IMSANZ

INTERNAL MEDICINE SOCIETY OF AUSTRALIA & NEW ZEALAND

DECEMBER 2008

President
Alasdair MacDonald, TAS

Vice President and Hon Secretary
Nick Buckmaster, QLD

Hon Treasurer
Tony Ryan, WA

Immediate Past President
Phillippa Poole, NZ

Councillors
Rob Pickles, NSW
Ian Scott, QLD
Don Campbell, VIC
Dawn DeWitt, VIC
Andrew Bowers, NZ
Andrew Burns, NZ
Nicole Hancock, TAS
Emma Spencer, NT
Josephine Thomas, SA
Jaye Martin, WA

Advanced Trainee Reps
James Macdonald, QLD
Helen Kenealy, NZ

SAC Councillors
Adrianne Anderson, VIC
Denise Aitken, NZ

Secretariat
145 Macquarie Street
Sydney NSW 2000
AUSTRALIA

Telephone
+ 61 2 9256 9630

Facsimile
+ 61 2 9247 7214

E-mail
imsanz@racp.edu.au

Website
www.imsanz.org.au

Copyright © 2008 IMSANZ

From the President...

It's that time of year again which gives an opportunity to review the year's activities and to look forward to 2009. Since the last newsletter, much has happened and, initially, I should report on the undifferentiated on-take document. I thank all who took the trouble to send feedback and there were many. The draft was also discussed at AMDC council level and the feelings there echoed much of the feedback from Australia's side of the Tasman. As I said in my accompanying letter, the document was requested by the College to assist Australian registration boards in credentialing physicians to participate in acute undifferentiated on-take but never was intended to exclude competent physicians from participation in these activities. In New Zealand dual training is the norm and retreating from that as the standard for participation in on-take would be foolish but the workforce pressures and the nature of advanced training over the years in Australia requires a different solution. Nobody would argue that participation in acute undifferentiated on-take does not require a specific set of skills and competencies and that these need to be up to date. But how would the credentialing and registration bodies assess this? Mandating currency of participation and defining minimum participation is fraught with problems as the feedback from Australia indicated, and the SAC or other IMSANZ or College committees do not have the time or resources to work case by case through those participating nor is this necessarily appropriate. It seems to my mind sensible to suggest that all those physicians currently participating in acute undifferentiated on-take have the requisite skills and should know whether those skills are being maintained and updated them in order to continue in such practice. However, the current training program has less than half the clinical exposure that most of us had in our training because of the safe working hours initiatives and although I support this it means in real terms they have seen half the number of clinical cases that used to be seen (although trainees are more likely to be awake whilst they see them!). In tandem with this has been the growing take-over of much of the initial care of acute medical presentations by emergency physicians such that cases are much less acute by the time a medical trainee is involved. Although AMU's, MAPU's and the acute medicine movement is redressing this, there is a long way to go before the current trainees uniformly get enough exposure to acutely ill undifferentiated patients for all to be ready to practice as a solo physician in a rural centre without emergency physician support once awarded their FRACP. This is even more of a problem if their FRACP is in a subspecialty that no longer includes a non-core year and instead mandates 3 years training in a single discipline. It therefore remains our challenge whilst encouraging dual training in General Medicine to develop an easily administered guideline particularly for Australia that acknowledges clinical competencies in

Continued next page...

In this issue...

Welcome New Members 2
Internal Medicine Training in Western Australia 3
IMSANZ's Newest Life Member 4
Physicians Week 2009 4
General Internal Medicine Across Health Care Sectors 5
Conference Round-Up 8
IMSANZ Awards and Scholarships 2009 9
Autumn Scientific Meeting 9
Forthcoming Meetings 10
What's New on the Website 10
Guidelines Updated For Infective Endocarditis Prophylaxis In Valvular Heart Disease 11

acute undifferentiated on-take and allows the inclusion of all physicians who are currently trained and up to date in those skills. I should note that the views expressed on this issue are personal after widespread consultation, including the feedback of the membership, and do not necessarily represent the views of all members on council.

On to less controversial matters, I can report the success of the WCIM in Buenos Aires and the Society was well represented in the run up to 2010 WCIM in Melbourne. Hard yards were put into delegate boosting for 2010 and lessons were learnt from an organisational perspective. A bit of cultural exchange occurred and the Argentinean hosts made sure we had an enjoyable stay. I and a number of colleagues moved on to the Society of Acute Medicine Meeting in London and several of us checked out some acute medical units while we were there including myself, Ian Scott, Don Campbell, Andrew Bowers and Harvey Newnman. The total number of IMSANZ members at the meeting was closer to a dozen and I left feeling much more confident that the principles we hold dear are similar to those held by many of their membership. Ian gave a very interesting and well received plenary session and all of us enjoyed far too much hospitality from the Society of Acute Medicine membership.

Society members and councillors continue to serve the Society and the RACP in ways too numerous to mention but I would like to single out the members of the SAC who give up a great deal of time to the process of advanced training and to whom we and the RACP owe a debt of gratitude. I would also like to thank Phillippa Poole for her continuing contribution on both sides of the Tasman and to Mary Fitzgerald for her tireless support and patience. Finally I would like to thank Dawn for the work she put in to the aborted Shepparton meeting and express my hope that the excellent program sees light at a suitable time in the New Year.

