IMSANZ

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From the President...

The General Matters

There have been some positive developments for IMSANZ and general medicine in the months since the last newsletter in August 2006. Some of these are outlined in much more detail within these pages. As this is such a bumper issue, I'll just provide you with a brief overview of some of the most significant issues, along with some 'future gazing' for 2007.

One of the best pieces of news is that our membership is growing steadily, and diversifying. There are around 430 of you at years' end, when traditionally membership numbers are nearer the 400 mark. Many of the new members are advanced trainees thanks to the combined efforts of our enthusiastic AT reps Jo Thomas and Ingrid Naden. Welcome to all of you! We need more consultants though - keep up the shoulder tapping – we aim to have 500 members in total by the end of 2007.

At the joint RACP (NZ) / IMSANZ/ Nephrology Queenstown meeting those present voted unanimously to extend an invitation to our Pacific physician and physician trainee colleagues to join us as associate members. We are in the process of sending these letters, and look forward very much to welcoming our Pacific friends into the IMSANZ fold.

IMSANZ Council has voted Alasdair MacDonald from Launceston, Tasmania, to the Australian Vice President position. I'm delighted to have Alasdair in that role, not least to give Ian Scott a hard-earned break from one role. I have expressed our appreciation to Ian for continuing in the acting VP role for over a year. Alasdair is looking forward to increasing his contributions over the next year. Already he has produced a draft IMSANZ position statement on hospitalists (see Page 6) and he's recently travelled to Taiwan to WCIM 2006, as a prelude to WCIM meeting to be hosted by the RACP and IMSANZ in Melbourne in 2010.

Alasdair MacDonald

Michael Kennedy

For the first time since the founding of our society in 1997 Michael Kennedy, from Sydney, is no longer on Council as his term has expired. Over that time he has held roles as Treasurer, NSW rep, and SAC nominee. Michael has great insight into the issues for general medicine in Sydney, the complexities of the PBS and prescribing, as well as the history and inner workings of IMSANZ. Michael still

As you turn the pages...

remains the Public Officer for IMSANZ. Michael has also served on the SAC in General Medicine Committee for nearly 9 years as a co-ordinator of advanced training and has assisted the Committee immensely, approving a lot of applications and renewing numerous projects. Our grateful thanks are due to Michael for all that he has contributed to the society and general medicine over the years.

Peter Nolan has resigned from Council both as Queensland Rural rep and Hon secretary. Nick Buckmaster has taken over both of these roles - thanks so much Peter for your contributions and welcome Nick!

As far as general physician education goes, there are several developments:

- The RACP has tabled a statement on flexibility in advanced training such that core training in any one subspecialty cannot exceed two years (see page 14). Feedback is currently being solicited from all subspeciality societies. IMSANZ Council has endorsed this document as it believes that it can only enhance the acquisition of generalist skills both within individuals and among physicians as a group.
- Leonie Callaway, Mary-Ann Ryall and I spent a day in Brisbane in October incorporating a relatively small amount of feedback into the RACP basic training curriculum. The draft curriculum has been very well received here and overseas. Once the assessment plan is incorporated into the template this will be ready for piloting in early 2007.
- Now that the basic training curriculum is completed, IMSANZ has been asked to be one of a small group of societies and chapters to pilot their advanced training curriculum in 2007. This means some work for a small group of us over the next few months to ensure that the competencies clearly build on those in the basic curriculum, and differentiate a general physician from a GP, 'hospitalist" or any other type of physician. Wider consultation with the membership is planned for early 2007.
- There is a huge amount of discussion happening on both sides of the Tasman as to how to shorten the total length of medical training. This is forcing consideration of when differentiation into specialty, and then into subspeciality, might occur. For NZ, at least, it is looking as though the earliest one might enter a specialty will be the second post graduate year, even though it should be possible to condense the period encompassing the final year of med school / PGY1 and 2 / basic training. There seems to be a desire to create a large cadre of redeployable physicians with general competencies, no matter whether a subspeciality is entered as well.

Drs Mahesh (ex President CSIM) and Shoba (GP Hospitalist) Raju enjoying NZ's Bethell's Beach.

Internationally, links are being further consolidated. I'll be attending the SGIM meeting in Toronto that includes the first International Symposium in General Internal Medicine on 25th April 2007 (see page 12). Patrick Fiddes recently attended the Society of Acute Medicine meeting in UK. His report is enclosed and Council is liaising with that society. The ex president of the Canadian Society of Internal Medicine, Mahesh Raju, from St John, holidayed in Australia and New Zealand recently. During a West Coast beach walk we reaffirmed that general physicians in each of our respective countries faced similar issues; namely, inequitable remuneration and conditions compared with subspecialty colleagues, and a lack of valuing of the skills that general physicians could offer the health system. We also agreed that we all tend to underestimate the key role general physicians have in training the whole future medical workforce.

On page 16, Ian Scott has outlined some of the gains being made in 'Restoring the Balance' between generalists and subspecialists. The document continues to provide an excellent strategic framework for Council and RACP going forward into 2007, 2008 and beyond. One of the most urgent tasks in 2007 is to attract more physician trainees in Australia into general medicine. There are only around 54 in Australia currently (cf 110 in NZ). Work must happen at the multiple levels as outlined in the RtB framework, and through the work of others such as AACP (remuneration), and the SAC (training pathways). I'm most keen to hear of any other successful initiatives at local level to attract trainees e.g. training networks, extra funding and extra training positions. It's important to remember that our positive role modelling and enthusiasm are extremely powerful determinants in trainees' career choices.

Other key work in 2007 will include the establishing of an MOU with the RACP with respect to support (people and money) for the increased activity IMSANZ is taking on mainly in the areas of general physician workforce development. Negotiations are required with the RACP in respect of future ASMs and the shape of the WCIM in 2010. If we make significant progress on all the fronts mentioned, 2007 will indeed be a memorable 10th year of IMSANZ's existence.

It remains for me to wish you all a restful and restorative festive season, however you choose to celebrate!

See you in 2007.

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

The Ministry of Health and Ministry of Education in the People's Republic of China co-funded the program of research on the system and standards of internal medicine training. Currently, the China Medical Doctor's Association is developing training programs in medical subspecialty areas, and setting training and service management standards for their facilities in internal medicine. The purpose of training in internal medicine is to develop a physician competent to provide comprehensive medical care in adult internal medicine or one or more of the sectional specialties.

1. Components of training in internal medicine

Trainees in internal medicine are required to complete a specified program of training and assessment to be eligible for registration in internal medicine. All training programs will include active supervised clinical work in general medicine or in accepted medical subspecialties. The training program in adult internal medicine is a minimum of 3 years, divided into two year core training and one year non-core training, with a clinical examination at the end of training followed by further experience in clinically related fields or in a research program. Core training comprises up of five or six terms of minimum four months duration in the following subspecialties: Cardiology, Respiratory Medicine, Intensive Care, Gastroenterology and Hepatology, Haematology / Medical Oncology, Nephrology, Rheumatology, Critical Care, Neurology/Stroke, Obstetric Medicine, Infectious Diseases, Endocrinology and Metabolic diseases and Clinical Pharmacology. Up to 12 months of non-core training may be undertaken in the other specialties comprising Geriatric Medicine, Rehabilitation Medicine, Immunology and Allergy, Chemical Pathology / Clinical Biochemistry, Emergency medicine, Medical Imaging, Psychiatry, Nuclear Medicine, Palliative Medicine, and Alcohol dependency.

Admission to qualification and registration with the Medical Board of Internal Medicine occurs after completion of all training requirements. The clinical examination to qualify in internal medicine, which can be attempted in the third year of training or later, comprises written and clinical component, both of which must be completed successfully. Entry into advanced training occurs after satisfactory completion of basic training and success in the examination.

The author Dr Guangji Zeng, at work

2. Staff training programs in internal medicine

The medical care administration of the Ministry of Health is responsible for advising the Board of Health on the training program, assessment and examination. The Committee for Physician Training within the provincial boards of health has direct responsibility for overseeing physician training. At my institution, the Sun Yet-Sen University Cancer at Guangzhou, Southern China, the Department of Internal Medicine offers four types of training programs;

1) Categorical program comprising three years of comprehensive training in General Medicine for individuals destined for careers in either academic or community-based General Internal Medicine, and for individuals who will go on to seek sub-specialty fellowship training. Each year my hospital recruits a talented and diverse group of about 20 trainees (also called Special Training Diplomats) into the categorical program. The training is broad-based, providing exposure to generalists, hospitalists, and a wide variety of sub-specialists. All of the training occurs in an academic environment, under the supervision of Sun Yet-sen University faculty members, and exposes the learners to cutting edge technology and world-class research. These trainees alternate three months of Internal Medicine with three months of other subspecialties over the course of three years.
2) Physician scientist program which represents an option for qualified candidates to receive training in the Internal Medicine Program for two years, followed by clinical and research training in a subspecialty fellowship program. Candidates for this program are those completing medical school with joint M.D. and Ph.D. degrees. The Department of Internal Medicine is committed to the policies and procedures of the Internal Medicine Research Pathway, assuring that individuals will be eligible for certification in Internal Medicine and in a subspecialty on completion of the training program.
3) Preliminary year in internal medicine aimed at trainees undergoing subspecialty training with the intention of providing a tailored experience for residents, jointly developed by the Internal Medicine program leadership together with the Program Directors from each of the participating specialties.

