IMSANZ

INTERNAL MEDICINE SOCIETY OF AUSTRALIA & NEW ZEALAND

APRIL 2009

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

From the President...

One quarter of 2009 has already passed our basic trainees have the results of their written exam and the focus changes to the clinical exam, it is a time of year that part of me enjoys I get the opportunity to be tutored on current treatments of things I don't see every day by a group of basic trainees full to the brim with current or should these days I say up to date knowledge of the "broad church" of general medicine as they present trial long and short cases. I find myself scurrying away sometimes to check something that I thought I new, but has moved on since the last time I reviewed the topic. Then in late July I get a 10 day intensive national finishing school as part of the NEP panel (despite now many years as an examiner as opposed to an examinee for the first few days that bell still brings me out in a cold sweat and I still travel with my 1st edition of Talley and O'Connor though I rarely open it these days and am no longer a devotee of the style).

This year brings more definition to the major challenges that face our specialty. The New Year also brings a need to develop as society, and as individuals, a clearer insight into the increasing diversity in the way in which general physicians ply their trade. The relative simplicity of balancing the views of 2 countries of traditionally working general physicians has been overtaken by an enormous number of conflicting agendas. No doubt some of these issues aren't new but many of us are just coming to grips with challenges they present. The acute medicine movement and the NHS influence on particularly Australian health departments constitutes both a threat to some of our older models of care but also an opportunity to restore our tradition role in the care of the acute exacerbations of our patient's chronic diseases and also to care for that even rarer bird the isolated acute illness. In Western Australia the imminent introduction of a 4 hour rule presents challenges with respect to capacity issues within hospitals and the associated access block to residential care. Across much of Australia and also in NZ the chicane behind which patients queue up is not the general medical team's ability to assess and make an admission decision, but the team's capacity to find places for the frail, elderly and ready for discharge after their acute episode, however still dependant and requiring care. A failure of the states and the commonwealth to effectively recognise and cooperate in resourcing this will only serve to feed discontent and unrest as punitive measures start biting for breaches of the 4 hour rule. But the models of care that role out of a 4 hour rule when the systems capacity allows the transfer of patients to an inpatient area do present an exciting opportunity for medicine to once again care for sick patients at presentation and for our seriously down skilled registrars to gain acute assessment and treatment skills along with gaining experience in acute medical procedures (something that should still be part of all basic training and is essential to the advanced training of those who wish to work in this sector of general medicine).

Continued next page...

In this issue...

PRESIDENT'S REPORT

General medicine needs to embrace this opportunity to take the leadership and be seen to be the owners of the field of acute generalism in hospital medicine. Otherwise this field will develop alone as a separate specialty as it has in the UK or even become a specialty quite distinct from physician practice all together as part of emergency medicine. No doubt in the future there may be opportunities for dual training with emergency medicine but to relinquish all ownership of this area would be a mistake. However this isn't for everyone and the core business of consulting general medicine is no less important so the ambitions of documents such as "Restoring the Balance" are still at the top of our priority list. In doing this we need to address issues around training particularly the importance of real dual training of generalists to practice the care of chronic co morbidity patients in the community not just generalists who practice general medicine in the acute hospital environment and their procedural subspecialty in the community sector. There are however remuneration disincentives to such community practice, that are particularly pertinent in Australia which continues to lag behind NZ, even after the good work of the AACP in developing the new 132 and 133 item numbers. Perhaps we should be looking at the example set by our geriatrician colleagues in developing new extended practice item numbers for their own use as geriatricians. Hence instead of arguing that we are geriatricians or part geriatricians, therefore we should be allowed to use their numbers, we should be arguing that we are General Physicians (and proud of it). So as such, both in urban and regional Australia, we undertake the management of many of the most complex co morbidity patients, whatever there age and in that context there should be extended care item numbers with parallels to some of those used by other specialties but that can only be used by General Physicians thus creating a carrot rather than a stick model for dual training with respect to this aspect of the incentives to be general physicians.

In finishing this report I must once again thank our New Zealand membership for their hospitality in Wellington a couple of weeks ago. I attended the annual autumn meeting which is always a highlight, from an educational perspective and from a social perspective. The program included an excellent presentation by Davis Balestracci on statistics as they might be used particularly in quality improvement activities (and I actually understood it), the other highlights for me were the stroke update and quality of the trainee presentations. The dinner at Boomrock was extraordinary: the spectacular view; the apparent isolation and the sports sampler of golf, clay pigeon shooting etc, not to mention a lovely meal and good friends. Visits to Wellington for someone who spent a number of formative years in Hobart have a feeling of going home even the wind is similar. I would like to thank Victoria Jantke again for her work and the committee of Kyle Perrin, Pip Shirtcliffe, Nicola Smith, Stephen Dee and Sisra Jayathissa.

ALASDAIR MACDONALD
IMSANZ President

TRIBUTE TO IAN SCOTT

This is Ian's last few weeks on council and it is only fitting that his papers on the work in progress, the achievements and the challenges still ahead in the wake of "Restoring the Balance", be a highlight of this newsletter. In addition, his vision for the direction and distance left to travel to see general medicine safely placed in its appropriate leadership role in both Australian and New Zealand physician practice gives us food for further thought and I know Ian will continue to be active in this progress and keep us as General Physicians accountable to the agenda. At the same time I felt it is the right time to pay some tribute Ian's work. As one does these days I Googled Ian and already knowing a lot about him and particularly his role in the progress of general medicine, I was overwhelmed by the body of work he has done across this and many other areas particularly in quality assurance.

However, instead of cutting and pasting his biography with his CV and a publication list which is a fitting tribute to his professional contribution to this point I will just acknowledge their magnitude and spend some time to offer my personal thanks for his guidance and perhaps offer some comments and discussion about the guidance he gives us all with these documents.

In respect of the report card on the achievements to date following "Restoring the Balance" the promotion of departments of general medicine have seen a more cohesive identity for General Physicians in hospitals established and provided an infrastructure for training without which the growth in numbers and influence cannot occur. However these departments need to move up the hierarchy within hospitals such that they are seen as the drivers of health policy reform and the innovators in respect of models of care. When you go to a hospital website the drop down menu for the division of medicine has General at the top not an after thought at the bottom as General Physicians should be the overall co-ordinators both of patient care in the sense of their care and triaging role in acute medicine but also in the big picture of medicine divisional structure and patient journey. Only through further development of the points Ian makes will we see this role evolve in his and IMSANZ's vision of departments of general medicine.

Improving physician training and CPD in general medicine needs the ongoing work on a competency based model with reference back to a structured curriculum and the ability to interpret key aspects of the content to apply it to the increasing breadth of general physician practice without seeing subdivision of general medicine beyond named areas of interest and dual training opportunities. As Ian points out the importance of developments in these areas and the role of mentoring in training must be not only encouraged, but driven in part by IMSANZ, as well as an advocacy role with other training schemes to allow access for general trainees in respect of interest and exposure as well as formal dual training.

The non tertiary centralised capital city based practice of general medicine and its training opportunities must be high on our agenda, as Ian notes with the on going development of hub and spoke models and with appropriate valuing of the training opportunities these hospitals provide. At the same time, we need to champion the integration of technology into accessing training and CPD for trainees and for overseas trained physicians working in regional and remote parts of Australia and New Zealand and in area of need positions.

The inequities in the relative valuing of cognitive verses procedural practice have seen some advances through the new item numbers resultant from the work of the AACP, but as other subspecialties precede towards extended practice specialty specific forms of remuneration general physicians as a group need to stand up and demand recognition for their special skills. As Ian says, "this is a work in progress" which demands a strong role from IMSANZ in advocating at all levels.

In Ian's second document the "Taking charge of our own destiny in a time of great change" we see Ian's enormous value to our society; he has succinctly outlined the issues and the evidence base around the direction forward. We as general physicians must be loud and proud of our skills and not continue to compare ourselves to other sub specialists with the "we are as good as approach". We need to see ourselves as the experts in complexity and not apologise for our generalism, hence advocating its virtue and valuing the breadth of the job we do, both in professional recognition but also in remuneration. I believe as our roles grow we must continue to make sure we identify the things that unite us as generalists and be tolerant and inclusive of the diversity of solutions that encompass the increasing "broad church" of general medicine.

As always, I would like to thank Ian for his work, his inspiration and his ability to put the process of advancing general medicine on a scientific and evidence based footing. I look forward to him continuing this role as a member and as invaluable advocate for our society.

ALASDAIR MACDONALD
IMSANZ President

IMSANZ New Zealand Autumn Meeting Presentations

Presentations from the IMSANZ NZ Autumn Meeting in Wellington are now available in the Members Only section of the website. http://www.imsanz.org.au/members/resources/meetings/

If you have difficulty accessing the site or need your username and password, please contact the secretariat imsanz@racp.edu.au

NEWS UPDATE FROM NEW ZEALAND

Over eighty delegates enjoyed the IMSANZ meeting in Wellington on 19 and 20 March. This will be reported elsewhere, but sincere thanks are due to Pip Shirtcliffe, Sisira Jayathissa, Kyle Perrin, Nicola Smith, Stephen Dee and all the speakers for an excellent two day programme.

