IMSANZ
INTERNAL MEDICINE SOCIETY OF AUSTRALIA & NEW ZEALAND

APRIL 2007

Secretariat
145 Macquarie Street
Sydney NSW 2000
AUSTRALIA

Telephone
+ 61 2 9256 9630

Facsimile
+ 61 2 9247 7214

Email
imsanz@racp.edu.au

Website
www.imsanz.org.au

From the President...

By the time you read this we will have had the first of our three IMSANZ meetings this year at Waiheke Island, Auckland. With over 50 delegates this will be the largest autumn meeting in recent times (Report on *page 11*). Details of the other 2007 meetings in Adelaide and Christchurch may be found in this newsletter. In 2008 we plan to meet with the RACP in Adelaide in May, and in a rural setting in Victoria later in the year.

Recent discussions at IMSANZ Council, RACP, and at various educational meetings have begged the question, 'Is general medicine a subspecialty of medicine?' If you are reading this as one of over 440 IMSANZ members (a record!), it is likely you consider yourself primarily a general physician/trainee with the interest and skills to practice general medicine and to supervise others training in general medicine. You will have been recognised as having such skills by appointments and credentialing committees within the health system, or have set up your private practice with a general medicine focus.

RACP President, Nip Thompson, states on the website that "the RACP represents physicians in 25 medical sub-specialties including public health, occupational medicine and rehabilitation medicine." General medicine has long had its own SACs and an equal voice at Specialties Board. The advanced training curriculum in general medicine is in near-final draft and shortly to be circulated to IMSANZ members for comment. We were invited to do this work with the RACP over three years ago, along with all the other specialty societies and chapters.

The starting point for the curriculum was a list of the attitudes and competencies displayed by a competent general physician practicing general medicine. The competencies are organised under five domains, namely: hospital care; community and ambulatory care; consultation and liaison medicine; systems of care, and evidence - based practice. The writing team felt strongly that two of the distinguishing hallmarks of general physicians were that they:

- show willingness and capability to manage a diverse spectrum of clinical problems and patient casemix in a variety of clinical settings
- accept responsibility for patients who have difficulty accessing care

On the face of it, therefore, the answer seems obvious that general medicine is a subspecialty of medicine. This then raises another question-is training under the General Medicine SAC a necessary prerequisite to participation in acute undifferentiated medical rosters?

To answer this is more difficult. There is a range of views as to what extent RACP fellows are still able to express the '(general) physician within'. Can all those with FRACP do general medicine? Should they? Who should decide? Gerard Carroll, cardiologist and general physician (Wagga Wagga), and until recently co-chair of

Continued next page...

In this issue...

PRESIDENT'S REPORT

RACP NSW State Committee expresses this tension well:

"… anyone who passes the FRACP clinical exam and does the next two or three years training in a subspecialty, but maintains generalist skills (e.g. via medical registrar roster) is a functional physician with the capacity for generalist skills." I think this has been the position taken by the College for longer than my lifetime. I can see carnage this side of the Tasman (with respect to rosters, the pursuit of a role for the generalist, the right of a subspecialist to manage the whole patient) if the determination of clinical competence in General Medicine becomes the exclusive domain of the SAC in General Medicine. Sanctioning of such a division of competence may cause the collateral damage of excluding subspecialists from the newly developing item numbers dealing with complex, multisystem patients.

A balanced physician workforce for the health needs of Australia and New Zealand has to consist of general physicians alone, general physicians with subspecialty skills, subspecialists with general medicine skills and subspecialists alone. Arguably the majority should be in either of the two middle groups.

Unfortunately, the workforce situation in general medicine in Australia is not improving. A recent snapshot estimates over 150 vacancies nationwide, yet only 38 advanced trainees in general medicine. Only four of these were in NSW despite 33% of all RACP trainees being in that state. Acute medicine admission and planning units are being set up but are having difficulty recruiting appropriately trained physicians. In recent years General Medicine has slipped from being second to cardiology as the speciality with the largest number of consultants, to fifth, having been overtaken by gastroenterology, thoracic medicine and neurology.

Recently, IMSANZ members made a detailed submission to the National Health Workforce Secretariat regarding the general physician workforce situation in Australia. Extracts from this appear on *page 7*. We were supported by members of the AACP whose main thrust is negotiation of new consultation items for consultant physicians and paediatricians (proposed items 111 & 117) to cover comprehensive medical assessments and chronic disease management with multiple co-morbidities.

The current workforce trends for general physicians are not likely to be reversed in the short to medium term. If the health of communities is not to suffer, provision of acute and ambulatory general medical services must, therefore, increasingly fall on subspecialists, and those currently in training in specialities other than general medicine. They must be capable of meeting this challenge. Can the RACP assure us of this?

Each specialty society in RACP is developing an advanced training curriculum in isolation. This is problematic if we are to have the majority of RACP diplomates as general physicians with subspecialty skills, or subspecialists with general medicine skills. To date IMSANZ has seen only the geriatrics curriculum, and has had input to none. There has been no agreement at RACP level as to how much of each curriculum is mandatory, and how much optional. There has been no overt statement as to how dual training might be facilitated or mandated, and it's not clear if the RACP believes that specialty societies have some role in the fostering of medical expertise for advanced trainees outside of their own subspecialty. How are subspecialties then ensuring that there are sufficient subspecialists with general medicine skills?

Whether this all means general medicine is a 'subspecialty' probably depends on your perspective. There is a defined skill set and standards that IMSANZ and the General Medicine SAC have a large role in determining. Yet these bodies cannot claim the exclusivity of training oversight in quite the same way as the other subspecialties do.

The RACP is the umbrella training organisation with links to government, the health sector and to the other specialty societies. It needs to give some urgent consideration to defining core basic training, and general medicine training where it overlaps with those of other subspecialities. For example, IMSANZ has become aware that basic trainees in Sydney have very little recognisable general medicine experience, and discussion has occurred at the level of CPT as to what might constitute an acceptable alternative. To my mind, the RACP has no alternative but to mandate substantial general medical experience during basic training, under the supervision of consultants with expertise in general medicine. All RACP basic trainees should have in-training assessments of evaluating and managing undifferentiated medical patients. The breadth and depth of physicianly skills should be enhanced during advanced training by undertaking acute general medical call, training outside the speciality, consultations on patients from other services, and managing patients with co-morbidities. There's certainly no guarantee currently that this will occur.

In order to establish a policy framework for RACP training and workforce discussions, IMSANZ Council and the new Chair of the Adult Medicine Divisional Committee, John Kolbe, have been working on some draft principles for consideration by that committee. These will also act as principles for the MOU that IMSANZ expects to negotiate with the RACP in 2007.

IMSANZ Council will continue to work where it can to ensure the acute general medicine needs of the population will be met in the foreseeable future. Training and workforce issues will feature at each of our meetings this year. You can assist in tangible ways by: keeping your State councillor informed of your local situation; ensuring that general physicians are on any appointments committees where subspecialists are being employed to undertake general medicine duties, and, finally, by letting us know what you think.

PHILLIPPA POOLE
President

Rethinking the validity and relevance of generalist vs subspecialist quality of care comparisons

It is often claimed that subspecialists provide better quality of care than general physicians, thus providing a reason as to why the healthcare system needs, and must continue to produce, more subspecialists. Observational studies have been, and continue to be, published that conclude, for a given diagnosis, process of care measures (and, in a smaller number of studies, patient outcomes) are superior for subspecialists. But a recent article[1] and editorial[2] in the first issue of Archives of Internal Medicine for 2007 challenges the validity and relevance of such analyses.

The validity question

Before one accepts the results of a study inferring better care from specialists, a number of factors need to be considered:

- What was the study design? Randomised controlled trials (RCTs) which assign patients with a given diagnosis to either specialist or generalist care would be the most valid study design as all known (and unknown) confounders that might impact on quality of care would be evenly distributed between the two groups. In the absence of an RCT, then a prospective cohort study in which, at inception, patients in either arm are matched, as fully as possible, for clinical characteristics would be the next best design. After that you are left with studies of less rigorous design with post-hoc statistical adjustments that attempt to compensate for the uneven distribution of patient characteristics between the two groups (see below).
- What were the measures of care quality? Evidence-based process of care indicators (defined as the number of eligible patients who received specific trial-proven, guideline-concordant therapies or interventions) are the most valid quality measures. Patient outcomes such as death, disability, morbid events and satisfaction, while important, can be subject to confounding and are often more distant in time compared to processes which are under direct, immediate control of physicians. These process measures should preferably relate to real-world care of actual patients as opposed to hypothetical case studies where physician self-report may be subject to social response and other forms of bias.
- Has selection bias been accounted for? Patients seen by specialists may differ greatly from those seen by generalists in terms of disease severity, frequency and type of comorbid conditions, demographics, socioeconomic status, access to care and personal resources. In studies which do not use evidence-based process of care indicators that are relatively immune to such influences, then some statistical form of casemix adjustment must be used (such as multivariate risk adjustment models or propensity score analyses). Bear in mind however that these are all post-hoc adjustments and may not fully account for all possible confounders.
- Have 'care environment' factors been considered? Physicians, both generalist and specialist, do not practice in a vacuum. Variables in the practice environment such as patient numbers and physician years of experience, professional isolation, availability of guidelines, care pathways and information technology support, and access to disease management programs may all influence care over and above physician knowledge and skill.

The systematic review of studies undertaken by Smetana et al[1] comparing generalist with specialist care of patients with one of 10 discrete medical condition attempted to take all these factors into account. The anatomy of the review was as follows: using a comprehensive search strategy of studies published between 1980 and April 2005, 49 studies (from 2459 citations) were included: 28 cohort studies (9 prospective), 19 cross-sectional studies, and 2 RCTs covering diagnoses of coronary artery disease (16 studies), congestive heart failure (6), diabetes (6), HIV infection (5), hypertension (3), breast cancer (3), and liver disease, rheumatoid arthritis, tuberculosis and COPD (1 each). Studies excluded were those lacking primary data, a discrete medical diagnosis, at least one quantitative, well-defined outcome measure, or 50 or more subjects in each comparison group. The main results were:

- Of 49 studies, 24 studies (49%) favoured specialty care, 13 (27%) found no difference in outcomes, 7 (14%) varied in results according to individual outcome measures, 1 (2%) depended on physician experience and 4 (8%) favoured generalist care. For some of our subspecialty colleagues these results might be saluted as game, set and match to them – but let's take a look at the methodological rigour.
- In the 24 studies favouring specialist care (group 1) versus the 17 studies finding no differences or favouring generalist care (group 2):
    - 1 RCT found no differences in outcomes while the other RCT had results varying by individual outcome.
    - Selection bias was adequately addressed in 14 (58%) of group 1 studies vs 12 (71%) of group 2 (although not statistically significant, p=0.52).
    - Multivariate casemix adjustment was undertaken in 16 (67%) of group 1 studies vs 16 (94%) of group 2 (nearly significant, p=0.06).
    - Analysis of practice environment factors was undertaken only 3 times among 96 instances (3%) in group 1 studies vs 10 of 68 instances (15%) in group 2 (p=0.009).
    - Casemix adjustment and analysis of at least one practice environment factor was undertaken in only 3 (13%) of 24 studies favouring specialty care vs 3 of 4 (75%) studies favouring generalist care (p=0.02).

