IMSANZ
INTERNAL MEDICINE SOCIETY *of Australia & New Zealand*

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Secretariat
145 Macquarie Street
Sydney NSW 2000
AUSTRALIA

Telephone
+ 61 2 9256 9630

Facsimile
+ 61 2 9247 7214

Email
imsanz@racp.edu.au

Website
www.imsanz.org.au

From the President...

The General Matters

In recent weeks I've heard several times that general medicine is in bad shape. The first was feedback in the IMSANZ membership survey that Council was doing well in "promoting the dying breed of general physicians"; the second was in a report from a New Zealand Director of Physician Training (DPT) who had attended an RACP Education Strategy workshop in Sydney with other DPTs. He observed that general medicine in Australia was in decline with the attendance of a significant number of DPTs who were not general physicians, and some hospitals reporting no general medical teams. These comments came close behind a request to participate in a Skills Day debate at the RACP Congress with the moot "That the future is sub-specialisation; the generalist belongs to the past".

My overwhelming fear of debating aside, these negative statements about general medicine provoke two emotions. First, there is incredulity. This springs from the knowledge that the changing population demographics and health disparities evident in the community don't indicate any less of a need for generalist medical services. We also hear that patients value the care of physicians with broad knowledge and who willingly manage anything, but who area also pragmatic in balancing treatment priorities. We have the added advantage that we don't 'break the bank'. Then there is anger - a hardening of resolve, and the determination of "not on my shift"; nor, for that matter, that of my successor in 2007 (whoever that may be).

General medicine encompasses both the craft and the people who practise it. Both are inextricably linked and efforts must be directed at enhancing both. While IMSANZ may appear to be primarily focussed on the development and maintenance of a quality general physician workforce, as members, we must be seen to continue to advocate for the patients for whom we care, and for general medicine.

In the end, though, to attract people to any job in medicine, it must be "good to do". It must be intellectually stimulating, flexible, and with the presence of strong role models. General medicine has few problems meeting these three criteria, except where general medical services no longer exist. The biggest problems now faced by general medicine in attracting trainees, many of whom are making career choices to some extent influenced by the need to repay student debts, are the relative inequities in conditions and rewards compared to other subspecialties. Until jurisdictions value, reward and nurture general medical practice as they do the other subspecialty areas, general medicine will continue to struggle in some areas.

As you turn the pages...

PRESIDENT'S REPORT

IMSANZ Council is well aware of the issues and is pushing hard for general medicine and general physicians. You, the members, continue to give us very strong support for what we are trying to do. Through the membership survey you have volunteered some constructive ideas; these will be collated and promulgated.

I believe that significant progress is being made through other avenues too.

1. IMSANZ Council continues to work closely with the RACP under the framework provided by the joint position paper - Restoring the Balance. Ian Scott updates us in his article on *page 15*. RACP president Jill Sewell and CEO, Craig Patterson continue to advocate strongly for the importance of generalists in the health system.
2. Ex IMSANZ president Les Bolitho now chairs the Australian Association of Consultant Physicians. One of the association's main goals is to advocate for fair rebates for cognitive consultant work (see the article on *page 8*).
3. There is good progress being made on the RACP Education Strategy (see the article on *page 4*). There has been significant input from IMSANZ members into the curricula developed to date. The next stages will be critical though as the RACP will need to moderate the approaches being taken by each of the subspecialties. IMSANZ is very keen to see that the opportunities for general medicine training are enhanced, and will be watching this process carefully.
4. Finally, the Australian Productivity Commission was tasked with identifying issues impacting on the health workforce, plus proposing solutions to ensure continued delivery of quality health care over the next ten years. Released in January 2006, the 435 page report is available from http://www.pc.gov.au/study/healthworkforce/finalreport/index.html.

The executive summary of the report stated that areas of need such as mental health, aged care and disability, indigenous health, and asylum seeker and refugee health will not be addressed unless the inequities in funding and conditions are addressed. Widespread shifts in attitude in the health system are also required.

The report proposes three reforms for the medical benefits schedule:

- "A more transparent process for assessing proposed changes to: the range of services and health professionals (medical and non-medical) covered by the MBS; referral rights for diagnostic and specialist services; and prescribing rights under the Pharmaceutical Benefits Scheme…
- Priority given to investigating the extent of the bias in rebates in favour of procedural over consultative services, and how any significant bias should be addressed…
- MBS rebates payable for a wider range of services delegated by an approved practitioner (medical or non-medical) to another suitably qualified health professional. Those rebates should be set at a lower level than would have applied if the delegating practitioner had delivered the service, but be sufficient to maintain an incentive to delegate..."

The Royal Australasian College of Physicians submission to the Productivity Commission acknowledged the need for more generalist skills:

> *"If the aim is to enhance equity in the distribution of the work force across Australia, the likelihood of the outer urban, regional and rural health services each acquiring a 'critical mass' of consultant physicians and paediatricians will be enhanced if greater numbers can provide 'generalist' specialist services ..."*

So did the Committee of Deans of Australian Medical Schools:

> *"… the growing provision of health care by teams rather than individuals, particularly for the aged and chronically ill, has presented the as yet largely unrealised challenge of interprofessional education and learning … suggested a different paradigm of medical practice, one which was more community-based and more generalist."*

We must graft onto, and use the opportunities provided to exert influence with such stakeholders in the health system. Please do this at your local level, plus continue to talk to your reps on Council about how and where we might gain even more traction.

The next opportunity to see most of you will be in Cairns in May at the RACP congress, or in Queenstown in September. At these meetings we hope to revive any flagging spirits and to allay those doubts about the viability of general medicine!

Thanks to Ian Scott, Martin Brigden, Clive Hadfield, Peter Boyd and Mary Fitzgerald for their work in getting the Cairns programme together. Oh and please don't forget to send me any debating tips! We have to win this one.

PHILLIPPA POOLE
President IMSANZ
p.poole@auckland.ac.nz

NOTICE OF ANNUAL GENERAL MEETING

IMSANZ Annual General Meeting to be held on Monday, 8th May, 2006 at the Cairns Convention Centre, Room 1 at 5.30pm.

One of the clear-cut findings of the recent needs analysis survey of IMSANZ members were the relatively low levels of awareness and use of the society's website. To remedy this shortcoming, we will, as of this issue, include a short update on what has been recently posted on the website (www.imsanz.org.au) together with any other external links to resources thought to be of use to IMSANZ members.

IMSANZ website

Slide presentations from the IMSANZ Annual Scientific Meeting, Alice Springs 2005.

All presentations given by society and invited speakers at the ASM are available for downloading. *Go to "What's New" link on the home page and click on "ASM Resources".*

IMSANZ Position Statement on Standards for Acute Medical Assessment and Planning Units in Public and Private Hospitals.

This document written by the IMSANZ Working Group on Acute Medical Assessment and Planning Units chaired by John Henley from Auckland details the rationale, organisational structure, policies and procedures, and methods of performance evaluation that should apply to the set-up and conduct of such units. All authors have had in-depth experience in establishing and running these units in their respective institutions. *Go to "What's New" link on the home page and click on "Publications and Position Statements".*

Critically Appraised Topics Library.

