



*Internal Medicine Society of Australia and New Zealand
Royal Australasian College of Physicians
Health Policy Unit*

A black and white photograph of a stethoscope, with the chest piece in the foreground and the tubing looping across the frame. The background is blurred, showing what appears to be a person's face.

General Medicine in Australia and New Zealand

The Way Forward

The Royal Australasian College of Physicians believes in open dialogue with the community to ensure sustainable solutions are found to the many challenges identified in the health sector. This document is produced in collaboration with the Health Policy Unit of the Royal Australasian College of Physicians.



ISBN 0909 783 462

© **Internal Medicine Society of Australia and New Zealand**

Published by The Royal Australasian College of Physicians and the Internal Medicine Society of Australia and New Zealand, Sydney, 2000.

Further copies and information available from:

IMSANZ

145 Macquarie Street, Sydney NSW 2000

Ph: 61 2 9256 5444, Fax: 61 2 9252 3310

Email: imsanz@raipedu.au

Introduction

The Internal Medicine Society of Australia & New Zealand (IMSANZ) in association with the Health Policy Unit of the RACP, and with the support of the President and Council of the Royal Australasian College of Physicians has produced the accompanying document, “*General Medicine in Australia and New Zealand*”.

This document outlines the current position of General Medicine in Australasia and, more importantly, details plans to re-establish General Medicine in a central role in the provision of secondary and tertiary care over the next decade.

The goals and objectives set out in the section of the paper headed “The Way Forward” will initially have a focus on informing consumer groups, health policy makers, health administrators, and other health care providers in a constructive way of the strengths General Medicine has to offer in provision of health care in the new millennium, particularly its cost-effectiveness.

The document also has a major focus on plans for training of more General Physicians to meet the shortages which exist, particularly in rural/provincial areas, and major metropolitan centres. We look forward to what we believe is a significant and very positive initiative in health care provision in Australasia.

Neil Graham
President
IMSANZ

Richard Larkins
President
RACP

Executive Summary

General physicians have a breadth and depth of knowledge and experience which makes them ideally suited to providing high quality specialist services across a spectrum of health and illness, which is not limited by the boundaries of medical subspecialties. These capacities place general physicians in important and responsible positions as clinicians, teachers and researchers. These roles are particularly relevant to the care of patients whose problems are undifferentiated and/or affect multiple organ systems, where clinical issues do not fall neatly within the domains of sub-specialties, and where the integration of multi-disciplinary expertise may be required.¹⁻³

The practice of general medicine however, is at risk of disappearing from public and private practice alike. The average age of general physicians is significantly older than that of subspecialists.⁷ RACP workforce statistics show a disproportionately small number of general physicians being trained in relation to subspecialists, declining numbers of general physicians in teaching hospitals, and inadequate numbers of general physicians servicing metropolitan, provincial and rural populations.⁷ New Zealand medical workforce surveys have shown that over the past ten years the ratio of subspecialists to generalists has increased from 2:1 to greater than 3.5:1. In addition, the number of general physicians available to service the specialist needs of rural and remote centres is approaching crisis point in some areas.

The reasons for the decline of general medicine are many and complex, and include matters relating to remuneration, changes in technology and hospital practice lifestyle issues, and loss of academic departments of general medicine and general physician role models.

One of the most significant outcomes from a decline in general medicine has been the compartmentalisation of care by medical subspecialty. This means that significant co-morbidity and patient concerns unrelated to the particular subspecialty are overlooked, misdiagnosed or inappropriately managed. Some hospitals are using subspecialist services exclusively to deliver health care to populations with complex multi-system medical problems. This process may not always be in the best interests of patients, or cost effective for the organisation.

General physicians and IMSANZ will therefore constructively engage hospital administrators, general practitioners and subspecialty groups in the debate on roles and responsibilities of general physicians and general medical units. Important points to be considered and emphasised in these discussions are:

1. A generalist has a wide range of skills to offer but is best utilised as a consultant physician for complex, multi-faceted or undiagnosed cases, and should remain involved in such cases as a supervisor of ongoing care if there are significant and multiple co-morbid conditions.
2. Role models provided by general physicians are needed in modern times given the increasing complexity, intensity and cost of specialist practice in internal medicine.
3. General physicians or general medical units can contribute substantially at secondary and tertiary centres to the acute care of undifferentiated and/or severely ill patients with multi-system disease, in collaboration especially with emergency departments and intensive care units.