IMSANZ in 2008 has been a strong and busy society. It continues to make enormous contributions to the RACP and perhaps this contribution is at times undervalued by the College but without IMSANZ and its members many fundamental College activities would fall over or struggle to survive. I would like to thank all the membership for their hard work this year and wish you all Seasons Greetings and a safe holiday period.

ALASDAIR MACDONALD
IMSANZ President

Senior Executive Members of the ISIM in Buenos Aires

IMSANZ would like to welcome the following New Members:

- Dr Mark Birch - Newcastle, NSW
- Dr Rodd Brockett, Brisbane, QLD
- Dr Bennett Franjic - Brisbane, QLD
- Dr Martin Laurent - St Leonards, NSW
- Dr Wendy Busby - Dunedin, NZ
- Dr Neil Smith - Melbourne, VIC
- Dr Tom Thomson, Wellington, NZ
- Dr Robyn Toomath - Wellington, NZ
- Dr Ajay Verma - Canterbury, NSW

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

- Dr Sara Barnes - Macleod, VIC
- Dr Timothy Bennett - Melbourne, VIC
- Dr Edith Kohler - Perth, WA
- Dr Tracey Putt - Dunedin, NZ
- Dr Suganathan Pathmanathan - Bull Creek, WA
- Dr Belinda Suthers - Newcastle, NSW
- Dr Celia Ting - Doncaster East, VIC

INTERNAL MEDICINE TRAINING IN WESTERN AUSTRALIA – "RESTORING A WORKFORCE"

Editor: This is the fifth in a series of articles describing innovations in advanced training in General Medicine developed with advocacy from IMSANZ through the recommendations of Restoring the Balance.

Western Australia like the rest of Australia and New Zealand entered the new millennium with a shortage of general physicians. The Restoring the Balance document identified a shortfall of at least 25 general physicians in 2003, and suggested ways forward to deal with the shortage. This lack of general physicians reflected years of underinvestment in training and the rise of procedural medical subspecialties which have been seen as more attractive to trainees due to better pay and conditions and a perceived greater status within the medical community.

At approximately the same time as the Restoring the Balance document being released, the Western Australian State Government released its long awaited Health Reform agenda. This document identified many deficiencies within WA health including an over centralisation of health care at the expense of community based care and the lack of provision of specialised health care to rural and remote Western Australia. Amongst the recommendations was to increase services to these areas, in particular hospital programs and chronic disease management programs. These services were to be provided by general physicians.

In early 2006 a group of general physicians (Drs Tony Ryan, Stephen Richards, Andrew Wesseldine and myself) formed an informal association to determine whether we could coordinate training within Western Australia. At this time there was no structured training in Western Australia, and less than a handful of general medicine trainees had graduated in the previous 15 years. Through direct contact with trainees we managed to secure approximately 6 new trainees for 2007 which suggested a need for a structured training scheme.

Starting a new training scheme inevitably led to difficulty. Historically, the Internal Medicine trainees had used modified basic training positions for their rotations. However, with an expanded number of trainees this began to have an adverse impact on the Basic Training program as the impost of our trainees led to fewer rotations for this important group of trainees. Moreover, we continued to have difficulty sourcing some specialty positions, especially endocrinology, gastroenterology and infectious diseases. Finally, some departments remained wary of our trainees using the Internal Medicine Training pathway as a backdoor into their specialty.

With all of these issues in mind we approached the Department of Health WA (DOHWA) in 2007 for assistance with our training scheme – especially executive and financial support. To our great relief we found this support was forthcoming and a collaborative relationship has been formed and maintained.

Through 2008 we were able to put together a business case for Internal Medicine training in WA. This document made its way through the Department before being signed off just after the recent State election. The following is the structure of our training scheme in WA.

1. Training will be centralised and that an executive committee will manage this process. The committee is responsible for the selection and progress of candidates within the Training scheme.
2. The committee is responsible for developing specialty rotations which are solely for the purposes of Internal Medicine Training. We have now established five specialty rotations in tertiary hospitals – these are in endocrinology, infectious diseases, cardiology and respiratory medicine (x2). These are in addition to the 5 general medicine rotations, and the historical internal medicine training rotations that have existed such as stroke medicine, obstetric medicine and Intensive Care Medicine. For 2009 we have been able to fill these rotations. Where we can't fill a rotation we are able to "trade" with the DPT to get a rotation that we require on a priority basis. It should be noted that the Specialty Departments don't own these rotations, but are able to accept or decline a nominated internal medicine candidate. They can not be used for subspecialty trainees without the consent of the Internal Medicine training scheme and the DPT.
3. The Committee and DOHWA are responsible for funding the scheme. The funding we have currently is for 10 FTE and a sessional payment for members of the committee to run the scheme.
4. The Committee is responsible for promoting Internal Medicine as a viable career option to the trainees. We are also responsible for the provision of educational programs for our trainees to facilitate both learning and camaraderie within the scheme.
5. The Committee is not responsible for assessing trainees or securing a rotation for a particular trainee, this remains the responsibility of the supervisor.

We currently have 12 registered trainees in Western Australia. Our first graduates will gain FRACP in mid 2009, and thereafter we expect a steady stream of new Internal Medicine physicians. There are still many challenges for Internal Medicine within Western Australia, however we believe that through this training scheme we can begin to stabilise workforce numbers, before eventually beginning to increase the workforce in Internal Medicine.

In 2009 we aim to increase our recurrent funding to 15 FTE for Internal Medicine Training, as well as to seek out new opportunities for training in rural and remote areas.

