IMSANZ

INTERNAL MEDICINE SOCIETY *of Australia & New Zealand*

AUGUST 2006

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From the President...

The General Matters

A warm, personal welcome to those of you who have recently joined our ranks, and to new IMSANZ Councillors Tony Ryan from Perth, David Taverner from Adelaide and Richard King from Melbourne. It was super to see so many of you in Cairns and to receive constructive input into IMSANZ affairs at the AGM. Thanks again to Ian Scott and the team from Cairns – Martin Brigden, Clive Hadfield, and Peter Boyd for putting together such an interesting and varied programme. Informal feedback was that the IMSANZ-sponsored sessions, in particular, were very well-received. Jo Thomas and Ian Scott give their perspectives on the meeting on *pages 15 and 18*.

There were some specific highlights as far as general physicians are concerned. One was winning the debate (see photo on *page 15*) by soundly arguing against the moot: "That the future is sub-specialisation; the generalist belongs to the past". Our team comprised a 'decathlete' of medicine (Phillippa), an ageing baby boomer (Jill Sewell), and Sir William Osler himself (Richmond Jeremy). We had by far the easier time of it, and pitied the poor affirmative team that included our very own Leonie Callaway. The audience helped our cause by providing only the very scantiest applause for the opposition.

The need for the right balance between generalists and subspecialists came up subsequently in several fora, and in discussions among delegates during breaks. At times this yielded a continuing lack of awareness among others of the really big issues facing general physicians, namely workforce shortages and maldistribution, and inequalities compared with subspecialists in workload, remuneration and conditions. On the other hand, it was refreshing to talk to other like-minded colleagues in paediatrics, public health and occupational medicine about how 'we' are going to match health care resources to heath needs in the local, national and international sense. Professor Richard Larkins cautioned an attentive audience regarding the rapid increase in overall expenditure in healthcare in Australia, yet the iterative underfunding of public healthcare and education.

Those who attended the rural forum were inspired by reflective pieces on remote physician services from Stephen Brady, Martin Brigden and Graeme Maguire. Les Bolitho informed us about the Victorian Experience with credentialling and privileging. There is at least one definite indication of interest in an 'outback' position as a direct result of the meeting. To paraphrase Graeme - one more physician makes a really big difference in more remote areas. If you have even a smidgeon of interest

As you turn the pages...

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in taking up one of these challenging and rewarding positions, please contact one of those named people, via IMSANZ if necessary.

The conference dinner provided an opportunity to offer on your behalf IMSANZ's thanks to the departing RACP President, Jill Sewell, who has embraced and promoted the RACP/IMSANZ "Restoring the Balance" position paper.

Since Cairns, Ian Scott has led a concerted campaign to ensure that the "Restoring the Balance" position paper gets onto senior health bureaucrats' desks. Responses to date have been encouraging yet continue to show an under-appreciation of our skills and the roles that general physicians can and could play in the system! You are referred to the eMJA of 3rd July, focusing as it does on workforce and task transfer. This contains several very important articles, including one from Jill Sewell in which she refers extensively to the "Restoring the Balance" document.

The advanced training curriculum in general internal medicine, along with a position paper on acceptable pathways to becoming a general physician, are priorities for completion this year. The new RACP basic training curriculum, written largely by IMSANZ members, is being piloted in Adelaide and Auckland over the next couple of months. Watch this space!

The refreshing atmosphere at Cairns created by having a friendly meeting in a lovely setting away from major city centres is a tried and true formula for IMSANZ meetings. The next one of these is the RACP / IMSANZ / ANZSN meeting in Queenstown 19-22 September 2006 (details at http://www.dcms.co.nz/racp); early bird registration closes on 9th August. There will be an autumn meeting 22-24 March on Waiheke Island near Auckland. After that, we'll meet in Adelaide with the geriatricians from 5-8 September 2007. It's no coincidence that these are stunning venues near excellent wine growing areas. Consider this a personal invitation from the President to see you there - you should be assured of a professionally and socially rewarding experience!

Having three major IMSANZ meetings in the next 15 months creates the opportunity to continue the growth in the society, both in terms of numbers, and in promoting the role of general medicine in health systems. Along with disease management updates, it would be good to showcase research and audit, including that into health care delivery. Please support RACP trainees to attend at least one of these meetings and to present their work. If you have specific topics you'd like to see on the programme or offers of presentations please contact me.

Finally, Michele Levinson has stepped down as newsletter editor. Council thanks Michele for all her work in transforming the organ into something that is now very smart, and well-received by the membership. Despite Michele's stepping down, this issue is, thankfully, more than full! Ian Scott has now stepped into the breach as the new Editor; he will welcome articles and feedback. Jointly, we wish you happy reading.

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

The Great Debate - Peter Goss, Leonie Callaway, Robin Mortimer, Geoffrey Metz, Phillippa Poole, Jill Sewell and Richmond Jeremy.

INTRODUCTION OF NEW PACIFIC ASSOCIATE MEMBERSHIP CATEGORY

It is proposed (P. Poole/ R. Moulds) that the articles of membership in the RULES OF THE INTERNAL MEDICINE SOCIETY OF AUSTRALIA AND NEW ZEALAND Inc. (2003) be amended to include a specific Pacific Associate Membership Category (new article 3.5).

This will assist physicians and trainees in the Pacific by allowing closer collegial relationships among physicians in the region, as well as opportunities to enhance their CME through meetings and access to website resources. There are likely to be around 10 physicians and 10 trainees to whom the new category might apply. Dr Rob Moulds has agreed to be the liaison person between Council and the Pacific physicians. IMSANZ associate members currently pay a quarter of the full fees. This is an important consideration given the differing conditions of service, and remuneration available, for Pacific physicians.

Existing articles of membership

3. Membership

3.1 Any Fellow of the RACP who practises as a general physician in Internal Medicine, with or without a specialty interest, shall be eligible for membership as an ordinary member.

3.2 Any Fellow of the RACP who practices predominantly as a specialist, and has an interest in general internal medicine, shall be eligible for membership as an ordinary member.

3.3 Any medical practitioner who is not a Fellow of the RACP but who is recognised as a consultant physician in accordance with the definition as enunciated, shall be eligible for membership as an ordinary member.

3.4 Any Advanced Trainee shall be eligible for membership as an associate member.

3.5 Any medical practitioner who resides overseas, and is not a Fellow of the RACP but who is recognized as a consultant physician in accordance with the definition as enunciated, or who has an interest as a consultant in general medicine, shall be eligible for overseas membership.*

3.6 Any member of IMSANZ who has given exemplary and/or distinguished service to general medicine in Australia and New Zealand will be appointed as a Life Member at the discretion of the IMSANZ Council. No subscriptions will be payable but will have full voting rights.

3.7 Honorary members - these will be distinguished overseas physicians who are members of similar societies and will be decided by the IMSANZ executive and approved by IMSANZ Council. No subscription fees will be payable and there are no voting rights.

3.8 Retired members - members who have retired from active clinical practice may remain as honorary members with no fees payable, no voting rights but will receive the Society Newsletter.

3.9 Voting rights - the only members who have voting rights are financial ordinary members, associate members and life members.

3.10 Applications for membership of the Society shall be lodged with the IMSANZ Secretariat on the form approved by the Council together with the subscription fee. New memberships will be approved by Council and published in the Society's Newsletter.

** A Consultant Physician is a practitioner who by training and experience in internal medicine, paediatrics or one of their sectional specialities is able to give a learned opinion regarding the patient as a whole and whose practice is exclusively on referral.*

Proposed articles of membership

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3.1 Any Fellow of the RACP who practises as a general physician in Internal Medicine, with or without a specialty interest, shall be eligible for membership as an ordinary member.

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3.3 Any medical practitioner who is not a Fellow of the RACP but who is recognised as a consultant physician in accordance with the definition as enunciated*, shall be eligible for membership as an ordinary member.

3.4 Any Advanced Trainee shall be eligible for membership as an associate member.

3.5 Any medical practitioner resident in the Pacific Islands who is recognised as a consultant physician in accordance with the definition as enunciated*, or who is enrolled in a recognised physician training programme, shall be eligible for membership as a Pacific associate member.

3.6 Any medical practitioner who resides overseas, and is not a Fellow of the RACP but who is recognized as a consultant physician in accordance with the definition as enunciated*, or who has an interest as a consultant in general medicine, shall be eligible for overseas membership.

3.7 Any member of IMSANZ who has given exemplary and/or distinguished service to general medicine in Australia and

NOTICE OF EXTRAORDINARY MEETING

An Extraordinary Meeting will be held to discuss the above Rule change on Pacific Membership at

Rydges Lakeview Hotel
Queenstown, New Zealand

20th September 2006 at 3.00 pm

New Zealand will be appointed as a Life Member at the discretion of the IMSANZ Council. No subscriptions will be payable but will have full voting rights.

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IMSANZ would like to welcome the following New Members:

- Dr Stuart Lee - Auckland, NZ
- Dr Mandeep Mathur - Ipswich, QLD
- Dr Wilfrid Newman - Mackay, QLD
- Dr Harvey Newnham - Box Hill, VIC
- Dr Ashim Sinha - Cairns, QLD
- Dr David Taverner - Adelaide, SA
- Dr Janet Vial - Hobart, TAS
- Dr Belinda Weich - Mackay, QLD

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

- Dr Razvan Ghiculescu - Brisbane, QLD
- Dr Joanne Holden - Wellington, NZ
- Dr Ingrid Naden - Auckland, NZ
- Dr Amy Osborne - Melbourne, VIC

RACP Medal for Clinical Service in Rural and Remote Areas 2006

IMSANZ congratulates Dr Leslie E Bolitho who received the RACP Medal for *Clinical Service In Rural and Remote Areas 2006*!

Dr Les Bolitho received the RACP Medal for Clinical Service in "Rural and Remote Areas 2006", and was delighted to be able to accept the Medal on behalf of his family, patients, and all the colleagues and staff he has been involved with over the years. His wife, Sally, and adult children Sarah, Laura and Timothy travelled to Cairns for the presentation at the RACP Ceremony in May 2006.

Les and Sally moved to Wangaratta, Northeast Victoria, on receiving his Fellowship in February 1983, and commenced Consultant Physician practice at Wangaratta District Base Hospital (now Northeast Health Wangaratta) and in rooms based practice. Outreach services to Myrtleford and Yarrawonga followed soon after arrival, and continue on a weekly basis.

Continuing interest in supporting rural physician practice resulting in his involvement with the Victorian Rural Physicians Network (VRPN), and involvement with the University Department of Rural Health, Shepparton, resulted in the First World Rural Internal Medicine Specialists Conference in 2002 associated with the 5th World Conference in Rural Health (WONCA).

An interest in broader medico-political interests and General Internal Medicine led to his role as President , Internal Medicine Society of Australia and New Zealand (IMSANZ) from 2001-2003, with a role on the RACP Specialties Board. Election to the RACP Adult Medicine Division in 2004 was combined with election to the RACP Council, a role in which he pursues with interest and vigour. In December 2005 he expanded his medicopolitical interests and was elected President, of the revitalised Australian Association of Consultant Physicians, which is challenging and requires significant concentration.

