



## **President's Report 2004**

It is with pleasure that I recount the activities of IMSANZ over the last 12 months. It has been a year of major change within the college and a year in which IMSANZ has been able to forge a new agenda in general medicine. Let me first thank all members of council for their efforts during this time and to you our members for your thoughts and comments on the various initiatives we have undertaken.

### **Annual Scientific Meeting**

The 2004 college ASM in Canberra is the second for which the Adult Medicine program has been organised more or less entirely by a committee of IMSANZ councillors. Les Bolitho and Mary-Ann Ryall are to be particularly congratulated for their work in producing a very interesting scientific program. However this has not been without some struggle against disco-ordinated interactions with central college office and the absence, until recently, of reimbursement of costs incurred by IMSANZ in organising the 2003 and 2004 meetings. There was also dissatisfaction at the unilateral decision by the college in March this year to reconsider the host site for the 2005 meeting which originally had been Wellington but was proposed to be Auckland. I am pleased to say that following discussions involving myself, Les Bolitho, Craig Patterson (CEO) and Geoffrey Metz that a more streamlined ASM organising structure has been introduced, IMSANZ will be paid \$10,000 for costs incurred in organising the 2004 meeting, and an inspection of facilities at the two NZ sites has led to reinstatement of Wellington as the host city for 2005. As a consequence, IMSANZ has accepted the invitation from the college to assist in organising the 2005 meeting.

### **Strategic Plan 2003-2007**

In August last year, IMSANZ Council ratified a 5 year strategic plan for the Society which included a major restructuring of Council operations and functions in the form of a new committee structure. The aim was to make Council policy-making more inclusive, to share the increasing workload of the Council more evenly among its members, and to allow councillors to select the areas of work best suited to their interests and skills. Each committee was to address specific issues and aims to achieve various objectives using a number of strategies outlined in the August 2003 newsletter. More recently, Council decided that portfolios may function better than committees and that the original list of 7 committees could be further consolidated to four. The current portfolios comprise Resources (comprising Members and Expenditure) chaired by Les Bolitho, Education and Training chaired by Phillippa Poole, Communications and Health Policy chaired by Justin LaBrooy, and Research chaired by myself. It is of interest that in the new college organizational structure proposed by the college CEO, departments similar to the portfolio structure now existing within IMSANZ are planned which, we hope, will make our interactions with the college more efficient. The portfolios are engaged in various activities and outcomes will be reported in the newsletter from time to time. I encourage members to forward any thoughts or comments they have to the relevant portfolio chair.

### **Report and Recommendations from the 2003 General Medicine Forum**

The official college report on the General Medicine Forum held in March 2003 was released a year later in March this year and it has been summarised in the April newsletter. To briefly recap, the Forum was a response to the concern of the college to the decline in general medicine services and the diminishing number of general physicians and general medicine trainees. The key issues confronting general medicine in Australia and New Zealand were discussed along with strategies that the RACP could implement, or recommend to other bodies, to strengthen general medicine. Training programs relevant to general physician trainees were also discussed and are now part of the review of the entire college training program being undertaken by the Education Strategy Taskforce.

The Forum was attended by Fellows and trainees from Australia and New Zealand and representatives of the federal and NSW, Queensland and Victorian health departments, AMWAC, the Medical Training Education Council of NSW, and the Hunter Area Health Services. It is worth restating the Forum recommendations developed and endorsed by both the Adult Medicine Division Committee and IMSANZ:

