# IMSANZ NEWSLETTER

## SPRING 2013

## IMSANZ Council

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**Vice President**
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Rob Pickles, NSW

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**ADVANCED TRAINEE REPRESENTATIVES**

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## President's Report

Dr John Gommans
IMSANZ President

Each winter sees General Physicians busy coping with a surge in acute demand. Winter is usually predictable – it arrives every year without fail although the accompanying influenza outbreak may be somewhat variable in its severity. Equally predictable is that this surge of seasonal illnesses impacts disproportionately on General Medical Services.
Read the full article...

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### Information Sheet: Conversion to a Company Limited by Guarantee and Adoption of a Constitution

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The proposals will be discussed and voted on at the annual general meeting on 13th September 2013. Approval of the proposals is subject to a special resolution of the members in favour of the proposal. The following information is for members to provide some background as to why these changes are being proposed and what impact they will have on how IMSANZ operates.
Read the full article...

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)
Andrew Burns (NZ)

## 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 have joined ahead of our Annual Scientific Meeting in Newcastle.

Click to view list of new members

## Meetings and Events

Please click here to view the full list of meetings and events

*IMSANZ 2013 Annual Scientific Meeting*
*Newcastle*
*Australia*
*13-15 September 2013*


## Editorial

A/Prof Sergio Diez Alvarez
Newsletter Editor

Many will be aware of the recent damning Francis report following the Mid Staffordshire failures in the delivery of safe high quality care. This breach in basic health care delivery needs to be internalised by all stakeholders, clinicians and administrators alike.
Read the full article...

## Australian Update

Prof Don Campbell
IMSANZ Vice President & President Elect

Wanted: New General Physicians
Apply now to avoid disappointment
Warning: New skills needed

"Having outlived, their usefulness, general physicians have outlived their uselessness", comforting words from Gad Trevaks, Victoria's First Health Commissioner, and a source of wise epithets. We witness with great satisfaction the renaissance of the generalist in hospital and community settings, but a confident assertion, the new generalist wont look like the old.
Read the full article...

## New Zealand Update

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Kiwi Presidents of IMSANZ serve a dual role as both the Australasian Leader of the society and as spokesperson for NZ issues. Of necessity the Australian Vice President (VP) carries a higher workload attending to their local issues..
Read the full article...

## SAC Report - Aus

Dr Rob Pickles
Chairs, SAC Aus

The SAC in General and Acute Care Medicine met face-to-face in Sydney in May, and again by teleconference in August. There are now over 300 trainees on our books, about 80% of whom are dual training.
Read the full article...

IMSANZ NZ Autumn Meeting
Bay of Islands
New Zealand
5-7 March 2014


*RACP Congress 2014*
*Auckland*
*New Zealand*
*18-21 May 2014*

## Career Opportunities

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

Click here to view the current vacancies



## SAC Report - NZ

Dr Andrew Burns
SAC NZ - IMSANZ Representative

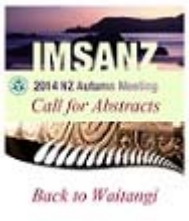
The SAC for General Medicine NZ met on 2nd August for the first of 2 meetings held each year, and was shifted at short notice from Wellington to Auckland due to concern surrounding recent Wellington earthquake activity.
Read More...

## Hutt 2013 Acute Medicine Conference

Dr Marion Leighton
IMSANZ Council

Hutt Hospital hosted their annual Acute Medicine Conference on 8-9 August and it was up to it's usual high standard.
Read the full article...

## 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 Autumn Meeting 2014.

**Deadline Date for Abstracts**: 5.00pm, 29th November 2013

http://www.imsanzconference.co.nz/page/abstracts

## Article - Fat City

Dr Karen Hitchcock
IMSANZ Council

The following article was originally published in The Monthly, March 2013.

### Fat City: What can stop Obesity?

Why obesity is not your doctor's problem.
Read the full article...

## Awards and Scholarships


Congratulations to our 2013 travel grant winners!

## IMSANZ Pacific Associate Member Travel Grant

Dr Martin Daimen from Papua New Guinea, will be attending the IMSANZ 2013 Annual Scientific Meeting in Newcastle. We look forward to hearing his report in the next Newsletter.

## IMSANZ Travelling Scholarship

Dr Herath Gunathilake, a trainee from NSW, will be travelling to Prague to attend the European Congress of Internal Medicine (ECIM) in October. We wish him well and look forward to reading his report.

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## President's Report

Each winter sees General Physicians busy coping with a surge in acute demand. Winter is usually predictable – it arrives every year without fail although the accompanying influenza outbreak may be somewhat variable in its severity. Equally predictable is that this surge of seasonal illnesses impacts disproportionately on General Medical Services. It is our patients with their multi-morbidity and/or age related frailty that are most easily tipped over the edge into non-coping and functional decline by their acute illnesses. Despite this many hospitals seem relatively unprepared when the surge of seasonal illnesses hit. Staffing is largely the same year round, elective surgical admissions and routine clinics continue despite the increased acute workloads, hospital budgets leave little or no reserve in capacity, and occupancy rates remain high despite evidence regarding inefficiency when bed occupancy exceeds 85%. Even if funds were made available where do you find spare capacity such as additional hospital or aged residential care beds, or staff? Many important questions are difficult to answer; will further investment in primary care really reduce ED presentations, and if so where would that money come from? What is the "right number" of acute admissions for a medical team to manage? What should the ideal multi-disciplinary medical team look like? Will reducing my length of stay with earlier discharges just increase pressure on my clinics or my readmission rate? What is the humble General Physician to do when their clinical leaders and service managers struggle with these same dilemmas? Thankfully, at least in New Zealand, this winter appears to be milder than usual and the influenza season has not yet arrived. However, relying on luck is not usually a recommended coping strategy.

A better strategy is sharing our collective experiences preferably supported by an adequate evidence base. Where better to achieve this and also celebrate the arrival of spring than at our own Annual Scientific Meeting in Newcastle NSW from 13-15 September. This is appropriately themed as "The Practical Physician" and I congratulate Rob Pickles and the NSW based organizing team on the great programme they have put together. It looks like more than 200 will be attending!

At the Newcastle meeting we will hold our Society's AGM, the first in 18 months since we shifted the timing of our AGM from the May RACP Congress to our September ASM. This provides an opportunity for members to feedback to Council regarding any issues that concern them and suggestions for future developments. There are also some important amendments required in our Constitution arising from changes in NSW law (where we are registered) and an opportunity to update some of our membership criteria.

My mantra has always been that our trainees are our future, hence moves in recent years to enhance the influence of our younger colleagues on Council i.e. both trainees and recently qualified physicians within 5-7 years of gaining their fellowship. With over 500 advanced trainees under the SAC in General and Acute Care Medicine across Australia and NZ our future looks bright. This combined with the renaissance of Generalism in both countries ensures that our influence in the College cannot be underestimated.

