IMSANZ NEWSLETTER

AUTUMN 2013

IMSANZ Council

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President's Report

Dr John Gommans
IMSANZ President

Welcome to the first of our e-newsletters and belated apologies for those of you still waiting for the missing December printed newsletter and wondering what the Society has been up to since you last heard from us.
Read the full article...

Editorial

A/Prof Sergio Diez Alvarez
Newsletter Editor

When considering the role of generalists in the current health care system in Australasia one has to give some thoughts to the recently widely publicised Mid Staffordshire Foundation Trust debacle haunting the NHS.
Read the full article...

Australian Update

Prof Don Campbell
IMSANZ Vice President &
President Elect

Along with our President John Gommans I attended the Conjoint Medical Education seminar, run by the RACP, and RACS with the Royal College of Physicians and Surgeons of Canada on March 8th in Sydney.
Read the full article...

Australian Capital Territory
Ashwin Swaminathan

ADVANCED TRAINEE REPRESENTATIVES

Australia
Karen Hitchcock, NSW

New Zealand
Laurie Wing

RECENTLY QUALIFIED PHYSICIAN REPRESENTATIVES

Australia
Sara Barnes, VIC
Greg Plowman, QLD

New Zealand
Michelle Downie
Marion Leighton

SAC REPRESENTATIVES
Rob Pickles (AUS)

Welcome to our New Members

Since the formation of IMSANZ in 1997, the society has grown from strength to strength. We would like to welcome our new members, particularly those who joined at the NZ branch meeting earlier this month.

Click to view list of new members

Awards and Scholarships

The following awards are currently **OPEN**. Please click on the award to view the terms and conditions and to apply.

IMSANZ Pacific Associate Member Travel Grant

IMSANZ Travelling Scholarship

Meetings and Events

New Zealand Update

Dr John Gommans
IMSANZ President

IMSANZ has been very active in New Zealand in the last six months, especially hosting three meetings within 12 months.
Read the full article...

SAC Report

Dr Rob Pickles and Dr David Spriggs
Chairs, SAC Aus & NZ

Advanced Trainee numbers continue to rise in both Australia and New Zealand, with 283 registered in Australia as of February 2013. Approximately 70% are dual trainees.
Read the full article...

Advanced Trainee Report

Dr Laurie Wing
IMSANZ Advanced Trainee Representative, NZ

Many advanced trainees face an important decision at the onset of their advanced training; whether or not to dual train.
Read the full article...

IMSANZ NZ Branch Meeting - Mt Ruapehu Reviews

Dr Pamela Hale, Dr Christian Hulett and Dr Katie Thorne
IMSANZ Member Reviews

The IMSANZ NZ Branch Meeting 2013 was held earlier this month at Mt Ruapehu with over 100 delegates attending. Click here to view reports and photos from some of our members.
Read the full article...

RACP Congress
Perth 26-29 May 2013

ANZSGM ASM 2013
Adelaide SA, 17-19 June 2013

Acute Medicine Conference
Hutt Hospital, 8-9 August 2013

IMSANZ 2013 Annual Scientific Meeting
Newcastle 13-15 September 2013

Click to view the full list of events on the IMSANZ Website

Career Opportunities

There are a number of career opportunities listed on the IMSANZ website.

Click here to view the current vacancies

Dual training program to begin in regional NSW

For the first time in Australia, trainees will have the opportunity to apply for an advanced, dual training program in regional NSW that is mapped out and pre-accredited over four years. Visit the IMSANZ website for further information and the latest news: http://www.imsanz.org.au/latest-news

Telehealth - In the Spotlight

One of our IMSANZ members, Dr Jorge do Campo, has recently been in the spotlight in an interview and news article on Telehealth.

Watch the interview:
http://vimeo.com/57963192
View the news article:
http://www.pulseitmagazine.com.au

For further information on telehealth, please visit the RACP Telehealth

IMSANZ 2012 Annual Scientific Meeting Review

Dr Marion Leighton
IMSANZ Member Review

In our last newsletter we promised to provide a review of the Queenstown meeting. Dr Marion Leighton reports on the 2012 Annual Scientific Meeting held in picturesque Queenstown, New Zealand.
Read the full article...

Tri-College Conjoint Medical Education Seminar Report

Dr Rob Pickles
IMSANZ Hon Secretary

The theme of the Conjoint Medical Education Seminar 2013 recently held in Sydney was "Serving the Community: Training Generalists and Extending Specialists". Click here to read the full report from Rob Pickles.
Read the full article...

IMSANZ De Zoysa NZ Trainee Prize

We are very grateful for the contribution of Dr Neil De Zoysa and his family over the years to IMSANZ.

Congratulations to Dr Katie Thorne winner of the 2013 IMSANZ De Zoysa NZ Trainee Prize.
Read the full article...

IMSANZ Travel Scholarship Winner

Dr Lloyd Nash
Winner of the 2012 IMSANZ Travel Scholarship

Click here to read the full report from

website:
http://www.racptelehealth.com.au/

Dr Lloyd Nash from his experience attending the Medical Ethics Conference in London, September 2012.
Read the full article...

General Interest - James Craig

Prof Don Campbell

Earlier this year a friend of mine rang me up. “You like an adventure”, he said. “What about going on the James Craig, from Hobart to Sydney as ship’s doctor?”.
Read the full article...

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President's Report

Welcome to the first of our e-newsletters and belated apologies for those of you still waiting for the missing December printed newsletter and wondering what the Society has been up to since you last heard from us.

Our Society is growing rapidly both in numbers and in influence across Australasia and we have had to focus on improving backroom functions to support this growth. For example the number of trainees in General and Acute Care Medicine have increased dramatically, now numbering about 500 (February: 283 in Australia and 216 in NZ) and we have been working with Health Workforce Australia on training and workforce development. Several members are serving on the Adult Medicine Division Committee of RACP and our Annual Scientific meetings are increasingly popular. This increased activity has resulted in some “growing pains” with the need for a major review and update of the website including enabling on-line subscription renewal and better access to resources such as presentations from past meetings. We have created job descriptions for key Council positions – for example previously the incoming President learned from their predecessor what the role really involved! We have also reviewed the rules regarding our various awards and scholarships. To support our current Trainee representatives in ensuring that the future members and leaders of our society have a strong influence within the Society we have expanded Council with new positions created for ‘younger’ General Physicians within seven years of qualification (two for each side of the Tasman).

The engine room of the Society and responsible for the real work is our solitary Executive Officer, Leigh-anne Shannon, working out of her small office in Macquarie Street Sydney. Our resources were thinly stretched with the website upgrade late last year but we assure you that we are now on top of outstanding issues; normal and hopefully enhanced service is resumed.

One of the key aims of this society is to support and promote “Generalism”, and General Internal Medicine. To this end we are actively involved in the RACP working group on General Medicine led by one of our ex-Presidents, Alasdair MacDonald, and our Australian Vice President, Don Campbell, is leading work that strengthens our relationship with Health Workforce Australia – see his report regarding this. On 8th March a ‘Tri-College’ meeting of representatives from the RACP, RACS and the Canadian College of Physicians and Surgeons meet in Sydney to address the topic of ‘Serving the Community: Training Generalists and Extending Specialists Generalism’. This was a rewarding, thought provoking and at times very humorous meeting of surgeons, physicians and rural doctors from across the three countries; although perhaps we were all preaching to the converted. I represented IMSANZ on a panel discussion and IMSANZ representatives included Don Campbell as the IMSANZ VP and Rob Pickles as IMSANZ Secretary and chair of our Specialist Training Committee

in General & Acute Care Medicine – see Rob's report for more information.

Our trainees are the future of our Society. Council is constantly working to ensure we have a good curriculum for training purposes and that adequate training positions are available hence a strong commitment to the Specialist Training Committees in General and Acute Care Medicine in both countries. The addition of four recently qualified physicians to Council helps close a gap between our two trainee reps and the more senior members on Council. We need to encourage and nurture our potential future leaders if we are to avoid being run (overrun?) solely by those with grey hair.

