and it was agreed not to commit IMSANZ to this initiative at this time, although we remain a keen observer of the process.

Six submissions were received from the Cardiac Society, Thoracic Society, GE Society, an alliance between the a partnership between the Endocrine Society, Diabetes Society and Bone and Mineral Society, the Society for Geriatric Medicine, and the Association of Neurologists. We were informed on 18/8/04 that the Cardiac Society, the Thoracic Society and the Geriatricians have been chosen to participate in the pilot programs. We wish our colleagues well in undertaking what will be a major program of reform of college structure and operations.

However, we also respectfully ask that, given the impact their deliberations will have on the way the college interacts in the future with all specialty societies, not just theirs, those involved in these pilot programs will assume the responsibility of conducting these pilots impartially, democratically and transparently, and in a way that will not disadvantage any one society relative to others. I am reliably informed that the Cardiac Society had indicated to the college that it had $500,000 at its disposal to share with the college, in addition to its in-house resources, in operationalising the conjoint committee and implementing changes in training programs and other areas of activity that the committee may recommend. Those of us belonging to societies which are unable to raise such amounts of discretionary funding hope that the college administration, in its selection of societies and the subsequent development of policy and procedures under which future conjoint committees will operate, will not be unduly in uenced by the financial strength of individual societies who may stand to benefit from this exercise to the detriment of smaller and/or financially weaker societies.

As you turn the pages...

PRESIDENT'S REPORT

August 2004

It does appear likely, driven by issues of governance and logistics, that, in the future, the college would prefer to form conjoint committees with a small group of single or amalgamated societies rather than have 27 separate committees involving every individual society and faculty. The presidents of the three endocrine-related societies mentioned above clearly recognised the advantage of uniting to form an entity that could wield more in uence than could be achieved if they were to operate in isolation, despite their past history of wanting to follow somewhat separate paths. I suggest IMSANZ should consider doing the same, and the society with which we have most in common is, in my view, the Australian Society of Geriatric Medicine (ASGM). We are both 'generalist' societies with members who have trained in, and practise, both general and geriatric medicine, and we share common 'whole-patient' approaches and values. I and other members of council are presently engaged in conversation with our counterparts in ASGM regarding the potential of establishing an alliance between our two societies.

This new conjoint committee initiative is going to have considerable ramifications on the future functioning and accountability of the college (see article inside), and we will need to monitor developments closely to ensure that collegiate attitudes and values on which the RACP was founded are not usurped by a play of power politics.

General medicine in Sydney teaching hospitals

Subsequent to comments I made in the April newsletter, it is with disappointment that I advise that IMSANZ has received no reply, written or verbal, from the Director General of Health in NSW (Robyn Kruk) in response to the letter I wrote to her regarding our concern at the appointment to general medicine posts in some Sydney teaching hospitals of specialists with limited experience in general medicine. These appointments were driven by expediency in light of the revelations of the HICC inquiry into the Campbelltown-Camden hospitals (the 'Cam affair').

On a more positive note, I was able to discuss the views of IMSANZ about the most appropriate remedial action with the new president of the college, Jill Sewell, and she has voiced the need for more general medicine services in Sydney in talks with local area health bureaucrats and in public forums. NSW authorities have approved a statewide proposal that, beginning in January 2005, all basic physician trainees will rotate to rural and outer metropolitan hospitals as well as inner city institutions within specified hospital networks. While on paper the requirements for support of a proper learning environment and supervision look reasonable, the college and IMSANZ will need to monitor the real situation closely. More overseas trained doctors are also being recruited and the college has submitted advice about overseas qualifications and work settings that might allow more rapid assessment at employer level for areas of need. IMSANZ members are willing to be involved in ensuring position descriptions re ect best practice from a generalist perspective.

Recent scientific meetings

The 2004 RACP Annual Scientific Meeting in May has come and gone and, with the attendance of more than 900 delegates, it was another successful meeting in which the Adult Medicine program organised by an IMSANZ committee led by Les Bolitho and Mary-Ann Ryall was a key factor in attracting so many registrants. Our thanks to Les and Mary-Ann and all the councillors who tirelessly and without remuneration worked towards achieving such a pleasing outcome. Highlights of the meeting are recounted in succeeding pages.

One of the greatest pleasures I had at the ASM was chairing the IMSANZ Advanced Trainee Free Papers session, in which no less than 7 candidates vied for the IMSANZ award sponsored by Roche pharmaceuticals. The quality of all seven presentations was outstanding and it was a very difficult task for our judges to choose a winner. All abstracts will be published in a forthcoming issue of the Internal Medicine Journal. I would ask all those who supervise advanced trainees to encourage these young folk to start thinking now about working on a presentation for the 2005 meeting. More details on how to submit an abstract can be obtained from our secretary.

I was also able to attend the New Zealand RACP joint annual scientific meeting in Christchurch during the first week of August, organised by members of IMSANZ (in particular David Cole and John Thwaites), in collaboration with folk from the Thoracic, Infectious Disease and Respiratory Sciences Societies. The lectures and workshops dealing with the management of pulmonary thromboembolism and chronic obstructive pulmonary disease were evidence-based and practical, and the conference dinner with its "Hawaiian" theme was great fun. I enjoyed the opportunity to talk with many of our NZ colleagues on various matters at the IMSANZ business meeting and throughout the conference.

Acute medical units led by general physicians

One of the things that struck me as I listened to the many high-quality presentations given by a number of our members at the RACP ASM in Canberra was that we do not have a vehicle for disseminating knowledge of these and other innovative projects to the wider membership. As a result, the editors have adopted my suggestion for a regular feature in the newsletter that will detail interesting new projects being undertaken by general physicians and which have implications for, or could be replicated by, general physicians elsewhere. John Henley from New Zealand kicks off this new series with his description of the recently established Acute Medical Unit run by General Medicine at the newly rebuilt Auckland City Hospital. It is of interest that the Royal College of Physicians in the UK recently announced its support of the establishment of such units in all major hospitals throughout that country in an effort to improve quality and safety of acute inpatient care (see "Acute Medicine: Making it work for patients" RCP June 2004; Summary and recommendations available at: www.rcplondon.ac.uk/pubs/books/AcuteMedicine/AcuteMedicineSummary.pdf) It will be of interest to see what the response of the RACP is to this development. It is fair to say that acute medical units in Australian hospitals have had a chequered career to date

and more needs to be done in encouraging general physicians and our specialty colleagues to work collaboratively in establishing workable units for the betterment of patient care.

Advanced training curriculum

The advanced training curriculum is now in its penultimate draft and it was hoped to have circulated it by now to members for comment. The hitch has been the postponement of a college workshop that was scheduled for 30 June at which we had hoped to receive feedback on the draft from the college Education Unit before more general release. The curriculum is being reviewed by all Councillors and members of the SAC in General Medicine, and it is hoped may be circulated to the wider membership in the next month or two.