Continuing interests in medical student teaching since 1988, and more recently the Rural Clinical School, Shepparton has been very rewarding.

Les had great pleasure in accepting the RACP Medal for Clinical Service in Rural and Remote Areas 2006 and would like to acknowledge all those with whom he has had contact over the years, and who have provide advice, assistance and encouragement.

INEQUITIES OF ACCESS TO EFFECTIVE MEDICINES IN REGIONAL & RURAL AUSTRALIA

Recently IMSANZ Council has been grappling with the issue of the restricted ability of general physicians to prescribe certain pharmaceuticals on the PBS. Dr England (Katoomba, NSW) raised this issue in his letter to the editor in the April 2006 newsletter. Subsequently, a letter written by IMSANZ member Dr Rob Brodribb (Toowoomba, 100km west of Brisbane, Queensland) and addressed to Federal Health Minister Tony Abbott (excerpts reproduced below with permission) elicited a very brief negative response from departmental officers. Dr Brodribb then referred the matter to IMSANZ council and our response (see below) was forwarded on 23rd May to several parties including Tony Abbott, Kaye Veal (Manager, PBS and Specialised Drugs, Medicare Australia), Prof Shane Carney (Chair, RACP Therapeutics Committee), A/Prof John Kolbe (Chair RACP Specialties Board), and Prof Rick McLean (Chair, RACP Rural Taskforce). Disappointingly, at the time of putting this newsletter to press (20/7/06), no official replies have been received. This matter will be further discussed at the next IMSANZ Council meeting (Aug 1st), and we welcome any suggestions from members as to what our next steps should be: referring the matter to other bodies such as the AMA; enlisting the support of patient advocacy groups; seeking media attention.

Dear Sir / Madam,

IMSANZ Council believes there are inequities of access to numerous drugs under the present PBS restrictions which impact adversely on the quality of care of many patients cared by general physicians in non-metropolitan areas. We would ask that this issue be raised ..[within your jurisdiction]…..and beyond.

50% of Australians live in metropolitan centres, 25% in regional and a further 25% in rural areas. Patients outside of major cities with complex illnesses are often managed by general physicians. Neither the patients nor the general physician may have easy access to the subspecialists currently approved to prescribe specific medicines.

Members of IMSANZ have drawn to our attention specific situations (see attached letters) in which approval for use of specific medicines on the part of general physicians has proved difficult:

- infliximab for rheumatoid arthritis
- darbepoietin for anaemia of renal failure
- pamidronate and zolendronate for osteoporosis
- etanercept in rheumatoid arthritis

In each of these examples, a specific medical specialty is 'named' as the approved prescriber thus excluding all other specialists, including general physicians, from being able to access the drug. This is contrary to principles of the Quality Use of Medicines (QUM) programme, the objectives of which are to have treatment plans formulated, management options selected wisely, and medications chosen appropriately and prescribed safely and judiciously.

In contrast, as the attached examples demonstrate, considerable cost and inconvenience have been imposed on patients who have been required to access an approved subspecialist in metropolitan centres which may be hundreds of kilometers away. Safety may be compromised by virtue of a subspecialist, at some remote distance, being involved in prescribing a drug and monitoring patient response without being able to review the patient as regularly as may be considered prudent in making adjustments to medication, because of the tyranny of distance.

IMSANZ Council feels very strongly that consultant physicians practicing in General Medicine are well trained in therapeutics and frequently manage patients that require medications such as those cited. The Council is well aware of the reasons behind PBS scheduling of a particular drug which usually centre on the need for cost-containment of expensive medications.

IMSANZ Council considers the exclusion of all physicians except those in a specific subspecialty group from accessing a particular drug as being overly restrictive and contrary to QUM principles. A liberalization of the current restrictive wording would simply allow physicians requiring the relevant agent to continue their management without the need for unnecessary referral and imposing cost and inconvenience on their patients. It is highly unlikely that such a change would impact significantly on total drug expenditure of the PBS.

IMSANZ believes these cases raise the following issues:

1. How Medicare Australia and the Pharmaceutical Benefits Scheme determine who may prescribe costly new medicines.

IMSANZ believes access to medicines should be on the basis of a patient fulfilling the PBS criteria as judged by a competent specialist who may be either a general physician or a subspecialist. Many general physicians have undertaken subspecialty experience during their training, and feel competent to decide if a patient meets PBS criteria for supply. In some cases the general physician may already have experience in prescribing the medicine for other indications, and in monitoring patient response.

If there are to be restrictions, consideration might be given to dispensation for the location of the physician actually providing the service.

2. Stakeholder input into Pharmaceutical Benefits Advisory Committee (PBAC) approval of expensive new medicines.

General physicians have a valuable perspective to bring to discussions around drug approval through their experience in setting realistic treatment goals, and managing polypharmacy, particularly in patients with multiple comorbidities and those requiring end of life care.

IMSANZ is keen to work with all interested parties in remedying inequities in the PBS schedule and ensuring safe and equitable access to cost effective medicines for all Australians, regardless of their geographic location.

Yours sincerely,

Michael Kennedy, Councillor
Assoc Prof Ian Scott, Immediate Past President.
Assoc Prof Phillippa Poole, President.

Continued page 6

PROPOSAL FOR A GENERAL MEDICINE NETWORK - LLEW DAVIES

On the need for General Medicine Clinical Service Networks

As mentioned in the article 'Restoring the Balance – Progress Report' Queensland Health (QH) is looking at the possibility of establishing a General Medicine Clinical Services Network which could operate at the area health level and state-wide. IMSANZ member Llew Davies outlines his thoughts on this issue.

Certainly with the advent of renal, cardiology and other funded networks General Medicine could be more marginalised with time. Interestingly, Prof Mick Reid who is doing a strategic assessment of health services for QH, and was here in Rockhampton yesterday, raised without prompting the importance of general medicine in the health system. Perhaps we should formally represent our collective views to him.

We need to make the point that there are gross and unsafe shortages of generalists in regional areas. Gladstone for example, booming, prosperous, 35,000 people or so, has NO physicians at all. Clearly in an area like this you need 2 or 3 general physicians to start the provision of anything approaching safe services, as well as teaching in Medicine to junior house staff. One concept of generalists is that we are the pioneer physicians, first bringing specialised general medicine to developing areas, and that the provision of a resident physician service is infinitely better than fly-in, fly-out, or telemedicine services. To meet these needs we need more people training, and having a network might be one way of trying to see that general advanced trainees get the requisite blocks of preparation to cope in the regions. If people thinking of training in general medicine felt that QH was demonstrating affirmative action in their favour, more might take up the challenge.

I wonder also whether we should push more strongly our vital role in teaching. There is little doubt that teaching at medical student level is best done by general physicians and their units, or medicine becomes just an unbalanced collection of fragmented specialties. Unfortunately at the University of Queensland the year 4 medicine rotation is delivered as two four week specialty blocks. It seems to me this is not because students need such specialist exposure, but because there are not enough general units to go round. Students could therefore finish the course without having recent experience of a broad swathe of internal medicine. We have the capacity in the Rural Clinical Division to deliver broad teaching in general medicine to year 4, leavened with some specialist clinics, and this is certainly appreciated by students preparing for their final summative assessment.

From page 5

Excerpts from Dr Brodribb's letter to Tony Abbott Dated 27th March 2006

Dear Mr Abbott

I seek your urgent assistance to enable me to prescribe Etanercept to Mr X of Goondiwindi (a town 250 km southwest of Toowoomba). Mr X has severe erosive rheumatoid arthritis that has responded well to Etanercept. The rheumatologist I referred him for initiation of this drug has now retired. The nearest rheumatologist is 2.5 hrs drive away at Toowoomba and she has closed her practice to new patients. Mr X has less than 2 months supply from his last prescription.

I received my FRACP in General Medicine in 1985. As part of my advanced training towards the FRACP I underwent 12 months training in Rheumatology… I am an associate member of the Australian Rheumatology Association and have been treating patients with rheumatoid arthritis for 20 years… I have been prescribing TNF alpha blocking agents for patients with Crohn's disease for years and therefore have the skills to safely prescribe Etanercept.

Thanks to the assistance of the Commonwealth Government through MSOAP I now provide a fortnightly visiting internal medicine specialist service to Goondiwindi. I do not see why Mr Fleming should have to go to the expense and inconvenience of traveling to Brisbane (4 hours drive to the nearest rheumatologist or immunologist he could access) when he could safely receive his treatment in his home town…

Yours sincerely,

Rob Brodribb

Attached to this letter were copies of letters received from Pharmaceutical Advisors of Medicare Australia stating that they were unable to consider applications for Etanercept from physicians other than rheumatologists or clinical immunologists with expertise in the management of rheumatoid arthritis.

LETTER TO THE EDITOR

'Hands-on support is better than money in your pocket.'

To address the issue of retention of IMSANZ specialists in regional and rural areas it is essential to make professional life easier. A full-time, one-on-one practice nurse, 100% funded by the government would be the first step.

Currently my practice survives on the throughput of patients by my nurse. She prepares each patient prior to the consultation. She reads the referral letter and prepares the patient check list for a possible exercise stress test or echocardiogram. She does a urine analysis, takes blood pressure, computerized ECG and peak flow. In addition, she tracks lost discharge summaries, lipids and pathology results, as well as talking to the patient and their spouse. A nurse practitioner has the capability to become a gatekeeper to run the practice smoothly.

A rural 'itinerant barefoot' physician could see twice as many patients with a practice nurse compared to the old fashioned doctor, who does his own ECGs and blood pressure readings. With a practice nurse team in place it should be easier to find a locum physician allowing us to take holidays in the knowledge that our patients are continuing to receive appropriate care.

No government will pay for locums but, in the current political climate, governments that re-engage rural doctors by paying practice nurses to maintain services for specialists as against GPs in the bush is what the media wants to hear!

JOHN F ENGLAND
IMSANZ member
Consultant physician and cardiologist, Katoomba NSW

THE INTERNIST TODAY AND MULTI-SYSTEM MEDICINE IN AUSTRALASIA

Excerpts from a talk given to a course on Acute Care Medicine, Box Hill Melbourne – January 2006

The word 'Internist' comes from the German term "INNERE MEDIZIN", and Internal Medicine was adopted from this. Internal Medicine has been defined as a "non surgical specialty concerned with diseases of internal organs in adults," and physicians specialising in the field are know as "Internists, skilled in disease prevention, and in managing complex disorders of the body. Internists may be either generalists or specialists."

This last definition is particularly confusing. General Physicians are also specialists, and in the document "Restoring the Balance" put out recently by IMSANZ, internists were defined as 'Consultant General Physician' and 'Consultant Physician in a sub-speciality". Perhaps a generic term for both is a 'Specialist Physician', because it is well recognised that not too many people understand the word INTERNIST. In a recent survey, 31% said it was a doctor who dealt in internal organs, 17% a medical student and 17% didn't know, with many other suggestions.

Specialisation is inevitable in our health service, but not everyone thinks it is a good idea.