My reading of these results is that overall care provided by specialists *may* be better than that provided by generalists but the evidence is far from conclusive because of methodological shortcomings of many of the included studies. Also we need to be aware of other limitations of this review: 1) most studies combined the equivalent of Australasian general physicians in other countries with family and primary care practitioners and thus outcomes of general physicians are diluted in a broader group of non-physicians; 2) the search strategy may not have captured all relevant studies (I was disappointed that a study I had been involved with and which gave a no difference outcome was not retrieved[3] despite meeting the authors' eligibility criteria); 3) there is the potential for publication bias (negative studies

Continued next page...

RACP CONGRESS, MELBOURNE

6th - 10th May 2007

The RACP Adult Medicine Divisional Committee is delighted with the program for the Adult Medicine scientific meeting put together by A/Professor Michael Hooper and his team for this year's RACP Congress. The meeting will be held on 8-9 May 2007 at the Melbourne Convention Centre.

The program consists of high-quality specialty updates on a range of clinical topics and is designed to appeal to both Fellows and Trainees. The emphasis will be on the 'Clinical Year in Review', with presentations of the most important new papers on evidence-based medicine and key messages for general clinical practice from recent trials.

The Divisional Committee believes the program is an excellent opportunity to maintain and extend general medicine skills. Highlights will be:

- Advances in the management of stroke Professor Geoffrey Donnan, Priscilla Kincaid-Smith Orator
- Pathogenesis and treatment of primary systemic vasculitis Professor Charles Pusey, Sir Arthur Simms Commonwealth Visiting Professor
- Affluenza – the epidemic of 'diabesity'
- The pain of it all: an update for physicians
- Immune modulation in gastroenterology, rheumatology and neurology
- Preventing the complications of ageing
- Heart failure
- The importance of sleep to a general physician
- The new RACP training curricula – a practical workshop
- Medical issues in pregnancy
- Indigenous health – time to act on Aboriginal health
- Adolescent health and the transition to adult care
- Rural workforce problems: is task transfer a possible solution?
- Sexual health medicine
- Palliative medicine

As well there will be *The Best of Grand Rounds,* in which six selected advanced trainees will present interesting or unusual cases for discussion.

From page 3

showing no differences were less likely to have been submitted for publication or published); 4) studies only included patients with a discrete diagnosis and not patients with multiple chronic conditions for whom generalists may have fared better than specialists; and 5) other important outcome measures (such as resource utilisation, level of care co-ordination, and avoidance of unnecessary intervention) were not reported.

The relevance question

But Patrick and Ann O'Malley in their editorial[2] contend that quality of care comparisons are products of professional society self-interest and a desire, within a market environment, to claim professional turf (or 'market share'). They argue that such studies 'tend to be divisive and distracting, even if [it is] possible to perform [them] in a valid way,' when what we should be doing is tackling the much larger systemic issues that limit the ability of both generalists and specialists to provide their patients with quality care.

The factors they mention are the same as those IMSANZ has been concerned about for some time: lack of universal access to care; looming physician workforce shortage and ongoing physician maldistribution; fragmentation of care; perverse incentives created by current physician reimbursement mechanisms that encourage procedural and diagnostic services irrespective of their cost-effectiveness; and lack of incentives for physicians to co-ordinate and integrate care. The need for more 'generalism' and less 'specialism' is supported by ecological studies which indicate that patients who live in geographic areas with more generalists and less specialists per head of population have better outcomes and less consumption of health resources.[4-7]

The final words of our editorialists[2] in relation to specialty quality of care comparisons are worth repeating: 'Let the games stop! And let's get serious about studying and improving our entire system more than merely focusing on comparing individual elements of care delivery within a dysfunctional system. We believe that this is more likely to lead to better integrated structures and processes and better patient outcomes.'

IAN SCOTT

REFERENCES

1. **Smetana GW, Landon BE, Bindman AB, et al. A comparison of outcomes resulting from generalist vs specialist care for a single discrete medical condition. A systematic review and methodologic critique. Arch Intern Med 2007; 167: 10-20.**
2. **O'Malley PG, O'Malley AS. Studies comparing quality of care by specialty? Valid, relevant or neither? Arch Intern Med 2007; 167: 8-9.**
3. **Scott IA, Heath K, Harper C, Clough A. An Australian comparison of specialist care of acute myocardial infarction. Int J Qual Health Care 2003; 15: 155-161.**
4. **Starfield B, Shi L, Grover A, Macinko J. The effects of specialist supply on populations' health: assessing the evidence. Health Aff (Millwood) 2005 Jan-Jun; Suppl Web exclusives: W5-97 to W5-107.**
5. **Fisher ES, Wennberg DE, Stukel TA, et al. The implications of regional variations in Medicare spending. Part 1: the content, quality, and accessibility of care. Ann Intern Med 2003; 138: 273-287.**
6. **Fisher ES, Wennberg DE, Strukel TA, et al. The implications of regional variations in Medicare spending. Part 2: health outcomes and satisfaction with care. Ann Intern Med 2003; 138: 288-298.**
7. **Baicker K, Chandra A. Medicare spending, the physician workforce, and the beneficiaries' quality of care. Health Aff (Millwood) 2004 Jan-Jun; Suppl Web Exclusives: W4-184 to W4-197.**

Why a general physician culture is essential to understand where we came from and where we are going...

Not everyone will practice as a general physician but understanding and valuing a general physician culture as central to the way we practice medicine is the *only* way forward in a climate of increasingly complex medical interventions. In Australia and New Zealand, basic physician training begins to provide a broad overview of patient management and inculcates the trainee physician with the ability to prioritise a patient's medical problems and contexuralise them within a socio-cultural frame work ie. a woman from Toorak or Double Bay will probably prioritise her medical problems differently to a woman who resides in Ramingining in East Arnhem Land. An Australian trained physician should ultimately be able to recognise this reality, develop a rapport with each patient and not be threatened by the different expectations or values the individuals place on the interventions discussed. Equally during these early training years the concepts of patient rights and patient advocacy start to be shaped and thus the idea of patient focused care begins to be embedded. In terms of becoming a physician the completion of basic physician training after passing the physicians examinations is equivalent to reaching base camp, your eyes focused on the summit of Everest beyond. The exam is the beginning – not the end.

Basic physician training as it stands in Australia and New Zealand specifically values these concepts in a way that is not universally evident in medical education. These concepts spring from a generalist culture that is likewise absent in many other models of physician education. In many countries a doctor's word is law or 'lore' and the concept of a therapeutic partnership between patient and doctor is not centrally enshrined in training. The power of these concepts is a profound strength in Australian and New Zealand physicians training and is not something we should apologise for or down play – we should celebrate and champion it.

After the completion of basic physician training, during advanced training in general medicine these skills are maintained and updated in the context of ongoing broad clinical exposure. Trainees are not simply allowed to 'forget' the context in which everyday clinical decisions are made. They cannot retreat to the vacuum of single system medicine. General trainees and subsequently general physicians therefore should be in an optimal position to discuss the impact that competing medical priorities will have on a patient's quality of life. This is especially important in remote areas where access to treatment modalities is limited and pursuing them may mean leaving family, community, country and language. Discussing these realities is important to all people regardless of ethnic background. It can reasonably be expected that a physician workforce with a subspecialist focus *only* will abdicate its responsibility to discuss the impact of an isolated therapeutic intervention on the broad medical, social and spiritual context in which an individual operates. A clear example of this is the role of physicians in palliative care and end of life decisions. Often a palliative care or an intensive care physician operating with a generalist perspective will discuss the greater issues and help a patient place relative short and long term value on a particular set of interventions. These broad conversations often lead to a patient declining a specific intervention such as an operation, invasive ventilation, dialysis, more chemotherapy or more radiotherapy. The patient is encouraged to understand what is being 'offered' in terms of relative benefit and ultimate futility. They have an opportunity to reconcile a medical intervention without context with what they value as a human being. We cannot possibly hope to train enough palliative care physicians or intensive care specialists to take on this discussion exclusively and surely we should not have to. We need to remember – all they are doing is operating in a generalist framework. Neither will necessarily possess subspecialty skills specifically related to the patient's primary diagnosis. Not all situations relate to the stark finalities of death but almost all therapeutic decisions involve the concept of relative benefit and the physician must retain a generalist perspective in order to first do no harm. To maintain this perspective within medicine as a whole the culture of the general physician must be highly valued.

The Royal Australasian College of Physicians, if it is to call itself this, must train physicians who are capable of reconciling resource differentials across a vast continent and not just physicians who can only function within 50km of a quaternary referral centre. It can do this only by maintaining a generalist culture at its core. The re-development of a once robust generalist workforce in addition to a subspecialist workforce can and will improve the way medicine is practiced in both urban and rural centres and maintain the high standard of training that has existed to the current time. The idea of the 'whole patient' must remain paramount and both doctor and patient must expect to think 'What is the priority?' and 'How will this intervention negatively and positively affect my life?' The alternative is a purely consumerist approach where powerful special interest groups dominate resource allocation and the concept of patient focused care is sacrificed to the hegemony of the highest bidder.

EMMA SPENCER
General Physician
Infectious Diseases Physician
Director of Physician training
Royal Darwin Hospital

STOP PRESS

IMSANZ Meetings 2008

There will be a IMSANZ (NZ) meeting in autumn 2008. This will hopefully take place in the Bay of Plenty.

There will be an IMSANZ (Australia) meeting in rural Victoria in Spring 2008.

Watch this space!

CONTROVERSIES IN GENERAL MEDICINE

Following a call to the delegates of the IMSANZ Waiheke 2007 conference the following list of controversies was compiled. Thanks go to David Spriggs, Hugh Calvey, Robin Toomath and Paul Reeve for their contributions. In the event we had a very full programme, and did not manage to run a specific controversies session. There may have been more offered if members had been assured they would not have to present their controversy!

Nonetheless, it is felt worthwhile to reproduce the list in the newsletter as a source of potential topics for future conferences, journal clubs or research projects.

