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INTERNAL MEDICINE SOCIETY OF AUSTRALIA & NEW ZEALAND

AUGUST 2007

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From the President...

Kia ora, bula vinaka, talofa, maloleilei, hello.

The General Matters

Has the drought finally broken? Having just spent several days in Gippsland, Victoria, beset by a weather system that delivered 12 inches of rain in one day, there seemed some hope of this. In this final editorial before handing over the IMSANZ Presidency to Alasdair MacDonald at the AGM in September, it's heartening to report that there is evidence that the 'general medicine drought' may also be breaking.

General medicine is very much on state and national radar screens. In Australia, the Commonwealth CMO, Dr John Horvath, admitted at the recent MedEd 2007 conference that he and others had got it wrong in fostering super-specialisation (*see page 13* for the news item). This is a major change of direction from someone who played a major part in dismantling most of the general medical services in Sydney over the past two decades. There are now some glimmers of hope for the re-establishment of more General Medical units in Sydney - we are aware of at least two areas considering setting up acute undifferentiated medical services; more on this as discussions firm up. In the meantime, please continue to direct your Sydney-based colleagues to the IMSANZ position paper on MAPUs.

Against predictions, Les Bolitho and Jack Best from the AACP succeeded in getting the new complex disease MBS items approved in the last federal budget. How these benefits flow-on into salaries and workforce recruitment will be of utmost importance. The medical workforce is now a regular COAG agenda item, with even the Prime Minister taking an interest. Over the years, Di Howard and Emma Spencer have made IMSANZ aware of the dire health inequities existing in the Northern Territory; the issues are now, at least, being discussed, even if the Federal Government approach seems heavy-handed to some.

On the other side of the Tasman, the Ministers' Workforce Taskforce Report entitled 'Reshaping Medical Education and Training to Meet the Challenges of the 21st Century' was released in May. The full report is available from the Ministry of Health website[1]. Although yet to be ratified by Cabinet, recommendations include increasing medical student numbers towards national self sufficiency, and the setting up of a Medical Training Board to oversee the entire continuum of medical training. This Board would be charged with working with educational and training organisations to ensure that:

- all medical practitioners acquire a broad general foundation, which includes community and regional hospital experience, before entering vocational training
- the training system produces sufficient numbers of doctors entering the New Zealand workforce with training in general vocational scopes of practice.

My recent visit to Gippsland was to lead a team

Continued next page...

In this issue...

Principles of General Medicine Training 3
How Others See Us 8
Feminisation of Workforce and Generation X 9
Hospitalists - A New Breed 11
Chronic and Complex Conditions 13
Councillor Profile 14
Letter from the Pacific 17
General Internal Medicine Meeting Report 18
What's New on the Website 20
What's in the Journals 21
New Zealand Perspectives on the Hospitalist Debate 23
First International Conference - The Society for Acute Medicine 24
Forthcoming Meetings 26

to evaluate Monash University's proposal for a graduate Gippsland Medical School. Local students of rural or indigenous origin would have priority, undertaking the bulk of their medical programme in a regional / rural setting. Monash students already have the opportunity for placements at Latrobe Regional Hospital (one of five major regional hospitals in Victoria) and other smaller hospitals in the Gippsland region. The students we met from the current programme enthusiastically praised their clinical teachers, and their range of learning experiences; they believed they were performing better than their city counterparts and nearly all were planning to work in a regional setting in the longer term. The local hospital management seemed well aware of the need to employ generalists with other speciality interests, and not sub-specialists who 'have' to do general medicine.

To date there has been only a small increase in the number of general medical trainees in Australia to 48, up from 38 last year. Numbers in NZ are stable around the 120 mark, many of whom are dual training in another specialty.

Many of the advertisements in the recent RACP training supplement feature general medicine registrar positions; job ads for general physicians are becoming more prominent on the IMSANZ website and in the RACP news. The jobs are there….. we just need to fill them.

By 2012, Australia will graduate in excess of 3,000 doctors; this represents an 81% increase in the number of graduating doctors from 2005[2]. There will be more than 1,000 extra students in Victoria in 2012 than there are now. While GPs and hospital specialists are understandably very anxious about the supervision demands created by this 'tsunami' of students, medical schools are aware of this and are trying hard to minimise impacts by employing more staff (including nurse teachers), a wider range of clinical activities, clinical skills laboratories, and flexible / on-line course delivery methods. Channelling some of the students currently having excellent experiences in smaller centres into contextualised RACP regional training networks should result in more physicians prepared for medical practice outside metropolitan centres.

In late June, the RACP AMDC adopted a policy paper on Principles for Undifferentiated Medical Training. (*see pages 3-7*). Championed by Dr John Kolbe, Chair of the Adult Division, and three IMSANZ Councillors, this document sets out principles and action points for the RACP and IMSANZ in respect of training for provision of acute general medical services. We owe John a huge vote of thanks for pushing on with this. The document will be of immediate relevance in deliberations with the health sector and in shaping the direction of the RACP Education Strategy. It was also a necessary step to have this approved prior to starting negotiations on the MOU between the RACP and IMSANZ. Again, please use the Principles document to inform any local developments, and RACP committee work in which you are involved.

Hopefully these developments encourage your efforts for general medicine. We must ensure this general medicine drought is ended, for our patients' sakes. I'm confident new President Alasdair MacDonald, IMSANZ Council and membership will keep the RACP, the respective governments and the area health services focused on creating a physician workforce with the right skill set, in the right location, for arguably, the right price.

In closing, it's noteworthy that IMSANZ is now 10 years old. For the information of our newer members, IMSANZ was formed from the two respective national societies at the RACP meeting held in Auckland in May 1997. There is now a record membership of 454, with 14 Pacific members and two more life members, Neil Graham and Michael Kennedy (*see page 19*). For those of you coming to Adelaide in September, it'll be a chance to celebrate and revisit IMSANZ's history. The programme being developed by Justin La Brooy, Jo Thomas and Mark Morton looks great. I hope to catch up with many of you there.

PHILLIPPA POOLE
President

[1] http://www.moh.govt.nz/moh.nsf/pagesmh/6100/$File/reshaping-medical-education-workforce-taskforce.doc

[2] http://www.amsa.org.au/CLINTRAINING190607.pdf, accessed 6 July 2007

IMSANZ COUNCIL NEEDS YOU!

If you are passionate about retaining general medical services and you like what you are reading in the newsletter, PLEASE consider a position on IMSANZ Council. There are several upcoming retirements.
States in which we urgently need councillors are NSW, SA and WA.

Please contact, without obligation:

Phillippa Poole (President) - p.poole@auckland.ac.nz *OR*
Alasdair MacDonald (President Elect) - macmed@tassie.net.au

The Royal Australasian College of Physicians

Adult Medicine Division

28 June 2007

Professor Napier Thomson
President, Royal Australasian College of Physicians

Mr Craig Glenroy Patterson
CEO, Royal Australasian College of Physicians

Mr Gary Disher
Director – Policy and Communications, RACP

145 Macquarie Street
Sydney NSW 2000

Dear Nip, Craig and Gary

Principles of General Medicine Training

The attached document developed on behalf of AMDC and IMSANZ was unanimously endorsed at the recent AMDC meeting.

As you will note, the document deals with issues such as the current paucity of general physicians, the lack of trainees undertaking general medicine training with or without another specialty (especially in Australia), and also outlines a pragmatic solution to the current debate about the provision of acute undifferentiated medical call services.

This document has had a long gestation. As you are well aware there is a wide spectrum of views within AMDC on the role of general medicine/ the general physician and who should be able to undertake acute undifferentiated medical call. This document represents the consensus view of the Adult Medicine Division. I wish to commend the past, present and future Presidents of IMSANZ for their role in the development of this document. For them this document represents a compromise – but one that was made in a collegial and cooperative manner, and in a spirit of wishing to move this issue forward and enhance general medicine training throughout Australasia.

This document may have relevance to paediatrics and at Neil Wigg's request, a copy of the final document is being sent to the Division of Paediatrics and Child Health.

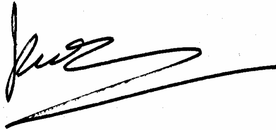
Where to now? I hope that in the current medico-political climate, this document could be used to demonstrate that there is general support within the Adult Medicine Division of the College for the training of more physicians in general medicine (± another specialty) and that governments and

jurisdictions could be lobbied to provide more training posts in general medicine and more training posts in other disciplines reserved for general medicine trainees. Of course the document has potential usefulness in discussions of other issues pertinent to general medicine with other interested parties.

I would be grateful if we could meet, possibly initially by teleconference, to discuss College initiatives in these areas and how each of us might best be employed to ensure the desired outcome.

With kind regards

Yours sincerely



A/Professor John Kolbe
President, Adult Medicine Division

cc A/Professor Phillippa Poole, President, IMSANZ
A/Professor Neil Wigg, President, P&CH Division

APPROVED BY AMDC
22 JUNE 2007

- PRINCIPLES OF GENERAL MEDICINE TRAINING -

OVER THE PAST YEAR OR SO IT HAS BECOME EVIDENT THAT THE RACP REQUIRES A POLICY FRAMEWORK FOR DISCUSSIONS AROUND PHYSICIAN TRAINING AND WORKFORCE, ESPECIALLY IN REGARD TO PROVISION OF ACUTE UNDIFFERENTIATED GENERAL MEDICINE SERVICES. WE RECOMMEND THE FOLLOWING PRINCIPLES BE ENDORSED BY THE RACP ADULT MEDICINE DIVISION.

JOHN KOLBE
PRESIDENT
ADULT MEDICINE DIVISION, RACP
IAN SCOTT
IMMEDIATE PAST PRESIDENT, IMSANZ

PHILLIPPA POOLE
PRESIDENT, INTERNAL MEDICINE SOCIETY OF AUSTRALIA AND NEW ZEALAND (IMSANZ)
ALASDAIR MacDONALD
PRESIDENT ELECT, IMSANZ

The Issues

The provision of the requisite numbers of physicians with general skills in managing patients with multiple problems, to meet the health care needs of the population in Australia and New Zealand is of increasing concern. The numbers of these physicians available to service the health needs of rural and remote centres has reached crisis point in some regions, and there are shortages in metropolitan and outer urban areas as well. This has serious implications for the quality and outcomes of care for patients. Although the situation is more acute in Australia many of the problems, and solutions, are common to both countries.

The IMSANZ/RACP joint position paper "*Restoring the Balance*"* discusses these topics in more detail, but the key issues can be stated as follows:

- There is a significant deficit in the number of physicians with general medicine skills in Australia to undertake the service requirements in acute general medicine units.
- The lack of general physicians in many (tertiary) training institutions exacerbates the problems in providing adequate training opportunities, supervision and mentorship of trainees in general medicine.
- Trainees specialising in general medicine have difficulty accessing both general medicine and other specialty training posts.
- The inequities in remuneration and employment conditions (rostering, workloads, training and service requirements) have resulted in a negative impact on the uptake of general medicine as a desirable and rewarding career choice.

Currently the provision of acute undifferentiated medical services in hospitals and ambulatory general medicine services to the population often requires the involvement of physicians trained in other specialties but who also possess and maintain broad general medicine skills. There is an urgent need to facilitate training in general medicine (with or without another speciality) to ensure an adequate supply of physicians trained to meet the health needs of the population in each country.

*Internal Medicine Society of Australia and New Zealand-Royal Australasian College of Physicians - *Restoring the Balance: an action plan for ensuring the equitable delivery of consultant services in general medicine in Australia and New Zealand 2005-2008.* Position Paper, September 2005.

Principles

The role of the general physician in health care
Beyond primary care, the medical health needs of the community are best served by a spectrum of physicians: from general physicians to other specialists and sub-specialists. The proportions will vary with different health systems and locations.

The RACP recognises that general physicians are specialists in internal medicine in their own right.

General physicians work closely with specialists, GPs, nurse practitioners and other grades of health care workers to ensure optimum care and patient outcomes.