DR JOHN GOMMANS FRACP
IMSANZ President

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The proposals will be discussed and voted on at the annual general meeting on 13th September 2013. Approval of the proposals is subject to a special resolution of the members in favour of the proposal. The following information is for members to provide some background as to why these changes are being proposed and what impact they will have on how IMSANZ operates.

**********

Where a member has any questions regarding this change they are encouraged to contact the IMSANZ Executive Officer via email at: imsanz@racp.edu.au

## Why is IMSANZ making the change?

In 2012, as part of regular review processes, the IMSANZ Council began a review of all governance policies, procedures and processes that impact on the way the association operates.

At the 2012 Annual General meeting, various changes to the Rules of the Society were put to members and approved by members. The most important of these changes relating to the change in financial years and ensuring the AGM was held in conjunction with our annual scientific meeting.

As part of the review, discussions were had surrounding the most appropriate structure of the association. Following these, it was indicated to members at the 2012 Annual General Meeting that IMSANZ would seek to make the change to a Company Limited by Guarantee at the 2013 AGM.

We have recently engaged EBL Legal to review the Rules of the Society in light of this proposed change and to assist IMSANZ in making this transition.

IMSANZ was originally established as an incorporated association under New South Wales law. This sets a range of expectations around how we conduct our business. In particular without the association becoming a Registered Australian body, it can limit our ability to operate nationally.

To ensure that IMSANZ can operate as a truly national association that has a clear structure, it was decided to explore options for reforming the organisation under Commonwealth law. The IMSANZ Council decided that it was most advantageous to reform as a company limited by guarantee, registered with ASIC and governed by the requirements of the Commonwealth Corporations Act.

## What are the key differences between an Incorporated Association and a Company Limited by Guarantee?

| | Incorporated Association (NSW) | Company Limited by Guarantee |
|---|---|---|
| Description | • A body corporate incorporated under the Associations Incorporation Act 2009 (NSW).<br>• Required to have the word "Incorporated" or "Inc" after its name. | • A body corporate incorporated under the Corporations Act 2001 (Cth).<br>• Required to have the word "Limited" or "Ltd" after its name. |
| Limited Liability | • The liability of members is limited, usually to membership and subscription fees. | • The liability of members is limited to the amount that they have agreed to contribute on the dissolution or winding up of the Company i.e., |

| | | |
|---|---|---|
| | | the guarantee amount. In this case, $20.00. |
| Areas of Operation | • Can only operate in NSW, unless it also incorporates in other states and territories of operation, or becomes a Registered Australian body. | • Can operate anywhere in Australia. |
| Regulatory Body | • Office of Fair Trading (NSW), and the relevant state regulator where it otherwise operates | • ASIC |
| Governing Officers | • Management Committee of at least 2 members.<br>• No requirement for a secretary.<br>• Must have a Public Officer. | • At least 3 directors, 2 of which must ordinarily reside in Australia.<br>• Must have at least 1 secretary, who must ordinarily reside in Australia.<br>• Must have a Public Officer. |
| Meeting of Members | • Rights of Members to vote and call meetings is decided by the group and written into the Rules<br>• A small percentage of Members may call a members meeting (usually around 5%).<br>• An AGM must be held annually, within 5-months of the end of the Company's financial year. | • The first AGM of a company registered through conversion, must be held within the calendar year of its registration. |
| Governing Law | • Associations Incorporation Act 2009 (NSW), and, if it is a Registered Australian body, the Corporations Act 2001 or if incorporated in other jurisdictions, the incorporated associations legislation of those jurisdictions. | • The Corporations Act 2001 |

## What are the key differences between the rules and the proposed constitution?

There are a range of differences between the current rules and the proposed constitution. Members are encouraged to read both documents and seek clarification on any particular issue.

Much of the intent of the current rules remains intact in the proposed Constitution, although generally with the meaning more clearly stated.

The following highlights some of the more significant differences that members' attention should be drawn to.

## Overview

Currently IMSANZ is registered as an incorporated association under New South Wales law. Because IMSANZ operates outside of New South Wales it is required to also be registered under the Corporations Act as an Australian Body.

The regulations pertaining to an incorporated association are primarily designed for small local entities. The proposed constitution will reform IMSANZ as a company limited by guarantee, governed by the provisions of the Commonwealth Corporations Act and supervised by ASIC.

Being a company registered under this legislation will impose clearer and greater governance obligations, and clarity around member rights and director duties.

## Changes to Governance

IMSANZ is currently governed by its Council generally, and more specifically but the executive committee of the Council. A Board of Directors, however, govern a company and the Corporations Act imposes strict obligations on those directors, both in terms of their duties and how those duties are to be carried out.

To ease the transition from association to company, and to better allow the functions of the Board to be carried out, the initial Board shall be made up of the members of the current executive committee of the Council. This should additionally allow an efficient transfer of organisational knowledge to the Board, and ensure Council members that are focused on activities other than governance and administration can continue to carry out those activities efficiently.

The term of office for a Director will be 2-years. Consecutive terms would usually not exceed six (6) years and the total term of office shall not exceed ten (10) years

Subject to the changes described below, the Council shall substantially retain its existing representative structure and mode of operation. It will additionally act as an advisory body to the Board.

## Changes to the IMSANZ Council

To further enhance the influence of our younger colleagues on Council and help us develop our future leaders we have in the last year, following a request for expressions of interest co-opted four recently qualified physicians (two each from Australia & NZ) to serve on Council alongside our two trainee representatives. Making these positions permanent is one of the changes to our constitution that we are asking you to approve.

## Clearer definitions for the IMSANZ Executive

The current rotation of the presidency from Australia to New Zealand ensures adequate representation across the Tasman. In line with the current rules, the new constitution will clarify that where there is no New Zealand President or immediate Past-President, Council shall also elect a Vice-President for New Zealand.

### Change to the terms of IMSANZ Councilors

The proposed constitution also places limits on terms for members of the IMSANZ Council (Board of Directors), of a maximum of ten (10) years, reducing this from twelve (12) years.

### Clearer definitions for membership

As trainees now account for 20% of IMSANZ members, it is important to ensure our basic trainees are included. The proposed constitution seeks to provide a clearer definition of the trainee membership category to include basic trainees alongside advanced trainees.

We also seek to more clearly define the retired membership category to ensure members are aware of their eligibility entitlements.

The proportion of non-medical associate members remains very small, indicating that we still have a long way to go if we are to become a truly multidisciplinary society. Discrepancies have existed in our rules regarding voting rights for associate members and we seek to clarify the rules to ensure their vote is counted.

### Aligning rules with current practices

To better align our rules with the practices and procedures of IMSANZ, we propose some slight wording changes to be reflected in the constitution; such as the Secretary providing for the safe custody of the common seal; procedures for members who wish to resign to notify the Executive Officer and tightening the rules from a risk management perspective to ensure official channels for signing documents on behalf of IMSANZ.

