IMSANZ
INTERNAL MEDICINE SOCIETY OF AUSTRALIA & NEW ZEALAND

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President's Report

I can echo the words Nick Buckmaster used in his first report as IMSANZ President "It is a privilege…" as indeed it is a real privilege to serve the society and follow in the footsteps of other great leaders. A quick review of our history reveals that IMSANZ started in 1997 with amalgamation of the two Australian and New Zealand societies that had represented General Physicians in their own country. There have been seven other presidents before me, two of them from New Zealand. However, I note only one woman amongst the eight of us, Phillippa Poole – a fellow Kiwi. If the society is to show true leadership then this is something we need to better address given the predominance of female trainees in General Medicine and Physician workforce. Each President's term has seen the society progress from strength to strength and Nick's legacy has been a continuation of this growth; more members, the establishment of our IMSANZ "Spring" Annual Scientific Meeting (ASM) following the first on the Gold Coast in 2010, updating of our constitution including a shift of our Annual General Meeting (AGM) away from the May College meeting to our own ASM, getting trainee representatives onto IMSANZ Council and successfully managing the transition following the retirement of Mary, longstanding servant of the society, to Leigh-anne, our new Executive Officer.

So a new President and new support staff – where does the society want its leaders to take them? Amongst the first priorities we have identified are the need to update our IT services and website so our support staff can manage this in house and don't spend most of their time doing paperwork instead of assisting members. Within six months we expect to have the ability to pay subscriptions on line, rapidly update resources such as meeting presentations (and delete old ones), easier access to information such as position statements and policies, a section for job vacancies and training positions, a section for council members & committees and a historical section. Feedback from members regarding what you really want from your society will be gratefully received. In addition we are focusing on some of our structures including "job descriptions" for Council Officers and members – we are now too large to rely on oral handovers from outgoing leaders. We also have a somewhat ad hoc mixture of awards, prizes and scholarships that are variably advertised and judged that require an overhaul.

As Nick states in his "Farewell report" the society is now a key player politically on both sides of the Tasman. It is no coincidence that the current Presidents of the College (Les Bolitho) and the Adult Medicine Division of the College (Alasdair MacDonald) are both General

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In this issue….

Physicians and ex-Presidents of IMSANZ. Both Health Workforce Australia and New Zealand are strong supporters of General Specialist training, and Prof Des Gorman FRACP, the Executive Chair of HWNZ is an invited speaker at our Queenstown IMSANZ meeting. IMSANZ members are active participants in the College's General Medicine Working Group (especially important for those Australian members struggling with accreditation by their new national registration authority). The new Memorandum of Understanding (MoU) with the College will recognises our key roles in training and policy advice – we may even need to consider a more formal process for engaging with members to ensure appropriate consultation occurs.

The May AGM was the last to be held at the College meeting. In future they will occur at our own Society's ASM, starting at the 2013 ASM to be held in Newcastle, September 13-15 next year. Other amendments to our constitution agreed at the May AGM included changing the financial reporting year (to fit with the new AGM dates), changes to the dissolution clause to protect our status as a not-for-profit entity with the Australian Taxation Office, clarification of the term 'Internal Medicine', expanding on the Society's objectives, updating the dispute resolution process, allowing voting by overseas members via postal ballot, instruction on casual vacancies in Council, and including provision for issuing meeting notices via electronic mail.

There will be an open Council meeting at the Queenstown meeting including the official signing of the new MOU between the College and IMSANZ; a chance to meet your Councillors. A number of further constitutional amendments are likely to be required in 2013, not least creating positions for "Members of less than 7 years" to ensure younger physicians are also represented on Council. In the interim we will shortly issue a request for "expressions of interest" from younger physicians to be co-opted onto Council. Another issue the society will need to address is the voting rights of associate members – we currently have rather contradictory different clauses in our constitution.

So – IMSANZ has a solid membership, our trainee numbers in Australia are exploding to finally exceed those of NZ where numbers continue their steady increase, we enjoy a good relationship with and have significant influence in the College, and health services in both countries recognise the increasing importance of "Generalism" in managing multimorbidity, chronic diseases and acute admissions. It is a good time to get involved! Let us know what you think and where you want your leaders to take you!

DR JOHN GOMMANS FRACP
President, IMSANZ

Immediate Past President's Report

This is my last message in relation to my presidency in our newsletter after handing over the reins at the Annual General Meeting to be held in Brisbane in May. It has been a great privilege to serve as the President of the Society for the last two years during a time where General and Acute Internal Medicine specialty services are finally gaining the recognition from policy makers on both sides of the Tasman as the lynchpin to an effective and affordable health system. The Society is increasingly being recognised as a pro-active and responsible stakeholder that is able to present a vision for the management of chronic diseases and for the efficient and safe care of acutely unwell hospital patients, and which is able to present options by which this vision can be achieved. Our relationship with the College of Physicians is strong, ensuring that we are consulted, and that our views are recognised as the College engages in policy debate.

Among the key achievements for the Society in recent years has been the success of our Society Trans-Tasman Annual Scientific Meetings. We have held these annually for the last 2 years with the third to be held in Queenstown New Zealand. As a result of the success of these meetings we feel it is time to look towards moving our Society Annual General Meeting away from the College Congress and to hold the AGM at the Trans-Tasman ASM. Unfortunately we have not been able to succeed in moving the AGM this year, but we have set the steps in motion for this to occur in future years. We are progressively dis-engaging from the organisation of the College Congress adult medicine program, and in the future will be likely to be responsible for organising 1 or 2 sessions, rather than a stream within the Congress program. This process has only been possible because of the hard work of our ASM program and organising committees, who have worked very hard in ensuring the success of the meetings in becoming an essential part of our members calendars. I also must acknowledge the success of the New Zealand regional meeting. Perhaps it is time for members in each of the Australian states to consider holding a similar event, possibly in collaboration with their local RACP state committee.

At the AGM in May we presented a number of rule changes to the attendees which ensured that the Society complies with its legislative requirements as an Association. We have received advice that the Society should consider changing corporate structures to become an organisation Limited by Guarantee, however the changes to our rules of association would be substantial and need to have review and discussion within the Society over the next 12 months. I leave this in John Gommans' capable hands.

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Immediate Past President's Report

I was very pleased to welcome Leigh-anne Shannon as our Society Executive Officer. Leigh-anne comes to us with huge experience already in managing a not-for-profit Association so we are very fortunate to have her working with us. She has hit the ground running despite the challenges in starting in a position with the Council spread across 2 different countries, and the President interstate and now overseas. Over time no doubt many of our members will have the opportunity to meet her in person.

