IMSANZ
INTERNAL MEDICINE SOCIETY *of Australia & New Zealand*

AUGUST 2005

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From the President...

The General Matters

This is my first editorial as President, having taken over the reins from Ian Scott at the RACP ASM held in Wellington, May 7-9 2005. It was really great to see so many IMSANZ faces there. Even though it was a busy few days, it was thoroughly stimulating and enjoyable - the support from all of you was palpable. Thanks!

Restoring The Balance

Our immediate past president Ian Scott has written an article on the Wellington ASM (see page XX) that he has labelled his "swansong". At this stage this appears to be anything but the case as he remains heavily involved in organising the Alice Springs meeting and the 2006 RACP Congress; in curriculum development, and, importantly, has guided the development of the IMSANZ action plan "Restoring the Balance". This document outlines a strategic framework for actions by our Society, along with the RACP and other stakeholders over the next few years. It is moving rapidly through processes that will result in the addition of the RACP imprimatur and an anticipated formal launch at the Alice Springs meeting in September. We are very grateful to the RACP President Jill Sewell and CEO Craig Patterson for their personal involvement in this process. Many of you have read and contributed to the document. It behoves all of us to act to implement the framework at local, state and national level to influence decision – making regarding both the organisation of our health services, and workforce development to ensure a balance between general medical and other subspecialty services to best serve the population. The latest version may be viewed on our website - please read it and use it in any way you see fit.

Thanks to Ian Scott

On your behalf, I would like again to thank the Past President Ian Scott for his farsightedness, and sterling leadership in the quality enhancement of a wide spectrum of IMSANZ activities. His hard work has left the Society all the stronger and it is my privilege to be asked to continue to build on the groundwork not only of Ian, but also of the previous presidents Les Bolitho, Neil Graham, and Rob Beattie. Ian's excellent and full report on recent IMSANZ activities is in the Annual Report, and is also accessible on the IMSANZ website www.imsanz.org.au.

IMSANZ Council

This year we farewelled from Council Les Bolitho, Di Howard, Simon Dimmitt, Bruce King and David Hammill, as well as Jaye Martin. The experience brought to the table by these wonderful people is immense and will be sorely

As you turn the pages...

PRESIDENT'S REPORT

August 2005

missed. We wish them very well and know they will continue to promote the cause of general internal medicine through local and other avenues. I can't recall an IMSANZ Council meeting without Les, and will particularly miss his energy and ideas. It's good to know that he sits with Justin La Brooy on the Adult Divisional Committee of RACP. Les also sits on the RACP Council.

In 2005 several new faces have been welcomed onto the IMSANZ Council:

Andrew Bowers (NZ), Gabriel Shannon (Rural NSW), Alasdair MacDonald (Rural Tas), Emma Spencer (NT Aust), Denise Aitken (NZ SAC), and James Williamson (Aust SAC). We still seek a metropolitan WA rep please!

It is now time for an Australian to indicate an interest in taking on the Australian VP role, with a view to taking on the IMSANZ Presidency in 2007. It is difficult for me to be really effective for you in Australia without this role filled. Ian Scott continues to provide support and guidance in an acting role. Please forward any suggestions to me directly, in confidence.

Congratulations

Congratulations to two of our members, Jon Douglas and Gerard Carroll who were awarded AM in the recent Queen's Birthday Honours, and to Rob Ziffer who received a RACP Medal.

Members

Please be on the lookout for possible future IMSANZ members in your local hospitals. Our current membership is just over 400 (100 in NZ) and it would be good to see nearer to 500 within two years. As we are a physician-only society (as opposed to other special societies who admit other allied health workers) this places us in a position of considerable bargaining strength from numbers alone, let alone for all the good reasons that we believe general medicine to be important!

There are over 110 advanced trainees in general medicine in NZ and over 60 in Australia - we'd like to see them all at upcoming meetings. Please encourage them to attend and to present any of their work – this may be in the form of difficult cases, audits, or research projects. IMSANZ has developed a number of travel scholarships to assist trainees in getting to meetings. In New Zealand, there is additional support available through the De Zoysa Family Trust.

RACP curriculum development:

The Basic Training curriculum is coming together well, in a process ably led by Leonie Callaway. The RACP should be able to showcase this before the end of the year, and hopefully satisfy the requirements of the AMC. What has been written appears very sensible and feasible. As there is heavy predominance of general physicians on the working group the curriculum reflects general medical practice very well and will provide a sound platform for advanced training in general medicine, and all the other specialties. Once this is nearer to finality, a review of the 2004 general medicine advanced training curriculum draft will follow, informed by your feedback and with a focus towards building on curriculum areas covered in basic training, removing unnecessary duplication.

Models of "grunt at the front":

John Henley at Auckland City Hospital has had several visits recently from IMSANZ members keen to see "his" Medical Assessment and Planning Unit (MAPU). The MAPU has worked well at this big metropolitan hospital and has saved the hospital repeatedly from bed crises. Patients and staff alike appreciate it. In this model, clinically stable patients referred from GPs are channelled straight through to the inpatient services configured to provide rapid, but appropriate multidisciplinary care with a view to early discharge. The service includes acute clinics and an Exercise ECG service 7 days per week. John and the medical teams work closely with the ED staff seeing unstable medical patients there, and also promoting early referral from ED to medical services for likely admissions. The ED director appreciates the minimizing of "bed block".

From a teaching perspective, the learning environment the MAPU creates is also a huge plus - exposing students and junior doctors to positive experiences as part of a large general medical team. Of course, one size doesn't fit all we invite you to share your successful models in this newsletter.

Involvement of IMSANZ in the RACP ASM:

For the past three years IMSANZ has organised the Adult Medicine Programme part of the ASM plus some other aspects. We are committed to providing an excellent Adult Medicine programme for the rebadged RACP Congress in Cairns 2006. This will include shared sessions with intensive care medicine, and occupational medicine.

The RACP has asked IMSANZ to indicate our level of commitment and the nature of that involvement beyond 2006. RACP sees IMSANZ as a core stakeholder in the ASM, and a withdrawal to threaten the viability of the ASM. RACP also has indicated strong support in several ways to ensuring the future of general medicine. They are very keen to make the meeting work better for IMSANZ. This discussion is in part being driven in the knowledge that the IMSANZ Council has agreed to co-host a meeting with the Australian (soon to be Australasian) Society of Geriatric Medicine (ASGM) in Adelaide in September 2007, separately from the RACP meeting. Council believes this "one off" opportunity with ASGM will allow exploration in depth of health and other issues in the care of older people. As there are a significant number of dual trainees in general and geriatric medicine, and some trainees are having to turning to geriatric placements to get broader experience, training issues are likely to feature high on the agenda as well.

I suggest that IMSANZ looks to its scientific meeting to:

- promote "general medicine" as a specialty that is relevant to current and future health needs through dissemination of advancements in basic, clinical science and health systems research, and development of relationships with other specialties;

- help create and support an identifiable group of general physicians, bearing in mind that there is a heterogeneous range of general physicianly practice;
- create an environment for shared problem solving, policy development, networking and development of ideas for collective action;
- promote, by meeting its location, general medicine in specific areas;
- attract trainees and fellows to both the meeting and to general medicine;
- create an environment in which to socialise and offer mutual support;
- publicly reward excellence in research and teaching.

As one Council member put it – "Most consultants would get to two scientific meetings a year at most. Most will want to go to another subspecialty meeting. Therefore, if the RACP meeting as it stands now is the other, it leaves little opportunity to work on specific, in-depth knowledge and skills for the specialty of general medicine, and to build our capacity as a group".

A quick straw poll of Council members indicates that, unanimously, they see advantages in continuing with a relationship with an RACP ASM or Congress model, but all have indicated that we do need to explore ways of allowing further development of the IMSANZ identity, as well as forming closer relationships with other specialty societies. We shall be working with the RACP towards this end and in the lead up to ICIM in 2010.

In terms of making a joint meeting more attractive, there have been some good suggestions raised already, namely: the addition of day of skills training (e.g echocardiography, difficult ECGs, exercise ECG supervision, application of NIV, gastroscopy, bronchoscopy) to attract trainees; asking RACP to fund a world - leading medical expert; alternate year meetings with the whole RACP and the alternate year with RACP(NZ); and RACP ensuring that there is a roster of specialty societies with which IMSANZ may share the programme at any given meeting. What would make a future RACP / IMSANZ meeting more attractive for you? Please air your ideas.