## Will this change affect my membership and benefits?

Membership categories, benefits and restrictions remain substantially the same, except for the following:

- voting rights have been extended to Associate members;
- the trainee membership category now includes basic trainees.

Some wording has been revised to clarify meaning and some technical adjustments in line with the Corporations Act.

That is, IMSANZ will still retain the current categories. Subsequent benefits of being a member will not be affected as these are governed by decisions of the IMSANZ Council / Board of Directors and are not part of the constitution.

There are no proposed changes to the fees for membership.

All members of a Company limited by guarantee are required to guarantee the obligations of the company up to a certain level. We have proposed a guarantee on the part of each member of $20.00. This means that, if IMSANZ is ever wound up and does not have sufficient funds to pay its debts, each member at the time of the winding up will be called upon to contribute $20.00 towards those debts. If the call on that guarantee provides insufficient funds, then all non-current members, who were members within the 12-months prior to the winding up, will be called on to contribute up to $20.00 towards those debts incurred prior to that member retiring as a member.

At this stage there is nothing further that you will have to do to remain a member of IMSANZ.

## When will these changes take affect?

IMSANZ members are being asked to consider and vote on these changes as part of the Annual General Meeting to be held on 13th September 2013. If the majority of members in attendance vote in favour of these changes, an application will be made to the Office of Fair Trading (NSW) to approve an application being made to ASIC for conversion to a Company Limited by Guarantee and registration under the Corporations Act. The new constitution, the name change, and the appointments to the Board will take effect as soon as registration occurs with ASIC.

This process is estimated to take up to 3-months.

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## Editorial

Many will be aware of the recent damning Francis report following the Mid Staffordshire failures in the delivery of safe high quality care. This breach in basic health care delivery needs to be internalised by all stakeholders, clinicians and administrators alike. I was pleased to see a swift response from the Royal College of Physicians of London that I felt warranted some discussion. The Colleges engage in advocacy and training and thus are well positioned to advice on potential solutions to this crisis in professionalism and "humanism" by putting the patient first.

As part of the detailed response from the RCP to the Francis report focuses on the following areas: standards, education and training, commissioning and information.

The Francis report has detailed recommendations on standards divided into fundamental, quality and aspirational. The report highlights the need to develop evidence-based clinical outcomes as a basis for all standards, with consensus-based process measures where outcome measures are not available. It is here that physicians and trainees need to engage local processes within their own hospitals to live these standards by determining how the clinicians can contribute to not only the determination of the standards themselves but also the monitoring of their implementation.

In the Australian context physicians need to familiarise themselves with the 10 new National Safety and Quality Health Service (NSQHS) standards introduced by the Australian Commission on Safety and Quality in Health Care (ACSQHC).

The RCP highlights the need for clinical audits to underpin the improvements in quality. Physicians and trainees need to explore possibilities of expanding the use of clinically relevant audits. In our daily we work we sometimes lose sight of the overall care we provide.
Audits not only need to look at generally accepted outcomes, but need to explore a broader set of desirable parameters such as safety, effectiveness, patient experience, equity, efficiency and sustainability. In order to do this, physicians need to engage administration and take ownership of the effectiveness of the care we deliver. Patient based cost data is unfortunately not always available, but in its absence, we need to use available craft or ward based data to consider how we perform our care.

Patient feedback needs to be integrate into our planning to ensure that we deliver care in a fashion that meets the expectations of patients while maintaining cost effectiveness. There would seem to be a tension between those, and yet intuitively, we should be able to optimise the match of the care we deliver as physicians and the care that our patients desire.

Engaging them in decision making is a way to promote better matching as it could be argued we sometimes focus on areas of care without explaining this focus to our patients. It is also important to engage our patients in real time (as opposed to through retrospective surveys) to better match their expectation. Patients often just want to have their views and needs heard, something that underpins the physician patient relationship.

The RCP report highlights the need to optimise the care of the elderly and to develop health care environments that are designed to meet the needs of a cohort of patients that have complex multimorbid presentations sometimes with specific needs such as dementia. Physicians are well placed to engage in the management of the elderly in a way that is patient centred and meets their specific requirements. The excellent work already performed in GEM units around the country can be expanded to other areas around the hospital and physicians are well equiped to lead this cultural change so that elderly patients report enhanced experience of the care they receive.

Finally we need to make sure that we support physicians and trainees who raise concerns through established risk management incident reporting systems. This is an area where we need to focus in order to ensure that clinicians feel comfortable highlighting areas where care does not meet the patient centred standards.

A/PROF SERGIO DIEZ ALVAREZ
IMSANZ Newsletter Editor

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### Warning: New skills needed

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In his recent commentary on the Francis Report into the mid staffs inquiry for RACP News in August, Stephen Leeder drew our attention to the editorial in the Journal of the Royal College of Physicians of Edinburgh (2013:43; 3-6). The editorial asserts that clinicians must re-engage in management of clinical services. Furthermore a very strong case is made for the re-emergent role of the generalist in the acute hospital setting, with emphasis on the role of senior clinical leadership with responsibility for continuity of care, and a recognition of the importance of dual training for acute medical specialists and the need for them to take this active clinical leadership role seven days per week.

New generalists will need training to equip them for lifelong learning, and will expect to reinvent their careers several times over during their working life. So what skills do we anticipate that they will need?

In Australia in 2013 we face a large increase in numbers of graduating doctors and a rapid expansion in number so of advanced trainees in General Medicine, a situation which will increase in the next few years. What skills will these trainees in General Medicine require, how will we train and supervise them and what sorts of doctors will they become?

The same edition of RACP News also draws attention to the need for dual training, a position very strongly promoted and supported by IMSANZ. For this to work however, our members will need to be active participants and lobbyists for our participation in the governance of the training programs developed to support this sort of initiative. At present Advanced Trainees in General Medicine struggle to get access to advanced training posts in subspecialties. The reasons for this are varied. Generalist trainees are actively discouraged from accessing such positions which increasingly are run as training programs at state level, administered by ad-hoc committees comprising representatives of those specialties from participating hospitals. There are serious problems with this arrangement from the generalist perspective including the lack of representation of the employer or the general physician, and a lack of an appeals mechanism for unsuccessful candidates. To top it off the subspecialties are increasingly looking to run 36-month core training programs instead of the previous system of 24 months core and 12 months elective training. This will effectively reduce throughput, increase the length of training time, and reduce access to subspecialty

training posts for general medicine Advanced Trainees.

We are hopeful that the college can support our endeavours to remediate this inequitable situation, and that ultimately IMSANZ will work with the College, Australian and State Governments and individual Healthcare Networks to administer a transparent, equitable and accountable training scheme in each state to support dual training to produce the “great general physicians for Australia”. We look with interest to see the outcomes of the initiatives in NSW.

