IMSANZ
INTERNAL MEDICINE SOCIETY OF AUSTRALIA & NEW ZEALAND

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President's Report

In sitting down to write this report I feel the need to reminisce a little on the last two and a half years. Let me start by recommending to all, that should the opportunity to serve in such a role come along grab it with both hands. I do perhaps see it with rose coloured glasses as it draws to a close (I do remember not feeling quite as well disposed when stuck in Melbourne airport for almost 24 hours on my way home from an AMDC meeting in Sydney) but the chance to participate in the Society's affairs and in the greater college affairs is not to be under-valued. I have been able to influence the direction that the generalism debate has travelled but more importantly I have had the chance to meet and co-operate with other physicians at local, national and international levels. I have gained a broad appreciation of the things that unite us and found perhaps to my surprise very little that divides us, once a dialogue is established.

During the time I have been in this role the Society has moved into the area of acute medicine in a much more transparent way and I stand up and take my part of the responsibility for this journey. I believe it is an integral part of hospital general physician practice and neither should nor could it be split from general internal medicine. As a result of this I have no doubt I have been identified and not always favourably with this movement in terms of its UK enthusiasts. At one point I thought I might have been the first IMSANZ president impeached within hours of taking up the position when the former President of the Society of Acute Medicine in the UK, and a friend of mine Derek Bell, provoked us into action with the announcement of the impending death of general medicine in the UK in the face of Acute Medicine at the Adelaide Congress. However, I am happy to report that I now believe that IMSANZ is, particularly with its broadened membership, in a position to be the recognised leader in this field but mature enough to see this as just one of the portfolios a general physician may practice in their professional life, and that General Medicine in Australia and New Zealand is very much alive and well. That in fact it is growing from an impetuous teenager into a mature Adult Medicine leader.

By the time you read this Nick Buckmaster will be in the Chair (or for those of you who know the IMSANZ office in Macquarie St more likely leaning against the cupboard as there is only room for Mary's chair) and with this will come exciting new directions and consolidation of current roles including those in acute medicine. I am confident Nick will bring new strength and emphasis in the areas of chronic disease management and the role of the general physician in multidisciplinary teams co-ordinating the care of complex needs patients. However, as a physician I continue like many of my colleagues to undertake much of my practice in the relative isolation in my private rooms in the suburbs of a community and like others often working only in a team

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that includes myself, the patient and the referring doctor. This model, although I acknowledge it is less prevalent than it used to be, remains an important model for many of our membership. The Society as a whole should continue to champion and support this aspect of practice beside all our other portfolios because it remains an invaluable resource in many communities supporting both general practice and often our surgical colleagues often completely outside the hospital system.

In winding up this contribution and moving on to others I must pay tribute to all those around me: councillors, past office bearers, Mary, college staff, members, fellows and my family without whom the role would have been impossible. I remain excited about the future of General Medicine and proud of what we do. So like all the past presidents before me I will continue to be active in the Society and the college on General Medicine's behalf, (it is a little addictive once you get involved). I look forward to seeing you all at upcoming meetings.

ALASDAIR MACDONALD
Past President IMSANZ

IMSANZ would like to welcome the following New Members:

- Dr Sagarika Attudawage, Cleveland, QLD
- Dr Erin Clark, Adelaide, SA
- Dr Catherine Gibb, Adelaide, SA
- Dr Judy Flores, Brisbane, QLD
- Dr Peter Kendall, Sydney, NSW
- Dr Ian McCrossin, Nowra, NSW
- Prof Mamun Mostafi, Patuakhali, Bangladesh
- Dr Prahlada Rao, Mysore, India
- Dr Seevaratnam Sivakumaran, Canberra, ACT
- Dr Roy Varghese, Geraldton, WA
- Dr Louella Vaughan, London, England
- Dr Paul Vinton, Frankston, VIC

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

- Dr Umayal Lakshman, Mt Isa, QLD
- Dr Rupali Sharma, Wellington, NZ
- Dr Sarah Whiting, Darwin, NT

Message from in-coming President

It is a privilege and a huge challenge to take on the role of President of IMSANZ at this time. Alasdair MacDonald has done an extraordinary job in his term to take the Society forward in leaps and bounds. Under his leadership we have just co-hosted the hugely successful World Congress of Internal Medicine and we have increased our membership to over 525 members. We have also seen for the first time in many decades, the start of an understanding of the importance of Generalism, and the place of expert Generalists to the sustainability of our health system amongst governments and policy makers. Alasdair has successfully built on the hard work of previous presidents to achieve these outcomes.

The challenge in the next few years will be to consolidate these gains in understanding and to ensure that health policy and health spending is effective at reversing the fragmentation that we see currently in our system. We will need to present to policy-makers a coherent vision for the role of General Physicians, and General Medical teams in providing support to General Practitioners in the management of complex patients with multiple co-morbidities, while also being the workforce required to ensure that these same patients transit through hospitals in the most efficient, effective and safe manner possible. We will need to lobby for pro-active strategies to ensure that we have a sustainable medical, allied health and nursing workforce into the future, starting with restoration of respect for our professions in the sphere of General Internal Medicine.

I am looking forward to building on the hard work that has been done to date. The current environment with major changes in health policy being debated represents a time of huge risks for our vision, but it also represents huge opportunities.

NICK BUCKMASTER

Young Investigator Award

The IMSANZ YI Award was won by Dr Margaret Lee from Victoria. The topic of Margaret's presentation was *"Medication chart intervention improves prophylaxis prescription in patients at high risk of venous thromboembolism"*.

Congratulations Margaret!

REVIEWS OF WCIM 2010 FROM PACIFIC ASSOCIATE MEMBERS FROM FIJI

Indigenous Dancers at Opening Ceremony

Training physicians to become general physicians is the answer to the Pacific Island countries. The Internal Medicine Society of Australia and New Zealand (IMSANZ) has been instrumental in training Physicians to become General Internal Medicine Physicians and it has achieved this by giving encouragement to physicians, organizing conferences and sending outcomes of the conference and updates on recent developments in internal medicine to its members online. I would like to thank IMSANZ for accepting us Pacific Island Physicians to become its Associate Members and for providing travelling grants to its members to attend conferences and seminars.

Attending world class conference like the World Congress in Internal Medicine (WCIM) was long overdue for me. I had previously attended a number of conferences and trainings in Australia and these included Drug and Alcohol Symposium in Brisbane, Internal Medicine training in John Hunter Hospital and bronchoscopy training in Prince Alfred Hospital in Melbourne but these trainings were way back. We have been regularly updated about the upcoming conferences and other activities of IMSANZ through its newsletter. I became aware of the WCIM through the IMSANZ Newsletter and I applied early to avoid any disappointment and I had high hopes of being nominated as a delegate for the Pacific Island Physician to attend the conference. T o my delight the response was positive.