"Consultant Physicians are a degree more remote (like Bishops) and therefore (again like Bishops) they need a double dose of grace to keep them sensitive to the personal and pastoral."

- Geoffrey Fisher, Archbishop of Canterbury

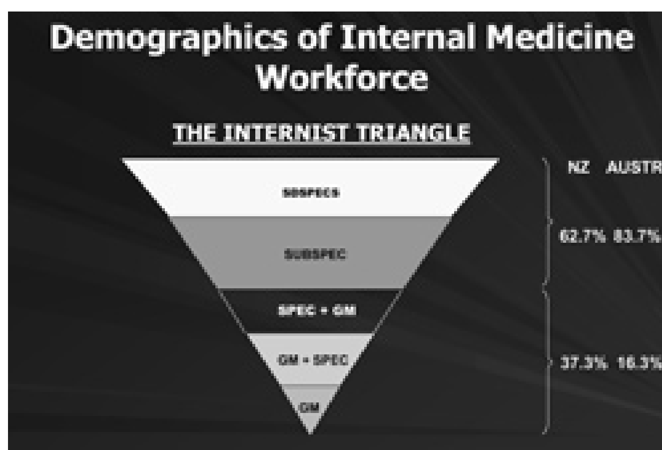
"Specialisation is proof how far medicine has skidded off the path. It lets them abandon heaps of medical expertise to sluggish ignorance in the way farmers dump excess production to keep prices up; an ability to claim non-knowledge."

- Wayne Hill, Contemporary English Journalist

Recognising the trend towards super-specialisation, how are Specialist Physicians coping with multisystem medicine in Australasia.

First we must look at the demographics of the internal medicine workforce.

Figure 1:



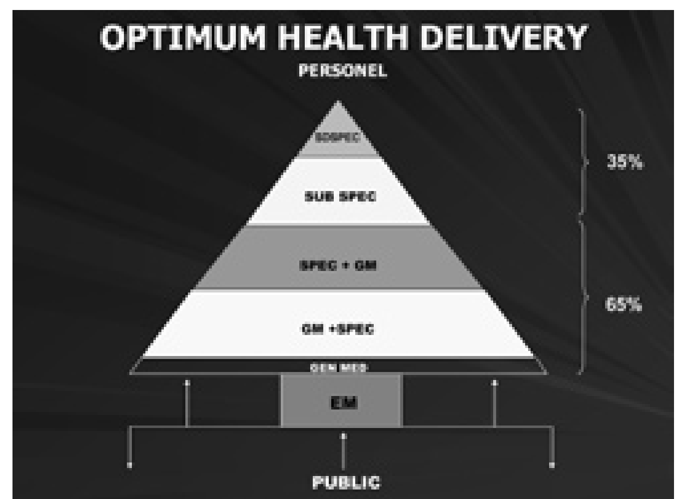
As can be seen 37.3% of specialist physicians in New Zealand, and 16.3% in Australia practice some form of General Medicine. The sub-specialists and super-duper specialists dominate the scene.

Although supported by increasing Emergency Medicine involvement, the health delivery is wobbling as it is not balanced by a strong General Medicine base.

Figure 2:

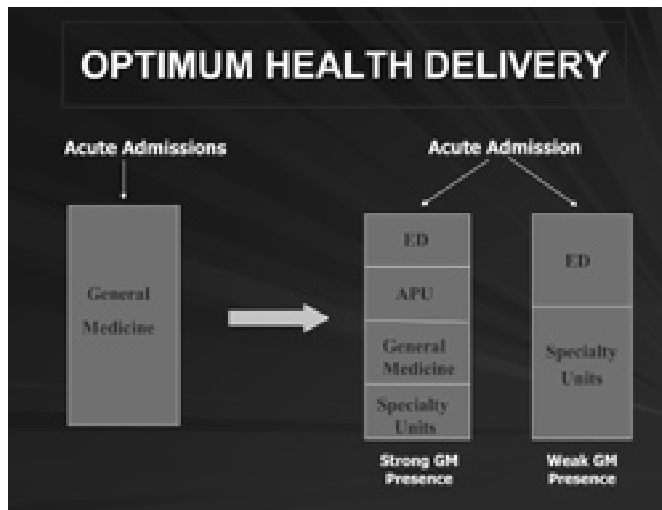
The Optimum Health Delivery to manage the ever increasing load of multi- system disease should perhaps reverse the previous percentages.

Figure 3:



In the hospital setting, there are varying ways in which acute assessment is managed. Many years ago General Medicine handled most acute medical problems. With the development of specialisation including Emergency Medicine, methods of acute assessment changed. The type of arrangement usually is predicated by the strength or otherwise of General Medicine departments. The development of Assessment and Planning units in many hospitals has improved Acute Medical Assessment.

Figure 4:



In America, the hospitalist has come to the fore. A 'Hospitalist' is defined as "a physician whose primary professional focus is the general medical care of hospitalised patients. Hospitalists may engage in clinical care, teaching research or leadership in the field of General Hospital Medicine."

In England, the 'Acute Care Physician' is being developed with major concerns relating to early burn out, and also in both situations considerable lack of continuity of care.

Part time physicians working in hospital and outpatients settings can provide continuity which has become even more important in multisystem disease management.

We must at all costs avoid the American experience.

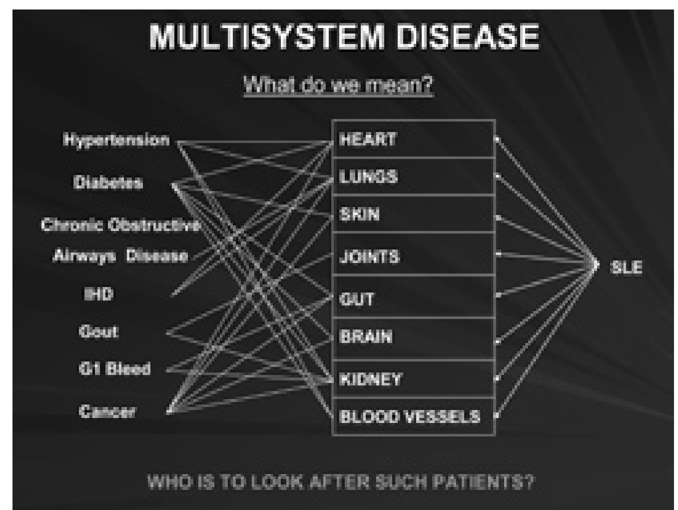
"Healthcare in the US can be a fragmented and depersonalised experience. Many patients find themselves in a nomadic environment, often shuffling among physicians who rarely communicate with each other, and have no single provider who is well informed about their overall care. Not surprisingly, patients' health care providers and purchasers all express widespread dissatisfaction in a system that while costly and technologically advanced, performs poorly on many measures of quality."

- Weiner 2004

What do we mean by multisystem disease?

It is the patient with many disorders affecting many organs, not a single disease affecting similar organs.

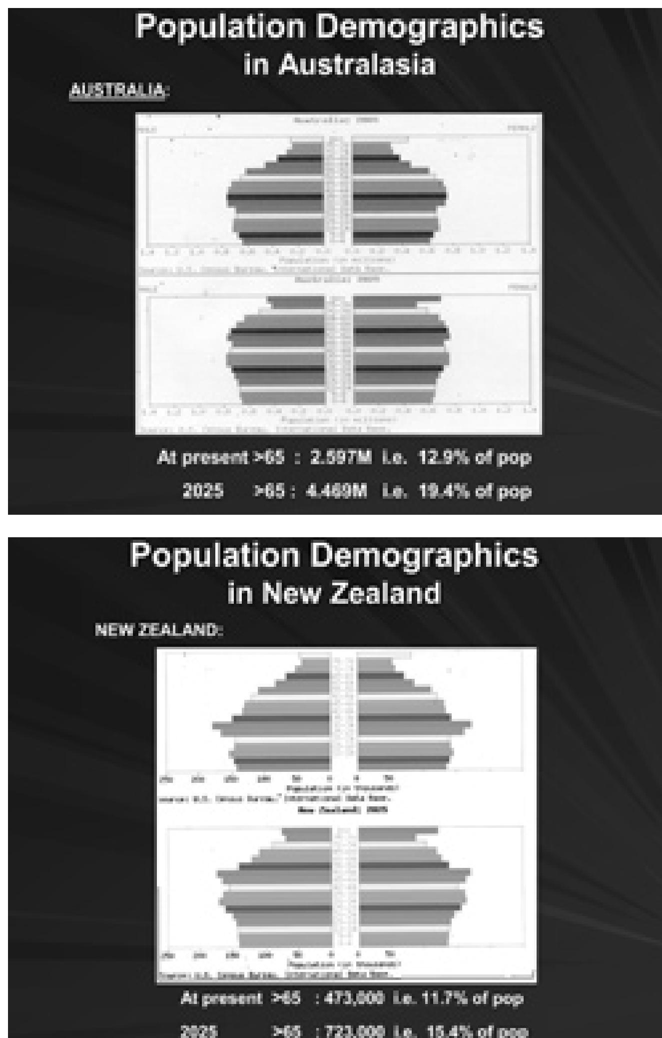
Figure 5:



Who is the best to manage these situations?

In my view it remains the General Physician. Why is a powerful medical base necessary? One has only to look at the demographics of both Australia and New Zealand to understand that many patients in the future will be older with multisystem disease.

Figure 6:



So what of the management of multisystem disease in the future?

- The majority of clinical attendances relate to chronic illness, not acute.
- Acute crises should be handled in similar fashion to all, but systems must cater for significant increase in problems related to chronic illness.
- The majority of clinical attendances are community, not hospital based.
- Need to build strong community 1º and 2º services.

If we believe that there are too many super-specialists creating an unbalanced health service, how has the imbalance come about?

It is said that "when students enter medical school, they care about the whole person, but by the time they graduate, all they care about is the hole in the person."

It would be fair to say that considerable student debt is more likely to push young graduates towards perceived high income earning specialties.

Some curricula remain very specialised and a broader view is important in the face of changing epidemiology in industrial societies. Chronic conditions not acute ailments are now the most common problems in industrial societies. We must develop a workforce best suited to cope with these changes.

The financial incentives remain in force for procedural specialties. Despite constant pleading to improve remuneration for cognitive specialties, little has been done and this remains a strong disincentive for specialties such as General Medicine.

Many decisions on hospital development have been more doctor-centred than patient centred. Although this I'm sure has resulted in wonderful departments, there is, on occasions, considerable separation between development and the public's requirements.

As our 'friend' Wayne Hill said, "Hospitals are always touted as designed for superior care, but they actually exist for the convenience of doctors."

Hospitals also have a tendency to become a little isolated for the communities' requirements and focus on day to day need.

A much closer liaison is required with the primary sector and services should be developed to support this sector.

It is interesting to note a draft Productivity Commission Report recently released in Australia, suggesting that the medical sector must increase productivity.

Commissioner Mr. Woods said, "if professionals become multi-skilled, rather than limited to one specialist area, it would allow doctors to treat a wide range of patients."