Congratulations go to Dr James Irwin (Waikato, previously Wellington) for winning the De Zoysa Young Investigator Award for his paper entitled "Disease incidence and treatment patterns of myelodysplasia in the Wellington Region from 2002-2007.

Over a glorious dinner at Boom Rock, Kiwis compiled a list of the IMSANZ (NZ) meetings past. Many of us harbor happy memories of these meetings, being as they are a chance for mutual support and a stimulus for further development of general medicine.

1995	Rotorua
1996	Taupo
1997	Mt Cook
1998	Paihia
1999	Wanganui
2000	Hotel du Vin, Mangatawhiri
2001	Mt Maunganui
2002	Akaroa
2003	Hawkes Bay
2004	Nelson
2005	none (RACP ASM Wellington)
2006	Palmerston North
2007	Waiheke
2008	Mt Maunganui
2009	Wellington
2010	??

There have been another two important IMSANZ meetings in recent times – Noosa 1998 and Alice Springs in 2005. Please note there will be no autumn IMSANZ meeting in 2010 as the World Congress of Internal Medicine is being held in Melbourne in March. Thus, offers for a spring meeting are required. If there are no offers, the alternative is to have the usual meeting with RACP (NZ) and another society in Oct/Nov 2010. It is suggested we look to hold a meeting in the Pacific in 2012 or 2013 with our Pacific colleagues.

Please diarise the RACP(NZ) / IMSANZ / ANZSGM /ANZSPM meeting in Auckland 4-6 November 2009; the Trainees' Day is on 3 November. There are more details on the IMSANZ website, but at least 2 overseas guest speakers have confirmed, and a wide ranging programme is planned.

In February, the new Minister of Health, Tony Ryall, announced a Health Voluntary Bonding Scheme for graduates who choose to work for two years in a hard-to-staff hospital then begin training in a hard-to-staff specialty (GP, general medicine, general surgery, psychiatry, or pathology) in the third year. After these three years, doctors would be eligible for $10,000 per year after tax. This is a strong signal about support of generalism in the regions from the new government. There is some caution being expressed by medial students and RMOs until details are finalised, but most organisations are supportive.

IMSANZ Presidents alternate between Australia and NZ in a ratio of 2:1. A New Zealander is next due to be the IMSANZ President in May 2012. It is important this person is on the IMSANZ Council shortly, if not already. Please feel free to approach me without obligation to discuss this. We currently have one NZ vacancy on Council created by Andrew Bowers, moving from the portfolio of a non-metropolitan rep to that of Chair of NZ SAC.

Finally, a special vote of thanks to Denise Aitken for her sterling work as member, and then chair of the NZ General Medicine SAC. Denise brought rigor to the role, and a practical wisdom. Those on the committee and IMSANZ Council will greatly miss her inputs.

PHILLIPPA POOLE
NZ Vice President

IMSANZ would like to welcome the following New Members:

- Dr Henriette Badenhorst, Tauranga NZ
- Dr Paul Collett, St Leonards NSW
- Dr Peter Disler, Bendigo VIC
- Dr Christopher Gilfillan, Box Hill VIC
- Dr Jane Ryan, Brisbane QLD
- Dr Ray Wilson, Burnie TAS

Pacific Assoicate Members:

- Dr William May, Lautoka FIJI

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

- Dr Fasial Ameer, Bedford Park SA
- Dr Nicolas Blair, Balmain NSW
- Dr Will Dransfield, Wellington NZ
- Dr David Gardner, Hamilton NZ
- Dr Madeleine Healy, North Carlton VIC
- Dr Cheryl Johnson, Auckland NZ
- Dr Keyvan Karimigalougahi, Manly NSW
- Dr Stephanie Lowe, Auckland NZ
- Dr Suzana Milosevic, Brisbane QLD
- Dr Tara Mui Kin Kok, Auckland NZ
- Dr Rachael Lloyd, Carlton VIC
- Dr Steve Marasovic, Taylors Hill VIC

TAKING CHARGE OF OUR OWN DESTINY IN A TIME OF GREAT CHANGE

As I am standing down from IMSANZ council in May after almost 6 years as a councillor and 2 years as president, what follows is a bit of a swan song on what I see as some of the key challenges and opportunities for our society over the coming decades.

Firstly the challenges. These include those we have been confronting for some time and include: static numbers of general physicians due to historical growth of subspecialisation, diminished training opportunities for general physician trainees in tertiary hospitals, and lower levels of remuneration compared to procedural specialists; threatened scope of practice due to encroachment of emergency and geriatric medicine, adolescent specialists, and vocationally trained "specialised" GPs, restrictive credentialling practices, and limited access to training in procedural skills; and underdeveloped academic base due to subspecialty monopolisation of research agendas, facilities and funding, and limited training and opportunity to participate in research endeavours.

But in addition to these are some really important over-arching challenges (and opportunities) conducive to radical changes in delivery of healthcare as governments, and society in general, attempt to ensure sustainable and equitable healthcare for an ageing population in times of limited resources. I was encouraged to think about these when recently invited to give a lecture at Townsville Hospital on the current and future roles of general physicians in the Australian healthcare system. This talk resonated with two other articles that have tried to set the future scene: an opinion piece I wrote a few years ago in the MJA,1 and a perspective published by Hemmer and colleagues in the American Journal of Medicine in 2007.2 The meta-challenges as I see them are these:

1) Increasing inability of healthcare systems based on single-organ subspecialties to provide necessary, continuous, integrated hospital and ambulatory care to aging populations with multiple, chronic illnesses. The current system whereby individual patient care is compartmentalized, management of co-morbidities and unrelated conditions are marginalized, and multiple specialists and prescribers give conflicting advice and treatments is unsustainable.
2) Increasing potential for harm due to absence of a single co-ordinator of specialist care who can prioritise management goals and selection of clinical interventions. The statistics are sobering: adverse drug reactions (ADRs) are implicated in 10%-30% hospital admissions of which 30-55% are potentially avoidable, with up to 18% in-patient deaths related to ADRs and 33% of discharged patients having an ADR over the next 12 months.3 If a 79-year-old woman with hypertension, osteoporosis, osteoarthritis, type 2 diabetes, and COPD were to receive all interventions mandated by specialty-driven clinical guidelines, that individual would receive up to 12 medicines requiring 19 doses per day taken up to 5 times/day with potential for >20 drug-disease, drug-drug and drug-diet interactions.4 The need to balance potential benefit with potential harm in both acute and chronic care of older populations and minimise the risks of polypharmacy is becoming a medical urgency.
3) Increasing cost of healthcare which now stands at 9.1% of GDP, of which up to $3 billion per annum (or 9% of healthcare expenditure) is spent on rectifying injuries and other adverse effects of healthcare. The seminal studies of Fisher et al showing no relation between amounts spent by hospitals on in-patient care (age and diagnosis adjusted) and standardized in-hospital mortality suggest that increasing levels of costly 'high-technology' subspecialty medicine are not returning appropriate levels of return on investment.[5] The Australian Medical Council and more recently the chief health officer of Australia Professor John Horvath (himself a former subspecialist physician) recognize this and have called for all specialty colleges to balance specialist training with population healthcare need, concluding that current training places undue emphasis on subspecialty medicine.
4) Need for more effective and efficient models of care in acute care (as a result of hospital bed shortage, access and exit blocks, and absent subacute or 'step-down' services), chronic care (due to currently poorly integrated and funded services) and health promotion and public health (due to neglected and inadequately funded activities). The fact that up to 60% of hospital admissions relate to potentially preventable complications of various chronic diseases underpins the need for generalists who can lead the development of holistic chronic disease management programs. There is growing evidence of the benefits of better integration of inpatient care and ambulatory care programs that transition patients between acute and chronic care settings. The proliferation in roles and levels of autonomy of nurses, allied health professionals, physician assistants and other newly defined professional positions is going to require senior clinicians with generalist skills to co-ordinate and harmonise the multiplicity of functions contained within multidisciplinary teams.
5) Growing imbalance between healthcare workforce and population needs, particularly involving rural, remote and disadvantaged populations. The declining numbers of general physicians in non-metropolitan centres pose a serious health threat for people living in such locales as witnessed in the growing gap in life expectancy between urban and non-urban populations, and this is now increasingly recognized by state and federal health departments.
6) Need to strengthen medical professionalism and productivity by inculcating among all clinicians the skills of medical expert / clinical decision maker, communicator, collaborator, manager, health advocate and scholar/researcher. In particular, clinicians need to have highly developed skills in critical appraisal and translation of research to practice, clinical informatics and decision-making under circumstances of uncertainty.

In their thought-provoking article, Hemmer et al analyse how the discipline of internal medicine within the context of the US healthcare system might react in response to 5 different future scenarios which range from the replacement of internal medicine by hospitalist medicine to the return of the generalist as the 'super-provider' of optimal holistic care across the spectrum of internal medicine. They argue that undertaking such scenario analyses assists general internists to better predict and proactively prepare for the future as events unfold and thus create and ensure their proper roles within it. I see merit in IMSANZ doing something similar, complemented by several other sentinel activities as follows.