We would be delighted to share experience and in particular our business case with other jurisdictions to promote dedicated general medicine training elsewhere.

TIM BATES
Chair, Internal Medicine Training Scheme (WA) IMTSWA
Timothy.bates@health.wa.gov.au

IMSANZ'S NEWEST LIFE MEMBER

A/Prof John Henley FRACP, Auckland, New Zealand

John Henley has been awarded life membership of IMSANZ for his monumental contributions to General Medicine in Australasia. He received this award at a farewell symposium held in his honour on 11th December 2008 at Auckland City Hospital. This event marked his retirement from public service, exactly 40 years since he first took up his appointment as House Physician at the then Auckland Hospital. He has worked in Auckland continuously for those 40 years with the exception of a two year Fellowship in Massachusetts General Hospital and Harvard Medical School between 1975 and 1977, sponsored by the Medical Research Council of New Zealand. He has looked after well over a 1000 patients per year over these 40 years.

Throughout a lifetime of professional practice John has demonstrated a strong commitment to the public health service in Auckland. He was a founding member of the NZ Society of Consultant Physicians in Internal Medicine from the early 1990's and then the Internal Medicine Society of Australia and New Zealand (IMSANZ) in 1997. John had also chaired the organising committee for that very successful Auckland RACP ASM in 1997 that included the formation of IMSANZ. Since then he has been a champion of General Internal Medicine as a specialty within New Zealand. As a consequence the specialty has flourished here and there is now widespread recognition of the contribution of this specialised branch of medicine to the delivery of healthcare throughout Australasia. Following a long stint as Clinical Director, General Medicine, Auckland City Hospital from 1993-2004, John switched his attention to leading the development of the Admission and Planning Unit at Auckland City Hospital (ACH).

In 2004, he became Clinical Director of the Assessment and Planning Unit. Since then he has been at the forefront of innovation in the management of patients acutely admitted to hospital. His work in Auckland is now internationally recognised. The APU was mentioned at the recent RACP ASM by IMSANZ member James Williamson, as the best model he had seen in Australasia or the UK. John has been asked to advise on this topic in various states in Australia and Canada, and has been a co-author of the IMSANZ position statement on Medical Admission Units.

Many of us in IMSANZ have been encouraged into general medicine by John and continue to use him as a mentor - he enthuses undergraduates, junior doctors and colleagues equally. His teaching methods include clinical vignettes, weekly quizzes at handover and his legendary '9 minute clinical examination' that never fails to draw crowds of students. Always ready to offer practical clinical advice he is recognised by peers as a 'master clinician'. His efforts to cajole junior staff to keep to his high professional standards are usually well-received, yet he can be a most enthusiastic participant in the social activities at IMSANZ meetings. For his efforts in education, John earned an IMSANZ Excellence in Clinical Teaching Award in 2005.

If one had to think of anyone in IMSANZ who exhibits the 'consummate general physician' it is hard to look past John. Fortunately for us all, John intends to locum in NZ and around the world and to maintain his involvement in IMSANZ.

PHILLIPPA POOLE
with assistance from David Spriggs and Gill Naden
November 2008

PHYSICIANS WEEK 2009

17th - 20th May, Sydney Convention Centre

Members are advised that IMSANZ is once again partnering the Adult Medicine Division to prepare a conference program for Physicians Week. The program will include specialty updates as well as sessions on Chronic Kidney Disease, Chronic Disease and E Health/Informatics. There is also a Free Papers Session for Fellows in the Program.

IMSANZ is delighted to have the opportunity, together with the Adult Medicine Division, to present the Priscilla Kincaid-Smith Oration. The Orator of this Plenary is Assoc Professor John Henley from New Zealand.

Once again we invite trainees to apply to present free papers in the *IMSANZ Young Investigator Award* a successful feature of recent Congresses.

A prize of $1,000 will be awarded to the best presentation.

Call for Abstracts: Abstracts submission for Physicians Week close on 23rd January 2009

GENERAL INTERNAL MEDICINE ACROSS HEALTH CARE SECTORS

General Physicians are highly trained medical practitioners with special skills in the assessment and management of patients with acute medical presentations to hospitals, the coordination of multiple services in the community following discharge, and skills in the longitudinal management of patients with the more frequent chronic diseases, especially where 2 or more of these diseases coexist in the same patient.

Patients suffering from chronic diseases are consuming an increasing proportion of health resources as our population ages, and obesity increases in prevalence. Our current health systems are poorly designed to provide coordinated care for patients with chronic disease, as they are characterised by fragmented health service provision by increasingly sub-specialised medical practitioners, by variable access to allied health and nursing services and by variable quality of communications between care providers. This is compounded by a complex labyrinth of funding sources with multiple eligibility criteria, exclusion criteria and reporting arrangements.

The General Practitioner is appropriately identified as the primary coordinator of patients suffering from chronic disease with the major roles in managing less complex aspects of the patient's condition day to day, and in facilitating access to health services. However, as the patient navigates between hospitals, sub-specialists and the community health care sector, the ability for GPs to provide a coherent plan, with rapid access to health maintenance, rehabilitation and acute care services is challenging. Assignment of case managers working in association with GPs may lead to better capacity for the GP to provide acute intermittent care as well as to provide longitudinal routine care. While there is an obvious potential role for Practice Nurses to become involved in case management, currently this is not widespread. In addition the capacity for Practice Nurses to access services for their patients within the State-run hospitals and Community Health Centres is limited.