Recommendations

Government

- Promote efficient use of health care resources so as to provide a high standard of care for individuals whilst achieving meaningful population health goals.
- Recognise the health consumers' role in the determination of appropriate care delivery mechanisms.
- Reconcile imperatives to rationalise acute hospital services, facilitate technological developments and achieve economies of scale with demands from the community for locally accessible, 'whole patient' health services.
- Recognise that economy and efficiency in health service delivery results from general physicians providing 'whole patient' health care.
- Recognise general physicians as key participants in clinical epidemiology and critical appraisal, ethics, clinical informatics, health technology assessment, clinical audit and health service research.
- Aim to provide the physical infrastructure and human resources required for the high-quality practice of internal medicine in non-metropolitan localities.

Hospitals and Universities

- Maintain or re-establish General Medical Units in metropolitan teaching hospitals.
- Expand general medical units in smaller hospitals.
- Workforce planning for generalist physicians should consider on-call working conditions.
- Develop attractive and useful training programs and rotations for general medicine advanced trainees.
- Expand (or re-establish) academic general medical units within universities and teaching hospitals.
- Develop hospital based data collection systems to help determine when generalist care is more appropriate than specialist care.

- Determine which hospital level services are delivered more efficiently and with better patient access by community based general physicians as opposed to tertiary hospital based subspecialists and vice versa.
- Determine protocols and pathways of providing care to patients who present initially with undifferentiated illness, but who may later require subspecialist expertise.

RACP and IMSANZ

- Further define roles and responsibilities of generalists and demonstrate and promote the value and cost effectiveness of general medicine units, general medical practice and training in general medicine to medical and hospital administrators, health bureaucrats and consumer groups.
- Promote the value of general medicine training and the culture of general medicine to undergraduates, interns and RACP basic trainees.
- Optimise general medicine training and clinical workforce numbers by working closely with the Australian Medical Workforce Advisory Committee (AMWAC) and the RACP to quantify and predict workforce requirements and distribution.

General Medicine and the General Physician

A general physician is one whose training and expertise enables practise as a consultant across the broad field of internal medicine as it applies to adolescents and adults. There are four areas where general physicians are cost effective care providers: undifferentiated problems; multi-system disease; acute presentations of single organ systems which are of mild to moderate complexity; and ambulatory and post-acute care which involves liaison with primary medical and non-medical providers.^{1,2}

General physician practice adopts a scientific approach to the patient as a whole person, notwithstanding an interest and training in a particular subspecialty field. General medicine is thus a vast specialty with respect to the knowledge, experience and skill required for effective practice.

This breadth and depth of knowledge and experience make general physicians ideally suited to providing high quality specialist services across a spectrum of health and illness which is not limited by the boundaries of medical sub-specialties. These capacities place general physicians in an important and responsible position as clinicians, teachers and researchers, particularly where problems are undifferentiated and affect multi organ

systems, where there are clinical issues which do not fall within the domains of subspecialties and where the integration of multi-disciplinary expertise may be required.³

General physicians are important to the delivery of health care in metropolitan, provincial and rural settings alike. As the number of patients presenting with complex co-morbidities increases with the ageing of our population, the likelihood of subspecialists being able to provide 'whole patient' care decreases. Increasing numbers of cross-referrals involving more subspecialists may result. In this situation, a general physician is likely to provide cost and patient care benefits. This phenomenon is not confined to provincial or rural practice and is increasingly being seen in our major public hospitals.

It is important to stress that the roles of general physicians and subspecialists are, and should remain, complementary rather than competitive.

Studies show that, as the primary provider, general physicians who consult subspecialty colleagues when appropriate can achieve equivalent outcomes at same or less cost for a range of clinical conditions.^{4,6} The appropriate use of general physicians in the tertiary hospital environment allows subspecialists to concentrate their efforts on difficult subspecialty cases which require their particular skills, consultations, and the development of systems to ensure quality care in the subspecialty, research and post graduate training.

The Internal Medicine Society of Australia & New Zealand (IMSANZ)

IMSANZ is the Australasian Society of General Physicians. It provides a mechanism to develop the academic and professional profile and culture of general physicians and to encourage the development or re-establishment of general medical units in teaching hospitals and networking of other hospitals to allow general medical training. It seeks to articulate, advocate for, and sponsor the educational, training, research and workforce requirements of general internal medicine. Since its inception, IMSANZ has publicised these issues in the production of training guidelines, policy documents, newsletters, and journal articles. It has also set up databases containing information on the geographic distribution, skills base, academic interests, and specialty affiliations of the general physician membership.