Continued next page...

Standing up for ourselves, extolling our virtues and challenging orthodoxy:

The sterile arguments around whether subspecialists provide better care than general physicians should not be allowed to distract or undermine our morale or sense of self-worth. There is no unequivocal evidence that we as general physicians provide inferior care, as exemplified by the following analyses. A recent review of 49 studies comparing generalist with subspecialist care for patients with single discrete medical conditions (CHF, IHD, diabetes, breast cancer, HIV, hypertension, rheumatoid arthritis, liver disease) revealed that 24 (49%) favoured specialty care while 17 (35%) no difference or favoured generalist care.6 Importantly, selection bias and failure to account for potential confounders were more prevalent in studies that favoured subspecialist care. Other observational studies show equivalent or even better care delivered by generalists. A study of 4 Melbourne hospitals using risk-adjusted casemix data showed no difference in efficiency or mortality between general and subspecialty units.7 Another study of 2617 patients admitted to a tertiary hospital revealed lower costs and length of stay but similar rates of mortality and readmissions for inpatients cared for by general physicians who were previously cared for by subspecialists.8 Finally, similar mortality, readmission and length of stay outcomes were seen for patients with AMI cared for by cardiologists alone versus general internists consulting with cardiologists as appropriate.9 More recently, two of our members wrote what Sir Humphrey may have labeled as a courageous article in the *BMJ* (and which was reproduced in the pages of this newsletter) contesting whether geriatric medicine should remain as a separate specialty in light of the fact that much of the past 'geriatric technology' was now shared among many different specialties, including general medicine.10 The current president has also provided a strong critique of hospitalism and the risk it imposes for specialist care in a society position statement. This sort of debate is healthy, not divisive, and distinguishes us as a group capable of independent thought and opinion.

The release of the joint RACP/IMSANZ position statement *Restoring the Balance* was a mutual recognition of the importance of general medicine and the need to sustain it as a discipline. It is very gratifying to see that this year's Priscilla Kincaid oration at the RACP annual scientific meeting is to be delivered by Dr John Henley from Auckland on the topic of general medicine. We need to continue to state, clearly and unequivocally, our view on the roles and function of general physicians and general internal medicine, the training requirements that need to be fulfilled in being able to competently practice our craft, and what we regard as valid standards and performance measures for purposes of accreditation and credentialing. If we cannot achieve consensus on such issues or, even worse, do not even bother to articulate them, then others will do it for us by default to our great undoing. My vision of the general physician of the future is one with several roles: gate-keeper to, and collaborator with, subspecialists; leader and innovator in new models of multidisciplinary care that centre on the needs of the whole patient; key provider of specialist care to rural and regional populations; teacher and researcher in broad field of general medicine and clinical decision-making; and advocate for health service improvement.

Defining our areas of special interest and expertise:

A defining feature of any discipline is ownership and exploitation of specific domains of clinical practice as being niche areas of interest and expertise. We have done this well in regards to acute medical assessment and planning units, perioperative medicine, and hospital quality and safety, by producing evidence-based guides and statements of standards for each of these topics. We need to do the same for chronic disease management, acute and chronic care integration, care of older patients, obstetric medicine, clinical informatics, palliative medicine, and clinical pharmacology inviting, where appropriate, other bodies with shared interests to participate in the process of producing position papers relevant to the needs of physicians who practice general medicine.

Participating in health policy formulation:

Policy-makers at all levels (governments, institutions, communities) are increasingly wanting to engage physicians in formulating micro- and macro- health policy aimed at improving delivery of healthcare. We need to seize opportunities to work for government, RACP, NHMRC and other agency-sponsored working parties or advisory panels where the terms of reference are pertinent to general medicine. It was important for IMSANZ to submit its own recommendations to the National Hospital and Health Reform Commission and gratifying to see that parts of our submission were referred to in the Commission's interim report released a few months ago. IMSANZ members sit on the RACP Quality Expert Advisory Group, Adult Medicine Division Committee and other key college bodies, but we need more members to sit on these strategic entities, as well as continuing to exercise influence within health departments, hospital committees, staff associations and professional groups. It would be useful to construct a profile of IMSANZ members as to their involvement in such activities so we all know who's doing what and demonstrate to trainees and others the depth of interest and commitment IMSANZ has to policy-making at all levels. Perhaps a profile template could be added to the next subscription notices for all to complete by simply cutting and pasting from existing CVs.

Building an academic base:

Another defining feature of a self-sufficient discipline is its ability to add new knowledge to medical science by undertaking original research. There are many unanswered questions in clinical practice and increasingly the healthcare system needs answers to problems around health service efficiency and effectiveness, optimal models of care, evaluation of benefits and risks of clinical interventions in 'real-world' patients, identification of valid and relevant research with potential to change practice, and robust methods for optimizing practice. The recently inaugurated Australian and New Zealand Internal Medicine Research Network holds much promise as it affords an opportunity for large-scale, multi-site research projects to be designed and executed by general physicians free of commercial bias and targeted at questions that funding bodies such as NHMRC and NICS are becoming more interested in. If a significant number of our members were to assist, even in

a small way, in the recruitment of patients and/or collection of data at their local sites, the cumulative effects on the effort as a whole would be enormous. In this way, practice audits, clinical reviews or case studies that would otherwise be destined to remain small, underpowered studies could be transformed into significant, important publishable works. I would like to see more stand alone IMSANZ scientific meetings planned over a 3 or 5 year cycle with more original presentations from both trainees and consultants which fill out the abstract section in the IMJ supplement. Societies of the same size or smaller than ours have greater research output in relative terms and we need to do better in this area, especially on the Australian side.

Being good mentors, teachers and role models:

Many of us perform these tasks well already but they remain essential attributes if we are to continue to attract students and trainees to our discipline and respect and support from our colleagues and patients. The writing of the new curricula for advanced training in general medicine was a major undertaking and an opportunity to redefine exactly what is it we do as general physicians. Ensuring our teaching keeps faith with the content of this document is a must. The efforts of those actively participating in student and trainee teaching in either public or private settings, providing outreach education to GPs and others in regional and remote centres, giving leadership to local community health initiatives and participating in the development of college curricula and assessment strategies are recognised every year in the awarding of college medals to general physicians who have made substantial contributions in these areas. But for every one who gets a medal, there are many other unsung heroes who are quietly and tirelessly doing good work across the spectrum of practice and teaching, and this too could be recorded in the IMSANZ members profile previously mentioned. I think it important that the database of training positions and programs for advanced trainees in general medicine be regularly updated and publicised to those who want to know how we can advance their aspirations to practice general medicine. The training scholarships and research fellowships offered by IMSANZ to young bright trainees have been a great success, as has the growth of innovative training programs and additional trainee positions in various parts of Australia and New Zealand. Demonstrating proficiency in clinical informatics for clinical practice, teaching and research (such as use of Cochrane Library, Best Evidence, and on-line journals) and use of clinical decision supports and data repositories builds respect as a physician who bases his/her decisions on evidence rather than anecdotal opinion.

Supporting and collaborating with each other:

Now for the hard part which I hope causes no offence but needs to be said. One of the characteristics many of us as general physicians pride ourselves on is our rugged individualism – our ability and desire to strike out on our own and create or do something no-one else has. This is, in many ways, a great strength, but it is also a potential weakness as it can breed distrust of others as not being good enough to share the project with or collaborate in its development and execution. I have been saddened to hear some general physicians attacking others as being untrustworthy or incompetent or not doing the right thing by others. Such attitudes eat away at our collective sense of unity and purpose and undermine morale. We have enough challenges to face without running the risk of self-generated implosion. Let us not go anywhere near becoming the physician equivalent of One Nation politics. Our society can only be strong and cohesive if we are open, tolerant and flexible in our dealings with one another and encourage each other to actively contribute to society affairs and activities (including the pages of this newsletter!). I'm aware that many would like to contribute more but find the pressures of work and family make this too difficult. My response is that the same pressures apply to your senior executive but we feel the sacrifice is necessary if our discipline is to survive and grow. Dividing the labour and sharing portfolios among a greater circle of people lessens the contribution required from any one individual. Let's all rise to the occasion and make this society, our discipline, your future and that of the next generation of general physicians more secure and prosperous. I wish the society and its executive well in their future endeavours and have enjoyed the opportunity to serve on its council.

