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INTERNAL MEDICINE SOCIETY *of Australia & New Zealand*

DECEMBER 2005

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From the President...

The General Matters

I hope that this finds all of our IMSANZ members looking forward to a little respite from busy schedules over the holiday period. During this time please take some time out for your own health, and for renewing and refreshing your relationships with families and others around you.

In the last month I have had the opportunity to travel to North America, at the invitation of the Canadian Society of Internal Medicine (CSIM). The main purpose of this trip was to participate in a symposium on the globalisation of general medicine, with representatives from our sister societies in North America (see the report on page 7). It also afforded me some valuable time with a typical US family I have known since a student exchange experience in New York State, in 1976.

The parents are now around seventy, and still extremely healthy and energetic. They no longer have a need for a GP (family doctor) as all their children are grown, but they do see value in having regular visits with an internist (general physician). They regularly utilise the services of a gastroenterologist and a neurologist. Each of these subspecialists has a physician's assistant who may be phoned or seen at short notice for straightforward issues. The family is extremely satisfied with their access to care and the calibre of the physicians' assistants who work very closely with the subspecialist. If they were to be admitted to hospital with a general medical problem, the inpatient care would be given by a hospitalist, working in close liaison with their internist in the community. Of course, this represents wonderful care for those who are fortunate to be able to afford it, and it also values the role of the general internist working both individually and in shared -care situations, although the internist is assuming some of what we know of as the primary care role.

At every step money must be made in order for the system to survive. As an example, as 'seniors' the American parents are now eligible for Medicare, yet still have to carry several top-up insurance plans. The complexity for resolving the relative contributions of each of the insurers to the reimbursement of the costs of physician visits is staggering even to US residents, and necessitates the involvement of offices full of bureaucrats.

As a result the USA spends 14.5% of its GDP on health versus NZ's 8.5%, Australia's 9.0% and Canada's 9.5%, yet in terms of life expectancy, USA fares worse than these other countries. This is supported by the finding through comparisons of Medicare spending among states in the USA that more is not necessarily better - in fact the reverse is true (Baicker and Chandra, 2004, Health Affairs). States with

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PRESIDENT’S REPORT

Season’s Greetings to you all!

higher ratios of specialists had lower quality measures (such as use of beta blocker after MI, monitoring of HBA1c in diabetics, use of mammography), and this was independent of the health of the population. When this trend is analysed further, higher spending is associated with more subspecialists and more likelihood of use of high cost, low utility health care such as ICU in the last six months of life. People in one county in Florida reportedly see more than 15 subspecialists in their last year of life. One explanation is that a higher number of subspecialists may lead to fragmentation of care as well as to increased costs.

In North America one is bombarded by Direct to Consumer advertising. For example, a TV ad for Plavix (clopidogrel) quotes “if you have a clotting problem, ask your doctor if this is right for you”. The pharmaceutical companies are increasingly bypassing clinicians and moving more to DTC forms of advertising. This inevitably feeds the ‘medicalisation’ of society and encourages the public to seek a pill, and presumably a doctor, for all ills. There are some moves to curb this though - pharmaceuticals are now subject to the familiar reference pricing strategy with quite considerable top - up payments required for non-approved brands.

At the other end of the scale there is an obvious mismatch between resources and health need for the approximately forty million Americans out of a total population of approximately 300 million with no effective access to health care.

I was intrigued by an article in the local newspaper about ‘surgicalists’ headed “These doctors will work 24/7”. A small hospital had just hired the services of two general surgeons to work on-call week-on, week-off to treat acute patients. Drivers for this initiative included staff shortages and the difficulty in getting private specialists to cover general surgical procedures for nights and weekends. These general surgeons will cover emergencies and routine, high volume procedures such as cholecystectomy and appendicectomy. The surgeons involved relish the idea of working totally in a hospital environment without the overheads and paperwork associated with solo private practice. By performing more procedures there is the potential for better patient outcomes. Interestingly, though, they are not hired by the hospital itself, but by a company in North Carolina that specialises in placing such generalists. The company reports having placed ‘laborists’ (O and G specialists) in some California hospitals. They clearly see this as a successful business opportunity.

The purpose of relating all of this is to provide food for thought as we seek to implement the joint IMSANZ / RACP position paper “Restoring the Balance”. If we are to avoid the underperforming and costly system of USA, the health systems in Australia and NZ clearly need cadres of physicians with the breadth and depth of skills, plus the mandate, to decide on the most appropriate care. These doctors shall work closely with subspecialty colleagues to design systems and to ensure patients do get the best care when it is needed. The incentives offered by all the stakeholders in the system must promote this type of approach. Unnecessary over-provision of care to the “worried well” has to be minimised.

To this end it is really heartening to see the momentum since the launch of the policy in September at Alice Springs. Members of IMSANZ Council are working closely with those in the higher echelons of the RACP to ensure that the dissemination is strategic, and that this message gets through to the right folk. The NSW RACP committee has become involved, and in planning to engage seriously with state health officials regarding the lack of access to general medical services in Sydney. Aidan Foy and a small group are looking at definitions of general medicine and workforce issues. Ian Scott is collating models and evidence of effectiveness of general medical units.

We do, however, need to back all of our claims with data. It is only with documentation of cost effectiveness and better health outcomes that we will win the arguments with those in charge of the pursestrings. Here is where you may assist. Please forward to Ian Scott or myself any descriptions of local examples of ‘successful’, general medical units or models of interaction with other services, especially those that are supported by outcomes or cost data. Please also indicate to us where you believe traction might be gained RIGHT NOW, and we will consider this as part of the implementation strategy. Of course none of this must stop you all “thinking globally, acting locally”, but please, your inputs will strengthen our global case to “Restore the Balance” with jurisdictions and colleagues.

Finally, I was intrigued by the rhetoric in the USA and Canada describing general internal medicine as a “new” specialty, when we tend to regard it as the good, old – fashioned, whole - person care that has existed for centuries. Maybe we need to take heed of how the USA and Canada are promoting GIM. This branding as “new” may have helped GIM retain the strong hold that it has in North America. We might all take heed of this approach and push this “new” specialty of GIM hard with what it has to offer the Australian and NZ health systems. Certainly, most of the health bureaucrats won’t have been around long enough to remember what it was like before the days of subspecialisation in the 70’s and 80’s.

My special thanks to all those who have contributed significantly to IMSANZ events and projects this year.

Season’s Greetings to you all.

PHILLIPPA POOLE
IMSANZ President

RETIRING COUNCILLOR

Leonie Callaway has retired as Advanced Trainee Representative on Council.

Leonie has contributed invaluable assistance to Council in her role as well

as her work with the new curriculum. Council wishes her well in her studies and career.

Two events occurred during September 2005 which has prompted me to reflect on the changes that have occurred in both my private and professional life.

The first was an invitation to talk at a meeting on Rural Physician workforce issues and to discuss "the personal dilemma I had faced in closing a private consultant practice in General Internal Medicine (GIM)". I chose instead to reflect on the changes that had occurred in GIM during my consultant career and those further changes that I see will be required to practice GIM in its emerging diversity. The second was my attendance at the first discrete scientific meeting of IMSANZ held at Alice Springs with an associated satellite meeting discussing remote physician practice.

These meetings have led me to discuss the professional changes I undertook at a time when perhaps I should have retired, to express to the membership of IMSANZ my views on issues confronting GIM and the difficulties facing both the RACP and IMSANZ in training sufficient physicians to undertake the roles required of general physicians in various Australian communities.

A change of direction

In December 2003, after 33.5 years, I closed my consultant practice in Wangaratta, North-Eastern Victoria. It had given me great personal and professional satisfaction to have spent the major component of my career serving that community and having the privilege of assisting in the training of many students, interns and registrars on rotation from the Royal Melbourne Hospital. The reasons for retiring from Wangaratta were many, the personal ones reflecting the opportunity to have my daughters complete their education in Melbourne and the professional ones reflecting my feeling I would find progressively more effort required to barely keep abreast of the continuing rapid expansion in medical knowledge and a strong wish not to see my standards imperceptibly decline.

It had been evident to me that aging practitioners may become less efficient, and I had no wish to personally experience such a change. Interestingly, in the Annals in February 2005, a systematic review of studies published between 1966 and 2004, confirmed that physicians who had been in practice longer may be at risk of providing lower-quality care.1

I had previously reflected on the ways in which we physicians cope with our increased public workloads, and those ways include placing greater reliance on junior staff, spending less time in careful clinical assessments, practicing defensive medicine with over investigation in place of clinical acumen, routinely applying protocol driven management systems and relying on guidelines rather than maintaining journal reading. Indeed I had probably implemented many of them, and had thought that I would probably increasingly deploy such in the face of the inevitable progressive decline in the currency of my knowledge. I have since observed that in a busy metropolitan hospital, the same mechanisms are well in place. But in addition, we have in large metropolitan hospitals, the capacity to consult widely.