Requirements for participating in acute undifferentiated general medical rosters
All physicians with an FRACP have undertaken at least three years of basic training across the breadth of internal medicine, including general medicine/acute undifferentiated medical call, and have undergone a rigorous assessment of their knowledge and skills in these areas.

All RACP basic trainees should have in-training assessments of evaluating and managing undifferentiated medical patients.

The breadth and depth of physicianly skills are enhanced during advanced training: by undertaking acute general medical call, training outside the speciality, consultations on patients from other services, and general clinical experience as a consequence of managing patients with co-morbidities. Training experience in acute general medical call requires involvement in patient management throughout the inpatient stay and beyond.

Because of the undifferentiated nature of many medical patients presenting acutely, the fact that many patients have multiple co-morbidities, and the likely need for ongoing management after the acute problem has been resolved, appropriate training across the spectrum of internal medicine is a requirement for participation in acute undifferentiated general medical rosters.

In order to undertake the provision of acute undifferentiated general medical services, the physician is required to have undertaken a period of supervised advanced training in undifferentiated acute medical call. This should take place within a service staffed by general physicians and/or other specialists with competence in general medicine. The training programme needs to be acceptable to the Specialist Advisory Committee (SAC) in General Medicine or equivalent.

Directors of general medical services need to be trained in general medicine.

The determination of whether an individual physician has the knowledge, skills and other attributes to participate in acute undifferentiated general medical rosters will be made by the credentialing committee of the employing institution. Any such decision would not only take into account the FRACP training undertaken but also any post-FRACP training, recency of practice in general medicine/acute undifferentiated general medical rosters and involvement in appropriate CPD. For a position that included the provision of undifferentiated general medical services it is expected that a general physician or a physician involved in undifferentiated general medical rosters should be among the applicant's referees. A similarly qualified person should be on the credentialing committee.

If the physician has not undertaken recent practice in acute general medicine (within the last five years), he or she should undertake a period of practice in acute undifferentiated general medical call under supervision before participating independently. If the period is greater than five years, the physician should undertake a period of up-skilling in the relevant areas before participating.

Ongoing ability to manage acute undifferentiated medical problems is dependent upon active participation in continuing professional development (CPD) which reflects an individual's clinical practice. For those participating in acute undifferentiated general medical rosters, a corresponding proportion of CPD should be directly related to the provision of acute care medicine.

The RACP strongly encourages physicians, especially those who aim to practise in rural and regional hospitals, to dual train in general medicine and another specialty.

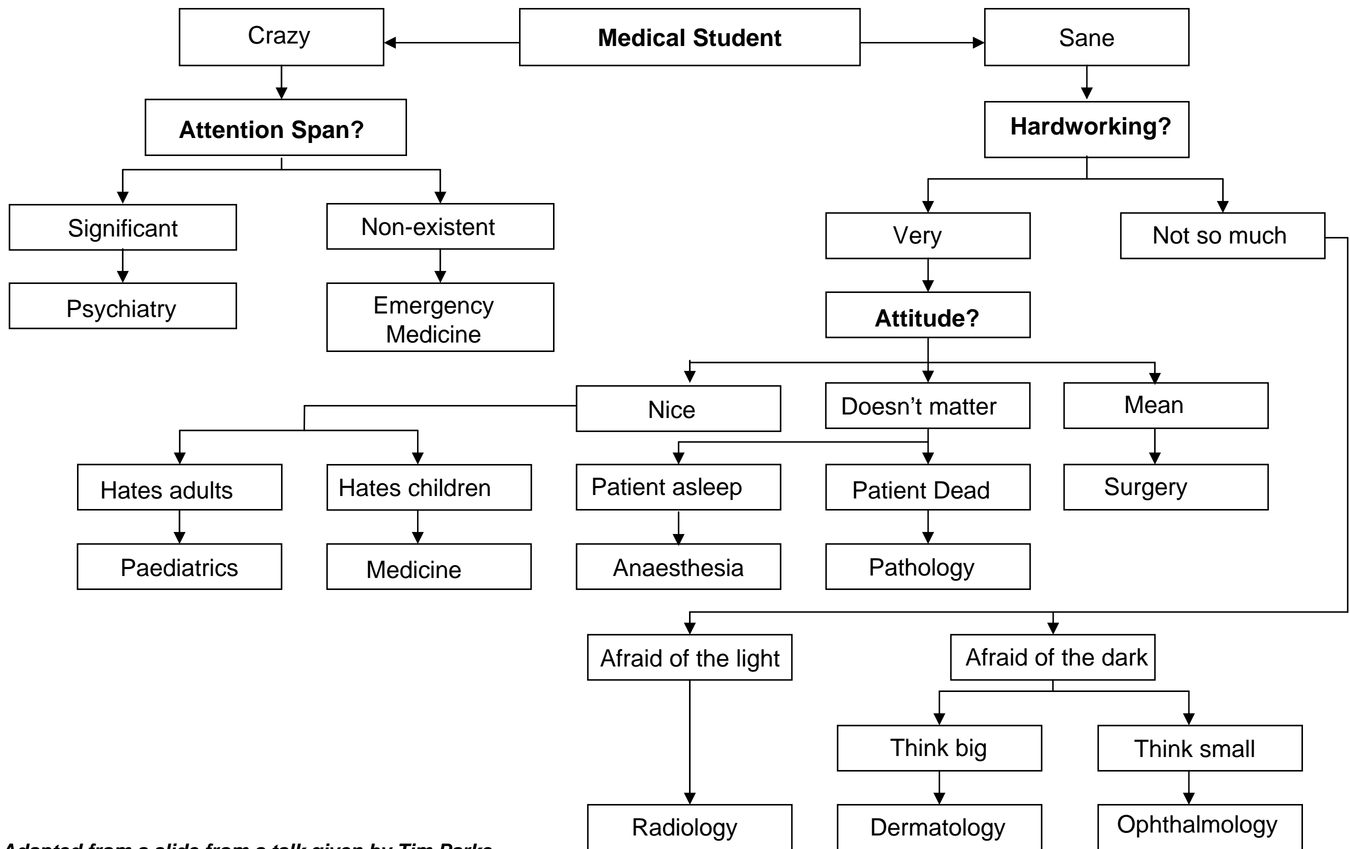
Key action points

1. The RACP will lobby the jurisdictions to provide appropriate training opportunities in order to increase the proportion of physicians with the skills to undertake acute undifferentiated medical call.

2. The RACP will ensure that its broad educational strategy supports the acquisition of the necessary advanced general medicine skills by Trainees and Fellows.

3. The RACP will encourage Specialty Societies to support the principles espoused in this paper in practical ways through the MOU process.

How others see us ....



Adapted from a slide from a talk given by Tim Parke at the Waiheke Island Conference in March 2007

HAVE YOUR SAY!

IMSANZ has joined with the RACP for the 2008 Congress in May next year.

We will be there running a parallel clearly badged IMSANZ Annual Scientific Meeting.

Opportunities exist for your input with program suggestions to the committee or participation in organisation or speaking.

It's your meeting get what you want!

Any thoughts contact:

Alasdair MacDonald (macmed@tassie.net.au) or

Phillippa Poole (p.poole@auckland.ac.nz)

FULL-TIME GENERAL PHYSICIAN

A full time position for a General Physician is available at the Department of Internal Medicine and Clinical Epidemiology, Princess Alexandra Hospital, Brisbane.

Inpatient and outpatient management of a wide spectrum of patients with chronic and complex diseases +/- acute exacerbations. Includes consultancy to the perioperative medical service. Subspecialty interests are encouraged as are teaching and research activities.

Subtropical metropolitan location in a large tertiary teaching hospital with 80 general medical beds. Diverse cultural and entertainment amenities with easy access to recreational Gold Coast and Sunshine Coast.

Remuneration package in excess of $300,000 per annum

Contact A/Prof Ian Scott on 61-7-34207355 or email ian_scott@health.qld.gov.au

APPLICATIONS CLOSE: August 27, 2007

FEMINISATION OF WORKFORCE AND GENERATION X - *What will the future hold?*

The history of women in medicine goes back to ancient times, and through to the present, with female practitioners weathering fluctuations in status influenced by the religious, social and scientific milieu in which they lived.

The term feminisation seems to have crept into medical parlance over the past 15-20 yrs, but in fact it has always been with us.

More than half the people involved in health care are and have always been women. Wise woman gathered herbs, infused them into vegetable remedies, and gave the everyday nursing care that was almost all the help available until 2 centuries ago. They bathed the arthritic, manipulated joints, looked after and delivered pregnant mothers. Since most of the remedies provided by physicians were ineffective, it may be said that most of practical medicine was in the hands of women.

Although men have for many years tried to dominate the medical scene (and were successful in some periods), in classical Egypt women had significant roles as physicians, notably in the medical schools of Heliopolis and Sais. Agamede of the golden hair in Homers Iliad was skilled in medicine and herbal care. Other women in classical Greece were known for their medical skill. Philista lectured so well that her pupils flocked to her, and was so attractive she had to lecture behind a curtain. (I can't remember that happening in Otago many years ago). About the same time Agnodice was a pupil of the famous Alexandrean Herophilus. There is a wonderful story about Agnodice. She is credited with achieving the role of a physician although it was forbidden to her by law.

A certain maiden named Agnodice desired to learn medicine; and so she cut her hair, donning the clothes of a man and became a student of Herophilus. After she learned medicine, she heard a woman crying out in the throes of labour, and she went to her assistance. The woman thinking she was a man refused her help. But Agnodice lifted up her clothes and revealed herself to be a woman, and was thus able to treat the patient.

When the male doctors found that their services were not required by the woman, they began to accuse Agnodice, saying she had seduced the woman and they accused the women of feigning illness to get visits from Agnodice. Once more she lifted her tunic to show she was indeed a woman. The male doctors then began to accuse her more vehemently for breaking the law forbidding women to study medicine.

At this point, the wives of the leading men arrived saying – you men are not spouses, but enemies as you are condemning her who discovered health for us. Then the Athenians amended the law so that free born women could study medicine.

This story tells me that some things change but others don't. Firstly you no longer have to lift your skirts to prove you are women doctors, but on the other hand power and egos still exist in male doctors, and of course women still rule the roost in their own households.

With the disintegration of the Roman Empire, Art, Literature and Medical Science declined, to be taken up mostly by the sisters of the Church, However as the medieval period progressed, the status of women declined, and later, women skilled in healing were treated as witches. From the 13th to 18th century women were excluded from medical education and practiced mostly as nurses and midwives, occupations considered subordinate by male doctors.

However, in Victorian times, women were allowed to enter medicine and have gone from strength to strength although obviously not without a struggle. Even as late as the 60's in the USA, medical schools were stating a preference for males.

That feminisation has occurred is beyond doubt, 50% of all medical students in NZ, Australia and the USA are women and the percentage is even higher in the UK. Whether there is equity in the workforce between men and women however is debateable, particularly relating to academic advancement.

At the same time that woman numbers were increasing in the workforce, another force was provoking changes in the way people were working. This of course was generation X. Generation X includes anyone born between 1961 and 1981. Prior to that time (1945 – 1961) you were a baby boomer and after 1981 you are generation Y.

The term was first used in a 1964 study of British youth by Jane Deverson. The study revealed a generation of teenagers who sleep together before they get married, don't believe in God, dislike the Queen and don't respect parents.

Douglas Coupland popularised the term generation X in his 1991 novel, "Generation X, Tales for an accelerated culture", where he characterised generation X'ers as cynical, naïve, disillusioned with the world of materialism, respecting no one and valuing nothing.

This certainly seems a little harsh but there is little doubt that generation X'ers have an entirely different attitude towards work and lifestyle than the generation before them – the so called "Baby Boomers".

Generation X'ers, do not want to work the long hours that were previously accepted as normal. They have a desire for autonomy and flexible schedules, celebrate excellence, not endurance. Close friends and family are more important than material success. There is an emphasis on personal growth expressing creativity and developing new and portable skills. They are cynical about organisations and support diversity. As might be expected they consider the baby boomers to be overly cautious, competitive, blindly loyal and hierarchy worshipping. They blame them for the chaos that they see.