The outcome of this fragmentation of care has been demonstrated by the high rates of preventable admission to hospitals, and poor access to community services leading to delays in discharge. Together this leads to bed block in Emergency departments, with resulting higher expense and poorer patient outcomes. It also arguably reduces overall satisfaction with services as it gives an impression to patients and their carers that service providers are uncaring.

In recent years there have been innovative models of care implemented to attempt to address these issues. These include the use of Medical Assessment Units (MAUs) as a model of care designed to streamline admission by intensive, initial consultant physician led assessment and management of patients admitted to hospital and Chronic Disease Management (CDMs) programs designed to coordinate care of patients with complex chronic diseases out in the community and to attempt to prevent hospital admission and morbidity. Both MAUs and CDMs are intrinsically well suited to General Physician practice, as in both there is the requirement to assess and manage patients with complex disease states, often with multiple co-existent chronic diseases, in association with a health-care team.

Currently, MAUs are usually run as stand-alone units within hospitals and have variable quality of communication with community services and with GPs. Similarly CDMs may be disconnected from Acute Hospital Services and are also often funded from a cobbled together range of funding streams, risking their viability, their capacity, their accessibility and the quality of their communication with other primary care providers.

Gold Coast General Medicine is planned to span across the acute sector and the community sector, its services interlocking with Chronic Disease community services, Aged care and rehabilitation services, subspecialty medical services, surgical services and the Emergency department.

The following services utilising general physicians are being developed or are already in place to provide rapid access to multidisciplinary assessment, management and rehabilitation services appropriate to the acuity of the presentation of the patient.

The Chronic Disease Program, HEAL (Health, Education, Activity, Lifestyle) has been established in 3 community health centres across the Gold Coast Health Service District to provide secondary care services to patients with IHD, CCF, Diabetes, Chronic Kidney disease, COPD and Multiple Sclerosis. It provides multidisciplinary team assessment, including, where appropriate, general medical assessment, and management through a case management model. All management recommendations are notified to the General practitioner prior to implementation to ensure there is opportunity for modification of plans with GP input. Assessment and treatment is provided by the full range of allied health workers and community nurses, including nurse practitioners and nurses with subspecialist advanced practice skills. Management includes provision of individual and group education on disease management, access to specific exercise and rehabilitation programs appropriate to the disease and the patient, pharmaceutical advice and management plans, and exacerbation management plans. Patients and GPs are informed that they can access the Rapid Access General Medical Clinic through their case manager if the patient suffers an exacerbation requiring specialist assistance.

The Rapid Access General Medical Clinic (RAM clinic) is a weekday, daily service provided at the Robina Hospital for general medical review of patients referred from the Emergency Department or from the Chronic Disease program. Patients are referred from the ED, The Medical Assessment Unit or from General Medical Inpatient units where there has been a diagnosis of a condition able to be treated in the community and there is a need for rapid review to monitor response to management. Patients are referred from the Chronic Disease Management program for rapid medical assessment and management of acute exacerbations of their known diseases. Because there is a clinic 5 days each week, delays in access to the clinics is avoided. A similar service at the Southport Hospital could significantly improve efficiency in the ED. Patients needing longer term follow-up are booked for routine General Medical Outpatient Clinics.

The Medical Assessment Units have yet to be built. Interim plans are in place to develop a service to place Medical Registrars in the Emergency Departments on their receiving days with a twice daily round by the on-call Medical Consultant. The general medical unit on take will assess patients likely to require admission under a medical unit and will determine whether the admission should be under a sub-specialty, or under their own

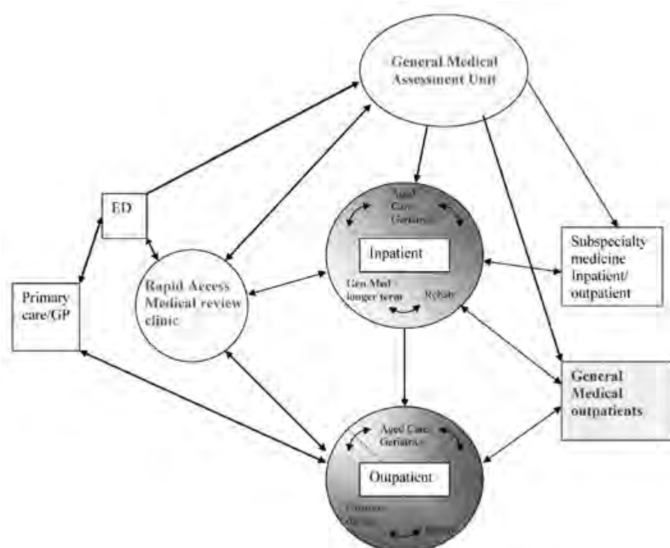
General Medical unit. It is intended that by early assessment, and inpatient unit allocation, there will be shortening of lengths of stay in ED, a reduction in Unit demarcation disputes, and potentially a reduction in unnecessary investigations, with consequent reductions in patient morbidity and ED access block. Once there are purpose built MAUs then the service will extend to direct admission of patients with triage category 3-5 acuity, and likely need for admission under a Medical unit. Close links with Geriatrics and Aged Care, as well as to Rehabilitation will ensure that patients are transferred to the appropriate sub-acute facility when acute care is not required.