General Physicians enjoy the chance to meet with their colleagues and our Annual Scientific Meeting is now strongly supported by members and like-minded colleagues. Last September it was New Zealand's turn to host the 2012 Australasian ASM of the Society which took place in Queenstown. Some 180 members enjoyed the superb location with the snow covered Remarkables mountain range visible across the Lake and the weather played its part - See the conference report for more information. About 90 NZ trainees held their annual meeting the day before and a number of guest speakers willingly gave their time to address the trainees. It was gratifying to see the significant number of trainees who stayed on to participate in the meeting and enjoy what Queenstown had to offer 'out of hours'. I encourage all members to attend the 2013 meeting which will be held in Newcastle NSW; 13-15 September.

Finally I thank my fellow Councilors for all their work on behalf of IMSANZ and General Medicine, and Leigh-anne for her excellent work behind the scenes. We welcome feedback on any aspect of how the society works for you and suggestions regarding how we can best support General Physicians and trainees.

DR JOHN GOMMANS FRACP
IMSANZ President

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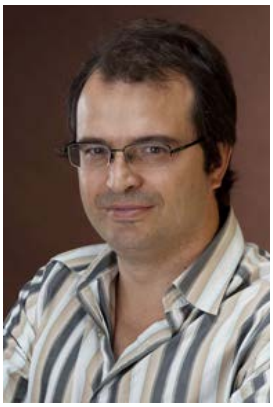
Editorial



When considering the role of generalists in the current health care system in Australasia one has to give some thoughts to the recently widely publicised Mid Staffordshire Foundation Trust debacle haunting the NHS. For those not familiar with the issues arising, Robert Francis QC released a damning report on the care received by patients attending the Mid Staffordshire hospital. The report highlighted deficits even in the most basic of care, and emphasised the shortages in the already demoralised clinical staff and its impact on patient care. This will only add to the already eroded public opinion of our profession.

Events like this, remind us that patient advocacy remains a core role of our profession. I would argue that general physicians are well positioned to embrace the role of patient advocate.

Generalists are often involved in care co-ordination amongst inter professional specialist groups, across the hospital and community health care sectors and even within multi disciplinary care teams. In these leadership roles, general physicians need to consider the impact of recent trends in health care delivery models on overall patient care and ensure that we prioritise professionalism in our care delivery.

Generalists are often in positions of influence, serving on hospital or college committees or boards where they can highlight observed deficits in care delivery. As an example, they are well positioned to promote infection control policies and influence others in the educational forums in which they partake.

Systemic failures of care delivery as happened in the Mid Staffordshire Trust serve to remind us all that as a professional group we need to spread our energies beyond the daily service delivery to ensure that all patients and their family receive the best possible care. This needs to be reflected in our IMSANZ annual scientific meetings with the celebration of strategies that highlight professionalism in the work place, especially those projects involving trainees as they are indeed the future of our profession.

A/PROF SERGIO DIEZ ALVAREZ
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Australian Update

Along with our President John Gommans I attended the Conjoint Medical Education seminar, run by the RACP, and RACS with the Royal College of Physicians and Surgeons of Canada on March 8th in Sydney. The title of the Seminar was “Serving the Community: Training Generalists and Extending Specialists.” At about the same time Health Workforce Australia published a consultation paper as a first step to developing the National Medical Training Advisory Network (NMTAN). The development of the NMTAN is one of the recommendations of the Health Workforce 2025 volume three on Medical Specialists. The consultation asks questions about the essential elements of coordinated medical training and possible functions of the network including the approach to producing the five-year rolling medical training plan/s.

Against this backdrop of increasing concern about workforce training, particularly of generalists, we also have the spectre of a number of special societies affiliated with the RACP seeking to increase core advanced training periods from two years to three years, whilst we have an increasing number of trainees seeking to undertake advanced training in both general medicine and another specialty.

So what is going on?
HWA recognize that there is a shortage of generalists. The joint college education meeting identifies that the shortage of generalists is a widespread problem and there is great concern about how to attract, train and retain generalists both in rural and metropolitan areas. There are lengthening queues to enter specialty advanced training whether as a general specialist or a specific specialist, whilst the unrecognized and unintended consequence of increasing the period of core training from two years to three years for some specialties is to reduce the effective throughput of trainees in those specialties by a third and increasingly to lock general trainees out of these specialty training positions.

What can be done about this and by whom?
For the College it will be very important to review the decision by some specialties to increase core-training periods from two to three years. At the policy level we need to get general specialist advanced training schemes recognized as being of equal importance to the specific specialist advanced training schemes, and also to ensure that remuneration for generalists is made more attractive particularly in relation to their role in acute medicine, chronic disease management and complex care.

At the service delivery level, there is scope for local advanced training rotation schemes to be put in place between metropolitan public and private hospitals and rural provincial training hospitals for acute and general rotations along with positions of appropriate duration and content in a variety of specific specialty advanced training positions. This will enable local general medicine advanced training programs to

flourish but it will require the support of sympathetic local administrators and engagement with supportive specific specialist units. This may necessitate the creation of separate funding streams or voucher systems for individual trainees to purchase their own training positions and programs.

As such generalist advanced programs mature and program directors learn from each others experience we will be better able to articulate our position to policy makers at various levels of government and at the health service management level. I anticipate that increasingly such programs will involve training specialists who have achieved dual recognition in a single organ specialty along with general medicine. This will enable us to achieve our goal of training the great general physicians for Australia, and the graduates from such a training program to successfully practice across a variety of settings from Byron Bay to Broome, from Hobart to Mt Isa, including as the need and interest dictate, expertise across a mixture of acute medicine, chronic disease management , complex geriatric care, transition care for adolescents, and consulting practice in obstetrics and peri-operative medicine. This is a very broad brush picture but I am confident that with clear articulation and attention to training program content, such programs will find favour with trainees and we will be successful in promoting the cause and interests of generalists on behalf of the community that we serve. These issues will be further explored at the RACP Annual Congress in May in Perth, where the congress title is Future Directions in Health.

On a personal note I note in passing that in Melbourne Sarah Whiting from the Alfred has successfully instituted a monthly inter-hospital clinical meeting for advanced trainees, which is establishing itself as a very worthwhile opportunity for case and research presentations, interchange of ideas and for trainees to get to know each other.

I look forward to seeing you in September at our Annual Scientific Meeting and AGM in Newcastle .

PROFESSOR DON CAMPBELL
IMSANZ Vice President and President Elect

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New Zealand Update

IMSANZ has been very active in New Zealand in the last six months, especially hosting three meetings within 12 months; the NZ Autumn 2012 meeting in Hamner Springs attended by about 90 members and supporters, the Australasian ASM in Queenstown last September attended by about 180 and the March 2013 NZ meeting at the Chateau Tongariro with over 100 attendees. Clearly General Medicine is well supported in NZ given the turnout for these meetings – see the reports on the Chateau meeting for more information. Interestingly increasing numbers of Australian and the occasional British & South African visiting physicians have also chosen to attend recent NZ meetings. While the talks were generally excellent there has also been much positive feedback regarding the social activities including the lunchtime walk – General Physicians obviously enjoy networking and a Trainee was overheard commenting that they didn't realise their seniors could have so much fun.

At the Chateau meeting we acknowledged the longstanding support of one of our most senior colleagues, Dr Neil de Zoysa. Many years ago Dr De Zoysa generously donated a significant sum of money to IMSANZ in recognition of his family's longstanding support for medical education both in their home country of Sri Lanka and also in New Zealand; hence the 'de Zoysa prize' awarded for the best presentation by a trainee at the NZ meeting of the society. This year Dr de Zoysa made a further generous donation to ensure that a meaningful prize will continue for future trainees. It was gratifying to involve him in presenting this year's prize to Dr Katie Thorne.

A couple of other NZ General Physicians need to be acknowledged for their achievements in ensuring recognition of the important leadership roles played by General Physicians and General Medicine in New Zealand. Firstly congratulations are in order to Dr Sisira Jayathissa from Hutt Hospital who last October became chair of the Pharmacology and Therapeutics Advisory Committee (PTAC), which is the most senior clinical advisory committee to PHARMAC. Congratulations are also in order for Phillippa Poole who earlier this year became Professor of Medicine at Auckland - New Zealand's largest tertiary service provider. Phillippa is a past president of IMSANZ and was the longest-standing IMSANZ Council member on record until her replacement as NZ large metropolitan centre representative by Robyn Toomath in 2012.