The College of Physicians in consultation with Specialty Societies has now produced a model Memorandum of Agreement which formalises agreement for the Society and the College to work together in areas of mutual interest, as well as ensuring that there is joint acknowledgement of the work done by the Society and its members in training, education policy implementation and public policy formulation. It also provides for the College to provide a range of services to the Society on a very competitive cost. It is likely that the Society Council will sign off the memorandum in the near future as well as formalising our tenancy in the current Society offices in Macquarie Street. The Society is currently working with the College to prepare a set of discussion papers relating to the recognition and credentialing of Physicians in General Medicine. The new Australian national process of registration for Medical practitioners has for the first time defined the specialty of individual Physicians. This has caused difficulties for a number of our members in applying for positions where there has been a requirement for registration as a Consultant General Physician, and where they have a registration in another specialty only. Previously it had been assumed that either recency of practice in Acute General medical take or the breadth of knowledge and experience gained during physician training was adequate for physicians to be credentialed and work within General Medicine services. This is no longer being seen as sufficient by many credentialing committees, so both the College and the Society are working to provide pathways so that all those with the skills and experience to ensure competence in the practice of General Medicine are able to obtain appropriate documentation acceptable both to the Australian Health Practitioners Registration Authority and to credentialing committees. The joint IMSANZ./College committee is working to make sure that the processes are fair, efficient and reasonably easy to navigate as neither organisation wishes to restrict the supply of physicians to positions, especially in regional and Rural centres.

I would like to comment also in this last message on the fantastic changes in our society over the last few years. The membership has grown, and there has been an explosion in the numbers of General Medicine Advanced trainees in Australia, with a steady growth in New Zealand. There are increasing numbers of Nursing and Allied Health joining the society and increasingly contributing to the ASMs. I think it will not be long before there are parallel sessions being provided around issues specific to these members, in addition to the contributions they are already making to posters etc. I can foresee overall membership continuing to grow rapidly over the next few years, making the future secure for our specialty.

I will close with a final remark regarding the IMSANZ council. It is rare to find such a group of individuals who are willing to give as much time to their profession. The breadth of knowledge and experience brought to our council meetings is daunting. These are the sort of people who inspired my love of General Medicine as a resident, and they are the people who are now leading the renaissance of our services. It is the deep concern for the breadth of healthcare and their respect and caring for people of all ages that comes across continually. I am proud to have led the council over the last two years and am very grateful for the support and guidance of all of them. I know the Society is in safe hands for the future with John Gommans taking over the Presidency and with Don Campbell waiting in the wings.

NICK BUCKMASTER FRACP
Immediate Past President, IMSANZ

WELCOME to our New Members

IMSANZ would like to welcome the following New Members:

- **Dr Peter McLaughlin**
- **Dr William Slater**
- **Dr Gerard de Jong**
- **Dr Jeffrey Rowland**
- **Dr Muhammad Hussain**
- **Dr Elizabeth Whiting**
- **Dr Cameron Jeremiah**
- **Dr Mary Parkin**
- **Dr Cameron Knott**
- **Dr Christiann Mostert**
- **Dr Annalise Philcox**
- **Dr Paul Wilson**

Trainee members

- **Dr Gary Girao,**
- **Dr Amee Sonigra**
- **Dr Jie Fok**
- **Dr Esra Venecourt-Jackson**
- **Dr Vikram Bhalla**
- **Dr Sarah Bell**
- **Dr Emma Losco**
- **Dr Ranjith Ralapanawa**
- **Dr Bibin George**
- **Dr Lisa Juckes**
- **Dr Corinne Tey**
- **Dr Roshini Cherian**
- **Dr Carl Peters**
- **Dr Jenna Allen**
- **Dr Tee Ong**
- **Dr Eve Fifield**
- **Dr Malcolm Phillip**
- **Dr So-Jung Park**
- **Dr Julia Girdwood**
- **Dr Susan Miles**
- **Dr Aik Haw Tan**
- **Dr Damiem Jackel**
- **Dr Asanka Withanage**
- **Dr Moayid Sherif**
- **Dr Adrian Chazan**
- **Dr Yanez Peerbaccus**
- **Dr Emile Altmann**
- **Dr Yamin Oo**

Pacific Associate members:

- **Dr Amrish Krishnan**
- **Dr Virgilio De Asa**
- **Dr Martin Daimen**

Allied Health Associate Members:

- **Ms Karen Blair**
- **Mr Christopher Parker**
- **Dr Simon Olenski**

What's New from the SAC?

Firstly, the committee extends a warm welcome to our new members, Dr Tuck Yong from Adelaide and A/Prof Nick Buckmaster from Gold Coast. Dr Yong responded to calls for new committee members late last year, and has subsequently accepted a position, whilst Nick also expressed an interest in a continuing role on the committee since his term as IMSANZ President ended.

New training guidelines were ratified by the College Education Committee (CEC) in November 2011 without modification. They are available on both the College (SAC) website as well as the IMSANZ website. Trainees and Fellows are encouraged to familiarise themselves with these guidelines – we still receive applications for training which demonstrate a lack of awareness as to what is required of terms in order to be accreditable towards training in General Medicine.

All 2011 first year trainees have been transitioned to the new guidelines throughout 2012 – this was carried out on a 'no disadvantage' basis. Also, please note all those who started training in 2011 will have been required to complete PREP requirements for 2011 by the end of June 2012 (this includes learning needs analysis and case based discussion) – in future years these requirements will need to be completed by the end of January of that training year along with Final Supervisors Reports.

One of the features of the new training guidelines is that from 2011 onwards only 2, rather than 3, projects will be required throughout the course of training in General Medicine. Please note that the first project must be received before the end of the 2nd year of training, in order to progress to the 3rd year.

The quality of many of the projects that are submitted are outstanding, especially, although not limited to, topics relating to health systems and quality improvement. It would be good to see more of these submitted for publication, or presentation at IMSANZ scientific meetings – some would also make a worthy contribution to IMSANZ News where they can enjoy a wider circulation amongst the Australasian General Medicine community.

Finally, it was heartening to see so many Australian trainees make it to the recent IMSANZ Annual Meeting in Queenstown. The standard of both oral and poster presentations was high, with keen competition for the awards!

