IMSANZ NEWSLETTER

SEPTEMBER 2014

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President's Report

Dr John Gommans
IMSANZ President

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Read more...

Remembering Ramesh

Ramesh Nagappan

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Read More...

New Zealand Update

Dr John Gommans
IMSANZ President

Following the highly successful 2014 Waitangi meeting organised by our Northland colleagues, my home province of Hawke's Bay is busy preparing for next years NZ meeting.
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SAC Report - Australia

Dr Rob Pickles
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NEWSLETTER EDITOR
Sergio Diez Alvarez

As we enter the post-exam period there are in excess of 430 trainees in General and Acute Care Medicine in Australia. These trainees occupy a wide range of training posts, from large metro and regional Teaching Hospitals, smaller District Hospitals, Public and Private, as well as some small rural health facilities.
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Beyond Acute Medicine: Where next for General Medicine in Australia and New Zealand?

A/Prof . Nick Buckmaster

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Read More...

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.

Click to view list of new members

IMSANZ NZ Conference 2015

We are delighted to welcome you to Hawke's Bay and the "Art of Living Well" - the 2015 New Zealand IMSANZ meeting. This is the only conference in NZ that specifically caters for General Physicians, trainees in General and Acute Care Medicine and all those who practice general medicine. It provides an ideal opportunity to network with your colleagues from around NZ and across the Tasman and this year our meeting also coincides with the NZ RACP trainees' day on the weekend providing an opportunity for trainees to interact with some of their future peers. We have a programme that will explore clinical updates, provoke discussion and challenge your thinking.

Late summer is a great time to experience Art Deco Napier, our wineries, the 100s of kilometres of cycle trails and the other delights of Hawke's Bay. Don't miss this opportunity to reflect, learn and network in a stunning environment.

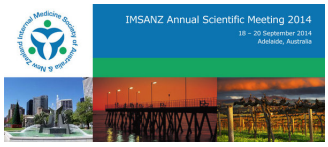
Visit www.imsanzconference.co.nz

Meetings and Events

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

Rural Medicine Conference 2014

IMSANZ is pleased to support the Rural



[IMSANZ Annual Scientific Meeting]
Adelaide Hilton
Adelaide, South Australia
18-20 September 2014

[Rural Medicine Conference 2014]
Dubbo Convention Centre
Dubbo, NSW
24-26 October 2014

[IMSANZ NZ Autumn Meeting]
Napier War Memorial Conference Centre
Napier, New Zealand
25-27 February 2015

Career Opportunities

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

[Click here to view the current vacancies]

Medicine Conference 2014

This is an event devoted to the practice of Internal Medicine in rural Australia. This 2 day event will provide an interactive and innovative approach in dealing with rural and remote medical issues. Leading experts from multiple specialties will provide updates on the latest advances in rural and remote health care.

Friday 24th - Sunday 26th October 2014, Dubbo Convention Centre

Read More...

Quality and Safety in Paris in the Spring-time

Dr Robyn Toomath

I went to this meeting in April with Pip Shirtcliffe and 60 or 70 other New Zealanders. A load of Aussies, a great many Brits, plenty of Scandinavians, some Canadians and tiny number of French delegates contributed to the 3,000 attendees. My hope was that I would come away with some clearer ideas as to how we might fashion a more patient-focused health service. I've been thinking about this for a while having read some interesting stuff from The States many years ago where they were designing the physical layout of hospitals around patient needs. This conference gave me a whole lot of new ideas.
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Submitting Content

We are always seeking contributions for our next Newsletter. These might include links to interesting articles that are pertinent to internal medicine, reports and reviews from conferences you might have attended, updates on progress/new developments in the subspecialties and any research of your own which you might like to share with other members.

To submit your content for consideration, please contact the Executive Officer via email imsanz@imsanz.org.au. Your submission will then be forwarded to our newsletter editor.

Updating your contact details

Have you recently moved or changed your email address? Our main form of communication with

our members is via email so to ensure you are receiving important information and updates, your correct contact details are needed. To check or update your details, login to the members section of the website. If you require any assistance, please contact imsanz@imsanz.org.au.