- Should we measure lipids in those with established stroke/MI?
- What is the role for cholinesterase inhibitors in dementia?
- Does management of hypertension in the very elderly kill patients or save their lives?
- Is CRP a useful risk maker for atherosclerosis?
- Duration of anticoagulants after venous thromboembolism?
- Do the cognitive specialists get their just rewards?
- How do we assess competence in experienced physicians?
- Is there any role for Mantoux testing in the diagnosis of TB?
- Are we over-prescribing blood products?
- What are the best systems for ensuring safe prescribing in the hospital and on discharge?
- Do junior doctors learn what we want them to learn?
- Should we knock down our medical libraries?
- Is urea estimation just an expensive waste of time in gen med patients?
- How do we manage expectations for care of the extremely old and frail?
- Optimal management strategy in AF
- Optimal management of hypertension
- Organisation of acute stroke care, esp. in the rural context
    - the applicability of thrombolysis outside of major centres
    - the safety of low dose LMW prophylaxis for DVT in acute stroke

The Gen Med / Speciality interface

- is gen medicine more cost effective than subspeciality care?
- what is the minimum training if one is to work as a consultant on acute undifferentiated medical rosters?

PHILLIPPA POOLE
Chair, IMSANZ Waiheke 2007

IMSANZ would like to welcome the following New Members:

- Dr Marco Bonollo, Melbourne, VIC
- Dr Tara Cowtan, Townsville, QLD
- Dr Terence Glynn, Campbelltown, SA
- Dr Heather Lane, Auckland, NZ
- Dr Tony Neaverson, Noosa, QLD
- Dr David Porter, Nelson, NZ
- Prof Napier Thomson, Melbourne, VIC

IMSANZ wish to welcome the following Associate Pacific Members:

- Dr Isoa Bakani, Suva, Fiji
- Dr Joji Malani, Suva, Fiji
- Dr Deo Narayan, Lautoka, Fiji
- Dr Joseva Nasaroa, Suva, Fiji
- Dr Omar Niazi, Labasa, Fiji

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

- Dr Girish Deshpande, Subiaco, WA
- Dr Lucy Grace, Auckland, NZ
- Dr Brendan Hanrahan, Brisbane, QLD
- Dr Helen Kenealy, Auckland, NZ
- Dr Vasant Mani, Ballarat, VIC
- Dr Golam Moinuddir Khadem, NZ
- Dr King Vee, Mark Lee, Perth, WA
- Dr Marion Leighton, Wellington, NZ
- Dr Mohammad Mohiuddin, Auckland, NZ

Excerpts from IMSANZ Council Submission to the National Health Workforce Secretariat (NHWS), February 2007

1. What are the current pressures within the practitioner's specialty?

The three major pressures are:

1.1 Greater patient loads on individual general physicians (24/7) resulting from:

- An aging demographic with more complex health needs as a result of multiple chronic illnesses;
- Attrition in general physician numbers due to retirement and an aging general physician workforce;
- The taking on of patients who are not accepted by, or regarded as within the province of, other specialist services in the system;
- Deficits in other health care services (e.g. Northern Territory lacks sufficient nursing home and hospice beds, and drug and alcohol services);
- Services setting up Medical Admission and Planning Units without sufficient staff to run them;
- Spillover of private practice General Medicine into the public sector in Areas of Need, owing to the fact that overseas doctors cannot set up private practice.

SOLUTIONS

- Increase numbers of general physicians, and trainees in general medicine;
- Increase training, continuing professional development, and career opportunities for physician trainees who are interested in pursuing a career as a general physician;
- More widespread recognition of the value of the efficiency of management by one consultant general physician rather than by multiple referrals to multiple subspecialists, with no one overall coordinator of care;
- Multipartite initiatives to make General Medicine a relatively more attractive career path;
- Parallel developments of primary and community care services to better address the health needs of the community;
- RACP to ensure that all trainees continue to contribute to acute general medical rosters throughout advanced training.

1.2 Perverse incentives in the health system leading to recruitment and retention problems:

- Poor remuneration relative to other specialists and GPs;
- Burdensome conditions of work:
  - Patients arrive 24/7, hence night and weekend call is frequent;
  - Because of inequities in rostering compared with subspecialities; general medicine registrars perceive general trainees to be less valuable and general medicine training jobs less attractive;
  - Relatively more junior trainees mean more calls and closer supervisory requirements;
  - No discretion in whether to accept patients.

SOLUTIONS

- Acknowledgment of key role of General Medicine to the health system;
- Improved remuneration for salaried and fee-for-service general physicians, with greater parity with procedural subspecialists and general practitioners;
- Greater transparency of, and accountability, of the process of equitable remuneration from the government, down to the directors of medicine;
- Improvement in the professional training allowance allocated to general physicians specifically – with some acknowledgement that those physicians who work remotely need more money and time to participate in continuing education;
- RACP to acknowledge the reality of night and relieving rosters and address these in a fair and equitable manner as they relate to all trainees across the broad church of the college;
- Adequate remuneration and time-in-lieu to compensate for out of hours work.

1.3 Bureaucratic threats to General Medicine services:

- IMSANZ wishes to draw NWHS attention to what it believes is a crisis in Sydney. The remaining General Medical Units in Sydney closed around 2000. Medically unwell patients are admitted by ED staff and managed in subspecialty units where staff may not necessarily be experienced in providing the range of care needed by these patients. As a consequence, there are no general medicine training opportunities in Sydney;
- Substitution of general medicine workforce with poorly-trained surrogates, such as hospitalists, in NSW:
  - The increasing complexity of available medical interventions means general physicians will be in greater demand to help establish and negotiate the priorities for each patient. This requires a very well trained consultant physician workforce with a generalist perspective. Poorly trained hospitalists will not be able to advocate effectively across a range of subspecialties.
- Competition with other professional groups (e.g. GPs wanting to subspecialise within primary care, emergency physicians wanting to specialise as 'acute general medicine' physicians).

SOLUTIONS

- States and RACP to accept and ensure the specialist workforce has sufficient general physicians within it to maintain a balance with the burgeoning number of subspecialists;
- Recognition by government licensing and regulatory bodies and by professional medical colleges (and their training committees) that a general physician fellowship is the

only accepted specialist qualification in general internal medicine;
- Increase education of the administration and an increase awareness in the community of the need for a generalist perspective;
- Re-establish General Medicine Units in Sydney.

2. What are the current workforce trends in the specialty?

Overall workforce demands for General Physicians will increase:

2.1 Increasing number of acute admissions coupled with increased expectations of General Physicians:

- The RCP in the UK has recommended that all patients admitted to hospital with acute medical problems (as distinct from surgical, obstetric or psychiatric problems) be admitted to a dedicated unit, staffed by at least 3 physicians, and be seen within 24 hours of admission with at least 15 minutes dedicated to that consultation (Royal College of Physicians of London. Acute medicine: making it work for patients. Report of a working party London: RCP, 2004);
- In Australia Admission and Planning units are being set up to help cope with this demand, but they require committed leadership and an increased presence from consultant general physicians. IMSANZ standards for such units may be found at: http://www.imsanz.org.au/resources/documents/IMSANZ_MAPU.pdf. Units at Royal Perth, The Canberra and Princess Alexandra Hospitals are recruiting for general physicians.
- In depth - knowledge and experience ("cognitive") types of practice will never be transferable to other health professionals;
- Smaller centres do not have registrars. In more recent years the quality of RMOs has often been marginal, placing increased pressures on consultant staff to provide more of the day-to-day 'hands-on' bedside care;
- Service requirements impact on adequate time for education (self and others), service development, quality improvement, health services administration, research, and professional college activities;
- Increased demands created by teaching medical students as a result of the setting up of Rural Clinical Schools.

2.2 Workforce shortages, with very few trainees in the pipeline:

- 2004 data collated for "Restoring the Balance" found a shortfall of about 130 general physicians in Australia. In Feb 2007 there are persisting shortages in all states of comparable magnitude to those noted in 2004;
- There are comparatively few RACP trainees in General Medicine. In recent years General Medicine and joint training registrars constitute only 3-6% of the total number of adult physician trainees in Australia. There were only 38 trainees in General Medicine in 2006;
- Subspecialists are becoming less inclined/ able to participate in "on-call" general medical rosters;
- Workforce directives and lifestyle choices reducing work week from a mean 50 hours;
- The general physician workforce is on average 5 years older than other physicians so there will be a greater workforce requirement sooner than in other subspecialty areas;
- An increasing number of general physicians are female. Women work on average 20% fewer hours per week than males. They will also more likely work part time and/or interrupt training and service;
- Over recent years, there has been no increase in numbers of general physicians completing the FRACP. There were 14 in 2005, 5% of the total of new Fellows;
- Reliance on Area of Need Overseas Trained Doctors to fill vacancies in Tasmania, Northern Territory and other rural areas;
- These shortages are more acute in regional and rural settings where there are fewer subspecialists.

SOLUTIONS

As per Question 1.

3. What needs to happen?

Changes as already listed in Q.1, plus:

- support for the new consultation items for consultant physicians and paediatricians currently under negotiation (proposed items 111 & 117) and which will cover comprehensive medical assessments and chronic disease management with multiple co-morbidities.

4. Vacancies.

See also answer to Q1. In Feb 2007 there are persisting shortages in all states of comparable magnitude to those noted in 2004. Recent estimates of vacancies in larger centres (established positions, except where otherwise stated) are:

NT 18 (based on need)	WA 23	NSW 3 in Hunter, potentially many more if GM re established
SA 25	Victoria 20 (reliance on Area of Need Physicians	Tas 10 (Area of need physicians and locums filling many posts)
Qld at least 20	ACT 4-5	

Based on the assumption that physicians will continue to work the mean of 50 hours per week they do now, IMSANZ predicts approximately 5-7 full time equivalent general physicians are needed per 100,000 population to provide adequate service, teaching and research capacity in general medicine. The ratio will vary depending on service configuration, distance from other sites, size of centre and critical mass of physicians on site to run rosters. Smaller regional centres require higher ratios than metropolitan centres. This compares to a current ratio of approximately 3 per 100,000. No more than 1 in 4 adult physicians practice any form of general medicine and of these only 50% regard their practice as being predominantly general medicine.