DR ROB PICKLES
Chair SAC General and Acute Care Medicine (Australia)

FORTHCOMING EVENTS

IMSANZ NZ Autumn Meeting, "*Off the Beaten Track*" 13-15 March 2013
Mt Ruapehu, New Zealand

RACP Future Directions in Health Congress 2013, 26-29 May 2013
Perth, Western Australia

IMSANZ Annual Scientific Meeting 2013, 13 – 15 September 2013
Newcastle, New South Wales

New Zealand Update

There has been significant activity in NZ since the last IMSANZ newsletter, much of it centred on meetings.

Hamner Springs 2012 NZ Autumn Meeting:

This was a memorable event for so many reasons, not least the after dinner entertainment provided by John Thwaites and his family band, assisted (if that is the correct word) by guest appearances from fellow conference organiser David Jardine. A classic example of General Physicians displaying multiple talents and real can do attitude. Lynda Booth, our conference organiser, successfully led a large contingent of physicians and even more trainees in a lively although somewhat uncoordinated Country & Western line dance. David Cole completed the Christchurch trio on the organising committee, all three ensuring that the teleconferences were always lively and entertaining, and that the conference was a success – the Christchurch contingent clearly enjoyed the opportunity to host their colleagues after the devastating 2011 earthquake abruptly curtailed any participation last years Taranaki meeting. On behalf of all those who attended, I thank my three Christchurch colleagues and Lynda for organising a great meeting. The scientific programme catered for all with presentations on medical impacts of the Canterbury earthquake from an Emergency Physician, Orthopaedic Surgeon, Psychiatrist and several Cardiologists; updates on non-earthquake tremors (neurology), infectious diseases and obstetric medicine; and an anticoagulation-thrombosis session that included PHARMAC medical advisors re dabigatran, and advice on how to thrombolyse strokes. The strength of general medicine training in NZ was ably demonstrated by the quality and diversity of the trainees' presentations; our future is in good hands. As usual the final session involved a series of controversies presented by members, the finale a complex General Medical case presented by the Blenheim team. Tessa La Varis, wearing a cowboy hat and packing pistols, ensured active audience participation in key decision-making moments as the case unfolded.

Hutt Acute Medicine Meeting July 2012: Our Hutt Hospital colleagues hosted the third of their increasingly popular two-day acute medicine courses on 26-27 July, filling a niche in the NZ market for a practically orientated programme targeting physicians and registrars involved in acute undifferentiated medical takes. The "Young Physicians" from the Wellington Region certainly know how to run an entertaining, informal and very useful meeting. This was the first I had attended but it won't be the last! After 23 years as a physician leading an inpatient team I particularly enjoyed the insightful presentation on "The Consultant Ward Round".

Queenstown IMSANZ Meeting: NZ hosts the 2012 Australasian Annual Scientific Meeting in Queenstown from 20-22 September providing an excellent opportunity for NZ members to welcome our Australian colleagues. The 2012 RACP NZ Trainees' day on the Wednesday will entice a number of trainees to stay on for the full meeting enhancing the interaction between Fellows and their future colleagues. The conference theme "Transitions" reflects the boundary zone in medicine often occupied by General Physicians. The meeting programme will be typically broad to reflect this with updates and controversies; and a focus on the transition zones between paediatric, adolescent and adult medicine; professional transitions including supporting younger physicians and options for older physicians entering their third age; and transitions into and out of hospital. For those travelling there is an aviation medicine talk on our patient's fitness to fly as well as what to do when you hear that dreaded "is there a doctor on board?" call over the intercom. Queenstown should be a popular venue!

NZ 2013 Autumn Meeting: I am grateful to Graeme Mills (Waikato), Denise Aitken (Rotorua) and David Spriggs (Auckland) for joining Lynda and I on the organising committee for a central North Island 2013 meeting. Confirmed dates are 13-15 March with chosen venue being The Chateau at Mt Ruapehu. The success of the Hamner Springs venue suggests that members are willing to go "off the beaten track" hence that is our conference theme. Meeting details will be available on the NZ conference website www.imanzconference.co.nz shortly after the Queenstown Australasian meeting.

The NZ Adult Medicine Division Committee. This NZ committee of the RACP chaired by A/Prof Mark Lane comprises the NZ heads of the various special societies of the college, education committee representatives and NZ RACP staff. It met in Wellington on 6 March and via teleconference on 19 July. Mark Lane has since become the NZ President elect and a new chair of AMDC will be announced shortly. Topics relevant to NZ General Physicians included;

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- Support for young consultants: Drs Kyle Perrin (representative of less than 7 years) & Justin Beardsley (Trainees representative) introduced a paper relating to “How to survive as a new consultant”. Lead author was Stephen Dee on behalf of IMSANZ and the SAC. This arose from the collective experiences of the Wellington younger physicians peer group. It was well received and is likely to be adopted for wider college use in NZ. Stephen will talk on this topic at the Queenstown IMSANZ meeting.

- A lively discussion took place at the March meeting with Peter Moodie, Medical Director of PHARMAC on the introduction of dabigatran, the process for nominating Fellows to PHARMAC Committees and the Hospital Pharmaceuticals process. We can look forward to closer consultation on future key issues.
- Feedback from Jonathan Christiansen (Chair of Adult Medicine Education Committee) on several issues including; the Educational Governance Review, Basic Training Qualifications, new policies on Flexible Training and Progression through Training, and Site Accreditation.
- Need to develop materials to support overseas trained physicians.
- A document relating to physicians practising in isolation.
- Update from Dr Leo Buchanan, Chair of Maori Health Committee, regarding practical measures to assist Fellows with cultural competence.

Finally I wish you all well and look forward to catching up with many of you in Queenstown or at the Chateau next year.

DR JOHN GOMMANS FRACP
President, IMSANZ

New Zealand Advanced Trainee Report

Attendance and presentations at national meetings is a vital part of training. We are fortunate in New Zealand that DHBs are generally supportive of their trainees attending these meetings. New Zealand is fortunate to be hosting two IMSANZ meetings this year. The IMSANZ meeting held in Hanmer Springs in March was a great success. From a trainee's perspective, it was certainly an informative and worthwhile meeting. The breadth of topics covered was again impressive, ranging from the Christchurch Emergency Department response following the February 2011 earthquake, to neurological infections and movement disorders. The IMSANZ stream at the RACP congress in Brisbane ensured a strong general medicine presence at the meeting. The much anticipated IMSANZ Annual Scientific Meeting will be held in Queenstown later this month. Importantly, the annual Trainee’s Day is scheduled for the day before the conference begins, and will hopefully draw many trainees from both Australia and New Zealand.