Finally, on top of training to achieve clinical technical competency our emerging cadre of general physicians will increasingly need to demonstrate an additional set of professional competencies including managerial and leadership skills. This will allow general physicians to re-engage with the management of clinical services as per Leeder’s commentary above, and also to participate more broadly in the engagement between our profession, government and the community we serve.

PROFESSOR DON CAMPBELL
IMSANZ Vice President and President Elect

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## New Zealand Update

Kiwi Presidents of IMSANZ serve a dual role as both the Australasian Leader of the society and as spokesperson for NZ issues. Of necessity the Australian Vice President (VP) carries a higher workload attending to their local issues. While our constitution allows for a NZ VP even when we have an NZ President and also for a potential "NZ Division" of IMSANZ, the six other NZ Physicians/trainees on Council (Robyn Toomath –larger metro, Andrew Bowers – smaller metro, Andrew Burns – SAC rep, Michelle Downie & Marion Leighton – recently qualified physician reps and Laurie Wing – trainee rep) ably support me and an informal email network works remarkably well when NZ specific advice is required. If necessary, we tap into the collective wisdom of past leaders and our wider NZ membership. At this stage we see no merit in creating a NZ subdivision and the NZ autumn meetings work well without one. I will finish my term as IMSANZ President about this time next year and then continue as "Immediate Past-President" (effectively the NZ VP) for another two years. We therefore have three years to prepare for the next NZ VP who should become IMSANZ President in 2018.

A key role of the NZ President or VP is representing IMSANZ on the **NZ Adult Medicine Division Committee of the RACP**, which consists of the leaders of all the Special Societies. Their collective views help inform the RACP's input into NZ issues such as physician training, PHARMAC changes, Medical Council plans for changes to pre-vocational training of PGY1-2 House Officers, HealthWorkforce NZ intentions on training and even the euthanasia debate.

By the time you read this our Hutt colleagues will have completed another or their well regarded **Hutt Acute Medicine meeting** targeting registrars and new consultants. I encourage as many Kiwi Physicians as possible to cross the Tasman and join our Australian colleagues at the **IMSANZ September ASM in Newcastle**. Train connections from Sydney to Newcastle work well and some smaller airlines link Newcastle to Sydney.

Plans for the next **NZ 2014 Autumn IMSANZ meeting** in the Bay of Islands are well advanced – save the dates of 5-7 March for a return to Waitangi. See the meeting website www.imsanzconference.co.nz for more information. Although the timetable is not yet finalized we have confirmed two clinical update sessions, the usual trainee and member presentations, and controversies. We also welcome Ramesh Nagappan back for an updated version of his infamous Quiz delivered at the 1997 Pahia meeting. Social activities include a welcome dinner on Wednesday evening; a chance to walk the treaty grounds with packed lunch on Thursday and the conference dinner will be via a ferry trip to the Duke of Marlborough Hotel in Russell.

Finally – this is your society. I encourage you to contact any of your NZ Council representatives if you have any issues or suggestions.

DR JOHN GOMMANS FRACP

President, IMSANZ

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# IMSANZ NEWSLETTER

SPRING 2013

## SAC Report - Aus

The SAC in General and Acute Care Medicine met face-to-face in Sydney in May, and again by teleconference in August. There are now over 300 trainees on our books, about 80% of whom are dual training. We recently bade farewell to Dr Nicole Hancock (Tas) who had come to the end of her 6 year tenure, and welcomed Dr Nicole Martin (Tas) in her place. Dr Ar Kar Aung (WA) completed his term as Advanced Trainee Representative, and was welcomed on to the committee as a full member, having nominated to stay on. Dr Herath Gunathilake (NSW) replaces Ar Kar as the AT rep – it was pleasing to see the keen interest amongst trainees in the election of their new SAC rep, with 5 nominations in a close-run election!

As mentioned by my colleague Andrew Burns from the NZ SAC, we are now very close to full alignment of both NZ and Australian training requirements. We are exploring electronic options for the trainee report process – this will be a valuable means of assessing training experiences across the country, but remains a work-in-progress.

The College has recently released draft policies which are open for comment until 16th September – these are the Trainee in Difficulty policy and Recognition of Prior Learning policy. I'd encourage Fellows who supervise ATs to familiarise themselves with these policies, and comment as appropriate.

The recruitment process for the NSW Ministry of Health/RACP Dual Training Rural Pilot is well underway, with the interviews taking place at the time of writing this report. It was gratifying to see some high calibre candidates keen to embark on a dual training pathway in endocrinology/general medicine as well as respiratory/general medicine with a strong rural focus.

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# IMSANZ NEWSLETTER

SPRING 2013

## SAC Report - NZ

The SAC for General Medicine NZ met on 2nd August for the first of 2 meetings held each year, and was shifted at short notice from Wellington to Auckland due to concern surrounding recent Wellington earthquake activity. Somehow the very able Education Officer Carolyn Lill managed the logistics of the shift without a hitch. This was the last meeting for 2 of our committee members and we bid farewell and thanks to Brandon Wong (Whangarei) and Anne Roche (Christchurch), who have come to the end of their tenure. In their stead the committee welcomes Michelle Downie (Invercargill) and Leighanne Hughes (Christchurch). Both Michelle and Leighanne are at the youthful end of the Fellow age-spectrum and they will no doubt bring a currency to what it means to be a trainee in GM.

The SAC currently supervises just over 190 trainees, but this number now pales in comparison with our Australian SAC who have over 300-a far-cry from the situation just a few years ago when they had very many fewer than NZ. Recent matters of note to our committee include the recent increase in core-training time for Cardiology and Nephrology (to 3 years), which has not been welcomed by the committee as it is likely to impact on access to associated runs for our GM trainees. There are ongoing efforts to align the Australian and NZ SAC training requirements (such as number of tools to be completed in a rotation) and we are now very close to achieving this. The relevance of trainee reports is a source of ongoing discussion with the committee of the opinion that they remain a good source of trainee reflection. Clinton Mitchell, as the AT representative on the committee, continues to advocate on behalf of trainees and has been recently involved in a work-group looking at the project requirement of AT. Before the end of the year there will be a site-accreditation visit for Middlemore Hospital and the committee will meet again on 2nd Decemeber-hopefully back in familiar surrounding of the college offices in Wellington.

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IMSANZ NEWSLETTER

SPRING 2013

# Hutt 2013 Acute Medicine Conference

Hutt Hospital hosted their annual Acute Medicine Conference on 8-9 August and it was up to it's usual high standard.

Rather than write about how great the speakers and the food were (they were both great) I thought I'd share some of the gems from the 2 days and some of my learning points. Hopefully they'll be helpful to a few other people….