1. The College affirms its support for general medicine training at both basic and advanced training levels, as well as the continued existence of general medicine as a subspecialty of internal medicine.
2. The College affirms its support for the concept that general medicine plays an important, cost-effective role in the provision of internal medicine health services in the Australasian environment, both in metropolitan and in regional and rural areas.
3. The College believes that academic general medicine units have an important role in sustaining and promoting the discipline of general medicine and the future training of specialists in general medicine.
4. In an environment in which all Fellows and trainees are being encouraged to acquire and maintain skills outside their subspecialty area, the specialty of general medicine should be recognised as being a provider of such skills.
5. The College will work with relevant external agencies, particularly the Commonwealth Department of Health and Ageing, State Health Departments and area health authorities, to address issues which are seen to impact negatively on the future of general medicine. These include issues such as rebates for cognitive work, the maintenance of general medicine units in tertiary hospitals, maintenance of and support for medical registrar positions in regional hospitals, and working conditions in rural and regional sites.
6. In relation to advanced training, the College will work with the SACs and specialty societies to ensure that: a) trainees in general medicine have access to a range of rotations, including those that include procedural skills that are appropriate and necessary for general physicians, particularly those in regional and rural areas; and b) trainees in other subspecialties are made aware of the benefits of elective training being undertaken outside the primary subspecialty area.

The Forum also heard support for the concept of dual training which is extensively practised in New Zealand and the United Kingdom. IMSANZ Council has proposed that the entire training program remain at the current duration of six years but instead comprise a '2+2+2' format. The first 2 years (PGY2 & 3) would comprise basic training followed by 4 years of advanced training comprising 2 years in a 'general medicine' curriculum (which could include rotations through general medicine units, subspecialty units, and other disciplines such as public health or occupational health) and 2 years in a designated subspecialty. The four years of advanced training could be undertaken in any order. This change in training would lead to dual certification in general medicine and a subspecialty.

There was also support, though by no means unanimous, for the mandatory rotation of basic trainees to regional and rural training posts for periods of no more than 6 months. Advanced trainees interested in pursuing careers as general physicians would also be strongly encouraged to undertake such rotations. Trainees at the Forum spoke of the educational and experiential benefits of rotating through regional hospitals which provided appropriate levels of supervision and training support. In the Hunter region of NSW a new model of trainee appointment has emerged whereby funding follows the trainee not the position, and in this way allows trainees to devise in liaison with others how they want to spend their time across a range of specialty rotations in both tertiary and regional hospitals. Aidan Foy and Julia Lowe have pioneered these new approaches as was discussed in the April newsletter.

In the months since March, Council has been working on developing a blueprint by which the Forum recommendations can be put into action, and I will refer to this later in my report.

### **Developing a Training Curriculum in General Medicine**

This leads on to the major task undertaken by the IMSANZ Curriculum Writing Group (CWG) led by Phillippa Poole and Andrew Bowers and comprising 12 councillors and members. As you know

the college is subjecting its training program to external review by the Australian Medical Council later this year in order to continue to be accredited as the college for physician training. For the first time in its history, and with the help of colleagues from the UK college, the RACP is asking every specialty society to develop a curriculum which will guide and underpin their individual training programs. As you would expect, writing a curriculum for general medicine is a challenge given the breadth of our discipline and the CWG was keen to define the distinctive characteristics of the general physician and orientate the curriculum towards developing these. More than 25 separate characteristics were listed for which learning objectives and sets of knowledge, skills and attitudes had to be written. The IMSANZ CWG began work with the attendance of myself, Les Bolitho, Briar Peat and Andrew Bowers at a CWG workshop in Sydney in mid-March this year. The penultimate draft of the curriculum was released to all members of Council and the SAC in General Medicine for comment on the 31/7/04, and it is hoped that release to all members will occur during August. This has been a major effort within a period of 4 months and I would like to acknowledge the efforts of all those involved.

### **Regional and Rural Services in General Medicine**

A major focus of attention for IMSANZ Council in recent times has been on how to improve the lot of general physicians working in regional and rural areas. Particular emphasis has centred on workforce needs and shortages in rural areas and access to physician trainees. Last August, David Russell from Victoria was instrumental in bringing these issues to a head in that state. Tertiary hospitals in Melbourne had threatened to terminate registrar rotations to the rural hospitals of Horsham and Wodonga on the basis that such rotations were perceived as a disincentive to attracting registrars in filling tertiary posts. In response, David wrote to the Victorian Minister of Human Services outlining the need for an equitable system of registrar secondment from Melbourne hospitals if closure of beds at regional hospitals was to be avoided. As a result, the CEOs of the relevant Melbourne hospitals, government officials and members of the Victorian state committee of the RACP met to work out a mutually agreed plan of secondment which stipulated, as from January this year, mandatory rotations to rural centres of basic physician trainees for a period of at least 3 months.