Extracts of RACP Australian data relevant to General Medicine (data kindly supplied by Sue Morey)

RACP 2006 advanced trainees by specialty and state/territory

	NSW	Vic	Qld	SA	WA	Tas	NT	ACT	Aust
Cardiology	51	37	15	14	6	3	1	2	129
Genetics	1	1	-	-	-	-	-	-	2
Clin Pharm	1	3	1	0	0	0	0	0	5
Endocrin	22	18	12	6	2	2	-	1	63
GE	28	19	6	8	5	2	-	4	72
Gen med	***4***	***13***	***8***	***6***	***5***	***2***	***-***	***4***	***38***
Geriatrics	25	27	7	5	12	0	0	2	78
Inf Dis	4	21	3	2	0	0	2	0	32
Oncology	29	23	8	2	4	1	0	1	68
Nephrology	10	14	3	5	3	1	0	1	37
Neurology	13	18	2	4	4	0	0	0	41
Nucl med	10	7	3	3	1	1	-	-	25
Paed	100	81	43	19	29	2	7	3	284
Palliative	7	1	0	3	2	0	0	0	13
Rheum	7	8	1	3	3	-	-	1	23
Resp/sleep	26	15	8	8	6	-	-	1	64
Total	338	306	120	88	80	14	12	16	974
%	34.7	31.4	12.3	9	8.2	1.4	1.2	1.6	100

RACP advanced trainees by specialty over 2000-2006

	2000	2001	2002	2003	2004	2005	2006
Cardiology	87	89	100	98	113	120	129
Genetics	2	1	0	0	0	1	2
Chem Path					2	3	4
Clin Pharm	3	6	3	9	11	6	5
Endocrin	35	42	45	44	55	53	63
GE	45	44	50	67	73	71	72
Gen med	***30***	***22***	***29***	***48***	***47***	***59***	***38***
Geriatrics	43	25	43	48	67	74	78
Haematolog	42	38	53	56	58	62	76
Immun	11	10	12	9	10	12	16
Inf Dis	27	29		48	44	43	32
Int care	11	14	13	26	18	6	1
Oncology	41	35	38	41	52	49	68
Microbiology							18
Nephrology	19	27	39	40	32	31	37
Neurology	28	29	38	41	42	41	41
Nucl med	12	10	11	19	22	28	25
Paed	143	147	180	233	258	234	284
Palliative med	11	10		17	19	9	13
Rheum	21	21	21	21	19	27	23
Resp/sleep	34	44	47	55	74	60	64
Total + joint training	586+59	587+56	690+78	829+91	921+88	906+84	974+115
Total	645	643	768	920	1009	936	1089
% Gen med	***4.7***	***3.4***	***3.8***	***5.2***	***4.7***	***6.3***	***3.5***

Speciality of those awarded FRACPs 2000-2005

	2000	2001	2002	2003	2004	2005
Cardiology	25	34	34	27	43	30
Genetics	0	4	1	0	0	0
Clinical pharmacology	0	1	0	0	0	1
Endocrinology	8	9	18	12	14	15
Gastro	17	13	15	18	24	29
Haematology	13	3	11	13	8	14
Infectious disease	11	11	10	16	14	10
Immunology	3	4	2	2	3	2
General Medicine	***12***	***13***	***8***	***9***	***11***	***14***
Geriatrics	15	14	16	12	16	11
Intensive Care	4	2			3	5
Oncology	14	9	13	12	16	10
Nephrology	11	5	9	20	14	10
Neurology	9	9	7	10	12	15
Nuclear med	5	4	3	5	6	8
Paediatrics	40	46	51	55	57	74
Palliative med	2	6	5	3	3	3
Rheumatology	13	5	5	8	7	9
Respiratory/sleep	17	10	15	16	10	16
Total + joint training	199+20	193+9	220+13	238+15	247+14	255+21
Total	219	202	233	253	261	276
% Gen med	***5.5***	***6.4***	***3.4***	***3.6***	***4.2***	***5***

IMSANZ (NZ) Christchurch Meeting

21st - 23rd November 2007

IMSANZ (NZ) will be joining RACP (NZ) and NZ Gastroenterological Society in Christchurch. There will be a Trainees' day on Tuesday, 20 November. Along with a dedicated IMSANZ half day, there will be sessions on GI Motility, Inflammatory Bowel Disease, Liver Disease, Endoscopy and Obesity.

IMSANZ contact is Dr David Jardine: David.Jardine@cdhb.govt.nz

More details will be posted on the IMSANZ website as they come to hand: www.imsanz.org.au/events

IMSANZ WAIHEKE ISLAND MEETING REPORT

22nd - 24th March 2006

Yet another outstanding IMSANZ meeting took place at idyllic Waiheke in the Hauraki Gulf, the sun drenched days and balmy evenings interspersed with excellent presentations. Relaxed delegates were seen playing inter-Tasman tennis, hiking the hills and swimming at Little Palm Beach.

Feedback about the presentations was excellent. A particularly high standard of presentations was shared with IMSANZ presenters and invited speakers. The talks covered a wide array of clinically relevant topics, ranging from chest radiology to delirium. Subspecialty updates were well received with visiting lecturers showcasing new techniques and advances, such as cardiac MRI and new classes of HIV medications.

Some of the Australian contingent at Waiheke, Nick Buckmaster (proud of his Trivia Quiz prize), Nicole Hancock, Haydn Walters, Hugh Calvey, Naser Abdul-Ghaffar (NZ), John Lowrey, Harvey Newnham and Belinda Weich

An important theme of the meeting was leadership, advancing the status of general medicine as a specialty and planning for the future. Lester Levy's talk set the tone, keeping the audience riveted without a single power point slide. He conveyed that the most important attribute of a leader is not charisma but rather individual strengths, self-awareness and authenticity. We were fascinated that the root word of 'passion' is 'sacrifice', and the root word of 'management' is 'manacles'!

Trainees enjoying themselves at the Waiheke Conference Dinner. Heather Lane, Lucy Grace, James Macdonald and Ingrid Hutton

A record turnout of 58 delegates arrived at the meeting, with 10 from Australia. Trainees from all over New Zealand presented thought provoking grand-round cases and research, and (an IMSANZ first) house officers presented their project to the group.

Zoë Raos getting ready to party

The De Zoysa Young Investigator Award was a close competition, with registrars presenting original and relevant research. Joanne Holden presented resuscitative directives among the elderly, Golam Khadem evaluated 700 patients from Taranaki with iron deficiency anaemia but Ingrid Hutton won the $500 prize with her chest drain teaching programme research.

Sanofi aventis provided a great experience for all IMSANZ delegates, the weekend ran smoothly thanks to their excellent support. The Irish themed dinner provided a great chance for mingling, with some very interesting shimmies on the dance floor. We all enjoyed our goodie bags (another IMSANZ first) with TIME magazines, chocolate bickies, free movie tickets and cheese.

John Wilson, Sisira Jayathissa and Golam Khadem enjoying a tea break

The organising committee for the IMSANZ (NZ) Waiheke Island conference would like to thank Sanofi aventis for their generous financial assistance. sponsorship and assistance at the conference.

Special thanks go to Paul Kelly, Anna Grandt, Bridget O'Connor and Hannaki Smalberger

During the course of the weekend the question was raised; 'How much is a physician worth?' By the end of the weekend as we were enjoying our final glass of sauvignon blanc, soaking up the city-scape from the ferry, I for one felt like a million bucks.

Presentations from the Waiheke Island Meeting can be found in the Members Only section of the website. The link is -

www.imsanz.org.au/members/resources/meetings/index.cfm

Higher haemoglobin target with erythropoietin is harmful in chronic kidney disease (CHOIR)

Clinical question

Is more aggressive use of erythropoietin associated with better outcomes in patients with chronic kidney disease (CKD)?

Bottom line

If erythropoietin is used in patients with CKD, the target haemoglobin should be 113 g/l rather than 135 g/l. A higher haemoglobin target is more likely to lead to death or adverse cardiovascular events.

Reference

Singh AK, Szczech L, Tang KL, et al, for the CHOIR Investigators. Correction of anemia with epoetin alfa in chronic kidney disease. N Engl J Med 2006; 355: 2085-2098.

Study design

Single site RCT (nonblinded) involving 1432 patients with CKD (glomerular filtration rate between 15 and 50 ml/min/1.73 square meters of body surface area) and anaemia (haemoglobin level <110g/l) who were randomized to receive weekly dosing of erythropoietin (epoetin alfa) sufficient to achieve either high or low haemoglobin targets (130-135 g/l and 105-110 g/l respectively). After approximately 25% of the patients had been enrolled these targets were increased to 135 and 113 g/l respectively. While this was an open-label trial (by necessity physicians had to adjust the dose to achieve the target haemoglobin and both patients and physicians knew to which group they had been assigned), the randomisation process was concealed. The primary outcome, analysed by intention to treat, was a composite of death, myocardial infarction, hospitalization for heart failure, and stroke (as ascertained by blinded assessors). Median follow-up was 16 months.

Results

The study was terminated early (at mean follow-up 16 months as opposed to intended 36 months) because at the time of the second interim analysis the risk of the primary outcome was significantly higher in the high haemoglobin target group (17.5% vs 13.5%; p=0.03; hazard ratio 1.34, 95%CI 1.03-1.74; NNH=25 for 16 months) and the probability that this trend would statistically reverse over the remainder of the study period was estimated less than 5%. There were no significant differences for individual end points, although there was a trend toward a higher risk of death (7.3% vs 5.0%; p=0.07) and hospitalization for heart failure (9.0% vs 6.6%; p=0.07). Quality of life and the likelihood of requiring renal replacement therapy were similar in both groups. Although the drop-out rate was high (~38%) because of need for dialysis and other reasons, the number of dropouts was similar between groups.

Commentary

This large RCT confirms results of previous observational studies that had suggested a higher incidence of thrombotic cardiovascular events in patients with CKD who were aggressively treated with erythropoietin. The next study should look at whether an even lower haemoglobin target (between 90 and 100g/l) may further lessen the risk of cardiovascular events without compromising quality of life or renal function.

IMSANZ Waiheke Meeting March 2007

*Great meeting - perfect size & venue for interactive learning. Learning opportunities were many, short and to the point.

*Young investigator award moves up a notch with increasingly good work by trainees, with interesting and relevant presenations of local research by the not always so young.

*Thought (and discussion) provoking key note address on leadership - we may have some of those catch phrases and images haunting us for sometime.

*Leadership; Phillippa whose industry and grasp of the NZ and Australian medicial scene is impressive - our grateful thanks for the endless hours of work on our behalf. Thanks also for organising such a great meeting.

*More leadership for the future demonstrated in the 1st ever presentation by house officers, which was first rate.

*Fun Pub quiz. There are some people though with unresolved issues re: competition and the results!!

*Many enjoyable interesting informative conversations, and opportunities to meet and reacquaint with colleagues facing similar challenges.

*Thanks to all who attended.

*Oh yes - Waiheke is stunningly beautiful, and the weather couldn't have been nicer!

DENISE AITKEN AND NIC CROOK

No cardiac testing is necessary for intermediate-risk vascular surgery patients receiving β-blockers

Clinical question

In intermediate-risk patients undergoing major vascular surgery who are receiving β-blocker therapy for tight control of heart rate, does further cardiac testing add value in preventing peri-operative cardiac death or non-fatal myocardial infarction (MI)?

Bottom line

A strategy of no cardiac testing was not inferior to a strategy of testing in preventing adverse outcomes in this particular group of surgical patients.