AMC accreditation survey

The Australian Medical Council interviewed members of the SAC in General Medicine on August 17 by telephone. The opportunity was taken to articulate some of our concerns with the current training program, especially in regards to access of advanced trainees in general medicine to subspecialty rotations.

Improving access to specialist services in rural Australia

As this newsletter goes to press, a teleconference is to be held on the 31st August involving Bob Wells (secretary of Department of Health and Ageing), John Horvath (Chief Health Officer), Robert Griew (CEO of the Northern Territory Department of Health), Jill Sewell (RACP president), Nip Thompson (RACP vice-president), Rick McLean (Chair, RACP Rural Taskforce and president AMDC), Craig Patterson (CEO college), and IMSANZ representatives (myself, Les Bolitho and Mark Morton) to discuss the issue of general medicine and supply of physicians to rural areas. Never before have so many heavyweights gathered at one meeting to address this important topic and I can ensure you we will not waste this opportunity to voice what we regard as the changes that need to be made at college and government levels to improve the current status. More on this in future correspondence.

In the December newsletter, we will also provide an abridged version of a discussion paper on improving rural specialist services recently released from the National Rural Health Policy Sub-committee of the Australian Health Ministers Advisory Council. This paper was informed by written and verbal submissions from various members of Council and I am pleased that many of our policies on physician training and service delivery involving general physicians have been clearly articulated in this document which will be considered by all Australian health ministers. This is a very important issue and will attract debate and presentations from key policy-makers at next year's clinical meeting in Alice Springs.

New councillors

A number of new councillors were announced at our recent AGM who replace those councillors completing terms of office. I wish to thank all those departing for their concerted efforts during their time on council and welcome our new folk at a time of much change and energy within IMSANZ. The new team members comprise Michelle Levinson, metro Vic (replacing David Russell), Peter Nolan, rural Qld (replacing Thein Htut), Christian da Garneet, rural WA (replacing Kenneth Ng), Nicole Hancock, metro Tas (replacing Rob Nightingale) and Patrick Gladding, AT rep NZ (replacing Graeme Dickson).

Council portfolios

At the last Council meeting in Canberra, it was agreed to rationalise the existing committee structure into a smaller number of portfolios. The new portfolios comprise Resources (comprising Members and Expenditure) chaired by Les Bolitho, Education and Training chaired by Phillippa Poole, Communications and Health Policy chaired by Justin LaBrooy, and Research chaired by myself. It is of interest that in the new college organizational structure proposed by the college CEO, departments similar to the portfolio structure now existing within IMSANZ are planned which, we hope, will make our interactions with the college more efficient. The portfolios are engaged in various activities and outcomes will be reported in the newsletter from time to time. I encourage members to forward any thoughts or comments they have to the relevant portfolio chair.

IMSANZ Annual Report 2003

Council recently decided that it was time that IMSANZ produced an annual report of its activities and financial status for a number of reasons: an annual report would provide a convenient summary of all the key developments of the Society over the previous 12 months; there is no longer enough space in the newsletter in which to report all this material; and it was thought desirable that we produce a stand-alone document that will help promote our society and ensure its accountability in the eyes of members and the wider public. Accordingly it is with pleasure that our inaugural report for 2003 is enclosed with this edition of the newsletter. I hope you find it informative and useful. We welcome your feedback in improving its content over future years.

As always, we invite our readers to send letters on any subject, as well as notification of any events, policy releases or published literature that you feel have implications for the current and future practice of general internal medicine.

IAN SCOTT
President, IMSANZ

NEW ZEALAND VICE PRESIDENT'S REPORT

IMSANZ (NZ) Business Meeting Christchurch (August 5, 2004)

There is a sense of momentum and progress on issues germane to general medicine, and general physicians, both within the RACP and in the health care systems in Australasia. More information on these and other initiatives is provided in the RACP News and the IMSANZ newsletter, as well as on the RACP and IMSANZ websites.

IMSANZ COUNCIL

- Welcome to Patrick Gladding as the new NZ Advanced Training (AT) representative.
- Council portfolios now match college structure
  1. education and training (Phillippa Poole)
  2. health policy and communications (Justin laBrooy)
  3. research (Ian Scott)
  4. resources (incl. membership) (Les Bolitho)

A draft strategic plan that includes all of these areas has been developed, however, there is a need to develop a specific NZ section of this document.

Relationship between Special Societies (SS) and RACP
RACP has asked for expressions of interest for SS to form conjoint committees (CC) with the Adult Medicine Divisional Committee. Six have been submitted, and two will be selected for a pilot. IMSANZ is adopting a "wait and see attitude", as we lack resources to commit to this, and have had an undertaking from the RACP that waiting will not prejudice IMSANZ.

There were some major concerns expressed at the NZ Specialties Board on July 30th that the CC may not meet NZ interests. The relationship among SS, Specialist Advisory Committees (SAC) and the RACP in NZ is relatively good. IMSANZ remains strongly opposed to joining the Australian and NZ SAC, given the relative strengths of general medicine in NZ, and the major differences in the health systems between the two countries.

1. EDUCATION AND TRAINING

RACP education strategy and General Internal Medicine AT Curriculum. Draft 5 of the general medical (GM) advanced training curriculum has been circulated to the SAC. We are ahead of many other special societies in the development of this and are therefore in a "holding pattern" at present. As yet the assessment of this has not been discussed, but will incorporate existing tools such as the professional learning portfolios.

Other RACP education projects just about to start include development of a generic curriculum ("the physician within") for all trainees, the development of basic training and the re-evaluation of the barrier assessment into advanced training. Continuing education for fellows is also a focus, and a revamp of the MOPS program is occurring.

Upcoming Meetings
- RACP ASM 8-11 May Wellington New Zealand 2005
- IMSANZ Alice Springs NT Australia 1-4 Sept 2005-convenors Steve Brady and Di Howard
- IMSANZ (NZ) early 2006 Palmerston North –convenor Kirsten Holst
- ESIM Alicante Oct 2004: Patrick Gladding has been selected as the AT representative. There is the opportunity for "faculty" to go. Suggest a NZ general physician representative in 2005.
- *Note: There was a lively discussion on the IMSANZ (NZ) meeting cycle from 2006. We agreed to meet with RACP (NZ) in the latter part of 2006 but plan to continue with the development of IMSANZ stand-alone meetings, and to look at ways to ensure that the IMSANZ identity remains at the forefront of joint meetings.*

RACP 2005 ASM update
Committee: Sisira Jayathissa, Pip Shirtcliffe, Ian Scott, Les Bolitho, and Phillippa Poole.