Educational techniques are diverse and comprise: a core curriculum developed and maintained for each rotation and also available in a web-based format that can be accessed from any computer terminal in the hospital; teaching conferences including medical grand rounds and case studies conducted weekly, bedside teaching on ward rounds provided by attending medical specialists; morning report conducted daily consisting of several case-based discussions presented by second and third year residents; case analysis conference involving twice weekly faculty lectures dealing with topics chosen from the core curriculum; a lecture series in the first 3 months of the year centred on appropriate evaluation and initial management of common problems and laboratory abnormalities; procedural training in gastrointestinal endoscopy, bronchoscopy, echocardiography, bone marrow puncture and thoracocentesis; and project work which may consist of a case report with a detailed review of the literature or a report of a research program.

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IMSANZ would like to welcome the following New Members:

- A/Prof John Attia - Newcastle, NSW
- Dr Heather Gardner - Auckland, NZ
- Dr Manjula Ratnaweera - Hamilton, NZ
- Dr Lynden Roberts - Melbourne, VIC
- Dr Eric Seal - East Kew, VIC
- Dr Campbell Thompson - Adelaide, SA

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

- Dr Thamarasa Abeysekera - Bankstown, NSW
- Dr Anmol Bassi - Mt Martha, VIC
- Dr Kate Cotter - Avoca Beach, NSW
- Dr Rajiv Gupta - Auckland, NZ
- Dr Vincent Ho - Sydney, NSW
- Dr Kavita Kumareswaran - Wellington, NZ
- Dr Sanjiv Lath - Armidale, NSW
- Dr Nelson Loh - Perth, WA
- Dr Stephen McBride - Auckland, NZ
- Dr James Macdonald - Brisbane, QLD
- Dr Michelle Reeves - Auckland, NZ
- Dr Zoë Raos - Auckland, NZ
- Dr Thomas Schulz - Melbourne, VIC
- Dr Nicola Smith - Wellington, NZ
- Dr Anthony Spencer - Christchurch, NZ
- Dr Elizabeth Stallworthy - Auckland, NZ
- Dr John Wilson - Wellington, NZ

3. Continuing education in internal medicine

Standardisation of ongoing training for medical specialists under the auspices of the National Continuous Medical Education Committee and a crackdown on revision and issuing of documents regarding the certification of continuous medical educational projects in internal medicine has strengthened the quality of training. The role of Comprehensive Medical Science Training Centers was further expanded, with 16 provinces, autonomous regions, and direct municipalities establishing such centers for internal medicine specialists. The Ministry of Health convened a national workshop on the training of resident physicians in 2002 which has led to basic training standards for every medical specialty, standards for training institutions, development of examination methods by relevant experts, and, in the future, an internal medicine specialist's training curriculum, quality control and evaluation system for the entire Chinese medical service sector.

4. Ongoing challenges

Three ongoing challenges include diversity of educational systems, insufficient electronic software and hardware for residency training programs, and absence of subspecialty training programs. Aside from adequate resourcing and funding which are essential to internal medicine training, emphasis is also being placed on better medical administration and better remuneration and public recognition of people with appropriate specialist training. The Medical Education Division of the Ministry of Health plans to review different provinces (or cities) and encourage those regions falling behind to set up their own training centers and form networks with major national training centers in order to improve the training process. China needs to improve the quality of training and management of trainers, and improve the skill levels of health workers in rural health facilities and district hospitals. Finally policies are required for professional and career development after graduation including more opportunities for post-graduate degrees such as Masters or PhDs.

Conclusion

China must accelerate the establishment of supervised training and continuing education programs in internal medicine in line with best international practice. Considerable progress has been made but more needs to be done.

GUANGJI ZENG, MD, PROFESSOR

Medical Oncologist, Medical Administrator, Department of Medical Quality Management, Sun Yet-Sen University Cancer Cancer, Guangzhou, P.R.China

IMSANZ Panel at Trainees Day

The inaugural Trainees Day at the Queenstown IMSANZ and RACP college meeting was held this year. A record number of registrars attended the conference overall, reaching double figures! The setting for the conference was fantastic, with delicious food and plenty of extra curricular activities. The snow was a little slushy by the end of the week, but the weather held out and there were some great days on the slopes.

Trainees Day was a real success, with interesting presentations and an informal structure. Practical and trainee-relevant topics were discussed, including the stress of the written and clinical examinations, how to put together a project, organising a fellowship overseas and an excellent session regarding how to approach a job interview. Hopefully, more basic and advanced trainees will attend in 2007. We would recommend it to anyone. Afterwards we trekked to the Mexican Restaurant for a Trainees Dinner involving Margheritas, burritos, meeting and greeting.

The conference was a great chance to meet other trainees, consultants, IMSANZ representatives and other attending personnel from around the country. Whipping up the gondola for dinner was quite a novelty, as was the entertainment from a crooner-style Frank Sinatra wannabe.

Updates from a variety of excellent speakers were well received by the trainees. Trainees and consultants alike appreciated the 'renal flavour' to the conference. The quality of the trainee presentations for general medicine and renal medicine was excellent, setting the standards for future talks.

Overall - a positive experience for all the trainees. See you at Waiheke!

ZOE RAOS
Auckland NZ

The RACP Trainees Day was held in September this year in Queenstown as part of the combined RACP/ IMSANZ Annual Scientific Meeting.

There was a great turnout for the day with a programme that catered for a wide range of needs from the basic trainee right through to an advanced trainee about to embark on consultancy. The programme was well received by all that attended. Topics covered ranged from the impact of the written part two examination, right down to the nuts and bolts of how to pass the "big one". Further practical advice was given on how to get an overseas fellowship, job interview advice, to pointers on projects, pathways of training and the role of the SAC. Updates on the curriculum were discussed.

The meeting was not only very practically orientated and informative but more importantly gave a great opportunity to network with other trainees throughout New Zealand to exchange ideas and advice. We look forward to the next trainee day.

JO HOLDEN
Senior Medical Registrar
Dual Trainee Geriatrics and General Medicine
Hutt Hospital

A full trainees day was part of this years combined IMSANZ/ Nephrology/ RACP meeting in Queenstown in September. This day followed on from a previous one hour trainee session at the Alice Springs meeting which demonstrated there was room for more.

The day was supported by the New Zealand Trainees Committee and from my perspective was a great success with 21 trainees attending.

The presentations were great, these were mostly offered by the trainees including presentations on the impact of the written exam, how to pass it, the Medical Registrar orientation programmes, quality and audit. There were panel discussions on the job interview and pathways of training which were very well received.

Attendees were enthusiastic in support of an annual trainees day with suggested topics for the future of leadership, teaching, contracts and new Consultant presentations.

DENISE AITKEN
Chair
Specialist Advisory Committee
General Medicine New Zealand

THE ISSUES SURROUNDING "HOSPITALISTS"

And A Proposed Position Statement From IMSANZ

Introduction

The term "Hospitalist" has sparked significant debate in the literature since its introduction in the mid 1990's. The initial debate in the American medical community centered on the threat to primary care that the introduction of Hospitalists constituted, particularly in the context of the US board based qualifications which, in the majority of postgraduate doctors, allowed practice across primary care and referral based hospital medicine. The new specialty of "Hospitalists" was seen as a potential threat to hospital access on the part of primary care trained physicians. Once the Hospitalist started to cross national borders the debate changed its focus and when the term reached Australian shores the debate centered around who should be the hospitalist- General Physicians, Intensivists or Emergency Physicians. Clearly the General Physician was and remains the obvious choice and the debate then moved onto how this could be advanced as a subspecialty interest of general physicians with an appropriate curriculum and training program.

Now we enter a new Hospitalist debate, born out of a workforce crisis in the provision of healthcare, particularly in NSW, and failure of the state and federal departments of health to recognize the looming disaster despite advice provided by IMSANZ and the RACP. Even though the blue print for a solution exists in the "Restoring the Balance" document, both levels of government seem to be taking an ill-informed and ill-advised path. In a medical manpower market where progress is being made towards the appropriate recognition and remuneration of the cognitive work undertaken in physician medical practice, the belief and assertion that complex medical patients in the hospital system require anything other than the standard of care provided by a physician are inappropriate. This potential "dumbing down" of the hospital medical workforce occurs at a time when ideas about how medical practitioners might be replaced in certain areas of practice by other health care professionals and technicians are gaining currency and which underpins the importance of overall supervision of patient care remaining in the hands of the physician.

The Hospitalist debate crosses the breadth of patient care, training and professional issues and below I have endeavored to address the key domains in which a trend towards Hospitalists within the medical workforce will impact.

What drives the push for Hospitalists?

The medical manpower crisis particularly in NSW has resulted in recent advertisements for, and discussion around, a "Hospitalist" model of care. This response to the current medical manpower crisis has produced vigorous debate at general medicine forums. The debate has focused on the appropriateness of this model to fill the workforce need, along with the role general physicians and the RACP as a whole should be playing in the development of the Hospitalist model. The need for Hospitalists in NSW stems directly from the depletion of general medicine staff positions and training opportunities in NSW teaching hospitals and is symptomatic of a more widespread imbalance between general medicine and subspecialty medicine in hospital practice in Australia. The naïve perception that there is an untapped pool of skilled medical practitioners who, with modest additional training, can assume responsibility for the care of frail, dependant, often elderly, patients with multiple interacting comorbidities is clearly in contradistinction to the view of the IMSANZ membership and would be in conflict with the RACP's current support for more of the fellowship being able to acquire generalist skills and practice a wider scope of medicine outside of single subspecialties. There is also the broader issue of which body should take responsibility for providing and accrediting postgraduate medical education for folk wishing to specialize in hospital medicine versus the other medical disciplines and the importance of the RACP and its special societies in guiding and consulting on this critical aspect of medical workforce education. Although there are several available models including the prevalent US based hospitalist model associated with 2 years of additional training (initially described in N Engl J Med 1996; 335: 514-517) clearly each of these have evolved in the local environment through a consultative process with existing disciplines. This consultative process must take place with all the players in hospital and community medicine as the impact of this decision will have implications across all areas, including reducing the numbers of applicants to current specialty training programs in favour of a fast track to similar levels of remuneration provided by means of the hospitalist model.