For their part the baby boomers think generation X'ers lack commitment to their careers, with an overall lack of work ethic.

What is even more important to recognise is that the desire for life and work balance is sought by both males and females. This is not just a woman thing. The involvement of menfolk in family lives has accentuated this, and although generation X'ers recognise there is a coming shortage of doctors, they are not going to be exploited and work long hours and be loyal, as had the baby boomers in the past. Their loyalty is to family and self, not to institutions. It does not make them any less caring to their patients, but it does alter the dynamic of the service provision. The statement "everyone in general is just not willing to devote 100% of their life to medicine any more" resonates through the hospitals and primary sector workplace.

What are the ongoing effects of feminisation and syndrome X? Women have made huge efforts in the past to accommodate work structures that were designed for male workers, with invisible domestic support. Quite rightly women are no longer willing to sacrifice good family values and lifestyle, and so the

number of hours worked by this group are likely to be less than previously seen and interestingly, they are being supported by generation X men, recognising family responsibilities childcare and spousal needs. Even if such a change did not occur naturally, it seems likely that it would change by statute, if the European workforce directive is anything to go by. This says that doctors should work no longer than 58 hours / week.

Of concern however, is that with this trend, there are fewer women in acute medical specialties, in academic medicine and in positions of seniority. Also compared to men women work fewer hours, see fewer patients (and provide fewer services) leave the profession sooner, and are less inclined to join professional organisations. All these must be factored in as we design our medical services of the future. It may be also important to not let the pendulum swing too far so that women completely dominate medicine. As a Dean in a Canadian Medical School said, “I am not lamenting the feminisation of medicine. What I lament is the absence of men.” Both groups are equally important partners in delivery of health care, especially as men continue to provide the majority of technical expertise.

So what will our health system look like in the future – or what should it look like?

Firstly the medical school should not only increase the intake of students (and possibly reduce the length of training) but should make sure by whatever means at their disposal that they are selecting the right people. You women already lead the way; you are recognised as having more empathy, spending more time listening to your patients. Perhaps with men, the marks are not the most important arbiter, in entry to medical school.

Secondly, training at both undergraduate and post graduate level should be competency based, not time based. There should be considerable flexibility in training to allow part time and job sharing opportunities.

The workforce must be pluripotential which certainly suits woman who can multi-task. We must develop a workforce which is patient-centred, collegial and both community and hospital based to cope with all aspects of our communities’ health problems.

We must organise more flexible rosters and be innovative on the way we manage hospitals. Having large numbers of staff covering the evenings but not able to cross cover is counter intuitive and means people have to do more nights with less ground force during the day. We must look at other groups that may support the medical staff in providing the service required. Physicians’ assistants, Nurse Practitioners, Nurse Specialists can all reduce the load in the hospital setting.

We must develop models of care that provide for part time work, job sharing with flexible rosters and hours; this may include developing multi disciplinary teams possibly led by a Physician.

We must sort out the demographic inequalities of care, and get away from the big hospital concept. We must also train Physicians who are able to look after all types, and so generalism must flourish to provide such a service.

You are now the movers and shakers of the medical profession, at least in terms of numbers. You must become more vocal in your requirements, more vigorous in your teaching, and more dominant in your need to create an environment that suits not only your patients’ need but your own as well.

Allan Key once said: “the best way to predict the future is to invent it!”

You all have a wonderful opportunity to provide and plan for a service that is good for everyone. Make sure you do not let this opportunity slip away.

JOHN HENLEY
Auckland NZ

IMSANZ would like to welcome the following New Members:

- Dr Michael Furlong, Dunedin, NZ
- Dr Katherine Kan, Box Hill, VIC
- Dr Nat Lenzo, East Fremantle, WA
- Dr Roland McCallum, Hobart, TAS
- Dr Elizabeth Mornin, Dunedin, NZ
- Dr William Pratt, Shoalhaven, NSW
- Dr Alistair Wright, Warragul, VIC

IMSANZ wish to welcome the following Associate Pacific Members:

- Dr Shrish Naresh Acharya, Nasinu, FIJI
- Dr Ane Reijeli Atalifo, Suva, FIJI
- Dr Sione Talanoa Latu, Nuku’alofa, TONGA
- Dr Veisinia Matoto, Suva, FIJI
- Dr Mikaele Mua, Suva, FIJI
- Dr Tevita Sukafa. Suva, FIJI
- Dr Simione Voceduadua, Suva, FIJI
- Dr Elizabeth Wore, Suva, FIJI

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

- Dr Simon Dalton, Christchurch, NZ
- Dr Daniel Garofalo, Auckland, NZ
- Dr Christopher Hutchinson, Christchurch, NZ
- Dr Heather Lane, Auckland, NZ
- Dr Tessa La Varis, Wellington, NZ
- Dr Andrew Langlands, Perth, WA
- Dr Philip Robinson, Wellington, NZ
- Dr Ravi Suppiah, Auckland, NZ

HOSPITALISTS - A NEW BREED

By Lynnette Hoffman

The first examples of a new type of doctor called 'hospitalists' have started work in Australia, but critics are concerned standards may slip. Lynnette Hoffman reports

On Christmas day a few years back, Mary Webber was the doctor on duty in a short-staffed Sydney emergency department. The elderly man in the bed before her was clearly unwell: high fever, racing pulse, heavy breathing, confused and complaining of persistent pain all over his body. Webber and her colleagues checked for the usual causes, but ruled them all out. No one could figure out why the man was so ill.

He'd been in a minor car accident a week earlier, but X-rays following the incident had shown no signs of fractures.

Webber tried to transfer him to a bigger tertiary hospital better equipped to handle his case, but three declined before a district hospital finally admitted him. Doctors then had to play "catch up'' trying to access various test results and information being held by at least three different hospitals. One registrar noted in the man's file that it wasn't clear who was even in charge of his case.

The delays added up, probably to about four days, Webber says. Eventually the man was diagnosed with a rare infection concealed in his spine -- but by then it was too late. He died shortly afterwards.

Whether or not that outcome could have been avoided is impossible to say, but Webber says if things had been handled differently he certainly would have stood a better chance.

"The doctors were following the normal processes, but if there had been a doctor whose job it was to check up on the tricky patients, someone who was senior enough to crash through some of the barriers and push some of the walls down, then this might not have happened,'' she says.

"Or at least it might have been picked up earlier. Everyone was working very hard, but the system itself had inherent flaws when it came to patients like him -- the system works very well for `in-the-box' patients who come down established pathways, but not so well for the out-of-the-box patients.''

Now a new brand of doctor designed to help manage and co-ordinate the care of those "out of the box'' patients is being piloted by NSW Health at five public hospitals, in an effort to improve safety and quality of care, and reduce errors and adverse events in a hospital system plagued by doctor shortages.

Webber, along with two of her colleagues at Ryde Hospital, doctors Michael Boyd and Ross White, have been among the first to take on this new role of "hospitalist'' -- a doctor who will work in hospitals in a generalist role that crosses the divisions between medical departments and specialties.

NSW Health has allocated $1.4 million over two years for the Hospitalist Pilot Project, and plans to recruit about 20 more doctors to the position in July.

Exactly what such doctors will do has some degree of flexibility. They will liaise between specialists and junior doctors, as well as with GPs in the wider community. Some will create mentoring programs for junior doctors that review difficult cases and discuss what could be improved; some will develop new systems to deal with longstanding problems, such as a database to improve the lines of communication with GPs.

The goal is to provide better continuity of care in a system that has become increasingly fragmented -- ideally improving quality of care for patients who are chronically ill or have complex needs, such as the elderly or people with multiple health problems that don't fit neatly into one area.

But not everyone is enthused with the idea.

In January the Internal Medicine Society of Australia and New Zealand released a position statement calling the plan a "short-sighted and inappropriate response to the workforce crisis'', that may ultimately result in substandard care as lesser-trained doctors are given the responsibility traditionally charged to general physicians who have to pass the same boards and standards as sub-specialists. "We're very much in favour of someone taking a holistic view, but we think the ideal hospitalist already exists in the form of general physicians,'' says society vice-president Alasdair MacDonald, who wrote the group's position statement.

"Rather than creating a whole new class of doctors who don't have the same qualifications, we should be putting our money into recruiting and training general physicians, and improving remuneration for them to restore the balance of generalists compared to sub-specialists.''

Hospitalists first emerged in the US in the 1990s, and there are now more than 10,000 there. The NSW project marks the first time the role has been formally trialled in metropolitan areas in Australia. Victoria, Queensland and WA have all informally expressed interest in the program, says Professor Katherine McGrath, the deputy director-general of health system performance, who sponsored the program at NSW Health.

In rural and regional areas -- where doctor shortages are more acute -- hospitalist-type roles are more common, though they often happen by default. In Queensland, however, the "rural generalist program'' has taken the idea to next level, developing a specific training module for rural doctors working in hospitals, and last year had that qualification recognised. Such formalisation is not on the cards in NSW.

NSW based the new position partly on the American model, which has had some promising results. A review of hospitalist programs published in the Journal of the American Medical Association found that patients' average length of hospital stay was decreased by almost 17 per cent, hospital costs dropped by more than 13 per cent and most patients were satisfied with the care they received (2002;287:487-494).

But there are inherent differences in the way the US and Australian models are set up. Under the US model, hospitalists have considerably more power than those being piloted in NSW. For example, in the US hospitalists can admit their own patients, while here the specialist is ultimately in charge of the patient and just delegates responsibility to the hospitalist. There are also differences in training and qualifications. In the US hospitalists are internal medicine specialists; about half are general physicians and the rest tend to be specialists in intensive care. Several academic centres have now developed hospitalist-focused postgraduate training.

By contrast, NSW Health is targeting doctors who have experience working in hospitals but have chosen not to undergo

further specialty training -- such as a senior career medical officer, or a GP who would like to work part-time in hospital. There is no separate qualification required to become a hospitalist, and it's being seen as a pathway for career medical officers to progress in their careers rather than a specialty in its own right. Training will be in short bursts in the form of one-day workshops, much like the way continuing professional development works, as opposed to any formal course, McGrath says.

The hospitalists will be working on contracts that range from two to five years -- eons compared to most junior medical officers, who rotate as frequently as every 10 weeks and registrars who rotate every six months to a year. "They know how the hospital system works and they can build a long-term relationship with the specialists,'' McGrath says. "The whole point is to ensure there is no slippage in standards of care -- the patient remains under the care of the specialist, and the hospitalist works under the delegation of the specialist -- that's where we differ from America. We've made it deliberately different to protect against any risks.''

But MacDonald says that itself may be part of the problem. He claims that if anything, hospitalists should be under the supervision of general physicians because hospitalists recruited here are unlikely to have the expertise and training to take responsibility for complex patients. If that's the case specialists may not trust them to hand over responsibility to begin with. Instead they'll seek assistance from another specialist, increasing cross-referrals and further complicating matters. "The optimum hospitalists already exists and what effectively we're doing is saying, well we can't train enough of them, so let's create somebody that's not trained to the same extent, hasn't had to stand up to the same scrutiny and hasn't had to do the same exams -- and employ them to do that work,'' he says. "And let's supervise them by people who don't necessarily have the breadth of specialist's knowledge across lots of disciplines, and by administrators who are often not from a clinical background.''

Even among proponents of hospitalists, there is some concern that the goals of the NSW pilot project may not reflect the achievements hospitalists have made overseas.

Bill Lancashire is a senior lecturer at the University of NSW Rural Clinical School and a critical care doctor at Port Macquarie Base Hospital. He is actively pushing to have hospitalists introduced there, and says they can help reduce demands on overburdened specialists by taking over management of some of the less complicated patients, as has occurred in the Canadian system. But as to whether it can actually diminish hospital errors, he is not so sure. "I think we need to think more about why we're doing it and what we hope to achieve. Across Australia there is a real concern about adverse events in hospitals, but this shouldn't just be a reflex response to that,'' Lancashire says. "We need the evidence to show that adverse events will be reduced, because overseas that hasn't been the impetus; it's been specialists being overwhelmed by patient numbers.''