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IMSANZ

145 Maquarie Street
Sydney NSW 2000
Australia

Contact

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President's Report

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It is with much sadness that we note the sudden passing of our colleague Assoc Prof Ramesh Nagappan, a champion for General Medicine on both sides of the Tasman who was well known to my generation and also the legions of trainees who went through his acute medicine course. We were privileged to have him return briefly to NZ earlier this year to participate in the New Zealand meeting at Waitangi where his infamous quiz mirrored one he gave at the same venue in 1997.

One duty but also in my opinion a major benefit of being IMSANZ President is getting the opportunity to represent the Society in various forums across Australasia, and sometimes overseas. At the recent College Congress in Auckland, I provided a clinical update for our other specialty colleagues on the topic “Meeting the needs of future medical inpatients” emphasising the importance of ‘generalism’ as a skill for all physicians. I have been invited to repeat this talk for the Flinders Medical Centre’s Grand Round while in Adelaide for our Society’s ASM next month. The RACP Congress was well supported by Physicians and Paediatricians from both sides of the Tasman, and always provides a great opportunity to catch up with old friends and make new ones.

In May I also attended a combined two day meeting of the UK Society for Acute Medicine (SAM) and Dutch Acute Medicine Society (DAM) held in Amsterdam; appropriately called either SAM DAM or SAMsterDAM. About 400 attended with a smattering of antipodeans amongst them. I participated in a session on comparative models of care; the most noticeable difference being that we have managed to avoid any separation between Acute and General Medicine. Our trainees working conditions also appear to be significantly better than their UK GM registrar colleagues.

In June I spent a week in Melbourne visiting Assoc Prof Harvey Newnham’s unit at the Alfred as a visiting speaker, including a Grand Round and participation in a one day seminar focusing on issues relating to frailty in acute medical admissions. Visiting other units is an ideal opportunity to explore new ways of doing things, and I particularly appreciated seeing first hand the Alfred team’s structured approach to interdisciplinary ward rounds and their Timely Quality Care initiatives.

Finally this will be my last newsletter article as President of IMSANZ. At our AGM in Adelaide during our Australasian Annual Scientific Meeting, Professor Don Campbell from Melbourne will take over the reins, becoming our 9th President. I thank him and the local organising committee for all the work they have done and look forward to meeting many of you there.

DR JOHN GOMMANS FRACP
IMSANZ President

www.imsanz.org.au

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Sydney NSW 2000
Australia

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Remembering Ramesh

Ramesh Nagappan

At the time of his untimely death at the age of 56 years, Ramesh Nagappan was the Director of Medicine & Director of Physician Education at Maroondah Hospital, Melbourne and an ICU Specialist at Epworth Eastern Hospital, Melbourne. He was an Associate Professor in the Faculty of Medicine, Monash University.

Ramesh qualified MBBS from the University of Madras in 1981, and subsequently had conferred upon him the degree of MD in 1984. For his MD dissertation "A PROFILE IN PRIMARY PULMONARY HYPERTENSION" he received his University's Gold Medal and the Silver Jubilee Gold Medal. After further training in New Zealand, Ramesh was admitted to Fellowship of the Royal Australasian College of Physicians and subsequently to Fellowship of the College of Intensive Care Medicine.

Ramesh early career included time as a broadcaster, sports commentator, journalist and TV compere in India. Clearly Ramesh carried these skills and attributes with him into his professional life.