How qualified are Hospitalists?

The potential institution of a new post graduate medical qualification to fill a workforce need when the ideal practitioner appropriately qualified for the position already exists, begs the question of why the current highly skilled and fully trained physicians practicing in general medicine are unable to attract new trainees into this challenging but rewarding discipline. Should not the government look at the disincentives to a career practicing in general medicine rather than introduce a new, lower standard of practitioner to perform tasks that are too complicated for all but the current subspecialists engaged in complex cross-discipline medical diagnosis and management. The duties of the new hospitalist and those of the physician trainee at basic or advance training level are also likely to cause tension particularly in the presence of different remuneration scales and incentives to hospital administration to use lower-paid Hospitalists to lower the costs of overtime and after hours rostering.

Who will supervise Hospitalists and assume ultimate clinical responsibility?

The issue of clinical responsibility has several aspects. If the health system, patients and the public are happy to accept a potentially lower standard of health care and to have the responsibility for clinical decision making given to a new medical practitioner strata with a less inclusive qualification, then the Hospitalist option may be appropriate in its rawest form. If this overall level of inpatient care (and potentially in the future outpatient care) is the only level the community needs and can afford, then the so called hospitalist may not require supervision. However, should we choose to introduce this new role at a supervised career medical officer (CMO) type level then clearly the most appropriate supervisor would be a general physician. The impact on some of our subspecialist colleagues, who practice solely within a subspecialty area which may be procedurally orientated, of taking clinical responsibility for care well outside their own

specialty by a hospitalist is likely to trigger quality issues and higher consultation rates between subspecialists than currently exist with resultant greater inefficiencies in care.

How good will the training models for Hospitalists be?

The model for training and assessing a new stream of Hospitalists who are to be regarded as having a postgraduate degree will require careful consideration, particularly if they are to assume responsibility for clinical decisions. In addition some state by state equivalence in training and qualification will be needed. Clearly the RACP should play a critical role in the development and accreditation of Hospitalist training programs as the curriculum content and development and training expertise already exists within the college. The introduction of new university programs which, at present, even struggle to assist with postgraduate year (PGY) 1&2 clinical training directed at simply consolidating undergraduate competencies, would further dilute teaching expertise and reduplicate training already provided within physician training programs. The fast proliferating but separate postgraduate teaching institutes will be simply unable to produce a quality teaching product without the good will of the physicians already overcommitted to basic physician training and raises again issues of inefficient duplication and need for standardisation.

The other difficult issue for current physicians is what assistance they would personally offer to training Hospitalists, particularly if an inappropriate training model is adopted and if university appointed physicians who practice general medicine are compelled to participate in such training programs. It would seem appropriate for IMSANZ to support in principle any individual physician who, depending on his/her circumstances, made a stand on this issue and, as a whole, to oppose universities requiring our members to train hospitalists outside a model that we support.

What might be MOPS and CPD requirements for Hospitalists?

Participation in MOPS and CPD is integral to any medical professional and a requirement for medical registration, and these processes exist within the college and are under constant review and refinement. Hence a Hospitalist model which has been declared as being appropriate to the college would require Hospitalists to participate in a college auspiced program. In contrast, current CPD programs for CMOs comprises a mixture of hospital based meetings which, in their content and aims, are unique to individual hospitals, industry sponsored meetings and web based associations such as the Australasian Society of Career Medical Officers.

What forms of remuneration might Hospitalists receive?

The issue of remuneration, although not the sole area of concern, will be critical to recruitment both in a positive and negative sense. Should full specialist awards be applied to this group then the flow on effect to the current levels of recruitment into specialties would be significant. It is unlikely that being an Hospitalist would be seen as an attractive career without a wage structure close to the level of a specialist.

How will standards of care be defined for Hospitalists?

Under the hospitalist model there is, by definition, going to be a lower level of training and a more limited list of competencies compared to the clinical competencies of general physicians. But lower quality care can lead to large increases in cost due to avoidable complications and adverse outcomes. IMSANZ clearly cannot support a decline in clinical care and so would only support a model where overseeing general physicians work in a supervisory role with the hospitalists.

The employment of Hospitalist starts the health system down the path of replacing existing medical practitioners with hospitalists in clinical care and then with technicians in procedural areas, as occurs in many overseas systems. These changes will impact on all aspects of our current hospitals and represent two halves of the same process of doctor substitution. Hence the headlong rush, for short term manpower reasons, into adopting a US-style hospitalist system needs to be tempered by a careful and considerate discussion with all the stake holders.

Who might be the likely applicants for Hospitalist positions?

In the current medical workforce environment the likely applicants for such positions fall into 2 groups: those who have failed to meet the required standard in physician training; and those who made a conscious decision not to take on the rigors of complex patient care and decision making in clinical care. Neither of these groups of doctors seems the ideal choice to take on poorly supervised or unsupervised care of the complex medical patients who currently occupy our public hospital wards.

What might be the role of the General Physician?

All the scenarios possible will not obviate the need for General Physicians and their colleagues such as Geriatricians to continue to provide care to patients who need those trained in multi-system consultative practice. At a time when the college and hospital governance bodies are aware of the need for a greater mass of skilled generalists and are seeking to implement solutions such as those contained within *Restoring the Balance,* why should the college and IMSANZ stand by and watch yet another threat to the survival in Australia and New Zealand of general physicians, when even the USA has made the survival of the Generalist critical to their system.

The potential threat of an unsustainable increase in cross-referral burden

Finally one of the likely outcomes of taking patient care out of the hands of the true all rounder (general physicians) will be an increase in the number of cross referrals for opinions from other subspecialist physicians. This will no doubt increase length of stay and increase the burden of work for other subspecialists.

What should be the official IMSANZ position to Hospitalists?

Below is a suggested IMSANZ position statement on the current Hospitalist issue which is up for council endorsement and if endorsed will be placed in the public arena on the web site and, if needed, distributed to relevant bodies as determined by council. At present this remains a personal view with helpful input from a number of council members.

IMSANZ's position on the recruitment and training of "hospitalists" other than FRACP holding physicians practicing in General Medicine and related subspecialty areas is that the current plan to recruit and train "hospitalists" represents a short sighted and inappropriate response to a workforce crisis already identified by IMSANZ and the RACP. The College has endorsed *Restoring the Balance* as an appropriate blue print to navigate this crisis and hence we as a society find ourselves in conflict with the current plan as it has appeared in recently advertised positions in NSW. Solving the current work force issues by inventing a new sub-discipline of Hospitalist which is not fully explored or planned, and has the potential to compromise patient care, is not appropriate. The issue of workforce management must take into account the on going need for physicians to practice general medicine and recognize that these individuals are appropriately trained to undertake the role of hospitalist in an environment of aging population with multiple co-morbidities and a rising expectation of favourable healthcare outcomes. Previous poor planning and undervaluing of the general physicians does not constitute an excuse to proceed with a plan to use under trained and potentially unsuitable medical practitioners just because it can be achieved in one electoral cycle rather than in the time frame of the current physician training program.

In addition, IMSANZ cannot support the training of physician competencies and clinical management in isolation from the College and feels that workforce solutions that are achieved without proper consultation and involvement with the College should not be supported. In the event that short term staffing crises mandate the placement of some form of CMO into the public hospital system, then these doctors should remain under the supervision of physicians and that all aspects of training, MOPS and CPD should be supervised by the college and that Hospitalists be offered an appropriate career path to and through physician training rather than an alternative that is substandard. The ideal hospitalist is a general physician and the solutions to the current workforce crisis are to remove the financial and professional disincentives to not only general medical training but to all cognitive consultative practice, and to create more appropriately resourced training positions to train FRACP-accredited Hospitalists who recognize that medical practice goes beyond hospital walls and requires training and skill in community and outpatient care.

ALASDAIR MACDONALD
Vice-President (Australia)

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Australasian Society of CMO's www.ascmo.org.au

Restoring the Balance www.imsanz.org.au

Following on from Dr Rob Brodribb's letter earlier this year, below is a reply to Rick McLean's enquiry to the PBAC.

Dear Rick,

The short term solution was that a rheumatologist was found to see the patient and fill out the necessary forms.

A permanent solution is being investigated by seeking advice from the Australian Rheumatology Association and the Royal Australasian College of Physicians in regards to extending the listing to include other physicians and if so what credentials would be required to ensure appropriate clinical use of the bDMARDS. A possible consideration would be for rheumatologists to initiate prescribing and other physicians be allowed to prescribe continuing treatment.

The next PBAC meeting will be held in November, so we have requested to have their views back in time for this matter to be discussed at that meeting.

Regards,

CAROLYN PATE
PBAC Secretariat
Pharmaceutical Benefits Branch
31st August 2006

IMSANZ MEMBERSHIP SURVEY RESULTS

2006

With their membership renewal notices IMSANZ members at the end of 2005 were asked to complete a survey regarding key IMSANZ activities. 186 of you (approx. 45% of total membership) took the time to give us feedback. The results of the quantitative part of the survey are presented here by country of origin.