Thinking in depth about this issue has been a valuable exercise. It has shown me even more clearly that General Medicine is a very broad church, yet we are united by the common philosophy of a willingness to care effectively for the whole patient and their problems, unconditionally. To me this is a major point of differentiation from other specialties, and might explain why it is so difficult to come up with a "one size fits all" meeting formula. Council will continue dialogue on this and other initiatives advancing the future of general medicine with the RACP and other stakeholders.

Upcoming Meetings

By the time you read this Alice Springs will have come and gone and we will be much the wiser about the IMSANZ identity and its future directions. I look forward to enjoying some time in the Red Centre. Thanks in advance to the organising team

Please diarise, and **make it a priority** to come to the IMSANZ meetings below. Plan to bring your trainee, and to present a paper.

IMSANZ Palmerston North (contact Kirsten Holst)	March 2006
2006 RACP Congress Cairns (Ian Scott)	7-10 May 2006
RACP (NZ) / IMSANZ / Nephrology Queenstown (Phillippa Poole)	20-22 Sept 2006
ASGM / IMSANZ Adelaide (Justin La Brooy, Mark Morton)	Sept 2007

Fun is guaranteed. We have already ensured that the Queenstown meeting incorporates a half day for visiting the Gibbston Valley wineries (with the best Pinot Noir), or the ski slopes of Coronet Peak. We will have a 10 year birthday party for IMSANZ in Adelaide in 2007!

I'll look forward to seeing you at the meetings. In the meantime, feel free to contact any of the Council members with ideas or offers of assistance, no matter how small – there is a lot to be done!

PHILLIPPA POOLE
p.poole@auckland.ac.nz

IMSANZ would like to welcome the following New Members:

- Dr John England, Katoomba, NSW
- Dr Karen Choong, Perth, WA
- Dr John Yamba, Mt Gambier, SA

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

- Dr Josephine Bates, Adelaide, SA
- Dr Ian Rosemergy, Wellington, NZ
- Dr Andrew Burns, Auckland, NZ

RECIPIENT OF THE RACP MEDAL

for Clinical Service in Rural and Remote Areas 2005 - Rob Ziffer

IMSANZ congratulates Rob Ziffer on his being awarded this RACP medal for recognition of outstanding clinical service in rural and remote areas. Since 1978, one year after being admitted to the fellowship, Rob has been Consultant Physician for Gippsland Base Hospital and a private consultant physician in Sale, Victoria. He has been a long serving member of the Executive of the Victorian Rural Physicians Network and a very active member of the Victorian State Committee of the RACP, including its Scientific/Continuing Education Sub-committee. In this role, he has been responsible for organising the Rural Physicians Week and the state committee's Rural Professorship Program, as well as videoconferencing the weekly college lecture series for basic and advanced trainees. He has been instrumental in promoting physician training sessions, up-skilling for Fellows, and advocating for educational infrastructure in rural centres. His efforts have been important in gaining acceptance of information technology for communication and training by country-based Fellows and trainees.

He has also served as the Victorian state's committee representative on the Board of the Rural Workforce Agency of Victoria (RWAV), has been appointed an ex-officio representative for Victoria on the RACP Rural Taskforce, and is heavily involved in a number of projects of the Support Scheme for Rural Specialists (SSRS), including the videoconferencing of the quarterly SSRS Continuing Education Workshops and the conduct of the SSRS Community Acquired Pneumonia Audit being run by the Victorian Rural Physicians Network.

In all these activities, as well as in his clinical practice, Rob has shown dedication, leadership and vision in his exemplary role as a general physician serving the needs of the rural community, his patients, his colleagues and the college over many years

Congratulations Rob!

General Medicine in the Spotlight

At the recent NSW Rural Physicians and Paediatricians Forum held in Sydney (May 28-29), outgoing IMSANZ President Ian Scott was granted the opportunity to extol the attractions and value of a career as a general physician to an audience of more than 100 delegates, many of whom were advanced trainees trying to decide their future vocation.

The Forum was attended by RACP President Jill Sewell, RACP Rural Taskforce chair Rick McLean and Federal Minister for Health Tony Abbott. IMSANZ member Gerard Carroll deserves special commendation for organising the Forum and inviting IMSANZ to present. The registration table featured a number of materials advertising IMSANZ and there were several interactive small group forums in which trainees were able to talk candidly with experienced consultants about what mattered most to them in choosing a lifetime specialty. It was gratifying to see that a number of trainees regarded the diversity of general physician practice and the lifestyle of a major regional centre very appealing. Their chief concerns centred on their ability, as trainees, to secure sufficient access to subspecialty training to develop skills necessary to maximising their utility as general physicians outside metropolitan centres, and to have, as practising consultants, the required infrastructure and professional support necessary for providing high quality care.

The IMSANZ Action Plan Restoring the Balance, which has been endorsed by the college, will, when implemented, address these concerns.

GLOBALISATION OF INTERNAL MEDICINE

Report from the 2005 SGIM Annual Scientific Meeting, New Orleans

Left to right: Bill Ghali (Canadian Society of Internal Medicine), Michael Jefferies (President, SGIM), Jacques Cornuz (Swiss Society of Internal Medicine), Raul Mejia (Argentinian Society of Internal Medicine), Junji Otaki (Japan Society of Internal Medicine), and Ian Scott (IMSANZ).

It was my privilege and pleasure to represent IMSANZ at the Annual Scientific Meeting of the Society of General Internal Medicine (SGIM) in New Orleans between May 11 and 14. As immediate past president I was invited to give a presentation on the history and current activities of our society at a symposium which featured similar talks from representatives of our sister societies in Canada (Bill Ghali), Japan (Junji Otaki), Argentina (Raul Mejia), and Switzerland (Jacques Cornuz).

In his introductory talk Bill Ghali noted how general internal medicine has flourished in the United States (US) in recent years with the widespread development of academic divisions of general internal medicine in almost all US medical schools. The growth of GIM is remarkable considering its youth as an academic discipline, with the trend toward the development of divisions of GIM in the US beginning only in the early 1970s as a result of a recognised need for increased numbers of physicians capable of providing comprehensive care to adults in ambulatory settings. In 1977, the SGIM was formed, which helped US general internists to define themselves in at least three distinct roles: 1) hospitalists, who by definition spend at least 25% of their time caring for hospitalised patients, a clinical profile that contrasts with that of many other American general internists who spend a majority of their time in out-patient primary care settings; 2) clinician educators, who spend varying degrees of their time teaching and/or participating in educational development endeavours (e.g. educational research, curriculum development); and 3) clinician researchers, who engage in a wide range of research activities in parallel to clinical and administrative duties.

Bill then referred to how the evolution of GIM in the US has occurred in parallel to the discipline's evolution in other countries, where GIM appears to have taken a somewhat different course. The aims of the symposium were: 1) to discuss international models of GIM relating to the discipline's academic development and growth, both inside and outside the US; and 2) introduce and promulgate the idea of an eventual 'globalisation' of academic GIM. It was noted that the discipline of GIM has, until now, grown and evolved *within* countries, with relatively little 'cross-pollination' across international borders. This was in contrast to disciplines like Cardiology, Gastroenterology and other subspecialties that have developed firmly established international entities, for which large annual international meetings are staged. The US-based SGIM certainly has some international members and attendees to its annual meetings, but many (perhaps most) of the non-American attendees developed their ties to SGIM through a period of academic GIM training in the US or because they have been encouraged to attend SGIM meetings by colleagues who themselves gained first-hand exposure to SGIM while training in the US.

The potential benefits of globalisation of GIM as an academic discipline are many, and a key first step toward such globalisation is an improved understanding of existing GIM models, hence the value of our respective 'case histories' in helping create a foundation of knowledge upon which a move toward the globalisation of GIM can begin.

GIM in Canada

The clinical profile of general internists in Canada most closely resembles that of general physicians in Australia/NZ and differs from that in the US, where general internists are heavily involved in the delivery of primary care. Here and in Canada, general internists are positioned as 'secondary level' consultants, providing consultative support to primary care practitioners caring for patients with multi-system disease and/or undifferentiated symptom presentations, but where further consultative support from subspecialists such as cardiologists, nephrologists, or gastroenterologists is needed from time to time, particularly when high technology procedural care is required.