1. Geriatrics – manage the acute admission in the following way. (courtesy of David le Couteur)

    a. Drugs – consider which you can stop…maybe all of them. We discussed how many is too many and how some physicians will try to reduce an older person's drug burden to less than 4 medications.

    b. Bugs – look for these and treat appropriately.

    c. Tweak co-morbidities – these are hard to deal with in an acute admission. Optimise treatment, but don't expect too much.

    d. 7 deadly sins of immobility. (If you can't think of 7, chose the 4 horsemen, and if you are over excited you can have the 10 commandments). Do not let your patient be immobile.

    e. Make a decision – what is the goal of this admission? Will your patient be going home, to rehab, for palliation? Or do you/they need more time and you will make a decision after the weekend?

2. Pharmacology in the first 48 hours. Consider stopping the following: (courtesy of David le Couteur and Chris Cameron)

    a. Anti-hypertensives. Does the patient have side effects? Could they benefit from a slightly higher blood pressure now they are 87?

    b. Diabetic meds. Metformin impairs appetite and hypos are more dangerous than hypers in the elderly.

    c. Statins. Is that statin renally cleared (atorvastatin is the least)? Are they getting side effects?

    d. PPI. Do they really need it long term? (Remember they may get rebound gastritis). Could it be the cause of their diarrhoea (microscopic colitis) or low magnesium?

    e. Other common medications causing microscopic colitis include: NSAIDs, aspirin, B-Blockers, simvastatin, SSRI's, carbamazepine,

ranitidine, and bisphosphonates.

f. Psychotropic drugs. Too many ills to write here. Wean 10% per day in hospital and 10% per week in the community.

g. Renal impairment – high risk drugs include bisphosphonates, LMWH, acyclovir, tranexamic acid and dabigatran. The eGFR may be an overestimate in the elderly (when compared to Cockcroft and Gault).

h. Hypersensitivity syndromes. Could be the cause of the admission. The offending drug could have already been stopped.

3. Neurology (courtesy Ian Rosemergy, Tom Thomson, Eileen Bass and Stuart Mossman)

a. Weakness  flexor policis longus (patient can't text) can be only sign of brachial neuritis.

b. Asystole during seizures. – look for brady-arrhythmias. Mostly seen in focal seizures. Consider an ICD. May have a role in SUDEP.

c. TIA – give 300mg aspirin at first contact.

d. Vertebro-basilar TIA – easily missed. Disorganised dizziness (pt finds it hard to articulate). If coupled with diplopia – bad sign. Need angiography (MR or CT) to diagnose.

e. Epilepsy: Mothers with epilepsy should not bathe their babies alone. All anti-epileptics are teratogenic, but seizures are worse. Ensure folate supplementation.

f. Headache – look for red flag symptoms. Something alongside the headache such as olfactory symptoms, worsening with valsava etc. History is still the most important test. Don't forget the blood vessels esp small SAH or dissection.

4. Nutrition (courtesy Chris Cameron)

a. Gastric Bypass – watch for complications. Thiamine deficiency in 1st 6 months – 104 patients reported with Wernicke's encephalopathy. Other deficiencies less acute, but can present years later even on supplementation.

We also discussed the hierarchy of need around prescribing – is evidence based medicine really the most important aspect, or are ethics (is this the right thing for this patient), epistemology (how we use our knowledge) and consideration of exploitation (what we gain from prescribing) more important.

In considering handover the advice was – talk about the sickest patient first and make the receiving team interact with the handover by asking questions and clarify information.

That's enough for now. This is an excellent little conference with relevant, practical advice on managing everyday problems. I'd recommend it to all advanced trainees and acute physicians. Look out for it, August 2014.

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# IMSANZ NEWSLETTER

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## Article - Fat City

The following article was originally published in The Monthly, March 2013.

### Fat City: What can stop Obesity?

Why obesity is not your doctor's problem.

In the late 1980s I spent a year in the US as an exchange student. The exchange organisation allocated me a local support person named Emily. Emily was white and loud and the fattest person I had ever seen outside a caravan park. She looked different from the rare very fat people I'd seen in Australia. She smelt good and her climate-controlled house meant she did not sweat. She was very well dressed. Her husband was some kind of professional; I didn't know they even made suits that big.

Emily's family ate like the bejesus. I went to her house once a month for pizza: heavy, oily discs of cheese half a metre across. One each. Before pizza one night I watched the daughter eat a huge bowl of guacamole with a dessertspoon. I couldn't take my eyes off her. I had no concept of calories; I'd simply never seen anyone eat so much avocado in one sitting. I wondered if it would make her vomit. I kept watching as she put down the empty bowl and turned the page of her novel.

I loved Emily. She cared for me the same way she ate: enthusiastically, generously, without restraint. Her bulk did not disgust me. But I never once ate any pizza. The thought of her pizzas made me sick. All those pools of fat. Twenty-five years later I am a physician and Australia is filling up with Emilys.

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Louise was an educated 35-year-old who had recently lost her high-ranking job and was making ends meet by freelance consulting. Admitted to my ward with pneumonia, she had a high fever and a fast pulse, needed oxygen and was coughing up large amounts of purulent sputum. She was also fat, weighing about 120 kg. I knew that – barring underlying lung disease – obesity was one of the greatest risk factors for life-

threatening pneumonia in young people. I felt a responsibility to tell her that her excess fat had harmed her in a way she may not have realised. Every day before my ward round I would say to myself that I was going to broach the subject with her. It seemed a good opportunity to intervene. And yet each time I stood by her bed and looked at her bedside table piled high with literary novels, open blocks of chocolate and teddy-bear biscuits, each time I lifted her pyjama top and pushed my stethoscope into her soft white flesh, I couldn't do it. I was embarrassed to mention her weight; it felt like I was a puritan taking the high moral ground. It felt mean.

As a doctor, I no longer know what to do about the obese. Australians are getting fatter, and our society is geared towards making them that way – consumption doesn't just drive economic growth. So is fatness a doctor's problem? Studies show that verbal interventions during an episode of serious acute illness can result in a change in behaviour – people quit smoking, cut down on their drinking and sometimes lose weight. But usually counselling people to lose weight is hopeless. Then there are the questions of morality, personal responsibility, associated diseases, resource allocation, quality of life and aesthetics. I have moments of clarity – I think of the way Emily ate – and obesity seems simple: more in than out. Then I am engulfed once again by the high science of genetics, by the concept that obesity is a disease.

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I love reading articles with titles like 'How I Lost 25 Kilos', even though the answer is always the same: I ate less. Barring the gravely ill and a couple of men, everyone I know wants to lose weight. We live in a society that judges people for being fat, yet has in place every possible means for making them so. Who wants to eat less – of anything – when food is so good and plentiful? It's hard to say no to something that is right in our faces, promising a bit of easy pleasure. It is especially hard to say no when the consequences of overeating come about in such a distant, gradual and mysterious way. I find it difficult to believe that an extra scoop of ice-cream will end up as fat somewhere on my body, even though I know how it happens at the enteric, metabolic and cellular levels. Perhaps this is what happens when we reach the head of the queue and order too much: a fantasy where eating has no consequence, where that pile of French fries and the burger with extra cheese are not our future bodies.

