The Royal Australasian
College of Physicians

Restoring the balance

An action plan for ensuring the equitable delivery of consultant services in general medicine in Australia and New Zealand 2005-2008

POSITION PAPER

Contents

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Preface

The Internal Medicine Society of Australia and New Zealand (IMSANZ) with the support of the President, Council, Adult Medicine Divisional Committee and Specialties Board of The Royal Australasian College of Physicians (RACP) has produced this position paper which details an action plan, and its rationale, for reforming the supply and delivery of consultant services in general medicine in Australia and New Zealand over the 3 years to 2008. It follows on from a discussion paper "The Way Forward – The Future of General Medicine in Australia and New Zealand" which was produced in 1998.

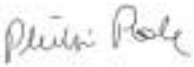
This document outlines the current position of general medicine in Australia and New Zealand in the context of increasing levels of subspecialisation which may not be appropriate for meeting the health care needs of populations in the 21st century. The document seeks to articulate a number of objectives and strategies for improving the current imbalance between general and non-general subspecialty consultant practice in internal medicine, and practical means for achieving these objectives.

This document was drafted by a writing group of IMSANZ Council and circulated to all members of IMSANZ, both trainees and consultant physicians, for comment between October and December 2004. Thus, the ideas contained within it represent those of the vast majority of practising general physicians. In producing this document, the federal IMSANZ Council has surveyed developments in general medicine in other countries and has reviewed literature (see References and Literature Reviewed) and solicited opinions from a number of individuals and organizations (see Acknowledgements). The draft document was then forwarded for comment to each of the Specialty Societies/Faculties/Chapters of the RACP between April and July 2005 and this feedback was used in revising the document prior to its endorsement by the RACP Adult Medicine Division and by RACP Council in August 2005.

"Restoring the Balance" aims to inform consumer groups, health policy makers, health administrators, and other health care providers of the need for promoting a greater level of practice in general medicine, and the means for creating equity in access to training and practice between the subspecialty of general medicine and the other subspecialties of adult medicine. The ultimate aim of these reforms is to ensure that the current and future needs of all people in Australia and New Zealand for consultant medical services are adequately met, irrespective of geographic locality, age, sex, race, socioeconomic background, or burden of illness.

We present this document as a significant initiative in optimising delivery of medical specialist health care in Australasia.

Ian Scott
President (2003-05)
IMSANZ



Phillippa Poole
President (2005-2007)
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President (2004-2006)
RACP

Executive Summary

Providers of specialist medical care in Australia and New Zealand is grappling with problematic issues of equitable access and affordability, continuity of care, integration of care among different practitioners, and whole-person orientation in management approach and patient counseling.

The consultant physician in general medicine has special expertise in addressing these issues, particularly in the following circumstances:

- Admission to hospital of acutely ill patients with multi-organ system involvement wherein admission under a general medical team may provide a more co-ordinated and efficient care option than admission under a single organ-centred care team (as typically provided by single-organ system subspecialty physicians).[4]
- Specialist assessment of community living patients with complex chronic and multisystem problems which requires attention to the 'whole person' and wider aspects of health not limited to the presenting complaint.[5]
- Provision of comprehensive assessment and co-ordination of subspecialty referrals for patients with complex problems living in rural and regional areas. The alternative is initial referral to several different subspecialty physicians who may practise at different venues. While such referrals are necessary in certain complicated and difficult cases, initial referral of all or most patients of this type is inefficient, expensive and potentially detrimental to optimal health outcomes, and imposes unnecessary cost and inconvenience on patients and their carers.

Currently there are insufficient numbers of consultant physicians in Australia and New Zealand who practise general medicine as their primary vocation to serve the population need generated by the increasing numbers of patients, in both hospital and community practice, who suffer from complex and multiple health problems. The numbers of general physicians available to service the health needs of rural and remote centres has reached crisis point in some regions, and there are shortages in all metropolitan and outer urban areas as well. This has serious implications for the quality and outcomes of care for patients who need specialist intervention. At present, there are vacancies for 180 general physicians across Australia and New Zealand, and this number will continue to rise with retirement of the current workforce, and decline in the numbers of physicians practising

in other subspecialties who are either able or willing to care for patients with conditions outside their subspecialty of training. Compounding this attrition is the fact that physician trainees who are the source of the next generation of physicians are choosing, for a variety of professional and personal reasons, to train in subspecialties other than general medicine, and who, in training as subspecialty physicians, do not receive any systematic training or incentive to maintain their general medical skills.