The General Medical Inpatient Units take patients selected from the Emergency Department (or the MAUs when developed) for admission under General Medicine. These patients in the future will be those assessed as requiring inpatient stay for more than 48 hours, and selected by the general physician on duty as suitable for general medical admission. Patients admitted to General Medical Inpatient units receive multidisciplinary treatment as appropriate. Patients will receive early assessment for Rehabilitation or for Aged Care services to ensure prompt commencement of discharge planning. Plans are in place to develop a contained area in new facilities to nurse behaviorally disturbed patients with medical care provided by general physicians in collaboration with Psychiatrists. General Medicine also provides the majority of **peri-operative medical support** to the surgical inpatients. Currently patients are referred to general medicine only when a medical complication occurs, however with increased numbers of general physicians the service would expand to provide pro-active assessment and monitoring of patients during the peri-operative period, with potential to reduce post-operative morbidity and length of stay.

Through these components of care, the General Medicine Department on the Gold Coast can provide an integrated multidisciplinary secondary and tertiary care services to improve care for the large numbers of patients suffering from the common chronic diseases as well as providing efficient management of patients presenting to the ED with common acute medical diseases. Unlike other medical sub-specialties, there is rarely need for multiple referrals for those frequent patients with multiple co-morbidities. In addition General Medicine has developed a close relationship with Geriatrics and with

Rehabilitation, ensuring easy and rapid transfer of patients across these specialties during the course of the care of the patient. Communication and transfer tools are being developed or are already in place to assist management of the patient by the General practitioner. General medicine is clinically sponsoring the roll-out of the Queensland Health Electronic Discharge Summary and has developed close linkages with the Gold Coast Division of General Practice, in association with the Community, Aged care, Rehabilitation and Allied Health service (CARAS).

By providing care in a variety of settings and reinforcing the role of General Physicians in the early assessment and management of undifferentiated patients, General Medicine is likely to be restored as an attractive career option for trainees. Access to appropriate training pathways has been identified as one of the key factors leading to current General Physician shortages. Gold Coast Health Service District is uniquely placed to provide advanced trainees in General Medicine exposure to subspecialty rotations at a tertiary hospital, as well as to acute general medical units in a community hospital environment. Exposure to General medical units with teaching by General Physicians also is critical for Medical students and prevocational Drs, by providing a strong generalist basis for their future careers.



Conceptual diagram for patients through the Gold Coast Acute and Sub-acute services

The Model of Care being developed on the Gold Coast is one in which the Acute Hospital Sector and the Community and Primary Care sectors are joined through the sharing of employment and services of medical, nursing and Allied Health. In particular Physicians, especially General Physicians are employed by Community Health to provide services and leadership for the Chronic Disease Management program. The key connectors between the sectors are the General Medical Physicians who have the role of assessing and managing patients in the Hospital acutely, and also providing longitudinal care in association with GPs and the CDM team. As well as providing initial assessment and participating in the development of Multi-disciplinary care plans, the General Physicians provide services in the management of acute exacerbations of disease, and are capable of managing approximately 90% of the medical patients presenting to Emergency Departments requiring hospital admission.

Current Barriers to General Physician longitudinal care model

There are multiple barriers presently to the model which may reduce its effectiveness and its sustainability.

1. **Culture:** There is a belief by many that sub-specialist care is necessarily better care. While this is likely to be true for patients with either rare conditions or those requiring a complex procedure, the opposite is likely for the majority of patients suffering from the common chronic diseases especially where there is multiple co-existent morbidities
2. **General physician workforce limitations:** It is well recognized that General Physician numbers in Australia have not increased appropriately to match demand for their services, as a result of inadequate numbers of trainees taking up General Medicine. A number of factors have been identified for this including a lack of training opportunities for General Medical trainees, especially in tertiary institutions, a lack of recognition of the specialty expertise of the General Physician by many sub-specialists, and an inconsistency between work-loads and remuneration for General Physicians, especially in the private sector. This situation is taken to an extreme in NSW where there have been no identified General Medical Training posts for many years. As a result there is a national shortage of General Physicians, which is particularly severe in Rural and Regional Australia. Employment of General Physicians to provide Chronic Disease management as well as provide acute service delivery is seen as a low priority by state hospitals.
3. **Funding issues for the multidisciplinary team:** There are problems with accessing Medicare funding for patients who are referred to Chronic Disease clinics from an Emergency Department or Public Hospital admission. This reduces the capacity of the clinics as State Governments are reluctant to fund non-hospital services, especially where Specialist medical care and the ordering of investigations is necessary for longitudinal care. Direct Federal Government funding of CDM services would potentially prevent freedom for the General Physician to move between the Hospital acute service and the Community. In addition there is some funding for access to allied health services for patients in the Private sector, but this is severely inadequate for most patients with chronic disease and cannot be used to provide care from the state community health sector. Recent new Medicare items have assisted where patients are referred directly to the General Physician, however there is a need for more universal access to rebates for all patients with chronic disease independent of referral pathway.
4. **Infrastructure issues:** Both State and the Commonwealth are providing funds for buildings to provide services for CDM programs. There is no evidence of joint planning as to where these are sited and possible models for shared public and private sector services. This causes gaps and overlaps in services within geographical locations. At the same time funding for Hospital redevelopments to provide inpatient wards suitable for elderly patients or for rapid review clinics is scarce.
5. **Training funding:** There is no funding model currently to allow General Medical trainees to access Medicare rebates for managing CDM patients in the community. It is critical that General Medical trainees are able to see all aspects of General Medicine if we are to reverse the poor image of General Medicine seen on the wards of tertiary Public Hospitals. Rotations designed to take advantage of Commonwealth funding through access to Medicare rebates in the Community as well as state funded rotations in subspecialties and MAUs will show a very different picture of the challenges and the benefits of General Medicine. There is also very little funding provided for the state to provide training for upgrading skills for community workers to care for potentially sicker patients in the community.
6. **Communication pathways and IT support:** Currently communication between the Acute Hospital sector and the community is notoriously poor. GPs and other community health workers are provided with inaccurate discharge summaries sent often weeks after discharge of their patient. Summaries are often handwritten and hard to read, especially where the GP attempts to integrate the summary into their electronic record by scanning. Frequently referrals to hospitals and State run community health services are equally poor, party as a result of complex referral rules and a lack of electronic referral pathways. Information, including chronic disease patient registries within each sector is held on multiple databases with necessary information inaccessible to health care workers in other sectors. Although Electronic communication is beyond the scope of this discussion, there are legislative barriers, including issues relating to privacy and the maintenance of patient databases which significantly impede the transfer of patient information between the heath sectors.