The Royal Australasian College of Physicians

The Royal Australasian College of Physicians (RACP) comprises a Fellowship of medical consultants who are committed to providing the highest quality of care in internal medicine, paediatrics and their sub-specialties for the people of Australia and New Zealand.

The RACP represents over 7,000 Fellows who include Fellows of the College and its Faculties of Rehabilitation Medicine, Public Health Medicine and Occupational Medicine. In addition, the RACP encompasses a range of associated Special Societies representing the spectrum of specialist practice in Internal Medicine. Core functions of the RACP include training, accreditation and maintenance of professional standards, research and policy in areas such as workforce, public health, health financing and systems development.

The Current Status of General Medicine in Australia and New Zealand

Challenges

General physician practice is at risk of disappearing from both public and private practice alike. The average age of general physicians is significantly older than that of subspecialists.⁷ Fewer physician trainees are graduating from advanced training programs in general medicine and then progressing to practice in this area.⁸ In addition, the numbers of general physicians available to service the specialist needs of rural and remote centres is approaching crisis point in some regions,⁹ adding further weight to the call for more general physician trainees.

Following is the profile of general physician practice in Australasia at present.

Queensland

The major metropolitan hospitals of Royal Brisbane and Princes Alexandra have established general medical units. Large regional centres (eg. Toowoomba, Nambour, Gold Coast) have departments of general medicine staffed by general physicians.

However, some provincial centres such as Mackay, Rockhampton, and Mt. Isa have precariously low numbers of general physicians.⁹ Based on a ratio of one physician to 10,000 population, it has been estimated that 41 additional general physicians are needed to service the provincial and mid-sized centres.¹⁰

South Australia

General medical units are in place at the Royal Adelaide, Modbury and Lyall McEwin Hospitals, with combined specialist, Flinders Medical Centre and general units at the remaining teaching hospitals. Although there are many general physicians in private practice, there is a need to plan the succession of Fellows currently in practice in regional centres.

Victoria

General medical units are well established at Royal Melbourne Hospital, Austin and Repatriation Medical Centre and St Vincent's Hospital. In recent years, certainly at RMH, there has

been and continues to be a drift of selected patients away from general medicine.

In contrast, general medicine is less well developed at the Alfred Hospital. In recent years, several trainees have moved away from the Alfred because of this.

Monash Medical Centre has two general units and an Acute Medical Unit for the Aged. There are no general medicine advanced trainees, and the eight consultants on the roster are subspecialists with an interest in general medicine.

Austin & Repatriation Medical centre - one of Victoria's largest teaching hospitals has four general medical units, each with four general physicians and each has a normal 18 beds although the number is often exceeded due to patient demand.

In the smaller and more peripheral hospitals such as Northern, Western, Dandenong, Sandringham, Frankston and Ringwood, general medical services are maintained.

Rural Victoria, with an estimated need for 20 general physicians, has hospitals with excellent General Physician services including subspecialty interests.

New South Wales

Royal North Shore Hospital retains a general medical unit, with an acute general medicine roster running in parallel with other specialty rosters including an acute Aged Care Service.

An advanced trainee program in general medicine is very active, including two rural positions. Liverpool, Concord, John Hunter and Newcastle Mater Misericordiae Hospitals have also retained general medical units and rosters. A general medicine training program in Newcastle includes a rural rotation.

All district hospitals in Sydney maintain general rosters. Wollongong retains a general admitting roster with patients often triaged to local smaller hospitals.

Physicians in rural practice estimate a need for twelve extra general physicians and varying numbers and types of subspecialists.

ACT

The Canberra Hospital now has no general medical units, general physician appointments or trainees. Calvary Hospital has a general medical 'take', with six physicians (two generalists with interests, and four subspecialists). A general medicine training program is in place and is awaiting an applicant.

Western Australia

All of the large public and private hospitals have active general medical units. Royal Perth Hospital and Fremantle Hospital have full-time academic general physicians. Attempts have been made to phase out general medical units at Sir Charles Gairdner Hospital, but it remains in a reasonably healthy state, albeit with only four physicians. Of the 60 general physicians in WA, only seven are based outside of Perth, with rural centres requiring an additional 20 general physicians.

Northern Territory

Most subspecialists still maintain a high degree of generalist practice and there is scope for generalists to practice in a subspecialty area. A further ten physicians could be utilised immediately, but this would still not allow the delivery of best practice as provided by colleagues in eastern seaboard centres.

Tasmania

All metropolitan and non-metropolitan hospitals have general medical units. Regional centres in Tasmania could absorb up to 10 extra general physicians with interests in various subspecialties.