The options I may have had in retiring from my practice reduced progressively, as it became clear to me and my fellow physicians in Wangaratta and to the hospitals, that we would not find an Australian physician to replace me. Ultimately I had to resolve to close my practice. Interestingly Wangaratta was able to attract an "area of need" Overseas Trained physician (OTP) some 6 months after my retirement and has since attracted another OTP.

Various RACP and IMSANZ workforce studies have well documented the aging of physicians practicing in rural communities in Australia and the low proportion of trainee physicians electing to train in GIM. It is evident that the replacement of those of us who retire will not be with local graduates who have trained in GIM, but with international medical graduates (IMG) whose training in GIM may be somewhat different to ours. The shortfall in trainees in GIM is however widespread, affecting other countries as well, and the potential solutions to this need further analysis.2

I was however not ready to retire fully, and was fortunate to have the opportunity to be appointed to a new part time position as Head of General Medicine at Peninsula Health, commencing February 2004. My responsibilities were to further develop GIM in Peninsula Health, and subsequently these were bracketed with Director of Physician Training (DPT) responsibilities, involvement in RACP Supervisor workshops, representing the General Medicine Specialist Advisory Committee in Overseas-Trained Physician interviews and a substantially reduced clinical workload. Teaching in its various modalities has become my major activity.

A new start in a public hospital

Frankston Hospital has a medical inpatient and Emergency Department throughput equal to some of the Melbourne University teaching hospitals, but with a disproportionately low basic physician trainee and consultant physician staff. It was reclassified as a level 3 training hospital in 2004 and the opportunity to be involved in the expansion of basic physician training (BPT) became a major continuing challenge. In 2004 the BPT medical registrars at Frankston Hospital comprised 8 international medical graduates and additionally 2 Melbourne graduates on rotation from the Alfred Hospital. There were 2 General Medicine Units (GMU), a GP Unit and many specialist medical Units. During 2005 the GMU's increased to 3 and a new GMU was established at Rosebud Hospital, a nearby community hospital which has been classified as a secondment hospital for BPT training. In 2006, there will be 4 GMU's at Frankston Hospital, with the one at Rosebud and we will have 16 BPT's in addition to the 2 on rotation from the Alfred. We will have 5 HMO2 BPT's in their first year of physician training and hope that we will be able to build on this in 2007. In Peninsula Health about half of all medical inpatients are admitted to GMU's. This expansion in GIM, GMU's and BPT numbers has been matched by the commencement of a physician training program with a "protected time" internal medicine curriculum knowledge and MCQ program together with an emphasis on teaching clinical skills. This program will be refined for 2006 and will again continue throughout the year.

We anticipate the development of a 16 bed Medical Assessment and Planning Unit (MAPU) in place of a mixed ED and medical

Short Stay Unit (SSU) during 2006, which will provide an additional challenge to the Division of Medicine.

These changes reflect the commitment of many of my colleagues in Peninsula Health, without which, this growth would not have occurred. The changes have been both challenging and rewarding, but much more remains to be achieved, for example, providing a professional development program, mentoring, achieving ambulatory medicine training in each GMU rotation, embedding evidence-based clinical practice, refining morning handovers, introducing a routine research component for each BPT and teaching as an integral component of every clinical activity undertaken with a BPT.

These changes are bringing Peninsula Health into line with other level 3 training hospitals.

The growth in GIM in Peninsula Health reflects the recognition that a significant proportion of medical patients admitted to hospitals throughout the world are best cared for by General Physicians, reflecting patients' increasing age, the presence of multiple co-morbidities, complex multisystem illnesses and the progressive acceptance that fragmented care by multiple specialist units is more expensive and may result in greater lengths of stay. As well, specialist units justifiably prefer to have patients with more specific single system illnesses.

How should the next generation of general physicians be trained?

The opportunity to have had over 33 years a career of being Consultant Physician in rural GIM, to then experience the very different issues confronting an outer metropolitan hospital with a rapidly changing BPT program and involvement in meetings with a wide range of fellow DPTs', have enhanced my views of the roles General Physicians have in different communities and how we need to structure programs to train physicians for quite diverse practices within the church of GIM.

I feel that the future General Physician will need to undertake dual training (2+2+2) or have a significant specialty component to his/her training, which will complement the RACP goal of releasing "the physician within" and so provide a better integration of general and specialist physician services in all hospitals. It is already happening, in that advertisements for positions in Melbourne outer metropolitan hospitals are beginning to specify such dual skills and responsibilities.

I think that the training required for "hospital and inpatient care" detailed in the IMSANZ curriculum will need to be "site specific" and suggest that there are three patterns of GIM practice which are emerging, forming the basis for training being able to be directed to the preferred future practice choice of the trainee. The particular characteristic of current GIM practice is its diversity, which IMSANZ has an opportunity to embed into the curriculum reflecting the substantial differences in the skills, interests and practices of IMSANZ members. These emerging patterns highlight the differences in training required for system specific specialities and GIM.

First, level 3 training hospitals will require a different type of physician to manage the evolving practise of acute medicine and its namesakes including MAPU or SSU or whatever it may be called, together with continuing to care for the older, complex inpatients with multiple co-morbidities and yet provide progressively more ward consultative, preoperative, administrative, clinical informatics, EBCP and educator services. These roles will develop further and are becoming specific fields within GIM. The GIM physicians in such training hospitals will become staff physicians, with considerable teaching responsibilities and the role of DPT's and Directors of Advanced Training (DATs) will expand to become expert medical educators. I think that it is inevitable that the larger rural base hospitals serving populations approaching 200,000 or above, will evolve into level 3 training hospitals. These highly specialised GIM physicians will have multiple expertise as well as conventional dual training.

Second, the smaller metropolitan hospitals and those rural hospitals serving populations between 80,000 and 150,000 will become level 1 or 2 training hospitals, and will require dual trained physicians who will remain predominantly in VMO positions providing a mix of specialist and general services to both hospital inpatients and their private practice. These hospitals will have physicians with skills for example in non-invasive cardiology, endoscopy, aged care, medical disorders of pregnancy and adolescent medicine. The concentration on acute medicine will be less and acute medical care will remain as part of the traditional Medical Units responsibility.

Third, I think that the smaller base hospitals and remote hospitals will continue to have a small number of GIM physicians who by virtue of the size of the community in which they practice, have to develop greater community medicine skills, but at the same time will be expected to provide some specialised skills in addition to their broad general skills. They will be expected to visit communities within their region, reflecting the current "hub and spoke" model of consultant practice. They too would need dual training, but with an emphasis on community and outreach medicine. The more intimate involvement in the life of these smaller communities creates a different type of practice to that of a metropolitan practice.

There may be particular individual characteristics required of such physicians, which have been the subject of much debate in seeking to identify what attracts a physician to rural practice and equally, what induces he or she to leave and I believe that further research is needed to better determine these characteristics and so enable IMSANZ to identify suitable BPT's to encourage into GIM training. The development of rural medical campuses by many universities may well give an opportunity to promote such research and enhance the growth of rural physician services.3

The training of a generalist without specific skill development is no longer required or indeed appropriate. It was that training which characterised the MRACP, the College diploma I obtained in 1967.

I see that in these different hospitals and communities, differentiated into level 3, level 2 and level 1, rural and remote, we will need for each generalists with specific but different skill sets and we must find ways in which we can structure training to suit these different needs.

I have taken the opportunity to bracket my site specific training suggestions to the hierarchy of the RACP training hospitals which

THE NEED TO HAVE ORDER IN OUR OWN BACKYARD

In recent weeks I and others on Council have been involved in a number of discussions with colleagues from various groups within the college in regards to implementing the recommendations contained within the recently released position statement – *Restoring the Balance*.

One of the most vexing issues is establishing (or re-establishing) general medicine units in teaching hospitals in metropolitan Sydney. Put simply, some very influential people within these hospitals, within the college and within government are very resistant to this idea on the basis of having experienced, at first hand, what they regard as examples of abject failure of the 'general medicine' model. They cite case studies of general physicians practising in both metropolitan and regional centres who have attempted to provide care beyond their level of competence, who have failed to refer very sick patients for subspecialist management in situations where the need for such referral was clearly apparent, who have adopted a 'closed shop-cold shoulder' attitude towards subspecialists with skills in general medicine who wished to establish a practice in a particular setting, and who were very protective of their turf to the point where their patients were essentially denied the opportunity to seek a second opinion.

Now I realise there are always two sides to an argument, and members of Council do not blithely assume the veracity of such statements on face value alone. But our further inquiries of particular cases have lent some credence to the criticisms being stated. This is of concern to Council as such actions threaten our credibility as competent physicians and undermine the case we are making for a greater presence of general physicians in metropolitan and regional hospitals.

Having said this, we can all cite cases where subspecialist-mediated care has also been associated with major failings, and where general physicians have been unjustifiably subjected to disrespectful and unprofessional behaviour on the part of subspecialist colleagues. There have been instances where such folk have assumed total care of particular patients referred by general physicians and have excluded us from any further involvement in ongoing care. We have all experienced the 'damned if you do - damned if you don't' scenario where referral to a subspecialist may elicit a reply which infers 'I'm not sure why you felt the need to refer this patient and waste my time (with copy to attending GP)' while another might provoke a reply suggesting 'I should have seen this patient weeks ago' (again with copy to attending GP).