As I state in my President's report – trainees are our future and their numbers continue to grow with over 200 Advanced Trainees currently under supervision by the NZ Specialist Advisory Committee in General and Acute Care Medicine. About 70% are currently undergoing dual training with another specialty. I thank all members of the SAC ably led by David Spriggs, for their work in supporting our trainees. We have an NZ trainee rep (Laurie Wing) on IMSANZ Council and two new positions for 'younger' ie recently qualified NZ physicians have been created on our Council with successful appointments of Michelle Downie (now Invercargill) and Marion Leighton

(Wellington). The other NZ Council members are Robyn Toomath (Auckland) and Andrew Burns (Hawke's Bay). Please contact any of us if you have issues that you think IMSANZ should be addressing on your behalf. At this stage we have not chosen the venue for the 2014 NZ meeting but I encourage you all to attend the 2013 ASM in Newcastle.

DR JOHN GOMMANS FRACP
President, IMSANZ

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SAC Report

Advanced Trainee numbers continue to rise in both Australia and New Zealand, with 283 registered in Australia as of February 2013. Approximately 70% are dual trainees. Whilst we are aware that some trainees in larger metro centres experience difficulties accessing sub-specialty rotations, there are such rotations to be had at smaller metro and larger regional centres. A common misconception is that the subspecialty run has to be at a post accredited for subspecialty training with that particular SAC/STC – this is not the case, provided the site is accredited for training by the SAC in General and Acute Care Medicine.

The NSW Ministry of Health has recently funded 2 positions for dual training in General Medicine and Respiratory Medicine, as well as Endocrinology. The General Medicine components are based in Dubbo and Orange in Western NSW, with the Respiratory and Endocrine components still undergoing selection by the Ministry. The eventual aim of this program is to meet targeted workforce requirements at the rural sites, with trainees being given the opportunity to potentially return as consultants to Dubbo and Orange. The consultation process with the College, Ministry, and relevant SAC/STCs is ongoing. This process will build on successful dual training pathways, such as the Hunter program, which over 8 years has trained in excess of 14 physicians, all of whom have remained in the Hunter and New England Region, or other rural/regional centres.

The College is rolling out Supervisor Training Workshops, with the first workshop oversubscribed at the Queenstown meeting in October 2012. There'll be a second workshop to be held at the Annual Scientific Meeting to be held in Newcastle from September 13-15. All current and intending supervisors are encouraged to attend, but please remember to register your intentions during the ASM registration process as attendance is limited to 30.

PREP Advanced Training requirements are largely unchanged for 2013, with respect to LNA, mini-CEX, and CbD. One change however, is that in both Australia and New Zealand, trainees are required to submit 2 projects across the course of their training. Projects completed by dual trainees under another SAC/STC can now be considered towards General Medicine training, provided they meet the basic requirements of our SAC. This avoids unnecessary duplication throughout the course of training. The College Working Party on Assessments is due to report sometime later this year, with its' report eagerly awaited.

In Australia, Dr Nicole Hancock (Tas) will be stepping down from the SAC at our May meeting. I'd like to take this opportunity to thank Nicole for her invaluable work over the past 8 years, especially in her role as Lead in Site Accreditation, and wish her well in future endeavours. Nicole will be replaced by Dr Nicole Martin, a fellow Tasmanian.

In New Zealand Drs Brandon Wong (Whangerei) and Ann Roche (Christchurch) will

be stepping down this year. Nominations from IMSANZ are being approached. We are very keen to have a wide geographic and demographic distribution on the SAC as local knowledge and contacts are important to ensure we are effective. We have a total of 168 General trainees. These make up 73% of all advanced trainees with the College in New Zealand. It is important that supervisors ensure they fulfill their roles in a timely fashion as the timetable is pretty tight for the approval of runs etc. We acknowledge that there are continuing changes to the training requirements. All trainees should be aware of these and they are available on the website. As ever, our SAC Education Officers are available to answer queries.

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

DR DAVID SPRIGGS
Chair SAC General and Acute Care Medicine (New Zealand)

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Advanced Trainee Report

Many advanced trainees face an important decision at the onset of their advanced training; whether or not to dual train. In the majority of cases this involves training in General Medicine and a subspecialty. Australasia has a need for general physicians, though General Medicine is often viewed by subspecialists as a less glamorous career path. I suspect it is the diversity and complexity of Internal Medicine that draws most generalists to this role.

There are many challenges with dual training. It takes longer to qualify, requires splitting your training priorities, and is increasingly being discouraged by some subspecialties and consultants. Maintaining a focus around the general medical aspect of training can also be difficult, and it is a delicate balancing act. When doing subspecialty rotations the supervising consultants typically work in the subspecialty and not general medicine. A mentor is particularly important in maintaining that connection to general medicine. As a advanced trainee in general medicine, I have always tried to attended the national IMSANZ meeting. However, this March I was presenting at a Diabetes in Pregnancy Meeting and unable to attend. I found that I really missed the connection with the General Medicine community that occurs at the IMSANZ meeting.

Trainees also face the decision of whether or not to pursue research during the course of their training. Most trainees are actively encouraged to write up cases or projects for publication, which is a crucial aspect of training. In many subspecialties, a PhD is strongly encouraged and can help to secure a consultant position in that particular subspecialty. This can be a difficult decision for trainees as it delays the transition from registrar to consultant, and reduces the focus on General Medicine. On the other hand, the diversity of experience may help to build a better rounded physician.

As an advanced trainee it is important to structure training according to the one's individual needs, and constantly re-assess that these are being met. The General Medicine- Subspecialty "tug of war" that occurs with dual trainees is likely to be ongoing struggle.

LAURIE WING
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IMSANZ NZ Branch Meeting - Mt Ruapehu Reviews

Additional photos from the meeting can now be found on our website:
http://www.imsanz.org.au/otherevents/2013-imsanz-nz-branch-meeting-mt-ruapehu

Presentations from the meeting can be downloaded here:
http://www.imsanz.org.au/resources/2013-nz-meeting-mt-ruapehu

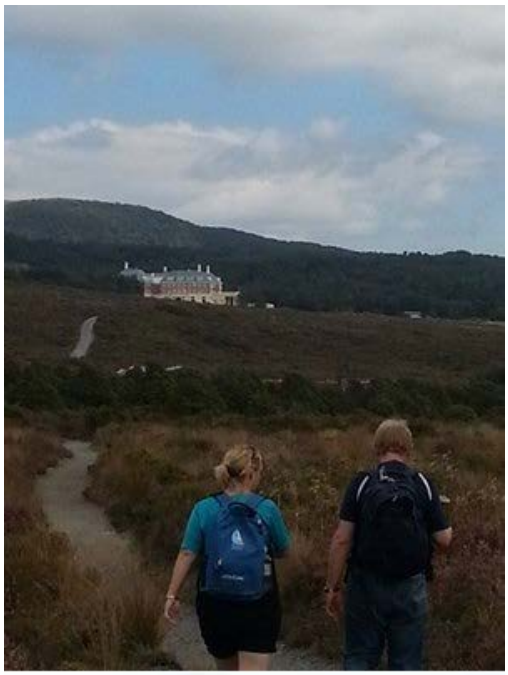
Report from Dr Pamela Hale

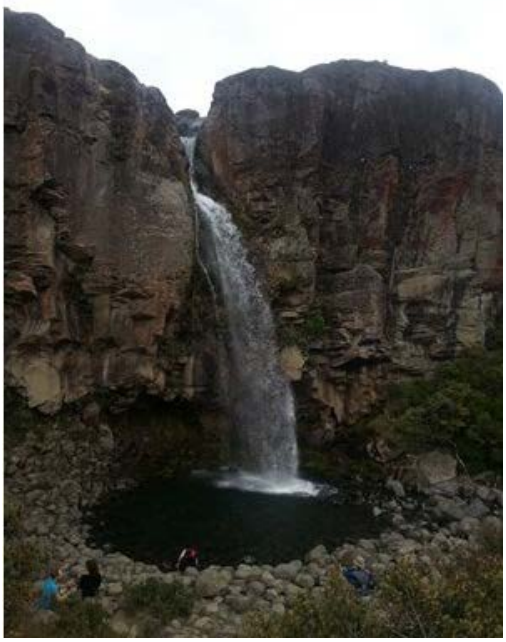
I was fortunate to attend the IMSANZ March meeting at the Chateau Tongariro with a very friendly bunch of general Physicians from all over NZ and a few Australians.