IAN SCOTT FRACP

REFERENCES

1. **Scott IA. Med J Aust 2006; 185: 213-6.**
2. **Hemmer PA, Costa ST, DeMarco DM, et al. Am J Med 2007; 120: 1091-1096.**
3. **Scott IA. Manuscript in preparation.**
4. **Boyd CM, Darer J, Boult C, et al. JAMA 2005; 294: 716-724.**
5. **Fisher ES, Wennberg DE, Stukel TA, et al. Ann Intern Med 2003; 138: 288-98.**
6. **Smetana GW, Landon BE, Bindman AB, et al. Arch Intern Med 2007; 167: 10-20.**
7. **Nosworthy J, Campbell D, Byrnes G, Staley C. Medical Inpatient Report. Clinical Epidemiology and Health Services Evaluation Unit, Melbourne Health, Melbourne. January 2001.**
8. **Parekh V, Saint S, Furney S, et al. J Gen Intern Med 2004; 19: 395-401.**
9. **Willison DJ, Soumerai SB, McLaughlin TJ, et al. Arch Intern Med 1998; 158: 1778-1783.**
10. **Mudge A, Denaro C. BMJ 2008; 337: 78-79.**

Notice of

ANNUAL GENERAL MEETING

of the
INTERNAL MEDICINE SOCIETY OF AUSTRALIA & NEW ZEALAND

to be held in
Bayside Room 102
Sydney Convention Centre
at 12.30 pm, Tuesday, 19 May 2009

AGENDA

1. Apologies
2. Minutes of the 14 May, 2008
3. President's Report
4. Honorary Treasurer's Report
5. Other matters

Alasdair MacDonald
President

Nick Buckmaster
Honorary Secretary

Please note that the Minutes from the last Annual General Meeting and signed Financial Report are posted on the website in the Members Only Section at http://www.imsanz.org.au/members/AGM.cfm

General Medical Registrar consultative service and quality assurance registrar position Royal Darwin Hospital

Darwin's unique geographical location leads to an abundance of fascinating pathology not seen elsewhere in Australia. Registrars who work here can expect broad exposure to indigenous health issues and the practice of medicine in a remote setting. We have strong ties to Alice Springs Hospital and subject to negotiation rotations between Alice Springs hospital and Darwin Hospital can be arranged.

Additional positions have recently been funded in the department of medicine commencing on the 27/7/2009. The new rotating positions are aimed at advanced trainees in general medicine and involve a purely consultative registrar service with follow-up daily consultant ward rounds. This position will be allocated no inpatient load. The position will also involve the development of ward based quality assurance exercises including audit.

The Royal Darwin Hospital is a level 2 teaching hospital accredited for two years of basic physician training. Rotations at Basic physician training registrar level include cardiology, nephrology, haematology, oncology, general medicine and palliative care. Additional rotations are accessible at RMO level, including intensive care and infectious diseases RMO.

The hospital is also accredited for advanced training in general medicine, infectious diseases, palliative care, endocrinology, clinical and laboratory haematology, cardiology, nephrology, oncology (subject to specific arrangements), outreach registrar and disease control medical registrar (through SAC in general medicine) as well as intensive care.

We are currently taking applicants for 2010. Trainees are encouraged to think about commencing a 1 or 2 year placement in July 2009.

For additional information please contact Dr Emma Spencer DPT Royal Darwin Hospital +61 8 8922 8888

RESTORING THE BALANCE: WHAT HAS BEEN ACHIEVED?

It is just on 3½ years ago that the joint IMSANZ/RACP position statement *Restoring the Balance* was officially launched at the IMSANZ Annual Scientific Meeting at Alice Springs in September 2005. Given the document comprised an action plan for the period 2005-2008 it is fitting in early 2009 to review what progress has been made in executing the strategic actions contained within it.

Promote departments of general medicine (or combined general medicine/other subspecialty departments) and acute medical wards in teaching hospitals

- Agree position descriptions for full-time (FT), part-time (PT) and visiting medical officer (VMO) consultant physicians who wish to practise general medicine, with or without a subspecialty interest. *A position description has been developed and is posted on the IMSANZ website*.
- Agree key selection criteria and credentialing requirements in general medicine for consultant physicians applying for positions in general medicine departments or combined general medicine/other subspecialty departments. *A draft document detailing the training and experiential requirements for consultants who wish to practice general medicine has been produced but lack of consensus among Australian and New Zealand colleagues around the specifics of exposure to undifferentiated acute on-call has prevented its final ratification. However debate continues and it is hoped an agreed document will be shortly forthcoming*.
- Assess the number and types of established positions and current vacancies in general medicine in all hospitals with >150 beds. *This has not been achieved to date although a survey questionnaire of all eligible hospitals is planned for late 2009*.
- Establish consultant physician positions (FT, PT, VMO) in general medicine in all hospitals >150 beds. *While an official census has not been undertaken, it is apparent from advertisements and health department websites that the number of consultant general physician positions has significantly increased over the last 5 years.*
- Agree definition and training accreditation requirements in general medicine for general medicine departments or combined general medicine/other subspecialty departments in hospitals of >150 beds. *The Specialist Advisory Committee (SAC) in General Medicine now applies more stringent criteria to accreditation of general medicine departments for training purposes and has undertaken more site visits in recent years.*
- Assess compliance of existing or soon-to-be-established general medicine departments, or combined general medicine/other subspecialty departments, with accreditation requirements in general medicine. *A survey of all hospitals with general medicine departments providing advanced training was undertaken in 2007 and compliance on all key criteria was judged to be in the main very good.*
- Identify hospitals which do not have general medicine departments, or combined general medicine/other subspecialty departments, evaluate the reasons why, and provide incentives and assistance for such hospitals to establish such departments. *This is yet to occur.*
- Agree definition and accreditation requirements for general physician-led acute medical wards (or acute medical assessment/planning/management units) in appropriately sized hospitals. *A position paper on standards for acute medical assessment and planning units in Australia and New Zealand was produced in 2006 and is posted on the IMSANZ website. It has formed the core operational document for 17 new units being established throughout NSW and elsewhere.*
- Mount campaigns to assist hospitals establish acute medical wards (or acute medical assessment/planning/management units) staffed by general physicians. *A web-based questionnaire of all current units throughout Australia and New Zealand is currently underway to assess adherence with IMSANZ-endorsed guidelines.*

Improve physician training and continuing professional development in general medicine

- Develop a list of competencies that must be acquired by end of training for advanced physician trainees in general medicine. *A list of competencies has been developed as part of the advanced training curricula in general medicine.*
- Develop and implement a structured curriculum in general medicine for both basic and advanced physician trainees. *A structured curriculum in general medicine for both basic and advanced physician trainees has been produced and is available at both the IMSANZ and RACP websites.*
- Develop and implement assessment methods for ensuring medical skills in general medicine have been acquired by all trainees who wish to practise general medicine, either as their prime subspecialty or as a subspecialty interest. *Members of the RACP/IMSANZ Curriculum Writing Group in General Medicine have detailed assessment methods appropriate for trainees in general medicine.*
- Promote mentoring schemes for all trainees in general medicine. *Mentoring schemes for trainees will be initiated in 2009 as part of the RACP Educational Strategy*.
- Ensure all general physicians who supervise trainees have appropriate mentoring and supervisory skills. *General physicians who wish to act as mentors and supervisors will be obliged to participate in workshops which will certify them as competent to undertake such tasks.*
- Ensure all basic physician trainees and all advanced trainees in general medicine receive a varied experience in general medicine in terms of casemix and clinical setting. *The RACP/IMSANZ Curriculum Writing Group in General Medicine has stipulated the minimum clinical experiences necessary to acquire the requisite knowledge, skills and attitudes of being a general physician*.
- Facilitate dual training (training in general medicine and another subspecialty leading to a registerable qualification in both) for advanced trainees in general medicine and ensure protected exposure for such trainees to subspecialty physician training. *The RACP now actively encourages dual training for all advanced trainees and to date 10 specialty societies have agreed to allow trainees of other specialties to access elective training in their specialty. The Cardiac Society of Australia and New Zealand is producing a curriculum in non-invasive cardiology for non-cardiologists who wish to pursue an interest in cardiology. Work is continuing in obtaining access to training on the part of major subspecialties such as respiratory medicine, gastroenterology and neurology. In several states, RtB has influenced health departments to establish additional training*

positions in general medicine whereby funding is linked to the trainee, not a hospital or hospital department, allowing the trainee to negotiate directly with subspecialty departments in formulating 2 years of elective training in a number of core subspecialties. Innovative training programs have been established in several sites such as Newcastle, Melbourne and Perth with support from health departments with the specific aim of graduating more physicians with generalist skills. The experiences of several advanced trainees involved in these new initiatives have been recounted in recent editions of the IMSANZ newsletter.