Fortunately there are many subspecialist colleagues who are happy to liaise with general physicians in regards to patient care amid an atmosphere of mutual respect and goodwill. In such cases each party knows, understands and respects the capacities of the other, and where there is a division of labour among the two such that patient care and outcome is rendered more optimal while the work of each type of physician is rendered more efficient and collaborative. We must all work to create more of these 'win-win' situations. As general physicians we cannot be seen to engage in discredited and isolationist attitudes and practice if we wish to acquire and maintain respect among the rest of the fellowship and promote our roles and functions among those with influence within the healthcare system.

Let us talk to our strengths certainly, but let us maintain open channels of communication with our subspecialist colleagues and continue to take opportunities for improving our knowledge and practice that such dialogue affords. Let us not give, by bad example, ammunition which those prejudiced few at the far right of the spectrum can use to discredit us and our ideals. We must ensure that our own backyard is fully in order.

IAN SCOTT

(From Page 4)

reflect the traditional levels of specialisation and organisational structure, but equally reflect the diversity, skill and specialisation in modern general medicine.

We must be able to arrange such training outside the narrow boundaries of a single hospital or indeed a city. Examples of such coordinated multisite training programs exist in rural Queensland hospitals and are essential in encouraging physicians to practice in the county. It seems self evident that physicians who enjoy and remain in rural practice have a rural background or have wives who have such.

The necessity is to micromanage such training and to have IMSANZ better placed as the society responsible for training in GIM.

I was pleased to see in attendance at the Alice Springs meeting 83 physicians, 23 from New Zealand, 23 from Australian metropolitan teaching hospitals, 20 from rural hospitals and 20 from other metropolitan sites. This reflects the wide distribution of physicians practicing GIM across Australasia. My semi-retirement and change from "private" to "public" illustrates only one of the many opportunities for new challenges seen amongst the attendees at the Alice meeting. That diversity is the strength on which IMSANZ must build.

I would have to encourage colleagues approaching the "retirement age" to look for new ventures and continue in some form of professional practice, where their skills and experience will be valued.

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PATRICK FIDDES
Frankston Vic

EUROPEAN SCHOOL OF INTERNAL MEDICINE

Alicante, Spain 2005

'Spanish time' is the term used to describe the ebb and flow of life governed by searing midday heat and long, pleasantly warm evenings. I am a fair-skinned European brought up in Central Scotland and trained in the visceral dislike of UV light after four years living close to the ozone hole in the South Island of NZ. I was grateful to be observing Spanish time in the merciful cool of a European autumn whilst participating in the 8th European School of Internal Medicine, courtesy of the IMSANZ traveling scholarship.

Firstly, as a recent addition to the IMSANZ, I wish to thank the membership for the opportunity to travel to this event. I am in my third year of dual advanced training in general internal medicine and infectious disease and valued the opportunity to participate, contribute and report on ESIM 8 for a great many reasons- so many in fact that it is difficult to know where to start in an article such as this.

The ESIM was the brainchild of Professor Jaime Merino, a prominent supporter of general internal medicine in Europe and past president of the European Federation of Internal Medicine, under whose auspices the school is run. The concept of a 'school' belies the greatest strength of this popular event - an emphasis on shared learning, cooperation, discussion and friendship. Trainees come to ESIM from a range of cultural, political and geographical backgrounds. Though Leon and I (and three fellows of the college) had probably traveled the greatest distance to attend, there were also delegates from Eastern Europe, Israel and the Baltic states.

The theme for this year was 'Emergencies in Medicine'. Using a variety of formats including lectures, case presentations, discussion groups and clinico-pathologic conferences, a broad range of topics were covered by a faculty with backgrounds as diverse as those of the delegates. I had the challenging duty of preparing a case presentation 'from Australasia' which seemed to be well received. Through these activities, I was struck by the similarity in the way medicine is practiced in various countries.

As one might expect, the close proximity of 100 young men and women for a week led to a friendly atmosphere, which was facilitated by the vigorous social programme. Discussions often strayed to topics outside of medicine, particularly in the small bars of central Alicante or whilst sampling tapas or the local sangria.

In making new friendships and acquaintances with trainees from Europe, I gained the strong impression that the experience for trainees in Australia and New Zealand is second to none. This was a particularly encouraging lesson for me, as I left the UK system at an early stage to work in New Zealand, and had only vague yardsticks with which to compare my progress with that of my colleagues at similar stages in the UK and Europe.

ESIM 8 was a milestone in my medical experience. I once again offer my thanks to the membership and council of IMSANZ for the scholarship. Finally, I would highly recommend ESIM to other IMSANZ members and welcome any enquiries to paul.huggan@healthotago.co.nz.

PAUL HUGGAN
New Zealand

GEOFFREY T EY TRAVELLING FELLOWSHIP FOR ISOLATED RURAL PHYSICIANS ($5000)

MURRAY-WILL FELLOWSHIP FOR RURAL PHYSICIANS ($10,000)

MAYNARD RENNIE FELLOWSHIP FOR ISOLATED RURAL PHYSICIANS ($5,000)

The above three awards have similar conditions as follows:

Purpose: To support rural physicians who are Fellows of the College or its Faculties or Chapters resident in Australia, seeking to further their own continuing education through a short-term project in an institution within Australia or overseas. The funds may be used for a training course, for a period of technical expertise updating, for visits to appropriate institutions, or for a replacement locum to cover the applicant's period away attending continuing education activities.

After a lengthy flight from Australia and a trusting taxi ride at night in an unknown European city I finally arrived in my hotel in Alicante, on the east coast of Spain. At about 10pm local time the hotel lobby and restaurant were full of elderly people. I couldn't help but wonder: Was I in the right place? Was I here for the 8th European School of Internal Medicine (ESIM8) meeting or was I invited here in the capacity as a treating resident doctor? I came to discover that ESIM8 was hosted in a hotel owned by a local medical insurance company, which in the off-season, was occupied by about a hundred or so elderly guests. The facilities were basic but comfortable and if you don't mind having dinner at 10pm it provided all the necessary amenities.

The following morning I found myself in a small classroom with 60 other doctors from around the world. After moments hesitation this classroom became a dynamic forum where ideas were expressed openly and friendly criticism was encouraged. Lasting 6 days, the meeting included over 25 lectures covering both a wide range of topics of Internal Medicine, and stimulating case presentations discussed by participants from all countries. Unlike other meetings I have attended the organisers of ESIM8 created an atmosphere for open debate and allowed flexibility for both discussion content and time. The evenings were filled with organised entertainment including dinners, a visit to a medieval castle and a nearby town, Elche. Although you don't find too many locals swimming at that time of year, there was also time for a leisurely stroll along the beach and a quick dip in the pleasant 20+ C Mediterranean Sea.

Behind the success of ESIM8 was Professor Jaime Merino. His warmth and enthusiasm for ESIM8 was noticed and appreciated by all participants and contributed to making this meeting stand out from others. Professor Merino made the effort to personally meet every participant at the meeting and went out of his way to ensure all felt welcome.

One of the highlights of ESIM8 was the interaction with young doctors from other countries; establishing new connections and discussing the subtle differences in medical practice between various countries. The conference was both educational and enjoyable and I would highly recommend it to others who wish to benefit from exchanging experiences and networking with international colleagues.

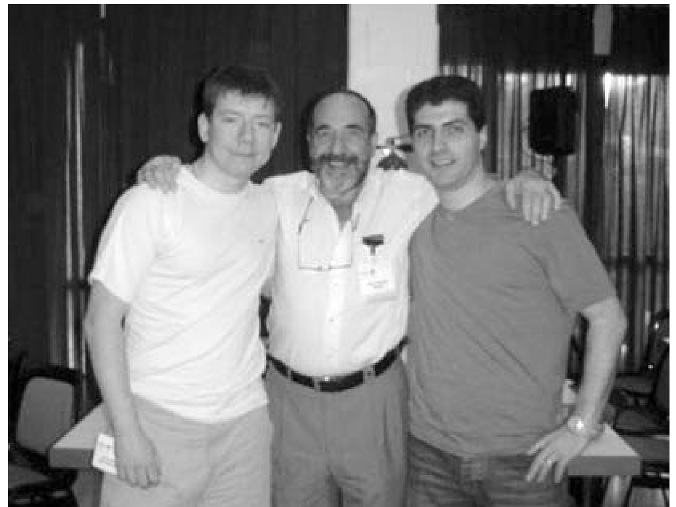
For those interested in learning more about ESIM8, some participants and one of the organisers, Dr Christopher Davidson, have created two websites:

www.esim2005.com *and*
http://homepage.mac.com/christopherdavidson/PhotoAlbum24.html

I would like to thank IMSANZ for this unique opportunity to attend ESIM8 and will conclude with the words from the song written by ESIM8 participants to Professor Merino:

Jaime we thank you all
We came from countries big and small
Now we'll go back and teach them something new
We are leaving on our jet planes
Let's hope that we will meet again
A big applause from all of us to you.