Ramesh published over 50 articles, book chapters and abstracts. He presented on over 150 occasions to national and international clinical and scientific meetings. Among his many career accomplishments Ramesh was, the time of his death, a member of the National Examining Panel, and Victorian State Examinations Coordinator, Royal Australasian College of Physicians as well as a National Examiner, Board of Examinations, for the College of Intensive Care Medicine Australia & New Zealand. As an organizer of the RACP clinical exams Ramesh meticulous attention to detail and commitment was well known and unrivalled.After moving to NZ in 1989, Ramesh initially held appointments as a physician trainee at Auckland, Middlemore, and Tauranga Hospitals before his appointment as a consultant physician at Whangarei Hospital. In that time he played a vital role supporting the establishment of the nascent IMSANZ including serving as Co-Editor, IMSANZ Newsletter from 1997-1999. Following his move to Australia in 2000 he held positions at Monash

Medical Centre and Box Hill Hospital prior to taking up his substantive appointment to Maroondah Hospital as Director of Medicine & Director of Physician Education.

Ramesh was prominent in the life of the RACP and IMSANZ on both sides of the Tasman, and very well known to many members. He played a very big role in getting IMSANZ to its current state and undoubtedly played a large role in forming its culture of inclusiveness and friendship. Ramesh entertained us with his quizzes at IMSANZ meetings, and packed in the crowds at his wonderful annual courses in Adult Medicine and ICU Medicine. Is it a surprise that Ramesh had a prior career as a sports announcer and commentator? His most recent contribution to the life of IMSANZ came at the IMSANZ New Zealand Annual Scientific Meeting at Bay of Islands earlier this year, concluded as we all knew it would, with the master showman himself conducting his clinical quiz. As quizmaster the correct answer was delivered with an acerbic yet friendly commentary that accurately measured the inadequacies of the hapless respondent. Little did we know then that this would be his final quiz.

Ramesh was a master clinician, showman and performer, an entrepreneur, and a masterful organizer. What words describe his character? Lets start with those that come readily to mind: Happy, warm hearted, generous of spirit, quick witted, fiercely intelligent, compassionate, but most important of all: friend and teacher. What a friend and what a teacher.

Those who were fortunate to have Ramesh as their teacher in preparation for the physicians exam will not forget the role that Ramesh played encouraging them to have the confidence, and do the necessary hard work, to become the doctor they aspired to be. We also received a further gift from Ramesh: the responsibility to be generous of spirit and encouraging to all those we come in contact with, be they our patients, our students, or our colleagues as we take on the responsibility of becoming that good doctor that we all aspire to be.

Ramesh touched our hearts and continues to inspire our lives. We are the better for the privilege of having known Ramesh.

Our deepest sympathies to his wife, Shalini, and two sons, Ashwin and Karthik.

PROFESSOR DON CAMPBELL
IMSANZ Vice President (Australia) and President Elect

www.imsanz.org.au

IMSANZ

145 Maquarie Street
Sydney NSW 2000

Contact

Ph: +61 2 9256 9630
Fax: +61 2 9247 7214

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Australia **Email:** imsanz@imsanz.org.au **Wed 9am - 2pm**
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New Zealand Update

Meeting Update -
Following the highly successful 2014 Waitangi meeting organised by our Northland colleagues, my home province of Hawke's Bay is busy preparing for next years NZ meeting. I thank my local colleagues on the organising committee; Andrew Burns, David Gardner, Elisabeth King (recently moved from Christchurch) and Steven Sawyers, ably supported by Sarah Buchanan as Trainee representative and Lynda Booth the ever efficient conference organiser. Save 25-27 February 2015 for a date in Napier as this conference themed 'The Art of Living' will be a popular meeting, not least because it looks likely that the NZ trainees day will also be held in Hawke's Bay on Saturday, 28 February.

NZ College News -
The NZ Adult Medicine Division Committee of the College meet in Wellington last month. As the NZ representative for the Society I attended this meeting, chaired by Humphrey Pullen, a Haematologist from the Waikato. This meeting of the NZ representatives of the various Special Societies advises the NZ Committee of the College on issues specifically relevant to NZ. A key paper of interest to General Physicians was a 'Physicians Practising in Isolation' document. There was useful trainee feedback regarding potential benefits of nationally organised rotations outside of the tertiary centres such as now occurs in Gastroenterology. Other topics included Fellows in Difficulty, Tackling Obesity (the NZMA report), Antimicrobial Resistance and Brochures for Overseas Trained Physicians. A major session was an informative and interactive presentation by Dr Stephen Streat from Organ Donation NZ followed by a long discussion that also included Dr Curtis Walker, a General and Renal Trainee representing our Maori Health Committee. Expect to see more from the College on these topics.