AUSTRALIA (142 replies)

	1 strongly agree	2 agree somewhat	3 neutral	4 disagree somewhat	5 strongly disagree	Mean
I find the newsletters interesting	42	67	13	4	1	1.86
The IMSANZ website is useful	32	29	35	5	5	2.18
IMSANZ Council is doing an effective job in promoting general medicine	25	60	19	4	1	2.05
IMSANZ Council is in touch with the needs of members	35	63	24	2	2	1.99
IMSANZ Council communicates well with members	37	62	24	2	1	1.95
IMSANZ membership represents value for money	40	50	29	6	1	2.03

	0	1 or 2	3-5	5-10	> 10
Number of articles you have contributed to the website or newsletter in last 2 years	106	16	2	1	
Number of times you have accessed the IMSANZ website in last 2 years	40	38	26	16	6
Number of times you have accessed the Members Resources section of the website in last 2 years	64	35	16	10	
Number of times you have accessed the CATs Library on the website since its inception in early 2005	92	41	6	3	
Number of RACP scientific meetings you have attended (incl. RACP(NZ)) in last 5 years	36	43	37	9	1
Number of other IMSANZ meetings attended (not including those jointly with RACP, above) in last 5 years	64	36	12	4	
Number of new IMSANZ members you have recruited, or helped recruit, in last 5 years	81	30	7	2	

NEW ZEALAND (44 replies)

	1 strongly agree	2 agree somewhat	3 neutral	4 disagree somewhat	5 strongly disagree	Mean
I find the newsletters interesting	19	18	6	1		1.75
The IMSANZ website is useful	8	13	16	2		2.20
IMSANZ Council is doing an effective job in promoting general medicine	21	19	3			1.58
IMSANZ Council is in touch with the needs of members	13	24	5	1		1.86
IMSANZ Council communicates well with members	15	24	4	1		1.80
IMSANZ membership represents value for money	19	18	3	2		1.71

	0	1 or 2	3-5	5-10	> 10
Number of articles you have contributed to the website or newsletter in last 2 years	36	5	2	1	
Number of times you have accessed the IMSANZ website in last 2 years	12	13	8	7	2
Number of times you have accessed the Members Resources section of the website in last 2 years	23	9	6	4	
Number of times you have accessed the CATs Library on the website since its inception in early 2005	29	8	5		1
Number of RACP scientific meetings you have attended (incl. RACP(NZ)) in last 5 years	7	17	14	4	1
Number of other IMSANZ meetings attended (not including those jointly with RACP, above) in last 5 years	6	18	17	1	1
Number of new IMSANZ members you have recruited, or helped recruit, in last 5 years	26	7	5	1	2

The qualitative comments were many and varied, but were constructive.

IMSANZ Newsletter

There was general support for the current three hard copy newsletter issues per year with more frequent e-news in between. Several would be happy to receive the newsletter electronically only. Most wanted it "not too heavy", but for it to be current and useful. Specific suggestions were: more personal ("I did it my way") type articles, a greater political focus, more literature reviews, notices about locums and support of rural and regional physicians, poetry, discussion fora, "what's new on the website," and more comprehensive notices about meetings. Several commented that the membership needed to contribute more articles. This is borne out by the quantitative data above. To ensure that the newsletter includes the wide range of articles you'd like to see, please feel free to make any contributions to your newsletter along the lines of the suggestions above.

Website

The quantitative data and qualitative comments both suggest we do need to focus on making the website more useful for members. Suggestions were: make it easier to remember username / password, more information on what has been updated (e.g. an email notification), better links between newsletter and website, more resources- links to other websites, meetings, locums, position papers. Consider a discussion forum for members.

In 2006 the following improvements have been made a section called "What's New" has been added to the home page, a section under training containing recent publications by members, links to sister societies will soon be added.

Council plans further review and development of the website in 2007. If you have specific expertise or comments to make, please contact the Secretariat. Please also forward any resources that would be of wider interest to IMSANZ members, for posting in the website (e.g. talks, position papers, protocols, CATS).

Work of IMSANZ Council and the secretariat

In this section there was very positive feedback- thank you! Council members were all very heartened by your obvious strong support for the work that we are doing on your behalf. Strengths were seen in our attempts to advance general medicine and in communication, but you also made comments on the wonderful people in IMSANZ, the enthusiasm, and the sense of humour.

Some comments stood out:

Keeping the generalist flame alive and raising the profile to a "proper" job - not just appropriate to areas of population that can not support the "real" specialists ie sub specialists.

Engaging profession re re-vitalizing general medicine.

The sense of cohesion amongst generalists is improving.

Excellent meetings – the main forté of IMSANZ.

As to where IMSANZ Council might do better, there were several points made on the relationship between general medicine training and workforce.

IMSANZ has only one major objective. We need trainees who want to do general medicine. Without trainees and willing participants there IMSANZ will not continue to exist.

The basic issue is the survival of general medicine. It is not popular with the registrars, long hours, complex work, poor status no clear job definition e.g. cardiologist v generalist.

More adverts for associate members (many budding internal physicians are now in basic training, from Western Australia at least).

More work on encouraging trainees to join, attend and present at conferences.

We do need to be careful how we promote general medical training - insisting on dual training or otherwise significantly lengthening training to promote dual training will, I believe ultimately keep large numbers of trainees away from general medicine to the "softer" option of subspecialties. A more flexible and pragmatic approach to training should be our goal.

Most comments, however, related to how IMSANZ Council might better advocate for general medicine and general physicians.

Liaise with other societies in Australia which focus on generalist approach - ASGM.

Perhaps alter focus on GM and aim to promote GM as the "New" subspecialty.

Remind the RACP of the importance of general physicians.

IMSANZ could represent the capacities of general physicians better to support organisations for diseases like diabetes, kidney disease, rheumatology etc. Information for the lay public produced by such organisations regularly indicates that once things become too complicated/specialised for the GP, patients should be referred to an endocrinologist, nephrologist, rheumatologist etc - never to a general physician.

Get a better deal for item 110 in Oz.

Try to advocate separate from RACP rather than always with RACP where issues become so politicised that they seem bland. I want some more "crisis in healthcare" coverage rather than apologies.

Produce more position statements, policies and resources on specific topics in general medicine relevant to clinical practice of general physicians.

Help with recruitment of physicians in smaller hospitals.

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'GIM' GOES GLOBAL: *The First International Symposium In General Internal Medicine – Toronto, April 2007*

William A. Ghali, MD, MPH, Jacques Cornuz, MD, MPH, and Donald Echenberg, MD.

The Departments of Medicine and Community Health Sciences, and Centre for Health and Policy Studies, University of Calgary (WAG); The Policlinique Médicale Universitaire, and Institute for Social and Preventive Medicine, University of Lausanne (JC); and the Department of Medicine, University of Sherbrooke (DE).

"To realize the full possibilities of this economy, we must reach beyond our own borders, to shape the revolution that is tearing down barriers and building new networks among nations and individuals, and economies and cultures: globalization. It's the central reality of our time."

- William J Clinton

"It has been said that arguing against globalization is like arguing against the laws of gravity."

- Kofi Annan

Mark your calendars. An important event is about to occur in Toronto next April – the staging of the First International Symposium in General Internal Medicine (GIM). The Symposium arises from over three years of dialogue among international leaders in GIM, and will be held in conjunction with the 30th Annual Meeting of the Society of General Internal Medicine (SGIM) at the Sheraton Centre Toronto (April 25-28, 2007).

GIM has, for the most part, evolved in country-specific 'silos' over the past several decades. This is in contrast to other subspecialties of Internal Medicine, which have developed a worldwide presence through the staging of large international meetings, and the associated formation of collaborative networks designed to advance agendas in research, education, and clinical care. Supporting the call for a more global role for GIM is the recognition that the clinical work of general internists is quite similar in many countries (eg. the United States, Canada, Switzerland, Japan, Argentina, Australia, and New Zealand) [1].

The differing emphasis on primary care roles for general internists may have led some to conclude that GIM differs too much between countries for interaction to be fruitful. However, this is a relatively minor issue when one considers our common areas of interest, such as the management of complex patients with multi-system disease, chronic disease management, prevention, and the management of patients with undifferentiated symptom presentations. GIM synergy is even greater when one considers the shared academic focus in areas such as medical education, clinical epidemiology, health services research, medical informatics, health economics, and the challenges of quality and safety [1].

The International Symposium in Toronto will feature sessions on quality of care and patient safety; the role of the general internist in global health; and the burgeoning areas of e-Health innovation and chronic disease management. This will be followed by the SGIM's Annual meeting, which has adopted the theme "The Puzzle of Quality: Clinical, Educational, and Research Solutions" – something we can all relate to. Further information can be found at www.sgim.org.

The rich mixture of plenary sessions, oral and poster research sessions, workshops and clinical updates has routinely attracted over 2000 attendees from the USA and abroad. In the past, relatively few Canadian general internists have attended, possibly because of a misperception that SGIM is focused exclusively on primary care. On the contrary, SGIM annual meetings have something to offer almost all clinical and academic profiles, including Canadian internists.

A wave of globalization is about to engulf GIM. Come to Toronto this spring, and help us take a first big step toward creating a vibrant and global discipline of General Internal Medicine!

References:

1. **Ghali WA, Greenberg PB, Mejia R, Otaki J, Cornuz J. International perspectives on general internal medicine and the case for 'globalization' of a discipline. Journal of General Internal medicine. 2006;21:197-200.**

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The feedback received from the survey validates current Council directions, yet, as we hoped, has highlighted areas on which we need to focus in 2007, such as advocacy and the website. Hopefully it is clear that many of your suggestions are being acted upon already.