Many general internists in Canada and here are hospital-based, and participate actively in the care of hospitalised adults, resembling the 'hospitalists' in the US. Many Canadian general internists also provide outpatient consultative care in parallel to inpatient activities, and some others provide only outpatient consultative care, without any inpatient role. Like their Antipodean counterparts, general internists in Canada are thriving in the areas of medical education (as 'clinician educators') and clinical research (as 'clinician researchers'), have led academic endeavors in clinical epidemiology (e.g. promoting the emergence and evolution of 'evidence-based medicine'), health services research, health economics, bioethics, medical informatics, and clinical pharmacology.

GIM in Switzerland

Prior to the early 1960s, general internists in Switzerland functioned primarily as consultants in ambulatory settings providing care to patients presenting with non-surgical, non-psychiatric and non-obstetrical clinical problems. Over that time, however, a number of general internists began to assume a primarily hospital-based role, functioning as 'chief physicians' on the general wards of public hospitals – a position that typically involved job-sharing with general surgeons.

From the mid 1960s until the present, Swiss general internists have gradually shifted into a primary care role, especially in

New Orleans mardi-gras procession heads down infamous Bourbon Street

urban areas – a trend that mirrors that in the US, and one precipitated by the emergence of subspecialties in the late 1960s, with procedure-based specialists such as cardiologists, pulmonologists, and gastroenterologists assuming a particularly high profile because of the technical procedures they perform. Thus, while some general internists continue to retain an important role in in-patient care, hospital practise is typified by a large penetration of subspecialists.

The shift of Swiss general internists toward ambulatory care, and more specifically a primary care role, is epitomised by the merger of GIM societies in two cantons (Vaud and Bern) with their corresponding regional societies of Family Medicine to create single entities representing the shared academic and professional interests of all primary care physicians, regardless of whether their training is in GIM or Family Medicine. In contrast, some Swiss general internists have assumed a clinical role in staffing the non-surgical portions of emergency rooms, as Switzerland does not have an independent specialty of emergency medicine.

The future of academic GIM in Switzerland appears bright with growing numbers of trainees pursuing careers in the discipline. The academic emergence of the discipline is also being recognised, as evidenced by the awarding – to general internists – of prizes in both 2002 and 2003 for the best scientific abstract presentations at the annual Swiss Society of Internal Medicine meeting.

GIM in Argentina

Argentina's history in the 20th century has been characterised by considerable political turmoil, with 1983 ushering in a period of democracy and political stability. The previous conflicts led to considerable socioeconomic decay and deterioration of many aspects of society, including health care and institutions for the education of health professionals. Despite the difficulties of the past 60 years, however, the quality of academic paediatric and internal medicine has been, to some extent, preserved.

Training in internal medicine has historically focused on in-patient care, with teaching and training in outpatient settings largely undervalued and for the most part non-existent. The focus in most departments of medicine across Argentina has, therefore, focused on in-patient subspecialty training. This pattern changed, however, in 1987 when the Dean of the University of Buenos Aires School of Medicine requested strategic assistance from academic colleagues based in the US (Department of Community Medicine of the Mount Sinai School of Medicine) in the organisation of enhanced adult ambulatory care services and corresponding training programs in its main teaching hospital (Hospital de Clínicas). In cooperation with US colleagues at Mt Sinai and within SGIM, and also a consortium from the Panamerican Federation of Associations of Medical Schools, the Buenos Aires School of Medicine succeeded in launching a General Internal Medicine training program that has had outpatient primary care as its main emphasis in training.

This new training program spawned considerable interest in primary care and the ambulatory care setting among medical trainees. The program's emphasis on the application of clinical epidemiology, novel approaches to medical education, and enhancement of communication skills in clinical care are all unique features that have helped define GIM as a new specialty in Argentina. In 1990 the Society of General Internal Medicine of Argentina (SAMIG) was created to further the development of the discipline, promote clinical research, and the education of physicians in this field. SAMIG's activities have been closely linked to those of the SGIM in the US, with which it has a formal agreement to cooperate in academic activities.

More recently in 1995, a General Internal Medicine Program commenced at Sanatorio Otamendi, a private academic hospital linked to Buenos Aires University, which is inpatient-based and promotes the concept of GIM "hospitalists". GIM in Argentina continues to gradually develop, but there remains a need for continued maturation of the discipline relative to more established in-patient subspecialty training programs.

GIM in Japan

It is only relatively recently that GIM has established itself as a distinct discipline in Japan, and as a result, it is perhaps less established than in other countries. The reasons for this are many, the most notable being a general lack of standardised training programs for primary care physicians in Japan. After World War II, the American occupation army implemented a one-year compulsory postgraduate internship in Japanese medical education, to be completed prior to initiating residency training. Although these internships provided some exposure to primary care training, they had a number of shortcomings including a lack of entrance standards, variable quality across

The changing faces of New Orleans jazz – Black American clarinet harmonises with Asian banjo guitar

institutions, and strong opposition to their existence among trainees. As a result, the Japanese government abolished compulsory internship in 1968. Residency training programs continued to exist in medical schools, but their emphasis was almost exclusively on subspecialty training, with relatively little attention to primary care training.

As a result, primary care in Japan has been provided primarily by internal medicine subspecialists who typically spent periods of time training and working as hospital-based subspecialists (e.g., 10 years) before later opening private outpatient offices in which they provide primary ambulatory care. In establishing such private practices, a large proportion of these physicians have labelled themselves as 'specialists in internal medicine'. However, many trained in other specialties such as surgery or psychiatry, but have also listed 'internal medicine' in their list of areas of specialisation, as Japanese physicians were able to advertise any specialty, regardless of their official expertise and training!

A number of physicians have thus established themselves in Japan as primary care providers without having formally trained in the area. Recognising this, the Ministry of Health and Welfare and the Japanese Society for Medical Education have repeatedly proposed that all postgraduate programs should dedicate a core segment of their programs to primary care training. Unfortunately, a lack of dedicated financial resources has been a barrier to implementing this proposal, but beginning in 2004, the Japanese government mandated that all residency programs include a set of compulsory rotations over two years at the beginning of residency training to establish basic clinical competence. All residents were to rotate through internal medicine, surgery, paediatrics, obstetrics, community medicine, and emergency medicine.

Similar to other countries, there is a distinction between 'general practitioners' (emerging from a variety of training backgrounds) who provide primary care, and internists who provide primary care, the latter representing a more formally trained group who have met the certification requirements of the Japanese Society of Internal Medicine. These requirements include four years of training in internal medicine subspecialties beyond the two years of compulsory general residency training introduced in 2004. Upon completion of such training, a large proportion go on to practice as internal medicine subspecialists, but a reasonable number go on to function as general internists, some assuming roles in the inpatient setting, while others assume outpatient primary care roles.

Active community-based general physicians from both the 'general practitioner' and 'general internist' streams have formed a Japanese Medical Society of Primary Care. More recently, these two clinician pools spawned the Japanese Academy of Family Medicine in 1986 and the Japanese Society of General Medicine in 1994. Given their common goals in promoting (and perhaps eventually regulating) primary care training, these organisations are now working together to implement a unified board for primary care physicians.

Academically, GIM is not yet fully-established as a medical discipline in Japan. While all 80 medical schools in Japan have departments of internal medicine, most of these emphasise subspecialty training. In addition, while 48 medical schools have divisions (or units) for teaching primary care in their affiliated hospitals, only 19 of these are run by general internists. Despite these modest numbers, the penetration of GIM divisions and university-based primary care training programs is gradually increasing.

Mississippi colonial grandeur in the French quarter New Orleans

The demand for general internists and accompanying training programs is increasing in Japan. The population is aging steadily, and as a result, there is an increasing need for physicians capable of caring for complex patients with multi-system disease. Furthermore, Japan's geography is characterised by many islands and mountainous districts for which there tends to be a shortage of generalist physicians. Residency training programs will need to address these areas of need.

The case for globalisation

The merit of globalisation lies in the potential for academic synergy across countries. While some international linkages between general internists in various countries have certainly developed, the majority of such linkages (with perhaps the exception of the US-Argentina collaboration described earlier)

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Congratulations...

GERARD CARROLL AM, FRACP

Congratulations go to Gerard Carroll who was recently awarded the AM in the Queen's Birthday Honours List for his contribution to rural medical services and to medical education

Gerard moved to the Riverina in 1991 and proceeded to expand cardiology services, initially establishing colour flow echodoppler and later transoesophageal echocardiography. Nuclear cardiology followed in 1992, and a cardiac catheterisation laboratory, the first in rural NSW, was established in 1997. Interventional cardiac services commenced in 2004 with assistance from Sydney-based cardiologists. Dr Carroll has been the Director of this successful Catheter Laboratory since 1997.