IMSANZ is coordinating the adult program for the Adult Division of the RACP (Tuesday/ Wednesday). Owing to the hard work of the Wellington group, this is coming together well, in three broad themes-clinical updates; emerging/reemerging diseases; professional skills; research. We are collaborating with Faculty of Public Health, and Paediatrics for a couple of sessions. Special Societies are being asked to nominate speakers and topics for sessions. There is a strong NZ avour!

Ideas for venue and after-dinner entertainment for the IMSANZ dinner on Tuesday night are welcome!

2. HEALTH POLICY AND COMMUNICATIONS

Workforce
The CD with templates outlining the environment for GM trainees at each hospital has been distributed to all new advanced trainees. This contains several NZ sites. An update is planned for later this year so get your hospitals on there. (email Mary Fitzgerald for a copy of the template imsanz@racp.edu.au). The word is out there in Australia that NZ provides good training, so detailing your positions should be beneficial to you.

Communications
- Tom Thompson has resigned as NZ newsletter editor. We desperately need a newshound/ arm twister to ensure that we continue to provide good copy from NZ. Please consider this important opportunity to put your writing skills to the fore.
- Over next 12 months the Executive will be updating the A5 booklet General Medicine-The Way Forward.

Website
The IMSANZ website is being revamped. Ideas welcome.

General medicine services
The council plans an emphasis in the next year on talking to health departments about the inclusion/retention of general medicine services (particularly for Sydney)

3. RESEARCH

Any general physician leading a research program that may be able to provide any advice or support to a general physician wishing to undertake a research project, please contact Ian Scott Ian_Scott@health.qld.gov.au.

GETTING THE BALANCE RIGHT

This is the first newsletter to IMSANZ members since the election of the new council. One of the outcomes of the Council's first meeting in May was to arrange portfolios for which individual council-members take responsibility and that match up with the re-organised College administrative structure. It is hoped that this will allow members to identify the relevant councillor to represent them and their opinions on the IMSANZ Council and through it, other levels of the College. The three portfolios that match the re-arranged units in the College are:

1. Education – Training & assessment, Examinations, Continuing Education and Professional Development.
2. Resources – Finance, IT, the Website and Database
3. Policy and Communications.

In addition, a 4th Portfolio will be Research which Ian Scott will chair.

I have been asked to act as the primary liaison for the Policy and Communications portfolio. I am taking the opportunity this newsletter provides to highlight both old and new policy issues that I sense IMSANZ needs to address. For some we need to be reactive because they are already on the College's agenda, for others, pro-active in getting them onto it.

Background history

The history of the College and the development of specialist internal medicine is vital to understanding the present challenges facing Internal Medicine. The College began with two groups, Paediatrics and Adult Medicine which were different both in practice and in training. The burgeoning of sub-specialty medicine and the formation of Special Societies in the 1950's which still continues, now with further divisions within sub-specialties, has led to significant changes in balance within the College. ASPIGM (Association of Physicians in General Medicine), the precursor of IMSANZ, came into existence because of the perception of senior members of the College that General Internal Medicine was at risk of being compromised in its capacity to in uence change by not having a distinct voice within the College. Considerable tension exists within the College as it attempts to provide a forum that meets the needs and aspirations of its various constituent groups. The establishment of the Faculties of the College (Public Health, Occupational Medicine and Rehabilitation), and the chapters that relate to the Adult Division (Palliative Care, Addiction Medicine, and Sexual Health) has increased the complexity of what once was a simpler organisation.

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4. RESOURCES AND MEMBERSHIP

Membership
Currently around 400 members, 100 in NZ. There are very few advanced trainees as members, although Patrick is working on this. Please encourage your advanced trainees to join ($50 AUD). Ian Scott has sent a letter to all who passed the examination in Australia and NZ.

Finances
Reasonably healthy, but small compared with larger and older specialty societies. Continued need to work on sponsorship.

Your NZ executive
Phillippa Poole, Bruce King, Andrew Bowers, Briar Peat, Brandon Wong, Patrick Gladding, Neil Graham (ex officio)

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General Medicine, Auckland City Hospital,
and University of Auckland

The Balance between General and Sub-specialty Medicine

The dominant issue that has remained the primary focus of IMSANZ since its inception, is identifying the place of general medicine and its optimal partnership with sub-specialty medicine in delivery of health care to the community. This is particularly pertinent in Australia; less so in New Zealand which has retained a more general focus.

The best fit in metropolitan areas and metropolitan teaching hospitals differs from what is optimal in outer city areas and in rural and regional Australia. There is less contention regarding the model outside metropolitan hospitals. The dominance of urban institutions in training and in uencing career choices of young graduates makes them key to the shape of the future physician workforce. In the NHS, the role of general medicine in providing the initial management of acute medical admissions and co-ordination of continuing care of patients with multiple co-morbidities is being advanced. There has been acceptance particularly in the USA, that the pendulum swing towards a dominance of sub-specialty medicine in large city hospitals can go too far, without demonstrable benefit in terms of outcomes. In Australia, this pattern has become the norm only in New South Wales. How a better balance can be re-established in NSW particularly given its relative population and health budget, will need to be a focus for IMSANZ in the short and medium term. Training programmes that include non-metropolitan hospitals, which are attractive to trainees and provide them with positive experiences that attract them to permanent positions in these areas, are being developed in a number of states. IMSANZ will need to engage State and Federal Departments of Health in ensuring that these reach fruition. The development of regional networks that provide the base for this is the subject of active discussion and negotiation in NSW at present.

Overlap between the Education and Policy Portfolios

Training and Continuing Professional Development have been drawn into one Department within the College and are the primary focus of another of the portfolios within IMSANZ. A curriculum for Internal Medicine, and policy relating to combined formal training in General Medicine and in a sub-specialty, are being developed as part of the College's new Educational initiative. Combined training is a preferred option in New

(Continue Page 6)

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Zealand. There needs to be further discussion with Specialist Advisory Committees supervising sub-specialty training, and Hospital Departments to facilitate positions enabling this pattern of training. At the most recent meeting of the Adult Medicine Divisional Committee, there was agreement upon the importance of providing training, assessment and certification of procedural skills for general physicians providing services to areas where there are no sub-specialists.

New structures for interaction between Special Societies and the College

This is another area of possible change within the College. It is likely that there will be a one year trial that will involve 2 or 3 Special Societies forming conjoint committees with the College to supervise training and continuing professional development. The details of this will need to be finalised in the next few months so that the trial can run in 2005.

The stated aim of this trial, which originated as a proposal from the Specialties Board, is to give Special Societies a greater sense of ownership of College procedures relating to the management of training. It will extend to other areas at present handled by the College but which these Societies see as of particular relevance to their constituents in the specialities they represent. If the benefits of changes made in this way are clear, the opportunity to participate in the model will be extended to other special societies such as IMSANZ. Both the Paediatrics Division of the College and the New Zealand part of the College will be maintaining a close watch on these developments as they do not identify the same need for change as has been articulated by some of the Special Societies.