Battles with our appetites and with our bodies are played out on television, in magazines, in the workplace, in families and in hospitals. Be fat in public and you will be weighed by strangers' eyes. The most radical thing on television this past year was the ordinarily flawed 70-kilo naked body of Lena Dunham in Girls: little girlish tits above big soft lumps and bumps. How shocking: the protagonist has a paunch and eats cupcakes in the bath. She blatantly displayed her body, a lone counterpoint to the usual stick-insect romantic heroines.

I have heard people say thinness is beautiful and coveted because it is difficult to achieve and rare now, the way curves apparently appeal in times of famine. There are activists who have set out to challenge the fat-is-ugly paradigm, to curb all this body hatred. I am sympathetic to many of their aims. However, their attempts to manipulate what we find beautiful have been crashingly unsuccessful. The Adipositivity Project – which uses artful photographs of morbidly obese half-naked models to reframe fatness as a thing of beauty – remains separatist and marginalised. And the occasional cover shot featuring a so-called plus-sized model is hardly cause for jubilation. These models – often thinner than the nation's average – are freakishly well-proportioned Amazons

with flawless faces. The pro-fat bloggers are smart, sassy and pissed off. I'd hang out with them. Yet, if they could click their fingers and be thin, would they? Would Lena Dunham? "I don't want to be skinny like a model," I've had more than one patient tell me, "I'd just like to look like Kate Winslet."

I don't know if there is any force that could purposefully change a culture's definition of beauty. Is fat inherently ugly? Ask Aristotle, Susie Orbach, Naomi Wolf. Their answers are different, their arguments from different places. It is not an empirical question although it reads as one. Today when we look at those who are thin, part of what we see is a triumph of will over gluttony, so the beauty is a moral beauty; it has little to do with health.

---

Questions of aesthetics aside, obesity is bad because it causes disease by, for instance, raising blood pressure and cholesterol levels, stuffing your liver full of fat, blocking your throat so you can't breathe at night, crushing your joints. Fat people are more likely to get blood clots, gallstones, gout and some cancers – as well as type 2 diabetes, which leads to all manner of medical mayhem. Fat men and women make less money, marry less often and are less educated than the lean. They are more often depressed. In the Framingham Heart Study, which has examined the causes of cardiovascular disease across generations, the very fat lived on average six to seven years less than the lean. The moderately fat lived three years less. If you quit smoking and get fat, you may as well have kept on smoking. These dire facts are not my opinion. They are based on empirical data extracted from large international trials and studies. I wish it were not so. I wish you could get really fat and stay healthy. I wish you could get morbidly obese and be considered beautiful. Maybe it will change with time, as we all become enormous, and we'll look back on the skinny-is-beautiful era with distaste, regarding high cheekbones, defined jaws and long sculptured thighs as skeletal and ugly. I cannot imagine this, but neither could I have imagined that we'd end up in a world so fat.

I listened recently to a neurosurgical registrar describing the difficulty of finding a spinal fracture under 10 centimetres of adipose (fatty) tissue. Neurosurgeons love precision; one false move on the inside and you won't remember your mum. The registrar's voice was filled with a kind of shocked horror. She had to send the car-crash victim to the scanner mid operation, with a metal screw embedded in his neck so the surgeons could find their bearings beneath the mattress of fat. Post-op, none of the neck braces were big enough to fit. To immobilise the man's spine the team used sandbags.

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This year I started work as the physician in an obesity clinic with a group of bariatric surgeons. No one else really wanted to do it. The attempt to help people lose weight is generally seen as one of the most futile acts we as doctors of internal medicine can perform: pretty much all we can do is make you feel crappier about yourself than you already do. But the surgeons can do something: they can clamp a band at the top of your stomach, cut half your stomach out or bypass part of your small intestine so food is not absorbed. The waiting list for our clinic is long. One of my patients gained 60

kilos between referral and consultation. Some of our patients have become so fat they can walk only five steps without needing a rest. Many are only in their 30s. My role at the clinic is to tighten up their diabetes control, make sure they don't have a catastrophic hormonal condition that has made them fat (no one ever does), treat their high blood pressure and discuss eating and exercise habits. To each patient we show a cartoon of a bolus of food travelling down the surprisingly long oesophagus and squeezing through the junction that leads to the stomach. I watch the food moving down slowly, over and over, one viewing per patient. This is how your food goes down, so if the surgeons lock a band here, it will take four times as long. You'll have to slow right down when you eat or you will vomit it all back out.

Now, every time I eat I imagine the food going down my throat, being squeezed by the muscles in my oesophagus before landing with a splat in my smaller-than-I'd-thought stomach. I find myself chewing more and waiting between mouthfuls. Sometimes I even put my fork down on the side of my plate between bites. I'd never done that before; I'd been an eat-and-run kind of girl. I was not at all overweight, but by the third clinic I'd lost 5 kilos.

When my brother was 30, he developed high blood pressure. A general physician checked him out for secondary causes. My brother drank a lot of whisky, smoked, and ate a ridiculous amount of food. It turned out these were the causes. The doctor advised that if my brother religiously took the handful of pills he was about to prescribe, he could get him another 20 years or so. The doctor picked up his pen, opened the script pad. My brother turned white. "Hang on," he said, "I'd like a couple more years than that."

Drugs can help you stay healthy when you are fat, but drugs and doctors cost money. If you are overweight, you cost 25% more per year to keep healthy than a slim person. If you are obese, you cost 45% more. And no drug can fix the functional impairment of being obese. Strap two fully loaded suitcases to the back of someone of normal weight and make them walk up stairs. That only gets them to around 120 kg, which isn't even close to the weight of many patients I see breaking into a sweat on the walk from the waiting room to my office, their knee joints slowly disintegrating. But so what? Motorised scooters are not so expensive. They too could be covered by Medicare.

There are other costs: the fatter you are the greater your ecological footprint. Globally, we are carrying 18.5 million tonnes of excess fat under the skin of the overweight and obese, which – if it were still food rather than adipose tissue – would feed 300 million people for life. Fat people have been compared to petrol-guzzling cars. I feel terrible typing these sentences. I apologise; they are ugly.

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I met Nora in a diabetes-outpatient clinic. She was 35 years old and had a five-year-old daughter. She had out-of-control diabetes, high blood pressure and fat swelling her liver. She weighed 155 kg and was 150 cm tall, putting her well into the category of morbidly obese. She struggled to lie flat on the examination table; she struggled to rise. Her feet were unkempt, with long yellowed nails and a rim of dark-brown skin cracking around the soles – a disaster waiting to happen for a diabetic, as they are prone to terrible foot infections that sometimes result in amputation. But Nora could not tend to

her feet. She could not even see them.