I had applied to go on two months leave in February and March of this year. The public Service Commission rules have changed back home. Anyone having accumulated annual or long service leave are suppose to take it or fear forfeiting them and there are no leave allowances. With the news of being selected as the recipient of the Pacific Island Traveling Grant for the conference, I proceeded to make arrangement for the trip.

I arrived in Australia long before the conference date to spend my leave and to visit my friends and relatives in Australia. While acquainting myself with the change of weather from summer to autumn and enjoying the Australian beer and a variety of food and fruits, I managed to update myself with the recent Australian and world news. The highlight was the Rudd Governments Total Health Reform where the new policy if implemented will take overall control of Health Funding as opposed to the current State controlled funding. In the world scene there were tsunamis and earthquakes in Chile and cyclones in Cook Islands, Tonga and cyclone Thomas back home.

Although developed countries like Australia needs highly specialized physicians in each discipline of medicine, Fiji is not ready for this. Development of specialized medicine in Fiji is at its infancy. A dialysis unit has been set up with the help of Kidney Foundation of Fiji, a cardiac catheter Lab has been set up in CWMH (mainly diagnostic) and endoscopy suites exist in all three Divisional hospitals. These facilities are run by General Physicians with sub-specialty interest in other disciplines of medicine. The Gastroenterology Society of Australia (GESA) has been instrumental in training general physicians in endoscopy procedures. There is room for developing sub-specialization in other disciplines in internal medicine.

For my first clinical session I chose chronic kidney disease (CKD) and calcium, phosphate, vitamin D metabolism and its risk in progression of cardiovascular disease as this was relevant to my clinical practice in Fiji. It was particularly difficult to choose which plenary session to attend as there were many presentations relevant to general physician going on simultaneously. We were told about the modifiable cardiovascular risk factors in patients with CKD and the other mechanism of accelerated cardiovascular disease in patients with CKD is due to deposition of calcium in the intima of the arteries and this leads to accelerated arteriosclerosis leading to coronary artery disease, stroke and premature death. These can be prevented by keeping the balance between phosphate, calcium and phosphate/calcium ratio to near normal and at the same time avoiding calcium containing calcium binders. We were also told about the newer calcium binders such as Serelamer and Lanthanum.

Prime Minister Kevin Rudd at the WCIM Opening Ceremony

CKD is a huge problem in Fiji because of high prevalence of hypertension and type 2 diabetes mellitus in young population. Dialysis facility in Fiji is still at its infancy, although a dialysis centre has been set up in CWMH with the help of Fiji Kidney Foundation. Cost becomes a major factor for patients who undergo haemo-dialysis or CAPD in Fiji as health insurance does not cover for dialysis. For my afternoon session I chose Endocrinology where topics such as tight diabetes control to reduce cardiovascular risk, UKPDS, obesity and few interesting thyroid diseases were presented by the three speakers. In the latter half of evening I chose a stroke session 2 where recent advances in stroke management such as t-TPA, hypothermia treatment and stem cell transplant were highlighted. Clinical cases on various etiological causes of stroke were also presented.

Cam Bennett, Alasdair MacDonald, Catherine Yelland and Nick Buckmaster

The session on Tuesday 23rd started with a keynote address by Peter Deutschmann who discussed on Global Health Initiatives, highlighting on three health specific Milenium Development goals. These were: 1.Reducing childhood mortality 2. Improving maternal health 3.Controlling infections such as malaria, tuberculosis and HIV/AIDS. The second plenary session was on tuberculosis where Rolf Streuli discussed on the global scene on tuberculosis, re-emergence of tuberculosis due to increasing incidence of HIV, DOTS regimen and emergence of MDR and extensive MDR and how these patients can be treated. I chose my next topic as medical oncology where the three speakers spoke on myths surrounding the curative treatment of elderly patients with malignancies, commonly occurring haematological malignancies in elderly and a study on colorectal cancer using Capecitabine and Bevacizumab.

I chose my first afternoon session on "Fitness for safety critical work" where the three speakers spoke on the three conditions: epilepsy, sleep disorders and color blindness, which can cause accidents at work place. These topics were particularly important in our setting as we as general physicians have to recommend to the employers about their fitness to continue to be employed and to the LTA on their fitness to drive vehicle. The last session of the day was a clinical case presented by the Australian Diabetes in Pregnancy Society and the Society of Obstetric Medicine of Australia and New Zealand with five penal. She was an aboriginal female from a remote medical centre in Sydney followed up in Dubbo Base Hospital. She was referred to the main hospital in Sydney late in her pregnancy and she was found to have a history of disabled first born child, two miscarriages, prolonged vomiting (due to hyperemesis and diabetic gastroparesis), poorly controlled diabetes mellitus, severe hypertension, severe diabetic retinopathy requiring urgent laser therapy, diabetic nephropathy and depression. This case illustrated that even in developed countries like Australia doctors face similar medical challenges as we do in a developing country like Fiji.

The conference on Wednesday 24th started on a high note with Priscilla Kincaid-Smith Oration and Cottrell Memorial lecture. Ian Reid presented on calcium controversy where his research showed that post menopausal women who are given high doses of calcium supplements develop accelerated vascular calcification leading to premature coronary artery disease, revascularization, stroke and sudden death. Rebecca Mason spoke in detail on vitamin D metabolism and its protective role in skin cancers and that it could be used to prevent skin cancers in future. The next presentation I attended was on inflammatory arthritis where the speaker spoke in detail about the pathogenesis of rheumatoid arthritis and recent developments in its therapy. The next two talks on obesity and gout were very interesting and useful to my clinical practice. The last talk of the day was on management of alcohol withdrawal, alcohol dependence and alcohol liver disease.

On Thursday 25th I attended a presentation on epilepsy which included genetic insults, neuro- imaging techniques and neuro-stimulation and targeted delivery for refractory cases. Of particular interest was the topic on anti-epileptic drugs in pregnancy. Studies have shown that Sodium Valproate when used in high doses (>1100mg) increases the risk of fetal abnormalities and decline in neuro-cognitive function and autism in growing child. In the closing keynote address, the speakers spoke on global warming leading to climate changes that in future will lead to health problems, rising sea levels, melting of ice, increasing temperatures leading to heat waves and decrease crop production.

The conference presented not only an opportunity for me to gain a lot knowledge by attending these high class clinical sessions but also to meet and catch up with my old friends. I was fortunate to catch up with old colleagues from John Hunter Hospital, New Zealand and Fiji. Obviously some of my friends had shown premature aging due to the stress they had gone through in the recent years. I also had the opportunity to attend the annual general meeting of INSANZ and met with the Secretariat, president elect and the outgoing president.