13 new CATs have been added to the library for the last quarter with the following titles. *Go to "What's New" link on the home page and click on "New CATs".*

- Intensive lipid lowering with statins unnecessary in stable CAD (IDEAL)
- Beta-blockers better than placebo but not other drugs in hypertension
- Continuous infusion of loop diuretics more effective than bolus injections in congestive heart failure
- Early IV then oral metoprolol in acute MI may be hazardous (COMMIT)
- Low-dose dopamine ineffective for acute renal failure
- Aspirin plus clopidogrel better than aspirin alone for short-term outcomes in AMI (COMMIT)
- As required beta-agonists as effective as regular beta-agonists in acute asthma
- Colchicine plus aspirin reduces recurrence rates after first episode of pericarditis
- Doubling dose of inhaled steroid has no effect on symptoms or need for oral steroid in deteriorating asthma
- Home BP monitoring more accurate and better predictor of prognosis in hypertension than clinic measurements
- Vasodilators ineffective for severe, asymptomatic aortic regurgitation
- Intensive insulin therapy in ICU does not improve mortality but reduces morbidity
- ACE inhibitors slow progression of renal dysfunction in advanced renal insufficiency

RACP (NZ)/IMSANZ/Nephrology Annual Scientific Meeting 2006 Queenstown.

The provisional scientific program for this meeting is now available. *Click on "Events" link on the home page*.

External links

Canadian Society of Internal Medicine.

The CSIM has posted a strategic document titled, *Care-fully: Defining a plan for general internal medicine in Canada. October 2005* that has many similarities to our own position statement *Restoring the Balance*. Several authors give different perspectives on GIM in regards to academia, hospitalists, rural and regional hospitals, community health, and government. The document begins with a forward by Prof David Sackett defining, as he sees them, the roles and strengths of general physicians. The pdf file can be accessed at www.csim.medical.org.

Members are asked to contribute any information on useful websites for inclusion in this update. Forward any material to Ian Scott at ian_scott@health.qld.gov.au or to the IMSANZ secretary at imsanz@racp.edu.au.

IAN SCOTT

IMSANZ would like to welcome the following New Members:

- Tracey McMillan - Auckland, NZ
- Arthur Nahill - Auckland, NZ
- Guang Ji Zeng - Guangzhou, China

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

- Alison Cutler - Brisbane, QLD
- Richard Baker - Toorak, VIC
- Katherine Bloomfield - Auckland, NZ
- Stephen Dee - Wellington, NZ
- Jason Denman - Brisbane, QLD
- Simon Lam - Vermont Sth, VIC
- Vance Manins - Caulfield Sth, VIC
- Caroline Summers - Brisbane, QLD
- Adrian Tramontana - East Keilor, VIC

RACP EDUCATION STRATEGY UPDATE

General Medicine

The IMSANZ / RACP Curriculum Writing Group (CWG) for the advanced training curriculum in general medicine is just about to embark on the next revision, informed by the recently drafted RACP Basic and Professional Qualities curricula, and the RACP plans for assessment. All three curricula have been developed separately, but with considerable input from general physicians into each one. Special mention must go to IMSANZ member Leonie Callaway who has done an amazing job in steering the Basic Curriculum developments. If you wish to give feedback on the Basic and Professional Qualities curricula please visit- http://www.racp.edu.au/members/edu/curriculum.cfm#eval.

The RACP sponsored a workshop in Auckland on the 23rd March attended by the CWG and Australia and NZ SAC reps. This was a very constructive meeting, providing plenty of grist for the CWG in its deliberations over the coming months. We agreed that it has already been extremely beneficial to have a common vision of the special skill set and attitudes of general physicians put down on paper, but do need to emphasise these and the advantages of general medicine in health system even more strongly and positively.

The group also felt it was important to develop specific competencies during advanced training in the domains of "systems of care", and in "evidence –based practice" in addition to those in already developed in "hospital care", "community and ambulatory care" and "consultation and liaison medicine".

The group endorsed several of the assessment approaches being suggested by the RACP. For example -task prioritisation might be assessed in a case - based, (or even ward - round) based discussion; teamwork might be assessed through multisource (or 360 degree) feedback. The RACP has proposed that all trainees have a penultimate year review with an "assessment board", however the CWG and SACs believe this might be better earlier, to assist in planning training pathways.

Issues and resolutions to come out of Auckland workshop were:

- We need to ensure that advanced training in general medicine is attractive, valued and credible, but clearly different from basic training, and other subspecialty training;
- The new curriculum must not create any further barriers or disincentives to training in general medicine;
- The balance of competency - based versus time - based training needs further consideration;
- We need to identify acceptable pathways for general medicine training (to include statements on dual training, rotations to regional centres, standardisation across the Tasman, ensuring guaranteed access to subspecialty rotations, any mandated attachments, general medicine rotations in advanced training);
- Dual training is to be encouraged but not mandated;
- We need to set the criteria for the accreditation of sites for physician training, and ensure these are enforced;
- Advanced trainees in general medicine deserve greater recognition, and some way of differentiating them from basic trainees, such as the award of Senior Registrar status;
- Ensuring any written examination has significant input from general physicians to ensure level is appropriate to manage common and important conditions;
- We need to link urgently with curriculum developments of other subspecialty societies:
  - ~ Access to suitable training sites
  - ~ Recognition of requirements for dual trainees
  - ~ Recognition of requirements for general medicine trainees in subspecialty attachments
  - ~ Maintaining of general medical skills for subspecialty trainees
  - ~ Access to and standards of procedural skills training (e.g. echo, endoscopy, bronchoscopy)
- We need to determine best form(s) of governance and management of advanced training in general medicine;
- There was support for the award of the FRACP in a discipline, to recognise that training requirements in that field have been completed
- IMSANZ / RACP should develop training modules in areas in which it has specific expertise e.g. cost effective models of care

Over the next 3-4 months, the CWG will refine the advanced training curriculum and circulate for consultation, with a view to completion in 2006.

PHILLIPPA POOLE
Chair CWG

Travel Scholarship

Advanced trainees are reminded that the deadline for the 2006 Travel Scholarship is fast approaching, forms need to be at the secretariat by 5 May 2006. imsanz@racp.edu.au.

Travel Scholarship forms can be found on the website http://www.imsanz.org.au/resources/awards.cfm#travel

REPORT ON 'GIMCWAG' MEETING

Auckland, 23rd March 2006

GIMCWAG = General Internal Medicine Curriculum Writing and Assessment Group.

Under the watchful tutelage of Phillippa Poole, IMSANZ President, and stewardship of Tony Rigley, RACP Education Department, a diverse array of clinical and academic minds assembled in Auckland on Thursday March 23, 2006 to assess, appraise and assemble the new Curriculum for General Internal Medicine to be introduced in 2007 or 2008.

The Curriculum has been developed by a wide and sage collection of the eminent minds in GIM, covering academic medicine, hospital based care, with consultation and liaison medicine, and ambulatory care practice. On this occasion the assembly included Peter Greenberg, Ian Scott, Mary-Ann Ryall, Clive Hadfield, James Williamson, Andrew Bowers, Denise Aitken, Les Bolitho and Tony McClelland. The meeting was held at the Villa Maria Winery and Conference Centre, located adjacent to the Auckland Airport- an interesting choice of venue for an active 'think- tank' meeting!

Discussions at the RACP/IMSANZ/SAC Curriculum workshop

The Curriculum has many aspects to explore and define, to ensure future generations of General Physicians receive experience in a broad range of clinical disciplines and practice settings, as well as encouraging evidence based practice and continuing professional development characteristics.

The Curriculum Overview consists of 4 overlapping areas in continuum: the Professional Qualities Curriculum which encompasses the knowledge, skills and attitudes required and utilised by all physicians and paediatricians; the Basic Training Curriculum - the broad based training foundation with overlapping common areas, and specific areas for Adult Medicine and Paediatrics and Child Health which enables trainees to acquire a 'breadth of competence' and to further develop a 'depth of competence'; after suitably completing the current entry examination the trainees progresses to the Advance Specialty training Curriculum, with the focussed in-depth study of the discipline and provides context for higher- order knowledge/ skills/attitude acquisition. There is a separate document for each Specialty, including General Internal Medicine; the learning continuum is directly involved with the Continuing Professional Development which is the foundation for the life-long learning process with CME/MOPS as integral part of physicianship.