As a member of the Riverina Cancer Care Community Trust Board, Gerard helped establish radiotherapy services in Wagga Wagga. Four million dollars was raised in 18 months to help build a modern fully-equipped cancer centre in 1999-2000.

Gerard played a major role in the establishment of the first School of Rural Health, Wagga Wagga. He was a member of the original Transitional Management Committee and the Community Advisory Board. He was appointed Associate Professor of Medicine at the University of NSW in 2002 and in this capacity has been heavily involved in the 4th year and 6th year medical student teaching. Gerard has been responsible for the establishment of rural rotating registrars in Wagga Wagga, and supervised the first Senior Medical Registrar appointment in 2004.

Gerard's other appointments have been; Chair, Medical Staff Council of WWBH 1995 to 1998; Chair, Greater Murray Medical Staff Council Executive1998- 2001; Specialist representative on Clinical Services Plan Advisory Committee for Greater Southern Area since October 2004; Physician representative on Clinical Governance Committee Wagga Wagga Base Hospital since 2003; member, Medical Advisory Committee, Calvary Hospital since 2004; member, RACP State Committee since 2002 and Co-Chair since 2004; Chair, NSW Rural Physician and Paediatrician Network since 2002; examiner, RACP clinical exam at St Vincent's and St George 1994-2001; member, National Examination Panel of RACP since 2002; member, Network Oversight Committee responsible for the new Network model for Basic Physician Training in NSW ; Chair, Steering Committee to establish and carry out feasibility study of a Rural Obstetric Training Network, 2003; member of the Advisory Committee for the federally funded Rural Obstetric Training Network; member, Medical Issues Committee, National Heart Foundation; and member, Clinical Issues Committee, NHF.

Gerard is married to Joanne. They have six children between the ages of 2 and 17 years. His hobbies include competition touch football and tennis. He is quite heavily involved in children's sport and is the "runner" for his two sons' Australian Rules football teams in Wagga Wagga.

(From Page 7)

have arisen in a somewhat haphazard, informal manner, and that the potential for increased international linkages and interaction is largely untapped.

A recently published Charter on Medical Professionalism* articulates the need for "commitment to professional competence and scientific knowledge" among physicians. Enhanced international cross-pollination and knowledge exchange would contribute importantly to the fulfilment of that commitment. Through unprecedented staging of the SGIM Annual Meeting in Vancouver in May 2003, and the inclusion in the meeting's program of high profile sessions featuring Canada's health care system, the leadership of SGIM demonstrated a clear interest in exposing its membership to international system models and the roles of internists within those models.

For each of the four non-US countries notably represented in SGIM membership (Canada, Switzerland, Argentina, and Japan), the representation typically arises from traceable links through individuals who spent time in US-based academic training, rather than from any international outreach activities from SGIM. The relative lack of representation of involvement in SGIM of general internists from Australia, New Zealand, the United Kingdom, and other European countries is notable, and underlines the considerable potential for increased international outreach of SGIM.

It has been argued that a new international society, rather than expanded outreach on the part of SGIM, should be considered as the means for promoting academic exchange in GIM. On the other hand, some argue that the US-based SGIM is already developing an increasingly international perspective (e.g. through the staging of its annual meeting in Canada), and that the remarkable academic strength and vibrancy of the Society make it the *de facto* choice for leadership of a move toward the 'globalisation' of the discipline. SGIM could proactively adopt a coordinated and targeted international outreach strategy to build bridges with societies of internal medicine in other countries.

There was preliminary talk in New Orleans of a vision for a large international GIM meeting in 2010, attended by perhaps as many as 1,000 international (non-US-based) attendees from across the world. The conference will feature increased international perspective, dialogue around international issues in academic GIM, exchange of ideas around clinical care and system models, and the spawning of new multinational collaborative ties in education and research. Watch this space.

IAN SCOTT

with acknowledgement to Bill Ghali, Junji Otaki, Raul Mejia, and Jacques Cornuz.

*Medical Professionalism Group. Medical professionalism in the new millennium: a physicians' charter. Ann Intern Med 2002;136:243-6.

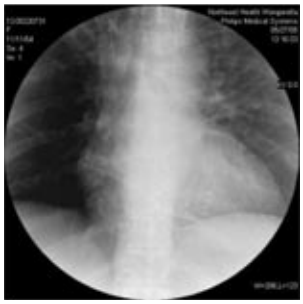
INFUSAPORT PROBLEMS

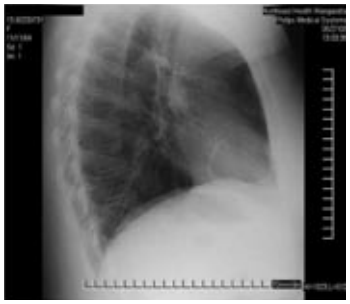
Dear all,

I am seeking information and other instances of Infusaport failure - especially fracture of catheter necessitating removal from R Heart.

The patient had an Infusaport inserted for chemotherapy for recurrent Ca Breast in October 2004. After 7 months, in May 2005, the catheter was more prominent subcutaneously and associated with mild right shoulder pain. Attempts to inject saline resulted in local discomfort due to subcutaneous infusion.

A chest x-ray reveals 11cm of catheter in R atrium straddling the tricuspid valve into the R ventricle.

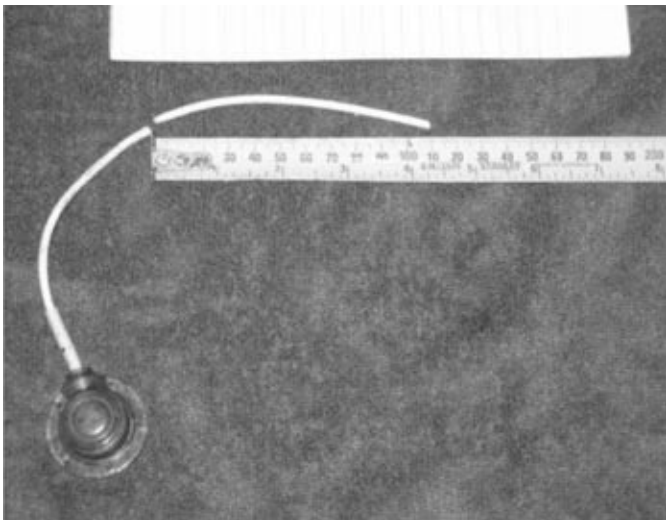




The patient was conveyed to a private radiology facility and the catheter was removed via a transfemoral approach using a goose neck snare.

Removal was relatively uneventful, apart from multiple ventricular and atrial arrhythmias complicating the procedure. Grasping the catheter ends was difficult as the one end was tightly wedged against the atrial wall and constantly moving, and the other embedded in the RV trabeculations. The subcutaneous section of the Infusaport was removed under GA, with insertion of a new Infusaport for ongoing chemotherapy.

The catheter appears to have been severed intravascularly – presumably by compression by the costoclavicular ligament or between the 1st rib and clavicle.



Although this potential complication is mentioned in the literature accompanying the Infusaport, with advice to avoid insertion via the medial route into the subclavian vein, there appears to be a potential fault with the catheter.

I would be interested to hear from other clinicians re the frequency of this problem.

I am aware of several anecdotal episodes over the past 10 years with several of the Long Term Venous Access devices. There appears to be a hiatus in the literature and information on this problem

I have submitted a report to the Therapeutic Goods Australia IRIS: Medical Device Incident Report Investigation Scheme.

Regards

LESLIE E BOLITHO
June 2005

Congratulations...

JON DOUGLAS AM, FRACP

Congratulations go to Jon Douglas who received the Order of Australia (AM) in the recent Queen's Birthday Honours List. Jon received his award under the general division for "service to medicine, particularly through a range of medical and administrative roles, professional organisations and specialist training programs for physicians.

Jon's many achievements include his term as second president of IMSANZ and an architect, along with Neil Graham, of the merger of the Australian and New Zealand societies to form IMSANZ; being chair of the Board of the Wesley Hospital in Brisbane; senior visiting general physician to the Royal Brisbane and Women's Hospital; inaugural chair of the College Lecture Series Committee for Queensland; and chair of past Scientific Organising Committees for RACP Annual Scientific Meetings held in Brisbane. Jon has also served as a great teacher and mentor to generations of medical students and physician trainees in Queensland and continues to conduct a busy private practice in addition to his work in medicolegal and workers compensation affairs.