LEON FISHER
Canberra ACT



Paul Huggan, Jaime Merino and Leon Fisher at the Alicante XIII training school in Alicante, Spain

IMSANZ would like to welcome the following New Members:

- Dr George Garas, Stirling, WA
- Dr Jane Hoare, Ipswich, QLD

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

- Dr Allen Boon Siew Lim, Auckland, NZ
- Dr Roshan Brito-Mutunayagam, Northgate, SA
- Dr Martin Brown, Manly, NSW
- Dr Christina Cameron, Wellington, NZ
- Dr Christina Chang, Carlton, Vic
- Dr Matthew Farrant, Whangarei, NZ
- Dr Gonesh Karmakar, Auckland, NZ
- Dr Senanayake Prematilake, Ballarat, Vic
- Dr Vikas Srivastava, Darwin, NT
- Dr Chi Wing Wong, Auckland, NZ

A LOCUM IN BROOME

"A Locum in Broome? That must have been interesting."

If the term includes challenging, fascinating, spectacular, educational, invigorating, and exhausting - yes, it was interesting.

The RACP had included my name on the locum list when I left public hospital medicine in mid 2000. I had enjoyed two brief periods as a locum in Kalgoorlie soon after retirement, but I was pleasantly surprised to be contacted again early in 2005. Could I work in Broome for a month, or two (or three)? After the initial exchange of phone calls and emails I agreed to fill in during August for Graeme Maguire, the incumbent adult physician. He would brief me during the first week and I would stand in for him for the rest of the month.

To be honest, I did not check beforehand whether I would be working solely in Broome (and lazing on the beach between times) or travelling to outlying clinics. If so, would it be driving or flying? As it turned out it was a mixture of the above - but with very little lazing on the beach!

The pattern included basic clinic commitments and teaching at Broome Hospital at the beginning of each week with a country trip for 2 to 3 days mid week; Derby by road in the first week, Aboriginal Community Clinics in the Dampier Peninsula by 4WD in the second week, Fitzroy Crossing, Hall's Creek and the Balgo Community in week three, and a visit to Kununurra and Kalumburu in week four. The latter two were by air, either commercial or by private charter.

Initially the 5 star apartment accommodation in Broome seemed unnecessarily generous but by the end of the locum it had become a welcome refuge each weekend after the stress of travel, clinical work and coming to grips with recurrently new surroundings and variable standards of accommodation.

I was fortunate that my wife was able to accompany me on most trips. Driving several hundred kilometres is always potentially hazardous but less so with an extra pair of eyes and conversation to keep one alert. An informal second opinion on imaging and help with a difficult thyroid problem was a bonus.

On the clinical side, I had expected the high frequency of diabetes and hypertension but was less prepared for the high prevalence of rheumatic fever and its sequelae. The amount of chest disease and the high proportion of autoimmune disease was unexpected. It was interesting to see people who had suffered from leprosy or had been in contact with it. The Oxford Handbook of Clinical Medicine frequently provided useful back-up for obscure diagnoses.

To a casual observer material resources seemed more than adequate. Hospitals and clinics were of high standard and seemed well equipped. Because of the distances involved, communication and transport facilities were sophisticated and effective. Some health professionals had worked in the system for some time but there was a significant number of transients, like myself. This inevitably militates against effective continuity of care. Medical cover in most areas and clinics was reasonably good with both general practitioner and specialist service regularly available. I must admit some confusion related to the responsibilities of the various health service authorities, and I was never absolutely sure about the lines of demarcation. Non-attendance and non-compliance with medication adversely affect the health of indigenous people. Always in the background are the longstanding problems of substandard living conditions and many of the problems shared with the rest of society - alcoholism, smoking, drug addiction, domestic violence and child abuse.

What were the negatives? The initial paperwork was daunting and several-fold more than was necessary for my earlier locums in Kalgoorlie. As I was computer illiterate beforehand, unused to more recent mobile phone technology and with no 4WD experience I climbed a steep technology learning curve on arrival.

What were the insights? The new knowledge? I now have a basic knowledge of the history and extent of the Ord River scheme and the Argyle diamond story. I had not been aware of the historic role of the Catholic Church in providing health care and education to remote indigenous communities. The vastness of the Kimberley amazed me. The endurance of the people both indigenous and more recent arrivals was impressive.

What were the surprises? The multiplicity and variability of the indigenous communities. The success of some and the failure of others was hard to explain.

Did I mention the frog lurking in the toilet bowl. Or the astonishing surprise of a flute recital by Jane Rutter at the Lombardina Social Club or meeting living history in the person of 91 year old Father Serafim at Kalumburu?

I'm planning to be back in the Kimberley Health Service next year and if you are tempted to do the same - I am afraid August is already spoken for.

CHRIS HUGHES
Physician

NEED A LOCUM?

If you are looking for a locum, please contact the Secretariat.

Phone: +61 2 9256 9630

Fax: +61 2 9247 7214

Email: imsanz@racp.edu.au

THE CSIM MEETING

Toronto, Canada, 2-5 November 2005

CSIM - Canadian Society of Internal Medicine.

Over two years ago the CSIM approached IMSANZ with the aim of promoting links in internal medicine globally. An invitation to this year's meeting ensued and I am indebted to CSIM President Mahesh Raju and the CSIM for their generosity and hospitality at what was a very stimulating meeting.

The CSIM has been running its scientific meeting separately from the RCPC for only the past four years. During this short time the meeting has reportedly seen an exponential rise in the number of attendees and quality of presentations. Over 330 delegates attended this, the largest meeting ever. Attendance figures were undoubtedly assisted by the co-sponsorship of the meeting by the Ontario chapter of the American College of Physicians. The CSIM itself has about 500 full members and 250 associates. As Canada has 30 million people compared with Australasia's 24 million, we are not a long way behind, relatively, in terms of membership, but do lag with respect to IMSANZ meeting attendance.

IMSANZ had been asked to contribute to a symposium entitled "Globalization in General Internal Medicine" (see the presenters in photo - *right*). By way of background, IMSANZ member Peter Greenberg has coauthored a paper with William Ghali from Calgary on a soon-to-be published paper comparing models of GIM around the world. This shows that Australia and New Zealand general physicians have the most in common with their Canadian counterparts, but while there are many similarities, there are still many parts of the of the world we know very little about. At the symposium Dr Ghali proposed the formation of a new international GIM group to promote the causes of GIM globally, perhaps to be led by the Society for General Internal Medicine (USA). All speakers endorsed the concept of thinking more globally, and ascertained that there were certainly more similarities than differences among the world's general physicians. Several of us felt, however, that it was premature to consider setting up yet another umbrella organisation when other international bodies such as EFIM and ISIM already exist. The upcoming meetings of ISIM, including that in Melbourne in 2010, were advertised to the attendees. We agreed to continue as a loose 'federation of chiefs' and plan to hold a more in-depth meeting at the SGIM in LA in 2006. There we might consider a meaningful project for our societies to be involved in, especially one that might support our colleagues in other nations. Another suggestion was that the societies might consider co-location of Pacific Rim GIM society meetings on a cyclical basis The CSIM has already appointed a council member to the "international" portfolio. This is certainly something we might consider - this person might have particular responsibility to the South Pacific and Asia. It is also important that we signal all our upcoming meetings to our sister societies and to physicians of the region.

The meeting was an excellent balance of plenary sessions, workshops, research presentations, special interest group meetings, clinical vignettes and "short snappers"- symposia containing several quick updates on important topics. As is usual with North American meetings one might have attended sessions continuously from dawn to well over dusk. One of the themes of the meeting was "wellness", with a focus on healthy meals and snacks, with several scheduled fitness activities.

Left to Right: Michael Barry (SGIM), Mahesh Raju (President CSIM), Phillippa Poole (IMSANZ), Bob Centor (SGIM), Sima Desai (ACP), Maria Bacchus (Chair, CSIM), William Ghali (CSIM)

The opening night dinner included a presentation of the five top papers in GIM in 2005. This was a very well-put-together talk by Sharon Straus who may be known to some as the coauthor of a book "Evidence Based Medicine- how to practice and teach EBM (3rd edn)". She developed her 'picks' through polls of colleagues. These papers and their clinical bottom lines were:

- Coronary revascularization before elective vascular surgery does not improve mortality even in high risk subgroups [McFalls et al NEJM 2004;351:2795-804];
- Cholinesterase inhibitors in AD have marginal clinical benefits and high likelihood of adverse effects [Kaduszkiewicz et al BMJ 2005;331:321-7];
- Aspirin plus esomeprazole has reduced likelihood of a GI rebleed than does clopidogrel [NEJM 2005;353:238-44];
- Intensive management of gestational diabetes reduces risk of serious perinatal complications [Crowther et al NEJM 2005;352:2477-86].