The RACP congress and the Hanmer meeting have made me reflect on other aspects crucial to developing one's medical career. As a trainee, these meetings provide an excellent forum for networking. The old saying that it is not about what you know, but who you know holds some truth. Many good opportunities come from the networking that occurs at meetings like the IMSANZ conference. The medical community in New Zealand is small, and it is a great advantage that trainees are often well known by consultants from different parts of the country.

The College recognises the importance of mentors for advanced trainees and they ask us to specifically identify a mentor in our applications for training. My own mentor, Dr Eileen Bass (General Physician at Hutt Hospital) has played a crucial role in helping to develop my medical career to date. Even as a basic trainee, a consultant mentor is vitally important. For me, Eileen encouraged me to sit the RACP exam early in my training, and has encouraged the development of the general medical part of my advanced training. Our senior colleagues also play a major role in introducing us to other consultants. Eileen introduced me to Dr Paul Reeve (Clinical Director of General Medicine and General Physician at Waikato Hospital) at a previous IMSANZ meeting. He has since taken on a role as a mentor and helped to nurture and support my general medical career. While most New Zealand advanced trainees choose to dual train with general medicine, the general medical aspect of training can become neglected as subspecialty training programmes expect to be given priority. Mentors act as positive role models and are crucial to maintaining the strength and focus of general medicine training.

LAURIE WING
NZ Trainee Representative

This article first appeared in *The Monthly, July 2012* and was written by IMSANZ's Australian Trainee Representative, Karen Hitchcock.

Last Resort: How the rebirth of general medicine will save lives

June is 83, lives alone and still drives herself to the shops. When she doesn't answer the telephone one morning, her daughter drops by to check on her and finds her lying naked in bed, in a soak of urine, staring at the ceiling. June turns her head at her daughter's call but does not seem to recognise her, nor does she respond to questions. Her daughter panics and calls an ambulance; she runs to the bathroom, throws June's pills into a plastic bag and gets her into a nightgown. Then she sits on the edge of the bed and cradles her mother's head in her lap. The ambulance officers arrive within half an hour; they note that, apart from a low-grade temperature, all the patient's vital signs are normal and she can spontaneously move all four limbs. They bring her to the hospital where I work as a doctor.

Excepting elective admissions for surgery and the like, beds in a public hospital are guarded by the Emergency Department; if you are sick and need admission you have to come through the ED. Most people have some idea of the drill: the triage nurse ranks the severity of your problem, and that ranking determines how quickly a doctor will see you. If you turn up in the morning and the nurse or ambulance suspects you are having a heart attack, you will be deemed a Category 1 patient and will be seen to immediately. If it is a large, acute heart attack you will likely be on the table having your angiogram and stents within the hour. If all goes well in the angiography suite, by late afternoon you'll be in a large white room, hooked up to monitors, watching the news, swallowing all your new pills and eating dinner. If you are June, or someone equivalent to her on the triage scale – an older person who has fallen down and can't walk, someone who's had a faint, has a fever, is dizzy or delirious or looks starved to death – you are considered a Category 4 or 5. This means that by dinner time you may still be lying on the trolley, perhaps in a corridor of the emergency department if things are really frantic, waiting to be seen by a doctor.

Informally, these patients are known as 'crumbles': they are not crashing towards their death like the guy with the heart attack; they are merely engaged in a slow, crumbling demise. When the elderly and not-crashing patients are finally seen, it will be by the most junior doctor in the department. This doctor may take a long time to work out what is going on. Meanwhile, the inexorable crumbling continues.

In theory, the triage system seems sound and unavoidable: if someone is dying in front of you – exsanguinating from an amputated limb, unable to breathe because they have a hole in a lung – you cannot ask them to lie down and wait their turn. If they are not helped immediately they will certainly die. If you don't immediately help the crumble – June, for example – she will not die, or at least she will not die in front of you. However, according to a report published by the Australasian College for Emergency Medicine, the mortality associated with excess waiting time in emergency departments in Australia exceeds 1500 deaths a year – more than the national road toll. The crumbles are engaged in slow-motion crashes that we cannot see until the final metres, by which time it is too late.

In 2011, the government commissioned an investigation into emergency department waiting times. The result was the formulation of National Emergency Access Targets. The stated aim was to "improve patient safety and quality of care by removing obstacles to patient flow that contribute to emergency department overcrowding". By 2015, 90% of all patients must move through emergency departments within four hours. I do not know if I can convey how radical this proposal is. It is like telling someone who jogs an easy 5 kilometres in 45 minutes every weekend that in a few years they will be expected to do the same distance in 15 minutes. Changes have been trialled in Western Australia since 2009 and there has been progress. Emergency waiting time targets are being met and patient mortality is down. But these improvements have come at a significant cost. An army of administrative staff spend their days on phones and on the floor policing and pushing patients through the funnel of the ED. Doctors and nurses are exhausted and relationships between medical and administrative staff are strained. Are we sacrificing good training in our desire for efficiency? Meeting the targets within the current triage system is proving extremely difficult. What is needed is a radical new way of running emergency departments so that everyone is seen quickly, so that somehow everyone takes precedence.

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There is no waiting room in front of the ED at the Royal London Hospital. There is no triage nurse. If you arrive sick, no matter your degree of morbidity or your age, you will be seen within ten minutes by the most senior doctor. She will look at you, talk to you, briefly examine you and, though she may not come up with a definitive diagnosis, she will at the very least be able to decide where you will best be managed and thus where you should go: to the medics, to the surgeons, to the ED proper for further stabilisation and investigation, or home.

It makes sense. I have a friend who is an art curator. After completing her basic degree, she hung out at art galleries, volunteered at the Heide museum, wrote a couple of theses and landed a job in a major public gallery. Her visual apparatus from eyes to occipital cortex is different from mine: it has been trained. She sees more and better. Where I see a pretty object on a stick, she

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sees a complex creation with a place in history, heavy with implication in the present and future. She assesses most of this in the time it takes me to appreciate that the object is suspended from a wire that reminds me of the line my dad used in the '70s to catch flathead. She is the senior emergency department physician and I am the intern doctor. The patient is the work of art.

The idea of adopting this streamlined model in Australia has met with some resistance: it turns the seemingly natural order of things on its head. Senior doctors have done their time; they don't want to be on the ground running with the pack. They want to supervise, be offered pre-digested summaries, teach, hand out gems here and there, some advice, point out their registrar's blind spots. They are the bosses.