Steve Brady, Ciara O'Sullivan and Mary Ann Ryall

My trip to Melbourne was really enjoyable and the wealth of knowledge that I gained in this Conference will be utilized in the day to day care of my patients in Fiji. I also managed to make a lot of contacts with physicians abroad with whom I can make future contact for consultations and patient referrals.

I, on behalf of my colleague physicians in Fiji and Ministry of Health would like to take this opportunity to thank IMSANZ for providing me with the traveling grant to attend this wonderful conference. I am sure that IMSANZ will continue to provide these grants to other physicians in Fiji to attend future conferences.

DR. DEO NARAYAN
General Physician, Lautoka Hospital
Winner of Pacific Associate Travel Grant

Past and present President's of IMSANZ with Mary Fitzgerald and Fijian Representatives

In March, I was fortunate to attend the World Congress of Internal Medicine (WCIM) in Melbourne, Australia. It was only fitting that a world class event like WCIM took place at a world class destination such as Melbourne, Victoria - the home of Australia's center of excellence for research. It was a privilege and honour to be amongst peers from over 50 countries worldwide that attended this international event.

At the opening keynote session, the initial talk was on "biotechnological developments and innovations". The buzz word was 'research'. Translational research, from bench to bedside and vice versa, has contributed to better understanding of the complexity of the human (patho)physiology and no doubt has led to advances in modern day therapies. As a clinician with a heavy clinical and academic loading, I personally find doing research daunting. However, I do agree that research is the way forward. I found Barry Marshall's "Man vs. Helicobacter", his personal journey to the Nobel Prize, inspiring. It is one thing to read or hear about a person but is another thing and more inspiring and memorable to be 'up close and personal'.

To my astonishment, the Prime Minister (PM) of Australia, Kevin Rudd, made a guest appearance. Suddenly, I regretted sitting 9 or so rows behind the front stage. Though I took zoomed pictures, the PM's name on the slide was more in focus then the image of the man himself. He gave a lengthy speech echoing his commitment to funding healthcare in Australia, I think. I guess I was caught up capturing the moment on my camera that I failed to pay attention to details of his speech.

Because of the plethora of presentations, it did get a bit confusing choosing which sessions to attend. I sure felt like a child wanting 'all the candies on the shelf'. But of course with time constraints, one has to map out priority areas of topic interest beforehand. Despite this, the rooms could get overfull easily when there were hot topics. Perhaps my only suggestion here to the organisers is to have bigger rooms for anticipated hot topics of the day. But again, what is "hot" today may not be so tomorrow. Thus, next time, I just have to make sure I leave the meal breaks sooner and be seated way before time. All of the presentations were indeed educational and very enriching. The quality of the presentations was just phenomenal as well.

At the IMSANZ AGM, immediate past President Alasdair MacDonald passed on the baton to new President Nick Buckmaster. It is time to "Walk the walk" as Dr MacDonald reiterated. Furthermore, IMSANZ has expanded its associate membership to embrace nurses and other allied health professionals. As a Pacific associate member, I am a proud member of IMSANZ.

In short, I must thank AusAid for their generous sponsorship and also thank WCIM organising committee for the complimentary registration. This superb opportunity has been absolutely educational and inspiring.

MAI LING S. PERMAN
Pacific Associate Member
Fiji School of Medicine

Joint IMSANZ - RACP (Qld) Annual Scientific Meeting

Date: 1-3 October, 2010
Venue: Sofitel Hotel, Broadbeach, Queensland

The Royal Australasian College of Physicians
New Zealand

Sessions at the Conference include:

- Hypertension
- Update in Cardiology
- Update in Vascular Medicine
- Update in Infectious Disease
- Update in Neurology
- Setting New Directions in Internal Medicine

For further information please contact the IMSANZ Secretariat or visit the website www.imsanz.org.au

Les Bolitho AM

Les was a founding member of IMSANZ and served on Council between 1997 and 2004 and was President between 2001 and 2003. Over his time in these roles he has been a tireless contributor to Society matters and a passionate advocate for general medicine in Australia and overseas. He was instrumental in winning the bid for the recent WCIM in Melbourne as a member of the International Society of Internal Medicine. He was awarded his Fellowship in 1983 and has been a consultant physician since then and is currently based in Wangaratta, Victoria.

Les' work with respect to IMSANZ has included an advocacy role for rural and regional physicians with the maintenance of a high standard of specialist medicine for all Australian communities. In addition to his role with IMSANZ he has been and remains a prominent figure of the RACP and has, in the past, held positions as a Board member and is a current member of the Adult Medicine Division Council. His contributions to the College were recognised in 2006 at their ASM where he was awarded a College Medal for "Clinical Service in Rural and Remote Areas". He has also served on the college Rural Taskforce.

Along with his continuing interest in supporting clinical practice in rural Victoria, he has also been instrumental in the Victorian Rural Physicians Network and has had a keen involvement in the University Department of Rural health at Shepparton and has been involved in the instigation and maintenance of the program of medical students and registrars rotated from the Royal Melbourne Hospital to gain rural experience at Wangaratta District Base Hospital.

Aside from these contributions to the area of general medicine, rural medicine and medical education, Les has taken a leadership role in respect of the medico-political interests of consultant physicians and was elected President of the revitalised Australian Association of Consultant Physicians. He has worked very hard in that role to advance the interests of physicians in the context of recruitment, remuneration and retention of the physician workforce.

George Tucker OAM

Leonard George Tucker received his MBBS from the University of Queensland in 1973. His rural training commenced with a rotation term as medical registrar to Toowoomba General Hospital from the Royal Brisbane Hospital in 1978. He became a Fellow of the College in 1980, rounding off his training with terms in gastroenterology and respiratory medicine in Scotland. On return to Australia in 1982 he established himself in Toowoomba where he continues to provide an outstanding clinical service to patients in south west Queensland and northern New South Wales.

During his 10 years as a VMO at Toowoomba Base Hospital, George was an enthusiastic contributor to ongoing medical and nursing education. He is an examiner for the RACP clinical exam and examines for the Australian Medical Council. George's enthusiasm for quality care has led him to involvement in coronary care, oncology, palliative care and stroke committees at St Vincent's and St Andrew's Hospitals in Toowoomba. He has encouraged and supported countless junior doctors over the years.

George established an advanced training position in general medicine in the private hospitals of Toowoomba. He has contributed generously to countless educational activities for doctors, nurses and other health professionals across south west Queensland. He has always been extremely generous in his time to colleagues and has done extensive teaching tours throughout the west.

George has devoted himself to many community projects over the years. He was instrumental in establishing a community hospice in Toowoomba. Since 1998 George has been a Chevalier of the Sovereign Order of St John of Jerusalem.