The review published in JAMA in 2002 found that while several studies showed hospitalists improved measures such as inpatient mortality and readmission rates, the results were inconsistent. Whether they will make a difference to safety and efficiency in Australia remains to be seen. The NSW pilot project ends in December next year.

ADMISSION SHEET

- Why the push for hospitalists?
- Doctors are working fewer hours, making it harder to fully staff all medical departments. In 2002 medical practitioners worked an average week of 44.4 hours a week, down from 48.1 in 1996.
- Even though the total number of doctors increased from 260 to 275 per 100,000 in that period, the number of full-time equivalent doctors dropped from 278 to 271.
- Hospitals are seeing more older patients who have more complicated health problems and less social support.
- Care is delivered according to the diagnosis rather than using a more holistic approach, creating "silos" in hospitals which are organised into separate medical departments -- creating problems when patients have complex conditions spanning different departments.
- Seventy per cent of patients in a UK study who died after surgery were emergency admissions, and frequently had other medical problems that were missed.
- Sources: Ryde Hospital, Dr Bill Lancashire

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Published in The Weekend Australian, 19 May 2007

Physician and Paediatric Training Curriculum Advanced Training Curriculum General Internal Medicine

Dear IMSANZ members

We invite you to read the latest version of the Advanced Training Curriculum in General Internal Medicine and provide feedback. The draft will is located in the members-only section of the IMSANZ website http://www.imsanz.org.au/news/index.cfm until October 1st 2007. Once this period is finished we will be looking to revise and pilot. Please note that the curriculum is designed to be used in conjunction with the RACP Professional Qualities Curriculum.

Any feedback you have should be provided to imsanz@racp.edu.au

Regards,

Phillippa Poole, on behalf of the 2007 IMSANZ Curriculum Writing Group.

Other members include Andrew Bowers, Mary Ann Ryall, Ian Scott, Peter Greenberg, Alasdair MacDonald, Denise Aitken, and Tony Rigley (RACP).

CHRONIC AND COMPLEX CONDITIONS

- Supporting Patient Care

Excerpts from the Commonwealth Budget 07-08 Papers

The Government will provide $291.3 million over four years to introduce two new Medicare items for consultant physicians who assess and manage patients with chronic and complex conditions. The scheduled fees for the new items will be $238.30 for an initial consultation of at least 45 minutes duration (MBS 111) and $119.30 for up to two subsequent consultations (MBS 117). These fees recognise the additional time and complexity involved in treating these patients. The items will be available from 1 November 2007.

Consultant physicians in sub-specialties are integral to the medical management and coordination of care of patients with complex conditions and multiple co-morbidities. This measure will enhance the medical management of patients with chronic and complex disease by supporting general practitioners and specialists in diagnosing or treating patients with difficult medical conditions. The treating practitioner can refer the patient to a consultant physician, who will provide an assessment and a comprehensive treatment plan.

Expense ($m)

	2007-08	2008-09	2009-10	2010-11
Department of Health and Ageing	43.4	68.3	73.1	78.2
Department of Veterans' Affairs	4.5	7.8	7.8	8.2
Total	47.9	76.1	80.9	86.4

FOCUS ON SUPER-SPECIALISTS 'WRONG'

The nation's top doctor has admitted the current focus on training super-specialists is a mistake, predicting there will be a return to more generalist specialists in the future.

Chief medical officer Professor John Horvath told the MedEd conference in Melbourne last week that it was time to shift away from "left toe versus right toe, descending versus ascending colon" specialists.

"A lot of us in this room were responsible for that approach; it was very fashionable in the 1970s," Professor Horvath said. "We got it wrong".

It was incumbent on medical educators to dispel the idea that you only became a generalist if you were not "smart enough" to be a super-specialist, he said.

ACRRM president Dr David Campbell welcomed the comments, saying a return to more generalist specialists would bring greater professional support for rural GPs.

There would be more opportunity for collaboration between generalist specialists and GPs, for example, through sharing anaestheric rosters, he said.

"[Rural practice] will feel a more supported environment; not such an isolated environment," Dr Campbell said.

There could also be more blurring of areas of responsibility between specialists and rural doctors, with ACRRM continuing to try to broaden the role of rural GPs, perhaps capturing "some of the territory that has been taken over by specialists", he said.

Delegates at the conference unanimously called for the establishment of a single authority to set training standards for Australia's medical workforce.

The Australian Medical Council should oversee training, with its reach extended to cover the "missing link" prevocational years.

Professor Horvath told the conference the Council of Australian Governments was moving ahead with plans to expand postgraduate training beyond teaching hospitals to private hospitals and other settings. The government had been "overwhelmed" by the high quality of proposals submitted so far, he said.

ARTICLE BY HEATHER FERGUSON

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19 April 2007

IMSANZ (NZ) Autumn Meeting

13-15 March 2008
Mount Maunganui, Bay of Plenty

Please diarise these dates for a the IMSANZ (NZ) Autumn meeting. Further details on the meeting and program will be available on the website shortly.

Organisers:

Neil.Graham@bopdhb.govt.nz
Philippa.Shirtcliffe@ccdhb.org.nz

Assoc Prof Phillippa Poole

BSc, MBChB, FRACP
IMSANZ President

Phillippa is a general physician at Auckland City Hospital and Associate Dean (Medical Programme) at the University of Auckland. She vaguely remembers the inaugural meeting of IMSANZ in Auckland in 1997, but has more detailed recall of the Council meetings since around 1999, as a NZ metropolitan representative. As NZ VP since 2003, and IMSANZ President from 2005, she has been heavily involved in physician curriculum development, and in making IMSANZ and its meetings appeal to a diverse range of members. She enjoys advocating for general medicine through various pathways to ensure that it remains a core component of health care systems and a desirable physician speciality.

While Council work is challenging at times, the tangible gains from the teamwork make it all worthwhile. Among the greatest pleasures have been the interactions with like-minded IMSANZ members at scientific and other meetings.

Dr Nick Buckmaster

Honorary Secretary

Nick Buckmaster is Director of General Medicine for the Gold Coast Health Service, encompassing 2 hospitals at Southport and at Robina. He trained in General Medicine and then extended his training to complete training in Respiratory Medicine before commencing as Director of Internal Medicine at the newly built Caboolture Hospital on the outskirts of Brisbane, where he stayed for 10 years prior to moving to the Gold Coast 3 years ago.

He has been actively involved in the medical politics in Queensland for the last 10 years, having led ASMOFQ, the salaried Drs union in Queensland through its inception and the successful salary package negotiations of 2005. He has also held various offices in the State Branch of AMA Queensland and continues as a councillor of the State Branch. He has formerly been on the State Committee of the RACP. He is a facilitator for training workshops for Advanced trainee supervisors and has played an active role in the organisation and quality of pre-vocational postgraduate education in Queensland. He is on a number of national workforce committees.

His interests lie around the development and implementation of systems which support high quality health care and this has led to his commitment to getting the signals right to support the key role of General Medicine in our health systems, as well as his work in Quality assurance and Quality improvement systems relating to General Medicine.

Assoc Prof Ian Scott

Immediate Past President,
QLD Metropolitan Representative

Dr Ian Scott is a Consultant General Physician and Director of the Department of Internal Medicine and Clinical Epidemiology at Princess Alexandra Hospital in Brisbane, and Associate Professor of Medicine at the University of Queensland. He has chaired the Brisbane Cardiac Consortium, a quality improvement program involving hospital clinicians and general practitioners throughout the Brisbane metropolitan area. He has chaired the Queensland Cardiac Collaborative since 2001 to the present time; is a member of the Queensland Health Safety and Quality Board and the Queensland Health Public Reporting Advisory Panel; and is a member of the Better Practice Committee of the Royal Australasian College of Physicians.

He was President of IMSANZ from May 2003 to May 2005 and acting Vice-president (Australia) from May 2005 to November 2006.

Dr Josephine Thomas

Advanced Trainee Rep Aust

Jo Thomas is the Advanced Trainee rep for Australia on the IMSANZ council, although she completed her general medicine training in 2005. Jo is currently working as a General Physician at The Royal Adelaide Hospital and completing training in Clinical Pharmacology part time. (She describes herself as sort of a hybrid registrar-consultant!)

Jo graduated from Flinders University South Australia in 1990. She has worked in General Practice in Sydney and Adelaide, obtaining her FRACGP, before pursuing Physician Training. Her clinical practice to date has spanned a wide range of areas, including: Addiction Medicine, Sexual health, Palliative care, Hypertension, General Internal Medicine and Clinical Pharmacology. She enjoys the breadth of general medicine and the opportunities for clinical teaching.

Dr Ingrid Hutton

Advanced Trainee Rep NZ

Ingrid Hutton is the Advanced Trainee rep for New Zealand on the IMSANZ council. She is currently at Middlemore Hospital in Auckland and is in her third year of dual training in rheumatology and general medicine. Anyone who has worked at Middlemore knows there is no such thing as single-organ disease so consequently, she gets great training!

Ingrid trained in the Dunedin Clinical School at Otago University and has been trying to warm up ever since. She has worked in Hawkes Bay, Sydney, Lismore, Gosford (NSW) and the UK.

Ingrid is also on the New Zealand trainees' committee, the Australasian Trainees' Committee and the NZ Committee for Examinations. She co-authored the study guide "How to Pass" and has helped set-up workshops for new medical registrars in the Auckland region.

Dr Emma Spencer

Northern Territory Representative

Emma Spencer is originally from Sydney and after an Alice Springs internship completed basic training at St Vincent's Hospital.

She is a fellow of the Royal Australasian College of Physicians and completed advanced training in general medicine in Far North QLD (Cairns, Mount Isa, Cape York and Torres Strait communities) and Infectious diseases training in QLD and Darwin. She currently works at the Royal Darwin Hospital in both public and private general medicine and is the Director of Physician Training. Her particular interests are rural and remote medical practice and she has been involved in

recruiting general medicine trainees to Darwin and organising advanced training in general medicine programs there.

As well as working in the Northern Territory and Cape York throughout her advanced training she spent five months working in a remote area in East Timor in 2000. She has travelled extensively in the developing world.

Emma is currently on maternity leave till May 2008 but would be very happy to talk to anyone wishing to come to the Northern Territory or anyone with questions concerning training in remote areas.

Dr Nicole Hancock

Tasmanian Metropolitan Representative

Nicole Hancock is Head of Department of General Internal Medicine at the Royal Hobart Hospital, Tasmania. Nicole is an enthusiastic and passionate advocate for GIM. She utilises information gained from councillor activities to determine strategies for optimising the role of Physicians practicing General Medicine in Hobart. Nicole enjoys the opportunity to hear about solutions from other sites for improving GIM cover and training.

Dr Andrew Bowers

New Zealand Smaller Metro Centre Representative

Andrew is proud to represent New Zealand members on the IMSANZ Council these are exciting times. IMSANZ is leading the renaissance of Internal Medicine in Australia and New Zealand. We now have more IM trainees in NZ than the any other specialty, so our future looks bright with ongoing good management. With your help we can really make a difference to patient care through appropriately realigning the path of healthcare delivery. Andrew has chosen to be heavily involved in IMSANZ and RACP affairs to help mould this change which he sees as better for patients, IM Specialists and Specialists in all other areas alike. Andrew is currently a senior member of the IM SAC in NZ.

He is a writer of both the basic and advanced training curriculum. He has been the Otago Representative to the NZ Committee of the RACP, the Director of Physician Training and the Otago representative to the Committee for Physician Training. He has been a co-opted RACP examiner for many years. He is on a large number of working groups for both IMSANZ and the RACP including several relating to the new direction of the College. Andrew works full time as a Physician in a busy Acute Internal Medicine service with HealthCare Otago and in the University of Otago as a Senior Clinical Lecturer.