- Consider modular, certifiable training in selected subspecialty skills for advanced trainees wishing to practise general medicine and another subspecialty interest, but who prefer not to undertake dual training. *This has not been achieved although the modular concept is appealing and has received backing from federal government and the National Hospitals and Health Reform Commission (NHHRC).*
- Promote state-based and region-based trainee selection and appointment schemes. *Many states have started to enact such schemes in combination with additional advanced trainee positions as previously mentioned.*
- Ensure all consultant physicians practising general medicine (with or without another subspecialty interest) undergo continuing professional development (CPD) in general medicine and the other subspecialty, and provide periodic documentation of clinical and CPD activities that attest to maintenance of clinical skills in general medicine and the other subspecialty). *IMSANZ has been active in producing a compendium of CPD resources (CATS library, evidence-based guides and presentations from scientific meetings) available at its website for all members and notifying all members of newly available resources via e-mail.*

Improve outer metropolitan, regional, rural and remote services in general medicine

- Establish regionalised (hub and spoke) hospital networks throughout Australia and New Zealand for the purposes of integrating service delivery, staffing and training. *This is still a work in progress but RtB has been influential in shaping health department policy at state level in strengthening regionalised networks in service plans which aim to provide more resources to regional hospitals and allow them to be more self-sufficient, and establishing state-wide general medicine service networks which advise government on the needs and policy options relevant to directors of general medicine in regional hospitals.*
- Implement rotations (minimum 3 months) of medical registrars from tertiary to outer metropolitan/regional/rural/remote hospitals sufficient to fill all non-tertiary registrar positions. *This is now considered a priority by many state health departments and has been facilitated by the active support of regionalised service networks.*
- Implement schemes for attracting general physicians to practise in outer metropolitan/regional/rural/remote areas. *This is still a work in progress but the additional training positions now available for general medicine trainees in several states are provided on the condition that the trainee intends to practice in non-metropolitan sites.*
- Increase federal and state funding towards establishing more local positions for physicians in general medicine and expanding local specialist infrastructure in rural/remote communities. *RtB aided by recent inquiries into substandard care in several regional hospitals has given the impetus to state health departments to establish more local specialist infrastructure in such sites.*
- Increase the level of MSOAP funding for positions in rural and remote sites for physician trainees and recently graduated fellows. *This has been endorsed by RACP and federal government although the 2008-09 budget contribution for MSOAP funding was less than requested.*
- Intensify locum and continuing professional development (CPD) support schemes (such as the Support Scheme for Rural Specialists) for isolated physicians in general medicine. *The RACP and IMSANZ advocated very strongly to government to continue funding such initiatives and although some funds were allocated in the 2008-09 budget, more was hoped for.*
- Establish mentoring and peer support schemes for overseas trained physicians in general medicine. *The SAC in General Medicine and RACP have been actively promoting such schemes but are limited somewhat by the availability of general physicians who wish to fulfil such roles.*
- Promote educational/CPD linkages between tertiary and regional/rural/remote hospitals within regionalised hospital networks. *RtB has influenced state health departments to invest more in telemedicine and videoconferencing facilities in rural and remote sites.*
- Develop culturally sensitive and site specific health management services in conjunction with local communities and health providers. *This remains a work in progress but the efforts of local opinion leaders such as Les Bolitho, George Tucker and Ian Smellie have been exemplary in this regard.*

Raise incentive for non-procedural physician practice

- Promote greater recognition by government of the value of cognitive, non-procedural work undertaken by all physicians, including general physicians. *This remains a work in progress but health ministries in New Zealand and statutory authorities in Australia such as the Australian Medical Council and NHHRC now recognise the importance of cognitive work in chronic disease management and health promotion.*
- Promote greater equity between procedural and non-procedural physicians in the level of remuneration provided under Medicare. *The inclusion in the 2008/09 budget of additional Medicare Benefit Schedule items (132 and 133) for specialist consultations dealing with complex and chronic disorders was a move in the right direction, achieved by strong lobbying from the Australian Association of Consultant Physicians.*
- Encourage state governments to adequately compensate general physicians in private practice for time spent in undertaking public hospital duties comprising committee work and teaching roles in addition to clinical work. *Several states have renewed their contracts with visiting physicians and inserted more generous provisions for rostered and overtime work.*
- Encourage state and federal authorities to provide financial incentives to general physicians to practise in rural and remote areas. *This remains a work in progress.*

"NOBLESSE OBLIGE" -

The White Coat Revisited

It has been said that the wearing of a White Coat by a Doctor can have important adverse effects on the therapeutic process. It reinforces a paternalistic relationship and creates an artificial boundary between the Doctor and the patient.

In the other hand, may it not give the patient greater confidence in the skill and professionalism of the treating physician? Would you feel relieved if your house was burning and the fire brigade arrived dressed in board shorts and cap? Is it not reassuring if threatened by a neighbours' drunken party when the Police arrive in marked car and blue uniform? Before even a word is said you often witness an instant calming of the foray. Some may call it bluff, others pharisaical control, but I am reminded of the term "noblesse oblige".

What we really mean by a "White Coat" however is not really the wearing of an unfriendly, sterile white uniform to hide behind during the cold exterior of a consultation, but rather, the carrying of a noble tradition of compassion, confidentiality, thoroughness and commitment that empowers the process with trust and honesty. A tradition that has been expounded by the shining lights of our profession from Hippocrates through to Versalius; in Lister and Jenner, and more personally through our own dear mentors who remain too numerous and modest to mention.

Recently I was approached by a woman whom I did not recall having ever seen before. She came to thank me. Bewildered, she related the story that some 3 years ago we had met at the front counter at a medical supply firm. I was paying my monthly account and she was desperately trying to deal with her delegated task of buying waterproof tape to seal off a gastrostomy stoma in a dear friend staying at her home. This other woman, who through illness had been forced to retire from the legal profession, was depressed, worn out and wanted to die.

The manager of the business was clearly uncomfortable about the transaction and looked to me for advice. I have no recollection of what was said, but the attendant woman apparently left with a new resolution to counsel her friend to persevere and to have hope that her surgery that had now prevented her from eating would have a better outcome given more time. She felt "capable and encouraged", by her words, because I "spoke with authority and compassion". The reason for identifying herself was to tell me that her friend was now living independently, no longer required PEG feeds and had achieved a number of personal goals that she had previously despaired would ever be possible, including some long pined for overseas travel.

I take no credit for the outcome of this now forgotten interchange, but have since reflected with some remorse on my "*noblesse oblige*". What really concerns me is not whether there are any others I have similarly so nonchalantly helped but rather, how many offhand or even silent comments have I made that have led a person to make an *adverse* personal decision affecting their health and well-being. And professionally, how many of my colleagues have I injured or maimed during their formative years of hospital training.

Sadly, as a not so considerate registrar, moulded in the persona of a terse and precise physician trainee, I still see before me the grimacing face of one resident who I castigated mercilessly for an error in an overnight medical admission. How many errors was I kindly corrected over or never knew about?

Did not Jesus Christ make an iconoclastic comment to the Scribes and Pharisees of his day that even in the most solemn of moments, if you "recall that your brethren have anything against you" stop what you are doing and go first and "be reconciled" (Matthew 5:23). The Doctor-Patient relationship is surely worthy of this degree of filial and mutual respect.

Is not wearing a White Coat, akin to the Speaker's Chair, the Mayor's Badge of Office, the Policeman's Cap? Is it not a sign to wearer and observer that this task at hand is being performed on a background of a great and noble profession and that we exercise this privilege in a democratic society fully aware of the responsibility that we carry. In addition, on those rare occasions when we do err, are we not then open to the process of external review and professional governance. Does it not remind us of the grave responsibility we have in Medicine to maintain the utmost respect for all human life. (Declaration of Geneva, 1948)

However, just as hand-cuffs and holster do not automatically create a responsible police officer, a White Coat does not alone engender the ideal Doctor. Nor do ornately framed Diplomas, Degrees and Fellowships. Clearly, it is the day to day commitment to the awesome task of patient focused care, manifest in the careful use of acquired skills that is the true apparel of a dedicated health care professional.

Indeed, if there is another tangible universal image of purity, simplicity, honesty and industriousness that encompasses all the sincere aspirations of clinical medicine, then I would gladly welcome it. Till then, I will take a moment each day as I pull my clinical White Coat over my tired shoulders to remember with humility my *Noblesse Oblige*.

PETER NOLAN, FRACP
March 2009

From page 10

- Encourage state and federal authorities to consider incentive payment systems that reimburse general physicians in private practice for their involvement in establishing or maintaining community or public health programs. *This remains a work in progress.*

Overall, RtB has helped advance the cause of general medicine, continues to act as a reference document in ongoing submissions to state and federal governments and other bodies such as NHHRC, and has provided leverage in our society's interactions with other specialty societies and external authorities such as medical boards. It is a unique document in being a joint position statement with RACP and one that no other society has produced to date. It continues to act as a blueprint for development of general medicine services into the future and it is hoped that a future IMSANZ executive will see fit to renew and update it over coming years.

IAN SCOTT, FRACP

TIME FOR A NEW LOOK AT INTERNAL MEDICINE REGISTRAR TRAINING

The role of the Internal Medicine specialist appears to be more secure now in New Zealand than it has been for some time. We are in a period of renaissance and growth. Our populations are aging and presenting with multiple pathologies, but they are also presenting in the most part acutely unwell. Both the Specialist Advisory Committees in New Zealand and Australia have noticed a considerable increase in trainees over the last years, with now over 170 advanced trainees in New Zealand alone, many times more than all the other specialties. This is also a trend I believe is occurring overseas but in somewhat different ways. Leading this change in Britain is the move towards Acute Medicine as its own emerging specialty. This is seen to some extent to be either an extension of IM, populated by many current IM specialists, or alternatively the replacement for IM leading to the death of the General Internist with the new society being distinct and separate from IM training. In the USA the hospitalist movement is expanding exponentially, although as many of you know they may have some difference in roles.