The Annual Scientific Meeting

The final item to mention in relation to possible change is the Annual Scientific Meeting. For the majority of Fellows who have a defined sub-specialty interest, attendance of this meeting does not feature on their agenda with anything like the same frequency as their Special Society meetings, if at all. A number of radical changes to the format of the ASM will be the focus of consideration in the next year. Given the central role taken by IMSANZ in the running of this meeting in the last few years as well as the decision to have an independent IMSANZ meeting in central Australia next year, consideration of changes in the ASM will be an area in which the Society needs to be pro-actively involved.

JUSTIN LA BROOY
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RACP JOINT ANNUAL SCIENTIFIC MEETING

Christchurch New Zealand

IMSANZ members (L to R) Paul Reeve, Denise Aitken and Andrew Bowers.

The recent RACP joint Annual Scientific Meeting in Christchurch NZ was a welcome opportunity for General Physicians to meet up with our Respiratory and Infectious Diseases colleagues. The three day meeting covered topics of great interest to all delegates.

On the first day, the theme was pneumonia, particularly assessment of severity of community acquired pneumonia. The most interesting "Sleep Medicine for General Physicians" workshop with case-based discussion raised our awareness of common sleep disorders other than obstructive sleep apnoea.

The second day centred around the topic of venous thromboembolism (VTE). There was much interest in Professor Richard Beasley's (Wellington) talk on air travel and VTE. His proposal of "SIT Syndrome" - seated immobility syndrome, rather than economy class syndrome had many people shifting uncomfortably in their seats! Peter Moore (Christchurch) spoke about pregnancy and pulmonary embolism, and management of VTE. The controversy relating to the D-dimmer assay was aired, highlighting the importance of knowing which assay your laboratory uses, and the importance of using the D-dimmer in association with pre-test probability and clinical judgement. A provocative talk from one of the key note speakers, Douglas Coghlan (Adelaide), generated debate over the usefulness of thrombophilia screening. He reminded clinicians that this is a genetic test that could have legal and insurance implications.

Asthma and COPD featured on the program for the last day. A interesting talk from Tam Eaton (Respiratory Physician, Auckland) on non-invasive ventilation reinforced its utility as a therapeutic option for the management of COPD. A workshop in the afternoon led by Phillippa Poole (Auckland) and Ian Town (Wellington) further expanded on the management of COPD, highlighting the latest COPDX guidelines from TSANZ. Throughout the meeting daily lung function workshops were useful in reinforcing basic principles for clinicians to use in everyday practice.

As always, the meeting proved to be a social success. On the first evening there was a poster viewing session with wine and cheese. The high quality NZ wines proved delightfully palatable and some managed to view more posters than others! This was followed by an informal IMSANZ get-together – dinner at a Christchurch riverside restaurant. A chance for those of us scattered around the countryside to catch up with friends and colleagues. The following evening, participation in the Hawaiian theme conference dinner was enthusiastic, allowing an opportunity to see the less formal and more creative side of our colleagues. A band, headed by David Jardine on the ukulele and John Thwaites on the guitar, provided the pre-dinner entertainment. We hadn't realised you could have an electric ukulele! Naturally the IMSANZ physicians were first on the dance oor and we all had a great evening.

During the conference an IMSANZ society meeting was held. Phillippa Poole and Ian Scott led discussion on current issues for internal medicine physicians. It was good to see some new faces and again sample some fine NZ wines.

In summary a most educational and enjoyable three days in Christchurch, and we look forward to the next opportunity to get together with our IMSANZ colleagues.

EILEEN BASS (Auckland)
HEATHER GARDNER (Auckland)
MARK BEEHRE (Wairarapa)

Ian Scott and Phillippa Poole with RACP(NZ)President, Martin Searle and Mrs Searle.

ADVANCED TRAINING CURRICULUM IN GENERAL INTERNAL MEDICINE

Following the release of the RACP education strategy in early 2004, a joint IMSANZ / General Medicine SAC Curriculum Writing Group (CWG) was set up by the IMSANZ Council to work on the advanced training curriculum for general medicine. In this group are: Phillippa Poole (NZ, chair), Andrew Bowers (NZ), Ian Scott, Mark Morton, Peter Greenberg, Les Bolitho, Di Howard, Leonie Callaway, Mary-Ann Ryall and Michael Kennedy. The work has been supported and enhanced by a reference group of Justin La Brooy, Llew Davies, Emma Spencer, Briar Peat (NZ), Aiden Foy, Julia Lowe, and Michele Levinson. Debra Le Bhers and Tony Wrigley at the RACP education development unit have provided support. The general medicine SACs are represented on the CWG by Mark Morton, Michael Kennedy and Andrew Bowers (NZ).

The impetus for this process has been the AMC accreditation visit to the RACP in August 2004 to examine whether its educational processes are capable of producing competent physicians and paediatricians for Australia and NZ. Another issue has been the realisation that the general medicine advanced training curriculum is vitally important for the future of general medicine. The curriculum document will include sections on current and future trends in healthcare, as well as the essential qualities of general medical practice. It will outline training requirements and assist us in determining our own MOPS needs. Importantly, it should serve as a reference and be a useful lever for use with health care providers to emphasize the importance of general medical services, and to ensure trainees have access to quality subspecialty attachments.

The initial step in the process has been the development of advanced training curricula for each of the college training programs. The rationale for starting at the end is to ensure a focus on the desired outcomes of training. For the specialty of general internal medicine these are encapsulated by the response to the question - "What are the desired competencies (knowledge, skills and attitudes) of a trained general physician?" By defining these first, the necessary training experiences and the assessments required to show that these competencies are achieved, follow more naturally. The RACP curriculum writing approach divides physician practice into the seven roles outlined by the CanMEDS taskforce. The CWGs have been asked to concentrate on the "Medical Expert" role for the advanced training curricula.

The other roles of communicator, collaborator, manager, health advocate, scholar/researcher, and professional, will be covered in the generic curriculum and therefore will be developed by groups with wider representation. Prof Kevin Forsyth, a paediatrician from Adelaide, is leading this development.

Not yet tackled is a determination of the assessment methods to be used in the specialist and the generic curricula, or in the barrier assessment between basic and advanced training. The debate about the Part 1 examination in the RACP News is worth following. All correspondents (thus far) have indicated a need for radical change of this assessment, with calls to increase its validity and reliability and to remove its extremely "high stakes" nature.

The CWG considers that the competencies for the role of "medical expert" may be further divided into three themes, being the three spheres of general physician practice, namely:

1. Hospital and Inpatient Care
2. Ambulatory / Community Care
3. Consultation Liaison

The first two are self explanatory, while the third refers to practice in which the general physician provides a specialist opinion and assistance with management of patients under the care of others. There are knowledge, skills and attitudes common to all three, but also some specific to each practice setting.