The Internal Medicine Society of Australia and New Zealand (IMSANZ), the representative body for physicians in general medicine, believes the first step in addressing this impending crisis, is for all jurisdictions – collegial, state and federal government, area health boards, hospital administration, clinical unit heads - to acknowledge and understand the problem and to develop and enact the necessary measures for ameliorating it. This document represents an action plan developed by IMSANZ, and supported by The Royal Australasian College of Physicians (RACP), directed at implementing a number of strategies for advancing the practice of general medicine in both countries.

The document lists a number of strategic actions and their associated timelines, accountable bodies, and performance indicators for each of the following key domains: 1) strengthening hospital departments of general medicine; 2) increasing the opportunities for physician training in general medicine; 3) enhancing services in general medicine in regional, rural and remote areas; and 4) improving conditions of remuneration and support in both public and private practice. The strategic actions are summarised below.

Strategic Actions

Promote departments of general medicine (or combined general medicine/other subspecialty departments) and acute medical wards in teaching hospitals

- Agree position descriptions for full-time (FT), part-time (PT) and visiting medical officer (VMO) consultant physicians who wish to practise general medicine, with or without a subspecialty interest.
- Agree key selection criteria and credentialing requirements in general medicine for consultant physicians applying for positions in general medicine departments or combined general medicine/other subspecialty departments.
- Assess the number and types of established positions and current vacancies in general medicine in all hospitals with >150 beds.

- Establish consultant physician positions (FT, PT, VMO) in general medicine in all hospitals >150 beds.
- Agree definition and training accreditation requirements in general medicine for general medicine departments or combined general medicine/other subspecialty departments in hospitals of >150 beds.
- Assess compliance of existing or soon-to-be-established general medicine departments, or combined general medicine/other subspecialty departments, with accreditation requirements in general medicine.
- Identify hospitals which do not have general medicine departments, or combined general medicine/other subspecialty departments, evaluate the reasons why, and provide incentives and assistance for such hospitals to establish such departments.
- Agree definition and accreditation requirements for general physician-led acute medical wards (or acute medical assessment/planning/management units) in appropriately sized hospitals.
- Mount campaigns to assist hospitals establish acute medical wards (or acute medical assessment/planning/management units) staffed by general physicians.

Improve physician training and continuing professional development in general medicine

- Develop a list of competencies that must be acquired by end of training for advanced physician trainees in general medicine.
- Develop and implement a structured curriculum in general medicine for both basic and advanced physician trainees.
- Develop and implement assessment methods for ensuring medical skills in general medicine have been acquired by all trainees who wish to practise general medicine, either as their prime subspecialty or as a subspecialty interest.
- Promote mentoring schemes for all trainees in general medicine.
- Ensure all general physicians who mentor or supervise trainees have appropriate mentoring and supervisory skills.
- Ensure all basic physician trainees and all advanced trainees in general medicine receive a varied experience in general medicine in terms of casemix and clinical setting.

- Facilitate dual training (training in general medicine and another subspecialty leading to a registerable qualification in both) for advanced trainees in general medicine and ensure protected exposure for such trainees to subspecialty physician training.
- Consider modular, certifiable training in selected subspecialty skills for advanced trainees wishing to practise general medicine and another subspecialty interest, but who prefer not to undertake dual training.
- Promote state-based and region-based trainee selection and appointment schemes.
- Ensure all consultant physicians practising general medicine (with or without another subspecialty interest) undergo continuing professional development (CPD) in general medicine and the other subspecialty, and provide periodic documentation of clinical and CPD activities that attest to maintenance of clinical skills in general medicine (and the other subspecialty).