HIGHLIGHTS - WELLINGTON MEETING

May 2005

The RACP Annual Scientific Meeting in Wellington May 8-11 held a number of highlights involving IMSANZ members which we relive in words and pictures as follows:

- Inauguration of the 7th IMSANZ president, Assoc Prof Phillippa Poole and farewell to the outgoing president, Assoc Prof Ian Scott at the Society's 14th Annual General Meeting.
- First presentation of the Award for Clinical Excellence to John Henley from Auckland
- RACP Medal for Clinical Service in Rural and Remote Areas awarded to Robert Ziffer from Sale, Victoria (see related article)
- Best Presentation Award sponsored by Roche Pharmaceuticals bestowed on two trainees whose presentations at the IMSANZ Free Papers session were judged to be of equally high quality. Congratulations to Tuck Yong and Josephine Thomas. Their respective presentations – An audit on d-dimer use in the assessment of patients with suspected acute pulmonary embolism; Secondary stroke prevention in patients discharged from the Royal Adelaide Hospital – exemplified the research talents and dedication to hard work of the upcoming generation of young physicians.
- Well attended session on the Future of General Medicine featuring guest speaker Prof Eric Larson, Chair of the Board of Regents of the American College of Physicians, together with an inspirational talk from John Henley on the virtues and importance of general physicians, preceded by a recounting of the forces that have led to a renaissance of general medicine from Ian Scott.
- John Henley also used his oratorical skills in a debate involving 5 other speakers that discussed the relevance of the history of medicine to today's practising physician. No need to guess which side John was on given his long experience in clinical practice and interest in how the past can inform the future.
- Scholarly and ground-breaking dissertation on new educational methods for creating caring competent physicians presented by Assoc Prof Dawn De Witt from Shepparton Rural Clinical School, Victoria.
- Controversial and thought-provoking session on matters of rural practice was organised and chaired by Dr Les Bolitho which featured Prof Eric Larson providing a US perspective, Dr Gillian Durham (Deputy Director-General of Health, NZ) summarising the NZ government's stance on rural health issues, and Dr Sue Page, president of the Rural Doctors Association of Australia, offering some hard-hitting comments about what's ailing the Australian rural health workforce.
- A philosophical debate on the evolution, education, and current status of physicians within the health professional community saw Phillippa Poole teamed up with Des Gorman and Prof John Scott from Auckland in what was a very thought provoking and historically grounded session.

CONGRATULATIONS to the winners of our Clinical Quiz at the Wellington ASM. The major prize winners were:

1st Paul Reeve (NZ)
2nd John Gorey (VIC)
3rd Les Bolitho (VIC)
4th John Henley (NZ)
5th Denise Aitken (NZ)

Thanks also to Ramesh Nagappan who once again kept all entertained during with his presentation.

And on the lighter social side:

- Great night of fine food and friendship at Shed 5 Restaurant on Monday night at the IMSANZ Dinner, at which Ian Scott thanked all present for their support during his presidency and reaffirmed the respect the Society now holds within the college community.
- After finishing up at Shed 5, IMSANZ members Cameron Bennett, Geoff Metz, Ian Scott and Leonie Callaway shared a late drink in the company of young party-goers at the Trainees Dinner held at the Dockside Restaurant and Bar and, of course, took the opportunity when presented to inform these aspiring fellows of the rewards that await them if they were to choose a career in general medicine.
- Another highly entertaining Clinical Quiz compiled and orchestrated by that photographic, photogenic quizmaster, Ramesh Nagappan from Melbourne. First prize for getting the highest number of right answers was Paul Reeve from Waikato, New Zealand.
- Public thanks to IMSANZ for its assistance in organising the Adult Medicine Scientific Program was given by college president, Jill Sewell at the Adult Medicine Division Dinner at the Wellington Convention Centre. As the wine and camaraderie flowed, past president Neil Graham challenged past treasurer Michael Kennedy to a contest of bench presses (push-ups) with thumbs only on the floor. The totally impartial Ian Scott adjudicated and concluded the contest to be a dead heat. Michael's performance has been captured on camera, but we caution readers who have to manipulate an endoscope or any hand-held probe the next day not to try this at home without first obtaining proper training in the technique from Drs Kennedy and Graham.
- Finally, a big thanks to Phillippa Poole, Philippa Shirtcliffe, Sisira Jayathissa, Les Bolitho, Ian Scott, Fairlie Clifton, and Mary Fitzgerald, who, as the IMSANZ/Adult Medicine Division Scientific Program Organising Committee, helped in making the Wellington meeting an educational and social success for all of us from IMSANZ who attended. Well done guys.

IAN SCOTT

ANOTHER CALL FOR THE RETURN OF THE GENERAL PHYSICIANS

This is an edited transcript of messages received on the IMSANZ website chatline.

Dr John Mac, GP, writes:

The value of a specialist for me is the one that gets a result with your difficult patient. Perhaps the current selection of specialists is too limited or one's preferred specialist is not up to scratch.

No, the problem is much deeper than that ...The system of medical specialisation used to be that all doctors graduated and worked in GP. After a time, some developed interests and expertise in particular areas, and GPs referred patients to these "specialised" GPs. These old time specialists had a broad knowledge, and were well able to deal with "difficult" patients, where the referring GP was struggling to make a diagnosis or get a handle on the problem.

But these dinosaurs have now died out. The new breed of specialists have been fast

tracked into their specialty, and learnt a lot about a little - especially to do the procedure that will be their meal ticket.

Now this is not to say that the new breed don't do good work - they do. But the new breed do not cope with the "difficult" patient. No. Send them the patient that needs the 'scope or the echo or the angiogram or whatever.

But to whom do you send the difficult diagnostic problem that doesn't seem to fit neatly into a particular pigeon hole ? ... There's no-one left who can clinically assess and work up such a difficult patient, except for the experienced GP who has somehow maintained high standards under the burden of multifactorial practice pressures.

Fortunately, there are still a few of them left, but I'm not sure for how long.

Les Bolitho replies:

The forte of the general physician is the patient with the undifferentiated

problem or the complex patient with multiple co-morbidities.

I am continuing to learn and become aware of new issues and situations on a daily basis - is this measured as experience or inexperience, or competence or incompetence? For example, in the past few weeks I have been involved with:

- a 62 yo lady on gemcitabine chemotherapy for carcinoma of the gallbladder, who developed progressive shortness of breath, due to non-cardiogenic pulmonary oedema

  (fatal outcome) - but I could explain to the family the cause of death;
- a 90 yo lady who became moribund at her birthday party- blood cultures grew Strep pneumoniae, and follow-up CXR 2 days later revealed left lower lobe changes (discharged home);
- a 65 yo man with atypical polymyalgia rheumatica in 2001 presents with abdominal sepsis, and retesting reveals positive ANF, dS-DNA and cardiolipin antibodies not previously present (now confused re 'sudden' label of SLE.)

There is a very active group of general physicians who can provide consultation for your difficult, complex or confusing patients. Please advocate for more general physicians in your community!!

Various shots from the Wellington Meeting, May 2005

Smooth dry season flying, cold desert mornings and a horizon that goes on forever. Priorities, experience and vistas are a little different in the Kimberley compared to training and working in east coast capital cities. Looking back over two years as the inaugural regional physician for the Kimberley region in far north Western Australia, I realise it has been a unique, rewarding and humbling experience. Every day I see that physicians in Australia can, can't and sometimes aren't willing to address the health of all Australians.

The Kimberley has a resident population of 40,000, half of whom are Aboriginal Australians, and over 250,000 visitors per year. For many, the Kimberley may mean balmy weather in winter, a holiday at Cable Beach Club Resort or driving from gorge to gorge along the Gibb River Road. From a regional specialist perspective, it represents the challenges and opportunities posed by a population spread over an area twice the size of Victoria. The Kimberley has one of the highest rates of infectious diseases and prevalence of chronic non-communicable diseases in the world. This is Australia's 'fourth world', existing in stark contrast to five star resorts in Broome peopled by affluent east coast tourists.

The Kimberley provides challenging and exciting opportunities for a resident physician living in Broome and travelling in the northwest of Australia. In addition, it offers a unique and enjoyable lifestyle. The grind of daily peak hour traffic and cold winters are replaced by walking on Cable Beach experiencing another spectacular sunset, and the opportunity to work with people who have a commitment to Aboriginal Australian and regional health care.