The survey has indicated areas in which the membership may be able to assist the work of Council, such as by working politically at a local level to advance general medicine, contributing articles to the newsletter, and creating resources for the website. We desperately need evidence of local initiatives to make effective representations to the various stakeholders in general medicine.

Interestingly, the only major difference between Australia and New Zealand was in the number of you who had not been to a dedicated IMSANZ meeting outside of an RACP meeting in the last 5 years - in Australia this was 45% of you, in NZ only 14%. Hopefully the wider range of meeting offerings in 2007 will appeal!

Thanks to all of those who replied, and to Mary Fitzgerald who collated the results.

PHILLIPPA POOLE
President IMSANZ

A MORNINGTON PENINSULA VIEW OF ACUTE MEDICINE

New Zealand and the United Kingdom have a common approach to training physicians. After having passed the basic qualifying examinations each trainee must undertake advanced training in both their chosen speciality and General Medicine (GM). Consequently each has physicians competent to and capable of undertaking the care of that substantial proportion of internal medicine patients admitted to hospital, those cared for by general physicians.

The United Kingdom traditionally admits the general medical patient to the on take speciality unit, so that rotating speciality units undertake the care of the GM patient thereby receiving that group of undifferentiated, multiply co-morbid, elderly and complex patients who do not have the "good fortune" to have a speciality specific illness. Such a system applies to the Trusts in each country. In Australasia, rural base hospitals are without the structure of the larger metropolitan hospitals, and consequently are dependant on those physicians who predominantly practice in GM to undertake the care of the full range of internal medical patients admitted. The management of this substantial group of medical patients, who are not speciality specific, has become a significant issue which has been well discussed, and each country has addressed the problem differently.

The USA has developed hospitalists, Australasia has enhanced the return of GM Units in metropolitan hospitals and advanced training in GM and the United Kingdom had developed the Acute Medicine Units (AMU's). In the UK the Australasian advanced trainee (APT) is called a speciality registrar (SPR).

I suspect I was the sole international registrant at the annual autumn meeting of the Society for Acute Medicine UK (SAM), in London in September 2006. There were over 400 attendees, well exceeding the 273 registrants, of whom over 70 were SPR's in Acute Medicine (AM) and over 20 were nurses, with the bulk of the registrants being physicians working in many AMU's in hospitals throughout the UK. The obvious success in attracting trainees to a speciality which is General Internal Medicine, in a country which has no GM inpatient Units, is an outstanding result, given that the first such units were started about 10 years ago.

This success of AM in the UK reflects the initiative of the joint Royal Colleges of Physicians over the past decade in publishing various reports, which have established the principles of AMU's and encouraged their development.

Committed physicians who saw the need to care for the medical patient in the first phase of his or her hospitalisation established SAM some 7 years ago. The growth of the Society has been progressive and impressive. AM was accepted as a distinct speciality of Internal Medicine by the Royal Colleges of Physicians in 2003 and there is now an established specific training program in place reflected by the 70 + SPR's in AM at the SAM meeting. The growth of the speciality is both progressive and impressive with both the numbers attending and the exponential growth in membership, now over 400.

I subsequently undertook day visits to 2 of the earlier such AM units in England, each with different management systems, each dealing with the acute medical patient. The first was the Emergency Admission Unit (EAU) at Norwich & Norfolk University Hospital with separate but adjacent Medical and Surgical EAU's under the management of a physician Director, Dr Paul Jenkins who has a background in intensive care. The EAU's are separated from but nearby the Emergency Department, The units were probably similar to the APU at Auckland City Hospital directed by John Henley. The second at Southampton General Hospital was more like the usual AM Unit in the United Kingdom and that, which is common in Australia. Dr Chris Roseveare is a gastroenterologist who has committed to acute medicine, but still does some speciality work.

These units illustrate the experience in Australia where the AMAPU, by whatever acronym, differs in name and function, but still manages the initial period of the hospitalisation of the medical patient not admitted to speciality specific medical units.

The guidelines and recommendations published by a committee of IMSANZ earlier this year reflect the reports of the Joint Royal Colleges of Physicians in the UK, the report by the Royal Melbourne Hospital Department of Epidemiology in 2004 at the request of the Victorian DHS and the experiences of physicians managing such units in different Australian states and in New Zealand.

It would seem that we in Australasia and those in the UK have developed similar pathways to deal with the acute GM patient, and that our similarities are such that it would seem desirable that IMSANZ commence a dialogue with SAM, to have representatives from each body attending each others future meetings.

Having attended the first scientific meeting of IMSANZ in Alice Springs last year and the 7th annual SAM autumn meeting in London last month, I was struck by the substantial similarities of the meetings, their content and of course the Societies.

The striking impression is the success SAM in having its speciality, AM, established as a well recognised distinct speciality with a specific training program, many SPR's and an evident commitment by the Royal Colleges in encouraging the further development of the speciality. Indeed, SAM has been asked to develop specific MCQ's to test the knowledge of AM in the College examinations.

I head, within the Department of GM in Peninsula Health, possibly the most recent MAPU to be commenced in Australia, which took its first patients on July 3rd 2006. We followed closely the recommendations of both the Royal Colleges reports and that of the RMH Dept Epidemiology. We were pleased to see a close concordance with the IMSANZ guidelines published as we were finalising the structure and management of our MAPU.

We have differed from the IMSANZ recommendations in emphasising the necessity of having twice daily consultant led rounds and have a concurrent morning consultant led round of the overnight admitted medical patients remaining in the ED, as part of the morning handover. This is similar in function to the rounds occurring at Southampton.

It is too early to report on our results, but we are discharging admitted patients from both the ED and MAPU each morning and from MAPU throughout the day and if necessary, evening. We have emphasised the need to have multidisciplinary planning meetings but the difficulties in accessing such professionals

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OUTCOMES OF RACP/IMSANZ CLINICAL INDICATOR WORKSHOP

The RACP and IMSANZ jointly hosted a workshop on design and implementation of clinical indicators for use in Internal Medicine in Sydney on November 10 at the newly renovated college function rooms. It featured presentations from Professor Donald Campbell from the Monash Institute of Health Services Research, Dr Caroline Brand from the Clinical Epidemiology and Health Services Evaluation Unit of Royal Melbourne Hospital (RMH) and Assoc Professor Ian Scott from the Department of Internal Medicine and Clinical Epidemiology at the Princess Alexandra Hospital. Topics included an overview of who is using, and what the evidence is, for clinical indicators, linkage of administrative outcome data with clinical audit using case-control methods, a practical demonstration of the Internal Medicine Indicator Project being undertaken at RMH, and a summary of the benefits and limitations of clinical indicators. The workshop was attended by 17 general physicians from around Australia and New Zealand who had an interest in advancing use of indicators within their own institutions and who participated in several break-out sessions aimed at identifying issues and achieving consensus relating to a core set of indicators that could be used by internal medicine units on both sides of the Tasman.

The workshop was lively and constructive and at its close three resolutions had been adopted: 1) the RMH indicator set would, with some local adaptations, be part of a core set for Australia and New Zealand; 2) the group of attendees would be formalised as an ongoing working group to continue developing and experimenting with current and new indicators and methods of implementation; and 3) another face-to-face workshop would be held in conjunction with the RACP ASM in Melbourne in May 2007. It is hoped that by October 2007 a set of agreed indicators for Internal Medicine can then be forwarded to the Australian Council of Healthcare Standards to replace those currently used by this organisation in its EQUiP and hospital accreditation programs. Thanks to Nik Todorovski at RACP who assisted in organising this workshop. PowerPoint presentations and conference proceedings from this workshop will be posted on the IMSANZ website for any member who has an interest in this area, and who would also be welcome to join the Working Group.

IAN SCOTT
Chair, RACP/IMSANZ Clinical Indicator Working Group

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on a daily basis need further discussion. We are reducing the LOS of admitted GM patients and have succeeded in instituting same day exercise tests for appropriate chest pain patients and echocardiographs for both heart failure and valvular heart disease patients. Priority access to MRI/A scans as well as other radiology is usually available within 24 hrs. We have developed a close relationship with HITH, and so are able to achieve early transfer of care and discharge from MAPU. Transfer to other inpatient units may occur at any time, whenever a bed is available. We have been able to effectively admit the substantial majority of GM patients to MAPU for acute management and either discharge directly or transfer to inpatient units within our goal timeframe. These small achievements represent improvements in the care of GM patients in Peninsula Health.

The list of causes of failures to deliver the goals of a MAPU, identified in the RMH 2004 report, have pertinence to us and our further planning. Access block is now our immediate problem in being able to transfer MAPU patients to inpatient General and Speciality Medical units, but is particularly so for the elderly who require further assessment with regards to rehabilitation, potential placement and establishment of Community supports to prevent readmissions. Concurrent rounds by both Acute Physicians and Geriatricians in MAPU, as occurs in Southampton daily at 1700pm, is a goal which we should strive to achieve through the establishment of an Acute Care of the Elderly GM Unit preferably co-located with the MAPU.

IMSANZ is committed to the re-establishment of GM as a substantial speciality in all hospitals, irrespective of their size. However, I wonder if the current achievement by IMSANZ in attracting trainees to undertake advanced training in General Internal Medicine in Australia, is as successful as that of SAM, which has the clear and substantial support of the Royal Colleges of Physicians, the UK Government and the various Trusts which administer health services. The numbers of APT's in GM attending the 2005 IMSANZ Alice Springs meeting and the RACP Scientific meeting in Cairns earlier this year did not seem proportionally as great as the attendance of SPR's at SAM 2006. It would be of interest to know how the development of AMAPU's in Australia has influenced the choices of APT's and if there is an actual growth in the number of such trainees electing GM.