In NZ the principle role of the IM specialist is already the management of the acutely ill medical patient with a focus being primarily on ward management. Many of you that have subspecialty interests are limiting outpatient work to your specialty interest.

There is a new NZ initiative being discussed to reduce ED waiting times to 6 hours from triage to ward. This has the potential to alter the way IM Physicians are applied to the workface by design or by default. Most of us see the writing on the wall that there will be more IM specialists at the coal face of acute care for more of our working week. Also in both Australia and New Zealand there is an emerging focus of the APU in delivery of acute care which in the most part is IM specialist led.

There is a general concern amongst IM specialist, and I personally agree, that the ED (FACEM) specialty could move to cover any perceived gaps in the workforce for acute internal medical services to the exclusion of IM specialists, at least in the first 24-48 hours. Our challenge for training is going to be to adapt our brand to take the lead in filling these positions with IM Specialists better suited to those roles, as well as to continue to fill the many other roles that our specialists fill.

A simple start to this rebranding could well be a name change. We have suggested that our SAC change its name to 'General and Acute Medicine' and this has been agreed to by our IMSANZ Council. I am pleased to announce that this has occurred on both sides of the Tasman and is now in place.

For several years in NZ we have been refining our requirements for the acute focus to advanced training by requiring (1) 6 months in Acute Internal Medicine (2) 6 months in either ICU, Cardiology, or Respiratory Medicine, (So called 'A' runs) and no more than 18 months out of 36 in any one specialty. It is perhaps notable that the NZ trainee usually has at least 12 additional months and usually more in a General IM unit in their basic training. This enables breadth of training, some acute focus to training, and still some reasonable personal choice. This also works better for those wishing to 'dual train' with another specialty as generally at least 18 months of their second specialty training is approved by our SAC, and often up to 2 years. We have also added 'acute medicine' to the 'A' list meaning specific training in the supervised APU. We are currently working to refine the requirements for an 'A' Run. For example we believe that a run entirely in the Cardiac Catheter Suite, as a part of Cardiology dual training, will not meet our aims of producing a consultant able to participate in an undifferentiated acute intake. This is not to say it doesn't have value, but it would not substitute for acute Cardiology.

This refinement may not go far enough. A registrar may fulfil training requirements with as little as 12 months in any acute specialty, no logbooks of competencies and indeed no specific requirements for acute procedures. Should we be training some specialists with a more acute focus and identifying them as such, with a potential reduction in breadth of training?

There has been discussion about whether the current IM training scheme should have either:

(1) A subspecialty interest developed within it requiring additional training in acute medicine either within the 3 years scheme or additional to it. This may mean that for example an anaesthetics rotation and an ICU rotation could be mandated in addition to the current acute specialty rotations, and additional curriculum requirements may apply. This may result in a separate 'branding' of some IM specialists as having a subspecialty interest, but this training should remain under the auspices of the IM SAC and IMSANZ.

(2) Develop a separate training scheme separated from the current General IM training as may be seen in Britain.

(3) Require all IM specialist trainees to develop extensive and more defined acute skills, beyond those currently expected of them.

All of these have some merit as well as pitfalls. The first and last options are not exclusive. Change will require careful yet timely consideration, development of competencies and extension of the advanced training curriculum, and I would hope general agreement of our members. No matter which direction we choose there is now a challenge at our feet to adapt to the emerging needs of the workforce and our patients. I look forward to opening this debate and hearing the views of our members.

ANDREW BOWERS
Chair
NZ General and Acute Medicine
Specialist Advisory Committee

THE CHANGING OF THE GUARD -

John Henley's Retirement December 11th 2008

John Henley was a willing, albeit apprehensive, participant in a raft of activities organised for Dec 11th designed to ensure that his retirement from Auckland District Health Board was marked in most apt fashion. Many of John's achievements appeared in the December IMSANZ newsletter.

The first event was the Medical Grand Round, held as usual at Thursday noon. This was one with a difference though. Professor Norman Sharpe, Professor Emeritus at The University of Auckland, and Medical Director of the National Heart Foundation reminisced about 'Grand Rounds - 1971 style', then presented one of his first cases with the original slides; a 46 year old man with 'altiuria' (urinating from a height)*. His account of the patient symptoms plus how he had slept at the patient's bedside for days kept the audience enthralled. Two medical registrars, Anthony Jordan and Joanne Scott then presented a Christmas Quiz, usually a job reserved for one John Henley. This was a lively mix of general knowledge, medical history, FRACP questions, clinical vignettes, and facts about John. IMSANZ member Peter Black topped the scores with 25/30 correct.

Christmas Elves Jo Scott and Anthony Jordan. The three men in the photograph -Stalin, Roosevelt and Churchill, all died of stroke.

There was a chance to catch up over lunch with visitors, retired physicians and colleagues. Then it was onto a Retirement Symposium, themed The Essential Physician. Each speaker had a strong link to John and had to address one of the CanMed physician roles**.

The Physician as Educator role had already been covered during Grand Round. Lucille Wilkinson talked on the 'medical expert role' describing the diagnostic treats in one of her recent general medicine ward rounds, aptly sandwiched by two of Glen Colquhoun's poems. Lucille will be taking over John's role as head of the Admission and Planning Unit - she indicated she was under no illusions as to the size of the shoes she has to fill.

The Clinical Director of ED, Tim Parke was asked to talk on professionalism. Always entertaining, he argued in a talk entitled 'Sluts, professionalism and sausages', that ED doctors and general physicians are the only true professionals left as they have to take "any one, any time". General physicians were the 'good sluts' though. He praised the relationship that John had built between APU and ED as the best he had seen anywhere in the world. Despite increasing numbers and decreasing lengths of stay, no patient had been on a corridor trolley in Auckland Hospital since 2005.

Tim Parke

A hallmark was the shared commitment and strong mutual learning between the two workforces. As to sausages… I'm still in the dark, but if you Google 'John Henley', this is one of the images you get!

IMSANZ stalwart David Jardine came from Christchurch for the event and shared some of his basic science research on baroreflexes and baroreflex failure, woven into a fascinating account of the tactics of the Battle of Trafalgar and how Lord Nelson might have died.

Robin Briant CBE arrived dressed for the part of health advocate (photo right). She highlighted the key role physicians have in advocating for those who have difficulty accessing health care, including those in regional-rural settings. Robin leads by example, as ever, and caused the audience to pause and reflect. She is currently working in Gisborne, having had recent stints as a physician in the Gaza strip and latterly, Pakistan, under particularly arduous circumstances.

Rae Varcoe spoke of the times when she and John were two of the four medical registrars at Auckland Hospital, and the mentors and role models of the day. She used 'Gaudeamus Igitur' the poem of John Stone, to emphasise the role of physician as communicator and the importance of time and physicianly presence in patient care. This moving poem is a compulsory read and speaks of the uncertainty and difficulty of physician roles.

Neurologist Richard Frith was the final speaker of the afternoon. After his 'strange but true story' of the rise and rise of one of the most incompetent managers we have ever seen in the NZ health system, Richard thanked John for his exceptional vision and drive in his work as a collaborator on several key projects at Auckland Hospital.

Ian Scott, Peter Greenberg, John Henley and Alasdair MacDonald.

By this stage, John had had ample chance to make comments on the presentations and so made a short right of reply. While John had been visibly moved by the afternoon's presentations, many of us were equally so. The afternoon was a testament to the breadth and depth of physicianly roles and the unique contribution each of us makes to medical practice.

Around 300 of John's colleagues, family and friends made their way to Ellerslie Racecourse for a gala dinner. Noteworthy was the large number of junior staff and their partners; testament to John's mentoring of generations of students and junior doctors. David Spriggs (Clinical Director, General Medicine) Garry Smith (CEO Auckland District Health Board) and John Henley spoke before dinner.

John was presented with a stunning set of sculpted bronze bookends, plus a retirement book full of good wishes, quotes and photos. After dinner, David Rowbotham hosted an excellent "John Henley - This Is Your Life" tribute with more than a little editorial licence in the visuals. This was greatly enjoyed by all. The months of preparation that had gone into the event came to fruition for a most marvellous evening. The organisers and the speechmakers could finally relax. It was a fine end to a memorable day for John, the hospital and general medicine in Australasia.

IMSANZ was well represented at the events, and thanks are due to Ian Scott, Peter Greenberg and Alasdair MacDonald who crossed the Tasman to help with the celebrations, and to welcome IMSANZ's newest life member.

All in IMSANZ wish you a long and happy retirement, John.

PHILLIPPA POOLE
December 2008

**The patient had DKA, but eventually died of probable sepsis*

***If anyone wishes to access the powerpoints of the presenters for their own use, please contact Lianne Maskell, e-mail LMaskell@adhb.govt.nz.*

IMSANZ MEETING WELLINGTON

March 2009

Firstly, my greatest appreciation to the President of IMSANZ and members of the Society for allowing me the opportunity to attend the Autumn Scientific Meeting recently held in Wellington. It was not only a well organised meeting with updates in general medical topics relevant to general physicians but also an opportunity to meet some of my old colleagues and consultants during my previous years at the then, Wellington Public Hospital.