The meeting was concentrating on the Advance Training Curriculum, the necessary advanced knowledge, skills and attitudes, and the Assessment processes potentially available- including MCQs, Mini CEx, DOPs, continuous assessments, and exit interviews. We are awaiting further information and guidance from the Education Strategy Implementation Board, and Director of Education (soon TBA)

The ESIB has advised the Specialty Societies the new Curriculum needs to be completed in 2006, although implementation may be delayed to enable complete implementation across all College training programs in 2008.

Watch this space for further developments!

LESLIE E BOLITHO, FRACP
Wangaratta
lbolitho@netc.net.au

Lunchtime at the RACP/IMSANZ/SAC Curriculum workshop from left, Mary-Ann Ryall (Canberra) with NZ SAC members Andrew Bowers, Denise Aitken, and Tony McLelland.

IMSANZ MEETING

Palmerston North, New Zealand

An IMSANZ meeting was held in Palmerston North, New Zealand on 24 and 25 March 2006. It was attended by about 20 Physicians and trainees from as far away as Whangarei and Wangaratta.

Many thanks to the organiser, Kirsten Holst, for choosing an interesting venue (the Rugby Institute) and putting together a varied program. We learned about the benefits of exercise, solving a murder mystery, how to get unregistered or unfunded medications for your patients, how to tighten ones buttocks to prevent syncope and how to recognise when your dog has eaten chocolate.

We discussed low private Physician fees (compared with private proceduralists and Surgeons), how to spend IMSANZ money, when to order a PET scan and the many benefits of exercise. In the tradition of all IMSANZ meetings, it was a weekend of serious learning, collegeal support, drinking good wine, laughing, dancing and falling asleep (in that order). May there be many more meetings like it.

Thank you Kirsten!

RICHARD EVERTS
Nelson Hospital

Eminent members of IMSANZ enjoying themselves at the Palmerston North meeting dinner

Phillippa Poole thanks Kirsten Holst for a great effort in organising the Palmerston North Meeting.

Midnight Touch Rugby (North Island versus South Island) after the IMSANZ dinner at the NZ Institute of Rugby. From left, Briar Peat, Andrew Cole, Paul Reeve and Janet Turnbull. New member and star running back Art Nahill looks on. The only Australian player present (Les Bolitho) retired early.


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HOLISTIC
CHARITY
CLARITY
CONFIDENTIAL
CONDITIONAL

AUSTRALIAN ASSOCIATION OF CONSULTANT PHYSICIANS - MARCH 2006 UPDATE

The Australian Association of Consultant Physicians (The AACP) – held an annual general meeting in December 2005. A new Council was elected with Dr Leslie E Bolitho – President, Dr Jack Best – Secretary / Treasurer, Prof Jerry Koutts, Immediate Past President, Assoc Prof Geoffrey Metz, Assoc Prof Gerard Carroll, Dr Louis McGuigan, Dr Andrew Nunn and Dr William Heddle, AMA Liaison.

The new and revitalised AACP is legally constituted and complies with ASIC requirements. The AACP has been registered for GST since 1 January 2006.

We have written to all Specialty Society Presidents introducing the AACP, explaining our role on remuneration proceedings with the AMA, MBCC and Department of Health and Aging. We will also be involved with Workforce issues.

We are seeking support from Specialty Societies and their members. We are encouraging all Fellows to become financial members of the AACP. We have recently sent letters to all Fellows of the College seeking their financial support and membership of the AACP ($99 including GST) for the calendar year from January 1 to December 31, 2006.

There are 540 current financial members of the AACP. For those who have joined in 2005 their membership has been extended to December 31, 2006. We are in need of more members to support the AACP and to extend the influence of the physician-base to ensure appropriate representation from Fellows across all Specialties and interests from consultant physicians and paediatricians.

The AACP Council has met on several occasions in Sydney, and on teleconference. We have established the Secretariat in Sydney. Our registered premises have now moved to Sydney.

We have applied to College Council to request seed funding for the Secretariat.

The Technical Reference Group has developed new Enhanced Physician Attendance Item (EPAI) descriptors and explanatory notes. We have met with the AMA, and held teleconferences with the AMA and Access Economics and are currently awaiting the report from Access Economics to be included in our submission.

The submission for EPAIs is well in progress. The new EPAIs numbers have been developed on the advice of the Department of Health and Aging. The Department is interested in new item numbers for current physician work. The existing physician attendance items 110, 116 and 119 will remain.

The AACP now has an Economist, Dr Robert Wilson, working with the Council. The AACP is in the process of developing a framework for submission for the new Enhanced Physician Attendance Items to the Department of Health and Aging. We will be approaching a Canberra based lobbyist to advise on our submission, prior to seeking a meeting with Minister Abbott in the near future. We are aiming to finalize the submission and enter negotiations with the MBCC and DoHA in the next six weeks.

Dr Sue Morey, Chair, RACP Workforce Committee has been seconded to advise the AACP on Workforce issues.

I would encourage all College Fellows to join the AACP and become actively involved with issues directly affecting the long term sustainability of Consultant Physician and Paediatrician practice.

DR LESLIE E. BOLITHO
President AACP
lbolitho@netc.net.au

CSIM Annual Meeting 2005

We are pleased to announce that many of the presentations given at the CSIM 2005 Annual Scientific Meeting in Toronto are now posted on-line.

For viewing, please visit http://www.csimonline.com, MEETINGS/CME, ANNUAL MEETING, 2005.

Members Survey 2006

Members who have not yet returned their membership survey are reminded that it is not too late.

Could you please return either by mail or fax (61 2 9247 7214).

If you require a copy of the survey please email imsanz@racp.edu.au

I have always respected Staph Aureus as a worthy adversary, even though I did think the dangers of MRSA were sometimes a bit over-exaggerated.

However I have learned to respect Staph Aureus even more here in Fiji, particularly amongst the Fijians. Why we seem to see worse infections in the Fijians than in the Indians or other races is an interesting question in itself – I initially thought it might be a genetic predisposition until I learned that the Fijian culture is to massage vigorously any painful lesion, including boils. However whatever the reason, the fact remains we are faced with some very difficult clinical situations related to Staph Aureus infections.

Two recent examples serve as interesting illustrations.

The first is a 40 year old Fijian school teacher who was well until she noticed an abrasion on her lower leg which had become infected. She didn't think much of it initially, but it rapidly spread and by the time she came to hospital her whole lower leg was massively cellulitic with huge pustular blisters covering most of the skin. She was also short of breath, and had widespread fluffy opacities on her chest Xray.

Unfortunately she came in at night, and blood cultures weren't taken until after she had been commenced on high dose cloxacillin. So we never grew Staph Aureus from her blood. However clinically there was little doubt that her problem was Staph Aureus septicaemia, and we continued the cloxacillin at a high dose – 2 gm 6 hrly – and also gave her oral rifampicin.

Over the first couple of days of her admission we were congratulating ourselves that we had probably just got her in time, as she was holding her own. Having initially been hypotensive, her blood pressure had stabilized, and her respiratory function had also not deteriorated. She had also not developed acute renal failure, which we had been worried about when she was first admitted.

However on the fourth day I was surprised to see that there was urine everywhere around her bed. I assumed someone had disconnected the catheter bag, but I was told the nurses were having a problem because the bag kept on bursting. When we looked at the fluid balance chart, according to the nurses she had put out over 8 litres of urine over the last 24 hours. And that didn't include the spilled urine.