It started with the usual welcome dinner and drinks which is a great way to start off the networking process. This was taken to extremes at the dinner the following night with its theme of good keen Kiwi men and women. (and some people were actually wearing gumboots!) We were all forced to participate in the activities which sounds cheesy but I haven't laughed as much at a conference dinner for years. It's amazing how competitive physicians can be and what lengths they will go to when there are prizes for the winning tables.

The venue was outstanding with the beautiful 1930's chateau and views of Mt Ngauruhoe and even some volcanic activity witnessed on my way home. The highlight for me was the 2 hour walk to see the Taranaki falls at lunchtime. Oh yes, I know I'm supposed to say the academic programme was the highlight but it would take a lot to beat the scenery.

Anyway, the academic programme was good. I especially enjoyed the sessions on





Physician Burn Out and the sessions challenging dogmas that we believe but that aren't substantiated eg on the management of fever , and the 12 lies we tell our medical students (eg JVPs are easy). There was a lot of talk about different ways to do general medicine and this is good to take back home and think of ways to improve your local service.

There were also some very good updates on a number of topics that were very useful for me which I suppose is the main reason we attend. The other reason being that it was all jolly good fun and I returned to Nelson feeling somewhat refreshed and more able to meet the daily work challenges. I will be attending the next IMSANZ meeting if at all possible.
(photos provided by Pamela)

Pamela Hale

Report from Dr Christian Hulett

Coming from the United States, I am accustomed to huge, impersonal medical meetings, and thus my recent participation in the 2013 "Off the Beaten Track" New

Zealand IMSANZ meeting seemed a breath of fresh air.

The setting was the lovely Chateau Tongariro Hotel with all of the old world charms of facility of its grandeur.

Two days of presentations proved to be medically pertinent and timely, with topics ranging from the medical problems associated with poverty, to rheumatology for the non-rheumatologist, to the ever relevant discussion on the appropriateness of advanced care planning. The enthusiasm with which each of the presenters brought their topics to the conference proved infectious, and served as fuel for hours worth of subsequent conversation.

But perhaps what set this conference apart from so many conferences was the collegial, approachable manner in which the presenters and course attendees were able to interact. There was none of the snooty, professional one-up-man-ship that seems to be the hallmark of so many conferences this day and age.

I hope I am fortunate enough to be a regular attendee of future IMSANZ conferences.

Christian Hulett

Report from Dr Katie Thorne

'Back on the beaten track'

I had the pleasure of attending the recent IMSANZ 'Off the beaten track' conference in Tongariro. It really was a privilege to hear such insightful, enlightening talks and in such a picturesque setting.

A mihi and address welcomed everyone to the region and conference and opened proceedings. The morning session focussed on those 'wicked' complex problems, such as smoking cessation and lifestyle interventions with diabetes, that trouble us all. It was refreshing to look at these topics with new perspectives with practical tips valuable to generalists at every level. The rest of the day's talks followed in similar fashion, tackling the topics of fever, exercise medicine and 'medical updates' in rheumatology, obstetric medicine and diabetes. A break in the program over lunch allowed time for delegates to stretch our legs and explore the local tramps and stunning surrounds.

The conference program called for attendees to don iconic Kiwi attire and prepare themselves for a night of kiwiana at the conference dinner. It was a particularly surreal moment sitting in the beautiful Chateau dressed in my beige brigade jersey, shorts and jandals with my colleagues sporting their black singlets, stubbies and gumboots!

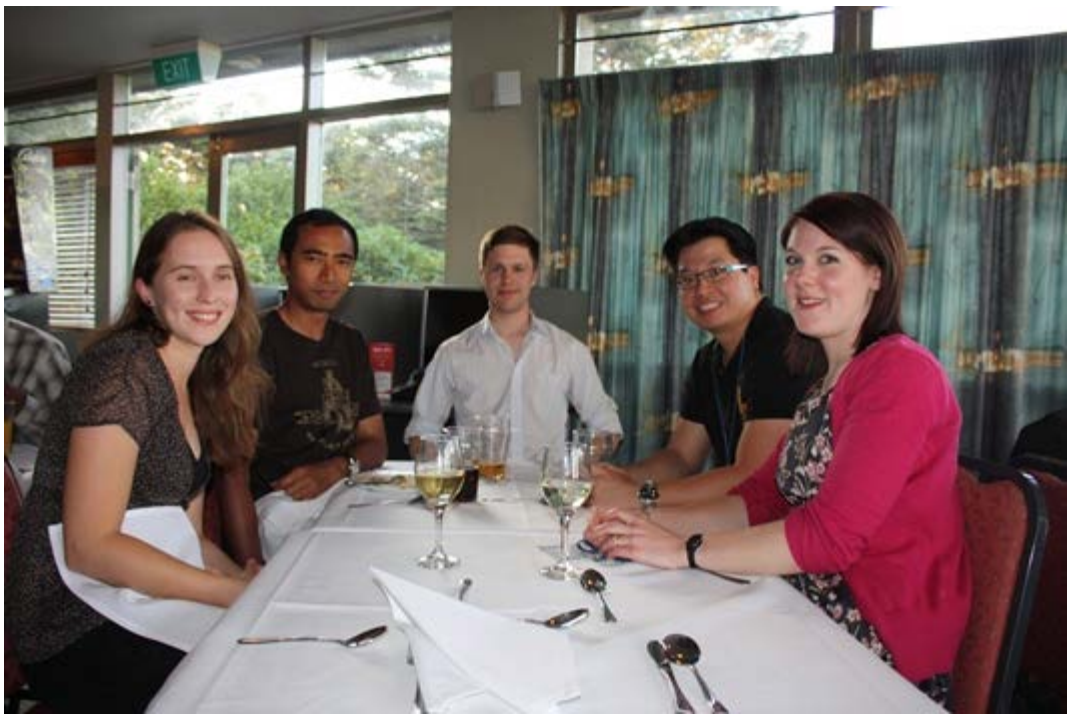
The following morning it was time for the trainee and member presentations. I was lucky enough to be able to present my paper looking at use of dabigatran in the Hutt Valley region of New Zealand. It always seems a little cruel making this the first thing after the night before, but in this instance it was helpful calming nerves a little by recalling a few things that made the audience less intimidating!

The afternoon was made up of another excellent set of topics, including fantastic talks on advanced care planning and palliative care as well as healthcare worker vaccinations, stroke service provision and tips on mentoring. One talk I particularly enjoyed broached the topic of 'physician burnout'. Personally having worked in a hospital service, in another country, where medics were seen as service providers and worked into exhaustion, it was heartening to hear a senior talk about the

important issue of looking after yourself as well as your patients. I was left with a warm fuzzy feeling knowing that I now work in a country and a service where physician well-being is promoted and supported.

Overall, a conference filled with heaps of educational wisdoms, good food and great company and all in a gorgeous setting that really celebrated the best of everything Kiwi.

Katie Thorne (IMSANZ De Zoysa Prize Winner)



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IMSANZ NEWSLETTER

AUTUMN 2013

IMSANZ 2012 Annual Scientific Meeting Review

Additional photos from the meeting can now be found on our website:
www.imsanz.org.au/otherevents/2012-imsanz-asm-queenstown

Presentations from the meeting can be downloaded here:
http://www.imsanz.org.au/resources/2012-imsanz-asm-queenstown

The 2012 Australasian scientific meeting was held in Queenstown in September. The theme of 'transitions' allowed for an excellent range of topics and speakers from both countries.

As our understanding and treatment of childhood genetic conditions improves, more young people need a general physician to look after their conditions once they grow out of the paediatric service. An excellent presentation on inborn errors of metabolism and also the diagnosis of late-onset forme-fruste diseases such as cystic fibrosis was a gem.

At the other end of the age spectrum we looked at polypharmacy and when to disengage medicine in favour of quality of life. The 'Less is More' series from the Archives of Internal Medicine was highly recommended and I have referred to this a number of times.