IMSAMZ is presently awaiting the college to mandate similar rotations for all basic trainees in all states. We have also proposed a regionalised system of registrar recruitment and rotation by which all geographic areas in Australia would be covered by a 'hub-and-spoke' model comprising a tertiary hospital and affiliated provincial and rural hospitals.

Recently, IMSANZ has compiled an inventory of advanced training positions in general medicine in 33 metropolitan and regional hospitals in Australia and New Zealand. Training guides and copies of the first issue of the database on CD were distributed to trainees yesterday at the Trainees Skill Day and will be advertised through our website and through offices of Directors of Medicine and Directors of Physician Training. This will allow all our advanced trainees who may be considering, or working towards, a career as a general physician to see the opportunities and special interests that hospitals, both tertiary and regional, have to offer.

Diane Howard and Kenneth Ng have formed a network of rural physicians throughout NT, SA and WA with the aim of providing professional and social support. This complements networks already existing in Victoria, NSW, and north Queensland. In NSW, Mike Kennedy and Kerry Goulston have been active within the Greater Metropolitan Transition Taskforce in promoting the return to Sydney teaching hospitals of general medical units staffed with full-time general physicians. Earlier this year I wrote to the NSW Director General of Health indicating our concern over the appointment of subspecialists with minimal skills in general medicine to general physician positions in outer Sydney hospitals. To date I have received no reply but we continue to monitor the situation. Finally we continue to support our colleagues who perform outreach services to remote communities by lobbying for more funding for the Medical Specialists Outreach Assistance Program and encouraging more of our metropolitan colleagues to consider locums and other forms of relief for our hard pressed rural colleagues.

### **Advancing General Medicine: An Agenda for Change**

In response to the General Medicine Forum recommendations, to resolutions about new working relationships between the college and the specialty societies, and to developments in the RACP Educational Strategy, IMSANZ has released a draft action plan for achieving a number of key objectives related to services and training in general medicine. This document with the above mentioned title has been reviewed by Council and has received contributions from Rick McLean, chair of the RACP Rural Taskforce and new chair of the AMDC, and Sue Morey, former Chief Health Officer of NSW. The plan comprises 4 domains comprising training, general medical units in teaching hospitals, rural and regional services, and professional development. For each domain, specific actions, timelines and performance criteria have been enunciated. This will be discussed in more detail later in the meeting so I will not dwell on it here, except to say that we ask all members to endorse the final document and do what they can within their local areas to implement the proposed actions.

### **Awards and Scholarships**

IMSANZ Council last year endorsed the establishment of a set of awards and scholarships worth up to \$18,000 per year for promoting excellence in research, teaching and professional development in general medicine, with emphasis given to trainees and fellows of less than 5 years standing. These sponsorships are in addition to the IMSANZ/Roche award given for best paper at the IMSANZ free paper session tomorrow. Our travelling scholarship and research fellowship were included in the 2004 college listing of awards and grants.

### **Communication Media**

In the last few months the Society has subjected its website to a full makeover, modernising its style and adding new features which were outlined in the April newsletter. I wish to thank Anne Kovach for her assistance in website design. The newsletter has also seen change with more content and an increase in the number of issues to 3 per year. I thank Michelle Levinson and Tom Thompson for all their editorial assistance in producing a first-class product. The Society has also introduced a monthly e-mail service to all members who have internet summarising recent developments in college and IMSANZ affairs that are of interest to our members. All these media improvements are designed to keep our members informed of news and aware of the efforts being made by the Society to represent their interests.