Similar comments were made as far back as 1993 in America.

"Virtually every analysis and review, including those by Government agencies, foundations and professional organisations, have concluded there are not enough practicing general physicians and too many highly specialised physicians for a rational health care system".

- Gerald Thompson 1993

"The graduate medical education system has with time become greatly misaligned with the needs of Americans".

- Jonathon Weiner 1996

Should there be more rigorous workforce planning; should the colleges be allowed to develop a workforce which may not serve the needs of the community in a balanced way.

Changing demographics demand our attention. Whatever group of physicians is thought to be best to fulfil the demands of older patients with chronic illness and multisystem disease – this group should be nurtured.

As you can suspect I think this group is the General Physicians. If not encouraged, some decisions in the future may be taken out of medical hands. Social forces and other financial forces may nudge management towards generalism.

There is little doubt the specialist directed management models have been in vogue in the past, and numerous papers suggest specialists do better in specific disease orientated conditions. Often however, we seem to be comparing apples with oranges in terms of resources.

Interestingly, several studies have shown that patients undergoing shared care (with subspec and GM input) do even better.

AACP Submission

The AACP Council has been very active over the past month developing the draft AACP Submission on new attendance items for consultant physicians and recognised equivalent specialists. It is proposed that these two new items termed 111 for Initial Comprehensive Consultant Physician Attendance and 117 for Subsequent Comprehensive Consultant Physician Review Attendance be introduced into the MBS in addition to the current 'standard' Consultation and Review item numbers 110, 116 & 119. There have been no new MBS items for consultant physician and paediatrician consultations in the past 22 years - since 1984!

The Australian Government, together with the Department of Health and Ageing recognise that there is an impending medical workforce crisis with inadequate numbers of consultant physicians and paediatricians willing to undertake the essential role of consultant practice. The majority of new Fellows of the Royal Australasian College of Physicians are instead pursuing careers involving procedural medicine specialties. It is anticipated that the AACP Submission to increase the value of the attendance items for consultant physicians will help provide the much needed increase in the number of consultant physicians and paediatricians willing to enter consultant practice. In turn, it is hoped the number of consultant physicians and paediatricians entering practices in outer metropolitan, regional, rural and remote areas will also increase.

Background briefings have been undertaken with the Minister's office and with the Secretary of the Department of Health and Ageing and officers in her Department. The Department's response has been encouraging and has generated considerable interest in and discussion of our draft proposal. However, there is still considerable work to be done in response to the Department's suggestions before the final Submission is made to the Minister for Health and Ageing.

AACP Membership

The AACP (founded in 1989) is recognised as the peak body representing Consultant Physicians and Paediatricians, and Faculty and Chapter Fellows in matters of economic and related workforce issues.

I encourage all College Fellows from the Divisions of Adult Medicine and Paediatrics & Child Health, and all Faculties and Chapters to join the AACP. There is strength in numbers and the correlation between the size of our membership (currently 967) and the extent of influence we have as an Association presenting a case such as we have in the present Submission, is considerable.

Please contact Ms Jenny Pigott at the AACP Secretariat on (02) 9810 0061, or email secretariat@aus-physicans.com.au for all enquiries and to receive an Application for Membership form.

We need your membership!

DR LESLIE E BOLITHO
President, AACP
lbolitho@lesbolitho.com.au
lbolitho@aus-physicians.com.au
July 2006

From page 9

The Generalist approach does not deny the value of subspecialty care, nor the skill of the "specialist within", which can offer expertise and unique services to patients with chronic illness, but General Medicine can remain the co-ordinator and integrator of specialty care.

Ecologist Garrett Hardin discussed the dilemma faced by herdsmen sharing a common grazing area. As long as the number of animals relative to the size of the field is not exceeded, the herdsmen can increase capacity without harm. Once capacity is exceeded, harm results.

He argued, resources are finite, with rapidly growing demand, and professionals and consumers need to work together, to ensure availability of information that will permit decisions that are in the best interests of society.

So what will be needed in the future to manage multisystem disease in Australasia?

We will need to enhance the primary care sector.

We will need to build up a physician base, skilled in the management of multisystem disease.

We must provide accessible outpatient services at a secondary level, to cope with increasing demands of chronic illness.

We must collaboratively work together with Emergency Medicine and other specialties in hospital settings and refer appropriately and we must provide settings in hospital to allow best process in acute care.

Organisation and working are strongly influenced by the establishment culture of a hospital, its history, its staffing and professional relationships, and personalities within.
But whatever the particular circumstances and characteristics of a service, it must be designed for the needs of the patients who use it.

– RACP Working Party 2002

So the final questions that must be asked and answered are…

- How can we make the benefits of basic and specialist health care accessible to all patients?
- How can the needs and services be best matched to the work force?
- If the current workforce is inappropriate for such needs and services, how best can this be remedied?

The success or otherwise of specialty physician services throughout Australasia depends on solutions being found. As Ferrier said last year, "The demands of a fragmented non-system can no longer be the dominant force in practice reorganisation - the design must address itself to the needs of patients and populations".

JOHN HENLEY
Auckland NZ

TRAINING GENERAL PHYSICIANS FOR FIJI AND THE PACIFIC

Each year AusAID sponsors two visitors to assist with teaching on The Pacific Master of Medicine (Internal Medicine) training programme based at the Fiji School of Medicine in Suva. This programme aims to increase the number of Pacific doctors trained in Internal Medicine, and thus to decrease reliance on expatriate doctors who may not be aware of the needs and constraints of practice in the region. An invitation from Prof Rob Moulds, IMSANZ member, and Head of the Department of Medicine at the School, created an opportunity to escape the cold in May for two wonderful weeks of clinical and academic activities.

The Master's trainees participate in a comprehensive, structured four year programme. This combines supervised hospital and outpatient practice with a parallel programme of core study modules and clinical skills training. Assessments include written exams, short cases (at the end of year 3), a pathology viva, a project and completion of a logbook of procedural skills. In addition to medical expert knowledge and highly developed professional skills, graduates are expected to be capable of providing leadership in their communities and to have management and public health expertise. There are currently six students in the second and third years of the Master's programme, two men from Fiji, two women from the Federated States of Micronesia, and one woman from each of Tonga and the Solomon Islands. These trainees currently function as medical registrars for the hospital in Suva. The programme ensures that at the end of training they are clinically very experienced.

As with RACP basic trainees, they were keen to work on their short case performance, especially with someone different! We had four very enjoyable sessions together, with no lack of suitable cases on which to hone our collective skills.

The hospital ward rounds with Rob's team were an intense experience for me, coming being from the shelter of a major metropolitan teaching hospital with all subspecialties "on tap". I've heard Steve Brady in Alice Springs say "we have to be able to look after anything for one day." In Fiji, this might well be "we have to look after anything medical, for as long as it takes." As the physicians take great care to keep up to date with best international practice, this care is often provided knowing that their patients might have a greater range of options overseas. The predictable difficulties with long term disease management created by social and geographic factors and lack of a comprehensive primary care infrastructure, mean that managing the outpatient population is a complex feature of the work.

Four teams look after all of the medical inpatients, with backup from a small ICU. The casemix encompasses the western world gamut of vascular diseases, heart failure, diabetes, PE, pneumonia, electrolyte disturbances, asthma and COPD, along with diseases of developing countries and everything that might elsewhere go to subspecialists. In those two weeks some notable cases were TB (several), varicella pneumonia, typhoid, meningitis in an HIV patient, CML, end stage myelofibrosis, SLE, CAPD peritonitis (CAPD privately obtained as there is no chronic dialysis provision in Fiji), a huge frontal lobe tumour in a Vanuatu student, prosthetic valve endocarditis, disseminated malignancies, hepatic failure, a massive (fatal) GI bleed in young man, and paraquat poisoning. Diagnosis and management of new pleural effusions happened several times per week.

In terms of pharmaceuticals available, there is an 'essential medicines' register, from which medicines may be prescribed at no cost to the patient. In general there is one medicine available per class. This register was developed by Prof Rob Moulds and does have the benefit that the available medicines are used very (cost) effectively. There is a wider range of medicines available privately, and a pleasant surprise was that imatinib (Glivec) was available free via an international agency for the few patients with Philadelphia +ve CML.

Shaun Flint, Joji Malani, Mrs Malani, Rob Moulds, Phillippa Poole and Anne Drake.

Future faces of Pacific medicine - Simi, Veisinia, Elisabeth, Lilly and Beth.

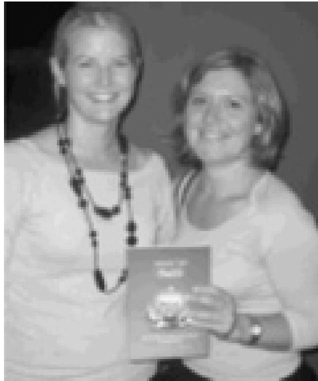
The medical teams work closely and meet on at least three occasions per week at shared XRay and pathology meetings, and a weekly unit meeting. Once a month there is a careful and frank review of all inpatient deaths at a mortality meeting. There are two grand rounds per week for all hospital staff. On the ward rounds medical students get to provide a summary and update of each case (some getting to the hospital at 0530 to prepare their presentations). All the meetings afforded excellent learning opportunities – junior staff had to present the salient patient details, leaving others to come up with a differential diagnosis before the relevant radiology or pathology was presented. Then usually followed a facilitated discussion on management – with a well -developed ethos on continuing to integrate best international practice guidelines / evidence into patient care within local resourcing and system constraints. As well as generating an excellent learning environment, the consultants used these shared opportunities to discuss their most difficult cases. There were more than a few! As a consequence the unit seemed to have retained a cohesiveness that is hard to maintain in big city medical units.

During one of the department meetings we discussed what IMSANZ might offer the Pacific physicians and trainees. It was

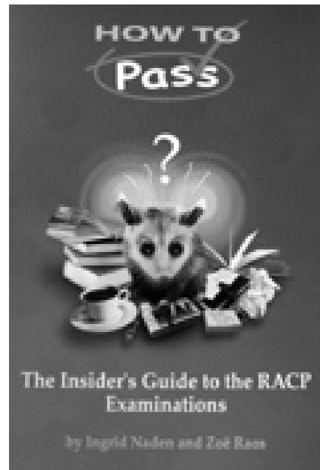
Continued page 12

‘HOW TO PASS’

An Insider’s Guide to the RACP Examinations



Ingrid Naden and Zoë Raos at the launch of ‘How to Pass’ at the CEC.



The Royal Australasian College of Physicians written and clinical examinations are very challenging. “It was the worst year of my life” is a widely heard sentiment from medical registrars, as they look back on their experiences.

Hopefully, the path to these gruelling exams will be made easier with the release of Australasia’s first purpose-written survival guide. ‘How to Pass: An insider’s guide to the RACP examinations’ is the brainchild of Zoë Raos and Ingrid Naden, who wrote the book in conjunction with the Clinical Education and Training Unit (CETU) at Auckland District Health Board. With a pass rate that varies from 50-70%, the RACP exams are notoriously hard. Ingrid Naden states “… we thought, let’s make it easier and help people to make the most of the time involved.”