At the Royal London, if you are the equivalent of a Category 4 or 5 general patient, you will not languish in the ED corridor for five hours before the intern takes your history, your blood, comes up with an interim diagnosis, discusses it with a consultant and then rings a ward medical registrar to come and admit you. At the Royal London the emergency consultant will deliver you directly into the hands of the general medicine team for immediate assessment and treatment in their acute ward.

Of course, there are a number of barriers to the flow of patients from the ED to the ward, such as the numbers of beds available and staff levels. But a major barrier is also the traditional model of what an emergency department does: sort, package and sell patients to teams. These are ugly words to describe sick people with, but they are the words that are used and they represent the practice as it stands. Ward registrars (the most senior of the trainees) will not traditionally accept (buy) any patient who has not been sorted (thoroughly investigated) and packaged (diagnosed or at least had a single organ system nominated as the main problem). This all takes time. After four hours the patient may well remain unseen, undiagnosed or diagnostically undifferentiated – and if you can't nominate an organ system in which the pathology lies it will be difficult for you to sell the patient.

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When I first started out as a medical registrar there would be daily arguments in the emergency department or over the telephone about which teams should accept the care of 'non-differentiated' patients with 'general' or multi-system decline. To be clear, registrars were not fighting to take the patients; they were fighting to avoid taking them. One of the most common arguments I heard was from the sub-specialties that perform interventional procedures such as angiograms (cardiology) or gastroscopies (gastroenterology): 'We won't take the patient as we don't need to do anything for them.' DOING SOMETHING for a patient was reduced to a procedural intervention, as if everything else the patient needed (assessment, monitoring, medicine, care) could be offered by anyone, and therefore not by them.

One of the last times I engaged in this behaviour myself was over a middle-aged patient with a rare neurological disorder – degenerative, untreatable – who came to the ED with worsening confusion and seizures that had probably been precipitated by a urinary tract infection. The neurology registrar and I faced off outside the patient's cubicle. (Neither of us had seen the patient yet, but we knew his story and, when it came down to it, we both knew how to treat him.) I argued that neurology should take the patient as they had cared for him over the years, knew about his underlying disease and could best manage his seizures. The neurology registrar argued that the patient's problem had a non-neurological cause (an infection) and so, even though it had resulted in a worsening of his neurological condition, someone else should manage the patient. "That's crazy," I said. "We're not taking him," the neuro reg said. The nurse pulled back the curtain and there was the patient, an emaciated man-boy in neat navy-blue pyjamas, his elderly parents sitting anxiously at either side of his bed. They'd heard everything.

There are many reasons why intelligent, hardworking and generally humane doctors might argue fiercely in order to avoid taking patients: we may have a huge patient load already; we may be working with a less-than-physicianly consultant (boss) who would disparage us for accepting patients with problems outside her organ of interest; we may feel the patient will be better managed by someone else, as we may have no idea what to do. Also, for patients to be moved to a ward bed and be seen by a treating team quickly we need two things: a team to accept the patient and a bed for them to go to.

When a patient is in the ED, we registrars feel secure in the knowledge that someone is looking after them. The patient cubicles all open to a central area crowded with doctors and nurses. The ratio of staff to patients is high. Once we bring a patient to our ward they become our responsibility. This can be a large burden if our list is already full of patients who are still chaotically unwell. The undifferentiated patient is usually complicated: they take more time to sort out; they are generally older and may be frail, which means more things will go wrong and there is more chance of causing inadvertent harm with any treatment we give. And if we accept them early we must have the staff and the time to work out what is wrong, organise investigations and formulate a treatment plan. One solution to this has been the development of acute medical assessment units. Though these are set up to accept the patients early from the ED, they are still a work in progress at most hospitals in Australia. How many doctors and nurses do you need to look after a group of un-worked-up atients? We do not want acute medical assessment units to become chaotic, crowded holding bays with the atmosphere of a developing-world clinic: people twisted up in sheets and hanging skewed from beds, calling for a non-existent nurse.

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The general physician in Australia had all but died out by the 1980s, everywhere except in the rural and remote hospitals that had neither the workforce nor the need for representatives of multiple sub-specialties. In the '80s and '90s there were virtually no general medicine physician trainees in Australia. The cities were in love with super sub-specialisation. Chapters were formed, training pathways developed. You didn't just become a cardiologist, you became an electrophysiology cardiologist, or an interventional cardiologist, or an echo-cardiologist. You specialised in one kind of lung disease, or at the very least you specialised in a single organ. This was necessary in the face of a vast expansion in knowledge. The physician's bible, HARRISON'S PRINCIPLES OF INTERNAL MEDICINE, has 4012 pages. It is far more manageable to have to know only 300 of them in detail.

In theory, all physicians receive a solid early training in general medicine: the holistic management of a patient, the focused juggling of the problems. We all sit the same exams after five years of working as a junior doctor, and then we all do three or four more years of specialty training. It is those final years that have become less focused on general medicine. And physicians differ in the extent to which they leave their generalist training behind them. I was on a ward round once, presenting a patient's medical history to the consultant respiratory specialist, when he interrupted me with a huge theatrical yawn and asked when I was going to get to the bit about the lungs. He had no interest in hearing about the other things contributing to the patient's decline: her heart, joints, bones and sugars. As far as he was concerned, I (the registrar) could fix them up myself or I could ignore them.

I found it difficult to choose a sub-specialty. I chose neurology at first. I thought I might sub-sub-specialise within the discipline in multiple sclerosis, or acute stroke or psychosomatic disorders. What could be cleverer than specialising in brains? I'd get to carry around gleaming equipment – ophthalmoscope, tuning forks, tendon hammers – in a shiny briefcase. I'd need a Chanel-red hat pin on hand at all times, to check a patient's visual fields. I could be the next Oliver Sacks.

For a year I participated in a general neurology clinic. It took me that long to admit it to myself: I loved my patients, but I was bored. No patient came because they could taste the colour green; no one mistook their wife for a hat. Patients turned up with two things: dizziness or headache. We'd rule out dangerous stuff like venous sinus thrombosis and cerebellar strokes and then give them reassurance or a pill.