In each of the three spheres of practice, physicians care for patients with characteristics across the following four dimensions:

- Acute - Chronic
- Undifferentiated - - - - - - - - - - - - - Differentiated
  (diagnosis and management) (management)
- Single-system diseases - - - - - - - - Multi-system diseases
- Adolescence to Old age

Trainees will, therefore, need to demonstrate competencies in all three spheres of practice, and across the four dimensions.

The CWG had intended to release a draft of the general medicine AT curriculum by this time. However, a planned RACP curriculum forum on 30th June was postponed and this has delayed further refinement of the document. The Gen Med SAC will have considered the draft curriculum when it meets the AMC in August. As it is now 31 pages long it will not be circulated to everyone. We are working on the best way to ensure that all those who wish to see it have the opportunity to do so.

If you are interested in joining the Reference Group, or in giving feedback on the curriculum feedback, please contact me. The best way is via email, p.poole@auckland.ac.nz.

PHILLIPPA POOLE
for the IMSANZ Curriculum Writing Group

RETIRING EDITOR

Many thanks to Tom Thompson for his hard work as the New Zealand editor of the IMSANZ newsletter. It is with regret that we received his resignation but wish him well and hope that he enjoys additional hours of recreation instead of labouring with letters.

Michele Levinson and Mary Fitzgerald

POSTCARD FROM THE ANCIENT CITY OF ANGKOR

Ian Scott and family at Ta Prohm

Recently my family and I did a tour of the ancient cities of Indochina – to Sukothai in the middle of Thailand, Siam Reap and the lost city of Angkor in Cambodia, Hoi An and Hue in Vietnam, and Luang Prabang in the jungles of northern Laos. The obvious question: why? Well a liking for Asia, its people, culture and cuisine was one reason, the prohibitive cost of holidaying in 2004 with the entire family of five in places such as Europe and North America was another, and a third reason was the inside information that my sister-in-law, a senior official in Community Aid Abroad, was able to give about these fantastic places, having travelled to these parts of the world as part of her duties. While the multiple vaccinations and need for malaria prophylaxis emphasised we were visiting the Third World, the relatively short ight to Bangkok and the less than $AUS30 per person on meals and air-conditioned accommodation for each day of the tour offset this minor inconvenience.

Walking among the ruins and reading their history, one was struck by how advanced their inhabitants were in regards to artistry, stone and metal work, ceramics, architecture, and, most importantly, communal development. The profound effects of religion, Buddhism and Hinduism in particular, were evident as the transcending spiritual forces that inspired the design of the cities with their many temples and monasteries.

The city of Angkor however deserves special mention. It truly is an underappreciated wonder of the world. It was the pinnacle of ancient Khmer civilisation, and occupied an area of 77 square miles in north-eastern Cambodia. No less than 40 separate self-contained temples, each with its own distinctive architecture and symbolism, and which individually would be of equal standing to Stonehenge or Buckingham Palace, have been reclaimed from the jungles by French-led archeology groups since the late 1800s, after the city was rediscovered by a naturalist named Henri Mouhot (who incidentally died from malaria and was buried at Luang Prabang). From the massive grandeur of the largest temple of Angkor Wat, to the diverse sculptures of Angkor Thom (the Baphuon and the Bayon), to the beautifully ornate and well preserved temple of Bantaey Srei (the Citadel of the Women, and indeed designed and lived in by women), to the dark and ghostly halls of Preah Khan and to the hill-top towers of Phnom Bakheng, the imagination, craftsmanship and perseverance of the builders of these structures can only be marvelled at.

The city was built between 802 and 1432 under the reign of successive members of the Jayavarman and Suryavarman dynasties. While Suryavarman II (reign 1113-1150) was the most brilliant of the Khmer rulers and instigated construction of the great temple of Angkor Wat, it was Jayavarman VII (reign 1181-1220) who was the most prolific builder, constructing more monuments, roads and bridges than all other kings put together. He was also a devout follower of Mahayana Buddhism and this permeated every aspect of his reign.

But a visit to Angkor is also a stark reminder of the transience and impermanence of seemingly impregnable human constructions, both physical and social. Why did the Khmer people abandon such a majestic place? Simple answer - the constant threat of invasion from neighbouring civilisations. Warriors from the kingdom of Champa (located in what is now central and south Vietnam) ravaged the city and set it on fire in 1177, and the Burmese carried out several military incursions over successive years. But it was the repeated invasions by the Thais during the 14th century, and a particularly brutal attack on Angkor Thom in 1431, which rendered Angkor unsuitable as a capital because of its proximity to the enemy and which caused the Khmers to gradually retreat and shift their capital southward over several years to present-day Phnom Penh. Revolt against the ruling class by poor folk resenting the building of extravagant buildings, depletion of adjacent forests, inadequate agricultural sustenance, and loss of manpower through wars which prevented maintenance of the hydraulic systems of the city are other cited explanations for the move away. Still, Angkor was never completely abandoned, some temples such as Angkor Wat being maintained by monks even in the 15th and 16th centuries.

Those in charge of restoring Angkor under the guidance of UNESCO and Cambodian authorities have decided to leave one temple – Ta Prohm – untouched, to let it remain at war with the jungle which seeks to envelop it. Parts of its grounds served as backdrop to scenes from the movie 'The Tombraiders' starring Angelina Jolle and Jon Voight. The sight of huge fig, banyan and kapok trees growing on top of, and into, the walls of this temple, their huge octopus-like roots seeming to entangle and devour the stone, conveys the notion that while the humans have left, their soul is still part of these buildings, buildings that are alive, locked in a fight for survival and the preservation of what was once something of exquisite beauty and meaning.

Each temple at Angkor comprised a single or several structures, positioned symmetrically around an east-west axis – consistent

Bantaey Sre

with the rising and setting of the sun – and orientated to the cardinal points. The fundamental architectural element was the shrine housing the sacred image which embodied the power of the king and represented a symbolic relationship between ruler and divinity. The ruler-divinity relationship lasted as long as the king lived, but when he died another ruler started the process anew. It was also common for a king to build a temple dedicated to his parents and other ancestors to ensure the continuation of the royal lineage. Other elements of the temples included open areas or courtyards, high walls with one or more entry gates (or gopuras), surrounding moats (up to 200 metres wide) bisected by raised causeways, pavilions and towers located at the cardinal points, and tiered edifices that rose from elevated platforms of stone.

Khmer sculpture adorns every building, with life-size guardians protecting the temples, lions guarding stairways, elephants adding grandeur, and multi-headed snakes (or nagas) and mythical birds (garuda) adding intrigue. Reliefs carved in stone are everywhere, rows of graceful asparas (or celestial nymphs) line cornices in perfect unison or dance on a lotus (the uppermost part of a tower), geometric medallions filled with intricate oral and leaf motif cover walls like tapestry, mythical crocodile-like beasts (or makara) and battle scenes spring to life, highly decorated sandstone blocks (or lintels) span doorways and windows, with richly decorated pediments (or frontons) forming outer layers above the lintels.