Phase 1 – clinical care

Perhaps the greatest challenge for a physician developing the first resident adult specialist service in such a region is to attempt to marry your own expectations with those of residents, health providers, and health fund managers and develop a model of care that is sustainable and morally defensible. A persuasive case could be made, and indeed may be expected by primary health care providers, to direct the resources of a single physician to providing clinical services only. On arriving in the Kimberley, my clinic roster reflected this. In the first year I was away from home for 120 days, approximately half of the weekday nights, providing an outreach service to 20 different health services and travelled over 130,000 km by road and air. With a partner working full time and two young children, the impact this had on personal, family and professional life was unsustainable. Nevertheless this first year provided the opportunity to meet, talk and work with a range of residents, patients and health providers across the region and to begin to develop a picture of the vision they shared for health and health care in the Kimberley.

As time passed, it was evident that if I were to be useful in addressing the problems in adult healthcare, the terms of reference would need to be broader than the clinical consultation. Whilst the primacy of addressing health determinants was clear (housing, education, economic disadvantage, water and sanitation) it was also apparent that opportunities remained in the health service arena. Primary healthcare resourcing, access and efficiency all provided potential areas for improvement. It was not enough to blame the health disadvantage I saw everyday on factors beyond my control.

Phase 2 – advocacy

With expectations now primed to supply an outreach service it was time to utilise advocacy wherever it could be directed. All health providers are clinical leaders and at least can speak from a perspective of local experience. As such their opinions are key to informing the discourse in health service development. The priority is to identify forums where this advocacy can inform policy and institute effective, sustainable improvements in health service delivery. I now sit on the Clinical Senate, a clinical advisory group for the State Department of Health, the Remote Area Renal Service subcommittee the Health Reform Agenda Working Group for the Commonwealth and on an advisory committee for the National Health Priority Action Council (NHPAC) in addition to commitments to various respiratory groups wearing my faded respiratory physician cap.

Phase 3 – 'think globally, act locally' local adult health service development

Working at a State and national level may eventually result in change but by the time such changes filter down to the local level it can sometimes be hard to identify exactly what has been achieved. It was time to 'think globally, act locally'. As the regional adult physician providing an outreach service, the immediate and most difficult task was improving chronic non-communicable disease care and thus Phase 3, the Kimberley Chronic Disease Steering Committee (KCDSC) was founded. It incorporated all service providers for State health services and the Aboriginal community-controlled health sector, a network of six health services across the Kimberley.

From this has developed the Kimberley Standard Drug List (KSDL), a minimal essential drug list for all health services in the Kimberley, to encourage consistency and security of drug supply for a mobile patient population, and the Kimberley Chronic Disease Protocols. Like the KSDL, these protocols seek to provide consistent care to a mobile population serviced by a transitory primary health care medical workforce which can sometimes have little opportunity to develop an appreciation of the complexities of health care provision in this challenging and unique environment.

(see www.healthykimberley.com.au)

Renal disease and particularly dialysis services have become a stark illustration of the 'tip' of the chronic non-communicable disease 'iceberg'. The Kimberley has a satellite dialysis centre which provides care to 40 people on haemodialysis and supports approximately 25 people on in-community dialysis, predominantly peritoneal dialysis. All are Aboriginal Australians. How much support should a single

regional specialist provide to such patients at the risk of ignoring the far greater number of people in whom earlier intervention can prevent the need for renal replacement therapy? Sometimes it is easier to highlight and concentrate on the 70 residents requiring dialysis rather than the 25% of adult Aboriginal Australians in the Kimberley who have diabetes and are at high risk for renal impairment. I was fortunate that the support from Perth for local dialysis patients was excellent and that the Kimberley already had a general practitioner with advanced renal skills.

Dialysis provision remains an important issue for local residents, health advocates and other health providers. As a result, the Kimberley Renal Review (KRR), a strategic and health service development document for the future planning of renal replacement services was undertaken. The Kimberley Renal Advisory Group (KRAG) was formed to assist with the implementation of KRR recommendations including increased support for dialysis and pre-dialysis patients and planning for a second Kimberley satellite dialysis centre. This is a stark reminder that the peak incidence of chronic disease complications, such as end-stage renal failure, has not yet been reached.

Phase 4 – sustainability

My children are growing older and their educational needs must be considered. They want their father at home (or more worryingly, get used to him being away) and I want to spend time with them and my partner. As a result, remaining in my current work situation for more than 5-10 years may be unrealistic. Perhaps more important is to be constantly aware of the risk of burn-out and disillusionment which can make the most helpful health provider risk damaging several years of constructive engagement.

Key to sustainability is ensuring a sufficient critical mass of practitioners to ensure the ethos and corporate memory of a service can be sustained even when one person departs. This is a perennial problem in the regional Australian health workforce and even more so in an environment where there is a single practitioner. Whilst the key may be first to recruit more than one adult specialist it is also imperative to ensure that specialist services do not revolve around specialists alone. Secretarial staff, clinical service coordinators, project officers for short term health service evaluation and development projects, database development and data entry staff for chronic non-communicable disease recall systems and chronic disease clinical support workers and educators can all form a sustainable adult health service unit which maintains the corporate memory and amplifies the benefits of adult specialists. Encouraging a health service to recognise the benefits of a team approach to adult specialist care can at times be difficult even with evidence of significant cost savings, improvements in efficiency of expensive clinical services, and greater staff retention which can accrue as a result of working as part of a team rather than an individual in isolation. Ongoing advocacy by adult medicine specialists is required.

Final reflections

As the sun sets over King George Sound, I fly into Derby. Since I left a small desert community two and a half hours ago, I have had time to reflect upon the difficulties confronting healthcare providers and residents of remote and isolated communities. However, the work opportunities and lifestyle offered in Broome and the Kimberley are more than adequate compensation. My partner, young children and I have a unique opportunity to experience a lifestyle far removed from chaotic city life with Perth and east coast capitals still accessible within a few hours by air.

Opportunities exist to make significant and sustainable improvements in remote and regional Australian health care. Rural Australians including Aboriginal and Torres Strait Islander people require access to the same standard of health care as those in urban Australia. Consultant physicians in general internal medicine have much to offer in provision of these services providing they have the stamina and skill to work in a resource-poor environment. These physicians also need to function as healthcare advocates and demonstrate a willingness to participate enthusiastically in the development of healthcare services in regional Australia.

It is time for the RACP, the State and Commonwealth Departments of Health to move beyond reviewing the crisis in regional specialist services and to implement initiatives that will address immediate workforce issues. Only three adult physicians remain outside Perth/Bunbury in Western Australia. Sustainability and development of adult specialist practice in regional Australia will rely on encouraging physician trainees to consider regional practice, a training scheme that includes the development of skills in healthcare service development and population health, and a work environment that will attract and retain physicians in regional Australia.

In the meantime, adult specialist physicians in regional Australia continue to provide essential care to an often disadvantaged population while experiencing a lifestyle that those in the cities would find hard to match.

GRAEME MAGUIRE
Kimberley physician
graeme.maguire@westnet.com.au

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

The future of Generalism. Larson EB et al. Ann Intern Med 2005;142:689-690.

This is an editorial to a supplement in the Annals of Internal Medicine which contains 4 papers which address themes relevant to the future of generalism in the USA: communication, both between providers and patients and between providers; integration; coordination; and rekindling student interest in generalist careers. Although much of the material relates to primary, rather than to consultant care, many of the themes are relevant to the latter.

Role of specialists in common chronic diseases. Gask L. BMJ 2005;330:651-653.

In this paper from Manchester, Linda Gask summarises the changing roles of "consultants". She considers that the first change required is to consider care across the *community*, rather than only to those specifically referred to clinics and to consultants in other settings. The second shift required is to introduce "stepped care" with closely monitored outcome data to define which patients are likely to benefit from more regular clinical supervision. These changes mean close generalist/specialist collaboration, including collaboration with specialist nurses

Long live generalism. Auerbach AD. J Gen Int Med 2005;20:208-209.

This paper is an editorial which highlights 3 papers relevant to admitted patients on general medical services. The first relates to the evolution of hospitalists, the second is a case-controlled study of patient medication and care-related risk factors for inpatient falls and the third is a prospective study of the reasons for prolonged hospitalisation on a general medicine teaching service.

Determining the professional attributes of a hospitalist: experience in one Australian metropolitan hospital. Kingston M. Intern Med J 2005;35:305-308.