While there is no substitute for practice and preparation, “there were simple strategies that saved us time, helped us cope and guaranteed extra marks”, explains Zoë. “There are excellent texts and websites out there, but so much key advice was from seniors in the coffee line or over lunch. Ingrid and I really wanted to put these pearls of wisdom in one place.”

Zoë and Ingrid based “How to Pass’ on their own experience, tips gathered from previous candidates past together with crucial advice from many RACP examiners. The book aims to guide a candidate through the whole process, from getting started in the written exam, dealing with stress, book reviews and course reviews right through to preparing for short and long cases, how to present a case and what to wear for the clinical exam. “A lot of what got us through the hard times was the knowledge that others had survived before us. We hope that our book will help the next group of candidates to understand that they are not alone!” says Ingrid.

The project took a year of hard work to complete, “but it was nothing compared to studying!”. Ingrid and Zoë are extremely grateful to their editor, Pat Starkey, who demonstrated that it was indeed possible to say something in less than 15 lines.

‘How to Pass’ will be distributed in hospitals throughout the country and is available by emailing Pat Starkey at CETU - pstarkey@adhb.govt.nz. Ingrid and Zoë would be delighted to hear any feedback from candidates past or future, as they work towards the next edition - zoe_raos@yahoo.co.nz.

Although it was the worst year of her life, Zoë believes that “those exams really did make me a better doctor”, Ingrid adding “I wish that this book had been around when I was doing it”.

From page 11

appreciated that there would be CME and collegial benefits from joining IMSANZ. Rob Moulds has offered to be the liaison person on behalf of the group. While technically fitting into the current ‘overseas’ membership category, Rob and my preference is to propose separate Pacific membership and associate membership categories of IMSANZ, with the possible future formation of a Pacific Chapter. We may also look again to holding an IMSANZ meeting in the Pacific region. To take account of the differing economies, it is proposed that membership fees for these 10-20 physicians and trainees be half those of Australian and NZ members. As our next AGM is not until September 2007, the proposal will be put to an IMSANZ Extraordinary General Meeting at Queenstown in Sept 2006.

The mood in Fiji was positive and optimistic. The visit coincided with the win by the Fiji Sevens team in the IRB series and the opening of the new multi party cabinet Parliament. The tendency in NZ for the national mood to mirror that of the rugby team’s performance pales in comparison to that seen in Fiji. After two coups, the people are determined to see the new government succeed, although the difficulties of ruling by several parties divided along largely racial lines are not to be underestimated.

My grateful thanks are due to Rob Moulds and his colleagues Drs Joji Malani, Anne Drake, and Shaun Flint at the School of Medicine, plus the other physicians at Colonial War Memorial Hospital in Suva (Drs Rao, Allan and May). Thanks also to the Master’s physician trainees Mua, Simi, Veisinia, Lilly, Beth and

Signs of an attack on the high smoking rates in Fiji. Nabila village won a WHO smoke free award in 2006.

Elisabeth for the privilege of being involved in their training. As an aside, Shaun Flint is an RACP advanced trainee from Melbourne who decided to take a year out of his training. He appears to be relishing the clinical and research opportunities afforded him in Fiji; something to consider!

I very much look forward to formalising IMSANZ links with the Pacific physicians and to assisting them in all their endeavours.

Vinaka vaka levu.

PHILLIPPA POOLE

BARRIERS TO TRAINING IN GEN. MEDICINE

Perspectives from Both Sides of the Fence

Below are reproductions of two e-mails generated shortly after a debate at the RACP Specialties Board meeting on March 10, 2006 relating to the barriers to training in general medicine as perceived by a Sydney based endocrinologist Dr Mark McLean and a Brisbane based general physician Dr Ian Scott.

Dear Ian.

After the Specialties Board meeting I promised to email some comments - sorry for the delay. There is no doubt that we need to see more people training towards a generalist career, and you have provided a very compelling analysis of the workforce consequences of the shortfall in general physicians. I would like to comment on 2 points.

Firstly, on your suggestion that the specialty societies encourage exposure of general medicine trainees to subspecialty training rotations for their elective (non-core) training. This is a good idea, but there are practical issues that will discourage it, at least in my specialty of Diabetes and Endocrinology. I am on our SAC and on the committee that manages centralized allocation of advanced trainee (AT) positions in NSW each year. We have about 24 core AT jobs to fill in NSW each year and always have an excess of applicants. So placing a general medicine trainee in one of those positions will be at the expense of an endocrine vocational trainee. I know the situation is essentially the same in Victoria, and I doubt there are many unfilled positions in the other states. However, I am sure there is extra training capacity in the system, but the hospitals will not provide funding for extra training positions. At our hospital we often have an overseas fellow or other supernumerary trainee who is self-funding or sponsored from their own country. We have more than enough work to give that person very good experience and supervision. Many other hospital departments could do this also if the additional trainee salary was funded from outside their department. I am sure many would be keen to have a general medicine trainee working with them if they didn't need to find the money to pay the salary, or displace a specialty vocational AT. So, I think your main challenge is to find money - then the training positions will probably be easy to create. Could IMSANZ create scholarships or training fellowships for general trainees who want to spend 6-12 months attached to a subspecialty unit? You could try making a case to the Commonwealth to fund positions, or attract the pharmaceutical industry money to create fellowships. I am sure many teaching hospital subspecialty units would then fall over each other to accept these trainees in their department if it meant they could have a free extra senior registrar.

On another issue, I am also director of physician training (DPT) at Westmead - the largest hospital in NSW. Like many teaching hospitals our Department of Medicine (>150 physicians) is completely subdivided into specialties and there are no card-carrying generalists in the whole place (a bad thing in my opinion, but a fact of life). Consequently, the SAC in General Medicine currently views us (and most NSW tertiary hospitals) as a place which is incapable of offering core training in General Medicine. I would argue that there is a wealth of clinical experience to be gained at places like this - no less valuable for a doctor intending to end up as a general physician practicing in a regional or rural centre. We also have affiliated secondment hospitals in our training network that have a General Medicine unit. It should be possible to create an appropriate rotation of subspecialty terms, combined with peripheral general medicine terms, that would represent good "core" training in General Medicine. It could be supervised by someone with a broad view of Medicine (eg the Professor of Medicine, the DPT, DAT or network DPT) even if that supervisor happens to be a sub-specialist. But as things stand at the moment such an arrangement is not acceptable as core training. I know you said "just change the name of a department to General Medicine" - but surely it is not the name that matters. If the content and supervision is good shouldn't that be acceptable?

I think some of these [IMSANZ and General Medicine SAC] policies are actually causing a barrier to the provision of training to intending generalists. I don't want to start a fight about it, I am just trying to highlight some issues from the other side of the fence. It is actually a pity that a fence even seems to exist. My interjection about this at the meeting probably appeared hostile - I apologize because that was not my intention.

Best wishes,

Dr Mark McLean

Staff Specialist,
Department of Diabetes & Endocrinology
Westmead Hospital
Westmead (Sydney) NSW

In reply

Thanks Mark for your comments. In regards to your first point, I would like to see the push for more AT positions in general medicine to be seen as "our" challenge (ie the college and all specialty societies together including IMSANZ) not "your" challenge (ie IMSANZ acting alone). If there is agreement among many of us that we need more generalists then we should all be lobbying hospitals and government for more training positions (we are doing just that with a letter co-signed by RACP president Jill Sewell going out to all health ministers and hospital CEOs requesting more training positions in general medicine), and then quarantining a number of these for ATs in General Medicine. In my institution (Princess Alexandra Hospital) we have created additional subspecialty rotations for use by both basic trainees and ATs in general medicine. Yes, subspecialty directors will always like to fill these positions with vocational ATs but if we all believe in promoting more generalism then that's what has to be done I feel.

As for IMSANZ paying for fellowships, or trying to attract funding from pharmaceutical industry, I do not think this will work, nor do I necessarily agree with the sentiment that our society, or commercial interests, should be expected to pay for our clinically practising trainees (not research fellows) to be properly trained whereas no other specialty has to do this. These would be adhoc positions for which we, as a not particularly wealthy society, could not ensure continuity from year to year. If we could get all physicians who practice and believe in generalism to vote with their wallets and become a paying member of our society, it might become a more viable proposition.

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POSITION VACANT

ADVANCED TRAINING GENERAL MEDICINE ROYAL DARWIN HOSPITAL

The Royal Darwin Hospital is a level 2 teaching hospital accredited for advanced training in general medicine and for one year of advanced training in each of endocrinology, nephrology and infectious diseases. Trainees pursuing dual qualification ie general medicine plus a subspecialty area of expertise are welcomed as are those whose interest is a career in pure general medicine.

Advanced trainees in general medicine, infectious diseases, cardiology and endocrinology are currently working at the Royal Darwin Hospital. There is an advanced training position in nephrology being filled by rotating advanced trainees in general medicine

General medicine trainees can expect to rotate through a combination of general medicine/endocrinology, general medicine/neurology and general medicine/infectious diseases terms. Three to six month rotations are also available in cardiology, palliative care medicine and nephrology. Outpatient nephrology clinics to remote satellite dialysis units such as those on the Tiwi Islands are proving to be popular amongst trainees. During this term trainees have unparalleled exposure to the management of chronic kidney disease and issues surrounding indigenous transplantation and dialysis access as they relate to people living in remote Australia. Six month rotations are encouraged through combined general medicine and haematology/oncology. Whilst in haematology, there is an emphasis on providing laboratory teaching time to complement clinical ward exposure.

For advanced trainees only who are interested in and dedicated to a future in rural and remote health, remote area clinics can be arranged on a case-by-case basis.

An onsite lecture series provides instruction in general medicine specific to medical practice in the Northern Territory. Snake Bite, melioidosis, imported malaria, basic malaria microscopy and the public health responsibilities of the physician are examples of topics covered in this series.

Contact: Emma Spencer, Physician
Royal Darwin Hospital
Tel: 08 8922 8888 (page 542)
Email: Emma.Spencer@nt.gov.au

As for accredited time in general medicine, I'm afraid that we must reiterate our stance that core time in general medicine for 12 months (although we are considering reducing this to 6 months for trainees who choose to undertake dual training) must be spent in an accredited general medicine unit which, I don't disagree, could very well be in a regional centre (and we have a number of NSW hospitals that have been accredited in this regard). However secondment hospitals in which there is no established general medicine unit with a general physician supervisor are not acceptable. Also, the training program supervisor must be a general physician and the program has to be prospectively accredited by our SAC. I do not dispute the view that many patients looked after in other subspecialties have multi-system problems that can act as foci for learning and training in general medicine, and which could constitute rotations for advanced trainees in general medicine in addition to the time spent in a general medicine unit.
What I and the SAC in General Medicine are not so sure about is whether the supervising subspecialty consultants (especially in large tertiary hospitals) are in a position to determine whether the AT in general medicine in their unit has achieved the necessary competencies to be able to undertake acute on-call as a general physician in a hospital setting (which is what they must be able to do) if there was no minimum time spent in an accredited general medicine unit which undertakes such duties. Anecdotal evidence of haematologists and neurologists being placed on acute general on-take in some Sydney hospitals who can't read an ECG would make your head spin. It may be that your experience in D&E and interest in general medicine may qualify you to do this very well but our SAC must have some assurance this is the case, and for that reason the supervisor has to be a general physician who can look critically at the quality of the term and the supervising consultants. Relying on a DPT or other person who may have no or few competencies in acute general medicine to certify the standard of training in general medicine is not acceptable, and no subspecialty SAC would accept this approach. If, however, you and your departmental colleagues participate in acute general medicine on-take and do clinics and consultations which have a broad multisystem approach, then we would be more than happy to consider accrediting your unit for advanced training in general medicine. If such accreditation is forthcoming, then a logical next step would be to consider renaming your department D&E and General Medicine, and this was the thinking underpinning my suggestion at the meeting.