Building materials included timber (which has long ago perished), brick, stucco, sandstone, laterite (a porous aerated mudstone), fired clay tiles and sheets of copper or bronze. All structures were built with blocks of dressed, but uncarved, stone which were carefully bedded and in many cases matched with very complicated shapes to mirror the joint of the adjacent stone. The joints themselves are remarkably fine and tight, laboriously rubbed with abrasive sand to form an exact match. Once in place and only then were the structures decorated by hundreds of stone carvers using designs created by the master carvers.

In Angkor, architecture is inspired and informed by religion. The artistic interpretations of India's two religions, Hinduism and Buddhism, were the main themes of Khmer art. Hinduism in particular inspired several cults including Shivaism (worship of Shiva, a benevolent god who is represented architecturally in the form of a linga, shaped like an erect phallus and usually made of polished stone) and Vishnuism (worship of Vishnu, the versatile preserver who reincarnates in human or animal forms – fish, tortoise, boar, lion, or horse - whenever evil threatens and guides man through dissemination of his love). Buddhism came later, particularly Mahayana Buddhism, which began as a reform movement against Hinduism, and whose teachings were expounded through the Sanskrit language. Its religious ideal was the Bodhisattva (or 'Enlightenment Being') who had performed enough merit to enter Nirvana but who renounces it to return to earth and help the sufferings of all humanity. While several Bodhisattvas appear in stone sculptures, including huge faces above the gateways of Angkor Thom, the most frequently encountered in reliefs is the Avalokiteshvara, the 'Lord of the World,' signified by a small Buddha seated in meditation on the head of an image, above the forehead, and having four arms carrying a ask, book, lotus and rosary.

Recently, on returning to the grind of everyday life and driving to work, I listened to the philosopher Alain De Botton on radio talking about the effects of travel on people, and suggesting that it's not the physical moving from one attraction to another that makes a holiday an experience, but the opportunity to get out of ourselves and immerse our psyche in another time and culture. He's absolutely right. Walking for 6 hours in 36 degree heat and 80% humidity, dwarfed by the these ancient temples, taking in the jungle-clad mountains, the at wetlands of paddy fields, the crowded village markets, the optimistic and friendly banter of the Indochinese people and their language, history, and culture, this was an experience that was demanding but exhilarating. You enjoyed the tropical downpour that cooled the afternoon air, you ate terrific Asian food (we have forgotten what real fresh fruit tastes like) and drank well (the local beers are as good as any), you relaxed watching the huge orange globe of the setting sun peeking through the thunderclouds, you cruised the Mekong sitting in a dug-out canoe, you listened to the chanting of young Buddhist monks at evening prayer, and you enjoyed the contrasts – the old shoemakers shop with its 18th century façade and wizen old man situated adjacent to a modern internet café where schoolchildren dressed in white searched the net doing their assignments.

I was glad my three teenage children (2 boys, 1 girl) came along for the experience, and saw another side of the world and its people. While they enjoyed the cheap shopping - the extra room in our luggage was soon filled by CDs, handbags, shoes, shirts, and other bounty – they also appreciated the walks among the ruins, the interactions with a different people and their way of life, and the realisation that modern Western civilisation is but one of a long line of advanced civilisations in the course of human history.

IAN SCOTT

Admission/Assessment & Planning Units (APU)

An ever increasing demand for hospital based treatment from an ageing population has resulted in a review of the ways in which patients can be assessed, managed and discharged in an efficient, cost effective fashion. With decreasing numbers of inpatient beds in most hospitals due to a financial imperative, the demand for a stand alone Medical Assessment / Admission and Planning Unit (APU) has escalated. Although not a new concept (the first such units opened in Dundee and Auckland in the mid 70's), many hospitals are now planning such units.

Auckland City Hospital opened its APU in October 2003. Situated alongside the Emergency Department (ED), it has 45 beds, including a fully monitored 11 bed high dependency unit. Since opening it has seen between 1100 and 1500 admissions per month, saving over 1000 inpatient bed days monthly. Length of stay can be up to 36 hours, and 45% of all patients admitted to the unit are discharged within that period. The average length of stay is approximately 16 hours, and 65% of the admissions are referred directly to the unit following GP referrals, bypassing the ED. The unit has a full time inpatient director, nurse manager, manager and nurse educator, with considerable cross over in management with ED. All inpatient services admit to the unit.

There are several important concepts that are vital for the success of such a unit.

1. **Excellent relationships with ED**

   The ability of general medicine and emergency departments to work together results in excellent patient care. It demands compromise, patience and good leadership in both units to provide a service that is efficient and benefits patients.

2. **Experienced medical staff, preferably at a senior level**

   It has always been a concern that our youngest most inexperienced staff admit patients. Putting more experienced physicians at the front door has increased the 'grunt at the front', has provided welcome support for junior staff and has resulted in more rapid turnover of short stay patients.

3. **Dedicated area for assessment, close to ED but separated from it**

   Rapid and close access to ED has proved very effective in managing acutely ill patients. It has also given junior staff access to experience in resuscitation in ED. The inpatient services in APU are responsible for their own patients. They must achieve target triage times and there is no default of care to ED. This has immeasurably improved the efficiency of inpatient services.

4. **Rapid access to investigations**

   The close proximity of radiology (plain XR, ultrasound and CT scanning), laboratory and exercise testing for chest pain, coupled with dedicated allied health support, has allowed for rapid assessment and discharge, restricting the numbers of patients requiring admission to inpatient beds.

5. **Rapid review by specialist departments**

   All inpatient services, including surgery, have rights of admission to the unit. Rapid referral to specialty units result in appropriate management and transfer, with the 'shared care' concept being very prevalent in the unit, but with the general medicine teams acting in many cases as the 'co-ordinator of care'.

6. **Ambulatory assessment and follow up clinics**

   Consulting rooms within the unit are available for acute ambulatory assessment, often preventing unnecessary admission. Patients can also be followed up after their admission in the ambulatory area, allowing for earlier discharge.

7. **Multiskilled nursing workforce**

   Our nurses must manage both acute medical and surgical cases. They have developed a broad skills base, and can be very exible in patient management.

8. **Presence of high dependency monitored beds**

   For some time there has been a lack of appropriate beds for patients not requiring admission to coronary care/intensive care units but too sick/unstable for the general wards. More seriously ill patients and those requiring chest pain assessment can be reviewed in high dependency monitored beds and stabilised before transfer or discharge.