Nora had been listed to have bariatric surgery – in her case, the fitting of a band around the top of her stomach. She said she was terrified of dying during the operation and had cancelled her appointment with the surgeons. I felt sorry for her and wanted to help her. But where to start? I told her that what was going to kill her was her current state of health, not the surgery. I asked her if she wanted to see her daughter grow up and have children. She looked shocked. She started to cry. I told her to go home and empty her cupboards of crap food. Sweet biscuits were her particular weakness. Open the packets, I told her, and dump them. I rebooked her consultation with the surgeons, and gave her the number of a meal-replacement service that she'd had success with in her 20s. Do this for your daughter, I said. She dried her eyes. At the consulting-room door she dropped her handbag and hugged me fiercely. Thank you, doctor. But for what? As a registrar in a group clinic, I was unlikely to encounter her again. It is fine to be tough if you are around to temper the consequences for the patient should your intervention fail. What if she couldn't dump the biscuits? What if all I had done was intensify her guilt and self-hatred?

I decided to join the bariatric surgeons because of patients like Nora. In the bariatric surgery clinic I ask my patients for the history of their weight gain, diets they have tried, the state of their health in general, their medication regimens and social situation. It is necessary to get some idea about their eating habits. They sit in the special wide-based chair with their thighs pressed together and hand over food diaries that read like a skinny dietician's. I sit in front of a 280-kilo patient and I keep my tone light and my questions broad: What do you tend to snack on, when you snack? Is it sweet stuff or salty stuff? He reads from his diary: Mid-morning snack: small green apple and two rice crackers. I continue: Do you ever feel full? Do you ever keep eating even though you are full? Have you ever eaten to the point of vomiting spontaneously and then kept on eating? Talking about food is the most difficult and enlightening part of the consultation. The emotion in the room thickens; I am acutely aware of the shame my patients feel. They describe to me what it is like to shop, ride on a bus, take a plane. They tell me that they no longer look into mirrors. I do not ask them to describe the biggest meal they have ever eaten or if they've ever eaten two dozen doughnuts in one sitting. I ask what I need to know to minimise the chances of harming the patients with inappropriate treatments. I do not wish to humiliate them or shame them. I do not wish to turn my fat patients into freaks. It takes time for them to trust me enough to tell me the truth about the mind-boggling volumes of food they consume.

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I once attended a hospital lecture on the genetic determinants of obesity delivered by a specialist physician. The doctor giving the talk was very fat. As he went on, his face got red and stains of sweat spread from his armpits. Obesity is genetic, he argued, wiping his brow: obesity is a disease. He said: If you make a fat person thin, you are sentencing them to a lifetime of hunger.

This depends on your definition of hunger. Eating is not a purely rational, biological act. I can give you a diet that will keep you full all day and make you lose weight, but it won't be very entertaining: it will be mainly made up of watery vegetables like cabbage and celery, egg whites and very lean meat. The pain of abstinence, of unmet desire, is something quite separate from the pain of an empty stomach. The pleasures of eating are complex and multifaceted. In our society, consumption is a form of entertainment

and pleasure. Eating is part of this: from the theatre of a meal at a fine-dining establishment to a bag of chips augmenting the television-viewing experience. Most people do not overeat because of a feeling of hunger emanating from the stomach; they are giving in to a desire to consume – they are seeking pleasure or relief, or hoping to fill a void.

I had a friend who had been anorexic and spent her teenage years in and out of hospital, being fed through a nasogastric tube. She recovered in her 20s and managed to channel all of her intrusive obsessional thinking about food into athletics. One day she said to me that she didn't understand why she could be hospitalised against her will for not eating enough, and yet there was no limitation on how fat you could get. It was completely unfair, she said, that you could be refused alcohol if intoxicated but roll into your local fish-and-chip shop 100 kg overweight and be served the equivalent of a week's worth of calories for lunch.

In thousands of labs across the planet, medical researchers are trying to find the cause of, and cure for, obesity. They examine genes, chemical exposures and metabolic pathways. They experiment with amphetamines, anticonvulsants, probiotics. Some of this research is funded by the companies that make and sell the food that makes us fat. In thousands of other labs across the planet, food scientists and marketers are working on ways to make you eat more. They employ highly sophisticated psychological and physiological research to this end; they examine the effects of colour, unit size, price, texture, packaging and advertising on human desire. Look around you: who is winning?

In some ways, scientific research has taken obesity outside the realm where it is a consequence of choices made by a more or less free-willed individual in a more or less free society, which nonetheless disapproves of excess. In current medical research obesity is often conceptualised as an unavoidable disease. It's your genes, your metabolism, the chemicals in your environment, what your mother ate when she was pregnant, whether she fed you at her breast. It is everything but what you choose to put in your mouth.

From a biological point of view, once the stomach has reached capacity, further consumption of food should cause more pain than pleasure. There are well-documented peripheral and central mechanisms – hormones, receptors – that should trigger an aversion to eating any more. But that depends on how strong the pleasure attached to the consumption is. Your stomach is full, but will you say no if I hold my finger dipped in melted dark chocolate to your lips? What if your house is empty and your stomach is full, but you have a bowl full of crunchy somethings sitting in your lap that will make the nothing on television seem bearable? What if inside and out of the house is a constant barrage of powerful images convincing you that the crunchy crap tastes fabulous, and it costs only four dollars for two jumbo packs?

We are attracted to what is forbidden and will resist only if we have a compelling reason to do so: pain, punishment, family disintegration, death. Eating 'bad' food is a relatively benign transgression; you can do it in public, you can do it in the park, in a primary-school playground. The consequences – fatness, disease, early death – are distant enough to be out of sight. Kant famously formulated that no man would sleep with the woman of his dreams if the consequence for him were death immediately afterwards. To stop people consuming vast amounts of the most desirable, calorie-laden, heavily promoted and affordable foodstuffs to appear before our naturally longing eyes, a public-health campaign would need to cause an aversion more

powerful than the pleasures promised.

A ban on advertising, graphic counter-campaigns, plain packaging and high taxes have all played a part in making Australia a country with one of the lowest percentages of smokers in the world. How might this approach translate to food? New York City funded an anti–soft drink commercial that showed a man guzzling a glass of blood-streaked liquefied fat. The tagline was “Don’t drink yourself fat”. Why not plaster packets of chips and chocolate with full-colour photographs of the rot that grows under an apron of fat, or a gangrenous foot caused by diabetes? And if you’re thinking, Eating the occasional chip won’t harm me; why punish everyone?, well, smoking the occasional cigarette won’t harm you much either. Any public-health campaign to curb obesity would need to be graphic, to make real the unpleasant consequences of pleasurable excess eating. A drug to treat overeating would need to do the same; not just make people feel full, but render them violently ill if they take an extra bite. But who would take this Kantian drug voluntarily?