Succession Planning -
At our upcoming AGM we are likely to face a need to replace some IMSANZ NZ Councillors as people reach the maximum terms allowed by our constitution for their positions. We also need to think about who will follow me as the next leader of our Society in New Zealand as I finish my term as Australasian President of IMANZ next month. As 'Past President" I will double as the NZ Vice President for the next two years but then we need to elect a new NZ Vice President who can take on the Presidency in four years time.

I have also been appointed as Chair elect of the NZAMD Committee mentioned above, having served on it for most of the last 10 years in various guises representing either Geriatric or General Medicine. Therefore, at some stage before the end of 2015 we will need another Physician (FRACP) to represent IMSANZ and minimise any potential conflict of interest between Chair and Society matters, preferably from amongst the NZ Councillors.

So if you have an interest in being on Council or would like to support a current Council colleague to work towards leadership roles, now is a good time to declare those intentions.

The Adelaide ASM -
Finally I wish you all well and look forward to catching up with many of you in Adelaide next month or in sunny Hawke's Bay next year.

DR JOHN GOMMANS FRACP
President, IMSANZ

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At all times however, we need to remain focussed on the need for adequate training and supervision, taking into account the whole-of-program experience for the trainee. The SAC is mindful of the difficulties trainees and supervisors may experience in assuring adequate breadth, as well as depth of training throughout the entire program. Increasingly State jurisdictions are starting to look at General Medicine (and other generalist) training opportunities, recognising the need for more Generalist-capable health practitioners. NSW and South Australia are working towards coordinated programs, whilst WA already has a centralised selection and appointment pathway.

Over the next year the SAC will be looking at individual hospitals in order to clarify the rotations on offer to trainees and to ensure greater consistency in our approach to certification of training. This will be incorporated into the site survey process in the future, and a working party will meet in Adelaide at the upcoming IMSANZ ASM to discuss the way forward on this issue. As always we welcome all suggestions and input.

DR ROB PICKLES FRACP
SAC Chair (Australia)

www.imsanz.org.au

IMSANZ

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Sydney NSW 2000
Australia

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Beyond Acute Medicine: Where next for General Medicine in Australia and New Zealand?

It has been an exciting time to be a General Physician in hospitals within Australia and New Zealand over recent years. Following the publication of the seminal paper, Restoring the Balance in 2005 there has been a rapid change in the recognition of General Medicine as a core function within acute facilities, with an increased focus on the use of our skills and knowledge in providing improvements in patient flow, better early hospital care through up-front consultant involvement and hopefully better teaching of junior doctors through increased supervision. The implementation of Medical Assessment Units, usually run by General Physicians, has provided shortened overall length of stay for patients, and usually a reduction in standardised mortality rates. Associated with this change has been a change in attitudes to General Medical teams by the other specialties within the hospitals. No longer are General Medical units perceived as purely being dumping grounds for patients requiring placement, but they are now perceived as being effective services for the vast numbers of complex patients with common multi-morbidity and associated acute exacerbations. The expertise of General Physicians in working to treat common acute problems as well as working with the multidisciplinary team to optimise management of the other disease processes for these patients is now well recognised and respected. The re-framing of the General Physician image is reflected in the sea-change in numbers of Advanced Trainees in General Medicine in Australia, in addition to a vast increase in those doing dual training. This is already leading to rapidly repairing the critical workforce shortages that had been present in salaried positions in Australia. Although there remain significant workforce distribution issues, the increase in trainees provides some confidence that we are heading towards much greater ability to provide an improved model of acute care in both countries.