Professor Dawn Elise DeWitt

MD, MSc, FACP, FRACP
Victorian Rural Representative

Professor Dawn DeWitt grew up in rural Wisconsin before moving to Australia in 2003. She is currently the Professor of Rural Medical Education, Head of the School of Rural Health, Dean of the Rural Clinical School at the University of Melbourne, and a practicing rural Consultant Physician in Shepparton. She completed an MSc at Cambridge and an MD at Harvard, before training as a general medicine physician at the University of Washington (UW), where she remained on the faculty for over 10 years.

While Director of Washington, Wyoming, Alaska, Montana, Idaho Regional Community Based Education for Internal Medicine, she worked on national medical education projects and committees, received several teaching awards, and chaired a U.S. National Board of Medical Examiners Committee. She was voted one of the “Best Doctors in America” in 2002, in 2006 she received the Inaugural UW Early Career Achievement Award. She has research interests in diabetes, rural/community-based medical education, electronic medical education, career choice, and personal-professional balance. Her publications include two books on Community Based Teaching.

Dr Mary-Ann Ryall

Honorary Treasurer and ACT Representative

Mary-Ann Ryall has held the position of ACT Rep since 2002 and is actually working as a community geriatrician around the ACT and Greater Southern area of NSW in order to support an addiction to postgraduate education (currently undertaking a PhD in education at the ANU).

Mary-Ann completed fellowship training under the SAC in general medicine (awarded 2000). In the process of relocating to Canberra with her family and attempting to establish herself as a generalist she somehow found herself on the IMSANZ council. Her professional life took a slightly different turn but she still continues to support IMSANZ and their role in promoting training and working in general medicine as the way of the future.

In recent years Mary-Ann’s main contribution has been in the area of curriculum development and she has served on a number of College working parties relating to implementation of the Education Strategy.

Alasdair MacDonald

President Elect, Tasmanian Rural Rep

After graduating from the University of Tasmania he commenced a career in General Practice before moving to Emergency medicine with a stint as acting director of the 350 bed hospital Emergency department then time as an ICU registrar before a career path in General Medicine became obvious. Following physician training in Adelaide Alasdair returned to Launceston to take up a position as a General Physician. During his time in Launceston he has had the opportunity to work with an innovative Department who have remodeled patient handover and the importance of GIM. He has been Director of General Medicine for the last 4-5 years and deputy department head over recent years. In addition to these commitments he is the inaugural director of the Stroke unit, having worked to establish it, and is the discipline head for medicine at the Launceston clinical school of the Tas Uni School of Medicine. Alasdair performs these roles as a VMO, together with 5 sessions in private practice.

Alasdair is passionate about GIM and IMSANZ’s role in it’s expansion he has a particular interest in maintaining GIM as the driver of acute medicine in Australia in part though medical assessment units and in the need to maintain some true specialist general physicians in ambulatory consulting practice to support general practitioners and our surgical colleagues in the management of complex comorbidity rich cases and undifferentiated cases, along with the encouragement of dual training to broaden our workforce appeal.

RACP Congress 2008

11 – 15 May 2008
Adelaide Convention Centre
South Australia

College Ceremony	Sunday 11 May 2008
Pre-conference Workshops	Sunday 11 May 2008
Professional Skills Day	Monday 12 May 2008
Adult Medicine Division Annual Meeting	Tuesday 13 to Wednesday 14 May 2008
IMSANZ Annual Meeting	Tuesday 13 to Wednesday 14 May 2008
Paediatrics & Child Health Annual Meeting	Tuesday 13 to Thursday 15 May 2008

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- Joint Faculty of Intensive Care Medicine
- Australian Rheumatology Association *
- Endocrine Society of Australia *

** Participation to be confirmed*

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Expressions of interest

If you are interested in attending the RACP Congress 2008, Physicians Week 2009 or WCIM 2010 and would like further information, please contact:

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LETTER FROM THE PACIFIC

Your Pacific Correspondent

I have always considered pericardial tamponade one of those things we should think about in a patient with unexplained heart failure, but which in fact we will seldom see.

So it was somewhat a surprise to have two patients within a week or so of each other, and they illustrate well the complexities and radically different outcomes of what can seem initially to be similar cases.

The first patient was a middle aged woman who was admitted to our rather rudimentary Coronary Care Unit with a provisional diagnosis of an acute ST elevation myocardial infarct. Her pain was typical, but her ECG had the saddle shaped ST elevation suggestive of pericarditis rather than that of an acute MI. So I was rather proud of myself when I listened carefully for a pericardial rub and there it was, scratching away nicely.

I gave the students a little bedside tutorial on the importance of making the distinction between pericarditis and an AMI, stopped her aspirin and beta-blocker, and we watched her over the next couple of days. Initially she seemed to improve, although it might just have been her relief that she wasn't having a heart attack. But her ESR remained very high, she continued to have a significant, albeit low grade, fever, and her rub didn't go away.

After waiting quite a few days, during which it became clear she wasn't getting better, I finally decided she probably had an autoimmune type of pericarditis, and after much thought decided to commence a trial of steroids. The effect was very gratifying, and after another three or four days she was sufficiently improved for us to send her home with a discharge diagnosis of a steroid responsive inflammatory pericarditis.

I was still silently congratulating myself a few days later only to be told when I arrived in the morning for the daily ward that she had been readmitted overnight very short of breath. A quick examination confirmed all my fears – she was hypotensive, had muffled heart sounds, and her JVP was up to her ears – and her chest Xray showed a dramatic increase in the heart shadow. Luckily one of our recent MMed graduates was seeing another patient in the same ward, so I persuaded him to do an urgent echo which confirmed tamponade, and he went on and did an immediate pericardiocentesis.

The fluid looked just like café latte – brown and milky – so she was commenced on broad spectrum antibiotics. However she required an urgent tap again the following day, so the surgeons then went in and performed a pericardial window. The next day we received the result of the culture of the fluid, and it had grown a Group B beta-haemolytic streptococcus which was sensitive to penicillin.

She never looked back after penicillin was commenced, and I rather shamefacedly presented her at one of our meetings as a case of bacterial pericarditis with tamponade precipitated by steroid therapy. I also reviewed her recently, and she was completely recovered and very grateful for our ministrations.

The second case unfortunately had a completely different outcome. He was a previous well middle-aged Fijian man who was complaining of shortness of breath. There was very little to find on physical examination except I thought I could hear something in diastole, and I had a lively discussion with the registrar as to whether it was a third heart sound or a mid diastolic murmur. He had some rather non-specific looking infiltrates on his chest Xray, but otherwise his initial investigations were normal.

We went ahead and did an echocardiograph, and were rather surprised to find he had quite a large pericardial effusion, and we were even more surprised when over the next few days he deteriorated and developed clear signs of tamponade confirmed by a repeat echo.

Again he had several taps, each of which only produced temporary relief, and the surgeons went ahead and did a window that relieved his symptoms much better.

In his case the fluid was a clear straw coloured exudate with virtually no cells, and the histology of the pericardial window, which we thought would give us the answer to the underlying pathology, was disappointingly unhelpful, just showing thick fibrous tissue.

In view of our lack of a definitive diagnosis we went ahead and treated him for TB, being the most important treatable cause. This included dexamethasone, so I felt we were also covering an autoimmune cause.

He also initially improved with the window and the steroids and anti-TB therapy, but I was concerned that the pulmonary infiltrate wasn't clearing. The concern then gradually turned to alarm as he began clearly to deteriorate again despite our treatment, and he died about a week or so later. My diagnosis had changed to a likely malignancy, as I couldn't think of anything else which would cause a slowly worsening pulmonary infiltrate and pericardial tamponade unresponsive to TB treatment and steroids.

Luckily his wife was as concerned as we were to know what was the cause of her husband's death, and she agreed to a limited postmortem. This confirmed our suspicion of malignancy, revealing widespread infiltration of the lungs and pericardium by an anaplastic looking adenocarcinoma.

So, two initially rather similar cases, but completely different pathology and outcomes. Interestingly, in both cases it could be argued that administration of steroids played a significant diagnostic role – in the first case by making the patient worse and thus hastening the correct diagnosis, and in the second case by having no effect, thus again pointing us towards an alternative, and unfortunately correct, diagnosis.

ROBERT MOULDS FRACP
Suva, Fiji

IMSANZ ANNUAL GENERAL MEETING

will be held in Meeting Room 2
Adelaide Convention Centre,
Adelaide at 12.00 noon,
September 7, 2007

GENERAL INTERNAL MEDICINE MEETING REPORT

Report on the First International Symposium in General Internal Medicine at the 30th Society of General Internal Medicine (SGIM) Meeting, 25-28 April 2007, Toronto, Canada

Over 1600 delegates attended this year's SGIM meeting themed "The Puzzle of Quality". The higher than usual number of international attendees may have been due to holding the meeting outside of the US and / or the attraction of this First International Symposium in GIM. This half day session was attended by around 150 people.

In contrast to international symposia in earlier years that compared the state of GIM in major nations, this one focussed on global roles for general physicians; an "eye on the world." Congratulations are due to William Ghali (Canada) and Jacques Cornuz (Switzerland) for putting such an exciting programme together.

The first speaker, Professor David Bates from Brigham and Women's at Harvard, outlined the WHO World Alliance research agenda on patient safety. The WHO Alliance exists to support all countries in improving their systems of care. Adverse events affect at least 10% of patients in hospitals in developed countries with this being a far bigger problem in developing countries. Early data from developing countries suggest there is a high prevalence of hospital deaths, 75% of which would be regarded as preventable in our systems. There was considerable difficulty in extracting data, but, somewhat surprisingly, better health record systems existed in some of the poorest countries; usually where government departments have been involved. Dr Bates indicated that generalists are well-suited to lead the patient safety agenda. IT and communications technology provide tools to advance global health quality, and they, in themselves, drive globalisation. As ever, the challenge remains to find meaningful quality measures that may be applied across national boundaries.

A personal journey that bridged the gap from academia to international aid was the theme for Dr Michael Schull, University of Toronto. Effective advocacy is important for physicians and academics. Undertaking work with a larger organisation such as Medicins sans Frontieres (MSF) may help prevent personal burnout. Michael believes that general physicians are well placed to contribute through such organisations; urging us not to be put off by a perceived lack of specific skills. He outlined the MSF campaign for access to essential medicines for HIV/AIDS which has been an unanticipated success. Lessons from working in developing countries will translate back to home settings; an example being a system to allow community workers to deliver chronic care to at the place of need (small villages).

Now back in Canada following a stint in Australia with IMSANZ member Dr Peter Greenberg, Dr Peter Sargious outlined the case for more sophisticated approaches to chronic disease management (CDM). Chronic diseases account for 60% of deaths worldwide, and over 75% of healthcare costs. Peter pointed out that the reason many of us feel overwhelmed is that we are working in antiquated health systems designed more for managing patients with acute admissions than with their chronic conditions in between these acute episodes. National primary care systems have recently been studied in terms of their preparedness to manage chronic disease (Schoen, Health Affairs 2006). NZ scored moderately well at 68%. The investigators found though, that only 18% of physicians in NZ write information down for patients. The prevalence of use of non-physician clinicians in CDM was higher in the UK (73%) than in NZ (57%) or Australia (38%). Peter made a plea to see CDM less in terms of remuneration and more in terms of developing the necessary infrastructural support. Again generalists are better placed to lead this agenda. He called for fora in which to share effective initiatives in CDM at a far earlier stage - not having to wait for publication. The development of a taxonomy of CDM is important in order to have a common understanding of what is being described.

One of the most provocative presentations came from Dr Alex Jadad from the Centre for Global eHealth Innovation at the University of Toronto. For those with familiarity with Cochrane reviews, this is the same person who 'invented' the Jadad scale. He really is a dynamo.