I feel that in AMAPU's, we can offer excellent training for BPT's and APT's in GM, which together with the ED resuscitation rooms and ICU rotations provide high quality training in AM for the General Internal Medicine Physician of the future.

I was asked by executive members of SAM, if Australasian Physicians would be interested in developing close ties with SAM and attending SAM's first International Meeting of AM planned for autumn 2007, provisionally in Glasgow. I expressed my personal view that this would establish a valuable association and be a meeting that I'd be most interested in attending. I'd hope that other General Physicians in Australasia will have similar views with regards to such a useful association and consider attending.

I hope that IMSANZ's Council will give consideration to commencing a dialogue with SAM, discussing the common problems, workloads and goals of both organisations and so reflect on the experiences of the SAM to further progress the resurgence of GM in Australia.

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This year's Annual Scientific Conference was a joint effort involving the IMSANZ, RACP and our Nephrology colleagues (ANZSN). The Queenstown venue provided a sweetener, with many taking the opportunity to bring family to share some of the recreational opportunities on offer. The 3 day meeting was preceded by a Trainee's Day, which saw over 20 attendees. Feedback about the day was strongly positive, with plans to repeat the opportunity in the future. Day one of the conference was kicked-off with an address by the Queenstown mayor. Contrary to expectation, he provided an interesting insight into the stresses and growth-pains facing the region, with it's heavy reliance on tourism, absentee property owners, high cost of living, and the transient and youthful work-force. This was followed by one of our invited speakers, Patrick Parfrey's insight into the management of cardiac disease in chronic renal disease. This Irish-Canadian is renowned for his work on renal transplantation, genetic renal disease and cardiac disease in dialysis patients - not to mention the fact that he appears to have had an equally productive career serving the Irish and Canadian rugby fraternity.

Competition for the RACP Young investigator and De Zoysa Prize for best IMSANZ Advanced Trainee Presentation was robust. Included in the line-up were an audit of the use of Zoledronate in South Auckland and the significance of ANCA in Churg-Strauss Syndrome. The winner of the RACP award was Patrick Gladding, who presented the antiplatelet effect of 6 NSAID's. He showed that Naproxen had significant anti-platelet effect, whilst Ibuprofen, Indomethicin and Celecoxib have none. He also showed that those recently administered Ibuprofen, Indomethicin or Naproxen are resistant to the anti-platelet effects of aspirin. The IMSANZ award went to Stephen Dee for his presentation on the use of a Morbidity and Mortality Review as a quality improvement tool at Hutt Hospital.

The afternoon was completed with a cardiac and renal update symposium. We heard a presentation by invited speaker Professor Garth Cooper on the pathogenesis of diabetic cardiomyopathy, an update on diastolic dysfunction (exercise related heart rate important to control; can be very sensitive to the effect of diuretics; no good evidence for any particular drug class in treatment) and the awful prognostic implications of a combination of pregnancy and underlying renal disease.

The evening's Conference Dinner in the restaurant at the top of the gondola was a superb affair. Somewhat late in the evening-

Phillippa Poole, Stephen Dee and Neil De Zoysa

Bruce King, Eileen Bass, Tom Thompson and Ian Dittmer

Sarah Lynn, Denise Aitken, James Williamson and Paul Reeve

and soon after the outbreak of some spontaneous poetry (mostly Irish, if I recall) - a group retired from the mountain top to the Irish pub at lake-level, where a small gathering of nephrologists and other physicians ruminated for a few happy hours.

The early morning of Thursday focused on metabolic issues: Anorexia Nervosa, the use of statins in renal failure and the association of obesity with the Metabolic Syndrome. Patrick Parfey elucidated the genetic aspects of cystic kidney disease and in the "Controversies in Renal Medicine Symposium" the dialysis of the very elderly, the avoidance of contrast nephropathy and the management of anaemia in renal disease provided cause for debate. Then it was time to enjoy an afternoon at leisure, with options such as a local wine-tour, an amphibious vehicle adventure, jet-boating and skiing being amongst the offerings. However the afternoon was spent, most delegates it seemed returned in time for a superb evening of wine-tasting - testament I think to the anticipation of tasting some (expensive) local Pinot Noir gratis. The tasting was conducted by a local wine-experience business, and provided a good sampling of some of the local Pinots (Noir and Gris), as well as some Riesling and Rose.

On Friday morning we were greeted to a clear day with fresh snow evident half-way down the mountain-slopes. Early-birders were able to attend an update of common medical problems: the use of thrombolysis in sub-massive PE (uncertain), the use of (up to 6) drugs at doses regarded as sub-therapeutic in a poly-pill (and the extension of this from the realms of

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In NSW, the Hunter-New England Health Service has applied to NSW Health for annual funding of $418,000 to implement an advanced training program in General Internal Medicine (GIM) for trainees of the RACP. The aim of the program, in line with RtB objectives, is to produce general physicians for a variety of roles, including medical services in regional and rural NSW and academic/research leaders. IMSANZ members John Attia and Aidan Foy, architects of the program, propose a 3-4 year training program that will build on the already established basic physician training network in the region. This advanced training program will offer rotations in regional and rural hospitals, a broader scope of training experience including acute and geriatric general medicine as well as ambulatory care, exposure to teaching and research activities and the opportunity to attain dual certification. Four advanced trainee positions will be offered each year and the outcomes of the training program will be monitored in terms of trainee satisfaction, the number of trainees obtaining certification (single and dual), and the eventual positions/practices taken up by the graduates at 5 and 10 years post-completion. IMSANZ council was pleased to provide a letter of endorsement that accompanied the submission, and a favourable response is eagerly waited from NSW Health so the program can start in 2007.

In Queensland, a workshop was conducted on 20/10/06 involving Directors of Internal Medicine of regional and tertiary hospitals throughout Queensland and representatives from Queensland Health to discuss various proposals from the Director – General of Health put forward in response to RtB. The workshop resolved to establish: 1) two training networks for basic physician trainees, one centred on Royal Brisbane and Women's Hospital (RBWH) and the other on Princess Alexandra Hospital (PAH) which will aim to provide 2-3 year career paths for trainees which involve rotations through regional as well as tertiary hospitals with emphasis on giving exposures to subspecialty medicine; 2) a state-wide Directors of Medicine Working Group which will oversee the training networks and make recommendations to QH on how workforce issues, professional opportunities and infrastructure pertaining to general medicine services can be improved; 3) a number of dedicated, supernumerary positions for advanced trainees in general medicine that can be used to provide rotations in subspecialty terms without competition from subspecialty advanced trainees. This latter proposal is already bearing fruit with PAH Division of Medicine agreeing to 1-2 such positions for 2008 whereby funding provided by the Division is linked to the position, not to a particular department, such that the trainee can choose what subspecialty rotations they desire and then choose the terms of highest value offered by the subspecialty units who compete for the chance to have an extra registrar in their unit at no cost to themselves.

In the Northern Territory, IMSANZ member Stephen Brady from Alice Springs reports that the newly appointed Minister of Health has issued a memorandum to all departmental staff stating that over the next 5 years, the Department of Health and Community Services intends to invest in developing its generalist medical workforce through the retention and building of a strong body of generalist psychiatrists, paediatricians, surgeons and physicians. Training of junior medical officers will also focus on these key streams. It is intended that the Territory will become a centre of generalist training for paediatricians, surgeons and physicians.

At the level of the college, the Specialties Board at its last meeting on 15/9/06 has considered a draft paper from the RtB Implementation Committee outlining amongst other things a more flexible training pathway for all advanced trainees which enables exposure to training in specialties including general medicine outside their primary specialty and thus to practise more as a generalist (see related article this issue). IMSANZ would prefer to see a push for dual certification whereby trainees undertake all the required training for both general medicine and subspecialty qualification. But the Australian moiety of the college appears reluctant to pursue this approach despite the fact that it works very well in New Zealand. Based on the negative responses received from a number of subspecialty societies in the past to the question of making the non-core year of their training programs open to other specialties, IMSANZ is not expecting a reversal of the trend with this latest proposal even though we are happy to endorse it and hope for a positive outcome.

IMSANZ Council would be pleased, as always, to hear about any other developments that members may be aware of that reflect the reforms and objectives laid out in RTB.

IAN SCOTT

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cardiovascular disease to that of psychiatric therapeutics) and the under-appreciated CVS risk in our lupus patients. This was followed by IMSANZ and ANZSN free-papers, presented in 2 concurrent sessions. In the IMSANZ sessions we heard of the 5 year positive experiences of an Acute Assessment Unit in Western Australia; the improved performance of lower-limb reflex examination in the seated patient; the infrequent use of effective treatments in high risk and the over-use in lower risk patients presenting with ACS; the burden of gout in renal-transplant recipients (and the strong association with those remaining on loop diuretics) and the approach to the management of lipids in the patient with a stroke. The morning was completed with a symposium on transplantation issues. Ian Dittmer provided insight into factors affecting the outcomes of renal transplant; Helen Pilmore explored strategies to optimise these outcomes and intensivist and Organ Donation NZ director Steven Street presented some of the wide-ranging issues surrounding organ donation in NZ – touching on those affecting the autonomy of the deceased and their grieving families, cultural, political and medical aspects. This concluded the conference, although many were staying longer.

On reflection, and as a relatively new member of IMSANZ, the meeting provided me with the right mix of medicine and pleasure. More than just another excuse to visit Queenstown, the conference proved to be a good learning and sharing experience: visiting Queenstown was just a bonus (as was that Pinot!).