For the 5th paper she tried to make sense of the apparently-conflicting results in 2005 from two systematic reviews (JAMA, Cochrane) and large RCTs (BMJ, Lancet) of the effect of Vit D3 +/- calcium for prevention of osteoporotic fractures. She concluded that the evidence now suggests that Vit D alone is not protective, but that Vit D3 plus calcium is effective at reducing fractures especially in those at highest risk (e.g. in a nursing home). She also provided very useful tips for searching for evidence, recommending the results or synopses provided by BMJ Updates (having the added advantage of being free), ACP Journal Club, Clinical Evidence, and EBM. For a more leisurely or in-depth search, the next tier of evidence would be Cochrane Reviews and PubMed. A good tip was that PubMed has a useful search refiner called Clinical Queries that should be used to find clinical trials.

Sharon followed up this talk with another excellent talk the next day in which she described General Medical Units as research laboratories. She shared with us the following research projects all undertaken recently by members of her team.

Examples were:

1. the impact of the SARS outbreak on medical professionalism of junior and senior medical staff;
2. the use of guidelines stored on hand held computers for patient care;
3. the use of a “ knowledge broker” for patient education, to improve transition form hospital to home;
4. a systematic review of interventions that reduce the likelihood of post LP headache.

Canadian physicians are fortunate in living closely with the legacy of Sir William Osler. Indeed, the CSIM has his portrait as the centre of their logo.

The Royal College Osler Lecture was given by Jean Gray, an extraordinary woman who has played leadership roles in clinical medicine, pharmacology and medical education. With her passions for medical history and rational prescribing, she presented a most entertaining and informative lecture, based on anticoagulant management of a case of a young woman with a PE, starting in Osler's time, and tracking management through the 20th century and out to 2010. In the future it is likely that initial warfarin dose will be determined by knowledge of an individual's haplotypes of both the Vit K epoxide reductase complex 1 enzyme and CYPC9. These both impact on dose requirements but in a predictable way. As an aside, did you know that Warfarin derived its name from a compound for poisoning rats - Wisconsin Alumni Research Foundation bishydroxycoumarin? It was only deemed safe for humans after a student took an overdose and survived.

Jean Gray also reminded us that current Direct To Consumer (DTC) advertising was not so far removed from that used by the snake oil salesmen of Osler's time. The heavy endorsements of products by 'reputable' experts and references to indigenous peoples in advertisements produced a century apart are astounding.

One of the most educational sessions was that on assessment and management of dizziness and syncope. The speaker was the engaging and humorous Jacques Bedard. His step-by-step practical approach, supplemented with a glossy learning guide, included revision of the Dix Hallpike test, and the Epley manouevre to treat Benign Positional Vertigo. This ended with a practical demonstration of both a positive test and the intervention on one of the attendees who had suffered from BPV for 11 years. One trusts she is now fully cured!

One of the most memorable features was the involvement of a good number of trainees in the meeting. In Canada, GIM trainees enter their programme straight from medical school, taking another 4-5 years to become a specialist (cf our 6-7 years total). Dual training is very unusual. Residents must spend at least 12 months on GIM units and one month each on critical care and cardiology early in their training before their major barrier examination.

The residents' research presentations and posters were of very high quality. They also presented clinical vignettes (unusual presentations of common diseases and common presentations of rare diseases) on the final day. One factor in having such strong inputs of residents into the conference seems to be the close relationship between the residents and their programme directors, many of whom were at the meeting. Another is that although the residents do not have to undertake projects during training they are strongly encouraged to do so. The research culture of the environment at the university teaching hospitals (such as those of McMaster, McGill, and University of Toronto) undoubtedly assists in engagement in these projects. As an example, one of the GIM trainees presented a very extensive systematic review of the features in the history, examination and investigations that had a high likelihood of predicting, or ruling out, heart failure. This has just been published (JAMA 2005; 294: 1944-1956) as part of 'The Rational Clinical Examination' series. I recommend you search out and read this and the other articles in the series for yourselves, as they are very relevant to good old-fashioned general medicine.

If you wish to attend a future CSIM meeting, the future dates are have been set for 2006, (Nov 1-4 in Calgary, Alberta), and for 2007 (October 10-13 in St John's, Newfoundland). My thanks are due again to the CSIM Council for this opportunity to visit and experience the meeting company and Toronto. The personal interchanges shall only strengthen general medicine both locally and globally.

PHILLIPPA POOLE
President IMSANZ

Clinical Course in Acute Care Medicine

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Ethical problems have a habit of bobbing up here in the Pacific in much the same way as they bob up in Oz or NZ. However there is still a local flavour to them, as a couple we've had recently illustrate.

The first involved a young man admitted on the Saturday morning of a long weekend. He had come to the Emergency Department several weeks earlier complaining of feeling weak, but nothing definite had been found and he had been discharged. However he had come back with worsening weakness, and it was then obvious that he was developing a paraplegia.

When I saw him on the Saturday morning, he still had reasonable movement of his legs, and he also still had some sensation, although there was a clear sensory level at about T6. I could also find no other problem, and no clue as to the cause of the paraplegia. Indeed he was a strapping young Fijian whose muscular build would have even stood out in a rugby team.

I explained to him the urgency and seriousness of the problem, and I noticed he was very uncommunicative. However my alarm bells didn't particularly ring about a likely problem until I noticed a policeman hovering nearby, and it transpired that he was an inmate of Suva's main prison.

For once the system swung into gear, despite it being a Saturday, and he had a CT myelogram that afternoon which showed a block at T6 together with an associated round paraspinal mass about the size of an orange. He was also seen by the orthopaedic surgeon on call who agreed to operate that evening. In the meantime we treated him for the two most likely treatable causes – a staph abscess or TB, both of which are not uncommon here.

I was therefore surprised the next morning to find he was still in the general medical ward. I asked why, and I was told he had refused surgery. When I spoke to him, he agreed he had refused. He said he wanted to discuss it with his mother first, and she lived in a remote village that was hard to contact. I explained to him again the seriousness and urgency of his problem, particularly since his paraplegia had clearly progressed over the 24 hours he had been in hospital, and I asked the orthopaedic surgeon to come back and see him. I also asked to be rung about the outcome.

At about 3:00pm I was rung to say he had refused again, and the surgeon wasn't prepared to operate without consent. So I went back in to the hospital to have one last try to persuade him. But I quickly realized it was futile – he basically refused to talk to me, simply listening to what I was saying and then not responding. The only thing he said was he still wanted to discuss it with his mother, who was still not contactable.

Over the next few days, he continued to refuse surgery, and despite our massive misgivings, we decided to respect his autonomy and not pressure him further. So we watched his paraplegia progress over the next few days to become complete.

And that is how things remained for a while. However one day about a week after his admission I was told he was refusing to have an intravenous line resited to enable us to continue his IV cloxacillin. We changed him to oral flucloxacillin and continued his TB treatment, but, perhaps not surprisingly, the next day he was also refusing all oral therapy. He said he didn't think the treatment was helping him, quite rightly pointing out he had got worse since he had commenced the treatment.

He did agree to a repeat CT scan, which showed if anything the mass was bigger. But he refused all other investigations and treatment, and over the next few weeks he developed a large pressure ulcer, and then a hectic fever. He refused blood cultures, continued to refuse all antibiotic therapy, and from there he went rapidly downhill, finally becoming deeply jaundiced and confused.

The only treatment we gave him over the last week or so of his life was a small dose of morphine when he was particularly confused and distressed. He died about four weeks after admission, having relentlessly deteriorated in front of our eyes from a strapping, muscular young man to a wasted wreck.

We were keen for a post mortem to be done, and his sister, who was the only member of his family who had come to see him and was worried his paraplegia might have been caused by abuse by the prison guards, was also keen to know the cause of his paraplegia and gave her consent. However unbeknown to us, the pathologists argued amongst themselves as to whether or not it should be done by the forensic pathologist – because the patient was a prisoner – or the hospital pathologist.

Unwisely in retrospect, we had written a death certificate stating the cause of death as septicaemia secondary to a pressure ulcer secondary to a paraplegia of unknown cause. Before the pathologists resolved their argument the prison officials came to pick up the body, and since they had a death certificate they refused to wait for the autopsy to be done.

So Jope died undiagnosed and untreated. We had respected the ethical principle of autonomy and did not override his refusal to undergo surgery and drug treatment. But it had probably cost him his life.

I still wonder if we could have done more to persuade him to accept treatment. But it was clear he had a profound distrust of authority. I never found out what was his crime, but even though he was paraplegic and bedridden the guards remained at his bedside during the whole of his hospital stay, so I assume he was classed as dangerous. I never spoke to the prison governor – perhaps I should have. I also never spoke to his mother, who as far as I know he also never actually got to speak to.

Jope deeply tested our adherence to the ethical principle of autonomy. I only hope I'm not tested again in quite such a distressing manner.

The second case illustrates the other side of the coin, and concerns a simple villager who presented with what initially seemed a fairly typical pneumonia. The student clerking her presented the case well, and finished with his assessment that she was a 55 year old woman with community acquired pneumonia of moderate severity, and he recommended her treatment be intravenous penicillin.