We wondered what on earth was happening, but charted her for 4hrly litres, as she was drinking OK, and said she was only feeling a bit thirsty. The next morning she was afebrile and from an infection point of view continuing to improve. However we were flabbergasted to see she had put out 24 litres of urine over the last 24 hours. She had a whole stack of water bottles by her bed, and said she felt like drinking all the time.

We are not able to measure serum or urine osmolality, but it seemed obvious that she had developed acute diabetes insipidus. But our problem was why? There was no evidence for any pituitary disturbance, so we assumed it was likely to be nephrogenic, and we racked our brains to think of a possible cause of acute nephrogenic diabetes insipidus. All we could come up with was a possible reaction to the combination of high dose cloxacillin and rifampicin.

We obviously didn't want to stop the antibiotics, as we seemed to be getting on top of the presumed Staph infection. But we also couldn't let her continue producing 24 litres of urine a day. So we decided to try to get hold of some vasopressin, and also to ask the laboratory about the usual sensitivities of their community acquired Staphs. Unfortunately there was not a single ampoule of vasopressin in the whole of Fiji, and we were told it would take about two weeks to get some in. But after hearing nearly all the Staphs were sensitive to chloramphenicol we switched her treatment to high dose chloramphenicol and crossed our fingers.

The next week or so was rather stormy, as her urine output only slowly declined and we had trouble keeping up with her losses – seven days later her output was still about 9 litres a day. However ever so slowly it continued to reduce, and her infection also continued to slowly improve.

She went home last week - about 6 weeks after her original presentation - passing normal amounts of urine, off chloramphenicol, with a normal chest Xray, and walking slowly on the recuperating leg. We still assume it was a case of antibiotic induced nephrogenic diabetes insipidus. But it was the Staph which started it all off.

The second case has not had such a successful outcome. He is an 18 year old Fijian boy who came in a few weeks before Xmas with a high fever and shortness of breath. When I first saw him, it was obvious he was severely ill - he had that toxic, apathetic look of a severely septic patient. And I can remember feeling guilty that I was excited by all his physical signs rather than feeling sad about his serious clinical state.

He had the full hand of signs of endocarditis – including pulp abscesses in two of his fingers, which I have never seen before. Clinically his valve lesions were mitral regurgitation and aortic regurgitation, and this was confirmed on echo, as was the endocarditis with massive vegetations seen on the aortic valve.

This time the blood cultures were taken first, and we then covered him with broad spectrum antibiotics, including cloxacillin. Within 24 hours we had a positive blood culture for gram positive cocci in clusters so we increased the dose of cloxacillin to the maximum and added rifampicin. A day later we had a positive identification of Staph Aureus sensitive to cloxacillin.

Over the next few weeks his signs and symptoms of sepsis gradually improved, and it needed all our powers of persuasion to convince him to stay in hospital over Xmas and New Year to complete 4 weeks of intravenous cloxacillin. We then discharged him on oral flucloxacillin plus probenecid for another 4 weeks. All the manifestations of endocarditis had disappeared by then, but it was already clear that his valve function had deteriorated markedly as he had developed all the signs of torrential aortic regurgitation.

His mother is a housegirl and his father disappeared years ago, so there was no hope of him getting overseas to have his aortic valve replaced. I last saw him a couple of weeks ago in severe heart failure, and looking like he won't last much longer. So the Staph ruined his valve despite our best endeavours.

These are only two recent examples of the many problems caused by Staph Aureus up here in Fiji. Thank heavens MRSA is not yet much of a problem – we have had only a few cases, mainly in the orthopaedic unit. However even the methicillin sensitive variety is a frightening adversary.

ROB MOULDS
Fiji

Early IV then oral metoprolol in acute MI may be hazardous (COMMIT)

Posted

Clinical question

Does the early use of intravenous followed by oral metoprolol improve outcomes in patients with acute myocardial infarction?

Bottom line

The early use of metoprolol in patients with acute myocardial infarction who are also receiving thrombolytics and aspirin provides no short-term benefit compared with placebo. In fact, early use increases the risk of cardiogenic shock, and thus use of metoprolol should be delayed until the patient is haemodynamically stable.

Reference

Chen ZM, Pan HC, Chen YP, et al for the COMMIT (ClOpidogrel and Metoprolol in Myocardial Infarction Trial) Collaborative Group. Early intravenous then oral metoprolol in 45,852 patients with acute myocardial infarction: randomised placebo-controlled trial. Lancet 2005; 366: 1622-32.

Study design

Multi-site RCT involving more than 45,000 patients presenting to Chinese hospitals with suspected acute myocardial infarction plus ST elevation, left-bundle branch block, or ST depression within 24 hours of the onset of the symptoms and who were randomly assigned (allocation concealed) to receive intravenous followed by oral metoprolol or placebo in addition to current standard practice (including aspirin and thrombolytics as indicated). Patients scheduled for primary angioplasty or those clinically judged as having "a small likelihood of benefit and high risk of adverse effects" from study medications, were excluded. The treating physicians were encouraged to prescribe beta-blockers and aspirin after discharge, but this was not required or monitored. The first 3 doses (5 mg or placebo) were given intravenously every 5 minutes as long as heart rate remained near 50 beats per minute and systolic blood pressure remained >90 mm Hg. After these initial doses, the patient received 50 mg metoprolol or placebo every 6 hours for the first day. From the second day on, the patients received 200 mg sustained-release metoprolol or placebo once daily for up to 4 weeks or until discharge from the hospital. Primary outcomes, assessed via intention to treat, were all-cause mortality and the composite of death, reinfarction, and cardiac arrest. Outcomes were assessed during the first 28 days or until hospital discharge. Only one patient in each group was lost to follow-up. The study was powerful enough to detect a 10% difference in event rates.

Results

92% of patients had ST elevation or left-bundle branch block, but 8% had ST depression.

There was no difference between groups in total mortality (~8%) or in the composite outcome (9.4% vs 9.9%). Allocation to metoprolol was associated with five fewer people having reinfarction (2.0% vs 2.5%; p=0.001) and five fewer having ventricular fibrillation (2.5% vs 3.0%; p=0.001) per 1000 treated. However, this was offset by more patients taking metoprolol developing cardiogenic shock during the first 24 hours than those taking placebo (5.0% vs 3.9%; NNH=90; 95% CI: 67-136).

Commentary

This trial is limited by including patients with both ST-elevation and non-ST-elevation myocardial infarction in whom effects of beta-blockers may differ. Also, the exclusion of patients deemed to be at risk of treatment-induced harm was a fairly subjective exclusion criteria which may bias in favour of beta-blockers and underestimate potential harm. Overall, the large sample size and observed risk of cardiogenic shock represents strong evidence to avoid early use of IV metoprolol in patients presenting with myocardial infarction. Possible exceptions may be patients with ongoing pain and ST elevation, tachycardia and hypertension despite administration of antiplatelet agents and thrombolysis.

European School of Internal Medicine

30 August – 6 September 2006

This year the ESIM will be held in the town of Sintra in Portugal. The school was previously held in Alicante, Spain.

Sintra is situated in the hills to the north of Lisbon. Lord Byron poetically described Sintra as *"this glorious Eden"*. It has been declared by UNESCO as a World Heritage Site.

Sintra is a granite outcrop, rising abruptly between a vast plain to the north and the estuary of the River Tagus to the south. It is a mountain range that twists and turns, projecting into the Atlantic Ocean to form Cabo da Roca, the headland that marks the westernmost point of continental Europe.