We are not trying to set up barriers to trainees wishing to undertake training in general medicine but we must insist on certain minimum standards, and we should have the right, as does every other SAC, to determine and accredit our own training program. Your lament of no generalists at Westmead 'as a fact of life' is something we must turn around and I invite you and any of your colleagues who are interested in promoting general medicine to join our society and together we can work towards constructing new training paths. If you would like to know more about our society's activities or access membership forms, our website is: www.imsanz.org.au.

Best regards,

Ian Scott

My Thoughts

As a new fellow, the Congress in Cairns was rather special for me. Naturally, the ceremony for formal admission of new fellows was a major reason for my attendance. No doubt this is always a special occasion for new fellows and their families. However, those in attendance would probably agree that Jill Sewell brought to the occasion very genuine warmth. Despite the large numbers, her welcome felt real and personal, further enhancing a formal and traditional occasion. Her acknowledgement of the support provided by families of trainees was well received by my family, and I'm sure we were not alone in that. The welcoming of new fellows and the presentation of awards was followed by her welcoming of the new president, Napier Thomson.

The Arthur E Mills Oration delivered by Noel Pearson, certainly provided food for thought. It was challenging to hear an indigenous Australian outline the grave situation in Northern Australia. He also expressed the hope that medical graduates could have both competence and cultural sensitivity, a sentiment reiterated in the Priscilla Kincaid-Smith Oration, delivered by Richard Larkins. Richard's insights into tertiary education were fascinating and somewhat disturbing. The reality of Australia's declining financial investment in tertiary education is something we should all be alarmed at. Quoting Donald Horne's "The Lucky Country" he expertly outlined our failure to transform into "The Clever Country".

The exchange of ideas is an obvious benefit of scientific meetings. There was a breadth of topics on order at Congress: from the politics of healthcare and the development of a new physician training curriculum; to the more conventional updates of management in specialty areas. However, I believe that the experience of these meetings is more than just a process of obtaining facts about the latest developments. I am always pleasantly surprised by my renewed enthusiasm when I return home. It seems that the opportunity to meet and hear about the work of colleagues is both stimulating and refreshing. Unarguably time away from the usual work pressures is also beneficial, allowing reflection and broadening of horizons.

The humorous side of RACP members was well evident in the History of Medicine Library Debate. Special mention goes to both Phillippa Poole for her Olympic medallist outfit and Jill Sewell for her "hippy chick" rendition of a baby boomer. For my money Richmond Jeremy made a very convincing William Osler, until his moustache came loose! Despite the entertainment, the serious side to the debate was a topic dear to the heart of IMSANZ members ("That the future of medicine is sub-specialisation; the generalist belongs to the past") and I believe the case for the negative was made most convincingly, despite the shocking attire of the debators.

There was a lot of talk about the workforce shortages which physicians are facing, particularly in the face of an aging population. This is something which has been a problem in rural areas for some time. I was interested to hear of the approach of physicians working in these grossly understaffed areas, where it is clearly not possible to see all patients directly. The development by Physicians, of models of care which can be transferred to the community setting appears to be a solution which could be applied to rural and metropolitan areas.

Finally, I would encourage all General Medicine trainees to consider attending future Congress and IMSANZ ASM meetings. Financial support is usually available from your hospitals, particularly if you take the opportunity to present your advanced trainee projects in the form of oral presentations or abstracts. Trainees should talk to their supervisors (and supervisors should encourage their trainees). Check the IMSANZ website and newsletters for upcoming events. See you at the next one!

JO THOMAS
IMSANZ Advanced Trainee representative

VACANCY FOR GENERAL PHYSICIAN DEPARTMENT OF INTERNAL MEDICINE

(Part-time Specialist/Visiting Medical Officer)
Princess Alexandra Hospital, Brisbane, Queensland.

Join a dynamic department of committed general physicians in a large metropolitan tertiary hospital located in the fast growing southeast corner of the Sunshine State. Areas of interest include acute stroke medicine, geriatric medicine, endocrinology, peri-operative medicine, clinical pharmacology, clinical epidemiology, and quality improvement science. A new Acute Medical Assessment and Planning Unit co-located with the Emergency Department is planned to open in 2008 as an extension to the department.

For further information contact: Dr Ian Scott, Director of Internal Medicine on 07 3240 7355 or email ian_scott@health.qld.gov.au

RESTORING THE BALANCE

Progress Report

The last 4 months has seen further large-scale responses to release of the joint RACP-IMSANZ position statement *Restoring the Balance (RtB) – An action plan for ensuring equitable delivery of consultant general medical services in Australia and New Zealand 2005-2008.* The document had already received coverage in the widely distributed health newsmagazine *Australian Doctor* which ran a feature article reporting our statistics on an impending shortage of general physicians and outlining our stated reasons for this shortage (Sept 2, 2005, 'Warning on general physicians').

More recently, immediate past RACP president Jill Sewell wrote in the *Medical Journal of Australia* (2006; 185:23-24) in an article entitled 'Task transfer: the view of the RACP' that "…the RACP is concerned that the balance between generalist physician and specialist physician skills has moved too far towards the latter. The College has been in discussion with senior health department bureaucrats in all states and territories about their future requirements for employment of physicians with generalist skills in acute care settings. These include general physicians and specialist physicians with a continuing role in generalist care. An action plan *Restoring the balance* has been developed with the Internal Medicine Society of Australia and New Zealand (cited in references with weblink). The strategic actions include: promoting departments of general medicine (or combined departments of general medicine and other subspecialties) and acute medical wards in teaching hospitals; improving physician training and continuing professional development in general medicine; improving outer metropolitan, regional, rural and remote services in general medicine; and raising the incentives for non-procedural physician practice…..'(p. 23)

In early May, IMSANZ distributed an open letter, signed by Phillippa Poole, Ian Scott and Jill Sewell, to all state and territory health ministers and directors general of health, and their New Zealand counterparts, calling them to be aware of the imminent crisis facing regional and rural communities in regards to access to specialist care because of a rapidly declining general physician workforce, and to pursue recommendations contained within *RtB* for ameliorating this worsening shortage. A copy of the executive summary from *RtB* was appended to the letter and the mail-out included hard copies of the full document. At the time of writing, the responses have been as follows:

- In Queensland, the Director-General of Health, Uschi Schreiber, wrote that copies of the letter had been distributed with a ministerial request for reply to all area health service heads and executive directors of medical services. The feedback received was 'extremely positive' with strong endorsement of recommendations contained within RtB. She indicated '… Queensland Health (QH) certainly recognises the need to take proactive steps to improve the situation with the general physician workforce within QH.' She committed QH to progressing several initiatives in the short term: 1) establishing a general medicine collaborative with a view to working towards the establishment of a general medicine clinical network in the longer term; 2) establishing a clinical training network for general medicine; 3) creating some protected subspecialty training posts for general medicine trainees in line with the College/Society's strategy; and 4) exploring work practice changes that may make general medicine more attractive as a specialty. She asked to hold a meeting with college, society and other relevant department officers to further discuss these initiatives.
- In NSW, the Director General of Health has forwarded the letter to all hospital chief executives and has requested another 30 copies of *RtB* to circulate to other key stakeholders.
- In WA, the Minister for Health Mr Jim McGinty replied to newly inaugurated RACP president Nip Thomson that a restructuring of health services was under way under the auspices of the Health Reform Implementation Taskforce which included expansion of general medical services in outer metropolitan and regional hospitals which, in turn, would necessitate employment of more general physicians. After receiving our letter and a copy of *RtB* he conferred with state RACP and IMSANZ representatives on what could be done further to assist this restructuring, and sought to engage in the near future with us at the national level.
- In the ACT, the Minister for Health, Katy Gallagher, circulated the position statement to the ACT Health Chief Executive and relevant senior department officers involved in workforce

A NEW JOURNAL

The Canadian Society of Internal Medicine is excited to announce the launch of its new Journal - the Canadian Journal of General Internal Medicine.

Watch for your copy in October 2006. The CJGIM will have many regular features from The General Internist along with an expanded focus on scientific research and review.

This new Journal needs your input. The CJGIM requires your submissions and feedback. You are invited to submit research, clinical articles, letters or commentary.

Please send your submissions and suggestions to csim@rcpsc.edu.

Dr Hector Baillie, Editor-in-Chief

The latest postings include:

- Call for Papers and Registration brochures as well as other weblinks for the forthcoming RACP/IMSANZ/ANZSN conference in Queenstown, September 20-22, 2006.
- Registration brochure and links for the North Queensland Physicians Conference, Cairns, September 1-2, 2006
- New Guidelines for Advanced Training in General Medicine commencing 2007, released from the SAC in General Medicine.
- New Critically Appraised Topics (CATs) with the following titles:
    - Ambulatory BP measurement more predictive of risk than clinic measurements
    - Aspirin and dipyridamole better than aspirin alone following cerebral ischemia (ESPRIT)
    - Beta-blockers do not prevent gastroesophageal varices in cirrhosis
    - Blood testing in hospital can cause anaemia
    - Clopidogrel plus aspirin inferior to warfarin in preventing vascular events in patients with non-rheumatic atrial fibrillation (ACTIVE W)
    - Clopidogrel and aspirin no better than aspirin alone in preventing events in high-risk vascular patients (CHARISMA)
    - Early initiation of statins following acute coronary syndromes does not reduce short-term risk
    - Eight clinical findings distinguish stroke from stroke mimics
    - Enoxaparin better than heparin for STEMI (ExTRACT-TIMI 25)
    - FOBT screening does not reduce all-cause mortality
    - Fondaparinux reduces mortality in patients with STEMI (OASIS-6)
    - Interferon-gamma reduces mortality in idiopathic pulmonary fibrosis
    - Lowering homocysteine levels with folate does not reduce CVD risk (HOPE 2)
    - MRI not accurate for diagnosis of multiple sclerosis
    - Omega 3 fats do not affect mortality or cardiovascular risk
    - Proteinuria on urinalysis adds to renal function in predicting worse outcome in patients with coronary artery disease (CARE)
    - Rescue angioplasty better than repeat lysis following failed thrombolysis in STEMI (REACT)
    - Risk of chronic atrial fibrillation following paroxysmal episodes
    - Risk of osteonecrosis of the jaws with bisphosphonate therapy
    - Self-monitoring anticoagulation better than clinics for preventing VTE

From page 16

planning. IMSANZ councillor Mary-Ann Ryall advises that she will confer with the newly appointed Director of Appointments and Training Unit of ACT Health in ensuring he makes the enactment of RtB recommendations one of his first priorities.