In this observational study from the Gold Coast Hospital in Southport, data was collected prospectively on 1,300 consecutive patients admitted to the general medical unit. This provided an opportunity to review the case load in terms of case-mix, and hence requirements for the professional skills of general physicians working as "hospitalists".

The impact of evidence on physicians' inpatient treatment decisions. Lucas BP et al. J Gen Intern Med 2004;19:402-409.

This considered a random sample of a 146 inpatients cared for by 33 internal medicine "attending physicians" in a large public teaching hospital in Cook County, Illinois. Investigators performed standardised literature searches and provided the results to the attending physicians, after diagnoses had been made and treatment plans established. The main outcome, the number of patients whose attending physicians would change treatment as a consequence of the literature searches, applied to 18% of 130 eligible patients. It was concluded that literature searching could improve treatment for many medical inpatients. An accompanying editorial (J Gen Int Med 2004;19:479-440) reminds us of the importance of evidence in the treatment of admitted patients.

An overview of the types of physicians treating acute cardiac conditions in Canada. Gong TK. Can J Cardiol 2004;20:282-291.

In Canada, cardiologists and general internists treat 65% of patients with acute myocardial infarction, but only 16% of patients admitted with congestive cardiac failure. Other patients are cared for by general practitioners or family physicians.

Physician specialization and the quality of care for human immunodeficiency virus infection. Landon BE et al. Arch Intern Med 2005;165:1133-1139.

This study like previous ones, show that generalists with appropriate experience and expertise in HIV care continue to provide high quality care, with some correlation of care-quality with the volume of patients seen.

Update in General Internal Medicine. Kroenke K, Logio K. Ann Intern Med 2004;141:213-220.

The Annals of Internal Medicine publishes regular updates from the annual session of American College of Physicians in general medicine, as well as some of the subspecialty areas.

"bmjupdates+". Access is from British Medical Journal home page at bmj.com. Registration (at no cost) is required.

"BMJ updates" is an excellent information service for general physicians wishing to learn "the best new evidence concerning important advances in health care, tailored to their interests". It is produced by the BMJ Publishing Group and the Health Information Research Unit at McMaster University (Canada). It includes an email alerting system and a searchable database of best published evidence. Expert research staff peruse ~ 50,000 articles from ~120 journals each year and select ~ 3000 according to strict critical appraisal and content criteria. These are then ranked according to "clinical relevance" by practising clinicians. Registrants can select options for the frequency of regular email alerts according to the level of clinical relevance of citations. You can become involved in the clinical relevance rating process.

This website, which includes links and tools for evidence based practice, is highly recommended.

Les Bolitho wishes to draw IMSANZ members attention to a series of general medical articles published in the Medical Journal of Australia. Go to http://www.mja.au. Click on "Topic lists" in the left panel, then on "General Medicine".

PETER GREENBERG
Melbourne

JILL SEWELL LAUNCH'S RtB DOCUMENT

'Restoring the Balance'

Phillippa Poole, Jill Sewell and Ian Scott after the launch of the Restoring the Balance document

Thank you Ian for inviting me to help launch this important document at the IMSANZ Annual Scientific Meeting. I am looking forward to talking with many of you today and discussing some of the current activities of the college.

I would like to start by acknowledging the hard work of those involved in developing this position statement. Particularly, A/Prof Ian Scott who really drove this issue and ensured that it remained on the agenda. I would also like to acknowledge all members of IMSANZ and RACP involved in developing the statement, including IMSANZ President A/Prof Phillippa Poole.

Restoring the Balance is an extremely important statement about the future for us, as physicians, and the health system as a whole.

RACP and IMSANZ will be lobbying the Australian Federal, State and Territory governments and the New Zealand government to implement all of the report's recommendations.

In particular, we want governments to really understand the important role general physician's play in the healthcare system.

In *Restoring the Balance* we are reminded that many patients no longer have the opportunity to be managed by general physicians. Sadly, this means they can be treated by many different physicians for each separate health problem. Their overall health may be at risk as a result of poor co-ordination of care or oversight of problems.

This document demonstrates to government that there are over 180 vacancies for general physicians in Australia and New Zealand.

This is a problem that can no longer be ignored.

We recommend government increase the incentives for physicians to train and practice as general physicians. This includes ensuring greater equity between procedural and non-procedural physicians in the level of remuneration provided under Medicare. **If this is achieved, it would be a huge leap forward.**

State governments should adequately compensate general physicians in private practice, for the time they spend in undertaking public hospital duties including demanding committee work and teaching roles in addition to clinical work.

We know that rural and regional areas desperately need more general physicians. We call on the all governments to implement schemes to attract general physicians to practice in these areas, such as improved financial incentives.

The paper also recommends funding should be increased toward establishing more rural and regional positions for physicians in general medicine, and for general physicians in training. And, expanding local specialist infrastructure in rural/remote communities.

As physicians, we know how excellent General Medicine Departments and Acute Medical Wards can be when adequately staffed by general physicians. **The challenge for us is making sure the decision makers realise this.**

We recommend that all teaching hospitals have Departments of General Medicine and Acute Medical Wards. Experience in New Zealand suggests that Acute Medical Wards provide more cost-efficient care, decrease hospital admission rates, save hospital bed days and streamline care delivery.

Restoring the Balance also looks at what the RACP and IMSANZ can do about the issue. The RACP will encourage trainees to train as general physicians and maintain their skills once graduated.

As all of you would be aware, we are changing the way physicians are trained and educated as part of the RACP Education Strategy.

We are developing a flexible training curriculum with competency based assessments, strengthening mentoring and supervision guidelines and planning to implement further opportunities for CPD. All this will impact on general physicians and will encourage physicians to maintain their general physician skills.

This is an exciting time of change for RACP and IMSANZ.

Restoring the Balance sets the agenda for our dealings with government and will become the basis for much of our lobbying activities in the coming years.

Hopefully, as a result, we will see the essential role of general physicians recognised and valued in the healthcare system.

A/PROF JILL SEWELL
President of The Royal Australasian College of Physicians

Delegates and flies enjoying the Bush BBQ

SPEECH OF IAN SCOTT TO RtB LAUNCH

IMSANZ ASM, Alice Springs

Rainbow Valley at sunset our venue for the Bush BBQ

It is my great pleasure to join with Phillippa and Associate Professor Jill Sewell in officially launching this position statement on behalf of the Internal Medicine Society of Australia and New Zealand (IMSANZ) and the Royal Australasian College of Physicians (RACP). *Restoring the Balance* has, as its basic premise, the vision of a better health care system – a system in which the practice of general physicians is appropriately balanced with that of subspecialty physicians in better serving the current and future health care needs of Australians and New Zealanders. *Restoring the Balance* seeks to make clear the contributions that general physicians can make in delivering optimal care to patients presenting acutely ill to hospitals and to the growing numbers of patients with chronic and complex health conditions.

Restoring the Balance brings attention to the need to rebuild the general physician workforce. It presents practical strategies for enhancing the capacity of general physicians to provide specialist care to communities in outer metropolitan, regional, rural and remote areas – areas where access to such care is becoming increasingly limited. This issue is particularly relevant to indigenous communities that are being cared for by the small numbers of dedicated general physicians in places like Alice Springs where we find ourselves today. We must strive to provide an appropriate standard of specialist medical care to all who need it no matter who they are or where they live.

General physicians are capable of providing this appropriate standard of care. They have the ability to manage patients with a diversity of illness and conditions and who can refer to subspecialty colleagues as and when needed. Having little or no access to any form of specialist care is clearly no standard at all. Yet such a situation exists in many outer metropolitan and regional centres throughout Australia and New Zealand where there is a critical shortage of general physicians. As parties responsible for upholding the standard of medical specialist care in both countries, the Internal Medicine Society and the RACP have, in partnership, produced this action plan which seeks to enhance our capacity to train and support consultant physicians in general medicine. While both parties endorse the value of, and need for, subspecialty medicine, we feel that it is not feasible and is potentially self-defeating to expect care in all settings to be the same as that found in large city-based tertiary hospitals populated with multiple subspecialty departments. As explained in *Restoring the Balance* an over-emphasis on subspecialist-mediated care may also not be the best way to optimise population health or the cost-effective use of limited healthcare resources. Patients themselves are wanting their care to be less fragmented among several specialists and instead more co-ordinated under the supervision of a single specialist.