George Tucker's enthusiasm for medicine resulted in his being awarded the RACP Medal for Clinical Service in Rural and Remote Areas in 2008. His continued dedication to high quality medicine has now received further recognition in the form of this Australia Day honour.

Well it came and went – the 2010 World Congress of Internal Medicine at the grand Melbourne Convention and Entertainment Centre proved to be a big success, attracting more than 2300 delegates from more than 20 countries who were offered a smorgasboard of plenaries, lectures, workshops, and free paper sessions. Members of IMSANZ made major contributions to both the organisation and the academic content of the meeting. A big vote of thanks is due to Les Bolitho (who along with Geoff Metz and Nip Thomson procured the meeting for Melbourne) and Alasdair MacDonald (who was a key player on the organising committee and as IMSANZ president participated in the official welcome and opening presentation which included a speech and a handshake from the Prime Minister).

The official program started with a pre-Congress workshop on Acute Medical Units which attracted more than 200 delegates and was organised by Harvey Newnham with support from the Victorian Government Department of Health. Sessions included an update on AMU operations in Australia as recently surveyed by IMSANZ (Paul Jenkins), a literature review of the effectiveness of AMUs (Ian Scott), planning for discharge from the AMU into subacute care and the community (Elizabeth Whiting) handling of information and avoidance of duplication between ED and AMU (Harvey Newnham) and unique experiences of an AMU in a regional centre (Diane Howard). Some interesting managerial insights into, and advocacy for, AMUs and general physicians as 'expert generalists' came from Andrew Way (CEO of Alfred Health, Victoria) in a presentation entitled 'Acute admissions – a UK to Victoria journey.' The perspectives of emergency physicians were on display with George Braitberg from Monash Medical Centre talking about ED access block and Anne-Maree Kelly from Western Hospital, Victoria giving a very cogent, evidence-based talk on chest pain evaluation and cardiac monitoring at the ED-AMU interface. Mark Mackay from the University of Adelaide gave us the nosokinetic view of how to apply mathematics and sophisticated software to predicting real-time need for beds and workers in hospital service management, while Keith Stockman from Monash Medical Centre gave a more personal and 'humanist' look at process engineering and change management within AMUs. Alison Mudge from Brisbane discussed whether readmissions to hospital necessarily reflect suboptimal care and questioned the effectiveness of various hospital avoidance strategies, while Peter Hunter, geriatrician from Alfred Health, provided an overview of the Victorian experience in augmenting subacute care, hospital in the home services and mobile assessment services aimed at lessening pressure on acute hospitals. The workshop featured several panel discussions which elicited wide-ranging debate from participants and helped refine ideas and perspectives. The overwhelming sense of the workshop was that AMUs are here to stay but that they will continue to evolve in their design and functions in response to local needs and priorities.

The Congress opening featured an unexpected visit from the PM Kevin Rudd who no doubt was keen to use an international meeting to get in first with his vision of hospital reform prior to the following day's debate with Tony Abbott at the National Press Club. While he said nothing new (and at one point showed a degree of ignorance as to what physicians actually do), some of the senior college executive, including our erstwhile president, were able to spend a half hour with the PM after his speech to enlighten him further on the roles of physicians, the need for more generalism in chronic disease management, and the looming inadequacy of training support and infrastructure for the significant numbers of additional trainees who will work their way through the hospital system over coming years.

Following the opening keynote which featured a very entertaining personal view from Nobel Prize winner Prof Barry Marshall, the Congress started in earnest. A large number of the presentations are now either posted on the college website or can be purchased on CD-ROM via www.evertechnology.com. But for those who were unable to attend WCIM and those who did but could not get to every session of choice, edited summaries of some of the key presentations from IMSANZ members are listed below grouped into themes. In keeping with our functions as expert generalists, topics focussed on acute medicine, quality improvement, medical education, and workforce needs. Our apologies to those members whose talks are not featured here – they were taken from the published abstract book which did not include all presentations. The IMSANZ Young Investigators Award was again a feature of the Congress and congratulations to Margaret Lee who was the winner out of 6 presentations for her study of a medication chart intervention which improved prescribing of prophylaxis in medical patients at high risk of venous thromboembolism.

Acute Medicine

The Australasian Medical Assessment Unit Survey

G McNeill, C Brand, K Clark, G Jenkins, I Scott, C Thompson, P Jenkins

Paul Jenkins from the University of Western Australia presented the results of the 2009 IMSANZ questionnaire survey of the design and operational characteristics of acute medical assessment units (MAUs) located within Australian and New Zealand hospitals, and how they compared with the formal standards promulgated by IMSANZ. Questionnaires were returned from 32 of 50 hospitals (response rate 64%). Among respondents, 22 (69%) had a functioning MAU, with most (15/22; 68%) being commissioned within the previous 2 years. There was marked variation in staffing and nursing skill base across the MAUs. Most units (78%) had the minimum number of recommended beds, but 15 (68%) were located distant from ED. Delay in transfer of patients from the ED to MAU occurred on a daily basis in 11 (50%) units. General physicians supervised the majority (14/22; 64%) of MAUs in which the emphasis on function was facilitating discharge of patients rather than managing patients with high acuity of illness. Existing MAUs in Australia and New Zealand are in their infancy and many are still evolving towards best practice standards.

Acute medicine and processes

Ian Scott, Alasdair MacDonald

Ian Scott looked into the future and presented new ideas on how AMUs might evolve to meet the needs of patient groups with specific problems (eg older patients and patients with 'surgical diagnoses', alcohol and substance abuse, or who are dying in ED) and those who do not require hospitalisation but

who are in need of expedited diagnostic work-ups, geriatric assessment, community support, and mental health review. Alasdair MacDonald provided an overview of AMUs ranging from purpose built co-located units in ED through to 'on take wards' sometimes many floors away from the ED and potentially in different buildings. In these units the care models in most cases continue to observe a 'unit of the day' model or struggle to reconcile the issues of continuity of care with more NHS style models. A novel suggestion was an acute care precinct that might include the ED, AMU and, in some cases, even Intensive Care and High Dependency Units which offered an opportunity for a blended competency based medical workforce. This could include general physicians practicing acute medicine, emergency specialists and intensivists all working together across this precinct with their complementary skills being applied to patient assessment and acute management in a cooperative environment that also facilitates undergraduate and postgraduate training. This may be accompanied by a parallel complementary assessment process replacing the current serial assessments with their inherent redundancy and focuses on a 'multiple disciplines of medicine' approach in concert with the multi-disciplinary approach of medicine, nursing and allied health professionals.