I tried nuclear medicine. It sounded very high-tech, and my mum loved that. I got to sit in a comfy wheelie chair in a quiet office with ambient lighting and endless cups of tea in my own cup and saucer, while I dictated reports about fuzzy scans of people with cancer or clots or broken bones. I looked for the black in the scan – that was the cancer. If someone had cancer metastases all through their bones, liver and lungs, we'd call it a Dalmatian scan and know they'd be dead in a few weeks. Lots of the people I scanned were slowly dying, but I didn't know them. I was in another room, and the scanner didn't pick up facial expressions. I would never have to be involved with a patient's actual death – unless someone had a cardiac arrest in my scanner, and if that happened to a passenger on a bus, you wouldn't expect the bus driver to fix her, would you? So there I sat, alone in a dark room with a bunch of fuzzy ugly scans, sipping another cup of tea.

Next up I thought I'd try endocrinology, where I'd specialise in diabetes and out-of-control hormones. I like diabetes, especially the kind you get if you're fat; I can relate to people who are struggling with the consequences of having done stuff they shouldn't have. And I like to intervene in a disease process before the consequences become irreversible. But I just couldn't get excited about the thyroid gland in the way all the endocrine bosses were, keen for treatment breakthroughs, keen to discuss whether we should palpate it, inject it, ablate it, scan it, irradiate it, or just watch it.

There are many advantages to sub-specialisation for the doctor: when you say you're an oncologist, everyone knows you administer medicine that dissolves bone marrow, fat and hair; people will open the door and let you go through first. And there are advantages for certain kinds of patients: if you are going to get an organ transplant, for example, it's probably a very good idea to be treated by someone with expert knowledge of what happens to you when your blood is pumped by a heart harvested from another body and sewn into the cavity of your chest. But what if you are getting old and have a bit of this and a bit of that? What if your kidneys pack it in at the same time as your heart and so you can't get an angiogram and there's more going on than either your GP or the nephrologist with a special interest in the autoimmune glomerulonephritides is comfortable with?

That general medicine was the only specialty for me became clear when I was treating an 84-year-old patient named Maria. I was working as a registrar on the respiratory unit and had been asked by another sub-specialty unit to take over her care as, in their opinion, her main problem was a chest infection. Before I met the patient I flicked through her notes. Her medical problems included emphysema requiring her to use continuous oxygen at home, congestive cardiac failure, multiple small strokes that had left her with a weak arm and chronic dizziness, atrial fibrillation, hypothyroidism, chronic daily headache and hypertension, and she had recently sustained a subdural brain haemorrhage in a fall. She was, at the time of my review, sporadically

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attending five separate sub-specialty clinics for the management of these problems. She lived with her daughter, who took sole care of her.

Maria was lying in the hospital bed. I introduced myself and asked her why she had come to hospital the day before. “I have a chest infection,” she said. “Yes,” I said, “but what did you feel that made you come in to hospital yesterday?” She told me again that she had a chest infection, and that her GP said he couldn’t help her, that she needed medicine in her vein. “But can you describe to me what it was you felt, your symptoms?” “I felt a chest infection, a chest infection,” she repeated, like I was stupid not to see the obvious. “When did you last feel well?” “Why are you asking me all of these questions?” she asked grumpily. I said, equally grumpily, “You have a lot of health problems and I am trying to keep an open mind about what is wrong, and if you want me to help you then you have to answer my questions and there are going to be a lot of them.” We faced off for a moment. “Two months ago,” she said. “And what has changed since then in the way you feel?” I asked. She closed her eyes and sighed, then said she felt very tired and weak, she couldn’t walk around the house easily anymore, she’d fallen over a few times, she’d had a terrible cough a few months back but the sputum was now clear, her headaches were bad and she felt her heart palpitating in her chest sometimes. She opened her eyes and looked at me. “If my daughter was here she could tell you better.” I picked up her hand and told her I would examine her, look at her blood tests and then call her daughter.

Even if Maria did have a chest infection, it was obvious that it was not her main problem: she needed to lose a bit of fluid; her heart rate needed slowing; her thyroid hormone levels needed checking; she needed to stop being prescribed so much prednisolone, which was contributing to her main problem of muscle weakness, which itself was probably a result of the de-conditioning that came with the immobility she had experienced during a chest infection a few months earlier. All of these medical problems needed sorting out, but above and beyond any medical management we could throw at her, what Maria needed was a course of physical rehabilitation if she was to return home with her daughter – which is what they both very much wanted. “I told Mum,” her daughter said to me on the telephone, crying, “if you can’t get out of bed, I can’t take care of you any more.”

As a representative of the respiratory unit my job was to take Maria under our bed card and prescribe antibiotics for her chest infection, if she had one. If she did not, in my opinion, have a chest infection, then it was my job to reject her, to leave her care in the hands of some other sub-specialty. But I saw that there was no sub-specialty that Maria fitted into neatly. No one would want her under their bed card.

Stories abound about patients who suffer the consequences of being treated ‘sub-specially’ by a sub-specialty. It happens on the surgical wards, too. I know of an elderly woman who recently fell and ripped a huge flap of skin off her elbow. She also had a sore hip. An X-ray of the hip was arranged in ED. The patient was admitted to the plastic surgeons who operated on her elbow. She recovered on the ward and was discharged home, but the pain in her hip worsened so she came back. The hip X-ray was reviewed in the ED – a week after it was taken. The plastic surgeons had taken exemplary care with her elbow. Too bad she had a snapped femur at the same time. They could not see beyond their own suture margins.

The problem is clear enough: in massive hospitals demarcated into care silos there has been a loss of a holistic approach to the patient. This means that the medical care of the elderly and the crumbling has to be artificially fragmented into the care of separate organ systems. From a best-practice perspective, a health resource perspective and from the perspective of Maria’s daughter, who was having to bring her to multiple appointments, what was chiefly needed was a good general physician to look after her, both as an inpatient and as an outpatient.

Some hospitals without a general medicine unit roster on a daily ‘physician of last resort’. This consultant doctor and her team must take all the patients rejected by the other sub-specialist teams; for that day they cannot say no. In other hospitals the registrars just argue and argue until one team gives in and accepts the ‘undifferentiated patient’. Either way it takes a long time for the patient to be admitted to the last resort. This situation is untenable. It is also inhumane and dangerous. Someone needs to WANT to look after these patients – the crumbles, the mysteries. A single team, headed by a doctor with expertise in treating a patient holistically, should direct their care. Yet these doctors – the general physicians – had become almost extinct.