Reference

Poldermans D, Bax JJ, Schouten O, et al. Should major vascular surgery be delayed because of preoperative cardiac testing in intermediate-risk patients receiving β-blocker therapy with tight heart rate control? J Am Coll Cardiol 2006; 48: 964-969.

Study design

Multisite RCT involving 770 patients (mean age 68 years; 75% male) scheduled for elective open abdominal aortic or infra-inguinal arterial surgery who had intermediate cardiac risk (defined as 1 or 2 of the following: age >70 years, angina, previous MI, history of congestive heart failure, drug therapy for diabetes, serum creatinine >160umol/l, previous stroke or transient ischaemic attack). Patients were randomised (concealed allocation, unblinded) to no preoperative cardiac testing or stress imaging (dobutamine echocardiography or dipyridamole perfusion scintigraphy) with patients showing extensive ischaemia on stress imaging being considered for preoperative coronary revascularisation. Patients in both groups were prescribed β-blockers with dose carefully adjusted to maintain resting heart rate of 60-65bpm both before and after surgery. The primary outcome, assessed by intention-to-treat, was a composite end-point of cardiac death or non-fatal MI at 30 days after surgery; secondary outcome was the composite end-point at 2 years.

Results

The primary outcome occurred in 1.8% (cardiac death 0.5%, non-fatal MI 1.3%) of the no-testing group vs 2.3% (1.6% and 0.7% respectively) of the testing group, a difference of 0.5% which was less than the prespecified inferiority difference of 4%; similar results were seen for the secondary outcome (3.1% vs 4.3%). In the testing group 12 of 34 patients with extensive ischaemia underwent revascularisation (10 PCI, 2 CABG) and 6 were unsuccessful. The median duration of screening to vascular surgery was 34 days (range 7-88 days) in the no-testing group vs 53 days (range 13-121 days) in the testing group (p<0.001).

Commentary

Cardiac death and nonfatal MI are common events in the peri-operative period, with rates up to 30% in high-risk patients (those with ≥ 3 risk factors based on the Revised Cardiac Risk Index [RCRI]) having vascular surgery (Lee et al, Circulation 1999; 100: 1043-9). Observational studies (Lindenauer et al N Engl J Med 2005; 353: 349-361) and some randomized trials (Devereaux et al BMJ 2005; 331: 313-316) suggest that peri-operative β-blocker therapy provides myocardial protection in intermediate-risk (RCRI score 1 to 2) and high-risk (RCRI score ≥ 3) patients.

As preoperative coronary revascularization has not been shown to be effective prophylaxis (McFalls et al N Engl J Med 2004; 351: 2795-2804), and if it has already been decided that, in the absence of contraindications, β-blocker therapy is to be given aiming for tight heart rate control, is there any added value in subjecting intermediate-risk patients to further preoperative cardiac testing? The results of this randomized non-inferiority trial suggest not. In patients allocated to stress testing and coronary revascularization when appropriate (extensive inducible ischemia and non-urgent surgery), the numbers of cardiac events at 30 days did not differ from those not tested. Only 34 of 386 patients (8.8%) who received testing showed extensive ischemia, of whom 14.7% had a cardiac event, and coronary revascularization, achieved in 6 of 12 eligible patients, did not improve the overall outcome of the group. The upper limit of the 95% CI in favour of testing was 1.2% compared with a prespecified non-inferiority boundary of 4%, which may seem liberal given an incidence of the primary endpoint of 5% in intermediate risk patients noted in an earlier study by the same group (Boersma et al. JAMA 2001; 285: 1865-1873). However, the observed rates of events in this study were much lower than in the previous study. One could also argue that the trial was underpowered to show a significant difference in outcomes due to test-instigated coronary revascularization.

ANZGSM / IMSANZ / IANA ANNUAL SCIENTIFIC MEETING

ADELAIDE CONVENTION CENTRE 5 - 8 SEPTEMBER 2007, ADELAIDE SA

IMSANZ will join with ANZGSM and IANA to hold its Annual Scientific Meeting at the Adelaide Convention Centre in Adelaide in September. Below are some of the sessions being held at the Meeting.

IMSANZ Members are reminded to tick the IMSANZ box as category of affiliation when filling in their registration form either electronically or on the hard copy. IMSANZ Council look forward to seeing you there.

The IMSANZ Annual General Meeting will also be held in Adelaide, details of the AGM will be circulated closer to the meeting. For more information go to: http://www.fcconventions.com.au/MedicineAgeingandNutrition2007

Plenaries

IMSANZ
- Prof Chris Mathias, UK: *Postural Hypotension - its mechanisms and effects*

ANZSGM
- Shaun O'Keeffe, Ireland: *Delirium*

Servier Australasian speaker
- Andrew Tonkin (title TBC)

(IANA) OVER-NUTRITION
- Dr Peter Clifton, CSIRO, SA: *Nutritional management of coronary risk factors in the elderly*
- Prof Gary Wittert, SA: *Drug and surgery treatment of the morbidly obese person*

KEYPAD Sessions:
Dementia
Gait disorders
Evidence based medicine

Workshops

Models of Care
- Prasad Matthews, CMC, Vellore, India
- Dr John Henley, NZ
- Dr Cameron Bennett, QLD

Infectious Diseases Update
- Dr David Shaw, SA: *An update on endocarditis with particular reference to culture negative endocarditis*
- Prof John Turnidge, SA: *What's new in antibiotics*
- Prof Justin La Brooy, SA: *The changing scene in viral hepatitis*

Stroke
- Dr Alasdair MacDonald, Tas: *Regional stroke unit experience*
- Prof Andrew Tonkin Vic: *Vascular risk*

Cardiology 2:
Electricity and the Heart: Implantable Devices, Pacemakers and Arrythmias
- Prof Prash Sanders, SA
- Dr Glenn Young, SA

Cardiology 1:
Acute Coronary Syndromes and Cardiac Failure
- A/Prof Phil Aylward, SA
- Dr Margaret Arstall, SA

Update in Osteoporosis
- Prof Alastair Goss, University of Adelaide: *Osteonecrosis and bisphosphonate therapy*
- Dr Tony Roberts, Royal Adelaide Hospital: *New agents*
- Prof Chris Nordin, RAH: *Vitamin D – Residential care practicalities of research in practice*

Respiratory
- Dr Robert Adams, SA: *Asthma*
- Dr Peter Frith, SA: *Palliative oxygen, pulmonary rehab*

Renal Medicine
- Dr Toby Coates, SA: *CRF in older people*
- Dr Stephen McDonald, SA: *Renovascular disease*

Pharmacology
- Prof Felix Bochner, SA
- Prof Paul Rolan, SA

Dementia
- Dr Jane Hecker, SA
- Prof Bruno Vellas, USA

Perioperative Medicine
- Dr Catherine Gibb SA
- Dr Paul Drysdale SA

IMSANZ/Roche Advanced Trainees Award
Free Papers

***Breakfast Sessions include*:**

- *New treatments in rheumatology*
  Dr Susanna Proudman, SA
- *Sleep disorders*
  Prof Doug McEvoy, SA
- *Vasculitis*
  Dr Chen Au Peh, SA
- *Myelodysplastic syndromes*
  Dr Chi-Hung Hui, Hanson Institute, SA
- *The ageing liver*
  Prof David LeCouteur, NSW
- *Antioxidants*
  R James Joseph USA

SPECIALISATION AND MORE SPECIALISATION

Are there dangers ahead?

As I contemplated what has happened to our health system over the years, some words of Alice in Wonderland came to mind.

"Would you please tell me 'asked Alice' which way I ought to go from here? That depends a good deal in where you want to get to 'said the cat.' "So long as I get somewhere" Alice added. "Oh you're sure to do that" said the cat, "if you only walk long enough."

The Story so Far

I think these comments seem to sum up our helter skelter rush into super specialisation – we have got somewhere, but we really don't know exactly where we are going. Although the term specialist has been around since antiquity, medicine and surgery remained very general until the early 20th century. The development of specialisation has been very much more prominent in the United States but it has also played a dominant role in medicine and surgery in Australasia.

Although recognising the positive features of technical and technological innovations, the downside of specialisation has also been evident. In fact, some people think that unfettered super specialisation is not a good idea at all. Wayne Hill, a contemporary English journalist said, "Specialisation is proof how far medicine has skidded off the path" and later "it lets them abandon heaps of medical expertise to sluggish ignorance in the way farmers dump excess production to keep prices up. That is the genius of specialisation – an ability to claim general non-knowledge."

Geoffrey Fisher (an Archbishop of Canterbury) took a rather softer tack. Consultant physicians (and here and throughout this article we will be referring to physicians generically - including medical and surgical consultants) are a degree more remote (like Bishops) and therefore (again like Bishops) they need a double dose of grace to keep them sensitive to the personal and pastoral.

And finally Rosemary Stevens, author of *American Medicine and the Public Interest – A History of Specialisation* stated perhaps a little cynically "for a century specialisation has been portrayed as a force for disorganisation in medical care, challenges in medical education, opportunities for profit seeking, and power plays amongst rival claimants." In her book she also highlights the obvious advantages of super specialisation, but I suspect we could apply some of her more negative comments to New Zealand, but on a much smaller scale, perhaps protected by a stronger generalist element at specialty level, and a much more powerful primary care sector.

Doctors have been able to move into specialties and indeed little niches in specialties with very little regulation. In my own field of internal medicine you can become any type of specialist if you can find a program to take you – there is no control by the college, and the training programs are dominated by the large tertiary and secondary hospitals who have little knowledge or indeed often interest in global community requirements. Manpower projections have had a lot to do with the number of specialists produced, but very little to do with their roles and services demographically and geographically.

Patients themselves have been implicated as one of the reasons for the rush towards super specialisation. They now seem to want (especially in America) a specialist for every part of the body; experts defined by body parts and disease. Perhaps part of the blame was that the primary care and generalist sector did not sell their obvious assets well enough. Three major forces encouraged specialisation, particularly over the last sixty years. The first was of course the explosion of medical knowledge requiring subdivision to be handled by medical practitioners, the second was the belief in superior skills of experts, and the third was competitive (and at times not very collaborative) practice.

Interestingly, the first medical speciality Board in the United States was ophthalmology, incorporated in 1917, amid turf wars with the optometrist. Otolaryngology made its way in 1924, Internal Medicine in 1936, General Surgery 1937 and in 1944, there were more self styled specialists than generalists. This concern over the decline in General Practice prompted their specialty being formed in 1969, and in 1979 Emergency Medicine joined the group, carving out an enormous niche of acute care medicine. Today some of this is being taken back by a new species of generalist called the hospitalist or acute care physician, roles that have been developed to cope in areas unable to maintain care with rostered generalists.