### **Consultancies and Representations**

Over the last 12 months, IMSANZ was invited to review and provide formal endorsement of a number of clinical practice guidelines released by national bodies. These included the stroke guidelines from the National Stroke Foundation, the revised hypertension guidelines from the National Heart Foundation, and the secondary prevention guidelines for heart disease from the Cardiac Society of Australia and New Zealand. IMSANZ also received and made responses to a discussion document dealing with avoidable admissions in older people commissioned by the federal health department, and Gerard Carroll represented IMSANZ at a meeting discussing pre-hospital management of myocardial infarction convened by the Cardiac Society. Les Bolitho attended the Australian Health Care Summit in September last year as a representative of both IMSANZ and the RACP Rural Taskforce. Michael Kennedy assists Australian Prescriber and serves on a New Drugs Working Group of the National Prescribing Service, and I serve as a member of the National Institute of Clinical Studies Heart Failure Advisory Group. Our New Zealand colleagues have been involved in making submissions to their government on issues such as medical misadventure, pharmacy tenders, workforce strategies, and response plans to major disease outbreaks.

### **Scientific Meetings and Presentations**

IMSANZ was pleased to sponsor two advanced trainees, Drs Sarah Lynn and Andrew Wesseldine to attend the European School of Internal Medicine in Alicante, Spain in October last year. In addition to the RACP ASM, other scientific meetings involving IMSANZ have been the combined NZ Rheumatology Association/RACP/IMSANZ meeting in Rotorua in August last year, the very successful NZ IMSANZ meeting in Nelson last month organised by Bruce King, and the forthcoming RACP NZ/TSANZ/IMSANZ meeting in Christchurch in August. I have been involved in

organising a national heart forum sponsored by NICS to be held in Canberra in June. Also, IMSANZ represented by Les Bolitho is assisting the RACP in its bid in Granada later this year for Melbourne to be anointed host city for the 2010 International Congress of Internal Medicine. This meeting attracts more than 3,000 delegates from around the world and is the annual forum of the International Society of Internal Medicine of which the RACP became a member 2 years ago. We are very fortunate in having both its president and secretary-general as keynote speakers at a plenary session at the Canberra ASM talking to the issue of the need for more generalists.

IMSANZ Council at its meeting yesterday endorsed the idea of having an IMSANZ scientific meeting in the latter half of 2005 in Alice Springs to be conducted from 1<sup>st</sup> to 4<sup>th</sup> September. Stephen Brady and Diane Howard will comprise the local organising committee and the meeting content will comprise multiple presentations covering the spectrum of clinical practice, with special emphasis on the needs of the rural and remote physician.

### **New Members and Councillors**

On behalf of the Society I welcome the 35 new members who have joined us over the last year. I would also like to express the gratitude of council to the efforts over the last 2 years of Rob Nightingale, Kenneth Ng, Thein Htut and Graeme Dickson who today have completed their terms as councillors. We wish them well and know they will continue their ongoing interest in society affairs. I also regret the need for David Russell to stand down for personal reasons and look forward to his being able to rejoin council in the near future. As their replacements on Council I welcome Nicole Hancock from Tasmania, Peter Nolan from Queensland, Christian de Chaneet from WA, Michele Levinson from Victoria, and Patrick Gladding from NZ. It is also my pleasure to announce that Phillipa Poole has accepted nomination as president elect for 2005 and will become our first female president. Finally I would like to give special thanks to the Society's secretariat, Mary Fitzgerald. Mary took over from Cherie McCune after last year's AGM and has had a baptism of fire, having to cope with a surge in workload and a complete relocation of her office back to 145 Macquarie Street. She has managed to execute all the tasks we have handed to her with both efficiency and remarkable affability and she deserves our appreciation for a difficult job well done.

### **Closing Comments**

In closing I hope this report gives an indication of the level of activity that IMSANZ is presently engaged in. This Society has come a long way since its beginnings in 1992 but there are new challenges that we will all need to grapple with over the next few years. There are three certainties in life: death, taxes and change; and if we are to take full advantage of the opportunities that change provides us in shaping the agenda of college and government policy in a way that allows general medicine to flourish, then we must be prepared as a community of physicians to be actively involved and be the engineers of that change. Our society and our discipline can only have influence if those who practise within it stand united and committed to a vision of progress and the means for achieving it. I thank all members for their support.

Ian Scott  
President, IMSANZ  
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