New Zealand

General medical units continue to be an important part of acute medical services. In the past there have been concerns about the decline of general medicine in major centres such as Wellington and Dunedin. But these general medical units have since become driving forces within their organisations. Although essential within larger provincial hospitals, the lack of newly qualified generalists means hospitals appoint subspecialists. There is a decline of medical services in smaller centres, with issues of lifestyle, clinical workloads and locum relief being frequently cited reasons for resignation. It is estimated that 50 general physicians nationwide could be placed immediately.

Based on this profile, approximately 160 additional general physicians are needed right now to meet current shortfalls in the provincial and rural physician workforce in Australia and New Zealand. More will be needed over time as the ranks of practicing physicians diminish as a result of retirement or relocation. However, RACP workforce statistics show a disproportionately small number of general physicians being trained in relation to subspecialists, declining numbers of general physicians in teaching hospitals and inadequate numbers of general physicians servicing metropolitan, provincial and rural populations.⁷ New Zealand medical workforce surveys have shown that over the past ten years the ratio of subspecialists to generalists has increased from 2:1 to greater than 3.5:1.

It is recognised that many physicians who undertake advanced training in subspecialty, eventually undertake practice where they have significant responsibilities in general medicine. Given adequate general medical training and experience during basic physician training, and some breadth to their advanced training, this is perfectly reasonable and often an excellent model in large and smaller provincial centres where several physicians each with areas of subspecialty expertise share general medical responsibilities.

Many public teaching hospitals in Australia have been closing medical beds, decreasing the number of general physician Visiting Medical Officers (VMOs), and streaming acute patients to subspecialty units. Financial cutbacks and managerial changes have produced major stresses, including increased competition for scarce resources, sometimes resulting in a reduction in the number and functional capacity of what are cost-effective general medical units. This has been accentuated by competing subspecialty interests, especially those which attract proportionately greater revenue from inpatient procedural services provided to patients with single system disease, as opposed general medical units which offer services which are relatively more consultative, and directed at patients with multi-system problems, who incur longer hospital stays and who have an increasing demand for services in outpatient settings.¹¹

Opportunities

General physicians remain passionate about general medicine. Their varied roles and responsibilities provide a high level of job satisfaction. Hospital based general physicians are involved in service provision, medical student education and postgraduate trainee supervision. There are many opportunities for generalist-led research in leading areas such as evidence-based medicine, clinical epidemiology, health services research and clinical informatics.¹² Moreover, the tools and methods of evidence-based medicine are making

medical literature readily accessible and interpretable to general physicians. Evidence - Based Medicine is also becoming more relevant to the needs of health service managers and policy makers who are also responsible for making informed decisions with regards to efficient and equitable allocation and use of limited resources.

The current emphasis on “access” in health policy promotes tertiary level service development at a regional rather than central level. This in turn necessitates that subspecialty units redistribute resources and workforce to regional hospitals which are frequently staffed by full-time and visiting general physicians.

Managers in many tertiary hospitals as well as professional colleagues such as surgeons and psychiatrists are actively campaigning for retention of general medicine services given the need for managing patients with multi-system and expansion undifferentiated problems. The drive for greater efficiencies in hospital care demands more involvement of general physicians given the higher marginal costs associated with care provided exclusively by subspecialists and the need for better integration of health service delivery.

With the advocacy of IMSANZ and local opinion leaders, teaching hospitals are developing more structured training programs for general trainees, particularly as a means of attracting and retaining these medical registrars within general medicine training programs. These trainees can then be seconded to affiliated regional hospitals, with whom cross-referral links are being developed.

In New Zealand, general medical units exist in most hospitals demonstrating good collaborative relationships between general practitioners, general physicians and subspecialty colleagues. Examples of such relationships include:

- Rapid and appropriate referral via a general physician to subspecialty groups on the basis of valid and defined selection criteria¹³
- General medical assessment for the majority of surgical patients.
- Integration of geriatricians into general medical units facilitating service enhancements and more efficient geriatric evaluation and rehabilitation. Such integration is even more important given the separation of funding of general medical from geriatric and rehabilitation services.

General physicians are well placed to offer broad based teaching with an emphasis on humanistic and diagnostic skills, particularly under conditions of uncertainty. A large amount of undergraduate and postgraduate clinical education is provided by general physicians. Whilst funding for postgraduate teaching is becoming more constrained,

workforce needs and the provision of intergrated and cost effective care suggest a need to enhance support for general medicine training.