Improve outer metropolitan, regional, rural and remote services in general medicine

- Establish regionalised (hub and spoke) hospital networks throughout Australia and New Zealand for the purposes of integrating service delivery, staffing and training.
- Implement rotations (minimum 3 months) of medical registrars from tertiary to outer metropolitan and regional hospitals sufficient to fill all non-tertiary registrar positions.
- Implement schemes for attracting general physicians to practise in outer metropolitan/regional/rural/remote areas.
- Increase federal and state funding towards establishing more local positions for physicians in general medicine and expanding local specialist infrastructure in rural/remote communities.
- Increase the level of Medical Specialist Outreach Assistance Program funding for positions in rural and remote sites for physician trainees and recently graduated fellows.
- Intensify locum and continuing professional development (CPD) support schemes (such as the Support Scheme for Rural Specialists) for isolated physicians in general medicine.

- Establish mentoring and peer support schemes for overseas trained physicians in general medicine.
- Promote educational/CPD linkages between tertiary and regional/rural/remote hospitals within regionalised hospital networks.
- Develop culturally sensitive and site specific health management services in conjunction with local communities and health providers.

Raise incentive for non-procedural physician practice

- Promote greater recognition by government of the value of cognitive, non-procedural work undertaken by all physicians, including general physicians.
- Promote greater equity between procedural and non-procedural physicians in the level of remuneration provided under Medicare.
- Encourage state governments to adequately compensate general physicians in private practice for time spent in undertaking public hospital duties comprising committee work and teaching roles in addition to clinical work.
- Encourage state and federal authorities to provide financial incentives to general physicians to practise in rural and remote areas.
- Encourage state and federal authorities to consider incentive payment systems that reimburse general physicians in private practice for their involvement in establishing or maintaining community or public health programs.

IMSANZ, in collaboration with the RACP, will attempt to refine and implement the objectives and strategic actions contained within this document over coming years. In particular IMSANZ will continue to forge partnerships with other 'generalist' disciplines such as geriatric medicine, emergency medicine, intensive care medicine and palliative care medicine. Representation from government (both state and federal) and the wider community, as well as from fellows of RACP, is invited in providing comment and feedback to the content of this document, and to attend meetings and forums where these recommendations are discussed. The RACP and IMSANZ hope that such collective action will enhance the quality of not only specialist services in general medicine but of services in all other subspecialties as well.

Glossary

To aid reader understanding the following terms used frequently throughout this document are defined below.

Consultants

A consultant is a doctor other than a general practitioner who has acquired, in addition to a basic medical degree, a qualification in a particular area of clinical practice, bestowed by a duly accredited professional medical college, and who sees (or consults on) patients only by referral from other doctors, primarily general practitioners. Examples of specialists are consultant physicians, consultant surgeons, consultant obstetricians, consultant paediatricians, and consultant psychiatrists.

Consultant physician

A consultant physician is one who practises in the area of adult medicine and who has specialist qualifications in the diagnosis, therapeutic and rehabilitative management of illnesses of adults that are of a medical nature. The specialist qualification comprises fellowship of The Royal Australasian College of Physicians and the consultant physician is called a Fellow of that College, with the letters 'FRACP.' Consultant physicians in turn may practise in one or more subspecialties of adult medicine.

Consultant general physician

A consultant general physician is one who practises in the subspecialty of general medicine and who, by training and experience across the spectrum of general medicine as applied to adolescents and adults, provides learned opinions and care recommendations for patients with a broad spectrum of medical illnesses that affect one or more organ systems. The general physician undertakes a complete review and appraisal of the patient's immediate medical problems and general health (including physical, psychological and social factors) and undertakes future health planning. The general physician may, in selected cases, refer his/her patient to a consultant physician in another subspecialty for additional advice and expertise. Synonymous terms that can be applied to consultant general physicians include: consultant physicians in internal medicine; consultant physicians in general medicine; general medicine consultant physicians; or internal medicine consultant physicians. These synonyms should not be confused with the terms of family physician, internist or hospitalist which do not refer to consultant general physicians but to other types of medical practitioners. General physicians may practise entirely in the subspecialty of general medicine or combine practice in general medicine with practice in another subspecialty of interest.