An Australian Medical Assessment and Planning Unit (MAPU) that failed to deliver efficiency improvements

L Roberts, R Payne, L Lea

Lynden Roberts from Townsville Hospital questioned whether MAPUs always achieve their stated efficiency objectives based on experience of the MAPU in his institution which opened in February 2007. Because of medical concerns about fragmented care decreasing patient safety, the MAPU model was changed in October 2008. The median LOS for all acute medical admissions was measured before (pre-MAPU), during the initial model, and after the introduction of the changed MAPU model. To avoid seasonal or transition-period effects, a 7-month continuous block of the same calendar months was selected in the three time periods for analysis. Day centre, dialysis patients, and patients staying longer than 14 days were excluded. Thirty-day readmission rates and in-hospital mortality was measured. The median LOS was 2 h shorter following the introduction of MAPU ($p<0.001$). This was associated with an increase in the number of medical admissions by an additional 2141 patients/year compared with pre-MAPU numbers. This increase in medical admissions was entirely explained by an increase in the rate of admission per ED presentation which rose from 11.7% to 14.0%. Safety measures were unchanged. There was no significant change in the median LOS following the change in the MAPU model after October 2008. The absence of a clinically significant decrease in median LOS was associated with an increase in the percentage of ED presentations admitted to medicine, suggesting a paradoxically decreased overall health care efficiency.

A Tale of Two MAUs

D Campbell, K Stockman

This session discussed the evolution of MAUs at Monash Medical Centre where general medical units care for up 90 inpatients and where a MAU has been operating in a converted medical ward since mid-2008. Currently an ED co-located MAU is being developed which will go-live in November 2009. The two phases of the MAU implementation have been used as a springboard to address a series of targeted changes to improve the model of care and streamline work practices in both General Medicine and along the entire continuum of care. A mixture of methods and principles from LEAN, Theory of Constraints, Six Sigma and other operations research methods such as simulation modelling have been applied, along with well trodden change management practices. This has resulted in significant improvements in operational performance as measured by throughput capacity (up 13%), peak capacity (up 20%), LOS (down 10%), standardisation of care and satisfaction of nursing, medical and allied health staff. A more proactive culture of continuous improvement has developed. The ward based MAU proved a positive step but limited the potential to eliminate duplicate effort in ED and to streamline diagnostic, imaging and specialty referral access.

Quality Improvement

Reduction in inappropriate hospital stay after effective health care interventions: A comparative audit

D McGouran, C Cameron, S Jayathissa

David McGouran and colleagues from Hutt Valley District Hospital in New Zealand raised concerns over inappropriate hospital stays attributable to inappropriate admissions or delayed discharge. They quoted recent studies showing between 20% and 33% of hospital bed days are accounted for by patients who could receive indicated care in alternative settings. In 2005 they created a protocol for auditing inappropriate bed stay which was prospectively applied during a 6-week period, and found that 21.8% of bed days were inappropriate of which the majority related to elderly patients living alone and in need of geriatric rehabilitation. Following this audit numerous changes to systems of care were implemented following which a prospective re-audit using the same protocol was conducted during a 6-week period in mid-2009. This revealed a significant reduction in the proportion of inappropriate bed days to 9.1% which equated to freeing up an extra five beds a day in a 54 bed general medical ward, with estimated savings of $835,850 per year. Major improvements were seen in the rehabilitation services, particularly among the elderly and those with stroke, and more resources were redirected to managing patients in the community and preventing readmissions. They concluded that efficiencies of health systems can be improved when managers and doctors' work together and conduct regular health service utilisation audits as a basis for remedial refinements to healthcare systems.

Models of care and outcomes in older medical patients

A Mudge, C Denaro

Alison Mudge and Charles Denaro from Royal Brisbane and Women's Hospital noted that care of the older patient is fast becoming the core business of general medicine. These patients comprise an increasing proportion of medical inpatients, and the long average hospital stays and poor clinical outcomes in this group serve as attractive targets for improvements in both efficiency and quality of care. Functional, cognitive and

nutritional impairments increase with age, commonly worsen with hospitalisation, and are predictive of poor outcomes. Recognition and management of these issues require an interdisciplinary, system level approach. In 2003, a model of interdisciplinary care was introduced into their general medical service and a controlled evaluation demonstrated improvements in efficiency and clinical outcomes consistent with previous literature. They described the model and the implementation and evaluation of subsequent modifications specifically addressing the issues of functional decline, delirium and poor nutrition. Practical challenges and barriers to implementation and sustainability were also discussed.

Reducing delirious discharges: Results of a quality improvement program

A Mudge, C Denaro, C Maussen

In a follow-up presentation, Alison Mudge went on to provide more detail on the part of their model of interdisciplinary care which targeted detection and management of delirium in general medical patients according to evidence-based guidelines. They implemented a multi-faceted program comprising: routine screening of admissions for delirium risk and delirium using the Confusion Assessment Method (CAM); intensive education of medical, nursing, and allied health staff; training and utilisation of additional nursing staff and volunteers; information for families; changes in bed management practices including use of a 'delirium bay;' and use of behaviour charts and pharmacological and non-pharmacological protocols for behaviour management. Evaluation was undertaken using a controlled trial (intervention versus control ward). Of 415 admission aged 65 or older, 219 were eligible and consented (92 intervention, 127 control). Forty-seven patients (22%) were delirious on admission screening, and only one case of incident delirium occurred during admission. Bed allocation practices significantly reduced the number of ward moves. Duration of prevalent delirium was difficult to assess because 40% of intervention and 62% of control patients (p=0.02) were discharged despite persisting delirium. The reduction in delirious discharges in the intervention group may reflect better delirium awareness, although this incurred a longer median length of stay (15 days vs. 9 days, p=0.1). They concluded that patients are frequently discharged despite persistent delirium which may be avoided by quality improvement interventions but at the expense of a longer hospital stay.

Implementation of an electronic medical handover tool improves accuracy and reduces omission of important information

E Ritchie, S Nanayakkara, J Antcliffe, H Newnham

Harvey Newnham and colleagues from Alfred Hospital in Melbourne targeted work practices which necessitate frequent shift changes involving general medical staff who are often caring for highly complex patients suffering from multiple co-morbidities and polypharmacy. Effective handover processes supported by accurate and comprehensive documentation are essential to minimise the inherent clinical risk associated with errors or omission. They described the effect of a shift of their morning handover documentation from a paper-based tool developed in 2007/2008 to an electronic form accessible through Cerner Powerchart. Fifty randomly selected hand-written patient handover sheets recorded between January and March 2009 (prior to the introduction of the electronic tool) were compared with the electronic handover records relating to 50 admissions during August 2009. Each record was examined for the presence of legible information in the following fields which were deemed essential for effective handover: patient name, date of birth or age, UR number, admission date and admitting registrar name. They also recorded the number of items listed in Past Medical History, Current Issues, and Management Plan to determine the 'completeness' of clinical information in each handover. They found that key information was missing from the many of the written records: patient name 2%, DOB or age 20%, UR number 10%, admission date 6%, registrar name 88%, compared to no such omissions for the electronic record. Other clinical information was also less extensively documented in the written vs electronic record including: Past History 3.9 vs. 7.1 items respectively, Current Issues 2.4 vs. 3.1 items, and Management Plan 3.0 vs. 6.4 items. During the trial period 50% of handovers were recorded electronically. They concluded that introduction of the electronic patient handover tool had improved the accuracy of patient identifiers and increased the level of clinical detail in their patient handovers. Further education and training of staff and identification of barriers to the use of this electronic tool will be required to improve its utilisation.