Restoring the Balance seeks to ensure sufficient numbers of physician trainees continue to graduate with skills necessary for the good management of patients who present acutely ill to hospitals located some distance from major tertiary centres. It offers suggestions on how hospital appointments, training programs, continuing professional development schemes, financial remuneration and working conditions for general physicians, in both public and private practice, can be improved and placed on a more equal footing with those of other specialties. Such an achievement will induce more of our young and bright physician trainees to choose the practice of general medicine as a future career.

Restoring the Balance also emphasises the importance of integrating the thinking (or cognitive) aspects of physician practice with the procedural aspects of our craft. This means we must adequately remunerate the non-procedural or consultative parts of our interactions with patients – the thinking, counselling and educating parts of our work. Currently financial reward is skewed too much towards the procedural or technical parts of specialist practice. Turning this around is vital if we are to improve health and prevent illness in aging populations that have, or at risk of developing, multiple, chronic diseases. Such a shift will also better meet the needs and preferences of our patients and help to ensure that costly, high-technology investigations and treatments are directed more to those patients who stand to gain most benefit with least harm.

Ciara O'Sullivan, Steve Brady, Graeme Maguire and Paul Lawton our outback Australia team

John Henley sitting on a Todd River tree branch thus we have "Henley on Todd"!

Andrew Wesseldine receiving his IMSANZ/Roche free papers award from Phillippa Poole

Andrew Burns, Ajay Kumar and Alan Jenner enjoying pre-dinner drinks at Desert Park

Restoring the Balance calls for close collaboration, mutual respect and teamwork among general and subspecialty physicians irrespective of whether they work in the same city or hospital, or work in geographically separate hospitals and communities. In achieving this aim, *Restoring the Balance* advocates for greater networking between tertiary hospitals dominated by subspecialists and community hospitals dominated by general physicians, with greater sharing between the two of expertise and resources, and of trainees. It also advocates for subspecialty physician training and education programs to be more flexible and accessible to general physician trainees so that they too can acquire selected skills which better equip them to provide care for people living outside major metropolitan centres.

Restoring the Balance also asks for recognition of the contributions general physicians make towards medical teaching, research, health administration and public health. It seeks to strengthen the academic and clinical foundations of our discipline by expanding the service, research and teaching capacities of general medicine departments in teaching hospitals and clinical schools. It highlights the many niche areas in clinical practice in which general physicians, by virtue of their broad interests and expertise, can both provide service and undertake research. Examples of such niche areas include peri-operative medicine, obstetric medicine, palliative care, chronic and complex care, and clinical epidemiology.

In total *Restoring the Balance* articulates positive, practical steps that the Internal Medicine Society and the RACP can take in improving care provided by physicians to all Australians and New Zealanders. We acknowledge the input and support this document has received from the Specialties Board, the Adult Medicine Division Committee and the Council of the RACP as well as from the 450 members of the Internal Medicine Society.

We now face the task of translating the aims and objectives of *Restoring the Balance* into action. If we are to be successful, we will need the buy-in and support of a number of different jurisdictions including federal, state and territory governments, area health boards, hospital administrations, and heads of hospital clinical units. We will also need the co-operation of the fellowship and the administrative staff of the RACP and of each of the Specialty Societies. There is much work to do and no

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CATs LIBRARY TAKES OFF

More than 40 CATs are now posted on the CATs Library which aims to quickly bring research articles of high quality and impact to the notice of busy general physicians. Titles recently added include:

- Adding aspirin to clopidogrel in high-risk patients with recent stroke or TIA does not improve outcomes
- Intensive lipid lowering better after acute coronary syndrome improves outcome
- Low dose aspirin plus esomeprazole less likely than clopidogrel alone to cause recurrent ulcer bleeding
- Compression stockings prevent post-thrombotic syndrome
- Calcium and vitamin D3 do not prevent recurrent low-trauma osteoporotic fractures in elderly patients
- Factors which predict a poorer prognosis after initial diagnosis of Alzheimer's disease
- Clopidogrel added to aspirin improves outcomes in ST-elevation AMI
- Coronary artery revascularisation prior to elective vascular surgery of no benefit in stable coronary disease
- Glucose-insulin-potassium infusions confer no benefit in patients with ST-elevation AMI
- ICD implantation but not amiodarone improves survival in patients with chronic heart failure
- Warfarin harmful compared to aspirin in patients with symptomatic intracranial arterial stenosis
- As-needed inhaled steroids produce better symptom control than regular steroids in mild asthma
- Low molecular weight heparin combined with reperfusion therapy reduces mortality in ST-elevation AMI
- Early evacuation surgery no better than conservative treatment in spontaneous supratentorial intracerebral bleeding
- Recombinant activated factor VII infusion improves outcomes in acute intracerebral haemorrhage

The following members are gratefully acknowledged for submitting contributions to the CATs Library over the past 4 months:

- Graham Hall
- Su Mien Yeoh
- Spencer Toombes
- Nicole Hancock
- Peter Nolan

Don't forget: you can earn 2 MOPS points per CAT. For more information, log onto www.imsanz.org.au/resources and follow the links to the CATs Library.

IAN SCOTT
Editor, CATs Library

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Patrick Fiddes, Justin La Brooy and Rob Ziffer enjoying nibbles before the conference dinner

doubt there will be challenges on the road ahead. But the fact that we are here today launching this document is testament to the collective good will and understanding that exists within the physician community about the need to ensure equity in the delivery of consultant services in general medicine.

I thank everyone who has participated in today's launch for their assistance and look forward to your ongoing support as we turn words into deeds. In particular I wish to publicly thank the president of the RACP, Associate Professor Jill Sewell for her counsel and support in the birth of *Restoring the Balance* and invite her now to speak to it on behalf of the College.

IAN SCOTT

IMSANZ Alice Springs 1 - 4 September 2005

IMSANZ Council was delighted that over 100 delegates attended this meeting at the Alice Springs Convention Centre. We were joined by RACP President Jill Sewell who participated in the formal launch of the IMSANZ / RACP Action Plan "Restoring the Balance" then generously stayed on for the remainder of the conference.

Tarun Weeramanthri opened with a thought - provoking reflection on physicians as "street level bureaucrats", offering a range of strategies to ensure clinicians get traction at the managerial level and beyond. John Henley challenged us to lead the reestablishment of medical professionalism, and Rick McLean contributed to both the preconference forum and the conference plenary on strategies to address rural and remote health workforce shortages. Congratulations to Andrew Wesseldine (WA, via NZ) for winning the free paper prize for his audit of first seizures in the elderly.

The remainder of the programme was devoted to in - depth updates of common and important medical problems, as well as a discussion of the modifications to "gold standard" approaches required when patients are indigenous and / or distant from metropolitan sites. The major presentations will be available on the IMSANZ website, and there will be more on the conference in subsequent newsletters.

With plenty of time for social activities and to take in the local sights, the conference was an opportunity to recharge and to renew commitment to general medicine. Our grateful thanks are due to Steve Brady, Di Howard, Ian Scott, Mary Fitzgerald, and Dart Associates for putting on such an excellent event.

PHILLIPPA POOLE

2005	**October**	**European School of Internal Medicine VIII** *Emergencies In Internal Medicine* 22nd - 28th October ~ Alicante, Spain
	November	**Canadian Society of Internal Medicine Annual Scientific Meeting** 2nd - 5th November ~ Marriott Eaton Centre, Toronto, Canada Email: csim@rcpsc.edu Web: www.csimonline.com **Australian Association of Neurologists** *World Congress of Neurology* 5th - 11th November ~ Sydney Enquiries: Shonna Peasley at Event Planners Email: shonnap@eventplanners.com.au Web: www.wcn2005.com
	December	**Asia Pacific Interventional Advances Conference** *First annual cardiovascular interventional symposium* *Developments in diagnostic and interventional cardiology* 29th November - 2nd December ~ Newcastle Civic Precinct, Newcastle Enquiries: apia@willorganise.com.au Web: www.apia.org.au
2006	**February**	**Medicine in the Extremities: Land, Sea and Space** 28th February - 10th March ~ Antarctica For more information: Email: sales@peregrineadventures.com Tel: +61 03 9662 2700 Web: www.peregrineadventures.com/pdfs/Medical_Conference_28Feb06.pdf
	March	**IMSANZ Palmerston North** For more information contact Kirsten Holst
	May	**RACP Cairns Congress 2006** 7th - 11th May ~ Cairns International Hotel, Cairns, Queensland
	September	**RACP (NZ) / IMSANZ / Nephrology, Queenstown** 20th - 22nd September
2007	**September**	**ASGM / IMSANZ Combined Meeting** September ~ Adelaide

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 is now 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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