IMSANZ travel scholarships have seen advanced trainees attend the ESIM with for many years.

Home BP monitoring more accurate and better predictor of prognosis in hypertension than clinic measurements

Posted

Clinical question

How does home blood pressure monitoring compare to clinic readings in assessing blood pressure burden and risk of future complications in patients with or without hypertension?

Bottom line

Blood pressure measurements taken at home with validated automatic monitors average lower than readings obtained in the office. Such measurements also better prognostic indicators of hypertensive complications. Before consigning patients to a diagnosis and treatment of hypertension, or before changing drug therapy, undertake a few days of at-home monitoring as it might avoid over diagnosis and over treatment.

Reference

Verberk WJ, Kroon AA, Kessels AG, de Leeuw PW. Home blood pressure measurement. A systematic review. J Am Coll Cardiol 2005; 46: 743-51.

Study design

Systematic review of RCTs of home self-monitoring of blood pressure to determine its role in hypertension management. Reviewers searched 3 databases for trials comparing self-measurement of blood pressure using validated self-measurement devices (see www.bhsoc.org for a list) with in-office monitoring. The report does not clearly outline how the articles were selected or abstracted, although articles that evaluated patients with and without antihypertensive drug treatment without the possibility to distinguish both groups were excluded. Morning and evening readings over several days (the authors estimate 3 days, averaging the results from the second and third days) were deemed necessary to accurately portray a patient's usual blood pressure.

Results

Blood pressures of untreated patients, taken at home, are lower than those measured in the office (on average 6.9 mm Hg systolic and 4.9 mm Hg diastolic), with the discrepancy in systolic blood pressure being more pronounced in older patients. Similarly, blood pressure readings at home were lower on average by 5.3 mm Hg systolic and 3.1 mm Hg diastolic, irrespective of age. Several studies, though their results are not clearly outlined in this paper, revealed that home blood pressure measurements correlated better with target organ damage and cardiovascular mortality, and correlate well with 24-hour continuous blood pressure monitoring.

Commentary

Blood pressure can be measured in the office or at home using an automated self-measuring device or through the use of 24-hour ambulatory blood pressure monitoring. This review, together with another review of ambulatory blood pressure monitoring (see related CAT), confirm that diagnosing, treating, or prognosticating effects of, hypertension in patients, especially elderly patients, on the basis of random clinic measurements is prone to error and may place the patient at risk of harm.

Intensive insulin therapy may improve survival in some critically ill medical patients

Posted

Clinical question

In patients who are critically ill and requiring medical ICU admission, does intensive insulin therapy improve their overall prognosis?

Bottom line

Intensive insulin therapy does not reduce mortality among all patients in the medical ICU, but may be beneficial in patients whose ICU stay exceeds 3 days. However there may be potential harm in patients with shorter stays.

Reference

Van den Berghe G, Wilmer A, Hermans G, et al. Intensive insulin therapy in the medical ICU. N Engl J Med 2006; 354: 449-61.

Study design

Single site RCT involving 1200 adult patients with anticipated ICU stays (≥ 3 days) who were randomized (?partial concealment with sealed envelopes) to conventional insulin treatment (continuous insulin infusion if BSL >12 mmol/L and adjusted to maintain BSL 10-11 mmol/L) or intensive insulin treatment (insulin infusion started when BSL >6.1 mmol/L and adjusted to maintain BSL 4.4 to 6.1 mmol/L). Excluded patients were surgical ICU patients, medical patients able to receive oral nutrition, and those with do-not-resuscitate orders, participating in other studies, or whose family members were unable to provide consent. Approximately 17% of patients had known diabetes.

BSLs were measured at one-to-four-hour intervals on arterial blood or glucometer capillary blood, and adjustments to insulin dose were made by ICU nurses using titration guidelines adapted from a previous study. More frequent BSL measurements were performed whenever the attending nurse considered them necessary and whenever there had been a steep rise or fall in BSL on previous reading. When patients were hemodynamically stable, enteral feeding was started according to routine guidelines, and attempted as early as possible. Patients were considered ready for discharge when they no longer needed vital-organ support and were receiving at least two thirds of their caloric intake by the normal enteral route, or when they were

sent to a ward. Physicians on the wards to which patients were transferred had no access to the results of BSL testing and were unaware of treatment assignment.

Primary outcome measure, analysed by intention-to-treat, was all-cause in-hospital death, as assessed by investigators blinded to treatment assignment who also determined cause of death in the ICU. Causes of deaths occurring after discharge from ICU could not be identified. Secondary outcome measures were mortality in ICU, 90-day mortality, days to weaning from mechanical ventilation, days in the ICU and in the hospital, initiation of dialysis, new kidney injury during intensive care (level of serum creatinine twice that present on admission to the ICU or peak level 220 µmol/L), days of inotropic or vasopressor support, hyperinflammation (CRP>150 mg/dL), bacteremia, prolonged (>10 days) use of antibiotics, and hyperbilirubinemia (bilirubin >51 µmol/L). Use of intensive care resources was assessed on the basis of cumulative Therapeutic Intervention Scoring System-28 (TISS-28) scores (the sum of daily scores), indicating total number of interventions per patient. Predefined subgroup analysis for patients staying in the ICU for at least a third day was also performed.

Results

Of 1200 randomised patients, 767 remained in the ICU for at least a third day. Baseline characteristics were well matched between groups.

Among the 1200 patients included in the intention-to-treat analysis, ICU and in-hospital mortality were not significantly reduced by intensive insulin therapy. For all patients, mortality in ICU at day 3 (2.8% vs 3.9%) and in-hospital mortality at day 3 (3.6% vs 4.0%) were no different between treatment groups. Beyond the third day, intensive insulin therapy, reduced in-hospital mortality from 52.5% to 43.0% (p=0.03), with a trend (p=0.06) to reduced all-cause death in the ICU.

Some morbidities such as reduction in newly acquired kidney injury (8.9% vs 5.9%, p=0.04), earlier weaning from mechanical ventilation, (hazard ratio [HR]=1.21; p=0.03), along with earlier discharge from the ICU (HR=1.15; p=0.04) and from the hospital (HR=1.16; p=0.05) were less common in the intensively treated group compared to the conventionally treated group. However other morbidities such as bacteremia were not reduced in the intensively treated group.

Commentary

This study has raised many questions that need to be addressed:

1) Could tight glycemic control (BSL 4.4-6.6 mmol/L) be harmful in patients who require <3 days in ICU? There were more deaths (56 vs 42) among those receiving intensive insulin therapy, although this was not statistically significant. Unfortunately, there is no easy way to predict the duration of a patient's stay in the ICU and therefore, it remains unclear which patients should receive intensive insulin therapy as they enter the ICU.
2) It is not clear cut if BSL 4.4-6.6 mmol/L is the optimal target range in this group of medical ICU patients as compared to surgical ICU patients in whom this range was shown to reduce mortality by 7% in absolute terms. Perhaps a higher range (e.g., 4.4-8.0 mmol/L) may be more beneficial given pathophysiology of medical illnesses requiring ICU admission can be very different from that of surgical ICU patients.
3) Hypoglycemia is an independent risk factor for mortality in medical ICU patients. The use of parenteral nutrition in this study was aggressive with potentially more risk of hypoglycemia. Although episodes of hypoglycemia (defined as ≤2.2 mmol/L) did not result in seizures, the implications of such episodes and of more moderate hypoglycemia for long-term neurocognitive functioning have not been assessed adequately in critically ill patients.
4) The demonstration of benefit in the subpopulation of 767 patients with >3 days ICU stay came from a subgroup analysis, admittedly pre-specified, but this result may still be a chance finding given that this analysis was not the primary outcome assessed by intention-to-treat.
5) The lack of blinding of clinicians and nurses, while prevented by the need for safe insulin titration and close BSL monitoring, may have introduced bias favouring intensive insulin therapy. Also results were not adjusted for multiple comparisons which may lead to overestimation of statistical significance.