Improving handover with electronic notes

S Barnes, D Wunderlinch, D Campbell, K Stockman

In another talk on the same topic, Don Campbell and colleagues from Monash Medical Centre (MMC) described how their general medical units care for up 90 inpatients at a time, with six junior medical teams and three consultants operating under standardised operating principles. Like many general medical units, their teams use hand written or typed working notes to keep track of key patient details in parallel with the official medical record system. Available hospital systems at MMC did not support this essential and widespread practice. In the second quarter of 2009 a trial of an in-house electronic working notes and to-do system known as OpenKIMS was commenced with the aim of improving medical handover by improving the quality of medical team working notes and ensuring ready access to information from past admissions and other systems, such as pathology. The user interface was a desktop web browser linked to a central server. Their evaluation found that OpenKIMS fitted well into the medical workflow of general medicine and was associated with rapid uptake. A survey of users found a significantly higher level of satisfaction with handover, note keeping and discharge summary preparation. Consistency of working notes greatly improved and admission and discharge summaries were easily prepared for inclusion in the medical record. They reported that there is potential to extend OpenKIMS to nursing and allied health.

The Early Warning Score implementation reduced the number of unexpected deaths

J Do Campo, M Anderson, C Shennan, K Goss, M Roberts, S Owen, L Dent, P Showell, P Woodcock, A MacDonald

Early recognition of the deteriorating patient (ERDP) is a challenge in medical and surgical wards. In August 2009 at the

Launceston General Hospital (LGH), the Early Warning Score (EWS) was introduced in all adult patient wards. The EWS is a simple physiological scoring system that can be calculated at the patient's bedside based on conscious level, blood pressure, heart rate, respiratory rate and urine output. If the score is ≥3 points, ward nurses are able to trigger a sequence of calls, first to the home team registrar and then, after 15 min delay, to the Consultant or the ICU team. If the patient's clinical condition deteriorates further the nurse can activate code blue (CB). During July 2009 ward nurse educators undertook a period of EWS training of nurses while junior doctors also received information and education and their pager communication system modified using text messages for the EWS. From January to July 2009 prior to EWS implementation, there were 70 CB at LGH (53 survived the event with 17 deaths) compared to 21 CB (18 survived with 3 deaths) during August to October 2009 following implementation. The EWS generated an education pathway for bedside ward nurses, whose training now incorporates basic intensive care nursing skills, and who are able to contact the Consultant directly, resulting in better communication and less delay in intervention. The EWS has proven successful in improving ERDP and reducing the numbers of unexpected deaths.

Medical education

Integrating mini – CEX into the normal workflow

P Poole, J Owen

Phillippa Poole from Auckland opened this workshop noting that workplace based assessments such as mini-CEX are being increasingly used in postgraduate training, including the RACP PREP program. This tool aims to: promote direct observation of, and feedback to, trainees; assist in guiding the nature and direction of trainee learning; and assist in monitoring trainee progress and achievement of curricula learning objectives. This interactive workshop provided an introduction to the nature and use of mini-CEX within the context of medical specialty training and the role that mini-CEX can play in informing feedback to trainees. The session drew on participants' experiences and observations, discussed the role of the assessor, highlighted the value of providing appropriate and timely feedback to trainees, and debated issues around rating scales.

Understanding and Improving Clinical Reasoning

I Scott

Ian Scott led an interactive workshop which focused on the epidemiology and cognitive psychology of errors in clinical reasoning, and discussed meta-cognitive skills (thinking about one's thinking) which might be used to reduce their occurrence. Reasoning error is ubiquitous to medical practice and much of it should be viewed not as a function of incompetence or inadequate knowledge, but as frailty of human thinking under conditions of complexity, uncertainty and pressure of time. The workshop used several case studies to illustrate conceptual constructs and debiasing strategies that may assist clinicians in making more accurate diagnostic and management decisions. The use of narrative and analytic approaches to thinking were explored and attention was given to undifferentiated clinical presentations, competing disease risk, trade-offs between treatment toxicity and benefit, and overall goals of care and patient preferences. The workshop was oversubscribed with more than 120 delegates in attendance, and a show of hands at the end indicated that 75% had acquired new skills which they would now apply to their clinical practice.

Dealing with hype and spin

I Scott

In this lecture, the focus was on increasing awareness among physicians of common forms of bias in the design, conduct and reporting of published clinical studies. Case examples were used to show how this inaccurate and potentially misleading literature can lead to patient harm or waste of resources if accepted uncritically, and to emphasise the key methodological criteria physicians need to understand if they are to be more discerning in their translation of published research into clinical practice.

Medical Education Workshop: Supervision and feedback

L Callaway, C Mellis

Leonie Callaway and Craig Mellis facilitated this interactive workshop which focussed on the need for effective, educationally focussed supervision and support of trainees in their clinical and professional development. They noted that many supervisors feel inadequately trained for this important role, especially in regards to giving effective feedback. Likewise, many trainees feel feedback from their clinical supervisors is insufficient and/or ineffective. Commencing with a brief overview of the published evidence regarding 'supervision & feedback', the workshop then proceeded to case studies, role play, and collegial discussion aimed at: defining what supervision is; understanding the elements of effective supervision and support; modelling how to give effective feedback to trainees; discussing what does and does not work, and why; reflecting on the practicalities of providing supervision of clinical practice; and sharing strategies and experiences for providing effective supervision and feedback.

Medical Education Workshop: Learning from successful learners and having difficult conversations with others

L Callaway, G Reynolds

In another workshop, Leonie Callaway asked the question: Why do some learners struggle while others do not? Drawing on different case studies and the experiences of the presenters, the audience was encouraged to discuss their experiences and ideas. Simple pragmatic approaches to talking to trainees experiencing difficulties were a central feature of the workshop. Participants were also shown how to recognise the attributes of successful learners, assist learners by using meta-cognitive approaches, recognise the importance of 'modelling' in learning, and apply simple strategies when having difficult conversations.