So is it time for General and Acute Medicine to sit back and relax about the future? I don't believe that this is either appropriate or wise. There are pressures within the specialty with some advocating that we should have a new specialty of Acute Medicine, whilst others (myself included) believe that the skill of acute assessment and management of undifferentiated acute disease is a core part of the armamentarium of all General Physicians. In addition, we have concentrated on the role of the General Physician in the acute facilities over recent years, and have done relatively little to enhance the role within the community and in the healthcare continuum. This concentration on the expensive part of our scope of practice is understandable when we look back on the time when our workforce was severely depleted, and appeared to be at risk of disappearing to organ centric specialties, however I believe it is time to plan for our role in the community.

Our increasing consultant workforce now provides greater capacity for changes in models of care at a time when "Generalism" is at the forefront of Government health system planning. Increasingly General Practitioners are looking after patients with multi-morbidity and chronic disease, and under the current model these patients are referred

to multiple specialists who provide organ specific advice, often contradicting the previous specialist. The General Practitioner is often ill-equipped to balance the conflicting guidelines for the management of these patients, while communications between acute facilities, specialists and the GP is too frequently inadequate. The patients and families are confused, and spend large parts of their time sitting in waiting rooms. The usual response to changes in disease status or deterioration in patient function is either a referral to hospital or a call to the ambulance service. No wonder governments of all persuasions are now talking about Integrated Care.

So what does this mean for our profession? Talk to a GP and they will tell you that access to a General Physician is gold. Many referrals from GPs to specialist physicians are requests for advice on the management of relatively acute or chronic common problems. Our ability to think broadly when confronted with diagnostic dilemmas is highly valued, and we are able to provide advice on appropriate management on the majority of chronic diseases. The change in workforce is likely to increase access to General Medicine services in Australia and new Zealand over coming years. Consequently we are in a position where we can and should take an increasing role in the outpatient and community management of these patients, which would in turn allow the organ specialists to focus on the diagnosis and management of rare diseases or those requiring complex procedures.

In addition the majority of multi-morbid patients do not suffer from rare diseases which would require organ specific specialty management, and therefore a General Physician is usually able to provide comprehensive advice and where necessary ongoing review without the need for the patient to attend multiple specialists. This would reduce the fragmentation of care which is both expensive and arguably ineffective. Our experience in providing holistic assessment, our knowledge of disease trajectories, and our skills in working with complexity and with multidisciplinary teams gives us a unique ability to work with patients and GPs in developing and implementing effective healthcare management plans for these patients. Of course some patients do require more specialised consultation especially where procedures are required, however often the advice received from the organ specific specialist needs to be balanced against the overall state of the patient. It is likely that our engagement in this role may well reduce many of the admissions to our hospitals, and again the workforce changes may well provide much improved capacity for us to provide these services.

I therefore believe that it is timely for us to further strengthen our role in our health systems outside the acute facilities. We need to be at the forefront of developing and implementing integrated models of care, with the General Physician as a key supporter for General Practitioners. We need to become increasingly an intervening layer between GPs and the organ specialists for many of their patients, ensuring cost effective access to specialist services. We need to engage with government in overcoming some of the financial drivers and constraints which have fragmented healthcare in the past in Australia, and have led to the more acute centric role for General Physicians In New Zealand. We also need to increasingly provide training for junior doctors and advanced trainees in the community. With these changes we will further redefine the role of our profession in the modern health system. It is time to take our next step.

A/Prof NICK BUCKMASTER

145 Maquarie Street
Sydney NSW 2000
Australia

Ph: +61 2 9256 9630
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Arnagretta Hunter
Richard Lawrence
Guangji Zeng
Srinivasa Nama
Kate Grimwade
Karen Taylor
Jenny Chieng
Hugh Bakere
David Henderson
Chathurinie Aluthwala
Elke Hendrich
Kean Khoo
Allister Williams
Kirsten Ramsay
Uzodinma Dibia
Gary Yip