In New Zealand, the U.K. and to a lesser extent Australia, the GP still acts a leader in primary care, and may have protected our countries from over super specialisation. Despite this health care can become fragmented, and this is particularly so in the U.S.A. Managed care tried to restrict direct patient access to a specialist by imposing a generalist as a gatekeeper. This roundly failed, attacked by providers and consumers, and indeed not much enjoyed by the generalists as they came under fire.

Too much fragmentation of care may be self defeating, which has been reflected by an increasing disenchantment. Weiner wrote in 2004: "Healthcare in the U.S.A. can be fragmented and depersonalised experience. Many patients find themselves in a nomadic environment, often shuffling among physicians who rarely communicate with each other, and have no single provider who is well informed about their overall care. Not surprisingly, patients' health care providers and purchasers all express widespread dissatisfaction in a system that while costly and technologically advanced, performs poorly on many measures of quality."

The Dangers Ahead

So are there any dangers ahead if we allow super specialisation to become as rampant as it has in the U.S.A.? I believe there are, and it involves mostly the three attributes of *Professionalism, Generalism* and *Enthusiasm* (both patient and doctor).

Firstly **Professionalism**: It was perhaps naturally assumed that a high quality profession adequately served the public interest. The powerhouses were the medical schools, hospitals organised into specialties, and expanding autonomous certifying boards. Increasingly this assumption has come under question, and as specialisation grew, so did concerns about the technological efficacy of modern medicine, with massive cost over runs and failure to provide an effective service to the entire population. Medical doctors were losing their mystique, their autonomy and many considered their balance. Ivan Illich even delineated medicine as a professional conspiracy.

Associated with this was a rather self-interest focussed approach which was associated with the world we live in as much as a march to superspecialisation. Numerous papers over the last few years have bemoaned the fall off in professional standards. The Americans recently put forward a Charter of Professionalism with ten basic facets, competence, honesty, confidentiality, proper relationships, quality of care, responsibility, just distribution of finite resources, knowledge, trust and managing conflict of interest and improving access to care. That this document had to put out at all suggests a significant fall in professional standards that needed redressing. The failure of Medical Associations to attract physicians away from their specialty groups has reduced the ability to advocate for the profession as a whole, and has diminished the influence of Physicians as a profession. Many colleges exist to protect the rights and professional gains of doctors. Many professional associations are splintered by opposing views on all sorts of issues. There is a trend towards unionism, and fragmentation is the norm, with failure to gain collective agreement on almost any issue. We are indeed failing to satisfy patient and societal expectations and there is a loss of medical professional dedication to core values. As *Lord Phillips* said – there is a pressing need to shore up professional altruism.

The second attribute under threat is **Generalism:** As Martin Van der Weyden, editor of the Medical Journal of Australia, said: "The medical profession has changed from a cohesive entity, valuing generalism and with limited specialisation to one splintered by ultraspecialisation and competing agendas." As previously mentioned, this is not such a problem in New Zealand, but it could certainly become one, unless we manage to retain our balance.

The populace has said clearly that GPs and generalists are highly valued in our community and yet our health system, remuneration schedules, colleges and even medical schools have inadequately supported generalism. There are many reasons for this trend away from generalism (although some of us are fighting hard) but they include money, workload, status and the allure of super specialist medicine. There are considerable dangers if we disregard the generalist approach. Not only does it preclude good access to specialist care in areas outside big cosmopolitan centres, but it may paradoxically reduce the need for super specialist doctors.

U.K. academic Ellen Annanadale, in a paper entitled 'Medicine, a profession at risk' said "non-physician providers can sometimes deliver a comparable service at lower cost. This is fostered by specialisation which permits knowledge to be broken down into smaller tasks which can be undertaken by less skilled workers, and these workers time has come. Task substitution is now touted as a cure for current healthcare woes. We have nurse practitioners, nurse colonoscopists and mental health practitioners and the list is growing." With task substitution on the health reform agenda, we need to ask 'what do doctors do that others don't and indeed can't. Diagnose, manage, and care for patients, or just fade away."

On the patient side, an interesting article in the New York Times entitled "Awash in information, patients face a lonely uncertain road," tells the story of patients with serious complex illness. The article made it abundantly clear that the patient needed a trusted relationship with a well trained compassionate generalist to help them co-ordinate care and navigate an overwhelming complex medical system.

The third and final danger is to **Enthusiasm:** Although it would be grossly unfair to say that superspecialism is solely responsible for a well documented fall off in medical enthusiasm, it does I believe contribute by fragmenting the workforce and reducing the collegiality which was one of medicine's strengths in the past. Although, we communicate with some of our specialty colleagues, involvement with others is very limited. Of course, other things contribute – loss of autonomy, constantly changing goal posts on the medical playing field, government and management interference, excessive workload and the frenetic pace of life which seems to be the norm now.

One certainly has to be strong and very optimistic to remain overtly enthusiastic about the global medical scene. However, there are things we must do for ourselves and our patients. We must put the 'HIP' back in HIPPOCRATIC making everyone recognise the importance of professional behaviour. We must choose our medical students wisely. There is a story of a Dean of a Medical School receiving a letter of recommendation for an applicant.

It was from a Professor of Biochemistry in a small college I had never heard of. He said, he dealt very little with premedical students and did not know what the admissions committee might be looking for. The student, he said was not an intellectual giant, though highly competent. He had not excelled in athletics, was not terribly literary and had no outstanding talents as regards art or music, and in general was a solid, steady, unexceptional young man – except in one respect. He had, the professor said, 'a servant's heart.' And though he wasn't sure, the professor went on, since he didn't know what the medical school thought was important, he believed as a patient he would want to be cared for by a doctor who had a servant's heart." Forgive my musings as an elderly medical dinosaur but I don't think we see as many "servants' hearts" as we did thirty years ago.

We must also provide role models relevant to the changing times, and to the expectation of our junior colleagues relating to a balanced life style and reduced working hours. We must reward excellence, not endurance. But with that improvement in working conditions they must be schooled in 'professional behaviour'. We must highlight and value the generalist both at primary and secondary level. There are major advances in all subspecialties at the present time. Stents that elute or even dissolve in cardiology, continuing development of CT, MRI and PET scanning, advances in chemotherapy and immunotherapy in cancer, transplantation of kidneys, lungs, pancreases and liver with better immunosuppressive therapy. The list can go on and on.

But the enthusiasm for the subspecialty advances must be tempered by the realisation that a very large percentage of patient care occurs in the community, carried out by primary care practitioners and generalist physicians. Conditions that might be considered rather humdrum to super specialists are not thought to be so by patients – conditions such as hypertension, hypercholesterolaemia, diabetes and obesity. Here too the list can go on and on, and failure to support such care will lead to major problems in global health in the future. I think if we can achieve the balance in our community between generalism

NEW 'MBAS' ITEM ENDORSEMENTS

The Minister for Health and Ageing on 5 February 2007 endorsed a number of recommendations made by the Medical Services Advisory Committee. Those relevant to the practice of general physicians are listed below.

Application 1087 Part A - Measurement of B-Type Natriuretic Peptide (hospital emergency setting)

The procedure: Brain natriuretic peptide testing involves a blood test to determine the level of cardiac neurohormone circulating in the blood of a patient suspected or diagnosed with heart failure. Levels of two types of cardiac neurohormone can be tested - brain natriuretic peptide (BNP) and N-terminal proBNP (NT-proBNP). The main role of BNP testing is as a "first line" test to rule out the diagnosis of heart failure.

MSAC has considered the safety, effectiveness and cost effectiveness of the use of assays of brain natriuretic peptides (BNP) in the diagnosis of heart failure in patients presenting with dyspnoea in the hospital emergency setting and the use of the assays in monitoring the progress of patients with heart failure. MSAC finds that there is sufficient evidence of the safety, effectiveness and cost effectiveness of the use of these assays in the diagnosis of heart failure but insufficient evidence of effectiveness and cost effectiveness for their use in monitoring the progress of patients with heart failure. MSAC recommends that public funding be provided for the use of assays of BNP in the diagnosis of heart failure in the hospital emergency setting.

Application 1098 - Breast Magnetic Resonance Imaging (MRI)

The procedure: Magnetic resonance imaging (MRI) uses a strong external magnetic field to produce images of biological tissues. It is particularly well suited to imaging blood vessels, other fluid filled structures and soft tissues and has been used in the diagnosis of breast cancer. Breast MRI is performed using an MRI machine fitted with a dedicated breast coil. A radiographer with specialised training in breast MRI is required for set-up and scanning.

The MSAC review concluded that existing mammography screening programs may be inadequate for detecting breast cancer in high risk women less than fifty years of age, due to its low sensitivity in this age group. There is strong evidence that breast MRI is a safe and effective diagnostic test and offers a significant increase in the early detection of breast cancer in high risk women less than 50 years of age, compared to mammography alone.

MSAC made the following recommendation: Breast MRI, when combined with mammography, is safe and effective in the diagnosis of breast cancer in asymptomatic women at high risk, when used as part of an organised surveillance program. Evidence suggests that breast MRI in combination with mammography may be cost-effective when compared with mammography alone in high risk women aged less than 50 years. MSAC recommends interim public funding for breast MRI in the diagnosis of breast cancer in asymptomatic women with a high risk of developing breast cancer when used as part of an organised surveillance program. Evidence should be reviewed in not less than 3 years.

Application 1102 - Double-balloon Enteroscopy

The procedure: Double-balloon Enteroscopy (DBE) can be used for the diagnostic and therapeutic benefit of patients with obscure gastrointestinal bleeding and/or small bowel pathologies. DBE is unique in that combines the characteristics of the capsule endoscope and push enteroscopy to enable the examination of the entire small bowel, to perform biopsies and other therapeutic interventions.

MSAC made the following recommendation: Double-balloon Enteroscopy (DBE) is a safe, minimally invasive technique for examining endoscopically the whole of the small intestine, allowing biopsy and certain therapeutic procedures at the same time. The most appropriate comparator is intraoperative enteroscopy. While there is no direct comparative data, it is likely to be safer to perform than the alternative, intraoperative enteroscopy. DBE is effective in allowing enteroscopic assessment and some treatment of the entire small intestine. Although more costly to Medicare than intraoperative enteroscopy, DBE is potentially cost saving for the entire health funding system. MSAC recommends public funding for DBE for the diagnosis and treatment of patients with obscure gastrointestinal bleeding.

From page 16

and super specialisation our patients will be well served. That and working to get a more cohesive professional workforce, becoming more active clinical leaders to take control once again, and standing up against bully boy management and government tactics will help us regain the enthusiasm that has been slipping away. It must however, always be directed at good patient care.