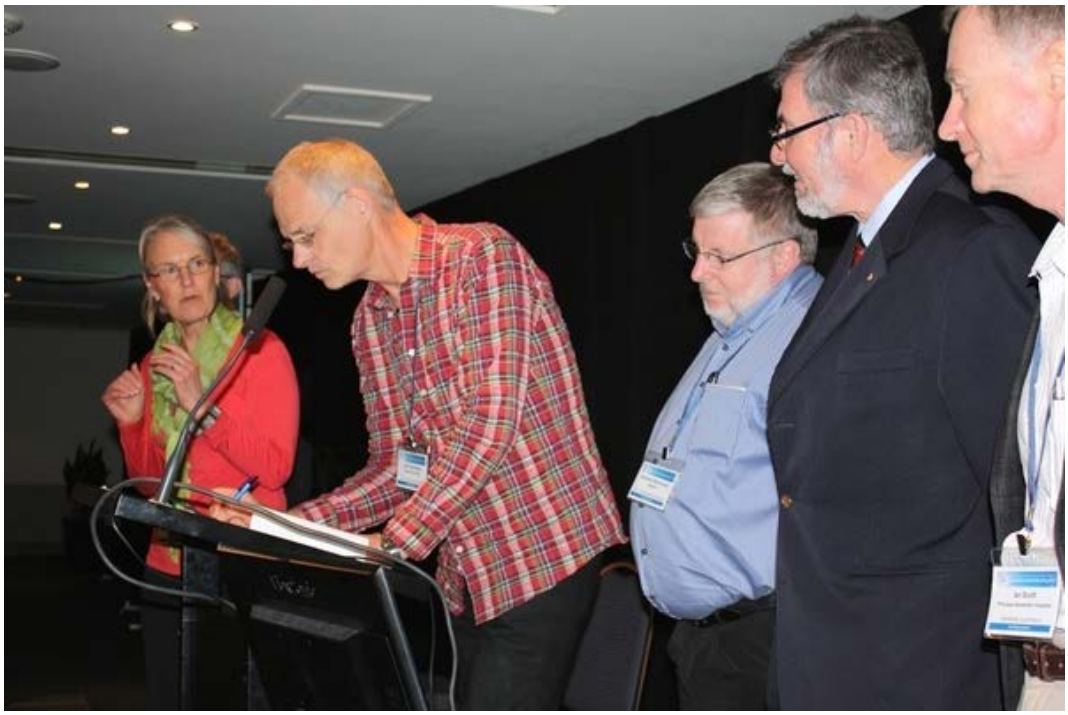
Some talks ranged from physicianly to professional including advice for patients who wish to fly, as well as what to do if our services are called upon mid-flight. Sleep and how to help people with severe insomnia who have tried all the usual sleep hygiene protocols was very useful and I have already referred a few patients to Tony Fernando's website – www.insomniaspecialist.co.nz and the associated Auckland University CALM webpages.

Such high quality talks throughout the conference from trainees to very senior colleagues meant the whole event lived up to the usual high standard of IMSANZ meetings.

Of course general physicians also know how to have the most fun with the conference dinner held at the Skyline restaurant after a beautiful gondola ride up the mountain.

As usual I thank the organising committee for all their hard work – it certainly paid off.

DR MARION LEIGHTON
IMSANZ Council, Recently Qualified Physician Representative (NZ)



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Tri-College Conjoint Medical Education Seminar Report


Q&A time

I recently attended this meeting, along with Dr John Gommans and Prof Don Campbell, representing IMSANZ and the SAC in General and Acute Care Medicine, and about 200 others. This was the 2nd such meeting of three medical specialty colleges, namely RACP, RACS (yes, that's right, surgeons!), along with the Royal College of Physicians and Surgeons of Canada. The first, held last year in Melbourne dealt with the issue of Professionalism. On this occasion the theme of the meeting was 'Serving the Community: Training Generalists and Extending Specialists' (photo supplied by the RACP).

In the true spirit of cooperation, the meeting was opened by A/Prof Les Bolitho (RACP), and closed by A/Prof Michael Hollands (RACS). In addition to the Colleges, other organisations represented included Health Workforce Australia, the Medical Board of Australia, NSW Ministry of Health, the Australian and New Zealand College of Anaesthetists, and the Australian College of Rural and Remote Medicine.

Initial speakers addressed the topic 'What is a Generalist?' These included A/Prof Phil Carson, a General Surgeon from Darwin who shared a truly inspirational model of cooperative generalism with very supportive sub-specialty surgeons in Royal Darwin Hospital, showing how a supportive approach in resource-strapped centres results in quality patient-centred care. This was very much a theme repeated by other surgeons through the day, who described the processes needed to drive patient-driven as opposed to doctor-driven care – to the point that they were quite choosey about who they recruited. Non-team players definitely were not welcome in their arenas! One fantastic quote, from Mr Andrew Connolly, a General and Colorectal surgeon at Counties Manukau DHB in Auckland, pointed to the fact that 'culture eats strategy for lunch'. He outlined a failed on-call roster that was subspecialty-based and unsustainable. In contrast, a General Surgical on-call roster with most subspecialties participating resulted in a sustainable and affordable roster – analysis of their after-hours surgical work showed that only 2% of after-hours presentations were truly subspecialty and not able to be handled by a competent General Surgeon. He reminded us that surgeons were 'frequently wrong but never in doubt' and nicely illustrated that if the culture of a unit or hospital was 'toxic' then dysfunctionality is hard to displace.

Dr Ruth Kearon from HWA spoke regarding maldistribution of our workforce and steps being taken at a Commonwealth level to address the needs long-term. Mrs Anne Kolbe (former President RACS, NZ-based paediatric plastic surgeon) showed frightening figures relating to the projected growth of medical costs as a proportion of GDP in the 3 countries – her challenge was that as a profession, if we don't address this then solutions will be imposed by the payers.

Initially, I had wondered why the three Colleges from Australia, New Zealand, and Canada had come together – it quickly dawned during an elegant presentation from Dr Jason Frank, an ED physician from Ottawa, currently Director of Specialty Education, Policy, and Standards at RCPSC, that there are many similarities between our countries. Perhaps more so between Australia and Canada, with similar population size in large countries, with very uneven population distribution as well as disadvantaged indigenous populations. His Canadian colleague Dr Bryce Taylor, another surgeon, reminded us of the paradox that doctors were 'strong proponents of progress and totally opposed to change' and defined a Canadian as 'a disarmed American with healthcare'.

Dr Marie-Louise Stokes (Director of Education, RACP) presented data relating to the number of trainees currently enrolled in General Medicine in Australia and New Zealand. She pointed to the lag in the numbers of graduating fellows, although that number has shown signs of a significant upward kick in the last 2 years.

Finally speakers in a panel discussion including Dr John Gommans (President IMSANZ), Prof Linda Snell from McGill University (a Canadian physician), a General Surgeon and a Rural Hospital Medicine Specialist presented thoughts which stimulated discussion around what needs to change to bring about continued success in addressing the 'Generalist' agenda. All panelists were asked to focus on 2-3 key issues from their perspective and coincidentally both physicians mentioned the need for rewarding careers for Generalists with the same three 'R's: Remuneration, Recognition and Respect. The second IMSANZ point was on the needs of general trainees including access to specialty training posts.

Finally, a wrap-up from Prof Richard Smallwood, outgoing Chair of the Medical Board of Australia, together with the presence of many from HWA and State Health Departments, leads me to be confident that the 'Generalist' agenda is well and truly on the front page. I left the meeting feeling that the future for generalist training is indeed brighter.

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

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IMSANZ De Zoysa NZ Trainee Prize

We are very grateful for the contribution of Dr Neil De Zoysa and his family over the years to IMSANZ.