Regardless of country, there is a demographic "tsunami" of health need and the current approach is unsustainable i.e. still in 19th century. He emphasised the point made decades ago by Ivan Illich in his book Medical Nemesis - the medical establishment has itself become a threat to health. He pointed out that knowledge overload exists already; for example, a search on Google using the terms 'chronic disease' results in over 50 million hits. He challenged the audience: can we avoid duplication? can we provide management at the point of need? can we make hospitals places of last resort? If we are to do so, the health system requires substantial reorganisation.

Jadad then gave some examples of how technology has the potential to change the way health care is delivered.

- More use may be made of Bluetooth to link patient blood glucose and BP recordings to a universal patient health record. These measures could be checked against preset parameters, with a revised management plan automatically returned to the patient.
- Patients already use YouTube and Wikipedia; more use could be made of these technologies for patient management and training, and for assessing clinician performance. He stated that each page on Wikipedia now has on average 14.2 edits. If incorrect information is posted, it gets corrected in an average time of only 10 minutes! We should stop reduplicating shared efforts at knowledge creation and make much more use of Wikipedia and other existing information sources.
- Patients have been found to be self-organising. On a UK breast cancer discussion site, 99% of 'posts' were found to be accurate.

With respect to peer review publications, Jadad blamed the tyranny of impact factors for journals now getting rich at the expense of investigator effort, and preventing timely dissemination of useful information. Is it time to challenge the establishment, moving to a system of more open peer review, and access to science for everyone? This is indeed happening, with new journal entitled "Open Medicine" in its early stages. Although the journal will be supported by expert bloggers, authors will use templates and doing much of the uploading work themselves. Watch this space.

The International symposium finished with outgoing SGIM President Dr Robert Centor echoing many points made through

the afternoon, and promoting 'blogging'. He has run his own blog for several years and has seen germs of ideas grow to great initiatives.

The only other SGIM session for specific comment was "Pushing the envelope: thinking about quality in a broader context." This lecture was given by Dr Nicole Laurie, previously an SGIM president, now Director of the RAND Centre for Population Health and Health Disparities.

She estimated that only 50% of recommended care gets undertaken. Providing all the recommended care to patients would take a GP or physician 60-80 hours / week; an untenable financial situation. She reminded us that clinical medicine makes only a modest contribution to overall health status, and that better process does not necessarily lead to better outcomes, especially for minority groups. Even if perfectly applied, disparities would still exist. To address these, something major and disruptive needs to happen. Dr Laurie believes that this must be a different way of engagement with communities to address their health needs and that thinking way outside the health system is needed to get results. The example given was to identify and define aspects of communities beset by inequities. It is possible to draw maps (or "blow ups") of these communities including where patients go for their medical care, locations of parks, supermarkets and other food suppliers. If policy was made so that everyone in a city lived within 10 minutes of a park, had good air quality and transport systems that allowed people to walk / ride to work, this would lead to a much healthier population.

She urged attendees to be creative, to encourage children to question their parents and teachers, not to be complacent, and to think 'really big'! General physicians will relate to her closing comments. She called for doctors to continue to look after the whole person, and not to be greedy or 'partialist'. In her words, doctors need to continue to be quality people!

With their broader view of clinical health care, general physicians will readily appreciate some of these newer ideas. The scope of general physicianly practice is ever widening, but we in IMSANZ seem to be well placed to meet the challenges of the 21st century both locally and globally.

My thanks to IMSANZ for sponsoring this trip.

PHILLIPPA POOLE
President, IMSANZ

RESEARCH REVIEW

A new resource publication titled "*Internal Medicine Research Review*" has been produced in New Zealand. This publication is edited by Sisira Jayathissa, a long time IMSANZ member. If you are interested in this publication, please go to **www.researchreview.co.nz**

Life Membership

IMSANZ Council voted unanimously at the last meeting to award Life Membership of IMSANZ Dr Michael Kennedy and Dr Neil Graham. They join Alex Cohen and Peter Greenberg, our only other "lifers". We extend congratulations to Michael and Neil along with the Society's thanks for contributions made over the past 10 years.

Dr Michael Kennedy MD FRACP, Sydney, Australia

Michael is a general physician and clinical pharmacologist in Sydney. He was a founding member of IMSANZ and has held several positions on the IMSANZ Council. He was the inaugural Honorary Treasurer in 1997 and became the IMSANZ Hon Secretary/Treasurer for 1999-2001. Michael then became a Co-opted Councillor as SAC representative until 2007. He served on the SAC in General Medicine Committee for nearly 9 years as a co-ordinator of advanced training.

In other roles, Michael has worked on behalf of general physicians and IMSANZ in addressing the shortage of General Medicine services in Sydney, and the idiosyncrasies in the PBS schedule.

He remains the IMSANZ Public Officer.

Dr Neil Graham MRCP, FRACP, Tauranga, NZ

Neil has been a General Physician at Tauranga Hospital, Bay of Plenty, NZ since 1985. He has a broad base to his practice with major subspecialty interests in Respiratory and Rheumatology Medicine. Over the years he has become more and more attached to the subspecialty of General Medicine particularly in areas such as multisystem disease and cases of relative diagnostic challenge.

Neil was President of the NZ Society of Consultant Physicians in Internal Medicine since it's founding in the early 1990's, and an inaugural member of IMSANZ Council.

He was the President of IMSANZ 1999-2001. During his tenure he co-authored with the then President of RACP, Richard Larkins, 'General Medicine: The Way Forward'. This publication gave "general medicine" a definition, identified key issues and set an agenda for reform over subsequent years.

Neil is well-known in IMSANZ for his support of general medicine meetings and enthusiasm for broader pursuits such as poetry and mountain-biking.

New CATs added to the library include:

- Use of BNP in predicting prognosis in acute heart failure
- Decreasing homocysteine levels does not lower risk of VTE
- PCI does not improve outcomes in optimally treated stable CAD
- Screening for abdominal aortic aneurysm saves lives and is cost-effective
- Rosiglitazone may increase risk of cardiovascular death and MI
- Vasodilators of little use with aortic insufficiency
- Sustained-release ropinirole improves advanced Parkinson's
- Pretreatment with omeprazole before endoscopy reduces bleeding
- Antioxidants may increase mortality
- Combination therapy with sulfasalazine and methotrexate is more effective than either drug alone in patients with rheumatoid arthritis
- Meta-analysis of anticoagulant VTE prophylaxis in hospitalised medical patients
- One yearly zoledronic acid is effective for post-menopausal osteoporosis
- Dietary sodium restriction reduces risk of cardiovascular events
- CCP more specific and just as sensitive as rheumatoid factor for diagnosing RA

An Increasing Focus on Generalism

In NZ the Minister's Workforce Taskforce has just reported back and includes the following recommendations (a Medical Training Board to be established to oversee the continuum of training from med school to speciality practice, factoring in workforce issues).

There is widespread support both in New Zealand and internationally for the view that broad generalist skills are desirable for all medical practitioners and should be the basis of learning in the undergraduate and early clinical training years leading to general registration. There is, however, a trend in many countries to increasing specialisation and sub-specialisation, a trend that is influenced in New Zealand to a large extent by the Australasian medical colleges. Because of the size and distribution of its population, New Zealand has a greater need for vocationally trained generalists, such as in general medicine, general surgery, general paediatrics, general practice. This should be reflected in the Medical Training Board's contracting arrangements.

Recommendation 5a

That the Medical Training Board work with educational and training organisations to ensure that:

- all medical practitioners acquire a broad general foundation, which includes community and regional hospital experience, before entering vocational training
- the training system produces sufficient numbers of doctors entering the New Zealand workforce with training in general vocational scopes of practice.

DR PHILLIPPA POOLE
President IMSANZ

RACP Medal for Clinical Service in Rural and Remote Areas 2007

IMSANZ wishes to congratulate Dr Diane Howard who received the RACP Medal *for Clinical Service in Rural and Remote Areas 2007.*

Diane Howard has worked as a General Physician and Endocrinologist in Darwin since 1978 and has provided excellent patient oriented medical care to the people of the Northern Territory. She has a strong commitment to Aboriginal health, particularly in diabetes and its co-morbidities and to developing specialist services in remote Australia.

Di trained in Adelaide and Sydney, she was one of the first physicians resident in the Northern Territory and has made important contributions to the development of health services at Royal Darwin and Darwin Private Hospitals. Whilst her major emphasis has been on patient care, Di has always been astutely aware of issues relating to registrar training and service delivery to remote regions.

Di was a member of the IMSANZ Council from its formation in 1997 until 2005 this included several years as Vice President.

Despite her workload Di has also been an elected member of the Adult Medicine Divisional Committee, Director of Physician Training at the Royal Darwin Hospital since 2001 and since 2002 has been a member of the RACP Northern Territory State Committee she was also invited to join the RACP Rural Taskforce in 2002.

Di has been an inspiration to generations of doctors, also providing inspiration and support to nursing staff and allied health and Aboriginal health workers in Darwin and surrounding communities.

Congratulations Di from the IMSANZ Council and members!

WHAT'S IN THE JOURNALS

July 2007

**1. A comparison of outcomes resulting from generalist vs specialist care for a single discrete medical condition A systematic review and methodologic critique.
Smetana GW, Landon BE, Bindman AB, Burstin H. et al. Arch Intern Med 2007; 167:10-20**

Of 49 publications retrieved, 24 favoured specialty care, 13 found no difference, 4 favoured generalist care, and in 1 study physician experience was shown to be relevant. In 7, the results depended on which outcomes were considered. Methodological shortcomes in individual studies makes interpretation of results difficult. For example, only 2 studies were randomised. Confounding is likely in many of the non-randomised studies, even with adjustments for case-mix. Publication bias is also likely, because more studies showing a difference in outcomes are likely to be published. Furthermore, disease-specific outcome measures may not fully account for the totality of care assessed when broader parameters are compared between the 2 groups. There were few studies in patients with chronic, in contrast to more acute conditions.

Also see the accompanying editorial: **Studies comparing quality of care by specialty. Valid, relevant or neither? O'Malley PG, O'Malley A. Arch Intern Med 2007; 167: 8-9**

**2. The locality rule and the physician's dilemma. Local medical practice vs the national standard of care.
Lewis MH, Gohagan JK, Merenstein DJ. JAMA 2007; 297:2633-2637**

The 'locality rule' in the USA is reviewed. The rule was based on the premise that rural physicians might be relatively disadvantaged because of fewer educational experiences and so should be held to a *local*, rather than to a broader standard of care. Established in the 1880s, it is currently disregarded by many courts, but it is still supported by a minority of US courts and in some jurisdictions. Local standards of care are often difficult to measure. In contrast to the 1880s there is now much better access to information and educational opportunities, irrespective of practice location. It is argued that persistence of the rule promotes substandard medical practice, and that currently, location is applicable only to access, rather than to the knowledge and skills of professionals.

3. The declining number and variety of procedures done by general internists: a resurvey of members of the American College of Physicians. Wigton RS, Alguire P. Ann Intern Med 2007; 146:355-360

This paper outlines self-reported procedures undertaken by members of the American College of Physicians in a 2004 survey, and compares the results to those of a similar survey in 1988. During this 18 years, the proportion of general internists doing various procedures fell by more than half, and the average number of different procedures fell from 16 to 7. Both studies showed that the range and number of procedures was greater in physicians who practise in smaller cities and hospitals, and in those who spent relatively more time in patient care.

**4. Emergency care in the first 48 hours. "Acute physicians" herald the new specialty of acute medicine
Lehman P. BMJ 2007; 334:218-219.**

Yet another specialty! In contrast to the situation in the USA, where the response to changing work patterns of junior doctors, fewer subspecialists electing to participate in 'take' and the demand for shorter stays in emergency departments has resulted in the growth of 'hospitalists', 'acute physicians' have evolved in the UK. This new breed of specialists manages medical patients for the first few days after admission, and is intended to become the link between home treatment and shorter, focused hospital treatment. Dame Carol Black, the last president of the Royal College of Physicians is paraphrased in the paper: "*a specialty can only exist when a robust body of publshed work provides evidence of what the specialty does and why it should continue to exist*".