Recommendations to the NHHRC

IMSANZ has submitted to the NHHRC a comprehensive list of recommendations relating to the draft principles published by the NHHRC. Adoption of these recommendations would address many of the issues highlighted in my discussion.

In addition I believe there needs to be 1) examination of new models where the state and the Commonwealth pool funds to provide infrastructure and funding for chronic diseases programs in the community, and 2) examination of the capacity for registers of chronic diseases can be established between divisions of GPs and State Health services.

Conclusion

The model under development at the Gold Coast Health Service would lead to a significant improvement in the efficiency and the quality of care of patients within both the acute hospital sector, and the Community sector if widely adopted. Barriers to optimal implementation have been identified but are not insurmountable and changes to the State/Federal health funding relationships could significantly improve the effectiveness of the model of care.

NICK BUCKMASTER
Gold Coast, QLD

WCIM Bueno Aires

A strong IMSANZ contingent was present at two recent general medicine conferences which spanned both hemispheres. At the World Congress of Internal Medicine (WCIM) held at the Sheraton International Convention Centre in Buenos Aires (16-20/9/08), current and former IMSANZ presidents Alasdair MacDonald, Les Bolitho, and Ian Scott, helped man the RACP-IMSANZ booth that sought to advertise the 2010 WCIM meeting in Melbourne. Posters of iconic Yarra and Australian landscapes, faun-coloured T-shirts with antipodean logos, and small, furry clip-on lapel koala bears comprised the attractions for luring people into taking a peek at what was in store in 2 tears time. The most entrepreneurial member of the trio was Les Bolitho who literally stood in the middle of the corridor and funnelled the hapless delegates towards the stand with his beaming ‘G’day, want to go to Australia?’, an offer of a free bear and a chance of winning a free trip for 2 to Melbourne and other prizes if prepared to express interest in attending by entering relevant details into an Excel file on a laptop computer. Those who escaped the attention of Les were then lassoed and picked off from the sidelines by Alasdair MacDonald and Ian Scott with cries of “Don’t miss this little beauty!!” Well, perhaps we exaggerate a little but the 1,500 bears went within the first day and more than 1,000 mostly South Americans indicated their desire to come Down Under in 2010. But when you consider that almost 10,000 delegates registered for the 2008 meeting (with a queue stretching literally 5 blocks from the convention centre and taking all day to process) we might have hoped for more entries.

Hans Kohler inviting delegates to the WCIM in Melbourne, March 2010

Some shortcomings of the BA meeting were noted for consideration in planning the 2010 Melbourne meeting, such as need for efficient registration procedures and a venue that could cater for the volume of people. Going from one session to another at times was like being in a cattle crush in need of an electric prodder or a yapping border collie leaping over the masses. Some of the rooms were too small for the audiences (but that’s been a problem at RACP meetings as well) and surprisingly the satchels had very little tourist information on what to do in and around BA. The South Americans started early at 8am and went through to 7pm with no tea or coffee breaks and lunch was a half hour ‘get your own’ which had some of us wondering where the registration fee went. However, many of the talks were of exceptionally good quality (with Nip Thompson and Geoffrey Metz being among the plenary speakers), the electronic translation aids worked very well (and were frequently necessary despite the official conference language that presenters were supposed to respect being English), and the after-hours sojourns to some excellent restaurants and the conference dinner held in an old beautifully restored warehouse preceded by a re-enactment of Argentinean history with horse-mounted characters as the dominant theme were all stand-out highlights. Don’t forget to diarise the Melbourne 2010 meeting for March 20-25 at the Melbourne Exhibition and Convention Centre.

Les Bolitho, Hans Kohler and Geoffrey Metz at the WCIM 2010 booth

SAM London

The 2nd International Conference of the Society of Acute Medicine (SAM) was held at Imperial College, London (29th - 30th September 2008) and included pre-conference site visits to several acute medical units (AMUs) in different London hospitals by a number of IMSANZ members including AM, IS, Donald Campbell, Campbell Thompson, and Harvey Newnham. Derek Bell and current SAM president Rid Dowdle provided great hospitality kicking off with dinner at one of the oldest, previously all-men clubs located in the financial district of town, followed by a reception at Imperial College staff club, and the conference dinner in a wood-lined barristers dormitory adorned by heraldry dating back to the mid-1500s. One of the sunniest autumn week-ends London could offer allowed some of us to enjoy a day sight-seeing and walking in the parks and the following day walking around the historic town of Bath, 90 mins train wide west of London. The conference itself was a fine mix of plenary sessions, interactive workshops, clinical updates and skills laboratories. The opportunity was also taken to forge further research links with SAM including agreement for a UK-Australia-New Zealand collaboration to undertake a systematic review of the literature around effectiveness of AMUs and to conduct an audit of all AMUs throughout the three countries. The idea of having WCIM in 2008 host a satellite meeting and share sessions with the 3rd SAM conference in Birmingham was also proposed and office-holders within both societies are exploring this possibility in depth.