TRAINEE MEMBERS

Krishna Kumar Kalpurath
Justin Keasberry
Sean Leow
Sandya Jalapu
Ghulam Sarwar
Armi Solanga-Reyes
Junaid Beig
Abdullah Alhaidari
David Sern Aun Lim
Sum Team Lo
Rina Andriani
Koliarne Tong
Katie Thorne
Tina Marinelli
Alyssa Kirby
Jan Kubovy
Kavitha Abdul Razak
Michael Perera
James Gray
Lakshika Kathriarachchi
Stacey Weedon
Tobias Cyril Egli
Paul Chin
Jessica Huang

Alex (Hung-Tiong) Lau
Amna Ashar
Daniel Chivanga
Hemantha Sarath Hewage
Wai Foong Hooi
Fahid Hashem
Cameron McLaren

ASSOCIATE MEMBERS

Kerryn Griffett

www.imsanz.org.au

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Rural Medicine Conference 2014 - Medicine for the Rural Curious

Friday 24th - Sunday 26th October 2014

Dubbo Convention Centre

An Event Devoted to the Practice of Internal Medicine in Rural Australia

This 2 day event will provide an interactive and innovative approach in dealing with rural and remote medical issues. Leading experts from multiple specialties will provide updates on the latest advances in rural and remote health care.

Rural doctors are faced with challenging situations on a daily basis, and the sheer diversity of their role means they are often dual trained, and manage multiple specialties as well as emergency medicine. With such a huge workload, it can often be hard for isolated rural doctors to keep up to date. The Rural Medicine Conference is designed to support the specific needs of rural and remote doctors, and includes a Pre-Event Program, Master Clinician's clinical case analysis and the latest clinical updates.

If you are a practitioner in rural and remote Australia or have an interest in these issues, we invite you to join us for this exciting event.

Event presented in conjunction with the Royal Australasian College of Physicians, University of Sydney
School of Rural Health, and the Internal Medicine Society of Australia & New Zealand

COST: REGISTER NOW for EARLY BIRD PRICE (until 20 September 2014)
EARLY BIRD $350 - Fellows of RACP, RACGP, IMSANZ and all other Medical Professionals
EARLY BIRD $250 - Trainee Doctors and Medical Students
Post Early Bird rate $400/$300
ENQUIRIES
Phone: RACP State Manager 02 9256 9645
Email: AdminNSWOffice@racp.edu.au

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Rural Medicine Conference 2014
MEDICINE FOR THE RURAL CURIOUS
An event devoted to the practice of internal medicine in rural Australia
24 - 26 OCTOBER 2014
DUBBO, NEW SOUTH WALES
Dubbo Regional Theatre & Conference Centre
EARLY BIRD price ends 20 SEPTEMBER 2014
To register contact RACP NSW/ACT State Office on AdminNSWOffice@racp.edu.au or +612 9256 9645
For program information visit www.racp.edu.au
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km/h
The Royal Australasian College of Physicians
SYDNEY
NSW
Health
Western NSW
Local Health District

SPEAKERS

Associate Professor Ian Kerridge - Associate Professor in Bioethics and Director of the Centre for Values, Ethics and the Law in Medicine (VELiM) at the University of Sydney and Staff Haematologist/BMT Physician at Royal North Shore Hospital, Sydney

Associate Professor John Worthington - Conjoint Associate Professor of the University of NSW, the Ingham Institute of Applied Medical Research, and a Senior Staff Specialist Neurologist at Liverpool Hospital.

Dr David Allen - Specialist in Occupational and Environmental Medicine Conjoint Senior Lecturer, University of New South Wales, lead of the RACP telehealth group

Dr Mark Douglas - Infectious Diseases Physician, Senior Lecturer in Hepatology and Virology, the Storr Liver Unit, Westmead Millennium Research Institute.