I complimented him on his presentation, and agreed with his assessment. However over the next few days, it became clear she wasn't responding to treatment. Her Xrays were worsening and her crackles sounded more like the "Velcro" crackles of pulmonary fibrosis than pneumonia. We changed antibiotics several times, and finally commenced steroids, but she continued to relentlessly deteriorate.

I was slow to appreciate that she might need intensive care treatment, so when it became clear she needed ventilation, I hadn't prepared her or her family for the shock of the sudden need for

intubation. So there was quite a bit of explaining to do with her children. Unfortunately, she continued to deteriorate in the ICU, and despite our best endeavours she died about 4 days later.

Where's the ethical issue, you might well be asking yourself. Well it suddenly arose when I went to the ICU to classify her diagnosis for the death certificate. As soon as I entered, the nurse handed me a letter from the Government laboratory. I had never had a letter like it before, so was mystified as to its contents. However it was soon clear – it contained the result of an HIV test on this patient, which was positive.

I was shocked – for several reasons. First, I was not aware an HIV test had been done on the patient. Second, she seemed the last person likely to have HIV – a seemingly innocent middle-aged Fijian woman from a remote village. And third, I had never considered HIV in her case and probably the only organism our treatment hadn't well covered was pneumocystis.

However I had an immediate practical problem – should I mention HIV on her death certificate? The result needed confirmation, which would take some weeks, but our experience is that confirmation is usually positive. As far as I knew, we also hadn't got her consent to do the test in the first place, and I was virtually certain that no one had said anything to her family about the possibility of HIV infection – I certainly hadn't.

I decided not to mention it on the death certificate, and I immediately tried to find out who ordered the test. After some sleuth work on the part of our registrar, it turned out the test had been ordered by the anaesthetic registrar when the patient had gone to the ICU. She had apparently worked in ICU units in other countries where it was routine to order HIV tests on all patients with severe pneumonia, so she had done it as a routine in this case. Unfortunately, she had since left the hospital so it wasn't possible to find out if she had sought consent from the patient or the family. However there was no reference to consent in the patient's hospital record.

Should we tell her family? Again I decided not to. I couldn't see how it could possibly help anyone. Even if the patient had had contacts to whom she might have transmitted the infection, they were presumably some time ago, and contact tracing was impossible now she was dead. We also know that the few women of her age with HIV in Fiji have usually been infected by their husbands who have served in peace keeping forces in Lebanon or other world trouble spots. We never saw her husband, so he might well have already died undiagnosed. And it would be very distressing for the family to bring it all out in the open now their mother was also dead.

So we just kept quiet – as if we had never received the result. I'm not sure if it was the right decision. But I was forced to rethink it several weeks later when I got the result of the confirmatory test, which was positive. I again decided to let sleeping dogs lie.

These sorts of ethical dilemmas are probably familiar to most IMSANZ members. However I still find them challenging to deal with, particularly when they involve the local culture and mores with which I am not so familiar. Would you have dealt with them the same way?

ROB MOULDS
Fiji

Dear IMSANZ,

Last month, I was fortunate to attend the European School of Internal Medicine (ESIM) course " Emergencies in Internal Medicine " held in Alicante, Spain. There were 65 delegates from 24 countries - the majority, advanced trainees selected by the Internal Medical Societies of their respective countries and, clearly, a very bright bunch. This was the 8th and final ESIM Meeting to be held in Alicante, convened and superbly organised by the charming Professor Jaime Merino.

Alicante is an arid city or 280,000 people on the southern Mediterranean coast of Spain where rainfall is expected on 30 days annually. We arrived in "winter " to find the hotel air-conditioning turned off and the swimming pool drained despite temperatures of up to 25 degrees C. Our one half day of recreation saw the group taken by double-decker bus to the Moorish City of Elx (Elche), an important centre of the Spanish shoe industry famous for its 200,000 palm trees. Several late afternoons were spent jogging several kms to the beach and swimming in the Mediterranean with no competition from the locals who must have considered the water too cold.

The Meeting comprised 21 clinical topics , 2 clinicopathological conferences, 2 "Spot diagnosis in medicine" and several presentations relating to organisation of care and assessment of competency. There were also 20 case presentations from representatives of 20 different countries with plenty of interactive discussion. The quality of presentations was largely of a high standard with only several low points and a broad range of subjects relevant to acute medicine were discussed.

The unique aspect of the meeting was the small delegate group and the uniform friendliness of those attending. Meal times and evenings were spent in informal exchange learning how Internal Medicine works across the European countries. Some contacts made will endure and a webpage has been established to maintain communication among the attendees. Check out the web page at www.esim2005.com - it is hoped that PowerPoint slides of all presentations will be available on the site soon and this may provide a useful teaching aid.

The location of next years meeting has yet to be determined. I recommend this learning opportunity without reservation.

Regards,

RICHARD LUKE
Hawkes Bay, NZ

Paul Duggan ; Dunedin, Gerry Whiting; Queensland; Jaime Merino ; David Coles ; Christchurch ; Richard Luke ; Hawkes Bay

PREDICTING GENERAL PHYSICIAN NUMBERS FOR NEW ZEALAND

(Abridged from a discussion paper prepared by IMSANZ NZ Executive at the request of the RACP (NZ) office, for the purpose of informing the Clinical Training Agency, which, in NZ, funds post graduate medical training).

Background:

IMSANZ is not aware of relevant forecasts or papers that indicate the most desirable ratio of General Physician per 100,000. There are several reasons why this is difficult to do, as discussed below. The most relevant work has been done by the Royal College of Physicians (RCP), UK. The RCP estimated 10 FTE physicians per 100,000 (http://www.rcplondon.ac.uk/college/mwu/mwu_03_census.pdf) as a benchmark for the whole physician workforce with the inference that many of these would need to practice general medicine to some degree. About 50% of physicians in UK practise some form of General Medicine but it is not clear whether they are trained / credentialled to do so, and how many FTE's they devote to this role. If this were 0.5 FTE this would result in a requirement for at least 5 FTE / 100, 000.

Before considering other UK data below it should be pointed out that in the UK, age-based acute admitting services are prevalent, and the UK, geriatricians take on much more acute care than they do in NZ (or Australia). In NZ the bulk of acute care of older people is undertaken by general medical services. How general physicians will work best with geriatricians to provide quality care for older people is an area that needs further exploration.

The RCP in 2000 produced a paper, 'Consultant workforce requirements in general medicine (GIM) and geriatric medicine' with the following as key points: (http://www.rcplondon.ac.uk/pubs/books/momp/wp_momp_part3.htm)

- "Consultants on small rotas (one in four to five) for acute GIM find that a disproportionately high and inflexible GIM workload impedes work in their specialties.
- Consultant rotas for GIM of around one in 10 to one in 13 (admitting about 20 patients) allow reasonable time for specialty work, while providing enough GIM cases to maintain experience.
- More consultants are needed in all the medical specialties linked with GIM. Targets are one consultant per 80,000 population for the specialties of cardiology, diabetes and endocrinology, respiratory medicine, and gastroenterology for district general hospitals in which such specialties are linked with GIM.
- The recommended number of consultant geriatricians, where geriatric medicine is linked with GIM, is one per 4,000 population over 75 years. (This equates to about one per 50,000 general population).
- The recommended number of physicians would be greater in districts with a large commitment to teaching or research.
- Local planning of medical and geriatric medicine services should examine the needs of each major specialty. Job plans should apportion the workload (including any contributions to general medicine) logically and fairly to reflect those needs.
- Regional and national planning should aim to promote equity by encouraging recruitment to achieve desirable levels of staffing in those districts which are presently least favoured".

In New Zealand, the general physician FTEs per 100,000 will depend on the geography; population demographic; whether metropolitan or non-metropolitan; presence of, and relationship to, other "general" specialties such as general practice, emergency medicine or geriatrics; presence of, and relationship to, other relevant subspecialties, especially cardiology, respiratory, renal, endocrinology /diabetes, neurology and critical care. It is important to incorporate some consideration of FTEs along with numbers, as most general physicians will combine general medicine with another subspecialty; the minority practice purely general medicine. In larger centres with a large cadre of general physicians it may be possible to work in general medicine for smaller proportions of time, although less than 0.3 FTE seems undesirable in terms of maintaining patient continuity, supervisor continuity and physician competence. On the other hand, in smaller centres, and in areas where there is a concentration of effort nearer the front door of the hospital in an acute admitting unit, it is likely that the proportion of FTE worked in general medicine per physician will need to be higher, perhaps nearer to 0.7 FTE or greater. There needs to be a mix of general physicians - some with general medicine their only or main interest, and others who combine it with another subspecialty or a related area such as medical education, administration or research.

A model of the current position in NZ:

There are currently about 310 physicians practising some form of general medicine in NZ. If one estimates that, on average, they are doing this 0.5 FTE (remembering that MCNZ 2003 data shows that an FTE is 50 hours per week), this is 155 FTEs. IMSANZ estimates that there are about 50 general physicians short nationally. Estimating job size as 0.5 FTE, this is at least 25 FTE short.