IMSANZ Travelling Scholarship

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

Value: AUD5,000

Eligibility: Advanced trainee or fellow of less than 5 years duration of the Royal Australasian College of Physicians, and who is a member of the Internal Medicine Society of Australia and New Zealand. Successful applicants will be required to explain how attendance at this meeting will be used to enhance the practice of Internal Medicine and to provide a 1000 word summary of the meeting attended for publication in the IMSANZ newsletter. Applications should to the IMSANZ Secretariat by 31 March 2009.

IMSANZ Research Fellowship

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

Value: AUD10,000. The fellowship is a total amount that is paid on a pro rata basis for the duration of enrolment in the research degree.

Eligibility: Advanced trainee or fellow of less than 5 years duration of the Royal Australasian College of Physicians; membership of the Internal Medicine Society of Australia and New Zealand; and enrolment in a higher research degree at a University in Australia or New Zealand. Applications should to the IMSANZ Secretariat by 31 March 2009.

IMSANZ Award for Best Scientific Publication in Internal Medicine

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

Value: AUD2,000

Eligibility: Advanced trainee or fellow of the Royal Australasian College of Physicians; membership of the Internal Medicine Society of Australia and New Zealand; publication of research in one of a list of peer-reviewed clinical journals.

IMSANZ Excellence in Clinical Education Award

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

Value: AUD1,000

Eligibility: Advanced trainee or fellow of the Royal Australasian College of Physicians; membership of the Internal Medicine Society of Australia and New Zealand; nominated by peers to receive award.

Application Process

Applications or nominations for these various awards will be sought 6 months prior to the annual general meeting of the Internal Medicine Society of Australia and New Zealand in the year the awards are to be granted. Whether any particular award will be offered in any particular year will be at the discretion of IMSANZ Council in terms of quality of applications and/or availability of funds. Guidelines for applications will be available from the IMSANZ secretary and will be in accordance with those issued by the RACP Research Advisory Committee. All applicants will be required to: have IMSANZ membership; provide referee contact details; be available for interview if required; and list relevant past academic record, publications and appointments.

IMSANZ Pacific Associate Member Travel Grant

Value: AUD1,500

Purpose: To assist one IMSANZ Pacific Associate Member of IMSANZ to travel to any IMSANZ or RACP meeting in either Australia or New Zealand. This grant will contribute towards the cost of airfares, registration and expenses associated with attending the meeting.

Application Process

Applications should to the IMSANZ Secretariat
by 29 January 2009.

AUTUMN SCIENTIFIC MEETING 2009

Internal Medicine Society of
Australia & New Zealand

In conjunction with Wellington and
Hutt Hospital General Medicine

Copthorne Hotel
Oriental Bay, Wellington

Wednesday 18th - Friday 20th March
(arrive Wednesday evening, depart Friday afternoon)

Sponsored by: Sanofi Aventis

Abstracts Close: 5pm Friday 20th February, 2009

Victoria Jantke is the Conference Organiser. Please direct any queries to her at vj@actrix.co.nz or phone +64 21 225 5867. Registration details will be emailed to you shortly and added to the IMSANZ website.

FORTHCOMING MEETINGS

Year	Month	Meeting
2009	MARCH	**IMSANZ New Zealand Autumn Meeting** **March 2009** Copthorne Hotel, Oriental Bay, Wellington For more details please visit the IMSANZ website: www.imsanz.org.au/events
	MAY	**RACP Physicians Week 2009** **17th - 21st May 2009** Sydney Convention Centre, Sydney The Priscilla Kincaid-Smith Oration will be presented by A/Prof John Henly, from Auckland, New Zealand. The title of the oration is *The Specialty of General Medicine - Past, Present and Future*. For more details go to the website at: www.physiciansweek.com
	OCTOBER	**Canadian Society of Internal Medicine** **21st - 24th October** The Canadian Society of General Medicine will celebrate their 25th anniversary with their Annual Scientific Meeting to be held in Ottawa. More details as they come to hand will be available on their website at www.csimonline.com. Key Presentations from this year's conference can also be found on their website.
	NOVEMBER	**RACP / IMSANZ / ANZ Society of Geriatric Medicine / Chapter of Palliative Care** **4th - 6th November 2009** A conjoint RACP/IMSANZ/ANZ Society of Geriatric Medicine / Chapter of Palliative Care meeting to be held in Auckland. Make a note in your diary. Details will be posted on the IMSANZ website when they become available. Website: www.imsanz.org.au/events
2010	MARCH	**World Congress of Internal Medicine** **20th - 25th March 2010** Melbourne Exhibition and Convention Centre, Melbourne, VIC. Website: www.imsanz.org.au/events/ Contact: wcim2010@tourhosts.com.au

What's new on the website

Position statement on credentialing for undifferentiated on-take has been posted and further comment is welcome.