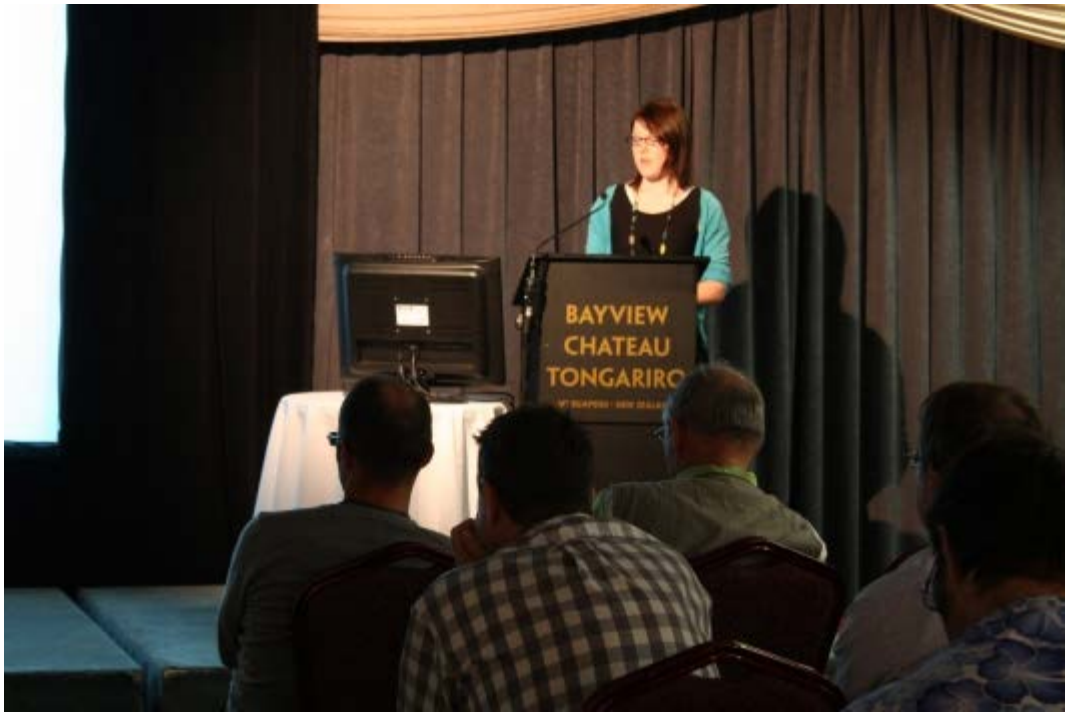
In 2005, Dr De Zoysa's donation was accompanied by a letter, stating "My kinsmen and relatives donated the land for the Ceylon medical college in the 1830s and in 1967 the house and premises for the Sri Lankan Medical Association and Library and Sri Lanka College of Physicians. I'd like to continue the tradition of donation."

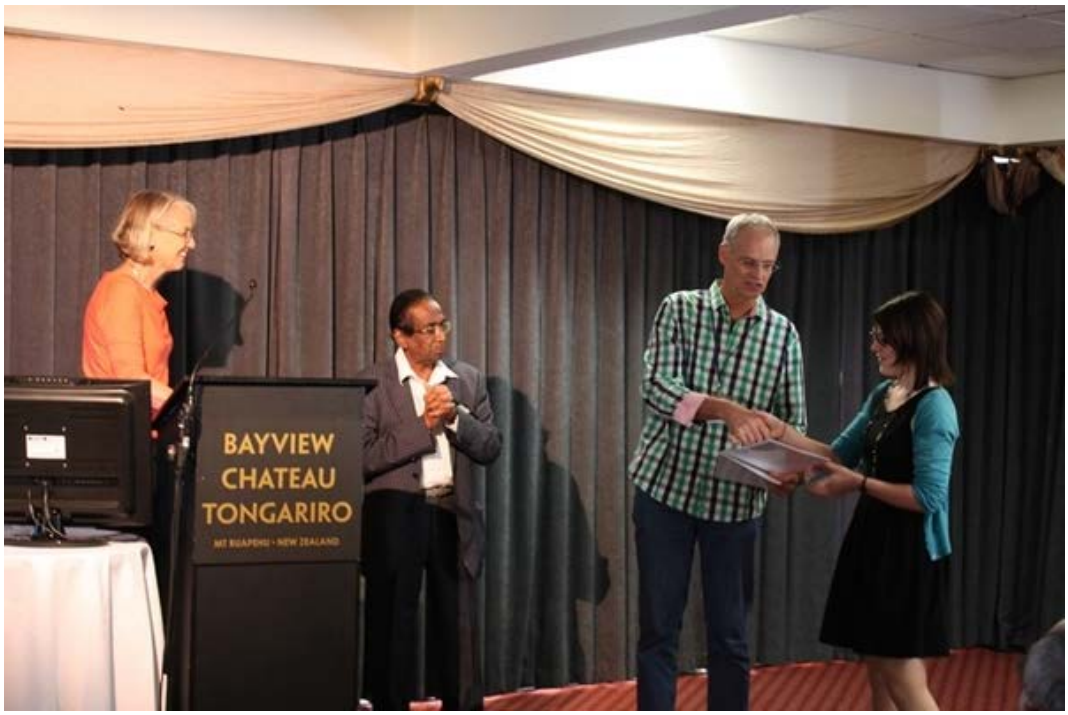
The contribution of physicians and trainee physicians in research is invaluable for the future of medicine.

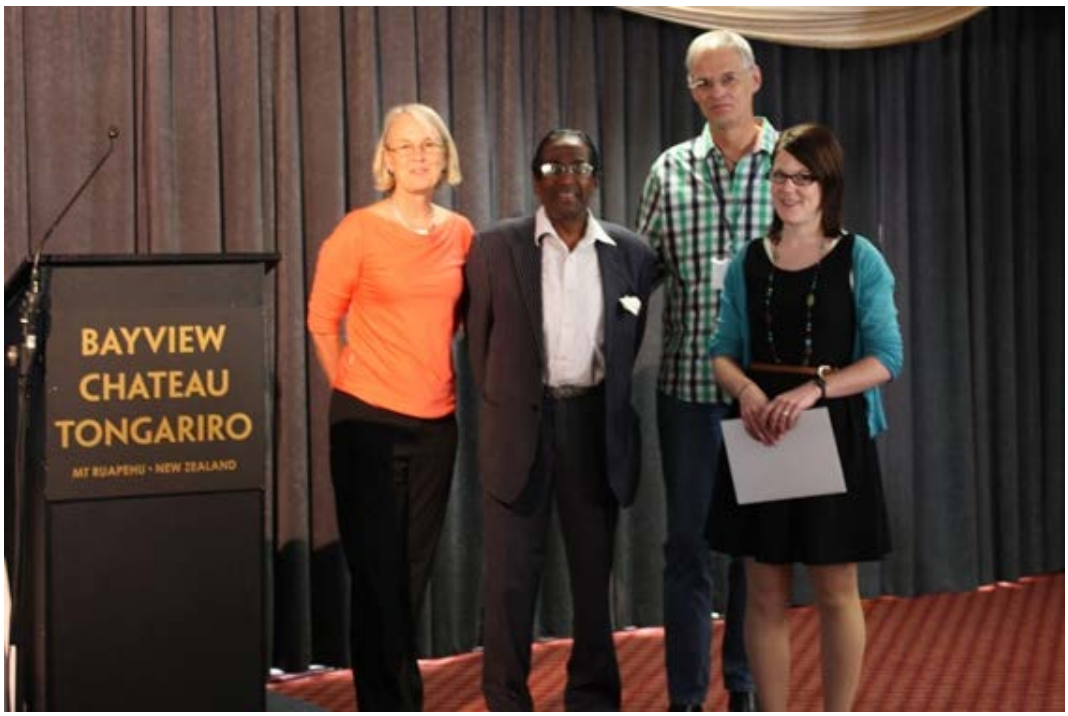
The standard of presentations for the Award in March was very high and we would like to congratulate our winner, Dr Katie Thorne for her presentation "Adherence and Outcomes of Patients Prescribed Dabigatran (Pradaxa) a Direct Thrombin Inhibitor".

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.

Photos below of Dr Katie Thorne (winner), Dr John Gommans (IMSANZ President), Prof Phillippa Poole (IMSANZ Past President) and Dr Neil De Zoysa.