Consultant physicians in other subspecialties

These comprise consultant physicians who, by in-depth training and experience in a focused area of practice, provide learned opinions and care recommendations for patients with complex and difficult medical illnesses affecting a particular organ system (such as the cardiovascular or respiratory system) or which share a common pathology (such as cancer or infectious disease) or which require specific types of formalised care (such as rehabilitation, peri-operative care, extended or transitional care, residential care and community care of frail, older patients). In this way, a consultant physician who deals with problems of the cardiovascular system (heart and blood vessels) is a consultant cardiologist; those dealing with infections of the body are consultant infectious disease physicians; those who provide formalised medical and rehabilitation care for older persons in multidisciplinary programs include consultant geriatricians. There are now more than 20 different types of subspecialty physicians including gastroenterologists (gastrointestinal system), neurologists (nervous system), endocrinologists (endocrine system), nephrologists (kidneys and urinary system), haematologists (blood and lymphatics system), rheumatologists (joints and musculoskeletal system), oncologists (different forms of cancer), and palliative care physicians (different forms of advanced disease and end-of-life care). Some subspecialty physicians may also undertake practise in general medicine.

General Medicine

General medicine (sometimes termed general internal medicine) is the clinical subspecialty that encompasses the specialist care of a broad spectrum of medical illnesses affecting one or more different organ systems in individual patients and which is practised by a consultant general physician.

RACP/FRACP

Royal Australasian College of Physicians/Fellow of The Royal Australasian College of Physicians.

IMSANZ

Internal Medicine Society of Australia and New Zealand.

SAC

Specialist Advisory Committee.

1. Introduction

The consultant practice of adult medicine in Australia and New Zealand has changed significantly in the last 50 years as a result of three basic factors – the explosion of knowledge, increasing subspecialisation, and remuneration that favours procedural rather than cognitive practice. While the change in practice has served specific health care needs of the community, there are competing changes, some short term and some longer term, that are starting to have a negative impact on health care. These are the ageing of the population, the health workforce shortage, the maldistribution of consultant physicians, and limited resources for health care.

The impact of subspecialisation

The area of consultant medical practice in which the changes are seen most starkly and in which perhaps the greatest negative effect is likely to occur is that of general medicine. Consultant physicians in general medicine, or general physicians, together with geriatricians will be increasingly called upon to provide the chronic and complex care necessary for older people as the population generally ages. However the consultant practice of adult medicine is becoming increasingly segmented into subspecialties – there are now over 20 – and for a combination of reasons, those entering physician training are attracted more towards subspecialties that provide acute procedural medicine in metropolitan public and private hospitals.[1] The trend in Australia and New Zealand is not unique. Similar trends are occurring worldwide and professional organisations in a number of countries have raised concerns and are starting to take action,[2] especially in light of the growing realisation of the essential role of generalist physicians to maintaining viable, integrated health care systems.[3]

Emerging problems in care delivery

Problems with access, affordability, equity, continuity of care, integration, whole-person orientation and comprehensiveness are now at the forefront of issues facing consultant medical practice. While IMSANZ and RACP clearly recognize the value of subspecialty medicine and support subspecialty physicians, the general physician has special expertise that should be utilised in many areas, particularly in the following circumstances:

1. Admission to hospital of acutely ill patients with multi-organ system involvement wherein admission under a general medical team may provide a more co-ordinated and efficient care option than admission under a single organ-centred care team (as typically provided by single-organ system subspecialty physicians).[4]

2. Specialist assessment of community living patients with complex chronic and multisystem problems which requires attention to the 'whole person' and wider aspects of health not limited to the presenting complaint.[5]

3. Provision of comprehensive assessment and co-ordination of subspecialty referrals for patients with complex problems living in rural and regional areas. The alternative is initial referral to several different subspecialty physicians who may practise at different venues. While such referrals are necessary in certain complicated and difficult cases, initial referral of all or most patients of this type is inefficient, expensive and potentially detrimental to optimal health outcomes, and imposes unnecessary cost and inconvenience on patients and their carers.