Associate Professor Randall Greenberg - Associate Professor of Medicine, School of Rural Health, and Director of Medical Services, Dubbo Base Hospital

Associate Professor Mark Arnold - Associate Dean and Head, University of Sydney School of Rural Health

Dr Jeniffer Fiore-Chapman & Dr Colin McLintock - Staff Specialist Nephrologists, Dubbo Base Hospital

Dr Andrew French - Clinical Lecturer in Medicine, School of Rural Health

Dr Brett Jones - Research Group Leader, Hepatology, Department of Liver and Digestive Diseases, Kolling Institute

Dr Robert Pickles - Conjoint Senior Lecturer, School of Biomedical Sciences and Pharmacy, Faculty of Health and Medicine, the University of Newcastle

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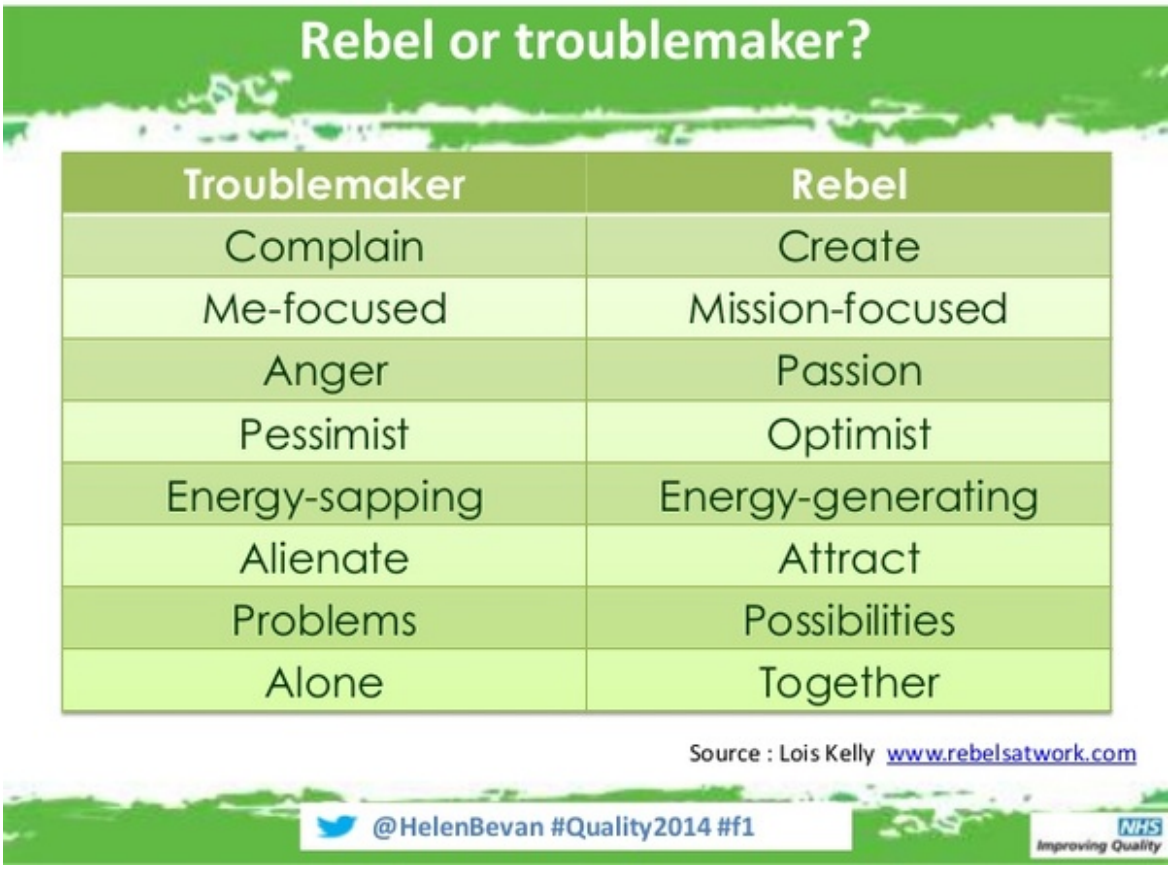
Quality and Safety in Paris in the Spring-time

I went to this meeting in April with Pip Shirtcliffe and 60 or 70 other New Zealanders. A load of Aussies, a great many Brits, plenty of Scandinavians, some Canadians and tiny number of French delegates contributed to the 3,000 attendees. My hope was that I would come away with some clearer ideas as to how we might fashion a more patient-focused health service. I've been thinking about this for a while having read some interesting stuff from The States many years ago where they were designing the physical layout of hospitals around patient needs. This conference gave me a whole lot of new ideas.