In Fiji where general medicine is at its best as far as extremes of cases and clinical signs are concerned, we are limited in regards to diagnostics and tertiary care. The week before leaving Fiji for the IMSANZ meeting, I had completed sessions of gastroscopy, bronchoscopy, inserted an IJ catheter for acute dialysis and had a number of ICU cases that required further diagnostic workup. In addition, I had 6 cases of young people with stroke and additional cases of terminally ill patients. So, not only that we practice very general medicine, but in Fiji and the Pacific Island Countries (PICs), the buck also stops with you as regards sub-specialty medicine care. It is therefore refreshing to have attended this meeting with excellent speakers and presentations. The topics presented therefore were very much relevant to our scenario but in some aspects of diagnostics and treatment, they are beyond our resources and clinical expertise. It is important however for us in the PICs to be able to understand the relevance of these topics and decide how relevant it is to our system and financial obligation understanding that even when we use the best of our clinical experience, we may still require a further confirmatory test. The following is only a brief review of an excellent program.

Although statistics is one of the most important tools in evaluating our performance and allowing us to properly put in strategic planning for our service, it has never been my favorite subject or topic. Davis Baestracci's presentation however, in the use of statistics in quality improvement perspective has to be one of the best I have attended. He brings alive the subject and his presentation is a must for all health and clinical administrators. I strongly feel that as clinicians, we do not appreciate or participate enough in evaluating our clinical performance and I wonder why this was not emphasised enough in our training. His presentation would be relevant for any system and we would hope to get him across to the pacific islands to assist us in this area.

The sessions on TIA and stroke management by Alan Barber and John Gommans were particularly of interest to me since we do have a high incidence of strokes in Fiji. In an area where there is only one CT scanner (and no MRI) in the whole country, our ability to urgently evaluate all acute neurological deficit is limited. The message however of attending to strokes urgently particularly at its early phase and the fact that TIA can be an earlier form of the stroke syndrome came through clearly. I understand that these messages are being filtered out to all general practitioners and physicians because of the urgency of treatment. In addition, the use of TPA thrombolytics although useful in reversing or limiting neurological injury requires expensive radiological setup and specialist neurologist which would be beyond our capability in the pacific islands for some time. The use of intra-arterial Urokinase and emergency craniotomy is beyond our capability in the Pacific Islands and these options are provided for young patients falling outside the protocol of TPA and probably provide the only chance of neurological improvement.

In Rheumatoid Arthritis - New Presentation, Rebecca Grainer reviewed cases and reviewed the diagnostics and early DMARDS improve outcome of treatment. I was particularly interested in the use of Anti CCP antibody particularly in rheumatoid factor negative patients. Although 5 – 10% patients may have RF negative, it is reassuring to have Anti-CCP antibody as a sensitive and more specific test for RA. We have found patients in Fiji who clinically have rheumatoid arthritis but with RF negative test, the availability of Anti CCP would be extremely useful. The early recognition of the disease, bedside ultra sound, MRI use, early DMARDS and the proper management of flare-ups is emphasised.

The genomic medicine and Palliative Care were all excellent presentations and I can only admire the work and organisations put into these specialties. Richard Beasley's discussion on 3 difficult cases of Venous Thromboembolism (VTE) was excellent and highlighted some of the difficult management issues and updates in management of VTE.

The last session of the conference, a debate on "Do Not Resuscitate Orders" (Robert Logan Vs David Spriggs) probably was the icing on the cake on a well organised program. I thought that the younger David Spriggs initially provided a convincing discussion in support of the controversial subject. But Robert Logan equally convincingly used the conservative approach and aging wisdom to counteract a difficult subject. The presentations on both sides of the argument were well presented that I am now not sure what our stance should be in Fiji.

This is my first time to an IMSANZ meeting and I was quite impressed with the "new look Wellington" and the view from the Copthorne Hotel were excellent. I could not recognise most of the central Wellington which now looks different and much more sophisticated than during my days back in the mid-80s. I even watched the super 14 game between the Wellington Hurricanes and the Sharks but unfortunately, my team lost. One of the highlights was meeting with physicians from Australia and New Zealand and particularly old colleagues (Richard Beasley, Neil Graham, Robin Toomath, John Gommans and previous consultants Geoff Robinson and Tim Mailing.

I missed the wine tasting by Atarangi Vineyard but enjoyed the Dinner at the Boomrock which was the highlight of my social event. Situated very high on a mountain and viewing the South Islands, we are reminded of its height when a glider was flying almost at our level. The evening weather was fantastic, and we had the opportunity to relax in a perfect environment. A mini golf spot provided a challenge for the golfers and we must have cleared over 200 golf balls. The dinner was superb with excellent wine and we returned by bus to the Copthorne late in the evening singing with the strum of a ukulele.

I enjoyed every moment of being at the conference, to benefit from the resources available and share in the updates of medicine. It is amazing what years can do to your appearance as we meet other colleagues after 20 years but surprisingly, my previous consultants appeared not to have aged. It was also an opportunity to meet with Phillippa Poole who had been instrumental in the inclusion of the Pacific Associate Membership to IMSANZ.

Thank you again for the opportunity and I assure you that the meeting has been of great benefit for general physician like us from the Pacific Island countries. Hopefully, we may be able to have another go in organising an IMSANZ meeting at the Denarau Resort in Fiji which unfortunately did not eventuate in 2000.

DR JOJI MALANI
Suva, Fiji

Editor's note:
Joji Malani was the winner of the Pacific Associate Travel Scholarship for 2009

IMSANZ MEETING WELLINGTON

March 2009

Joji Malani, Fiji, Alasdair MacDonald, OZ and Davis Balestracci, USA.

James Irwin receiving the Neil De Zoysa Prize.

The 2009 IMSANZ Autumn meeting was held in Wellington, capital city of New Zealand on 19th and 20th of March. For the first time the meeting was held on weekdays instead of the traditional weekend meeting.

The meeting was well subscribed. For the first time there were more than 80 registrants. Over 20 general medical trainees attended the meeting and this was comparatively higher than previous years. There were eight visiting delegates from Australia, two from the United States and one from Fiji adding to the international flavour.

Those who came to Wellington on Wednesday participated in vine tasting by Ata-Rangi vineyard of Martinborough. We had an opportunity to listen to the owner of the vineyard about history of wine making in Martinborough and their conservation programme.

The first morning started with two inspiring sessions by Davis Balestracci, our guest speaker, from the USA. He spoke well on the use of statistics in quality improvement including use of run charts, collecting relevant data and understanding and interpreting analysis. I am sure most of us got a lot out of these sessions about using relevant statistics in monitoring and improvement of our clinical practice.

After lunch there were 4 advanced trainee presentations. Dr James Irwin was awarded the Dr Neil de Zoysa prize for his audit on myelodysplastic syndrome. There were two free papers on quality of prescribing by Tim Mailing and Ian Scott. The papers highlighted the potential harm caused by over prescribing and challenges we face to minimize harm. This is likely to be one of the challenges physicians need to grapple with on a regular basis.

The first day concluded with a stimulating symposium on stroke, transient ischaemic attacks and development of stroke services. There was a lot of interest from the audience with a lively panel discussion.

The dinner was held at the Boom Rock restaurant with natural surroundings and stunning views over the Cook Strait to the South Island. Some participated in clay bird shooting and others tried to swing their golf clubs “rather unsuccessfully”.

The highlights of the second day were the talk on open disclosure by Mr Ron Patterson, Health and Disability Commissioner and debate on discussing resuscitation orders with patients. The Commissioners’ speech was very informative. The debaters addressed the issue well and provided lot of humour and entertainment. There were updates on rheumatology, genomic medicine, palliative care, venous thrombo embolism and movement disorders.

Overall the conference was well attended. Feedback suggested that contents were relevant and useful. We hope a 2-week day format should be considered for future IMSANZ autumn meetings.

DRS SISIRA JAYATHISSA & PIP SHIRTCLIFFE
Wellington

TO THE EDITOR...

Over the last twelve months many of us have been hurt by the collapse of our superannuation to the extent that, of necessity, we are compelled to remain in the work force.

This poses a problem for many General Physicians who have been dependant upon their Hospital Practice for a significant portion of their gross income. In personal terms this meant the continuation of on call arrangements at a time when I should have been “slowing down”.

I would be interested in finding out just how many colleagues have indeed had to postpone their retirement and would like to reduce or abolish their on call arrangements but maintain their income by other legitimate means. I do have a proposal that may interest colleagues.

Any interested could contact me direct by writing in confidence to me at the address below

TONY NEAVERSON
36 Southern Cross Parade
Sunrise Beach Q 4567
February 3rd 2009

WHAT'S IN THE JOURNALS

March 2009

Predicting, preparing for, and creating the future: What will happen to internal medicine?