Prudent and efficient use of limited health care resources is a necessity in present day Australia and New Zealand. This may be better achieved in many settings by employment of a consultant physician trained in general medicine. Data from the US indicates that states with more generalist physicians use more effective care and demonstrate lower Medicare spending per capita while those with more subspecialty physicians have higher costs and lower quality of care.[6] A possible explanation is that greater use of intensive, costly care driven by a higher geographic density of subspecialty physicians crowds out the use of more effective care provided by generalist physicians.[6]

A recent review of health services in Western Australia identified a substantial emphasis on tertiary hospital care to the detriment of secondary hospitals and population-based approaches and reported that about 80% of admissions to Perth's tertiary hospitals are for secondary type services and general hospital care.[7] These findings are consistent with other population-based studies which show that increasing the level of spending per patient in diseases such as acute myocardial infarction, on the basis of more care provision by subspecialty physicians, does not necessarily lead to an improvement in outcomes as measured by in-patient mortality or patient satisfaction.[8,9]

Moreover, many observational studies that suggest better care and outcomes for patients treated by subspecialty as opposed to generalist physicians[10] do not account for confounding due to effects of physician-level clustering, differences between physician groups in patient casemix, and other sources of bias.[11] In contrast, parallel cohort studies conducted in Australia which have adjusted results for casemix differences and clustering suggest that non-procedural care provided by general physicians, compared to that

provided by subspecialty physicians, is as efficient and produces equivalent clinical outcomes for patient populations as a whole[12] as well as for subpopulations of patients with specific clinical conditions such as acute myocardial infarction.[13,14] In regional and remote centres, outreach services provided by community general physicians cost hospital budgets $450 less per patient than do hospital-based subspecialty clinics, with no decrease in quality or outcome of care.[15]

One of the most robust findings in health services research is that population rates of many procedures correlate very closely with supply-side variables such as availability of subspecialty physicians, hospital beds, and high-level technology, while showing very poor correlations with indicators of need such as illness rates and mortality.[8,9,16] For example, thresholds for coronary angiography fall as the per capita ratio of cardiologists and catheterisation laboratories increase, leading to increasing probability that angiography will be applied to patients with less severe disease.[17] Low-risk patients with acute coronary syndromes cared for by cardiologists are more likely to receive invasive intervention than similar risk patients cared for by non-cardiology physicians.[18] More intensive diagnosis and therapy mediated by subspecialty physicians can lead to patient harm, through detection of 'abnormalities' with little prognostic meaning, and increased risk for iatrogenesis from medications or surgery.[19,20] Greater population benefit may therefore derive from general physicians acting more as a filter between patients and high-technology, subspecialty-mediated care.[21]

Health care systems such as the Veterans Administration in the US which have reorganized themselves to enhance access to general medical care have achieved better continuity of care, higher rates of primary and secondary preventive services, fewer hospitalisations, and lower death rates.[22] In Australia, the only one of four Clinical Support Systems Programs supervised by the RACP which featured core involvement of general physicians and primary care practitioners improved quality of in-hospital and post-hospital care of patients hospitalised with acute cardiac conditions, and reduced mortality at 12 months follow-up.[23]

Promoting the role of general physicians

A core problem is the inadequate numbers of consultant physicians who practise general medicine as their primary vocation. This is exacerbated by the relative paucity of consultant physicians in a range of other subspecialties who are either able or willing to care for patients with conditions outside their subspecialty of training. A key driver behind

this problem is that physician trainees are entering advanced training in subspecialties in greater proportions than in general medicine[1] and those that train in some subspecialties are unable, for a variety of reasons, to maintain or augment their general medical skills.