Factors Contributing to the Current Status

In the past 20 years or more, internal medicine has evolved with the appreciation that basic physiological, immunological and pathological mechanisms are common to all tissue, organs and disease processes. This has increasingly united physicians with different areas of interest into common intellectual and clinical territory. In specialties where procedural techniques constitute a major component of the physician's time, there is a risk of increasing isolation from the broader dynamics of consultative internal medicine. This may lead to a lack of confidence outside the particular subspecialty, and a reduced knowledge base and competence in certain areas of practice.¹⁴

The reasons for the decline of general medicine vis-a-vis the subspecialties are many and complex:

- Expansion in recent decades of subspecialisation
- Advances in technology driving growth in subspecialisation
- Historical inequity in remuneration between procedural and non-procedural generalists
- More full-time subspecialists in teaching hospitals with comparatively small numbers of general physicians
- Loss of academic departments of general medicine
- Limited research opportunities for generalists because of demands on them for clinical care and teaching
- Fewer hospital general physician role models for trainees, many of whom are subsequently attracted to subspecialties during training
- Lack of definition of the role of the generalist vis-a-vie subspecialists
- Perceived lack of career prospects for general physicians on the assumption that all clinical work in the future will be done by subspecialists
- Inadequately structured training programs for advanced trainees in general medicine
- Concern on the part of trainees about managing the vast amounts of medical knowledge required to practice general medicine.

These constraining influences are not however immutable. Trainees aspiring to procedural subspecialties as lucrative sources of income may become redundant as technological advances in equipment become unaffordable.¹⁴ In addition, within subspecialties, expert groups of non-medical providers such as coronary care nurses, oncology unit nurses, dialysis technicians, and radiologists now exert considerable influence in policy making and management of individual patients.¹⁴

Impacts on Health Care and the Health Care System

As health care systems change, general physicians continue to provide cost efficient and effective, quality whole-of-patient care. The major impacts of losing general medicine are:

- Compartmentalisation of care by medical specialty meaning that significant co-morbidities and patient concerns unrelated to the particular subspecialty are easily overlooked, misdiagnosed or inappropriately managed.
- Increased cross-referral between subspecialists, resulting in patients seeing multiple providers and incurring increased costs.
- Patient inconvenience as a result of extra time visiting subspecialists and longer hospital stays due to multiple referrals.
- Concerns about quality of patient care if other disciplines such as intensive care and emergency medicine assume primary responsibility for acute patient care under the banner of 'hospitalism'.^{15, 16}
- Increasing shortage of general physicians within metropolitan hospitals, as well as regional and rural areas.
- Increasing costs of excessive supply of subspecialty services which may not provide commensurate returns in improved patient outcomes.

RACP Advanced Training in General Medicine

The process of training as a general physician begins during the undergraduate years and facilitates the development of essential skills and attitudes required for a worthwhile and satisfying professional life. While clinical skills are critical, additional skills are required for the teaching, administrative and research roles which consultant general physicians ultimately fulfil.

The total number of advanced trainees in general medicine has remained static over the

past five years, averaging 45 advanced trainees per year. This number of trainees overestimates the number who complete advanced general medical training. A disturbing proportion (70%) switch to a subspecialty after the first year of advanced training.⁸ Moreover, over 85% of all RACP trainees continue to train in subspecialties.⁷

Reasons for the marked preference for subspecialty training at the expense of general medicine are many and complex:

- The loss of academic departments of general medicine in major teaching hospitals
- Difficulties faced by general trainees in competing for coveted subspecialty training positions
- Lack of general physician role models for trainees
- Perception of fewer job opportunities
- Perception that a career path may only be in regional or rural centres
- Perception that a career in general medicine consists entirely of providing consultative services and general medical teaching, to the exclusion of research and procedural activity
- Perception of little academic stimulus eg. pathways to higher degrees
- Perception of personal inability to manage the explosion in medical knowledge in order to practise effectively
- Negative labelling of generalists on the part of influential subspecialists in hospitals, professional societies and patient support groups.

Although the training program in general medicine indicates a need for procedural training, general medicine advanced trainees are often unable to compete for coveted subspecialty training positions. The future may see more advanced trainees obtaining accreditation in both general medicine and a subspecialty, using the provisions of the post-FRACP training and accreditation guidelines.³ Dual accreditation should be encouraged where budding subspecialists are obliged to assume general responsibilities and where general physicians function partly as subspecialists.