- No responses have been received from Victoria, South Australia or the Northern Territory. Justin La Brooy (Adelaide) advises that he is aware the document having been circulated to senior hospital managers.
- The Ministry of Health in New Zealand advised that a report of the Doctors in Training Workforce Roundtable was recently released and it contained reference to the RACP/IMSANZ position paper *Restoring the Balance.* The Minister of Health Hon Pete Hodgson is establishing a new committee to advise him on implementation of the Roundtable's recommendations and will be sure to provide copies of the IMSANZ letter to the committee.

The RACP/IMSANZ RtB Implementation Committee held its most recent meeting on June 30 and is continuing to progress the development of a position statement around the development of alternative clinical training pathways within the advanced training program that would allow more generalism across all subspecialty training. The enactment of such pathways would be supported by all teaching hospitals having a Department of General Medicine, Internal Medicine or equivalent. The statement recommends that the Specialist Advisory Committees indicate that they will allow trainees to spend the elective year outside the chosen subspecialty if trainees so wish. Depending on the intended practice setting, this might comprise two six-month terms in subspecialties other than the primary subspecialty, or six to twelve months in general medicine. Furthermore, those who complete approved training and subsequently practise predominantly but not exclusively within a particular subspecialty should still be welcome as full members of the relevant sub-specialist society. The statement also recommends that, within their local training arrangements, Departments/Units make a proportion of training positions available to advanced trainees from outside the subspecialty. An earlier draft of this statement has been circulated to some RACP state committees, in combination with copies of RtB, and the Queensland committee at least has written to the college indicating its unanimous support for both documents. The final version of the statement will be presented to the Specialties Board for endorsement on September 15, and to the Education Strategy Implementation Board following that.

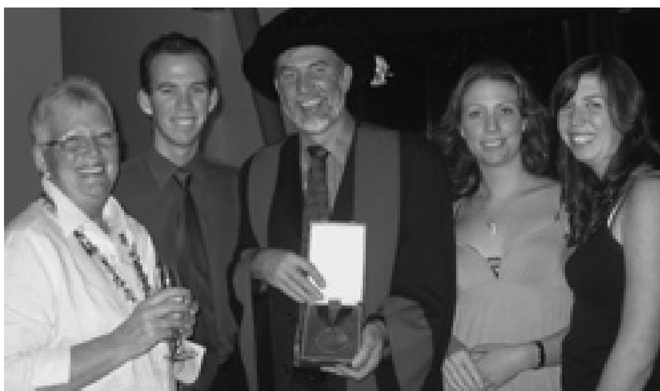
The progress to date is encouraging but more needs to be achieved if the impending crisis in regional and rural general medicine services is to be averted. Watch this space and please let us know of any further local developments that may assist the cause.

IAN SCOTT

ROUND-UP OF CAIRNS 2006

The Cairns meeting proved successful with a very well received Adult Medicine program, thanks to the efforts of the IMSANZ organising team comprising Peter Boyd, Clive Hadfield, Martin Brigden, Ian Scott, and Mary Fitzgerald. Meeting highlights included:

- College ceremony awarding of RACP Medal to former IMSANZ president Dr Leslie Bolitho his contributions to Regional and Rural Medicine. Les' achievements in rural medicine are profiled on *page 2* of this issue.
- History of Medicine Library debate titled: "That the future is sub-specialisation; the generalist belongs to the past." The affirmative team comprised former RACP president Robin Mortimer, IMSANZ's own Leonie Callaway (boooo!!!!!), and Peter Goss. The negative team included immediate past RACP president Jill Sewell, IMSANZ president Phillippa Poole, and past CSANZ president Richmond Jeremy. The negative team added some colour and humour to the debate with Jill dressing up as a 'baby boomer' gone retro with '60s style dress, Phillippa doning sportsgear as the 'decathlete' in medicine, and Richmond impersonating that quintessential general physician, Sir William Osler. The debate was moderated by IMSANZ member and RACP president-elect Geoff Metz with the winning team being chosen using a rigorously objective method – the loudness and duration of audience applause. We are pleased to report that the negative team won resoundingly and proved beyond reasonable doubt that the future very much needs general physicians.



Bolitho Family celebrating Les' RACP Medal in Cairns.

That the future is sub-specialisation; the generalist belongs to the past debate.

- The IMSANZ Free Papers session attracted 6 high quality presentations from advanced trainees and deciding a winner of the IMSANZ/Roche Advanced Trainee Award proved a very difficult task for the judges. Dr Leon Fisher, formerly from the Canberra Hospital, was successful with his presentation of a controlled study assessing the efficacy of prophylactic use of proton-pump inhibitor in 415 elderly patients undergoing hip fracture surgery in reducing risk of peri-operative gastrointestinal haemorrhage. The abstract of his talk will be published in a forthcoming issue of *Internal Medicine Journal* and his full presentation will be posted on the college website.

Trevor Thornell, Leon Fisher and Phillippa Poole.

- Sessions sponsored, chaired or involving IMSANZ members which proved of great interest included:
    - Workshop on achieving better practice which featured presentations on use of clinical indicators to close evidence-practice gaps (Ian Scott-IMSANZ), a toolkit to support measurement in clinical practice (Caroline Brand), engaging physicians in quality improvement (Grant Phelps-IMSANZ), and redesigning general medicine services at Flinders (Campbell Thompson).
    - Symposium on improving quality and safety that featured Prof Bruce Barraclough (former chair of the Australian Council for Quality and Safety in Health Care) outlining work undertaken by the ACQSHC over the last 10 years, Peter Cameron (Emergency physician, Alfred Hospital) describing maleffects of hospital overcrowding on patient health, Stephen Duckett (Director Reform and Development,

Ian Scott, Bruce Barraclough, Stephen Duckett, Nip Thomson and Peter Cameron.

Queensland Health) detailing his initiatives in reforming the public health system in Queensland and Nip Thomson (president RACP) presenting what the RACP is doing to enhance quality and safety.
    - Symposium on peri-operative medicine which featured interesting talks on assessment and management of peri-operative cardiovascular risk (Prof Tom Marwick), pre-operative DVT prophylaxis and anticoagulation issues (Doug Coghlan) and peri-operative respiratory evaluation and optimisation (Robert Lodge, IMSANZ).
    - 'Trials on trial' session dealing with the topic 'Clinical studies and trials: Answering questions we never thought to ask' presented by Prof John Funder AO.
    - Conjoint sessions involving IMSANZ and the Faculty of Occupational Medicine which featured presentations on the vocational consequences and options for management following an initial presentation of epilepsy, debate on whether aviation medicine was too broad a topic to fit within the confines of occupational medicine, and the interface between military medicine and toxicology in regards to health surveillance programs, determining fitness to work in the military, effects of uranium exposure, and use of alcohol as a chemo-prophylactic agent for combat troops in preventing post-traumatic stress syndrome.
    - Sunrise 'meet the expert' sessions which included talks from IMSANZ members Clive Hadfield (experiences in outreach medicine in the Cape) and Peter Boyd (update in GI bleeding).
    - A Rural Medicine symposium featured presentations by Stephen Brady, Martin Brigden, and Graeme Maguire on workforce and practice issues integral to rural practice, and Les Bolitho talked to the challenging topic of credentialing and privileging in Victoria.
    - Clinical Quiz led by that magical quizmaster Ramesh Nagappan.
- The Adult Medicine dinner held at the Grand Ballroom of the Hilton Cairns Hotel capped off a very convivial conference with Mary Fitzgerald being thanked and presented with a gift for her tireless work in helping to organise the 2006 program by Dr Michael Hooper from Sydney who will chair the committee responsible for organising the Adult Medicine program at the 2007 Congress in Melbourne.
- The IMSANZ Annual General Meeting held on May 8 was well attended and endorsed a number of resolutions detailed in the President's report.

IMSANZ Council had decided last year that it would not be offering its services in organising the RACP Congress May 2007 program due to our commitment to a joint scientific meeting with the Australian Society of Geriatric Medicine in June 2007 and to a joint meeting with Australasian Society of Nephrology and NZ RACP in Queenstown in September 2006. Whether IMSANZ is able to assist RACP for the 2008 Congress will be decided by IMSANZ Council in due course after taking into account future society commitments.

IMSANZ Council Meeting, Cairns.

Standing room only - a popular symposium on Osteoporosis and other Bone Disorders.

2006 CLINICAL QUIZ WINNERS

Once again the Clinical Quiz was a hit at the RACP Cairns Congress. Congratulations go to the following winners.

1st Alistair Wright, Vic
- $200 Book Voucher

2nd Edward Janus, Vic
- $100 Book Voucher

3rd Vigna Ganaseamoorthy
- $50 Book Voucher

Best Registrar - Vigna Ganaseamoorthy
- $75 Book Voucher

IMSANZ thanks Ramesh Nagappan for his contribution to the Congress Program and entertaining presentation.

Year	Month	Meeting
2006	**September**	**North Queensland Physicians Conference** 1 & 2 September Cairns Base Hospital For more information email: john.mcbride@jcu.edu.au
	October	**The World Congress on Controversies in Obesity, Diabetes and Hypertension (CODHy)** 26 - 29 October Estrel Hotel ~ Berlin, Germany Further details at: www.codhy.com
	November	**CSIM Meeting 2006** 1 - 4 November Calgary ~ Alberta, Canada *CSIM Annual Scientific Meeting November at the Hyatt Regency* Further information: http://csim.medical.org/
		Diabetes in Indigenous People Forum 13 - 15 November Melbourne Exhibition Centre Email: diabetes@meetingsfirst.com.au Phone: +61 3 9739 7697
2007	**March**	**Medical Challenges Series** Infectious Disease: Changing Times 4 March - Peregrine Voyager - 10 night Antarctic voyage Megan Stewart Email: expedition@peregrineadventures.com Phone: +61 3 8601 4307 Web: www.peregrineadventures.com/antarctica/specialist_voyages.asp
		IMSANZ NZ Fall Meeting 22 - 24 March Waiheke Island Resort ~ Auckland *TSANZ Meeting will be held in Auckland immediately after the IMSANZ meeting*
	September	**ASGM / IMSANZ Combined Meeting** 5 - 8 September Adelaide Convention Centre ~ Adelaide, South Australia
	October	**CSIM Meeting 2007** 10 - 13 October St John's ~ Newfoundland, Canada

Determining the respective roles of general physicians and subspecialists in patient care

General physicians are specialists in the management of complex and chronic medical illnesses and oversee a vast array of medical problems experienced by patients of all ages. Many subspecialists who wish to focus on acute or procedural care, in addition to long-term management of complex disorders within their area of expertise, can become oversubscribed with patients with chronic medical problems that could be best managed by a general physician. Such demand on subspecialists in turn limits their availability to see new or acute referrals. In tertiary hospitals it is relatively easy to 'throw a pass' to a subspecialist and expect him/her to catch the ball and run with it until he/she wants to send the patient back. In regional hospitals the passes get longer and are more likely to be dropped. In addition, when patients have multiple chronic conditions, there is the risk that treating one condition according to guidelines (eg. asthma with steroids) may worsen other co-morbid conditions (such as diabetes or osteoporosis). Multiple subspecialists, each with a focus on one aspect of the patient's condition, may require a general physician 'quarterback' to co-ordinate care, and assess and balance the care of 'competing' conditions.[1]

A recent article in the *American Journal of Medicine*[2] outlines an approach to defining 'generalist' and subspecialist roles that is being trialled by the Association of Specialty Professors (ASP) Workforce Committee in the US under the auspices of the Association of Professors of Medicine (APM), a national organisation of departments of internal medicine at US medical schools and affiliated teaching hospitals. This approach is trying to answer the following questions for a focused set of chronic illnesses:

1. When, and for what indications, should patients be referred from generalist to subspecialist?
2. When should patients be referred back from subspecialist to generalist, or co-managed between the two?
3. What are the data to support these recommendations?
4. What methods of communication do we recommend between generalists and subspecialists?
5. In what areas should generalists be educated in order to provide higher quality care for specific conditions? What are the available forums for this education?
6. How should subspecialists deal with health maintenance issues in patients for whom they are principal providers of care?
7. What future research questions need to be answered?