Fortunately, it’s dawning on authorities that the public needs hospitals and doctors to serve an ageing community among whom chronic diseases are on the rise; that hospitals need large general medical units with the staff, facilities and funding to scoop the chaotically unwell and the crumbling patients out of ED, to assess and treat them promptly and to go on caring for them till they are well. In Victoria, every major tertiary hospital has a general medicine department run by a mix of dual-trained physicians, general physicians and sub-specialists who either have a genuine interest in general medicine or who can’t get a job in their chosen field.

Although there is still a dire shortage of committed generalists, there are now almost 300 registrars currently training to be general physicians. This shift in the delivery of specialist and hospital health care in Australia has brought with it a number of challenges. Having managed

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to attract this new generation of doctors to the practice of general medicine, we find we are unable to train them. To train as a general physician you are required by the Royal Australian College of Physicians to work two six-month sub-specialty terms. Finding departments that will employ general medicine trainees is proving extremely difficult, even when the trainee brings funding for most of her own salary. It seems sub-specialty departments on the whole do not wish to foster these strays; after 50 years of rapidly increasing medical knowledge, and the concomitant division of that knowledge into separate areas of practice based on organ systems, they want to produce doctors in their own image. Some sub-specialty associations are even putting in barriers to discourage their trainees from training both as a sub-specialist and a general physician, a combination that is especially valuable in rural areas where there may not be a full-time need for a cardiologist.

June arrives in my hospital's emergency department. Fifteen minutes later the emergency consultant rings me: "We have a patient for you. Eighty-three-year-old woman from home alone, found incontinent and confused. Stable, with a low-grade temperature. We've taken blood, urine, cultures and done a chest X-ray. May we send her up?"

We have 15 patients on our list, we've just received two new ones and they want us to accept June too. But yes, he may send her up. This is the rebirth of acute and general medicine as a specialty in Australia. We will see June in our acute assessment unit, start her on fluids and antibiotics and check her test results as they come through. She most likely has a urinary tract infection with associated delirium. Early treatment will increase her chances of getting better and getting home. We split our team and I'm relying on my junior registrar to let me know if anything dire or unexpected shows up in any of the patients I don't have time to see. There's no way my intern's going home on time today; she's juggling pathology forms and X-ray requests and faxes from other hospitals and scribbling like mad in the chart, translating my questions and the patient's answers into a smooth narrative that explains why they're here. Meanwhile her pager is going off and the nurses are harassing her for discharge summaries and scripts for other patients who are ready to leave. I'm thinking that another doctor or two and a few more nurses wouldn't go astray here. The last resort may have had a makeover, but we're still a bit thin on the ground.

KAREN HITCHCOCK
Australian Trainee Representative

EXPRESSION OF INTEREST

IMSANZ Council 'Younger Physician Representatives'

As the Trainee Representatives on Council finish their traineeships and with a growing number of younger physicians entering the general medicine workforce, IMSANZ is looking to co-opt younger physician representatives (less than 5-7 years from achieving physician status) on council, two from Australia and two from New Zealand.

We are now seeking expressions of interests to fulfil these roles. If you are interested, or would like to nominate someone for these positions, please contact the Executive Officer via email imsanz@racp.edu.au or visit www.imsanz.org.au/members to download the relevant documents.

CALL FOR ABSTRACTS

Physicians and Trainees who are members of IMSANZ and other attendees, are invited to submit abstracts to be considered for presentation at the IMSANZ NZ Annual Scientific Meeting 2013.

Deadline Date for Abstracts:
5.00pm, 30th November 2012

General Information

All abstracts should be original research. Broadly, this could also include an audit, a case report, or a description of a new innovation in health services delivery or education; however, the onus is on the author to demonstrate the significance of any work offered for this conference.

Please visit the NZ conference website for further details
www.imsanzconference.co.nz

IMSANZ Young Investigator Award (May)

The RACP Congress saw some very talented trainees present in the IMSANZ Free Paper Session. The standard of presentations for this award was very high and we would like to congratulate our first prize winner, **Dr Rebekah Shakhovskoy** for her presentation "Following-Up on our Most Vulnerable Patients - A Retrospective Audit of the Post-Hospital Care of Medical Patients with Recurrent Admissions".

The 'runner up' was **Chris Parker**, for his presentation "Epidemiology of Hepatocellular Carcinoma in the Top End'.

IMSANZ Young Investigator Award Prize Winners
Dr Rebekah Shakhovskoy WINNER (top right)
Christopher Parker RUNNER-UP receiving his prize from with Dr John Gommans (top left)

IMSANZ Advanced Trainee Award (September)

The standard of presentations for the Advanced Trainee Award was very high and we would like to congratulate our first prize winner, **Dr Yamin Oo** for her presentation *"The frequency distribution of length of stay: a superior indicator of hospital performance"*.

The 'runner up' was **Dr Rebecca Sander**, for her presentation *"Assessment of acute chest pain – does it require clinical acumen or high-tech?"*.

Following the session we received many positive comments from Fellows and Trainees about the high quality of presentations. Thank you to all trainees who submit their abstracts in consideration for the prize. Your contribution to the success of the program is greatly appreciated.

IMSANZ Advanced Trainee Poster Prize

Congratulations to **Dr Tim Bennett** on winning the IMSANZ Advanced Trainee Poster Prize for his poster presentation on *"An Audit of Patients Managed for Musculoskeletal Problems by the General Medical Inpatient Service at Western Health"*.

The contribution of physicians and trainee physicians in research is invaluable for the future of medicine and winning this award is an indicator of future success in their careers.

IMSANZ Advanced Trainee Award Prize Winners
Dr Yamin Oo, WINNER (top left)
Dr Rebecca Sander RUNNER-UP (top right)
Poster Display (below)

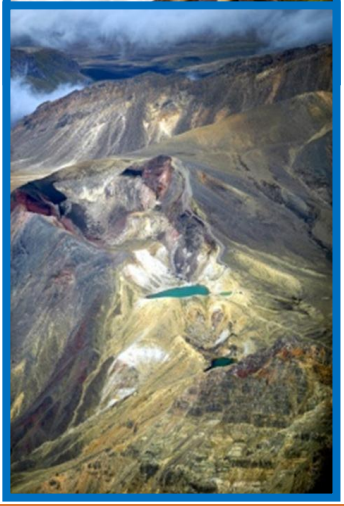
IMSANZ Travel Scholarship Winners

IMSANZ Pacific Associate Member Travel Scholarship 2012

Congratulations to **Dr William May** on being awarded the IMSANZ Pacific Associate Member Travel Scholarship for 2012. Dr May will be attending the IMSANZ 2012 Annual Scientific Meeting in Queenstown and I'm sure will gain great benefit in attending.