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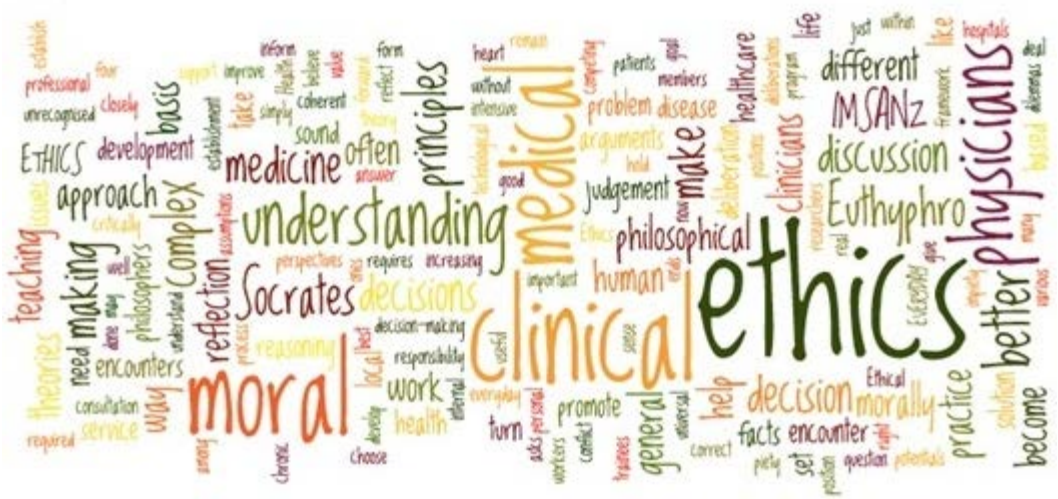


IMSANZ Travel Scholarship Winner

Ethics in the clinical encounter

Medicine has been a stunning beneficiary of the rapid technological and economic development of the last century. While rapidly advancing technology presents physicians with unparalleled capacity to intervene in the course of illness, the precise goals of such intervention remain less clear. Hans Jonas observes that in a technically sophisticated society ends and means become reversed, “specialisation and new techniques thus proliferate almost independently of costs and needs, and particularly without conscious reflection on which of the ends of medicine should take precedence” (1). In other words, what can be done is often confused with what should be done.

As physicians in internal medicine, we are at the forefront of these deliberations. This reflects our uniquely global approach to the diagnosis and management of chronic and complex multi-system disease. We are often called upon to manage the conflicting demands of technological possibility and resource utilisation, along with the values of patients and their families and carers, as well as with the law. With the increasing prevalence of chronic and degenerative disease, pressures on scarce resources and increasing community expectations, there is much greater complexity in the ethical dimensions of clinical decision-making. Therefore as physicians we have a great responsibility to engage in ethical deliberation to weigh often-competing ethical priorities.

I believe that such engagement requires more discussion and more teaching of the basis for ethical deliberations within our own discipline. Many clinicians now turn to general physicians for guidance, but where do general physicians turn for help? And how do we general physicians increase our understanding of the basis for our decisions and recommendations?

The principles approach…

A quick survey of medical staff on the wards of most hospitals about the basis for their ethical decision-making will likely settle upon the four principles of medical ethics published by Beauchamp and Childress in Principles of Biomedical Ethics (2). These four principles – respect for autonomy, beneficence, non-maleficence and justice – attempt to make sense of so many competing ethical theories and provide clinicians with a simple, accessible and culturally neutral framework for ethical reflection. By moving beyond the ideological purity of different philosophical streams and settling on a small number of universally accepted moral commitments, the principles based approach offers clinicians practical tools for incorporating ethical reflection into their daily practice. The universal acceptability of the principles also overcomes the problem of moral relativism: the idea that in plural societies we all have such different ethical, religious, philosophical, political, cultural and personal perspectives, that we couldn't possibly agree on any moral commitments. Regardless of our own personal perspective, we can plainly agree that these four principles express important and common moral concerns relevant to clinical practice. However, as these are prima facie commitments - that is the four principles apply morally unless they conflict with one another – an unresolved limitation of this approach is the lack of guidance when the principles are in conflict. Frustratingly, this is too often the case in the most complex of ethical problems.

A philosophical approach…

To better prepare us as physicians for the complexity of moral decision-making, I argue a more sound understanding of the moral philosophy that informs our medical ethics is required. Ethical problems in clinical medicine will rarely have an obvious, neat and single solution, but we clinicians need to find a morally acceptable way to proceed in dealing with these problems. In reaching a moral judgement, some arguments are simply more coherent, and hold more closely to the facts. We must therefore work through a process of moral reasoning: that is trying to understand a position in the light of other positions, the assumptions, beliefs, attitudes and emotions underlying such positions and settle on a rational argument that supports the most morally sound solution. We need not all become philosophers or ethicists, but we each have a responsibility to critically evaluate the assumptions and arguments underlying our moral decision-making in medicine. A more sophisticated understanding of the process of moral reasoning can help us clinicians individually and collectively make our decisions better.

The Euthyphro dilemma and moral reasoning

A philosophical approach to ethical decision-making is fundamentally a critical one, lying squarely in the Socratic tradition to examine the true basis of things. Its purpose, at its core, is to make this kind of decision making more intellectually rigorous. We as physicians should therefore practice the process of moral reasoning just as we do other clinical skills. A great template for this process of reasoning can be found in the Socratic dialogues such as this one, where through an interrogation Socrates has Euthyphro explain his understanding of a universal moral code, which becomes increasingly unstuck (for those interested, the translated text can be found here http://classics.mit.edu/Plato/euthyfro.html).

Socrates meets Euthyphro outside the court of Athens; Socrates accused by the state of impiety, and Euthyphro an accuser of his own father of impiety. Euthyphro professes to be an expert in piety, and Socrates asks for his wise counsel so it might help him in his trial. During the dialogue that ensues, Socrates asks Euthyphro to establish a universal definition of piety. Euthyphro enters into various circular

arguments before becoming frustrated and leaving Socrates unsatisfied, and without an ultimate explanation (3).

Ultimately there is likely no single right thing to do, so we must exercise our moral imagination to envision various possibilities for action in each clinical context and participate in dialogues with others find a morally acceptable way to proceed. This process of rigorously interrogating a claim, of examining its underlying values and assumptions, is the next step in ethical decision making beyond a basic understanding of the four principles. It holds the possibility of a more sophisticated ethical practice.

What next?

I have had the privilege of receiving the IMSANZ Travelling Scholarship in 2012, to improve my understanding of the major philosophical streams that inform medical ethics, and to critically reflect on exactly how best to develop the understanding and wisdom which is so critical to problem solving in complex ethical and clinical encounters.

I would now like to promote a conversation among members of IMSANZ about the way forward in the teaching and practice of medical ethics in our College, our Society and our local hospitals and clinics. I propose that we set to work on the following tasks, and I would like to hear from you if you have had success with any of these initiatives, or if you would like to become involved in their development.

1. The establishment of local multidisciplinary discussion groups, akin to journal clubs, going through the process of moral reasoning in complex ethical encounters. This could take the form of imaginative moral reasoning, using real clinical cases to identify problems and interrogate issues from various perspectives.

2. To develop curricula to equip general medicine trainees with the skills required to better understand the philosophical basis for ethical decision-making. This could take the form of analysing relevant competing theories of medical ethics, the process of moral reasoning, as well as the value and scope of the principles based approach.

3. Consideration of a clinical ethics consultation service at your local hospital aiming to optimally inform ward-based decision-making about complex ethical decisions. A similar ethics consultation service was successfully implemented and evaluated in the USA, where the researchers report the service complemented the ethics committee and was a useful support for physicians, patients and families (4). Often a “coalface” discussion about clinical ethical dilemmas when and where they arise, with an appropriately skilled facilitator such as a clinical ethicist, is an excellent way to promote better understanding of ethical issues within clinical encounters.

4. The establishment of an annual intensive professional development program open to medical and nursing professionals, health administrators, researchers and members of ethics committees aimed primarily at improving the teaching and practice of clinical ethics. The format would be interactive, with seminars followed by small and large group discussions facilitated by clinicians, ethicists and philosophers. Such a program could offer rich opportunities to explore difficult concepts and to collaborate with and learn from the experience of other clinicians and those from different professional backgrounds.

I appreciate the support of IMSANZ on this journey to promote the discussion and reflection on clinical ethics among trainees and physicians in internal medicine.I look forward to hearing from you at lloyd.nash@mh.org.au.