ANDREW BURNS
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Flexibility vs Prescription - Time for Firm Guidance

This document was submitted to Specialties Board at its meeting on15/9/06 and is reproduced here with permission of Board chair Dr John Kolbe.

A guiding principle for the RACP's training programs has always been flexibility but recent trends have been towards greater prescription or direction. In the area of workforce, although the RACP's mission is the production of a workforce that optimally meets the health care needs of the community, it has generally done little to ensure that this occurs. Finally, while the link between training and workforce is undeniable, and although much has been done recently through the education strategy to ensure the curriculum reflects the required skills of the workforce at a broad level, little has been done to provide direction about the balance between broad and subspecialist skills expected of new fellows.

Three recent key events mean that there is an opportunity to have an impact on these issues – the education strategy and subsequent appointment of a Director of Education which has the ability to fundamentally reshape training content, the governance review including the development of memoranda of understanding with the specialty societies that will reshape the way in which advanced training is delivered, and the document "Restoring the Balance", which increases the profile of general medicine within the RACP and in the eyes of state and Commonwealth health departments.

The broad direction of the education strategy and the workforce required to meet healthcare needs of the community must be over-riding considerations and the RACP must provide firm guidance about how it requires the three-way balance between subspecialisation, general medicine and broad practice to be addressed.

Overarching principles

The RACP with the support of the Director/Dean of Education and the workforce portfolio must establish some basic principles around subspecialty and general medicine and broad practice to guide training and CPD, and workforce considerations. These should include:

- ***The healthcare needs of the community are best served by a spectrum of physicians: from generalists to specialists to subspecialists and sub-sub specialists. The proportions will vary with different health systems and locations.*** The RACP continues to support the award of the fellowship diploma without subspecialty restriction.
- ***All physicians have undertaken at least three years of basic training across the breadth of internal medicine and have undergone a rigorous assessment of these knowledge and skills.*** Those who subsequently train across a range of subspecialties before receiving fellowship (even though the entirety of the training may be undertaken under the auspices of one training committee) and whose post-fellowship practice covers a range of subspecialties must be considered capable of providing "broad" training to upcoming trainees.
- ***Trainees must have the opportunity to undertake programs that cover a spectrum from pure subspecialty training and practice through to practice in which the subspecialty is a smaller component.*** If trainees wish to train across several subspecialties, including general medicine, they must be actively supported and training committees must work together to ensure that trainees are not disadvantaged. The facilitation of cross-subspecialty training will require individual hospital departments to make available training positions to trainees from other subspecialties. This will occur most effectively when training positions are allocated on a networked basis so that no single hospital department will need to make this accommodation on a regular basis.
- ***No advanced training program should require more than two years core training in the one subspecialty.*** While recognising the value of additional training in the subspecialty, research training or training in what is deemed to be a most appropriate complementary subspecialty, this should be optional.
- ***CPD should reflect clinical practice. For those undertaking practice which involves acute care of unstreamed patients an appropriate part of CPD should be related to the maintenance of broad skills across a range of relevant subspecialties. All physicians should undertake at least 10% of their CPD activities outside their major area of clinical practice. This should cover related and relevant subspecialty areas and areas specified in the Professional Qualities curriculum.*** Ongoing CPD requirements and credentialling (and re-credentialling) of those who practise across several subspecialties are important issues to be addressed through the memoranda of understanding and training arrangements. This will require a cooperative approach across subspecialty groups. Of particular importance will be the needs of those who practise primarily in a subspecialty as well as more broadly, particularly participating in acute on-take rosters. While recognising that they may not have undertaken full training in general medicine, there must be a mechanism for recognising and supporting their broad skills.

The way forward

Once agreement has been reached that the principles are appropriate there will need to be an active promotion of them and any resulting policy issues with the specialty societies and SACs and discussion with those health departments that are keen to promote general medicine (and broad) training and practice.

RICK MCLEAN/JOHN KOLBE/SUE MOREY
14th September 2006

2007	
MARCH	**IMSANZ NZ Autumn Meeting** 22-24 March 2007 Waiheke Island Resort, Auckland Numbers are limited so please send expression of interest on form available on the website: www.imsanz.org.au/events/ *TSANZ Meeting will be held in Auckland immediately after the IMSANZ meeting*
APRIL	**30th Annual Meeting of the Society of General Internal Medicine (SGIM)** 25-28 April 2007 Sheraton Centre Toronto, Canada Website: www.sgim.org/am07/
	Society for Acute Medicine (UK) - Spring Meeting 2007 26-27 April 2007 Cedar Court Hotel, Halifax, W Yorkshire Website: www.acutemedicine.org.uk
MAY	**RACP Congress 2007** 6-10 May 2007 Melbourne, Victoria Website: ww.racpcongress.com/program.asp
	European Federation of Internal Medicine (EFIM-6 Congress) 23-26 May 2007 Lisbon Congress Center, Lisbon, Portugal For further details email info@efim2007.com Website: www.efim2007.com
SEPTEMBER	**ANZSGM / IMSANZ / IANA Combined Meeting** 5-8 September 2007 Adelaide Convention Centre, Adelaide, South Australia Website: www.fcconventions.com.au/MedicineAgeingandNutrition2007
OCTOBER	**CSIM Meeting 2007** 10-13 October 2007 St John's, Newfoundland, Canada Email: csim@rcpsc.edu Website: www.csimonline.com
NOVEMBER	**RACP (NZ) / Gastro / IMSANZ** 21-23 November 2007 Christchurch

TRAVEL SCHOLARSHIP WINNERS REPORTS

European School of Internal Medicine 2006 - Sintra, Portugal

I am a third year advanced trainee in general internal medicine I was fortunate and delighted to attend the European School of Internal Medicine's 9th edition course (ESIM9) held in Sintra, situated north of Lisbon, the historic city and the capital of Portugal with the courtesy of the IMSANZ travelling scholarship. Sintra has been declared by UNESCO as world Heritage site for its fascinating landscapes with mountains, parks, historic palaces, calmer and warmer beaches. Having attended many conferences in the past, I consider this meeting is unique and both enjoyable and educative. This was the first time this course was held out of Spain. The previous eight editions were held in Alicante, Spain under the Directorship of well-respected Professor Jaime Merino. This year's course was superbly organised and hosted by Portuguese society of Internal Medicine under the directorship of Dr Antonio Martins Baptista. The meeting venue was a beautiful air force academy with excellent facilities.

There were 52 residents from 20 countries selected and supported by the internal medical societies of their respective countries. Most of them are being trained in internal medicine while some of them were dual trainees with sub-speciality interests. It was interesting to meet this friendly bunch of doctors from different social, cultural and geographical backgrounds and sharing their experiences. There were also 12 lecturers from different countries participated.

Chris Davidson (UK, Vice President EFIM), Vigna Ganesamoorthy (NZ) and Stefan Lindgren (President EFIM).

The meeting had a good balance of academic activities and social programme. The academic programme comprised of 12 lectures on a wide range of clinical topics, two clinico – pathological conferences and five workshops. The workshops were aimed to understand different health systems and issues an internal physician encounters in day-to-day clinical practise. Workshops such as ethical issues in different clinical scenarios, horizontal prioritising of health-care resources, and different identities of internal medicine around Europe generated debate and discussion among participants. In addition there were 19 clinical cases presented from participating countries which highlighted the similarities and slight differences in management depends on the availability of investigations and treatment. All presentations were of good standards. I also had an opportunity to present a clinical case, which seemed to be well received.

A fantastic social programme was organised in the evenings with dining and plenty of wine, dance, music, entertainment and tours. We were taken for a double – decker bus tour in Lisbon to view its famous historical buildings and churches, which were re built after the destruction when the city was wreaked by the earthquake of 1755. The delegates also had the opportunity to tour in historic Sintra and were able to spend half day in the beach on the free entertainment day. Time passed very quickly and the final closing dinner was a mixture of joy and sorrow of leaving Sintra and the great friendly atmosphere we had.

Antonio Martins Baptista (Director ESIM-9, Portugal), Chris Davidson, Stefan Lindgren, Lorenzo Dagna and Vigna Ganesamoorthy.

It was an unforgettable experience and difficult to describe in words. I am also reassured that our training programme and our experiences are not inferior by any means to our European colleagues. I once again wish to convey my thanks to IMSANZ for the travelling scholarship.

I would highly recommend this conference to others. For those interested in learning more about ESIM9, please visit to the website - http://esim.spmi.pt.

VIGNA GANESAMOORTHY
New Zealand

CSIM Meeting November 2006 - Calgary, Canada

I was very fortunate to have the opportunity to attend the Annual Scientific Meeting of the Canadian Society of Internal Medicine in early November 2006. The conference was held in Calgary, Alberta, host to the 1998 Winter Olympics and home to around one million people. It is a lovely area. The city was already covered in snow, the shops decorated with Christmas lights and the stunningly beautiful Rocky Mountains only an hour away.

Canada is the second largest country in the world but it is relatively sparsely populated with only 32 million people

Continued page 20

The results of the membership survey (see related article this issue) indicate an underutilisation of the website by most members coupled with several suggestions for making the site more attractive.

The request for a common log-in through the RACP portal is something that we have been thinking about for some time but it involves linking with the RACP database and being able to recognise physicians who are both financial IMSANZ members and fellows. There is also the problem with IMSANZ members who are not fellows of the college. We will take the subject up again with our web-master.