Questions 1-3:

The committee has developed a series of referral "grids" with evidence-based suggestions for referral and back referral between 'generalists' (defined here to include both general internists and primary care practitioners) and subspecialists. Six clinical topic areas for the grids were selected from a longer list generated by ASP Council members before the start of the project. Criteria for selecting the final set included authors' perception of frequency with which the disorder is encountered in practice; importance of the generalist-subspecialist interface (eg. a need for early referral of patients with rheumatoid arthritis); presence of existing literature to support recommendations; and interest and expertise of individual workforce committee members.

The topics chosen included cardiovascular diseases, chronic renal disease, COPD and asthma, irritable bowel syndrome and inflammatory bowel disease, diabetes mellitus, and rheumatologic disorders. Each draft grid (examples reproduced in the tables), developed using supporting literature as available, was then shared with subspecialty society members and with members of the Society of General Internal Medicine (SGIM) for additional feedback. Because research in the area of appropriate timing of referrals is in its infancy in most fields (with the field of nephrology being most advanced),[3] the authors advised that the grids should be viewed as initial proposals, inviting further expansion and refinements, rather than final guidelines. The key issue they emphasised should be what care the patient needs to receive, rather than who provides it. Concepts which featured frequently included 'co-management' – where patients are followed by the generalist with periodic input by a subspecialist – and 'balance of care' – where a shift to subspecialist occurs during disease flares and then back to the generalist after stability is achieved. Central to both concepts was how best to communicate the specifics and importance of evidence-based recommendations between subspecialists and generalists.

Some caveats:

The disadvantage of these grids from an Australian/New Zealand perspective is that, as noted, 'generalist' in the US encompasses primary care practitioners as well as general internists, and as a result the recommendations for 'generalist' are overinclusive. They need to be more refined in distinguishing general physicians from general practitioners, and making clear the referral interfaces between both physicians (general and subspecialist) and general practitioners. Also, the grids will, of necessity, have to be adapted for different regions owing to differences in geographic demography, health service configurations, health area policies, and the training and skill mix of resident medical practitioners. Special consideration should also be given, particularly at the level of specific diseases, to ensuring that referral patterns reflect the need for equitable access to specialist care on the part of disadvantaged groups and indigenous populations. Finally, in locations where groups of general physicians with a subspecialty interest cover most organ systems and dominate, in terms of numbers, over subspecialists, referral grids based on a dichotomy of generalist and subspecialist may not apply.

Question 4:

In relation to communication methods, the ASP committee found little or no literature concerning how subspecialists and generalists communicate about their patients, but recommended that generalists send copies of clinic notes to subspecialists, even when there is no or little change in status, and that subspecialists consider a disease-specific electronic template for transferring information to generalists in a timely manner. Subspecialists' letters should detail suggestions such as specific guidelines to be followed, as well as indications for re-referral. Personalised contact between subspecialist and generalist, combined with

structured referral letters which make clear the reason, the question, the laboratory data collected to date, and the clinical evidence surrounding the referral, would also enhance effective communication.

Question 5:

In regards to how best to bring the evidence into the clinical encounter and update generalists on new advances, the committee suggested a two-pronged approach. First, involve generalists in the development of chronic disease guidelines, which are developed through subspecialty societies. This process is occurring in Australia/New Zealand with IMSANZ providing input and officially endorsing recently released guidelines on acute coronary syndromes from the Cardiac Society of Australia and New Zealand. Second, scientific meetings with generalist audiences (eg IMSANZ meetings and RACP Congress) can highlight clear and focused talks on common chronic illnesses, led by both generalists and subspecialists, laying out the evidence for chronic illness management and mechanisms for reviewing evidence at the point of care.

Question 6:

When the subspecialist is the principal provider of care, some aspects of health maintenance and preventive care for specific conditions may not achieve priority, which may be more reliably achieved in a generalist clinic.

Question 7:

Many studies suggesting care of patients with specific diseases is better when provided by subspecialists than by generalists[4,5] are not applicable to the Australasian context as these studies have used an American definition of generalist which, as noted, includes primary care practitioner. Also, few of these studies have adequately accounted for confounding due to referral bias, variable case mix and physician "clustering."[6] Education methods should be assessed for efficacy, not only with regard to transmitting information but as to whether they improve the care of patients. Research questions include: Does high quality generalist-subspecialist interaction lead to more satisfied providers and patients? In what ways can e-mail and other information systems improve generalist-subspecialist communication and patient care? Finally, how does patient preference enter into the equation: if patients wish ongoing subspecialty care despite evidence that care and outcomes would be similar or better in the hands of a generalist, can we educate patients so that over time they are willing to follow this advice?

Where to from here?

IMSANZ is considering establishing a General Physician-Subspecialist Interface Working Group to develop a similar methodology to that discussed in this article but which is more applicable to local contexts. Ideally this group should include a number of general physicians with a subspecialty interest as well as trainees who have undertaken dual training, as these folk would be best placed to better define the nuances at the practice interfaces which need to be incorporated into any referral recommendations. Practice pattern grids should use available evidence to guide decisions, and the grids should be based upon what is best for the care of the patients rather than the "turf" of the physician. In the end, the grid concept proposes a "dynamic equilibrium" in which patients are referred back and forth between general physicians and subspecialists depending upon the acuity of their medical conditions. The grids provided may lay the groundwork for implementing other ways for furthering the goal of integrated, coordinated care between subspecialists and general physicians. To move in this direction, education and communication issues should be actively addressed by both IMSANZ and subspecialty societies. Results of such a process may be better care and improved outcomes for patients, an increase in satisfaction on the part of both subspecialists and general physicians, and a better idea of the workforce implications if these practice patterns were to become widely adopted.

Readers are invited to feedback their ideas on this proposal and to consider nominating themselves for membership on the working group.

IAN SCOTT, BRISBANE
PHILLIPPA POOLE, AUCKLAND
PETER GREENBERG, MELBOURNE
DAVID SPRIGGS, AUCKLAND
JOHN HENLEY, AUCKLAND

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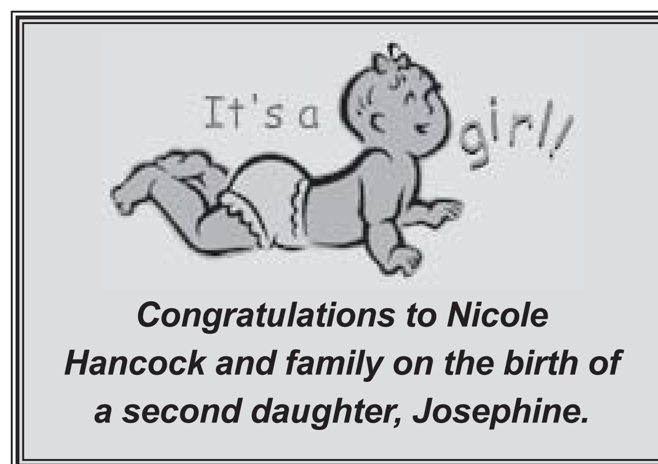

Congratulations to Nicole Hancock and family on the birth of a second daughter, Josephine.

At the 2006 AGM held in Cairns several members of council retired on rotation. IMSANZ wishes to thank Justin La Brooy, Leonie Callaway, Michele Levinson, Patrick Gladding and Christian de Chaneet for their ongoing interest in the Society's affairs.

Michele has also retired as editor of the IMSANZ Newsletter. IMSANZ thanks for her contributions and hard work on the newsletter.

A warm welcome goes to the new council members who have replaced retiring members.

David Taverner takes over the SA Metropolitan area representation from Justin La Brooy, Tony Ryan takes over the WA Metropolitan area from Christian de Chaneet, Richard King takes over the Victorian Metropolitan area from Michele Levinson and Dawn DeWitt has accepted the position of Victorian Rural representative.

Josephine Thomas has replaced Leonie Callaway as Advanced Trainee Representative in Australia. Ingrid Naden has replaced Patrick Gladding as Advanced Trainee Representative in New Zealand.

Contact details for the new council representatives are as follows:

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From page 22

Examples of practice referral grids (adapted from ref 2.)

Clinical condition	Generalist	Subspecialist
Mild-moderate COPD	Ongoing management; refer to subspecialist if unstable, uncertain diagnosis (eg interstitial lung disease)	Available for consultation
Severe COPD (pCO_2 >60mmHg), FEV_1 <1.0, cor pulmonale)	General medical care; co-management of stable, severe cases	Principal care for exacerbations; if stable, co-management with generalist
Advanced chronic kidney disease (CKD)	Identify patients with early CKD; evaluate and manage anaemia, bone disease, hypertension, nutrition, dyslipidaemia, counselling and rehabilitation	Prepare for renal replacement therapy in terms of modality and transplant evaluation; assist with indications for erythropoietin, management of complex imbalances in electrolytes and refractory hypertension.
Chronic heart failure (CHF)	Long-term general medical care; management of mild-to moderate (class I-III) CHF; co-management of severe (class IV) CHF	Principal care by cardiologist, or co-management with generalist and heart failure subspecialist; principal post-transplant care; co-management of device recipient with subspecialist in pacemaker/defibrillator or assist devices
Rheumatoid arthritis	Initiate diagnostic evaluation, refer for physiotherapy and occupational therapy, initiate nonsteroidal therapy, manage general medical care, monitor for adverse drug reactions from DMARD therapy with subspecialist	Verify diagnosis, initiate DMARD; assume principal care for high risk or complex clinical manifestations; administer intra-articular steroids; determine indications for orthopaedic surgery

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: Ian_Scott@health.qld.gov.au

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

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