The outcome of ongoing large-scale, multicenter, RCTs examining glycemic control in the ICU, such as the Glucontrol study and the Normoglycaemia in Intensive Care Evaluation and Survival Using Glucose Algorithm Regulation [NICE-SUGAR] study, may shed further light on this issue.

For now a reasonable approach according to one editorialist may be to provide adequate exogenous insulin to achieve target BSL <8.3 mmol/L, at least during the first 3 days in the ICU, and then, if stay persists beyond 3 days, a goal of normoglycemia (4.4 to 6.1 mmol per liter) could then be considered.

Acknowledgement to Dr Su Mien Yeoh who wrote the first draft of this CAT

For more CATs please go to the members section of the website - http://www.imsanz.org.au/members/resources/CATs/library.cfm

STOP PRESS!

The 2007 Autumn IMSANZ meeting will be held in the Auckland region, possibly at Waiheke Island.

Offers to convene this meeting are welcome p.poole@auckland.ac.nz

Advanced Training in General Medicine and Renal Medicine

Royal Darwin Hospital, Northern Territory

Position Description:

Two positions exist: Level/Salary range $65,787 - $94,244 depending on level of experience.

The Royal Darwin Hospital is accredited for a year in advanced training in renal medicine and general medicine. The following positions would be suitable for either applicant. The first position is that of senior renal registrar based at the Royal Darwin Hospital and commences on the 24th of July 2006 for a period of 6 months. The Darwin department is part of the Northern Territory Renal Services formed by the amalgamation of the Royal Darwin Hospital and the Alice Springs Hospital. Satellite dialysis units service the Tiwi Islands, Palmerston, Katherine and Tennant Creek. The second position is that of outpatient general medical registrar attached to the renal department.

This registrar participates predominantly in out patient general medical clinics, visiting satellite dialysis units as well as remote area clinics.

This position allows for an understanding of the uniqueness of medical practice in this part of Australia and the challenges faced by patients and health care providers in overcoming the tyranny of distance and of working across culture and language lines. Training in these area involves exposure to a wide variety of renal pathology and general medicine including the unique infectious complications specific to the Northern Territory. Applicants wishing to apply for a longer period of time can negotiate a twelve month contract with subsequent rotations through cardiology, the junior infectious diseases position, endocrine/general medicine etc. For those wishing for broader experience and who possess some anaesthetic or intensive care skills, secondments to Gove District Hospital in East Arnhem can be arranged on a case by case basis.

Applicants must be registered with the Northern Territory Medical Registration Board.

Conditions of service include 6 weeks leave a year and relocation costs.

Please contact Dr Emma Spencer, Physician in Charge of recruitment, Royal Darwin Hospital 08 8922 8888 page 542, Emma.Spencer@nt.gov.au

Applications Close: 24 July 2006

ANNUAL SCIENTIFIC MEETING 2006

Don't forget to diarise the RACP(NZ) / IMSANZ / ANZSN meeting to be held at Rydges Hotel, Queenstown 20-22 September 2006, with a Trainees Day to be held on the 19th September.

This meeting of general physicians and nephrologists will have a focus on topics of interest to both groups. These include diabetes, the metabolic syndrome, cardiac disease and aspects of chronic renal disease, including renal replacement therapies.

We are fortunate to have as keynote speaker Dr Patrick Parfrey. Dr Patrick Parfrey is a University Research Professor and director of the Patient Research Centre with the Health Care Corporation of St. John's, Canada. Dr. Parfrey is an internationally renowned scientist and clinical epidemiologist. He has been investigating the causes, risk factors and treatment of kidney disease for more than two decades. His early research was in the area of renal transplantation and his discovery of the adverse effect of certain anti-rejection treatments on patients with hepatitis B who had received a transplant has had direct clinical implication. He has also made important contributions in the area of genetic renal disease. He is also a leading world expert on the subject of cardiac disease in dialysis patients. With a keen interest in rugby he is looking forward to his visit to NZ. In Canada, he has provided outstanding leadership to the sport of rugby, coaching teams at the local, provincial and national levels and serving as president of Rugby Canada.

The programme is guaranteed to be informative and stimulating. It is also intended to be family-friendly with time scheduled for enjoying the exceptional attractions that Queenstown has to offer. Preliminary details may be found on: www.dcms.co.nz/racp or http://www.imsanz.org.au/events/.

Nominations for IMSANZ Australian Vice President / President Elect

Your society needs you!

Council wishes to receive names for, or suggestions as to who might take over, the acting Australian Vice Presidency role from Ian Scott. This person would then step into the Presidency in 2007 at the end of Phillippa's two year term. The role is varied, challenging and rewarding. The President is ably supported by Mary (secretariat), past presidents, and other Council members with their key interests.

It's critical IMSANZ retains the current momentum- to enhance general medicine and to support general physician workforce development.

Ian Scott or Phillippa Poole would be more than happy to discuss with you just what it entails.

Nominations to Mary Fitzgerald, imsanz@racp.edu.au as soon as possible please.

IMPLEMENTING THE ACTION PLAN

Progress Report

The joint IMSANZ/RACP position statement Restoring the Balance (RtB) which contained an action plan for rejuvenating training in, and practise of, general internal medicine was launched at the IMSANZ ASM in Alice Springs on September 2, 2005. So what's happened since then? A fair bit as summarised below:

Dissemination of RtB: The first 3,000 booklets have been distributed to all IMSANZ members, senior college office-holders, members of Adult Medicine Division Committee and Specialties Board, senior health department officials at state and federal level, and a number of external bodies. Another print run of 3,000 copies has been commissioned by the college and the statement has been posted on the RACP and IMSANZ websites and has featured in RACP News. At the time of the launch there was coverage by both newspapers and radio at state and federal level.

The document has been, or is soon to be, tabled and discussed at meetings of all college state committees, and offices of all Specialty Societies have been forwarded a copy with the offer of presentations by IMSANZ councillors to Society meetings to further discuss the contents and implications of the document.

Establishment of RtB Implementation Committee: IMSANZ and RACP have convened the RtB Implementation Committee comprising A/Prof Gerard Carroll (Chair, IMSANZ member, NSW), Profs Rick McLean, Phillippa Poole and Ian Scott, Dr Sue Morley, Gary Disher and Fairlie Clifton. This committee has had three teleconferences to date and the following actions taken:

- Drafting of a 2-page document which outlines the dire shortage in physicians capable of practising general medicine which is placing rural, regional and outer metropolitan areas at crisis point accompanied by 4 key resolutions that need to be enacted by RACP and state and area health authorities to address this situation. This document is to be discussed at Specialties Board and forwarded to specialty society SAC chairs, health area CEOs and state and federal Chief Health Officers. The proposed resolutions are:
  - ~ Acceptance of more general (or other subspecialist) training as part of, or after, the non-core year of advanced training within a subspecialty.
  - ~ Adoption by Specialist Advisory Committees of an inclusive attitude towards allowing elective year to be spent outside the chosen specialty.
  - ~ Establishment of departments of internal medicine or equivalent within all teaching hospitals.
  - ~ Assignment of a proportion of training positions in Specialty departments/units to trainees from without their discipline (general or other).
- Gathering of RACP-held data on all advanced trainees that have registered with SAC for General Medicine in their first year of advanced training program between 2001 and 2004, and related this to the specialty SAC in which they were registered in their second year of training. (Data tables are available for viewing on the IMSANZ website under link "Restoring the Balance"). The basic message is that there is considerable leakage (up to 66%) from General Medicine after the first year of training, and of those who continue in General Medicine, about 40% undergo dual training in other specialties. This data set provides trends across states and different specialties and between Australia and New Zealand. It identifies Victoria and New South Wales as the states which have the most leakage, with Cardiology, Gastroenterology, Respiratory Medicine and Nephrology being the specialties accounting for the majority of transfers. This data, combined with results of a questionnaire survey currently under way of advanced trainees that have transferred to other specialties (but not under a dual training option), will be used to determine the reasons why initial choice of General Medicine for advanced training was not maintained.
- Profiles of all hospitals in all states have been obtained from RACP Training Accreditation surveys showing which hospitals are not accredited by SAC in General Medicine for advanced training in general medicine but are accredited for other specialties. The chief administrators and directors of physician training within these hospitals are currently being contacted and asked to provide reasons why general medicine units do not exist or, if they do, why they have failed to achieve accreditation.
- Letter of request has been forwarded to presidents of all Specialty Society SACs asking whether their advanced training program would allow trainees to spend their non-core year in another subspecialty (including general medicine) and, conversely, whether general medicine trainees are eligible to undertake an accredited year in that subspecialty. Of the 15 adult SACs that replied, non-core year in another specialty was permissible for 4 (Clinical Immunology/Allergy; Clinical Pharmacology; Geriatric Medicine; Palliative Medicine) and regarded as not feasible for the rest (Cardiology; Clinical Genetics; Endocrinology; Gastroenterology; Haematology; Infectious Diseases; Medical Oncology; Neurology; Nuclear Medicine; Respiratory Medicine and Rheumatology). Nephrology did not reply. Cardiology was the only SAC that indicated interest in providing an elective year of training in non-invasive cardiology for general physician trainees. Clearly there is work to be done in persuading specialty society SACs to inject more flexibility into their training programs with the aim of promoting more generalist skills.

Profiling strengths of general physician models of care. IMSANZ is working to compile evidence of effectiveness of general physician models of care, to issue position statements in practice areas wherein general physicians have special expertise, and to develop educational resources and training courses in topics within the province of general medicine. The latest IMSANZ product is a position statement on Acute Medicine Assessment and Planning Units written by a working group led by John Henley (see What's New on the Web).

Lobbying for improved remuneration. Les Bolitho is inaugural president of the Australian Association of Consultant Physicians whose Technical Reference Group has developed new Enhanced Physician Attendance Items (EPAI) which are to be submitted to the Department of Health and Ageing, and which will complement existing items 110, 116 and 119. More details are to be found in the accompanying article in this issue.

So progress is being made in implementing RtB, but more is needed. In this regard we ask all members of IMSANZ to assist and advocate wherever and whenever they can in realising the objectives we have set ourselves in RtB.

IAN SCOTT

Physician specialty and mortality among elderly patients hospitalised with heart failure.

Foody JM, Rathore SS, Wang Y, Herrin J, Masoudi FA, Havranek EP, Krumholz HM. Am J Med 2005: 118:1120-1125

An evaluation of outcomes in 25869 US Medicare beneficiaries admitted with heart failure, according to the speciality of their attending physician. The primary outcome, 30 day mortality, was lowest in patients cared for by cardiologists in comparison to internists and other generalists, including family practitioners.

International perspectives on general internal medicine and the case for "globalisation" of a discipline.

Ghali WA, Greenberg PB, Mejia R, Otaki J, Cornuz J. J Gen Intern Med 2006; 21:197-200

Models of general internal medicine across several countries are compared. The possibility of "globalisation" of general internal medicine as an academic and clinical discipline is considered. Ian Scott and Phillipa Poole have met with William Ghali and colleagues at meetings of the US Society of General Internal Medicine to progress this possibility further. Also see Ian Scott's paper in the IMSANZ newsletter August 2005: 5-8

Cautionary tales in the clinical interpretation of therapeutic trial reports.

Scott IA, Greenberg PB. Intern Med J. 2005; 35:611-621

This is the first in a series of 'cautionary tales' written by Ian Scott and other colleagues from IMSANZ's Evidence-based Medicine Working Group. The objective is to outline and illustrate the strengths and weaknesses of various kinds of publications, as an aid to critical appraisal for clinicians.

Academic general internal medicine; past, present and future.

Centor RM, Huddle TS. Am J Med 2006; 119:172-175

This paper outlines the history and evolution of academic general internal medicine in the USA, from the perspective of the USA Association of Chiefs of General Internal Medicine (ACGIM). Current issues and future directions are considered.

Mentorship in academic general internal medicine. Results of a survey of mentors.

Luckhaupt SE, Chin MH, Mangione CM, Phillips RS, Bell D, Leonard AC, Tsevat J. J Gen Intern Med. 2005; 20:1014-1018

This reports a national survey of 111 USA mentors. Co-mentoring with other mentors, and mentoring from a long distance were common, and most mentoring was not funded.

Associations between the hospitalist model of care and quality-of-care-related outcomes in patients undergoing hip fracture surgery

Roy A, Heckman MG, Roy V. Mayo Clin Proc. 2006; 81:28-31

A retrospective study of 118 consecutive patients with hip fracture admitted to the Mayo Clinic during 2002. Comparisons were made between peri-operative care by hospitalists and traditional medical consultants. Time to both consultation and surgery were shorter in the hospitalist group, which also showed a trend towards shorter stay and lower costs.

Update in hospital medicine

Weise JG, Holman RL. Ann Int Med 2006; 144:195-200

This summarises 11 papers, retrieved through a MEDLINE search and a detailed review of 15 major journals, published during 2004 and judged to be most important in this area.

Country connectivity: we love IT – or do we?

Bolitho L. RACP News 2006; Feb:6-7

Some wise tips from an experienced IT protagonist.

Locum required – General Physician, Queensland

Petrovsky N. RACP News 2006; Feb:9

An account of the challenges and experiences of a hospital-based endocrinologist, working as a locum at Bundaberg, Queensland, where he covered the daily medical intake for 12 consecutive days.

Good general practitioners will continue to be essential.

Lakhani M, Baker M. BMJ.2006;332:41-43

This paper speculates on what English primary care will look like in 2015. "Access to specialists will normally be facilitated by general practitioners, who will act as navigators of care."

Council Vacancies

IMSANZ Council has vacancies for both metropolitan and rural Western Australia representatives and an Advanced Trainee representative for New Zealand.

Talk to a member of council if you want to be in on the action. Enthusiasm and a commitment to general medicine are the only requirements.

Nomination forms available from the IMSANZ Secretariat.

2006	**May**	**RACP Cairns Congress 2006** May 7-11 Cairns International Hotel CAIRNS, QUEENSLAND http://congress.racp.edu.au/index.cfm?objectid=AD53B7D9-92A2-A8FF-194A0CEA0CF70730#tue
	August	**European School of Internal Medicine 2006** August 30 - September 6 SINTRA, PORTUGAL (Sintra is a small picturesque town in the hills north of Lisbon) Travel Scholarships are available for this meeting on website address below - *Closing Date: May 5, 2006* Scholarship forms: www.imsanz.org.au/resources/awards.cfm#travel
	September	**RACP (NZ) / IMSANZ / Nephrology** September 20-22 Rydges Hotel QUEENSTOWN, NEW ZEALAND **Trainees' Day** September 19 For more details go to our website: www.imsanz.org.au/events/
	November	**CSIM Meeting 2006** November 1-4 Calgary ALBERTA, CANADA Further information: http://csim.medical.org/ *Follow prompts Meetings/CME, Annual Meeting, 2006*
2007	**September**	**ASGM / IMSANZ Combined Meeting** September 5-8 Adelaide Convention Centre ADELAIDE, SOUTH AUSTRALIA
	October	**CSIM Meeting 2007** October 10-13 St John's NEWFOUNDLAND, CANADA

Dear Editor,

I thoroughly enjoyed reading the position paper "Restoring the Balance" and feel sure that I saw somewhere in that or in the accompanying RACP News a request to send any views on these matters to your committee.