CATs

You may be wondering why no new CATs have been posted since April. The editor gives his apologies but due to overwhelming clinical commitments he has not had a chance to write them up but as we now enter the festive season with a chance for some down time, the CAT drought should be broken. But please feel free to forward any CATs you would like included. Many thanks to Drs Golam Khadem and Su Mien Yeoh for their contributions.

The IMSANZ newsletter needs you

Which brings me to a final note. The newsletter is always in need of more articles and too often it falls to the same few individuals to compose something as the publishing deadline draws near. So can I ask all members, including councillors, to make a New Year's resolution that they will write ONE letter to the editor or a short piece on something of interest to general physicians throughout 2009. With almost 500 members in our society we are not devoid of creative talent and I'm sure there are some literary artists out there just dying to come out and be published. I look forward to being deluged with copy in the coming year! We might even consider a prize of free registration at the 2009 RACP Physicians Week for the person who submits the best article for the April 2009 edition.

IAN SCOTT, Editor

GUIDELINES UPDATED FOR INFECTIVE ENDOCARDITIS PROPHYLAXIS IN VALVULAR HEART DISEASE

The American College of Cardiology and American Heart Association have updated their joint guidelines for preventing infective endocarditis (IE) in valvular heart disease.

The update, published http://content.onlinejacc.org/cgi/content/full/52/8/676 in the August 19 Journal of the American College of Cardiology, is based on new evidence that has emerged since the 2006 ACC/AHA Guidelines for the Management of Valvular Heart Disease were published. Major changes include:

- There are now no Class I recommendations for IE prophylaxis in patients with valvular heart disease;
- Antibiotic IE prophylaxis is no longer indicated in patients with aortic stenosis, mitral stenosis, or symptomatic or asymptomatic mitral valve prolapse. It is also not indicated in adolescents and young adults with native heart valve disease;
- It's not recommended to administer antibiotics solely to prevent IE in patients undergoing a genitourinary (GU) and gastrointestinal (GI) tract procedure. Nor is it recommended solely on the basis of an increased lifetime risk of IE.
- IE prophylaxis for dental procedures should only be used in patients with underlying cardiac conditions associated with the highest risk for adverse outcomes, such as prosthetic valves or prior IE. In those cases, prophylaxis is reasonable for procedures that involve manipulating gingival tissue or the periapical region of teeth, or perforating oral mucosa.

The guidelines were revised for several reasons. IE is more likely to result from frequent exposure to random bacteremias associated with daily activities than from bacteremia caused by a dental, GI tract or GU procedure. As well, the number of IE cases preventable by prophylaxis in patients undergoing those procedures is "exceedingly small," the article said. Also, the risk of adverse effects caused by antibiotics exceeds any benefit from prophylactic antibiotics.

Physicians should be prepared to discuss the updated guidelines with patients as the changes may cause some concern, the article said. Some doctors and patients may still be more comfortable continuing with prophylaxis for IE in certain circumstances; in those cases, the doctor should ensure that the risks associated with antibiotics are minor before prescribing them.

DAWN DEWITT

Head School of Rural Health
Rural Clinical School Dean
University of Melbourne

Private Practice opportunity for a Physician

St Andrew's Ipswich Private Hospital, QLD

This is an ideal opportunity for a new Fellow to establish a thriving private practice. Alternatively, this opportunity would also suit someone wanting to work part time and spend more time enjoying south east Queensland's enviable lifestyle.

St Andrew's Ipswich Private Hospital is a 101 bed community hospital that services the West Moreton region of south-east Queensland which is amongst the fastest growing areas of Australia.

The hospital has 36 dedicated general medical beds and a four bed Critical Care Unit. Current visiting specialists provide services in Internal Medicine, Respiratory, Endocrinology, Cardiology and Gastroenterology and there is collegial support in regard to call roster and leave cover. We provide full acute medical services, including cardiac and critical care with twenty four hour in-house Medical Officer cover and an After-Hours Medical Service providing support to the general practitioners in our local and regional community.

St Andrew's also enjoys a collaborative, professional relationship with the adjacent Ipswich General Hospital and we would be interested to assist in exploring what opportunities may be possible across both sites.

Establishing your private practice at St Andrew's…
The hospital offers a generous private practice assistance program to help new or transferring specialists set up their practice in Ipswich.

In addition, Ipswich is an eligible community of the "More Doctors for Outer Metropolitan Areas Relocation Incentive Grant", an initiative of the Australian Government, Dept of Health and Ageing. The aim of this initiative is to increase the supply of doctors to outer metropolitan areas by providing financial incentives (up to $40,000) to assist doctors setting up a private practice in eligible communities.
www.health.gov.au/outermetro

Contact us direct…
To find out more about this private practice opportunity please contact: **Chris Murphy, CEO**
(07) 3816 9901; (m) 0411 137 635;
(e) murphych@ramsayhealth.com.au or

Dr David Careless, General Physician,
Visiting Medical Specialist on (07) 3282 8044.

This is a wonderful opportunity to combine career with lifestyle!

www.ramsayjobs.com.au/docs

People caring for people

FROM THE
EDITORS

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

We are most grateful for contributions received from members.

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

We welcome contributions from physicians and advanced trainees.

Job vacancies and advertisements for locums can be published.

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

Tell us what you want!!

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

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

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

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

A/Prof Ian Scott
Director of Internal Medicine

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

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