Therefore, a rough estimate of present needs might be 180 FTE gen med for NZ

180 FTE / 4 million = 4.5 FTE / 100,000

Case Example: Auckland

The acute general medical service at Auckland City Hospital runs effectively on 8 FTE / 415,000 population in ADHB, or 1.9 FTE / 100,000. However the service works closely with other subspecialties and units such as CCU, the stroke unit, and ICU staffed by subspecialists. The 8 FTE is made up from contributions of 16 physicians. A similar formula exists at Counties Manukau, where, if they were fully staffed, this would result in 8 FTE / 400,000, or 2 FTE / 100,000 for general medicine.

As already mentioned 2 FTE / 100,000 represents the minimum ratio as the general medical service is fully supported by other subspecialty services and radiology, many on a 24/7 roster. This allows for caseloads to be quickly triaged and shared, and the possibility of patient problems being addressed very quickly. There is also the possibility of a 1:12 roster. This may sound luxurious, but as there are four admitting teams per day, this means being on call every 2-3 days and for part of every second weekend.

50% of New Zealanders receive medical care in non - metropolitan centres. In these centres general physicians will take on more of the roles done by others in tertiary centres, so physician FTE requirements per 100,000 will be higher. Very few of these centres will have independent admission streams for subspecialty acute medical admissions – all being channelled through general medical services. It is also uncertain if one could say which part of the time of a general physician who is also a subspecialist is spent doing the acute call, but we suspect most would say that it is general medical acute call. Very few centres have stroke units to support practice. In centres other than Auckland, most general physicians would consider their general medical practice to exceed 0.5 FTE. In Dunedin this averages 0.7 FTE, in Invercargill 0.8, and in Middlemore it is 0.6 FTE without a clinic. In smaller centres there is also the need to consider critical mass, including rostering, leave and CME requirements.

Some colleagues in smaller centres are working 55 hours plus just to meet the service needs.

Case Example: Tauranga

(information provided by Graeme Porter)

"This city has a demographic much as NZ will be in 2021. Tauranga Hospital's current staffing is 12 physicians (although advertising for number 13 has been ongoing over the past 6 years). One physician practices subspecialty Neurology and does not contribute to the acute medical admitting roster. Three practise subspecialty Cardiology and work a 1:3 week and 1:6 weekend acute admitting roster targeting admissions with a predominant cardiovascular flavour from the medical admissions. This splitting arose in part because the post take physician ward rounds were taking more than 8 hours to complete (Tauranga averages 25 admissions per 24 hours with the usual wild fluctuations related to winter and summer although the latter remains busy because of the summer holiday population influx). The splitting also arose in part because of increasing reluctance and ability of some physicians to manage acute cardiology problems. Eight other physicians also contribute to the acute medical admitting roster in a 1:6 basis; only three would consider themselves true generalists, all practice subspecialty medicine including respiratory, rheumatology, endocrinology/diabetes, gastroenterology, infectious diseases, and elderly medicine. The hospital has been unable to secure oncologists or renal physicians despite providing more than 25% of Midland region's work because of issues regarding sole practice and collegiality. This has impacted on acute medicine as inpatient care for these subspecialties is provided by the physician on call. Four of the top 10 DRGs for inpatient and outpatient numbers are respiratory, but there are only 1.3 FTEs currently in respiratory medicine, (and only 0.3FTE for first 6 months 2005). Although the outside perception of the Bay of Plenty is a "retirement" community (which is true for Tauranga with 18% plus of the Western Bay of Plenty population over the age of 65), 20% of the population are also Maori in the younger age group with very high prevalence of diabetes, respiratory disease, heart disease, renal disease and are high/heavy users of the Hospital.

All the Tauranga Hospital physicians feel the acute admitting component of their jobs is becoming more and more onerous and not sustainable without increasing physician numbers. There is no doubt that in Tauranga Hospital more and more physician time is now by default committed to providing the inpatient medical service, and physicians struggle to balance this with other commitments including teaching, CME and planning activities, and elective work for which there is an exponential growth in demand.

The causes are multifactorial but include:

- *the quality and experience of the registrar staffing (most registrars in Tauranga are pre FRACP written examination, and increasingly foreign medical graduates or locums)*
- *ongoing rapid population growth particularly of the elderly*
- *increasing acuity and complexity of chronic disease/co-morbidities in this population – and this also includes now a significant proportion of patients admitted to the adult surgical services who need to be managed by physicians*
- *Services for the elderly are chronically under- manpowered due to inability to fill geriatrician position, and this has major implications because of the important interface of Acute Medicine with Medicine for the Elderly*
- *Inadequate staffing hospital wide and beds to deal with local population (bed numbers have decreased, city population has doubled in last 20 years). This puts pressure on processing and discharging patients as quickly as possible (not necessarily increasing efficiency or a good thing for quality of care or safety)*
- *Hospital currently being rebuilt, major disruptions to current service provision, and predictions that will still not meet needs (bed numbers not increased and will fall during construction)*
- *expectations of the public to have the "best" care*

Regardless of physician numbers Tauranga Hospital is totally dependent on its RMO staffing to provide Acute Medical Services, and any significant shortage of RMOs for any period of time will cripple the hospital and impact on all areas of health provision.

It is clearly difficult to come up with a specific number of Physicians per population without considering all the associated factors above (Sub-specialist staffing, population demographics, RMO staffing/experience, and commitment to providing care at multiple sites). For Tauranga Hospital we believe Physician FTE will need to be doubled to approximately 24FTE to provide appropriate mix of inpatient and elective services at the Tauranga and Whakatane campuses.

Current Demands and Future Trends:

A more realistic scenario, considering general medicine to be 0.6 FTE, yields an estimate of 5.4 FTE general physicians per 100,000.

So the likely answer is that FOR NOW we need between 2 and 6 FTE /100,000 depending on service configuration, critical mass of physicians on site, and assuming that physicians will continue work the mean of 50 hours per week they do currently.

Based on the Tauranga experience above and for several

reasons outlined below, IMSANZ believes the workforce requirements for general physicians in NZ will undoubtably increase in the medium term. It is difficult to see how other grades of health professionals (e.g. see http://www.rcplondon.ac.uk/pubs/wp_hdup.htm) will be able to pick up the highly skilled practise of a general physician. For all the patients under their care general physicians are trained to rapidly assess all of the patient's problems, diagnose, prioritise, liaise with subspecialists and general practitioners, and initiate and deliver an appropriate, evidence based, and cost effective management plan. They also supervise and train the most junior medical staff in the health system.

Some factors leading to an increased workforce requirement to meet service needs:

- An ageing demographic with greater health needs that cannot be met solely by primary care. On the other hand admission to a subspecialty may be
- Increasing need to match health resources to health needs – generalism in health systems has been shown to help with this problem (Baicker and Chandra 2004).
- Admission and planning units are effective, but do require committed leadership and an increased presence from consultant general physicians
    - o The RCP in 2003 recommended that all patients admitted medically be admitted to a dedicated unit, staffed by at least 3 physicians, and be seen within 24 hours of admission with at least 15 minutes dedicated to that consultation (Royal College of Physicians of London. Acute medicine: making it work for patients. Report of a working party. London: RCP, 2004).
- One FTE currently involves working about 50 hours per week- work force directives and perceived negative incentives may force this to reduce.
- The level of junior cover is also important. Smaller centres do not have registrars. In more recent years the quality of RMOs has often been marginal, placing increased pressures on consultant staff. This needs to be considered when calculating required numbers. Lack of registrars has a major impact on on-call hours worked. Numbers are very important when it comes to acute call, the burden of which has long been unrecognised or ignored. In the future predicted workforce shortages, on can only anticipate problems for smaller centres getting worse unless there are major incentives provided for RMOS and consultant staff to work in these centres.
- There are moves to enforce the recommended 2/3 clinical service to 1/3 non contact time split in work roles in order to allow adequate time for education (self and others), service development, quality improvement, research, professional college activities, and health services administration. In smaller centres such as Wanganui this is not achievable unless there are more physicians on site.
- The general physician workforce is on average 5 years older than other physicians so there will be a greater workforce requirement sooner than in other specialty areas.
- An increasing number are female, and an increasing number may wish to work part time. Women work on average 20% fewer hours They will also more likely interrupt training and service.
- Many trainees dual train in general medicine and a subspecialty-some will move to practice exclusively in the subspecialty and be lost to general medicine. Perverse relative values (remuneration, conditions of work) do need to be corrected to reduce losses, but there will still need to be an excess number of trainees to account for losses.

Future requirements:

We estimate that there should be a target of at least 5 – 7 FTE general physicians per 100,000 in the medium term. This will vary among centres depending on service configurations, with smaller regional centres requiring higher ratios than metropolitan centres.

There are currently 110 advanced trainees in general medicine in NZ. This seems inadequate to replace the current general medical workforce, let alone build a stronger one.

PHILLIPPA POOLE
President IMSANZ
August 2005

Contributions to and comments on this paper were made by Graeme Porter, Andrew Bowers, Tom Thompson, Briar Peat, Peter Roberts, Ian Scott and Neil Graham.