By way of brief background I completed Medicine at the end of 1952, practised in Griffith, NSW, from 1955 to 1967 and in 1964-65 spent seven months in Sydney and passed the examination of the College. I returned to Griffith and then in 1967 moved to Canberra, practising first at the Royal Canberra Hospital and from 1974 at the Woden Valley Hospital, later renamed The Canberra Hospital. I retired from the hospital in 1995, continued to consult part-time until early 1997, when I took the position of ACT Director of Palliative Care, and retired completely in early 1999. During my time in Canberra I worked as a General Physician.

There are several points which could be of interest to the committee. The first is that it is essential to find a more suitable name than General Physician. When people ask me what I used to do and I use the above term, they congratulate me on having spent a useful life in general practice! There needs to be some term which shows proper appreciation of the breadth of knowledge and width of experience required by a General Physician. It may seem a minor matter but must be one of the factors influencing candidates in their choice of career. Unfortunately, I have no suggestions on this matter but it is so important that it would be appropriate to enlist the aid of someone who could help, perhaps from an advertising agency.

The second point is that the major resistance to general physicians, especially in tertiary hospitals, is from the Department of Medicine itself. I remember in the 1980s at the Woden Valley Hospital the Department set up a committee of three, including myself, to consider arranging that all admissions to the medical side of the hospital should come in initially under a general medical team which was to consist of general physicians and those sub-specialty physicians who were interested in that type of work. We prepared a submission to the Department but it was voted down. When I was the director of palliative care I was once again on the visiting staff of the Canberra Hospital and a circular came around in which a prominent member of the Medical School referred to "getting rid of the last remnants of General Medicine".

Certainly in Canberra the resistance to General Medicine came only from the Department of Medicine because all the other groups in the hospital, for example surgeons, obstetricians etc., preferred to have a general physician take charge of their problems rather than have to make the choice themselves of which particular subspecialty was appropriate for their difficulties. It would therefore be very useful to try to work with the other Colleges to exert pressure for the departments of general medicine.

It is obvious that physicians practising in non-teaching hospitals, especially away from capital cities, need to be general physicians but it is essential to raise the status of general medicine in the premier hospitals as otherwise candidates will continue to regard it as a second-tier occupation. There should be proper General Medical units and not have general physicians as appendages in other units, giving the impression they need to be watched by some proper physician (a sub-specialist).

In the RACP News of October, 2005, Dr Graham discusses Judging One's Colleagues. Although he was on a different subject it reminded me that one of the difficulties is that if one is intelligent and then confines oneself to a very limited sphere of knowledge it is inevitable that in that particular area one will be much more knowledgeable than those whose knowledge is spread horizontally rather than vertically. General physicians therefore have the problem that it is quite useless to talk to a cardiologist about gastroenterology and one always finds oneself speaking to one's subspecialty colleagues from an "inferior" position. These colleagues in general do not meditate upon what they do not know and therefore see their general colleagues as lesser doctors. This attitude is disseminated in subspecialty units so that the residents and registrars get the impression that being a sub-specialist is a "higher calling".

There is an interesting article in the same publication by Dr Kevin Forsyth. I know that he would have been restricted by the space available but I thought that the problem we face were borne out by his mentioning at the top of the second column "cardiology, gastroenterology, geriatric medicine". It seemed to show that even in the sections of the College involved in education General Medicine has a low profile.

I hope that these comments will be of some assistance when the committee is considering all the things that need to be done to "Restore the Balance".

DR FRANK LONG, FRACP

.....

Dear IMSANZ,

What a great Newsletter! I have spent a happy hour reading the fascinating articles contained within.

I will arrange for this to be posted on our European School of Internal Medicine (ESIM) website as well as European Federation of Internal Medicine (EFIM) because I think the young internists will also be very interested to see it and note the forthcoming meetings not only 'down under' but also in Canada and Antarctica! If you have any contact e-mail address for the Canadian Society of Internal Medicine (CSIM) meetings perhaps you could let me know - they might be interested to have some contact with EFIM with regard to promoting links in internal medicine globally. I was particularly interested to read the reports on ESIM and the ethical problems in the pacific.

EFIM would do well to reinstate 'our' newsletter which seems to have lapsed in recent times. Now that we have a new Secretary (Dr Jan Willem Elte, Netherlands), I will recommend that we take the initiative to produce something similar for Europe even if it is only once a year. We have been focusing on developing a better looking website this past year, and I think our Newsletter has rather taken up residence in the back seat - which is unfortunate!

Congratulations to IMSANZ on producing such an excellent and informative Newsletter!

Best wishes!

JANET STEVENS
EFIM

Dear President,

Prescriber Inequalities in Health Care (Gold Card or Platinum Card)

There are endless articles about the crisis in health care delivery to rural areas. Most medical services are city-centric in coastal areas of Australia and university centres in New Zealand. Part of the problem of reducing inequalities in health is to lift the barriers on physicians who actually practise in rural areas at the coal face.

Perhaps the prescriber number restrictions on Infliximab for active rheumatoid arthritis or Aranesp for anaemia in renal failure patients could be lifted according to the geographical isolated areas, where so many IMSANZ members practise. In other words the inequalities in access to medical care in rural areas could be lifted if governments gave special dispensations for the practice location provider number of the physician delivering the service.

For IMSANZ members who practice 300kms from the nearest state capital or teaching hospital, there are more and more restrictions on prescribing new drugs. More patients with rheumatoid arthritis are excluded from the new biological agents because they have no access to clinical immunologists or rheumatologists. For pensioners in Mudgee the waiting time for the nearest fly in/fly out rheumatologist two hours drive away is 4-6 months. One recent patient's experience was to drive to Sydney 5 hours away in a mechanically dubious vehicle and stay overnight and the cost of fuel and a specialist (who doesn't bulk bill) amounts to over one month's total pension payments. The 60 year little old smoking biddie in the eastern suburbs of Sydney will get the therapy before the 30 year old Aboriginal with an extended family in Coolah.

The growing frustration with bureaucratic restrictions is one of the driving forces for physicians to give up practice in rural areas. Patients are referred to IMSANZ members with more and more complex end stage illnesses. Patients' relatives in rural areas use the internet and Google more frequently and find out all the new avenues of therapies their loved ones are denied because they live in a remote area. The treating IMSANZ members are more hamstrung than ever in 2006. Aredia or Zometa infusions are another ball park and most IMSANZ members despair of the paperwork and restrictions on dementia drugs and the new generation of therapies beyond anticholinesterase drugs. The sense that your hands are tied, that you are not good enough to prescribe these new powerful drugs, leads to a growing sense of frustration.

How often do you phone the superspecialist on his mobile and you know he is not listening, still speaking to the patient in his rooms, distracted with paper work "oh, just send her down"? Someone's gain is someone else's loss. It was Aristotle who said to direct your anger towards the right issue (and the right person).

JOHN ENGLAND
Church Street Medical Centre
MUDGEE 2850

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: _____

_____

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.

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

Phone: +61 3 9500 0390
Fax: +61 3 9509 5700
Email: michelel@bigpond.net.au