**5. The primary care-specialty income gap: Why it matters
Bodenheimer T, Berenson RA, Rudolf P. Ann Intern Med 2007;146:301-306**

In spite of USA 'Resource-Based Relative Value Scales', designed to reduce the difference between payments for office visits and payments for procedures, the primary care (generalist)-specialty income gap has continued to widen. This paper calls for payent reforms to guarantee a strong primary care base to the US health care system.

**6. Care-Fully: summarizing the issues facing general internal medicine and the health care system in Canada
Canadian Society of Internal Medicine (CSIM). See http://csim.medical.org**

This collection of essays, articles and opinion pieces was developed by the Canadian Society of General Internal Medicine Key messages are 1) General Internal Medicine (GIM) is a unique discipline within the medical specialties. 2) General internists provide an approach to care which is increasingly needed in both rural and remote communities and in university centres. 3) There is an urgent need to recruit more residents to choose GIM careers to meet the needs of Canadians. 4) Increased support for the recruitment, training and retention of general internists is needed now to avert a crisis, both in patient care and in medical education.

If you have not done so, check out the CSIM website http://csim.medical.org *which includes many useful links for general*

internal medicine and for evidence based practice, and access to the Canadian Journal of General Internal Medicine.

**7. A history of internal medicine. Medical specialization as old as antiquity.
Echenberg D. Canadian Journal of General Internal Medicine 2007; 2: 8-10**

This short account of the history of medical specialization, begins with Herodotus and considers the beginnings and growth of internal medicine in America and elsewhere. The author is currently president of the Canadian Society of General Internal Medicine.

Continued on page 23

"ANOTHER GOOD REASON TO FOLLOW HORSES"

Preventive medicine is emerging as one of the major interventions available in today's society an emphasis which is likely to develop further over the next decade.

The improvement in management of established ischaemic disease over the last two decades is perhaps one of the outstanding advances in medical practice. However the rate of improvement is declining and negative aspects are increasing. For example individual failure rate of statin therapy to meet target guidelines has now reached 27-70% in general practice worldwide. Additionally we are now seeing drug eluting stents (once heralded as the answer to coronary artery disease) implode after only a couple of years.

It is evident that the time old adage "Prevention is better than cure" is now a truism.

Since 1984 I have been utilizing a form of exercise in a preventive cardiac programme : how I developed this programme and the sequelae may be of interest.

I was introduced into racing one day after attending a League game at Sydney Cricket Ground. As is our wont we retired to a local hostelry where I was introduced to a horse trainer. Having ascertained that I had never been to a race track in my life he advised me to save up and go to Rosehill racecourse in two week's time where he had a horse which would win at 100:1.

In company with friends and acquaintances I duly obliged and the horse "Roy Boy" duly won- he opened at 100:1 but started at 8:1.

This has nothing to do with the exercise programme. However some years later having been seduced into racing I now owned (in company with a bank) a stud at Moss Vale and read somewhere that in America trotting horses had been trained by heart rate meters. I took my trainer to a meeting held at Sydney University on this form of interval training with the idea that he would arrange for similar training of my horses. I had even invested in a heart rate meter!

All to no avail. He told me the monkeys (a loose term for track work riders) would not be prepared to sit on a horse for the necessary time to accomplish this task for the $5 they were paid.

At about the same time I had started an outpatient cardiac programme for post infarct and ischaemic patients at Western Suburbs Hospital. A flash of genius! Why not treat my patients in the same way instead of the horses. So I introduced interval training with short endurance phases of anaerobic heart rates to my unsuspecting victims. What, no informed consent!

We undertook pre and post exercise testing and lipid levels in these patients after six weeks of the programme. Surprisingly the vast majority improved in fitness, lowered blood pressure and enjoyed the process!!

In 1992 an article from Northern Ireland appeared in Circulation which demonstrated that if a patient had a HDL<1mmol/L and had an angioplasty he had a 64% chance of restenosing and that this restenosis occurred within two months and was more severe than the later six month stenosis. On the other hand if his HDL> 1mmol/L the risk was only 17%.

Amazingly then I went into my computer and to my surprise, in those patients in the interval training programme with low HDL levels, all had increased their HDL and a significant number had passed the 1mmol/L mark.

This programme has now been used in over 800 patients and we have not only shown very similar HDL results but have also shown improvement in fibrinogen, high sensitivity CRP, and isolated HDL. We even got a poster at the last cardiac society meeting!!!

We also noted that of those patients (50%) who had not attained their target lipid levels, a significant number (15%) did after the exercise and those primary prevention candidates who would have been given statin on the basis of their lipids after exercise 30% no longer met the criteria.

At an International Preventive Cardiology meeting in Surfers Paradise in 1988, I met a senior lecturer from Manchester who was running an Executive Training Programme for middle and senior executives. He was using a finger prick method for estimating lactate levels. He did this at the last minute of his exercise programme. If the lactate was greater than 2mmol/L he reduced the exercise level. He did not want any of his patients to die!

Much earlier in my life (1965) whilst I was a registrar in Barnet Hospital[1] in North London I had the luck to be able to measure the level of acidosis in fifty consecutive patients admitted with acute myocardial infarction. This study showed that those patients who were acidotic had the greatest death rate[2].

Nearly twenty years later I was exercising cardiac patients for short periods of time (3-5 minutes) at or above the anaerobic threshold without any morbidity or mortality. We were, however, giving patients a short break of one minute between each endurance phase.

Whilst the patients do show a degree of lactic acidosis it is rare to exceed 5mmol/L- and the period of exercise and therefore acidosis is limited to a maximum of fifteen minutes.

The clinical results speak for themselves and may be viewed on www.neocardia.com.

With the introduction of radiological demonstration of coronary pathology and the continuing imploding of stents perhaps the future for Cardiology is in Prevention and our day will come!

TONY NEAVERSON
Preventive Cardiologist
Noosa Hospital, Noosaville.
Queensland 4566

June 26th 2007

[1] Barnet Hospital had the second ICU in the United Kingdom at that time.

[2] Neaverson MA "Metabolic Acidosis in Acute Myocardial Infarction" Brit Med Jour 1966;11:383

NEW ZEALAND PERSPECTIVES ON THE HOSPITALIST DEBATE

In New Zealand we have FRACP general and subspecialty physicians and trainees, and the same structure in ED. We also have a fairly long tradition of MOSS (medical officer special scale), career grade medical officers. The doctors are not in training programmes and do not hold College fellowships but have permanent contracts to work, under the supervision of specialist medical staff, in various hospital departments. In the various Auckland hospitals, there are or have been MOSS working in Oncology, Renal medicine, Cardiology, Acute Care medicine and in other districts ED at least.

The term Hospitalist is a recent American coining as we know, to describe the fact that there is a place for hospital based acute internal medicine!!

I feel quite strongly that in dealing with hospital administrators, whom I believe do not truly grasp the nuances of this and who are seduced by this new, American (and therefore better on both accounts) concept, that we should point out that we have been doing this for years, that the Americans are trying to catch up to where we are and that we have our own understood terminology and should use it rather that muddying the waters with new and poorly defined terms.

So, are they looking for specialist staff, then they should be looking for FRACP general physicians, and ensuring there are enough trainees, or do they want doctors working in grades below this? If so, then in NZ, use the term we know, MOSS, and if you have an Australian equivalent use that. These doctors would in NZ require specialist oversight.

Maybe as a special society, we should consider whether we would like there to be a College Diploma in Acute care medicine, open to all registered medical practitioners, but not a specialist qualification, similar to the Diploma in Palliative Care.

DR BRIAR PEAT
IMSANZ Councillor
Senior Lecturer in Medicine
General Physician Counties Manukau DHB (CMDHB)

CMDHB embraced the concept of HMOs (or MOSS) in the 1990s. As far as I can work out this was in response mainly to the difficulty in recruiting to certain areas within the organisation and related to the relatively large pool of non-FRACP overseas trained specialists around at the time. They were appointed to acute medicine posts, renal medicine (help co-manage burgeoning dialysis pts) and emergency medicine. I don't think that the "experiment" has worked for the following reasons:

1. Lack of ongoing professional development of the HMOs (no professional society to support them)
2. Lack of respect shown to them by Registrars in training who saw themselves as superior to HMOs and reinforced by lack of acknowledgement that HMOs are an integral part of service by SMOs and with a status similar to their own
3. Pay structure not substantially different from SMOs so not cost effective
4. Variability in performance and difficulty in current employment environment in managing poor performers
5. Difficulty in involving them in afterhours roster. SMOs don't regard them as equivalent and skill set different from that of registrars.

Personally I believe we are better off using FRACP grads to take more responsibility for managing the continuum of care and not just popular elements and in supporting growth of nurse specialists and in allied health personnel. Whilst occasional HMOs work very well and are of desirable standard the overall effect has been a reduction in quality of service and the creation of another tier which has been very difficult to adequately administer.

DR JEFF GARRETT
Respiratory Physician
Clinical Director of Medicine
Counties Manukau DHB (CMDHB)

From page 21

8. Evidence-based guide to perioperative medicine
Scott IA, Lodge RS, Russell DM. Intern Med J 2007; 37:389-401

This excellent and practical guide distils the essence of high quality care in the peri-operative period. It is based on a literature search and review of relevant publications which address a variety of potential interventions. Topics include cardiac and pulmonary risk stratification and risk reduction strategies, diabetes and hyperglycemia, sepsis, venous thromboembolism prophylaxis, peri-operative anticoagulation and the relationship between surgical outcomes and surgical expertise. The authors are very well known to IMSANZ. The topic was first presented at an IMSANZ/RACP scientific meeting.

9. The evolving science of translating the research evidence into clinical practice
Scott IA. ACP Journal Club, May-June 2007; 146:A8

Ian Scott, immediate past president of IMSANZ, in his characteristic well-referenced and thorough style, overviews the evolution of evidence-to-practice translation. He discusses the failure of passive evidence 'diffusion', the limitations of the availability of pre-packaged knowledge', of 'pushing' guidelines and of delivering 'evidence' to where it is needed, at the 'coal-face'. He considers the relatively unstudied role of social interactions in evidence-translation, and of the reality of multiple players, including patients, who share together the evidence 'property', and who therefore need a common language, which is yet to evolve. The broad gap between a worthwhile randomized clinical trial leading to changes in clinician behaviour is discussed. He proposes a future which focuses not only on the clinician/patient level, but also at higher social/organisational and political/economic levels.