In response to shortages in the general physician workforce, the RACP in North Queensland has developed an advanced training program in general medicine. This program offers a balanced three year training program in general medicine with unquestioned access to subspecialist rotations and procedural training in bronchoscopy, gastroscopy and echocardiography. Although intended to boost rural workforce numbers,

the program is also ideal for those training in general medicine and intending to establish a metropolitan practice with a subspecialty interest.

The RACP Victorian Rural Physicians Network is also establishing a training program which offers advanced trainees opportunities for training in general medicine for up to three years. There are many aspects of these programs which are applicable to general medical training in other states and in New Zealand.

The Role of the General Physician

General Practitioners (GPs) are traditionally viewed as the 'gate keepers' of the health care system in both Australia and New Zealand. In this role GPs seek opinions from specialists on diagnosis and management. As health systems move towards the provision of more integrated health care, the general physician is ideally placed between the GP and the subspecialists, to provide cost effective investigation, treatment and management options for common medical conditions..

With the growth in subspecialisation, there has been growing pressure from patients, their relatives and general practitioners, as well as some medico-legal pressures, for patients to be seen by a subspecialist. However, patients are also increasingly asserting their right to choose 'the best doctor' not just the one selected by their GP. In undifferentiated problems and multi-system disease, the best specialist is probably the general physician.¹⁷

As the population ages, much of the future acute medicine caseload will comprise elderly patients with multiple co-morbidities. General physicians with their broad training and experience in general internal medicine are well placed in this area to provide effective specialist care.¹⁸

General physicians integrate well with other colleagues (e.g. general practice, surgery, emergency medicine, psychiatry, geriatrics and other specialties) to provide an overview of medical management which may be lost with exclusive subspecialty care.¹⁹

Hospitals, health care managers and funders are recognising the potential gains in both the quality and efficiency of health care when medical services are provided by a team in which the 'breadth' of skills of generalists complement the 'depth' of skills of subspecialists.²⁰ The establishment throughout a number of Australasian hospitals, of acute medical assessment and intervention units operated by general physicians, which integrate with emergency medicine and subspecialty departments, recognises the value of involving broadly-trained physicians in the provision of acute medical care. These units provide facilities for urgent assessment and investigation of patients presenting with acute medical

problems, often negating the need for in-patient admission. As such, they are an important part of an efficient health service.^{21, 22}

There are examples within many Australian teaching hospitals of the close association between general medical units and subspecialty units in the management of patients with general medical and peri-operative problems.²³ General medicine departments in hospitals also assume responsibility for providing services in areas such as hypertension, lipidology, clinical pharmacology, vascular medicine, palliative care, acute stroke management, and non-invasive cardiology – services which deal with conditions which do not fit neatly into single disciplines and which are amenable to generalists wanting to develop a non-procedural interest.

In New Zealand, general physicians can also play an important role in the New Zealand Government's plans for the provision of integrated health care services and the coordination of Maori care at secondary level. To ensure active participation in these areas, general physician workforce numbers in moderate to large sized provincial centres need to be reviewed with a view to increasing numbers, and re-establishing an academic base for general medicine.

The Way Forward

In determining the way forward for IMSANZ, there are a number of questions which are often asked. Answers to these questions provide a guide to the type of strategies which will help improve the status of general medicine.

1. What is General Medicine?

Aim: To define general medicine as it relates to current consultant practice and to promote this widely.

Who: IMSANZ Council, RACP – Directorate of Education, Medical Workforce Advisory Committee.

Time: 2001 – 2002

Outcome: A current definition of general medicine which will enable AMWAC, State Health Authorities, hospitals, trainees and physicians to identify more accurately the subspecialty of general medicine and so help to determine workforce needs.

2. How is General Medicine practised?

Aim: To identify innovative general medicine practice in metropolitan teaching hospitals and determine the attractive elements of such models of service delivery.

Who: RACP Council, IMSANZ Council, metropolitan teaching hospitals

Time: 2001 – 2002

Outcome: A paradigm of how general physicians are being utilised within current health service provision to provide career guidance for RACP trainees, and service development guidelines for health care providers.

3. How do we encourage trainees into General Medicine?

Aim: To develop a structured mentor program for RACP basic trainees and advanced trainees in general medicine, focusing on the appeal of general medicine as a career. To promote ways of improving lifestyle aspects of general medical practice, especially in non-metropolitan areas.

Who: IMSANZ councillors, General Medicine SAC, general physicians in teaching hospitals, Directors of Physician Training, Health Administrators, Ministry of Health Officials.