I started off at a one day workshop for 'The School for Health and Care Radicals' the day prior to the conference. From this I came away with the following ideas: hierarchy is dead - networking is where it's at; if you want to make small scale changes do it through close/tight (traditional) connections; if you want to make large scale changes you need to do it through loose/distant connections. The facilitators are great fans of twitter to the extent that all presentations at the meeting had a twitter hash tag and tweeting workshops were held each lunch time to get people started.

There was a great slide that distinguished radicals from trouble-makers. I'm not sure if you change from one to the other but you can see why rebels get listened to and trouble makers get dismissed.



The conference proper started the next day and straight away the emphasis was on patient focused care. I really liked the notion that the only common denominator in the series of processes that a patient experiences is the patient him/herself and that delivering value as defined by the end-user will equate to value by any other measure. Certainly when we do our patient surveys they are clear that they want effective safe care – as well as courteous behaviour and clear communication. There were

great anecdotes demonstrating that our perceptions of a patient's experience in hospital are markedly different from the patient themselves. Best was a story from an orthopaedic surgeon whose Mum was admitted to his hospital. He was terribly proud of the way she had been treated and cared for. Some weeks ago he was shocked to hear his mother describe it as the most terrifying experience she had in her life.

Shadowing is a technique being used widely to understand what the patient experiences. In some organizations senior clinicians do this – once is enough to radically change one's perspective we learned. This has led to significant service redesign – such as allowing patients waiting for surgery to see the theatre list (their name only) so that they could see how far away they are from surgery. There were more anecdotes that reinforced the fact that it's not individuals but the system that dictates whether a patient has a good or a bad time in hospital.

The most exciting session for me was the one entitled 'Open Notes – Patients and doctors on the same page.' It started with a talk by Stefan Biesdorf an IT expert from the corporate world (McKinsey) who updated us on where we have got to with digital healthcare. Apparently the iPhone-6 will have software for both recording and interpreting ECGs. Already Mayo and Cleveland Clinics offer 2nd opinions via the internet and many organisations enable outpatient bookings with specialists to be made in the same way that I book a hair appointment. In an era where most of us book our airline flights and do all our banking via the internet it makes sense that we expect healthcare to be available in the same way. He said that this is definitely happening and the only question is whether it will be led by Google or the medical profession. He suggested that the latter would be better but the former was more likely.

The second speaker was the wonderful Tom Delbanco, professor of primary care at Harvard Medical School and co-founder of the OpenNotes initiative for shared notes. He described how more than 3 million Americans have access to their medical records and what this has meant for both patients and doctors. This started as the sharing of electronic health records of ambulatory care patients but is now being extended to inpatients. This initiative started at a workshop many years ago where someone coined the phrase "nothing about me, without me". I found these talks hugely inspiring and I wanted to go straight back to Auckland Hospital and put the patient's notes on the bedside locker for them and their families to read. Can you imagine how useful it would be when the smart, lawyer daughter of your non-English-speaking Tongan patient comes in to hospital during the evening and is able to read your notes and make corrections or suggestions for you via the notes? The increase in safety where the patient or family members are able to read the drug chart and see that you have left off important medication or prescribed something to which they are allergic? Obviously there are logistical questions with regard to privacy, health literacy and so forth but the good news is that we had a breakfast meeting in Paris where Gillian Bohm from the Health Quality and Safety Commission asked for ideas that we could work on collectively and it was agreed that Open Notes was the project that we were most keen to pursue.

I think there is going to be a sea-change whereby digital access to health information will transfer power from the medical profession to patients. 'Bring it on' I say. It will be good for us too.

DR ROBYN TOOMATH

145 Maquarie Street
Sydney NSW 2000
Australia

Ph: +61 2 9256 9630
Fax: +61 2 9247 7214
Email: imsanz@imsanz.org.au

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