Let me close with a little NZ joke: The two Southern men were talking together. The son said to the father, 'Dad, I think I am going to divorce my wife.' 'Why is that son?' 'She hasn't talked to me for 6 months' came the reply. 'Don't be too hasty son – women like that are a rare breed.' I think if we are too hasty with over specialisation the trifecta of *professionalism*, *generalism*, and *enthusiasm* will become rare breeds that will not only be bad for our profession, but more importantly for our patients.

JOHN HENLEY
Auckland NZ

**Excerpts from a speech given at the New Zealand ORL Annual Dinner, December 2006*

1. Update in General Internal Medicine

Knight CL, Fihn SD. Ann Intern Med 2006; 145:52-61

This is the annual summary from the American College of Physicians 2006 meeting. Topics include coronary artery disease, Vitamin E, osteoporosis, perioperative consultation, abdominal aortic aneurysm, colon cancer, dementia, hypertension and peptic ulcer disease.

2. Training to be a generalist

Internal Medicine Training: Putt or get off the green (editorial) Schroeder SA, Sox HC. Ann Intern Med 2006; 144:938-939

Redesigning training for internal medicine Weinberger SE, Smith LG, Collier VU. Ann Intern Med 2006; 144:927-932

Redesigning residency education in internal medicine: a position paper from the Association of Program Directors in Internal Medicine. Fitzgibbons JP, Bordley DR, Berkowitz LR, Miller BW, Henderson MC. Ann Intern Med 2006; 144:920-926

This editorial and the accompanying 2 papers discuss reform in internal medicine residency education. One of the papers comes from the American College of Physicians and other from the Association of Program Directors in Internal Medicine Council. The editorial emphasises the requirement for more ambulatory care learning during training. The ACP paper discusses undergraduate medical education as well as postgraduate training in internal medicine. Although the environment, training and practice of general internal medicine in the USA and Australasia are different, especially as US internists see unreferred patients, many of the US proposals remain relevant.

3. Impact of specialty of admitting physician and type of hospital on care and outcome for myocardial infarction in England and Wales during 2004-5: observational study

Birkhead J, Weston C, Lowe D. BMJ 2006; 332:1306-1311

This observational study of about 90,000 patients admitted to hospitals in England and Wales during 2004-2005 showed that patients cared for by cardiologists were younger, had fewer comorbidities, were more likely to receive established treatments and angiography, and had a lower adjusted 90 day mortality. The extent of cardiological input into the care of patients admitted under non-cardiologists is unclear and, when assessing outcomes, no adjustment was made for differences in risk reflecting the different populations of patients cared for by cardiologists and non-cardiologists.

4. Only specialists should diagnose Parkinson's disease.

Mayor S. BMJ 2006; 333:14

A recently-published clinical practice guideline (see www.nice.org.uk) from the UK National Institute of Clinical Effectiveness (NICE) states that "People with suspected Parkinson's Disease should be referred quickly and untreated, to a specialist with expertise in the differential diagnosis of this condition".

5. Cancer diagnosis, treatment and survival in indigenous and non-indigenous Australians: a matched cohort study.

Valery PC, Coory M, Stirling J, Green AC. Lancet 2006; 367:1842-1848

This observational study of 815 indigenous and 810 non-indigenous patients with cancer diagnosed in Queensland between 1997 and 2002, and treated in the public sector, showed that non-indigenous cancer patients survived longer, even after adjustment for stage at diagnosis and type of cancer treatment, and for more comorbidities in indigenous patients. It was considered that "… better understanding of cultural differences and attitudes to cancer and its treatment could translate into meaningful public health and clinical interventions to improve cancer survival in indigenous Australians".

6. Exploring the generalist-subspecialist interface in internal medicine

Linzer M, Myerburg RJ, Kutner JS, Wilcox CM, Oddone E, DeHoratius RJ, Naccarelli GV – ASP Workforce Committee. Am J Med 2006;119:528-537

The content of this article was discussed in the August 2006 newsletter.

7. Death of the generalist

Ramachandran A, Anastasopoulos C. Australian Doctor June 2, 2006:1-2

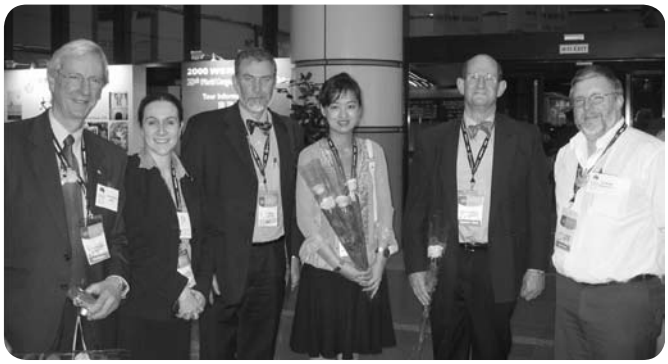
In a survey of 135 Australian general practitioners by "Australian Doctor", 41% believed that subspecialisation (in general practice) was "the way of the future", because doctors were no longer able to convey every area of general practice medicine. 13% of practitioners said that they were already specialised in a particular area of general practice, 37% stated that they undertook a mixture of general and special interest work, 10% were considering moving into a specialised area of general practice and 41% did not subspecialise, and did not intend to.

PETER GREENBERG
Melbourne

WORLD CONGRESS IN INTERNAL MEDICINE

2006 Taipei, Taiwan

The 28th World Congress in Internal Medicine was held in Taipei, Taiwan from November 10-13, 2006 at the Taipei International Convention Centre. The Congress scientific program was an interesting combination of international speakers providing updates and overviews, combined with national protocols and regional presentations. There was an enthusiastic international contingent present at the Congress, easily eclipsed by those attending the 'local' meeting of the Taiwan Internal Medical Society Conference – over 5.600 delegates attended the TIMSC held on level 2 of the TICC where the meeting was held in Chinese – the WCIM international presentation language is English.



From left to right : A/Prof Geoffrey Metz; Ms Pauline Lamb, Tour Hosts PCO; Les Bolitho; Jennifer Tung, MCVB Hong Kong; Prof Nip Thomson, PRACP & Executive ISIM; Alasdair MacDonald at Closing Ceremony, WCIM2006 Taipei, Taiwan

The organisation and presentation of the Congress was professional and cleanly executed. The audiovisual presentations require professional attendance in all sessions.

I had the privilege of attending the WCIM 2006 as a member of the 'Australasian' RACP delegation with Prof Napier Thomson, PRACP and ISIM executive delegate www.acponline.org/isim/, Associate Professor Geoffrey Metz, VP RACP, Dr Alasdair MacDonald, IMSANZ P-elect, and myself. We were accompanied by Ms Pauline Lamb, congress manager, Tour Hosts professional conference organisers, and Ms Jennifer Tung, based in Hong Kong as representative of Melbourne Convention and Visitors Bureau. Important organisational and logistic information was gleaned form the local organisers. (eg The local TWIMS registration was mostly funded by the Taiwanese government for all undergraduate and hospital based doctors, and industry support for WCIM2006 was in the region of $US1m). There were many valuable insights from discussions with our colleagues which we aim to introduce for our WCIM 2010.

The government of Victoria has provided significant support for the WCIM 2010 to be held in Melbourne at the new Melbourne Convention and Conference Centre, currently under construction beside the Yarra River, with completion date by early 2009, which will be in time for WCIM 2010 from March 20-25, 2010 www.wcim2010.com.au.

The Congress is a combination of contemporary updates, controversial sessions and workshops, and plenary sessions providing international overviews and opinion seminars. The Congress had a successful combination of academic interest, with clinical perspectives.

The social program including Welcome and Closing Ceremonies held in conjunction with the trade display, dinners and social events, including conducted sightseeing tours, and a visit to the National Palace Museum, which contains a treasury of Chinese antiquities of amazing beauty and finesse.

We held discussion with the ISIM executive, with official presentations of progress and updates on preparations for the WCIM Melbourne 2010. Although planning is in the embryonic stage, the WCIM strategy is evolving with each committee meeting.

Alasdair MacDonald and I had the opportunity to visit the East Coast of Taiwan and explore the Taroko Gorge region. Taiwan is an island with an area approximately the size of Victoria, with a population of nearly 20m people, mainly of Chinese descent. The formation and politics of the region (People's Republic of China vs the Republic of China) were ever present, (there was an international incident during our visit of a PRC submarine shadowing a US navy warship in the Taiwan Strait). Taipei is a large urban city with over 3 million people – similar in size to Melbourne, but with a very distinct (Asian) character. Traffic is furious and ever-present, although an early morning walk around the neighbourhood revealed multiple, disciplined exercise groups, Tai Chi and yoga devotees. The peoples markets and night markets provided a challenging and sensorius display of food, produce ,stalls and milling throng of friendly people.

National Palace Museum, Taipei- display of national Chinese treasures data back to bronze age, and before- extraordinary gold, bronze, glass, ceramics, materials and paintings (all brought to Taiwan from mainland China during MaoTse Dung Revolution)

The trip down the East Coast is similar to the Great Ocean Road drive in Victoria, extending over 120 kms with high cliffs on one side extending up over 1000 feet (350m), with precipitous ocean drops on the other side. I had the (mis)fortune of sitting in the front of a transport van with the driver. Road rules are simplified in Taiwan – driving on the other side of the road naturally. The road rules can be summarised simply as pass where-ever - preferably over double lines (as you can always form a third lane with the oncoming truck); avoid braking at all costs (probably no brake pads worth talking about; accelerate at changing red lights (there is always a delay before the other traffic can move); and in the mountainous areas use all the road at anytime (including

Continued next page...

WHAT'S NEW ON THE WEBSITE

The draft IMSANZ position statement on Hospitalists has been posted for some weeks and members are invited to review and provide feedback. The move by NSW Health to employ hospitalists in a number of outer metropolitan Sydney hospitals has raised concern within the ranks of the Society and RACP as to whether this is the beginning of a systematic move to substitute hospitalists (who may have a diversity of background training and experiences) for properly trained and qualified physicians within these institutions. More on this topic elsewhere in this issue.

From page 19

on hairpin bends). I could not find a volunteer to take over the co-pilot position, but we all arrived safely, any way.

The scenery was spectacular. The Taroko Gorge is steep ravine between marble and granite cliffs which rise over 3500 feet (1500m) virtually vertically from the floor and river bed. Incredible scenery and wonderful rock and treed vegetation formations, were interspersed with various temples and monasteries. The top of the mountains remained mysterious and shrouded in gossamer clouds. Quite surreal and reminiscent of the Chinese landscape paintings!

Les Bolitho on swing bridge leading to Bud dhist Temple in upper reaches of Taroko Gorge (also other temples from Confucians and Hindi)

I would encourage all of you who can, to attend the WCIM2008 Buenos Aires, Argentina from September 17th to 20th, 2008 (www.isim2008buenosaires.com.ar). The WCIM is a successful blend of current international scientific presentations, reviews of national protocols, workshop discussions, poster presentations and the opportunity to develop and extend international networks and contacts. There is ample opportunity to experience the local culture and explore the natural beauty of these charming, interesting and fascinating countries.