PETER GREENBERG
Melbourne

SAM
The Society for Acute Medicine

1st International Conference
The Society for Acute Medicine
SECC, Glasgow 1st - 2nd October 2007

SUNDAY 30th SEPTEMBER

18.30 CONFERENCE CIVIC RECEPTION (INVITED GUESTS) CITY CHAMBERS, GEORGE SQUARE, GLASGOW

MONDAY 1st OCTOBER

09.00 REGISTRATION AND REFRESHMENTS

SESSION I

09.30 **OPENING ADDRESS**
DR MIKE JONES, PRESIDENT SOCIETY OF ACUTE MEDICINE

10.00 **ACUTE MEDICINE: MEETING THE NEEDS OF THE PATIENT**
DR HARRY BURNS, THE CHIEF MEDICAL OFFICER FOR SCOTLAND

10.45 REFRESHMENTS, EXHIBITION AND POSTER VIEWING

SESSION II CHAIR: DR BRIAN O. WILLIAMS, PRESIDENT ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF GLASGOW

11.15 **KEY NOTE ADDRESS: OUTREACH TEAMS AND EARLY WARNING SYSTEMS IN ACUTE CARE**
PROFESSOR KEN HILLMAN, PROFESSOR OF INTENSIVE CARE, NEW SOUTH WALES, AUSTRALIA

11.55 **A COST EFFECTIVE NEW MODEL OF CARE FOR ACUTE SERVICES**
PROFESSOR GRAHAM RAMSAY, MEDICAL DIRECTOR, WEST HERTFORDSHIRE HOSPITALS NHS TRUST. PREVIOUSLY PROFESSOR AND CHIEF OF INTENSIVE CARE AND TRAUMA SERVICES, UNIVERSITY OF MAASTRICHT

12.20 **CARE BUNDLES: SHOULD WE BE ADOPTING THEM?**
PROFESSOR DEREK BELL, PROFESSOR OF ACUTE MEDICINE, IMPERIAL COLLEGE, LONDON

12.45 LUNCH, EXHIBITION AND POSTER VIEWING

SESSION III CHAIR: DR MIKE JONES

14.0 **SOCIETY OF ACUTE MEDICINE PRESIDENTS INVITED LECTURE – GLASGOW COMA SCALE: THEN AND NOW**
PROFESSOR SIR GRAHAM M. TEASDALE, PROFESSOR OF NEUROSURGERY, UNIVERSITY OF GLASGOW. PAST PRESIDENT ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF GLASGOW

14.45 PARALLEL SESSIONS

THE YEAR IN REVIEW: KEY UPDATE	PROCEDURAL TECNIQUES LEARNING LABS MAX OF 20 DELEGATES IN EACH	PHYSICIAN ASSISTANTS: WHO ARE THEY & WHAT DO THEY DO?
MEDICAL: DR PAUL JENKINS, NORWICH **NURSING**: LIZ LEES, BIRMINGHAM **BUSINESS MANAGER**: NIGEL EDWARDS, DIRECTOR OF POLICY, NHS CONFEDERATION **AHP**: JUNE WYLIE, QUALITY IMPROVEMENT SCOTLAND	14.45-15.50 **ECHOCARDIOGRAPHY FOR ACUTE MEDICINE** DR PETER MILLS, LONDON & SPR 14.45-15.50 **RADIOLOGY FOR ACUTE MEDICINE** DR JAMES ENTWISLE, LEICESTER & SPR	TBC

15.50 REFRESHMENTS, EXHIBITION AND POSTER VIEWING

16.15 **THE QUALITY PERSPECTIVE FROM BOTH SIDES OF THE ALTANTIC***
CHAIR: PROFESSOR DEREK BELL, IMPERIAL COLLEGE, LONDON
DR CAROL HARADEN, VICE PRESIDENT, INSTITUTE FOR HEALTHCARE IMPROVEMENT, BOSTON, USA
PROFESSOR SIR GEORGE ALBERTI, NATIONAL CLINICAL DIRECTOR FOR EMERGENCY ACCESS, DOH, UK
* This session is sponsored by the Improvement & Support Team, Directorate of Delivery, Scottish Executive Health Department

17.30 CLOSE OF DAY 1

20.00 CONFERENCE DINNER – GLASGOW SCIENCE CENTRE

SAM The Society for Acute Medicine

TUESDAY 2nd OCTOBER

SUNRISE SESSIONS: 07.30–08.50 (MAXIMUM OF 20 DELEGATES IN EACH)

R&D OPPORTUNITIES IN THE UK	SAFETY STRATEGIES AT THE FRONT LINE	RE-ORGANISATION OF HEALTHCARE	USING DATA TO GUIDE CHANGE
PROFESSOR BRYAN WILLIAMS, UNIVERSITY OF LEICESTER JULIA WILLIAMS, HEALTH SERVICES RESEARCH, IMPERIAL COLLEGE **CHAIR**: PROFESSOR DEREK BELL	**CHAIR**: NICKI MCNANEY PROGRAMME DIRECTOR, SCOTTISH EXECUTIVE HEALTH DEPTARTMENT	**CHAIR**: NIGEL EDWARDS, POLICY DIRECTOR, NHS CONFEDERATION	DR FOSTER/TBC

08.30 REGISTRATION AND REFRESHMENTS

SESSION I CHAIR: **PROFESSOR IAN GILMORE, PRESIDENT ROYAL COLLEGE OF PHYSICIANS OF LONDON**

09.00 **PULMONARY EMBOLISM: THE FIRST 24 HOURS**
PROFESSOR VICTOR TAPSON, ASSOCIATE PROFESSOR OF PULMONARY AND CRITICAL CARE, DUKE UNIVERSITY, NORTH CAROLINA, USA

09.40 PARALLEL SESSIONS

INFLUENCING CLINICAL OUTCOMES	MAINTAINING INDEPENDENCE AT THE FRONT DOOR: A MULTI-DISCIPLINARY VIEW	SERVICE DESIGN AND DELIVERY
09.40-10.05 **BLEEDING EMERGENCIES FOR ACUTE PHYSICIANS** PROFESSOR ROGER BARTON, UNIVERISTY OF NEWCASTLE UPON TYNE 10.05-10.30 **TOXIC EPIDERMAL NECROLYSIS: LIFE OR DEATH?** DR ANNA CHAPMAN, DERMATOLOGY SPR, LONDON	10.05-10.30 **AMBULATORY CARE – WHERE SHOULD WE BE GOING?** TERESA MURPHY, LONDON 09.40-10.05 **DEVELOPING A NURSE-LED ACUTE MEDICAL WARD** VICKI LEAH, MID-ESSEX HOSPITAL.	DR FOSTER/TBC

10.30 REFRESHMENTS, EXHIBITION AND POSTER VIEWING

SESSION II CHAIR: **PROFESSOR NEIL J. DOUGLAS, PRESIDENT ROYAL COLLEGE OF PHYSICIANS OF EDINBURGH**

11.00 PARALLEL SESSIONS

KEY INSIGHTS FOR ACUTE MEDICINE IN	PROCEDURAL TECNIQUES LEARNING LABS MAX 20 DELEGATES IN EACH	MAINTAINING INDEPENDENCE AT THE FRONT DOOR: A MULTI-DISCIPLINARY VIEW CONT.	SERVICE DESIGN AND DELIVERY
11.00-11.20 **THE IMPORTANCE OF DIABETES AT THE FRONT DOOR** DR MIKE BAXTER, ST PETERS & ASHFORD HOSPITAL 11.20-11.40 **ACUTE CORONARY SYMPTOMS: WHAT'S NEW?** PROFESSOR DAVID NEWBY, EDINBURGH 11.40-12.00 **ACUTE STROKE: THE FIRST DAY** DR KEITH MUIR, GLASGOW 12.00-12.20 **COPD: FROM FRONTDOOR TO DISCHARGE** DR ROBIN STEVENSON, GLASGOW	11.00-12.20 **ECHOCARDIOGRAPHY FOR ACUTE MEDICINE** DR PETER MILLS & SPR, LONDON 11.00-12.20 **RADIOLOGY FOR ACUTE MEDICINE** DR JAMES ENTWISLE & SPR, LEICESTER	**IDENTIFICATION OF, AND IMMEDIATE TREATMENT FOR, THE SICK PATIENT** ANDREA BLAY, LONDON **ASSESSMENT OF OLDER PEOPLE IN MAU: CARE OF THE ELDERLY WITH PT/OT** ALISON MACKAY, DOUGIE LOWDON, NHS TAYSIDE **PHARMACY RISK SESSION** SPEAKER TBC	TBC

12.20 **CONTINUOUS QUALITY IMPROVEMENT IN AN AUSTRALIAN ACUTE ASSESSMENT UNIT OVER 6 YEARS**
DR JAMES WILLIAMSON, THE UNIVERSITY OF WESTERN AUSTRALIA SUPPORTED BY THE RCP, EDINBURGH

13.00 LUNCH, EXHIBITION AND POSTER VIEWING

SESSION III CHAIR: **KIRSTY WARK, BBC**

14.00 POSTER AWARD PRESENTATION

14.15 **"ACUTE CARE – THE FUTURE"** AN EXPERT PANEL

- THE COLLEGE PRESIDENTS
- DR MIKE JONES, PRESIDENT SOCIETY FOR ACUTE MEDICINE
- PROFESSOR SIR GEORGE ALBERTI, NATIONAL CLINICAL DIRECTOR FOR EMERGENCY ACCESS, DOH
- NIGEL EDWARDS, DIRECTOR OF POLICY, NHS CONFEDERATION
- OLIVIA GILES, PATIENT REPRESENTATIVE

15.30 **CONFERENCE CLOSING ADDRESS**
DR RHID DOWDLE, INCOMING PRESIDENT, SOCIETY FOR ACUTE MEDICINE

FORTHCOMING MEETINGS

Year	Month	Meeting
2007	**SEPTEMBER**	**ANZSGM / IMSANZ / IANA Combined Meeting, 5-8 September 2007** Adelaide Convention Centre, Adelaide, SA Website: www.fcconventions.com.au/MedicineAgeingandNutrition2007
	OCTOBER	**Society for Acute Medicine International Conference, 1-2 October 2007** Glasgow, Scotland The theme for the meeting will be “Setting New Standards for Acute Medicine”. Program details can be found on *page 24-25* or IMSANZ website: www.imsanz.org.au/events/index.cfm
		Canadian Society of Internal Medicine, 10-13 October 2007 Annual Scientific Meeting, St John’s Newfoundland Canada Email: csim@rcpsc.edu Website: www.csimonline.com
		East Timor Medical Association, 13-14 October 2007 Darwin, NT There has never been a more timely meeting than the joint meeting of the RACP NT and East Timor Medical Association (AMTL), *“Troubled Communities? Finding Long Term Solutions”*. Mark October 13-14 in your diary, and consider submitting an abstract to present. Make Darwin your spring holiday destination. The “call for abstracts” and further information can be obtained from lyn.tam@racp.edu.au.
		RACP Qld Annual Scientific Meeting, 27-28 October 2007 Sheraton Noosa Resort, Noosa, QLD Email: rfielding@qce.net.au
	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
2008	**MARCH**	**IMSANZ (NZ) Autumn Meeting, 13-15 March 2008** Mount Maunganui Information will be available on the IMSANZ website in due course Organisers: Neil.Graham@bopdhb.govt.nz *and* Philippa.Shirtcliffe@ccdhb.org.nz
	MAY	**RACP Congress, 11-15 May 2008** Adelaide Convention Centre, Adelaide, SA
2010	**MARCH**	**World Congress of Internal Medicine, 20-25 March 2010** Melbourne Exhibition and Convention Centre, Melbourne, VIC Website: www.imsanz.org.au/events/ Contact: wcim2010@tourhosts.com.au

Advanced Trainees in Australia, New Zealand and Fiji are invited apply for a Travel Assistance Grant (NZD200) to assist their travel to the IMSANZ (NZ) meeting in Christchurch, 21-23 November 2007. There are 10 grants available to those Advanced Trainees who attend the meeting, preference will be given to those presenting papers.

INTERNAL MEDICINE SOCIETY OF AUSTRALIA AND NEW ZEALAND

APPLICATION FOR IMSANZ AWARD FOR
IMSANZ Assistance to travel to Christchurch Meeting

Surname:.. First Name: ....

Address: ....

....

....

Phone: .... (w) ....(h)

Mobile: .... Email: ....

Year of Advanced Training First / Second / Third (Please indicate)

I wish to apply to be considered for the IMSANZ Advanced Trainee travel to Christchurch meeting grant of NZD200. Preference will be given to those presenting their work at the meeting.

I give the following details in support of my application.

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Please **return to:** IMSANZ Secretariat, imsanz@racp.edu.au asap

FROM THE

EDITORS

The aim of this Newsletter is to provide a forum for information and debate about issues concerning general internal medicine in Australia, New Zealand and elsewhere.

We are most grateful for contributions received from members.

The IMSANZ Newsletter is now published three times a year - in April, August and December.

We welcome contributions from physicians and advanced trainees.

Job vacancies and advertisements for locums can be published.

Please feel free to contact us with your thoughts and comments and give us some feedback concerning the contents and style of the newsletter.

Tell us what you want!!

The editors gratefully acknowledge the enthusiastic and creative input of Mary Fitzgerald, IMSANZ secretary.

When submitting **text** material for consideration for the IMSANZ Newsletter please send your submissions in Microsoft Word, Excel or Publisher applications (PC format only). **Images** should either be a JPEG or a TIFF format at 300dpi and no less than 100mm by 70mm.

Submissions should be sent to: ian_scott@health.qld.gov.au

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

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