The call for more position statements, locum advertisements, educational resources and links to other sites, including conference notifications, is reasonable although I hasten to add that we have a fair bit of this stuff already if you take a few minutes to fully look around the site. It is disappointing, considering the effort that is involved, to see that few folk access the CAT library which is the one of the best up-to-date resources available to general physicians and one not replicated by any other specialty society.

On the other hand, we recognise the need to provide more complete guidelines and synopses on specific topics that are frequently encountered in general medicine practice, and to that end, we have introduced a new department under 'Member Resources' entitled 'Evidence-based guidance for common clinical problems.' We will start with cardiovascular related topics and add respiratory medicine as the next section. Once again we ask members to contribute resources that they are aware of or have been involved in producing which may be of use to colleagues.

Other items recently posted, or about to be posted, include:

- IMSANZ position statement entitled "Re-examining the essentials on improving quality and safety of hospital care"
- Advertisements for new physician positions throughout Australia
- An evidence-based guide to peri-operative medicine
- New CATs
  - o Telephone counselling by a pharmacist reduces mortality in patients receiving polypharmacy
  - o Statins following stroke or TIA confer small benefit in preventing further stroke (SPARCL)
  - o Rosiglitazone promotes normoglycaemia in patients at high risk of developing diabetes (DREAM)
  - o Ramipril promotes normoglycaemia in patients at high risk of developing diabetes (DREAM)
  - o Parathyroid hormone effective in preventing fractures in postmenopausal women with prior fractures
  - o Naltrexone and behavioral interventions reduce alcohol dependence
  - o Heart failure with preserved ejection fraction has a similar prognosis to heart failure with reduced ejection fraction
  - o Continuation of anticoagulation in patients with abnormal D-dimer test following treatment for first unprovoked VTE reduces risk of recurrence (PROLONG)
  - o Anticholinergic agents better than beta-agonists in preventing respiratory deaths and severe exacerbation in COPD
  - o Add-on insulin glargine or rosiglitazone have similar efficacy in improving glycaemic control in type 2 insulin-naïve diabetic patients already receiving combination therapy of sulphonylurea and metformin
  - o Carotid artery stenting gives worse outcomes than carotid endarterectomy in symptomatic patients with carotid artery stenosis

From page 19

approximately. Many of the speakers were therefore familiar with the challenges of working outside major tertiary centres and the general approach was a nice balance of clinical excellence and everyday reality. The conference offered a full programme of interesting and relevant topics. There were a variety of workshops with a practical approach to topics such as interpreting difficult ECGs, managing vasculitis, haematology and endocrine emergencies, bedside teaching, interpreting chest x-ray and CT, and dealing with medical problems in pregnancy. There were also keynote speakers on topics such as diabetes, heart failure, atrial fibrillation and chronic renal failure. Newer issues covered included incretins in diabetes and the use of ACEIs in atrial fibrillation.

A frequent topic of informal discussion was the shortage of general physicians in Canada and their dependence at present on overseas recruitment. However they seemed much heartened by the large number of students and trainees attending the conference and this was felt to be very positive for the future of general medicine in the country. The other particularly interesting aspect for me was Canada's bilingualism. Although there was not a lot of emphasis on indigenous issues or language, the French language was very much present.

My very grateful thanks to IMSANZ for the opportunity to have such an enjoyable and educational experience.

ANNE MALONEY
Advanced Trainee General Medicine

INTERNAL MEDICINE SOCIETY OF AUSTRALIA & NEW ZEALAND
IN CONJUNCTION WITH
AUCKLAND GENERAL MEDICINE CONFERENCE 2007

Waiheke Island Resort, Auckland

Thursday 22nd March - Saturday 24th March

Close to award winning wineries!! Stunning venue...

A Provisional Programme, Registration Form, and Call for Abstracts will be available December 2006.

Accommodation and Activities options will be included.

As places will be limited to around 60-70, forms available on website www.imsanz.org.au/events/

Sponsored by: sanofi aventis

Staff Specialist Physician - Alice Springs NT

Come to Australia's beautiful Red Centre, and experience a unique working and living environment.

Alice Springs Hospital is looking for general or specialist medical consultants to join its Deptartment of Internal Medicine. Special skills in cardiology, gastroenterology, diabetes, infectious diseases or respiratory medicine would be most welcome but are not essential.

Alice Springs Hospital is a 164 bed teaching hospital affiliated with Flinders Medical School . The consultants, residents and registrars of the Department of Medicine are responsible for Medical outpatient clinics and a three unit 45 bed Medical ward as well as some outreach work. We are supported by the Departments of Emergency Medicine, Surgery and Radiology as well as by an Intensive Care Unit, and full laboratory facilities. In addition we have visiting consultants in many subspecialties.

We offer a fascinating job with friendly colleagues, a competitive salary with the opportunity of earning more through private practice and Medicare billing, six weeks paid annual leave, 10 days study leave with annual stipend, travel and relocation assistance within Australia and an initial three months of furnished, subsidised housing.

CONTACT DETAILS: Dr Stephen Brady (Director of internal Medicine, Alice Springs Hospital)
Tel: +61 8 8951 7777 | Email: Stephen.Brady@nt.gov.au | Applications close 1st January 2007

RATIONAL CLINICAL EXAMINATION

Simon Dimmitt

Rational Clinical Examination was written for medical undergraduates and trainees in general practice and internal medicine. It is a useful and succinct reference for all clinicians.

It was written by an experienced general physician and academic, incorporating much published evidence and has been enhanced with comments from numerous colleagues of the author.

The information is presented systematically and is easy to follow. Lists of differential diagnosis emphasise the most common conditions and the rationale and clinical context behind physical signs is discussed. The text is written as a foundation to leaning.

Although this title can be strategically read alongside more detailed textbooks, internet and other resources, it should be an extremely useful "stand-alone" clinical reference on the ward and in the office.

"....a marvellous integration of the elicitation of physical signs with their interpretation and clinical relevance. It is a very complete source which will be of enormous assistance to undergraduate students and those in vocational training" Prof Lou Landau, Former Dean, Faculty of Medicine and Dentistry UWA.

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Staff Specialist in Internal Medicine - Princess Alexandra Hospital, Brisbane

Applications are invited for full-time position of consultant physician in internal medicine within the Department of Internal Medicine and Clinical Epidemiology at Princess Alexandra Hospital, Brisbane. The position offers a total remuneration package worth up to $303,066 pa comprising salary between $126,472 and $142,745 pa, employer contribution to superannuation (up to 12.75%), annual leave loading (17.5%), private use of fully maintained vehicle, communication package, professional development allowance of $20,000 pa and 3.6 weeks pa leave, private practice arrangements plus overtime and on-call allowances, recreational leave of 5 weeks pa with 1.3 weeks pa accrual of long service leave, and flexible after-hours on-call roster which averages no more than 1 in 7.

Princess Alexandra Hospital is a large (640-bed) tertiary teaching hospital located in cosmopolitan sub-tropical Brisbane, a city of 1.2 million people, and less than 90 minutes drive from the famous recreational playgrounds of the Gold and Sunshine Coasts. The Department of Internal Medicine and Clinical Epidemiology has 80 inpatient beds and a team of 6 committed general physicians. Special interests include acute stroke medicine, geriatric medicine, diabetes, peri-operative medicine, clinical pharmacology, clinical epidemiology, quality improvement and care of the adult intellectually disabled.

Over the next 3 years the department will embark on several new initiatives including creation of a new 30-bed acute Medical Assessment and Planning Unit (MAPU) co-located with the Emergency Department (planned to open mid-2008), creation of a new Post-acute and Chronic Care Unit for patients with multiple chronic conditions, delivery of outreach consultative services in community-based clinics, and expansion of existing peri-operative medical services.

For an application kit contact +61 7 3240 5015 or email pa_recruitment@health.qld.gov.au

For further inquiries contact A/Prof Ian Scott (Director of Internal Medicine and Clinical Epidemiology, Princess Alexandra Hospital, Brisbane)

Tel: +61 7 3240 7355 | Mobile: 0412 668 472 | Email: ian_scott@health.qld.gov.au

IMSANZ Travelling Scholarship

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

VALUE: AUD5,000

ELIGIBILITY: Advanced trainee or fellow of the Royal Australasian College of Physicians of less than 5 years duration, who is a member of IMSANZ. Successful applicants will be required to explain how attendance at this meeting will be used to enhance the practice of Internal Medicine and to provide a 1,000 word summary of the meeting attended for publication in the IMSANZ Newsletter.

IMSANZ Research Fellowship

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

VALUE: AUD10,000

The fellowship is a total amount that is paid on a pro rata basis for the duration of enrolment in the research degree.

ELIGIBILITY: Advanced trainee or fellow of the Royal Australasian College of Physicians of less than 5 years duration, who is a member of IMSANZ; and enrolment in a higher research degree at a University in Australia or New Zealand.

IMSANZ Award for Best Scientific Publication in Internal Medicine

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

VALUE: AUD2,000

ELIGIBILITY: Advanced trainee or fellow of the Royal Australasian College of Physicians of less than 5 years duration, who is a member of IMSANZ; and publication of research in one of a list of selected peer-reviewed clinical journals.

IMSANZ Excellence in Clinical Education Award

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

VALUE: AUD1,000

ELIGIBILITY: Advanced trainee or fellow of the Royal Australasian College of Physicians; membership of IMSANZ; and nominated by peers to receive award.

More details and scholarship application forms can be found at www.imsanz.org.au/resources/awards.cfm

Applications for the Travel Scholarship should be sent to the IMSANZ Secretariat by 30th April 2007.

Dates and venue for the 2007 ESIM-10 are not yet confirmed but will be placed on the website as soon as they are received.

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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