9. **Good clerical support and information technology**

   There has been a significant upgrade in information technology which has improved rapid assessment. The importance of clerical input has been recognised and supported, and enhances clinical decision making.

The development of an Admission and Planning Unit at Auckland City Hospital has been a great success. It has improved inpatient morale, made inpatient services more accountable and reduced overcrowding in ED which has been greatly appreciated. It has also reduced the requirement for inpatient patient beds, but above all has improved patient care. It is a concept that should be looked at by all hospitals which are struggling with acute patient assessment and do not have such a unit.

ASS. PROF. JOHN HENLEY
Clinical Director
Admission and Planning Unit
Auckland City Hospital

FORTHCOMING MEETINGS

2004

2004	**September**	**International Congress of Internal Medicine (ICIM) Workshops** *Sept 26th - Oct 1st ~ Granada, Spain* For further information visit: www.fallsprevention.org.au or www.granada2004.com/frame-principal.htm
	October	**Casemix 2004 Conference** *10th - 13th ~ Sydney* **ESIM-7** *16th - 22nd ~ Alicante, Spain* For more details go to www.efim.org **Cardiology Skills for Rural Physicians** *22nd ~ Brisbane* For more details contact rfielding@qce.net.au
	November	**XIth International Congress on Antiphopholipid Antibodies** *14th - 18th ~ Sofitel Wentworth Hotel, Sydney* Visit the website: www.xith-icaa2004.unsw.edu.au/sydney/index.html Email: s.krilis@unsw.edu.au **Woolcock Institute of Medical Research** Sleep Loss Symposium *17th ~ Kerry Packer Auditorium, Royal Prince Alfred Hospital* More information at www.woolcock.org.au
2005	**May**	**RACP ASM 2005** *8th - 11th ~ Wellington, New Zealand*
	September	**IMSANZ Clinical Weekend** *1st - 4th ~ Alice Springs, Northern Territory*

CANBERRA 2004 ASM HIGHLIGHTS

- The RACP Medal for Clinical Service in Rural and Remote Areas 2004 was bestowed on IMSANZ members Llew Davies and Ian Smee at the College Ceremony in recognition of their outstanding services as general physicians providing care and education within their communities over an extended period of time. Congratulations to both Llew and Ian – well done. (Mary/Michele – see whether we can get hold off and reproduce the photos of Ian and Llew shaking hands with Robin Mortimer printed in recent RACP News).
- Dr Jacqueline Gilbert, an advanced trainee currently undertaking geriatric training at Sunshine Hospital Geriatric Medicine Unit in Sunshine, Victoria, was awarded the IMSANZ Advanced Trainees Award (kindly sponsored by Roche) for her presentation on the prevalence of inappropriate prescribing and underprescribing in elderly inpatients, presented at the IMSANZ Free Papers session. Her abstract, together with those of the other 6 presenters, will be published shortly in Internal Medicine Journal.
- The Conference Dinner for Adult Medicine held at the National Museum proved a very enjoyable night with a lively post-prandial presentation from the doctor- come physicist-come engineer-come entertainer Dr Karl Kruszelnicki. Food for thought as to what some of us could do if the daily practice of medicine proves to lose its appeal, but we still want to make a decent living!

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.

Do neurologists and primary care physicians agree on the extent of specialty involvement of patients referred to neurologists? Swarztrauber K& Vickrey BG. J Gen Intern Med 2004;19:654-661.

This paper describes a survey of US "family physicians" (general practitioners), general internists and neurologists who were presented with 3 clinical scenarios. Those generalists who chose specialist involvement were asked about the anticipated extent of such involvement. This was compared to the extent of the involvement preferred by the neurologist. Not surprisingly, the neurologists preferred a greater extent of specialty involvement than the primary care physicians. Although the US situation is different than that in Australia and New Zealand, one might expect similar findings here. There is worthwhile discussion of the reasons for such disagreement.

The future of general internal medicine: a community perspective. Baillie H, Kenyon M. The General Internist, Spring 2004. Access at http://csim.medical.org/newsletters.htm

Drs Baillie and Kenyon, from British Columbia, Canada, discuss issues relevant to community general internal medicine practice in the Newsletter of the Canadian Society of Internal Medicine.

Association of consultation between generalists and cardiologists with quality and outcomes of heart failure care. Ahmed A et al. Am Heart J;145:1086-1093.

This is an observational study of Medicare beneficiaries aged 65 years and older discharged 10 years ago from 11 Alabama hospitals with a principal diagnosis of heart failure. Of 175 patient studied, 13% were treated by cardiologists, 55% by generalists and 32% received consultative care. Consultative care was associated with greater odds of ACE-inhibitor use and evaluation of left ventricular function. In addition, there were fewer 90 day readmissions in patients receiving consultative care. The authors acknowledge the limitations of this observational study based on retrospective chart review, but the findings suggest benefits in both processes and outcomes from consultative care.

What effect does inpatient physician specialty and experience have on clinic outcomes and resource utilisation on a general medical service? Vikas P et al. J Gen Intern Med 2004;19:395-401

This is a retrospective cohort study of 2617 admissions to the General Medicine Service at the University of Michigan hospitals in Ann Arbor USA. Compared to rheumatologists and endocrinologists, adjusted mean length of stay was shorter for general internists in this academic general medicine service, but readmission rates and in-hospital mortality was similar. The findings are of interest but the relevance and applicability in antipodean settings is not clear.

Local thrombolysis or rapid transfer for primary angioplasty for patients presenting with ST segment elevation myocardial infarction to hospitals with angioplasty facilities. Scott I et al. Intern Med J 2004;34:373-377.

This CAT (Critically Appraised Topic) summarises recent data in "hot" area, along with two interesting but differing "commentaries".

Modernizing the paths to certification in internal medicine and its subspecialties. Goldman L. Am J Med 2004;117: 133-136 and Internal Medicine Reformation. Blackwell TA, Powell DA. Am J Med 2004;117:107-108.

As a response to difficulties recruiting young USA doctors into primary care and the medical subspecialties, it is proposed that senior medical students elect for and enter subspecialty training programmes after 2 rather than 3 years of general training. Career generalist training would also be shortened and specifically include ambulatory and 'hospitalist' streams, entered after the second year. Les Bolitho comments on possible changes to RACP training (2 years basic, 2 years general, 2 years subspecialty) in RACP News 2004;23/3 (July): 33.

British Medical Journal News roundup. Access from http://bmj.bmjjournals.com

In an effort to reduce costs, the French government announced in May 2004 that unreferred patients seeing specialists, irrespective of whether the referrer is a general practitioner or specialist, will require a "referral" to qualify for rebates, as in Australia. The plan also involves patients paying a small but non-reimbursable fee for each referred consultation

PETER GREENBERG
Melbourne

EXPERIMENTING WITH A NEW RACP GOVERNANCE STRUCTURE

The following article is an edited version of a letter sent on 29/06/04 to all Specialty Society presidents from Prof Rick McLean (Chair, AMDC) and Prof John Kolbe (Chair, Specialties Board). An expression of interest submission form was attached to this letter but is not reproduced here.