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In the bariatric clinic, we worry most about the compulsive eaters, as well as those who can nominate no other pleasure-seeking activity in their lives besides eating. The question is whether the patient will cope with a life of eating only three saucers of food a day with two little snacks in between. It is dangerous to overeat with a banded stomach. Those who do will vomit profusely, their oesophagus will dilate and may rupture, food can trickle into and infect their lungs. We do not want to cause harm. I explain to the patient: the surgeons are building a door between your body and the food. You have to respect that door; it will only open a crack for a little something to slip in. You must be able to tolerate the limitation.

I ask a young 200-kilo patient what he snacks on. “Nothing,” he says. I look him in the eye. Nothing? He nods. I ask him about his chronic skin infections, his diabetes. He tears up: “I eat hot chips and fried dim sims and drink three bottles of Coke every afternoon. The truth is I’m addicted to eating. I’m addicted.” He punches his thigh.

Addicted. The word is useless in my clinic, a mere barrier to any hope of self-determined change. My patient is not addicted; he’s a very lonely, unemployed young man who has gradually become socially isolated to the extent that the only thing available to him for comfort and entertainment is food. He has no friends, no money to buy other consumables, little education, no partner, no job. Some days he doesn’t leave his bed. The choice for him is to eat this food or experience no pleasure. The surgeon and I discuss his situation, concerned that he may overeat after the band has been fitted. We tell him that surgery may not be appropriate for him, given his situation. The patient is perturbed. “Well, what are you going to do for me if you won’t do the operation? Don’t you have some kind of ethical responsibility to help me lose weight?”

This is where the obesity-as-disease concept leads us – to a situation in which people demand that medicine shoulder the responsibility. What about the responsibility of the individual? And of society? My patient cries because the highlight of his day is returning from the supermarket with a plastic bag full of junk that he will eat and drink in his empty lounge room. What can I do for him? I can threaten him with his early demise, intensify his shame. I can offer him some evidence-based motivational lifestyle interventions – swap Coke for Diet Coke! Prescribe exercise? Walk for an hour at an

average pace and you'll only burn off the equivalent of one slice of bread. I could take the old-fashioned approach and wire his jaw shut. I have no hope of resolving his loneliness, his hopelessness, his lack of a job. I could, and do, refer him to a psychologist – if he's lucky he may land one who is talented and sensitive and will try to get to the root of why this young man hates his own guts. More likely he'll be offered a few sessions of behavioural therapy that will make everyone except him feel better.

But he's not like us, is he? He's in the minority; most people are just 20 or so kilos overweight. He's one of those people with an overeating disorder. Actually, I think he is just like most people, but he's got his volume on full. Corporations make it easier for us to eat than to abstain. They loudly promote and supply cheap, taste-intense, non-sating food that is bad for our bodies. They know us better than medicine does. When a fast-food chain dropped its television ads for a weekend, its revenue that week fell by more than 25%. There are more shelves in some supermarkets selling highly processed, nutrient-free combinations of starch, fat, sugar and colouring than there are bearing fresh fruit, vegetables, meat and grains combined. Very few people get obese and none get morbidly obese through the consumption of home-cooked whole foods. To get that fat, for most people, takes piles of highly refined, ready-to-chow junk food and drink. Try googling "what I ate when I was fat".

It is challenging to stay alive at weights above 300 kg. Three hundred is not a threshold – doubtless there is a continuum – but it is the 300 kg–plus people who come to the attention of a hospital, when their bodies start to die around them. I have been involved with, and heard of, a handful of such patients. They were all house-bound because they were no longer able to walk. To remove them from their houses required the state rescue services to demolish door frames. The state's bariatric ambulance must be mobilised. (A standard ambulance can only take a person weighing up to 220 kg.) The patients require special beds, special scanners – sometimes in the zoo – and a small army of medical staff to treat their failing organs. The worst problems involve the skin – it rots and becomes infected when it folds on itself – and the lungs, which are slowly squashed under the mass of flesh so that the patient's intercostal muscles can no longer move to let in the air.

To get that fat takes dedication and persistence. To burn off that much fat is almost impossible. Long-term hospitalisation – a year or more – with a very low calorie diet is really the only path, and even then the person does not leave the hospital in anything like normal shape. The sheets of skin that have grown around the blooming cushions of flesh do not spank back into non-existence. Other consequences of fatness are irreversible. Someone who has never been fat is metabolically healthier (they can eat more) and will live longer than someone who has been fat and no longer is.

A recent New England Journal of Medicine article dealing with the rise of chronic lifestyle-driven diseases calls for a change in the way physicians think about their patients. The author suggests that medical students should be taught to be less reductionist, to learn how psychological, social and economic factors all act as determinants of disease. I do not know what medical school is like in the US, but even our surgeons – the most hard-arsed of doctors – sit reeling before the tragic combinations of circumstance and choice that lead our patients to weigh two or three (or four or five) times what they should. The doctors I work with have an excellent grasp of the bio-psycho-social factors that contribute to our patients' states, but we are only doctors. All we have are the tools of our trade: our ears, our voices, our hands, our pills and our scalpels. The waiting rooms are full, the waiting lists are long, the demand is swelling. Obesity is in many ways the logical endpoint of the way we live. Prevention beats palliation, but we'd need psychologists, motivational speakers, social workers, dieticians and physiotherapists to work with us in order to have any hope of

tackling the problem. We'd need policy makers and activists. All we have are doctors like me.

Ostensibly cheap food heavily taxes both the individual and the community in terms of disease and redirected health resources. If longevity and the avoidance of disease remain among humanity's aims, we should try to prevent ourselves from getting very fat. Forget obesity as a disease; it's a ruse. For whatever reason, the majority of the population can no longer say I have had enough. For whatever reason, the majority of human beings respond to advertisements inviting them to enter a pleasure state by eating a day's worth of calories in one sitting, again and again. In the face of this, we are stuffed. We could say, "You are free agents, totally free, so pay for your own consequences." We could make people pay at the point of choice, via a food tax, or we could limit choice. The other option, always unspoken, is: let us have our cake. Let's just eat and eat, get fatter and fatter, and work out how best to live with it. This is where we are heading now: fatness, outside of morality, as an accepted consequence of the world as we have made it.

We can decide as a country, as a world, that we are going to consume what we have until we're done, eating as much as we wish and treating all the concomitant diseases by diverting substantial amounts of government revenue into medicine and pharmaceuticals. If we do choose this path – and we are most of the way there already – we must be honest about what we are choosing to do: to spend our country's money on the consequences of indiscriminate consumption.

If you come to me, your doctor, and you ask me to make you thin, for now I will have to cut you or drug you, as these are the only weapons I have to ward off the sirens. There will come a time when patients stop asking their doctors to make them thin. It will either be because fatness is rare again, or because it has become entirely accepted. The choice is in your hands. Are you going to eat it?

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