DR LES BOLITHO
FRACP
February 2007

The following CATs have been added to the CAT library (and apologies for the delayed posting of CATs for the December quarter of 2006).

- Urea breath tests most accurate test for detecting *Helicobacter pylori* infection in patients with upper gastrointestinal bleeding
- Surrogate decision makers are wrong in predicting patient preferences in a third of cases
- Simple clinical score can predict which patients with non-variceal upper GI bleeding may not require urgent endoscopy
- Rosiglitazone confers marginally lower treatment failure rate than metformin or glyburide in newly diagnosed type 2 diabetic patients (ADOPT)
- Raloxifene marginally increases risk of VTE and fatal stroke in postmenopausal women with coronary risk (RUTH)
- Prednisolone is effective short-term therapy for post-stroke complex regional pain syndrome
- PCI not useful for opening occluded infarct-related artery after completed STEMI (OAT)
- No cardiac testing is necessary for intermediate-risk vascular surgery patients receiving β-blockers
- Multiple biomarkers do not add to conventional risk factors in predicting cardiovascular risk in individual patients
- Multifaceted hospital interventions and hip protectors in nursing homes are modestly successful in preventing falls and fractures
- Higher haemoglobin target with erythropoietin is harmful in chronic kidney disease (CHOIR)
- Helical CT, echocardiography and MRI equally accurate in diagnosing thoracic aortic dissection
- Excessive lowering of blood pressure causes more harm than good in patients with coronary artery disease
- D-dimer can identify high-risk patients with idiopathic VTE for extended anticoagulation (PROLONG)
- Combined salmeterol-fluticasone therapy reduces exacerbations but does not lower mortality in patients with COPD (TORCH)
- Adding aspirin to oral anticoagulants lowers risk of arterial thromboembolism only in patients with mechanical heart valves

The following guidelines have been listed under the new Resource item 'Evidence-based guidance for common clinical problems'

- Acute coronary syndromes (CSANZ/NHFA guidelines 2006)
- Chronic heart failure (CSANZ/NHFA guidelines 2006)
- Hypertension (CSANZ/NHFA guidelines 2004)
- Hyperlipidaemia (CSANZ/NHFA guidelines 2005)
- Acute stroke (National Stroke Foundation 2005)
- Rheumatic heart disease (CSANZ/NHFA guidelines 2006)
- Valvular heart disease (ACC/AHA guidelines 2006)

AACP UPDATE

Greetings and welcome to 2007. I hope you have all had an enjoyable, restful and rewarding holiday season with your families and friends. The new year promises to be challenging and hopefully rewarding.

As you may have read in previous updates, or in the RACP news, the AACP Executive has been involved in the preparation of a major submission to the Australian Government seeking new attendance items for consultant physicians and paediatricians. It is important to point out that this submission is putting the most significant case for new attendance items for many years and, as such, its success will be dependent on recognition in the Federal Budget.

For those of you who may have been following my updates over the past six months or so, our submission has been progressing through the various levels of scrutiny within the Department of Health and Ageing. This has involved many meetings and discussions with senior Departmental officers to consider and reconsider many aspects of the submission.

In order to remain in consideration for a "place" in the 2007 Budget, we need widespread support from a range of Federal politicians – both MPs and Senators – and this has involved putting our case to many of them.

We continue to meet with the Department and to seek political support for our submission.

In addition to that of the RACP, we have also secured the support of the AMA, who recognise that the proposed new attendance items are vital to the future of consultant physician and paediatric practice.

I urge you to *become a member of the AACP or renew your membership now* and support the Executive, Council and your colleagues in pursuing a submission that will affect your future practice. Contact AACP at secretariat@aus-physicians.com.au or phone 02 9810 0061 for a membership application form.

LES BOLITHO

Commission Work Plan approved by Health Ministers

The Australian Commission on Safety and Quality in Healthcare's work plan has been approved by Health Ministers.

On 17 November 2006 the Australian Health Ministers' Conference approved the Commission's five year work plan for 2006/2007 to 2010/2011. The work plan details how the Commission will achieve safer, more effective and more responsive care for consumers. Improving the safety of hospitals will be an ongoing focus while safety and quality improvement in primary health care and the private sector is also part of the Commission's responsibilities. The work plan reflects Health Ministers' requirements for the Commission and also builds on the work of the former Council.

The Commission will work in close partnership with key stakeholder groups including consumers, health professionals and speciality groups and will communicate and advocate safety and quality messages and best practice to stakeholders and the broader public.

The work plan's focus is on initiatives to commence in the first twelve months. Details on the remaining years will be revisited at the end of 2006/2007 taking account of a review of achievements and lessons learned over its first year.

The full Commission Work Plan is available on the IMSANZ website at http://www.safetyandquality.org/internet/safety/publishing.nsf/Content/whats-new-lp

FORTHCOMING MEETINGS

2007

MAY	**RACP Congress 2007** 6 - 10 May 2007 Melbourne, Victoria Website: www.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
AUGUST	**European School of Internal Medicine - ESIM 10** The dates for the ESIM are 29-Aug-07 to 5-Sept-07 Watch our website for more details as they are received.
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 IMSANZ (NZ) will be joining RACP (NZ) and NZ Gastroenterological Society in Christchurch. There will be a Trainees' day on Tuesday 20th November. Along with a dedicated IMSANZ half day, there will be sessions on GI Motility, Inflammatory Bowel Disease, Liver Disease, Endoscopy and Obesity. The IMSANZ contact is Dr David Jardine (David.Jardine@cdhb.govt.nz) Email: David.Jardine@cdhb.govt.nz

Ready to establish your own private practice, or perhaps grow your existing practice?

Ramsay Health Care, Australia's largest and most respected operator of private hospitals is currently looking for specialists interested in pursuing opportunities to establish private practice in a number of locations.

We currently have several opportunities available for interested General Physicians. Assistance may be provided to successful practitioners with initial setup of rooms and marketing to establish a referral base within the community. Interested practitioners must have FRACP or equivalent and registration as a Specialist with the relevant State Medical Board/Authority.

Caboolture Private Hospital, QLD

Perfect time to step out on your own!

A General Physician is required at Caboolture Private Hospital to meet the growing needs of privately insured and DVA patients within the Shire.

Caboolture Private Hospital has 44 beds, 2 fully equipped Operating Theatres and a large and comfortable Day Oncology Unit. The Hospital is situated in close proximity to the Caboolture business centre and services the urban and rural communities surrounding Caboolture, Morayfield, Burpengary, Woodford, Dayboro, Bribie Island and Glasshouse Mountains.

Caboolture Private Hospital was the first hospital in Queensland to be collocated with a public hospital - Caboolture Public Hospital. Comprehensive Medical, Surgical and Oncology services are offered and this is reflective of community expectations for the Northern Brisbane region. The Hospital also has a contract with DVA and provides extensive services to veterans and their families. Access to Pathology, Radiology, Allied Health and Pharmacy Services is also available.

An on site RMO is available to assist with medical admissions Mon – Fri and the hospital is supported by the collocation arrangements with the Public Hospital.

In addition, Caboolture is an eligible community of the "More Doctors for Outer Metropolitan Areas" (www.health.gov.au/internet/wcms/publishing.nsf/content/work-outer-broch-drs), an initiative of the Australian Government, Dept of Health and Ageing.

Contact: Jane McGrath, Chief Executive Officer
T: (07) 3246 3133 (North West Private)
E: mcgrathj@ramsayhealth.com.au

Cairns Private Hospital, QLD

Come and join us in Australia's tropical north…

Cairns Private Hospital in tropical far north Queensland is located close to the Cairns city centre. The Cairns Private Hospital is a 133 bed facility, offering a range of services including, Surgical, Medical & Women's Health Units, Coronary Care, Day Surgery, Renal Dialysis, Oncology, Cardiac Catheter Laboratory & Sleep Disorders Clinic.

All major specialties are represented both privately and publicly in Cairns and there is an excellent opportunity for a general physician to commence practice. There is currently only one full time general physician working privately in Cairns. There are also three respiratory physicians and three cardiologists. Any new entrant would be welcomed to the medical community and receive a high level of colleague support.

Contact: Richard Lizzio, Chief Executive Officer
T: (07) 4052 5213 E: lizzior@ramsayhealth.com.au

Albury Wodonga Private Hospital, NSW

One of our Physicians is retiring and we need to replace him!

An opportunity exists for an energetic Physician to take over a well-established private practice at Albury-Wodonga Private Hospital - a 103 bed private hospital with five operating theatres and offers a wide range of medical and surgical services particularly in the areas of orthopaedics, urology, general surgery, ENT, and general medicine.

Established in 1979 by Ramsay Health Care, the hospital provides medical and surgical services to a catchment area of over 300,000 extending from North East Victoria through to the Southern Riverina District of New South Wales.

With onsite services such as pathology, imaging and pharmacy, high dependency unit, cardiac laboratory and specialist consulting suits, Albury Wodonga Private Hospital is considered one of the finest and most comprehensive private hospitals in regional Australia.

Contact: A/Prof Stuart Schneider, Chief Executive Officer
T: 0419 323 483 E: schneiders@ramsayhealth.com.au

Caloundra Private Hospital, QLD

Looking for a sea change in a rapidly growing area?

An exciting opportunity exists for General & Subspecialty Physicians at Caloundra Private Hospital which is located on Queensland's Sunshine Coast.

A ready-made, trouble free practice with private consulting rooms and secretarial support is available immediately for the successful practitioner/s.

Caloundra Private Hospital is located at the southern end of the Sunshine Coast in peaceful surroundings only minutes from the beach. The hospital has 64 beds and offers a range of surgical and medical services including respiratory, gastroenterology, rheumatology, cardiology, gynaecology, orthopaedics, ophthalmology, plastic and reconstructive, laparascopic and colorectal surgery. The hospital has a four bed High Dependency service to aid in the care of patients requiring a higher level of care and patients recovering from major surgery. 24 hour Resident Medical Officer cover is available.

Contact: Jenny McDonald, Chief Executive Officer
T: 0412 628 076 E: mcdonaldj@ramsayhealth.com.au

Ramsay Health Care – *People caring for people*

www.ramsayjobs.com.au

Partner with us…
& enjoy the benefits

Opportunities for DOCTORS

People caring for people

RAMSAY HEALTH CARE

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.

A/Prof Ian Scott
Director of Internal Medicine

Level 5B, Medical Specialties
Princess Alexandra Hospital
Ipswich Road, Brisbane
Queensland 4102

Phone: +61 7 3240 7355
Fax: +61 7 3240 7131
Email: ian_scott@health.qld.gov.au