Background

At a workshop in March 2004 involving representatives of a number of Specialty Societies and the College several resolutions were developed about a new relationship between Specialty Societies and the RACP. These were modified and endorsed by the Adult Medicine Divisional Committee (AMDC).

Specialties Board Recommendations

It became apparent that effective implementation of training and education strategies would require consideration of the entire spectrum of possible interactions between Specialty Societies and the College.

These include:

- *Training and Education* – basic training, advanced training, CPD, clinical policy guidelines, position papers
- *Finance and Resources* – staffing, employment, indemnity, budgeting, cost of accommodation, planning, sharing of resources
- *Policy and Communications* – databases, resources, IT, relationship with external agencies and government, formulation of responses, in uencing of policy.

These areas broadly align with the new Secretariat structure of the College (comprising the staff) and it was seen as being valuable to try to align the governance structure (comprising committees of Fellows) with this for maximum efficiency of operation. The Specialties Board is keen to assist in the development of new, constructive and outcomes-focussed relationships between the Specialty Societies and the College.

Conjoint Committees

At the core of the new relationship between the Specialty Societies and the College is the concept of a **Conjoint Committee** which would be a relationship of equals and which would have an executive rather than management role, probably reporting to the relevant Specialty Society Council and a Committee such as the ADMC to ensure that decisions can be acted upon without delay.

In the first instance the emphasis of the Conjoint Committees should be on training and education but with the acknowledgement that they will need to address broader issues to function effectively. It is not envisaged that the Conjoint Committee itself would operationalise decisions made in these areas but it would have a broad policy role, operational details being addressed by subcommittees or specific working groups.

As mentioned above, the area in which many Specialty Societies see a need to have reform is that of training and CPD, and therefore the Conjoint Committees will need to consider areas including:

- Basic training
- Advanced training
  - Selection into training
  - Curriculum development (including generic components)
  - Supervision (including support for supervisors)
  - Accreditation of sites
  - Access to training positions for trainees of other subspecialties
  - Trainee involvement/support (mentoring)
- Continuing Professional Development (includes “generic” and to other sub-specialties)
- Registration/recognition issues
- Credentialling/re-certification – who should undertake this role and in what circumstances

When considering these areas there are a number of generic issues that will need to be considered such as:

- Flexibility vs consistency
- Remote/rural issues
- Breadth of skills for all physicians
- Recruitment/workforce
- Allegiances/collaboration
- Evaluation of any new initiatives

At the Specialties Board meeting it was resolved that two (although 3 were subsequently selected) Specialty Societies would be chosen to undertake the initial pilot implementation before involving others. Important points were that:

- At least one Specialty Society should be large
- The two Societies should have different characteristics so that different aspects of the interaction between the Specialty Society and the College could be tested.
- A Conjoint Committee should cover the currently recognised subspecialty areas (areas covered by an existing SAC) and therefore applications will be accepted from a consortium of Specialty Societies, eg from a consortium of those involved in Endocrinology.
- Any Specialty Society interested in trialling the arrangement must demonstrate unanimous support of its Council (or Councils) and the relevant SAC for the process.

Proposal

The Specialties Board resolved to call for expressions of interest from all Specialty Societies to trial new ways of doing business between Specialty Societies and the College. An expression of interest should address:

Welcome to New Members

IMSANZ would like to welcome the following New Members:

- Dr Mark Beehre, Masterton, NZ
- Dr Gerrit Burger, Rockhampton, QLD
- Dr Christian de Chanéet, Bunbury, WA
- Dr John Cummins, Killara, NSW
- Dr Jeffrey D Faunt, Klemzig, SA
- Dr Paul Friedman, Tauranga NZ
- Dr Hamish Hart, Auckland NZ
- Dr Jacquelyn Martin, Armadale, WA
- Dr Geoffrey Metz, Richmond, VIC
- Dr Kujan Nagaratnam, North Rocks, NSW
- Dr Robert Park, Auckland, NZ
- Dr Gabriel Shannon, Orange NSW
- Dr Dawid Smalberger, Bundaberg, QLD
- Dr John Thwaites, Christchurch, NZ
- Dr Keith Tish, Dee Why, NSW

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

- Dr Roland Chee, Winthrop, WA
- Dr Catherine Geraghty, Herston Qld
- Dr Paul Huggan, Dunedin, NZ
- Dr Michael Lin, Newington, NSW
- Dr Natalie Martin, Hobart, Tas

(From Page 14)

- The attributes of the Specialty Society relevant to the initial implementation program (including resources)
- Current training and educational initiatives of the Specialty Society/SAC that might be included (this would include curriculum development, accreditation of training sites/ programs, etc)
- Current issues related to Training and Education, Finance and Resources and Policy and Communications which should be considered in any new arrangements, including possible resource implications
- Confirmation of support from the relevant Councils as indicated above.

Agreement about piloting new approaches between Specialty Societies and the College and timeframes for testing these new ways of doing business will be determined as part of the process.

CALL FOR EXPRESSION OF INTEREST

Specialist Advisory Committee in General Medicine

The Specialist Advisory Committee (SAC) in General Medicine is responsible for supervising, assessing, advising and supporting advanced trainees in General Medicine.

The SAC currently has a vacant committee position for an Advanced Trainee Representative (ATP). We are seeking expressions of interest from advanced trainees who would be willing to serve on the SAC for a two year period.

Key selection criteria are:

1. A current 2nd year advanced trainee specialising in general medicine, or a trainee who is planning to start his/her 2nd year of advanced training in general medicine at the beginning of 2005;
2. Able and willing to attend SAC meetings including teleconferences;
3. Prepared to adhere to confidentiality principles.

Desirable selection criteria are:

1. Involvement in College or Special Society training activities, at hospital, state or national level;
2. A keen commitment to in uence training and the further development of College policy.

The SAC meets regularly twice a year. One meeting occurs via teleconference and the other is a face to face meeting at the RACP Office in Sydney. The College covers the agreed travel and accommodation costs of all committee members. Additional teleconferences may be required for urgent issues.

Please send an expression of interest with a curriculum vitae to

Libby Percival, Administrative Officer
Department of Training & Assessment
Royal Australasian College of Physicians
145 Macquarie Street
Sydney NSW 2000
Email: libby.percival@racp.edu.au
by 20 August 2004

The next meeting of the SAC in General Medicine will be held at the RACP Office in Sydney on 5 November 2004.

A document outlining the role of the Advanced Trainee Representative will be provided upon request.

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:

Michele Levinson - michelel@bigpond.net.au

Should you wish to mail a disk please do so on a CD.

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