Workforce issues

The changing role of rural consultant physicians and paediatricians

L Bolitho

Les Bolitho from Wangaratta talked to the privilege of working and providing services to rural communities which rests in the hands of a select few specialists. Succession planning requires proactive involvement from all concerned. The choice of being a discussant, advisor, advocate, teacher, leader and sage takes time and application and requires acceptance by the local communities. There are increasing demands on physician time and expertise for teaching and guidance of undergraduates and postgraduate trainees in all health related fields, including medicine, nursing and allied health. The introduction of newer consultation processes, including case conferencing or telemedicine, can be utilised for assessment and education purposes. This requires changes to current practice, and the recognition by the health bureaucracy of the important role of consultant physicians and paediatricians. The challenge is to successfully tread the path between expectation and reality.

Rural physician workforce challenges

S Brady

Stephen Brady from Alice Springs Hospital gave a personal view of his long-term commitment to rural practice. For the last decade or more he has been one of the handful of physicians practising in the 'outback' of Australia. Practice as a specialist physician in the outback of Australia provides many unique logistical, clinical and cultural challenges related both to the unique location as well as to the various medical conditions not seen in mainstream clinical practice. With increasing remoteness the disease burden increases whilst the resources to deal with them diminishes - the 'inverse care law' of clinical medicine. Despite the challenges, models of care can be developed which result in outcomes which are as good or better than those achieved in mainstream practice. However, if the poorer outcomes in both indigenous health and the health outcomes of rural and remote regions are to be overcome, policies are needed which attract both a specialist and primary care workforce to rural and remote regions. The role of the community specialist physician and paediatrician needs to be further explored and developed.

COMPILED BY IAN SCOTT

ACUTE MEDICINE PHYSICIAN
HAWKE'S BAY HOSPITAL

Applications are invited for the position of Acute Medicine Physician. Applicants with additional sub speciality interests are also welcomed. The position is flexible and could suit either a full-time physician with both acute medicine other interests or a part-time candidate whose sole focus is Acute Medicine.

Serving a regional population of 150,000 people, Hawke's Bay Hospital is one of the largest regional hospitals in New Zealand, with 400 beds and all major specialties represented on-site except Neurosurgery, Plastic Surgery and Cardiothoracic Surgery.

The successful applicant will be the second of two Acute Medicine Physicians responsible for acute management of medical patients in our 20 bed Acute Assessment Unit (AAU). The unit is contiguous to and ably supported by a busy regional Emergency Department (31000 annual visits with high medical and surgical acuity), a high-spec Radiology Department and a level II Intensive Care Unit. The AAU manages ~2000 medical patients annually with a broad range of acute medical conditions. Average length of stay is 24-30 hours hours with approx. 15% of patients going on to more long term hospitalization. You would be working closely with our team of 14 Consultant Physicians, whose expertise covers all the major subspecialties and 5 Emergency Medicine specialists. This is a great opportunity to provide clinical guidance as part of a strong team of professional staff, who are focussed on providing high level acute care.

The successful applicant must be eligible for vocational (specialist) registration with the Medical Council of New Zealand and have an interest and expertise in the initial assessment and acute management of medical patients.

Hawke's Bay is a major wine growing region with a diverse range of things to see and do. For families enjoying the sun, there are beaches, the Splash Planet water theme park, and crystal clear rivers to explore. Hawke's Bay has excellent schools, cultural and sporting facilities.

Bathed in over 2200 hours of sunshine per year the Hawke's Bay is an ideal location for the mild to wild adventurer take a jet boat or go white water rafting. Experience hot air ballooning at sunrise or surfing in Mahia. Cycle between wineries, hike or take a leisurely journey along one of the 17 heritage trails around the region. You can hunt in the ranges, fish for brown and rainbow trout within minutes of leaving work, play golf at one of the 20 local courses or go yatching off Napier Harbour. Hawke's Bay is only four hours drive south to Wellington, five hours drive north to Auckland, and an hour and half to Taupo with its famous trout-fishing lake, rivers and nearby ski-resorts or a further hour to Rotorua and its geothermal resorts.

If you have any questions about this position, please contact Dr John Gommans (Clinical Director, Department of Medicine):
Tel: +64-6-8788109 or E-mail: john.gommans@hawkesbaydhb.govt.nz

Or for an application pack please contact Barbara Rowe:
Tel: +64-6-878-8109 or Email: barbara.rowe@hawkesbaydhb.govt.nz

Applications close on: 28th May 2010

FAREWELL PETER NIGEL BLACK FRACP

Professor Peter Black was an outstanding teacher and researcher at The University of Auckland and General Physician at Auckland City Hospital. Having completed a ward round on Sunday 10th January 2010 he died suddenly later at home. Peter was the greatly loved husband of Bernadette Salmon FRACP, paediatrician, and proud father of Claire.

Peter held a myriad of roles across the university and hospital, nationally and internationally. Although he had an international reputation in respiratory pharmacology research, Peter remained a passionately committed to general medicine, quality use of medicines, and medical education.

After completing his MBChB in 1980 at the University of Auckland and FRACP in 1985, Peter spent the next three years at the Department of Clinical Pharmacology, The Hammersmith Hospital, London, under the mentorship of Professor Sir Colin Dollery, one of the founding fathers of the discipline of Clinical Pharmacology. On his return to New Zealand in 1990, Peter was appointed Tutor Specialist, then consultant General Physician at Auckland Hospital, and Senior Lecturer, The University of Auckland.

Clinically, Peter had few equals, proving an encyclopaedia of medical knowledge for his colleagues, and a dedicated doctor to a wide range of patients, including those with complex airways disease. He loved nothing better than to debate diagnoses and patient management, and was increasingly interested in clinical reasoning. Areas for administrative improvement received his swift and full attention with Peter often the first to offer practical solutions.

To his trainees and students, he was a true mentor, and 'walked the walk' of clinical excellence. He had incredibly high expectations of all of them, only exceeded by the standards he set for himself. For all his mentees, he was a staunch advocate, providing advice and support throughout their paths to senior positions.

In the important area of medicines' safety, Peter developed an integrated theme of clinical pharmacology, prescribing and therapeutics within the MBChB programme, complementing this with leadership of regional strategies to improve prescribing.

Peter's research was remarkable in its breadth and depth, covering the complete spectrum from basic research, through to translational and clinical research in its many forms, including Cochrane systematic reviews and clinical trials. He had collaborations with many international groups, recently establishing the Australasian COPD Research Network with TSANZ colleagues. His current projects include the role of fibroblasts in COPD, and diet in airways diseases. The author of over 80 publications, one of his proudest moments came when he was promoted to Professor in 2009, delivering his inaugural lecture in October to a packed lecture theatre.