Hemmer PA et al. The American Journal of Medicine 2007; 120:1091-1096

Using the basic tenets of scenario planning, several potential outcomes for the future of internal medicine are presented. The scenarios cover a range of possibilities, from the collapse of academic medicine to the technology-driven "superinternist". The common themes apparent for the future of academic internal medicine are examined by speculation on the situation in 2025, in terms of evolution, revolution, science fiction, the return of the generalist and international trends. The necessity for internists to consider how to shape the future is emphasised.

Internal medicine training in the 21st century

Huddle TS, Heudebert GR. Academic Medicine 2008; 83(10): 910-915

Many argue that changes in the practice environment mandate changes in internal medicine training: a shorter duration, more conducive to role-differentiation among general internists, more supportive of sub-specialization and with more experience in ambulatory care, multidisciplinary team-based care, chronic disease management and quality improvement.

These authors contend that the claim that internal medicine training ought to mirror internal medicine practice is mistaken and propose a different model for training. Their model, like others, would involve a core experience in the first two years, but unlike others, would provide a conceptually coherent experience based on internal medicine's traditional ideal in that outpatient experience would be subsidiary to inpatient experience. As it is considered internists continue to face what has always been the internist's task, the resolution of complex and ill-defined patient problems into proper diagnoses and therapeutic options, internal medicine training must fit trainees for that task. Therefore training experience should reflect the realization of the Oslerian ideal: a substantial apprenticeship taking care of inpatients with a wide range of medical illnesses.

In a comment on this paper called "Osler in a brave new world" in the same issue, Humphrey HJ (Academic Medicine 2008; 83(10):897-899) says that "the singular most important challenge in our experiential, apprenticeship learning model in both the inpatient and the ambulatory settings is the subordination of the educational aspects of residency education to institutional service needs" and that that "all too commonly, patients arrive to the hospital bed with a diagnosis made even before the residents meet the patient".

In another comment called "Training internists for practice focused on meeting patient needs", Duffy DF (Academic Medicine 2008; 83(10):893-896) considers the evolution of internal medicine in the US through phases of consultant diagnostician, internal medicine sub-specialist, primary care general internist, and focused practice in hospital medicine and/or in comprehensive care. It is considered that "The concept of competency-based education and certification frees us from the mental prison of time-based formal training and lifelong one-time certification. Using reflection-in-action with mentors guiding reflection-on-action over sufficient contexts of care, with a sufficient number and variety of patients, should be the criteria for training in internal medicine."

Are Canadian general internal medicine training program graduates well prepared for their future careers?

Card SE et al. BMC Med Educ. 2006. Nov 17; 6:56

In a survey of Canadian general internal medicine trainees, it was found that "Gaps* were demonstrated in many of the CanMEDS 2000/2005 competencies. Medical problems of pregnancy, perioperative care, pain management, chronic care, ambulatory care and community GIM rotations were the medical expert areas with the largest gaps. Exposure to procedural skills was perceived to be lacking. Some procedural skills valued as important for current GIM trainees and performed frequently (example ambulatory ECG interpretation) had low preparation ratings by trainees. Other areas of perceived discrepancy between training and practice included: manager role (set up of an office), health advocate (counseling for prevention, for example smoking cessation), and professional (end of life issues, ethics)."

* differences between the importance of and the preparation for the competencies

Review of intern preparedness and education experiences in general medicine

Gome JJ et al. Intern Med J. 2008; 38:249-53

In a survey of interns' perception of their preparedness before commencing their rotation in general medicine and their attitudes towards educational experiences at St Vincent's Hospital in Melbourne, interns identified areas where they felt inadequately prepared included resuscitation skills and medico-legal aspects. When re-surveyed at the completion of their 10-week rotations, interns felt they had been better prepared for their role than they initially perceived, both generally and in specific aspects. Nine out of 16 parameters showed a significant increase in preparedness score at week 10 compared to week 1. Educational experiences most valued were peer-driven education sessions and informal registrar teaching. Formal consultant teaching and online learning were perceived as being the least useful.

Audit of the consultation process on general internal medicine services

Conley J et al. Qual Saf Health Care 2009; 18:59-62

In a sample of 200 of 2885 consultations requested by general internal medicine to medical sub-specialists, a clear clinical question was posed in only 69.7% of requests for consultation, illustrating suboptimal communication between physicians.

Performance of a web-based clinical diagnosis support system for internists

Graber ML, Mathew A. J Gen Intern Med. 2008;23 Suppl 1:37-40

The authors, *with knowledge of the final diagnosis*, either manually entered 3-6 key findings or pasted the entire case history, of 50 consecutive Internal Medicine case records published in the New England Journal of Medicine into the search-box of the 'Isabel' clinical decision support system. The correct diagnosis was provided in 48 of 50 cases (96%) when key findings were entered, and in 37 of the 50 cases (74%) when the

entire case history was entered. Pasting took seconds, manual entry less than a minute, and results were provided within 2-3 seconds with either approach.

Professional monopolies in medicine

Baerlocher MO and Detsky AS. JAMA 2009; 301:858-860

General physicians are familiar with 'turf battles' over patients, between specialists of different specialties(for example between generalists and subspecialists over who should treat patients with particular conditions), between healthcare professionals of the same specialty and between professionals of different disciplines (for example between obstetricians and midwives). Four examples are discussed along with causes and potential solutions such as government regulation, agreements between professional societies, relying on the marketplace, regional management boards(for example hospitals) and the threat of lawsuits.

A 'leaked' local example concerning disagreements between the Australian Association of Consultant Physicians (AACP) and the Royal Australian College of General Practitioners (RACGP) over 'care-plans' for the management of patients with chronic diseases was reported in "Australian Doctor" November 14 2008: http://www.australiandoctor.com.au/articles/ba/0c05b8ba.asp

Unburdening the difficult clinical encounter

Kroenke K. Arch Intern Med 2009; 169:333-334

In this editorial, which refers to a paper published in the same issue concerning 'difficult' encounters in primary care consultations (An PG et al. Arch Intern Med 2009; 169: 410-414), the author comments on the historical transition from a focus on difficult patients to one which also considers the physician. Tentative suggestions for minimising the burden of such difficult encounters are given, including intensifying physician training in the psychosocial aspects of care, early identification of patients' problems, accepting the inevitability of some difficult encounters, reforming the re-imbursement of cognitive consultations and "celebrating the well-navigated" clinical encounter".

Patient-Physician connectedness and quality of primary care

Atlas SJ et al. Ann Int Med 2009; 150:325-335

Like the study referred to in the above editorial, although this interesting and novel study refers to primary, rather than consultative care, it is likely to apply to the latter, especially in the management of those with complex chronic diseases. Guideline-consistent care was, not surprisingly, more frequent in patients 'connected' to particular *physicians* in contrast to those connected to particular *practices*.

Subspecialisation in surgery and the continuing challenge of providing emergency surgery services

Gough IR. MJA 2008; 189:358-359

In 2003 45% of Australian surgeons described themselves as practising general surgery with a subspecialty, but in about half of these the subspecialty comprised more than 90% of their practice, while in 2007, 51% of RACS training posts were in general surgery, but these only attracted 30% of applicants. Mr Gough's editorial discusses the local implications and possible solutions for the consequences of such trends.

Office management of patients with diastolic heart failure

Tzanetos K et al. CMAJ 2009; 180:520-527

A case scenario is followed by a systematic review of ambulatory treatment of diastolic heart failure and then by an excellent discussion. No drug interventions have been shown to improve survival. One study showed that the angiotensin-receptor blocker candesartan reduced hospitalisation due to heart failure, but with increased risks of hypotension, renal failure and hyperkalaemia.

Two recent publications illustrate the further potential of pharmacogenetics to influence prescribing patterns and their outcomes:

Genetic determinants of response to clopidogrel and cardiovascular events

Simon T et al. N Engl J Med 2009; 360:411-413

This study shows that the previously shown in vitro pharmacogenetic determinants of the response of patients to clopidogrel translate into relevant clinical outcomes, with higher risks of adverse cardiovascular outcomes in clopidogrel-treated patients with acute myocardial infarction who have particular genetic variants.

Estimation of the warfarin dose with clinical and pharmacogenetic data

Klein TE et al. N Engl J Med 2009; 360:811-813

More accurate prediction of maintenance warfarin dose was possible when genetic data were combined with clinical data than with clinical data alone.

Some of the 28 things I've learned in 28 years.

Detsky AS. Canadian Journal of General Internal Medicine 2008; 3(4):188-189

See CSIM website: http://www.andrewjohnpublishing.com/CGJIM/CJGIM.html

In accepting the Canadian Society for General Internal Medicine's David Sackett Senior Investigator award, Dr Detsky gives 11 short, sound pieces of advice to colleagues and potential colleagues. These include: doing what you like doing; avoiding procrastination and paying attention to detail; recognising that people often surprise you; working with reliable people you like; avoiding over-planning; developing conflict-resolution skills; recognising the core business of patient care; keeping research simple: and remembering that our families continue after our careers end.

PETER GREENBERG
Melbourne

FORTHCOMING MEETINGS

2009	**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*. IMSANZ has joined with the Adult Medicine Division to once again create a program stream for the Conference. 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. For further details visit www.imsanz.org.au/events/ or contact wcim2010@tourhosts.com.au

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