Time: 2001 onwards

Outcome: General Medicine mentors in each training site across Australia and New Zealand, with a program of activities for a year with resource support from IMSANZ office. Improved working conditions of general physicians.

4. What do trainees want in a General Medicine training program?

Aim: To develop three year training programs in general medicine using the models developed in North Queensland and rural Victoria.

Who: IMSANZ Council, physicians in regional centres, non-metropolitan teaching hospitals, RACP Rural Workforce and Training Program.

Time: 2001 – 2003

Outcome: Three-year general medicine training program in non-metropolitan Australia and provincial centres of New Zealand.

5. How do we stop losing trainees to the subspecialties?

- Aim:* To increase General Medicine Advanced Trainee retention in training programs.
- Who:* IMSANZ councillors, Directors of General Medical units in teaching hospitals, Directors of Training
- Time:* 2001 onwards.
- Outcome:* Improve the retention of general medicine trainees in each advanced training year. Increase the number of trainees graduating from the general medicine SAC by two per state each year.

6. How do we prepare trainees for 'the market place'?

- Aim:* To determine the need for dual RACP accreditation appropriate for specialist consultant practice.
- Who:* General Medicine SAC, IMSANZ Council, RACP training programs, hospital medical administrators.
- Time:* 2001 – 2002
- Outcome:* Advanced trainees in general medicine and subspecialty suitable for practice as general physicians with specialty interests.

7. How do we ensure IMSANZ represents general physicians at the policy decision level of central and state governments, RACP Council and hospitals?

- Aim:* Promote General Medicine in Australia and New Zealand as a resource document for policy and program decision makers and the general physician as a key component in intergrated service delivery.
- Who:* IMSANZ Councillors
- Time:* 2001 and ongoing
- Outcome:* Decision makers of influence seek IMSANZ Councillors for considered opinion on role of general physicians in health service delivery.

References

1. Scott IA, Greenberg P. General internal medicine in Australia and New Zealand – a renaissance. *MJA* 1998; 168: 104–5.
2. Wartman SA, Wilson M, Kahn N. The generalist health care workforce: issues and goals. *J Gen Intern Med* 1994; 9: S7–13.
3. RACP. Requirements for Physician Training - Internal Medicine. January, 2000.
4. Willison DJ, Soumerai SB, McLaughlin TJ, Gurwitz JH, et al. Consultation between cardiologists and generalists in the management of acute myocardial infarction. Implications for quality of care. *Arch Intern Med* 1998; 158: 1778–1783.
5. Regueiro CR, Hamel MB, Davis RB, Desbiens N, et al. A comparison of generalist and pulmonologist care for patients hospitalised with severe chronic obstructive pulmonary disease: resource intensity, hospital costs, and survival. *Am J Med* 1998; 105: 366–372.
6. Greenfield S, Rogers W, Mangotich M, Outcomes of patients with hypertension and non-insulin dependant diabetes melitus treated by different systems and specialties – results from the Medical Outcomes Studies. *JAMA* 1995; 274: 1436-1444.
7. Dent. O. Clinical workforce in Internal Medicine and Paediatrics in Australia, 1997. Fellowship Affairs, February 1999, pp 31–46.
8. Smith BJ, Darzins P, Heller RF. RACP survey of advanced trainees' job aspirations: the fate of those who pass the clinical exam of the RACP. Fellowship Affairs December 1993: 31–33.
9. Hadfield C. Rural manpower in Queensland – a start to tackling the problem? IMSANZ Newsletter June 1997: 6–7.
10. Hadfield C, Internal Medicine Workforce Survey, Provincial Queensland, January 1999. Unpublished.
11. Greenberg PB. Casemix funding: Implications for general physicians. Fellowship Affairs November 1995: 35–37.
12. Greenbeck MR. Educating physicians for the 21st century. *Acad Med* 1995; 70: 179–185.
13. Ladenson PW (ed) *The Consultation Guide*. Baltimore: Williams and Wilkins, 1999.
14. Niall J. Optimal decision making and general medicine [letter], Fellowship Affairs, February 1999: 7.