Dr Lloyd Nash

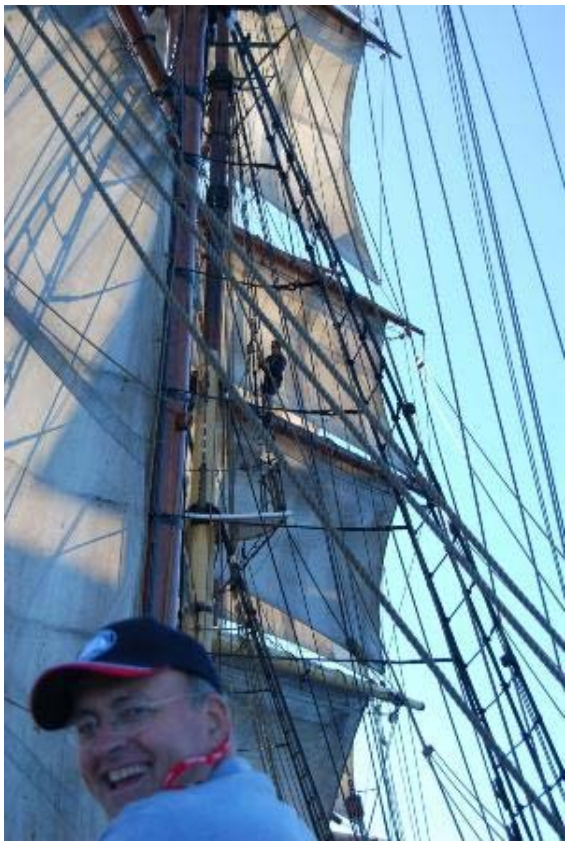
1. Freund PA. Experimentation with human subjects. New York,: G. Braziller; 1970. xviii, 470 p.
2. Beauchamp TL, Childress JF. Principles of biomedical ethics. 7th ed. New York: Oxford University Press; 2013. xvi, 459 p.
3. Plato, Jowett B. Euthyphro [human-read Audio Book]: Project Gutenberg; 2006. Available from: http://www.gutenberg.org/ebooks/19840 .
4. Tapper EB, Vercler CJ, Cruze D, Sexson W. Ethics consultation at a large urban public teaching hospital. Mayo Clin Proc.85(5):433-8. Epub 2010/05/04.

DR LLOYD NASH
IMSANZ Travel Scholarship Winner, 2012

IMSANZ NEWSLETTER

AUTUMN 2013

General Interest - James Craig



Earlier this year a friend of mine rang me up. “You like an adventure”, he said. “What about going on the James Craig, from Hobart to Sydney as ship’s doctor?” In case you didn’t know and were afraid to ask, the James Craig is a 3 masted 200 foot square rigger that started life as the Clan Macleod, launched out of Sutherland in 1874. She sailed 24 times round the Horn before being reborn as the James Craig sailing out of Auckland. As the James Craig she would have met an inglorious end as a sunken coal hulk on the Derwent shore south of Hobart but for some keen souls who refloated her and towed her to Sydney where she was lovingly restored (at considerable cost!). The James Craig is now the pride of the Sydney Heritage Fleet, moored at Pyrmont wharf next to the National Maritime Museum.

I stepped onto the ship at anchor at Princes Wharf in Hobart. “Oh boy”, I thought to myself. Once we were underway it became clear that despite being classed as an Officer and therefore not having to do watches it would be a very good idea to muck in with my watch and do what everyone else did. So watch member number 6 put on his dogtag and joined the Forewatch and did what sailors do (okay so I missed one watch from midnight to 4AM and two watches from 4 to 8, not bad in 8 days at sea). This was a good decision as I got to know some wonderful people and we formed a team.

What do sailors do? They overcome sea sickness, get their sea legs and pull on ropes when told to do so, mop out the heads when they are “Peggie” for the watch, and they steer when asked to try steering and they coil ropes (endlessly) to keep them tidy and prevent them from wearing out. “Did you go up the rigging?” Yes. “What do you do when you aren’t on a watch?” “Eat and sleep, not necessarily in that order”. “Did you go over the tops?” No. “Is it fun to steer the ship? “Yes, but it is incredibly hard work concentrating, and you have to tell the master what course you are steering not what course is set, if he asks you. The ships master had a strong presence, which I discovered, came from his former occupation as a submarine commander.

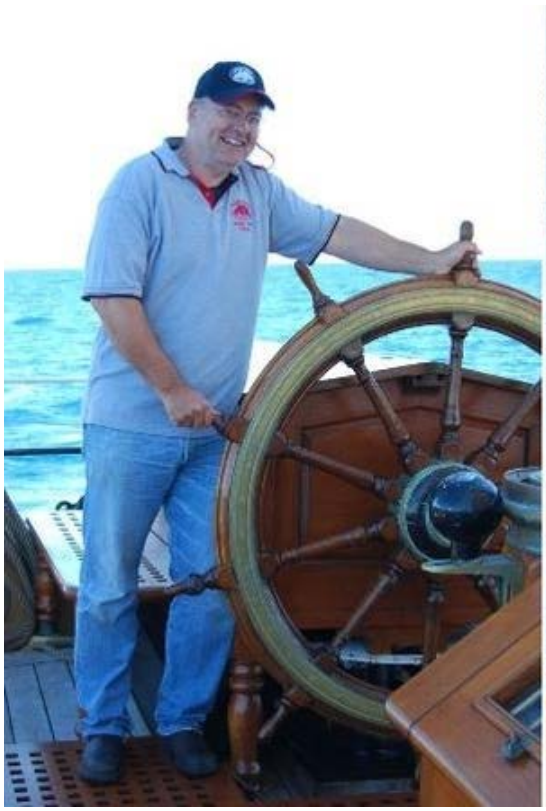
“Did you have to do any doctoring?” Yes. Thankfully nothing major and there was a truly wonderful Tasmanian nurse on board from a country town who can I am sure do anything, but is modest and deferred to the doctor, politely telling him, “You are in charge you know”. To which the doctor replied, “If you tell me what to do I will tell them to do it, and ensure you get the credit”. Thus a good deal was struck and the crew were well cared for.

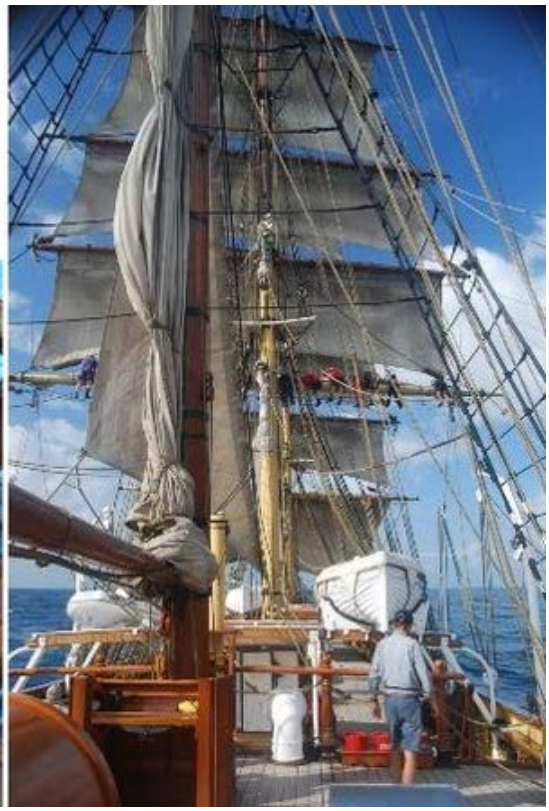
Lasting memories? Seeing a 15th Century Portuguese Caravelle in Hobart (it was built in Geelong), and coming through the Sydney Heads at 1AM. My main memory will be of the crew-members, who made me remember what a wonderful country this is because of its people.

For those who may want to find out more about the James Craig can I suggest you Google it and look at the Sydney Heritage Fleet. The story is fascinating and well worth a look. The ship is truly beautiful and likely to be in Melbourne for the Australian Navy centenary celebrations in September.

Don Campbell

PROFESSOR DON CAMPBELL
IMSANZ Vice President and President Elect





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