Cochrane Library now free to all New Zealanders

On November 13th the NZ government announced that the Cochrane Library of evidence-based reviews is now free to all in New Zealand. I'd suggest that if you are not already 'au fait' with Cochrane Reviews you will now need to be, in order to translate these for patients. The MOH is recommending that consumers go straight to the 'synopsis' part of the review.

To access the Library, go to the NZ MOH website http://www.moh.govt.nz/moh.nsf, and click on 'free online health information'. - Phillippa Poole

HOW SHOULD WE RESPOND TO THE IDEA OF 'GP SPECIALISTS'?

An article in the September 2 edition of Australian Doctor notes that, in filling the shortfall in specialist care as a result of insufficient numbers of general physicians, the Royal Australasian College of General Practitioners (RACGP) is wanting to train GPs as 'specialists' in a number of areas (such as diabetes, cardiovascular care, dermatitis, addiction medicine) with the right to claim for, and be remunerated under, specialist status.

It has been suggested that a Diploma in Internal Medicine might be an appropriate qualification and that the necessary training could be provided as university designed and evaluated courses. GPs with special interests (GPSIs) would work in community health centres and hospitals, but for a maximum of a couple of sessions a week to ensure they remained "well-rounded GPs". State governments would pay GPSIs at consultant rates for hospital sessions, and new Medicare items could be introduced to remunerate GPs at specialist rates in community settings.

Apparently this proposal is based on a UK scheme that has trained about 1200 GPSIs. The move would push GPs up the "complexity scale", according to the plan's architect, Associate Professor Steve Trumble, Director of Education at the University of Melbourne's department of general practice.

In response some experienced GPs cannot see any need for additional training given their clinical exposure to these prevalent diseases and that they are busy enough without adding the need for "specialist training". Their view was that general practice needs more GPs, not more "specialists," and that rebates for GP items already in existence need to be increased in value. One could also add there are other pressing priorities for the RACGP to attend to, such as reforming its training program, reducing medical error in primary care, improving professional development and raising the level of research in primary care, developing population targeted screening, prevention and public health programs, and collaborating with community pharmacists in improving medication use.

In response to this 'GP specialist' proposal IMSANZ Council approached the Specialties Board and the RACP President Jill Sewell to garner their views on this issue, and more recently the Adult Medicine Division Committee and College Council have formally considered the issue after seeking further information from the RACGP president, Professor Michael Kidd.

The general opinion, with which IMSANZ concurs, is that fellows should support the principle of up-skilling GPs in defined areas and be careful not to be seen as operating a 'closed shop.' It is inevitable that GPs will, for both their own professional fulfillment and in the course of providing better health care, want to develop special interests, and that this may be more pertinent in regional and rural areas. However, in the UK, where this process is formalised, there is a clear distinction between practitioners working in primary health care settings and those working in secondary and tertiary settings, where specialists are to be preferred.

Therefore it was recommended that such upskilling should occur in the context of:

1) recognising and remunerating up-skilled GPs at a level that does not compete with more extensively trained specialist physicians;
2) upskilling GPs with training programs that are developed and endorsed by a collaboration of RACP, RACGP, GP Education and Training organisations, and the Australasian College of Rural and Remote Medicine (ACRRM). It was felt undesirable that RACP be seen to have exclusive liaison with RACGP and not involve other bodies involved in GP training and that a joint, profession-led response was far preferable to stand-alone university devised courses; and
3) credentialing (and re-credentialing) procedures for up-skilled GPs be formally developed with involvement of all parties.
4) recognising that GP upskilling does not solve the shortage of general physicians and that concerted efforts to address this deficiency, as outlined in the RACP/IMSANZ position paper Restoring the Balance, should not be deflected by such initiatives.

There is no doubt that future proposals for enlarging scope of practice as potential solutions for physician workforce shortages and access to care problems, will come from other disciplines. As one senior fellow stated, physicians are being "white anted" from several quarters, with the surrendering of considerable professional ground to emergency doctors, intensivists, and other non-physician specialty groups. GPs and nurse practitioners are now positioning themselves for a similar onslaught, and GPs have already won concessions with government by being able to claim long consultation fees under chronic care items.

Many argue it is time for RACP and the fellowship to take a stand, define who we are, declare our scope of practice, and be prepared to fight for it for a change. Others concede that with a shrinking and increasingly fragmented medical workforce, we may need to be considering many radical changes, including 'specialised' GPs, nurse practitioners and realignment of remuneration for procedures, pathology, and clinical care. These are troublesome issues which many of us prefer to ignore, but which will recur persistently.

We have a difficult road to travel in protecting our physician brand and its marketability, while, at the same time, trying to exercise leadership and contribute to a better healthcare system. However the bottom line should be that foistering unrealistic expectations onto inadequately trained practitioners can be a danger to the community, and that there needs to be mutual respect and open discussion among the health professions in defining proper professional boundaries. IMSANZ members are welcome to express their views on this issue in the pages of this newsletter and in correspondence to senior office-holders of the college.

IAN SCOTT

with input from various members of RACP Specialties Board and with acknowledgement to its chair, Dr John Kolbe.

Year	Month	Meeting
2006	**February**	**Medicine in the Extremities: Land, Sea and Space** 28th February - 10th March Antarctica Email: sales@peregrineadventures.com Tel: +61 03 9662 2700 Web: www.peregrineadventures.com/pdfs/Medical_Conference_28Feb06.pdf
	March	**New Zealand Autumn IMSANZ Meeting** 24th - 25th March Palmerston North Institute of Rugby Massey University Email: Kirsten.Holst@midcentral.co.nz
	May	**RACP Cairns Congress 2006** 7th - 11th May Cairns International Hotel Cairns, Queensland
	September	**RACP (NZ) / IMSANZ / Nephrology** 20th - 22nd September Queenstown **Trainees' Day** 19th September
	November	**CSIM Meeting 2006** 1st - 4th November Calgary Alberta, Canada
2007	**September**	**ASGM / IMSANZ Combined Meeting** 20th - 22nd September Adelaide
	October	CSIM Meeting 2007 10th -13th October St John's Newfoundland, Canada

IMSANZ Travelling Scholarship

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

Value: $A5,000

Eligibility: Advanced trainee or fellow of less than 5 years duration of the Royal Australasian College of Physicians, and who is a member of the Internal Medicine Society of Australia and New Zealand. Successful applicants will be required to explain how attendance at this meeting will be used to enhance the practice of Internal Medicine and to provide a 1000 word summary of the meeting attended for publication in the IMSANZ newsletter.

IMSANZ Research Fellowship

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

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

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

IMSANZ Award for Best Scientific Publication in Internal Medicine

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

Value: $A2,000

Eligibility: Advanced trainee or fellow of the Royal Australasian College of Physicians; membership of the Internal Medicine Society of Australia and New Zealand; publication of research in one of a list of peer-reviewed clinical journals.

IMSANZ Excellence in Clinical Education Award

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

Value: $A1,000

Eligibility: Advanced trainee or fellow of the Royal Australasian College of Physicians; membership of the Internal Medicine Society of Australia and New Zealand; nominated by peers to receive award.

Application Process

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

Application forms can be found on www.imsanz.org.au or from the Secretariat imsanz@racp.edu.au.

NEW ZEALAND AUTUMN IMSANZ MEETING

March 24-25, 2006
Palmerston North, Institute of Rugby

Massey University

Have you ever dreamt of being an All Black? (Or maybe just of sleeping in one of their beds?)

IMSANZ 2006 NZ Autumn meeting is being held at the Institute of Rugby on the Massey Palmerston North Campus, which provides accommodation used usually by our elite sports people, with access to their gym and sports facilities, between sessions on:

- Sports advice for aging physicians and their patients
- Our 'exceptional' patients and interaction with 'Exceptional Circumstances' (aka Pharmac)
- Research in provincial NZ
- Current controversies in medicine and maybe some revisited
- Free papers from within our ranks, and from the trainees

As well as opportunities to sample 'doctor' made wine from round the country, listen to some poetry, visit some of the research facilities in the Massey proximity, and possibly even dance the night away!

The organising committee (Kirsten Holst, Andrew Herbert, Ross Hayton) would be delighted to hear from you, particularly if you have either an exceptional patient (and have battled with exceptional circumstances!) or free papers (remembering to organise your trainees now), and want to book a slot!

Schedule it now! Full day programme Friday 24 March, till mid afternoon Saturday 25 March. I will organise an informal dinner Thursday evening and accommodation is available from Thursday at the Institute.

Contact - Email: Kirsten.holst@midcentral.co.nz

NOTICE TO MEMBERS

Could you please ensure that your contact details, including email, are up-to-date.

If your details have changed, please complete this form and return to:

145 Macquarie Street
SYDNEY NSW 2000
Fax: +61 2 9247 7214
Or email your details to imsanz@racp.edu.au

PLEASE PRINT.

Full Name: ____

Old Address: ____

____

New Address: ____

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Phone: (   ) ______________________________

Fax: (   ) ______________________________

Email: ____

Specialty Interests: ____

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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