15. Hillman K. The changing role of acute-care hospitals. MJA 1999; 170: 325-328.
16. Scott I, Phillips P. Hospitals and Hospitalists: An alternative view. MJA 1999; 171: 312-314
17. Bennett J. The general physician – dinosaur or superman? J R Coll Physicians Lond 1997; 31: 6-7.
18. Rhodes JM, Harrison B, Black D, Spiro S, Almond S, Moore S. General internal medicine and specialty medicine – time to rethink the relationship. J R Coll Physicians Lond 1999; 33: 341-347.
19. Ward JD. The hospital general physician in the 1990s. J R Coll Physicians Lond. 1996; 30: 209-210.
20. Nash DB, Nash IS. Building the best team. Ann Intern Med 1997; 127: 72-73.
21. Wanklyn P, Hosker H, Pearson S, Belfield P. Slowing the rate of acute medical admissions. J R Coll Physicians Lond 1997; 31: 173-6.
22. Hampton JR, Gray A. The future of general medicine: lessons from an admissions ward. J R Coll Physicians Lond 1998; 32: 39-43.
23. Morton M. General Medicine in Adelaide. IMSANZ Newsletter, 1999.
24. Harrold LR, Field TS, Gurwitz JH. Knowledge, patterns of care, and outcomes of care from generalists and specialists. J Gen Intern Med 1999; 14: 499-511.
25. Greenfield S. The next generation of research in provider optimisation. J Gen Intern Med 1999; 14: 516-7.

Contributory Letters to *Fellowship Affairs** and IMSANZ Newsletter:

- *Bolitho L. Visions and realities. The pleasures of rural general physicianship. July 1997.
- *Philpot R. The importance of being generalist. July 1998.
- *Bassett M. Should the College regulate the physician workforce? November 1998.
- *Veitch P. & Finnegan T. Medical workforce: Time to take a stand. November 1998.
- *McGarity B. Shortage of Rural Physicians. April 1999.
- *Davoren P. Large cities V regional centres. July 1999.
- *Phelps G. & Watson J. The recruitment of rural specialists: why bother? July 1999
- Greenberg P. The hospitalist movement. IMSANZ Newsletter July 1999.
- Henley J. General Medicine in a tertiary metropolitan hospital: Auckland Hospital [NZ] IMSANZ Newsletter July 1999.

INTERNAL MEDICINE SOCIETY OF AUSTRALIA & NEW ZEALAND
COUNCIL MEMBERS 1999 - 2001

President

Dr Neil Graham FRACP
(PO Box 2267)
Tauranga New Zealand

Phone: 0011 64 7 578 1208 Rooms
Fax: 0015 64 7 577 9964
Email: neilgrah@pacifichealth.co.nz
ngramam@wave.co.nz

Vice - President

Dr Les Bolitho FRACP
6 Dixon Street
Wangaratta VIC 3677

Phone: 03 5721 5533
Fax: 03 5722 1781
Email: ibolitho@netc.net.au

Honorary Secretary/Treasurer

Dr Michael Kennedy FRACP
Level 4, 22 Darley Road
Manly NSW 2095

Phone: 02 9977 8265
Fax: 02 9977 4426

Councillors

Dr Simon Dimmitt FRACP
10 Murray Street
Perth WA 6000

Phone: 08 9224 1474
Fax: 08 9224 1477
Email: sdimmitt@medeserv.com.au

Dr David Hammill FRACP
PO Box 576
Dubbo NSW 2830

Phone: 02 6882 4244
Fax: 02 6882 1494

Dr Diane Howard FRACP
PO Box 40195
Casuarina NT 0811

Phone: 08 8920 6176
Fax: 08 8920 6183

Councillors Continued

Dr Bruce King FRACP
Dept of Medicine
Nelson Hospital
Nelson New Zealand

Phone: 64 3 546 1800
Fax: 64 3 546 1800
Email: bzkn@nn-hosp.nmhs.co.nz

Dr Bob Lodge FRACP
219 Gore Street
Fitzroy VIC 3065

Phone: 03 9416 1662
Fax: 03 9416 1944
Email: blodge@medeserv.com.au

Dr John Lowrey FRACP
248 Quay Street
Rockhampton QLD 4700

Phone: 07 4922 5482
Fax: 07 4922 2215

Dr Rob Nightingale FRACP
173 Macquarie Street
Hobart TAS 7000

Phone: 03 6234 9712
Fax: 03 6224 1417

Dr Martin Reeve FRACP
St John of God Hospital
PO Box 507
Bunbury WA 6231

Phone: 08 9721 8833
Fax: 08 9721 2945

Dr John Sands FRACP
47 Rosevears Drive
Legana TAS 7277

Phone: 03 6330 2650
Fax: 03 6330 2490
Email: jsands@utas.edu.au

Dr Ian Scott FRACP
Director of General Medicine
Princess Alexandra Hospital
Ipswich Road
Woolloongabba QLD 4102

Phone: 07 3240 2111
Fax: 07 3240 7104
Email: scotti@health.qld.gov.au