IMSANZ Travel Scholarship 2012

We are also pleased to congratulate **Dr Lloyd Nash** for being awarded the IMSANZ Travel Scholarship for 2012. Dr Nash will attend the clinical Medical Ethics course hosted by Imperial College London from 17th – 21st September 2012 and we look forward to hearing a report from him in the next newsletter.



IMSANZ NZ Autumn Meeting, Mt Ruapehu, New Zealand

You are welcomed and invited to the Volcanic plateau; a unique environment at its summer best in March. This is a chance to get "off the beaten track" both medically and physically. Take the opportunity to explore this region before or after the meeting with its world class tramping tracks, superb trout fishing, boating, rafting and mountain biking.

Come prepared for challenges, new ideas and innovative thinking. This is a meeting for general physicians and those who practice general medicine. It's a chance to think about what we do, how we could do it better, learn from others and celebrate our successes.

You will experience everything from future gazing to reflecting on the end of journeys, encompassing controversy, whilst thinking about mainstream medicine and exercise medicine on the way. You will even get a chance to "walk the talk".

Don't miss this opportunity to reflect, learn and network in stunning and unique surroundings.

Internal Medicine Society of Australia and New Zealand 2013 NZ Autumn Meeting

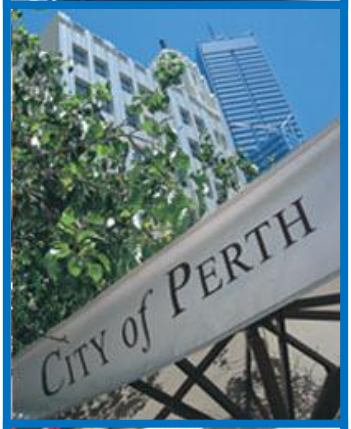
CALL FOR ABSTRACTS OPENS
24TH SEPTEMBER 2012

www.imsanzconference.co.nz

OFF THE BEATEN TRACK

SAVE THE DATE

13th to 15th March 2013
Chateau Tongariro Hotel
Mount Ruapehu, New Zealand



RACP FUTURE DIRECTIONS IN HEALTH CONGRESS 2013

26 – 29 May 2013 Perth Western Australia
Perth Convention & Exhibition Centre

The Royal Australasian College of Physicians

RACP Future Directions in Health Congress, Perth Western Australia

On behalf of the Congress Program Committee, it is my pleasure to invite you to attend the RACP Future Directions in Health Congress 2013. The Congress will be held from 26-29 May 2013 at the Perth Convention and Exhibition Centre in Perth, Western Australia.

The Congress is the premier annual event on the RACP calendar and will continue to provide RACP Fellows, physician trainees and visiting medical specialists with a stimulating forum to update their knowledge and skills in their area of specialty, and outside their area of practice, and as a physician.

The Congress theme and topics for the streams will be announced shortly.

I encourage you take the opportunity to experience the energetic atmosphere our host city Perth and its surrounds has to offer by incorporating a pre-or-post Congress tour as part of your Congress visit.

I look forward to seeing you then.

Dr Leslie E Bolitho AM
President
The Royal Australasian College of Physicians

IMSANZ Annual Scientific Meeting 2013, Newcastle, New South Wales

Gateway to the Hunter Valley's world famous wineries, Newcastle is Australia's second-oldest city. Located just two hours by road or train from Sydney, Newcastle is also on the doorstep of beautiful Port Stephens and its whale and dolphin watching.

With its beautiful beaches, award winning restaurants and innovative arts scene, Lonely Planet named Newcastle as one of the world's hottest cities in 2011.

The **IMSANZ Annual Scientific Meeting 2013** will be held in the magnificent Newcastle City Hall. Opened in 1929, it has been converted into a modern conference and theatre venue – while still retaining its sandstone walls and columns, clocktower, magnificent sweeping marble staircase and ballroom.

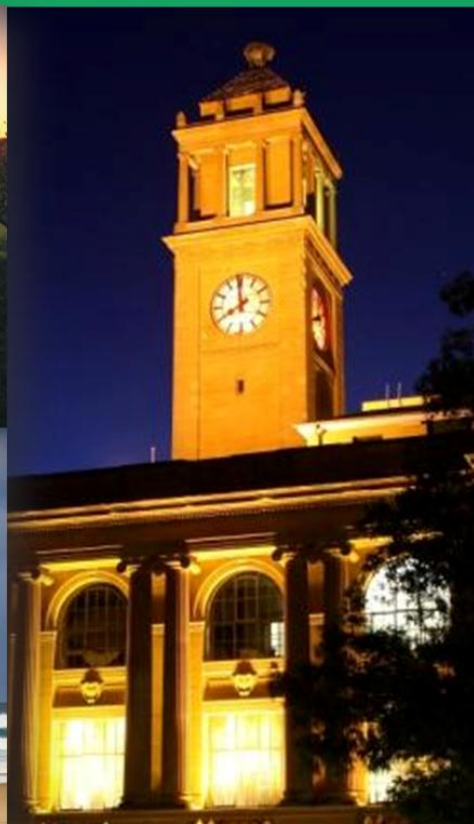
Further conference information can be found at www.imsanz2013.org.au or by emailing imsanz2013@conceptevents.com.au

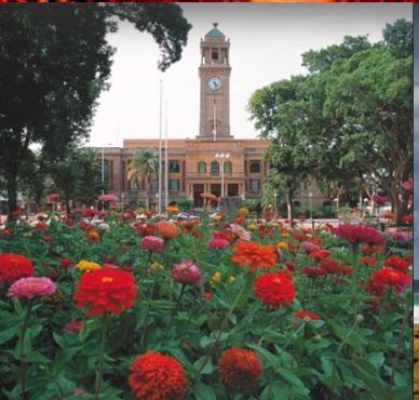
Mark the date in your diary and we look forward to seeing you at IMSANZ 2013.

IMSANZ Annual Scientific Meeting 2013

13 – 15 September 2013
Newcastle, Australia

Gateway to the Hunter





FROM THE EDITORS

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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 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 content and style of the newsletter.

Tell us what you want!!

When submitting text material for consideration for the IMSANZ newsletter please send your submissions *Microsoft Office* compatible applications.

Images should either be a JPEG, TIFF or bitmap format at 300dpi and no less than 100mm by 70mm.

Submissions should be sent to:

imsanz@racp.edu.au