At the time of his death, Peter was a member of the SAC Clinical Pharmacology, and Director of Advanced Training, Auckland region - a unique role he developed to improve coordination of training pathways, especially for those dual training in general medicine and a subspecialty. He had served as Chair of the NZ SAC in General Medicine from 1996-2000, as a Director of Physician Training, a member of the RACP Therapeutics Advisory Committee, and as an FRACP Part 1 clinical examiner. He was an active member of TSANZ, IMSANZ, ASCEPT, ASCIA and other respiratory societies.

Peter's sudden and untimely death has shocked everyone. He will be greatly missed by his many colleagues, patients, junior staff and students. While the magnitude of the loss of such a talented and productive clinical academic at the peak of his career is yet to be fully appreciated, he is recognised for his exceptional contributions to health care, research and medical education in the region.

Prepared by Dr Phillippa Poole, with the assistance of Dr John Kolbe, Dr James Paxton, and Dr Zoe Raos, Chair of the College Trainees' Committee.

The RACP Trainee's Committee awarded Dr Peter Black a posthumous Mentor Award at the WCIM conference dinner. The citation was read by advanced trainee, Dr David Bourke, and the award accepted by his colleague, Dr Phillippa Poole, who accepted the Mentor Award on behalf of Peter Black's family.

FORTHCOMING MEETINGS

2010	**MAY**	**Acute Medicine 2 day Conference - Hutt Hospital, Lower Hutt NZ** **6th - 7th May 2010** • Are you responsible for Acute Medical takes? • How secure do you feel about running an acute take? • Practical talks from Consultants involved in frontline medicine. • If you are a Registrar about to take full consultant responsibility or a Consultant and want an update. *Don't delay register your interest now, places are limited!* For details and a programme: E-mail: wendy.holmes@huttvalleydhb.org.nz Tel: +64 4 587 2519 Fax: +64 4 570 9254
	OCTOBER	**IMSANZ Trans Tasman Meeting** **1st - 3rd October 2010** IMSANZ will be holding an Australian and New Zealand combined ASM at the Sofitel Gold Coast in Broadbeach, Queensland. There will be no Spring Meeting in New Zealand in 2010. IMSANZ Website: http://www.imsanz.org.au/events/
		Canadian Society of Internal Medicine (SCIM) Annual Scientific Meeting **27th - 30th October 2010** The CSIM Annual Scientific Meeting will be held at the Hyatt Regency in Vancouver, BC.
2011	**MARCH**	**IMSANZ NZ Autumn Meeting** An Autumn meeting in Taranaki is being planned for March 2011. Details will be on the IMSANZ website as they come to hand.
2012	**NOVEMBER**	**XXXI World Congress of Internal Medicine** **11th - 15th November 2012** The XXX1 World Congres s of Internal Medicine will be held in Santiago, Chile Please make a note in your diary. Website: http://www2.kenes.com/wcim/Pages/Home.aspx

THE QUEENSLAND STATEWIDE GENERAL MEDICINE NETWORK

Queensland first developed clinical networks during and after the Forster Review of Health Services which was released during 2005. The review recognised the importance of clinician leadership in collaborating with health planners and managers in ensuring that health policy and resource allocation decisions were effective in leading to improvements in quality and safety of patient care. Queensland had been in the forefront of developing quality collaboratives in emergency medicine, renal medicine, stroke and cardiac disease funded from both state and Commonwealth sources. There had been some more localised multidisciplinary networks established for improving coordination of emergency and internal medicine services prior to the Review. The Review recommended expansion of these local networks and the establishment of a more formal structure to support and sustain their functions. Unfortunately, while a number of disease specific networks were subsequently established, there was initially no support for a General Medicine network.

However, in the last 12 months, this situation has changed. Senior general physicians including Ian Scott, Cam Bennett and myself were successful in making a case to Queensland Health (QH) that a Statewide General Medicine Clinical Network (SGMCN) would help to improve and sustain General Medicine services throughout Queensland. It was recognised that, without this structure, General Medicine was devoid of a voice in planning decisions, leading to a real risk that services at outer metropolitan and regional hospitals would be severely compromised by workforce dissatisfaction, isolation and poor funding. This view was strongly supported by the established sub-specialty networks and, as a result, the SGMCN was established in the middle of last year.

The role of the network is to provide policy advice to QH, to develop and assist in the implementation of service improvements at a Statewide level, to assist with the establishment and monitoring of clinical standards relevant to General Internal Medicine and to alert QH of any threats to efficient and effective general medicine services to Queenslanders. In addition, the network has a role in fostering training and education research, especially in health systems research.

The SGCMN has held an initial forum attended by over 100 people late last year to establish priorities for its work over the next couple of years. These include:

- Workforce planning, including identification of core skill sets for allied health and nurses in General Medicine services, and developing strategies for increasing workforce numbers in all the relevant professions in these services.
- Defining clearly the models of care relevant to General Medicine services across the state, including minimum requirements for establishing and maintaining services such as Acute Medical Assessment Units and Chronic Care Services.
- Establishing a core set of quality performance indicators relevant to General Medicine services and planning for coordinated measurement of these indicators as a basis for quality improvement.
- Establishing effective communication channels across the state to ensure that issues are able to be raised at an appropriate organisational level, and that there is sharing of relevant knowledge in an effective way to network members.
- Evaluating methods for ensuring rural and remote communities have access to effective General Medicine services.
- Evaluating systems and pathways to improve the effective transfer of patients between the Acute sector and Primary/ chronic disease/community care.

A working group has been established for each of these priority areas, with the exception of communication, led by members of the SGCMN steering committee. Communication is seen as a core role of the Steering committee itself.

It is early days in the work of these groups but already action plans and preliminary strategy documents have been produced. As far as I am aware there are no similar networks established elsewhere in Australia or New Zealand, despite there being subspecialty structures in most health jurisdictions. It is important that the work we have commenced in Queensland is reflected elsewhere, if for no other reason than providing a credible voice for General Medicine. I would encourage members to lobby their respective health departments to establish and support General Medicine networks and would be happy to add my voice to local leaders in making the case for this where required.

NICK BUCKMASTER FRACP
Chair, Queensland Statewide General Medicine Clinical Network

STOP PRESS

Congratulations go to Dr Les Bolitho AM, who has been elected as the next President of the RACP to succeed the current president, John Kolbe, in 2012. Well done Les!

Dr Alasdair MacDonald has been elected as Vice President of the Adult Medicine Division. Congratulations Alasdair

A/Prof Cam Bennett elected to Adult Medicine Division Council

FROM THE EDITORS

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

We are most grateful for contributions received from members.

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

We welcome contributions from physicians and advanced trainees.

Job vacancies and advertisements for locums can be published.

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

Tell us what you want!!

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

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

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

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

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