Another issue relates to the demography of the general physician workforce which, currently, is 5 years older, on average, than their subspecialty colleagues, and therefore will be retiring sooner.[1] Younger cohorts are increasingly made up of women who will work on average 80% of the hours of their male counterparts, and both men and women will want to work fewer hours than previous generations.[24]

A reaffirmation

In Sydney in March 2003, the RACP held a Forum on General Medicine, which addressed several key issues and outlined strategies that the RACP could implement or recommend to be addressed by other bodies in advancing general physician practice and training.[25] However, it has been difficult to effect any meaningful changes, as the solutions involve significant engagement of a number of stakeholders. In the UK, the Royal College of Physicians (RCP) has considered one aspect of the problem – the issue of acutely ill patients admitted to hospital with multiple medical problems - and has proposed the equivalent of establishing (or re-establishing) acute general medicine units in all hospitals, along with measures to improve the training of consultant physicians who will staff such units.[26] Similar problems and solutions have been identified by peak bodies representing general physicians in the US and Canada.[2] In New Zealand, the problem is being addressed more successfully by measures at the level of employing district health authorities.

A call for unified action

All jurisdictions – federal, state and territory governments, area health boards, hospital administration, and clinical unit heads – must acknowledge the problem of insufficient numbers of general physicians and embark on a variety of measures that address the causes and solutions. There needs to be a readily identifiable driver for change. It is critical therefore that the current and future shortage of general physicians, and its causes and ramifications, both short term and long term, are understood by all stakeholders and that a co-operative approach towards addressing the problem is taken. Any solution will involve actions by IMSANZ and the RACP. In Australia, area health authorities or their equivalents, state and territory health departments, and the Commonwealth Department of Health and Ageing will need to be engaged. In New Zealand, the relevant agencies are the Ministry of Health and the 22 District Health Boards.

2. Defining the roles of general medicine and the general physician

General physicians have specific expertise in care provision in multiple settings,[27-29] particularly in the areas of:

- Undifferentiated problems where a diagnosis is yet to be made;
- Multi-system diseases;
- Presentations with active disease involving single or multi-organ systems that are of mild to moderate complexity;
- Post-acute care which involves integration with primary medical and non-medical providers;
- Peri-operative care;
- Ambulatory and community based care.

General physicians have broad knowledge and skills

General physician practice adopts a scientific, evidence-based approach to the patient as a whole person, notwithstanding an interest and some level of training in another subspecialty. This approach includes detailed knowledge of the pathophysiology, diagnostics and therapeutics of a broad range of diseases. General medicine is thus a broad discipline 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 consultant services across a spectrum of health and illness. These capacities place general physicians in an important and responsible position as clinicians, teachers and researchers, particularly where clinical problems affect multiple organ systems, involve issues which do not fall within the domains of single organ-system subspecialties, and where integration of multidisciplinary expertise may be required.[29]

General physicians add value to subspecialty care

General physicians are important to the delivery of health care in metropolitan, outer metropolitan, regional and rural settings alike. The appropriate use of general physicians in the tertiary hospital environment allows physicians in other subspecialties to concentrate their efforts on difficult cases which require their particular skills. The same situation applies with respect to emergency medicine doctors who are being confronted with increasing numbers of non-urgent patients with medical problems presenting to

emergency departments. General physicians working with geriatricians also provide a continuum of care of older patients from the acute episode to post-acute care and rehabilitation. With the ageing of our population, the likelihood of single organ-system subspecialty physicians being able to provide "whole patient" care decreases, leading to increasing numbers of cross-referrals involving several different subspecialty physicians. In this situation, general physicians and geriatricians are likely to provide a continuum of cost-effective patient care.[4] This phenomenon is not confined to major public hospitals but also pertains to regional or rural practice.

General physicians as educators

General physicians are also very important in the education and training of undergraduate and graduate medical students, junior doctors, and basic physician trainees. In general medicine units, these learners assess and manage a wide range of patients, with a wide range of conditions, within a structured, multidisciplinary team-based environment. Good early learning experiences and exposure to positive role models predict a greater likelihood of future practice as a general physician.[30]

General physicians as providers of care in niche areas

There are examples within many Australasian teaching hospitals of the close association between general physicians and physicians in other subspecialties in the management of patients with general medical and peri-operative problems.[31] 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 chronic and complex care (disease management) – services which deal with conditions that may not fit neatly into single organ-system subspecialties and which are amenable to general physicians wanting to develop a non-procedural interest. General physicians integrate well with other colleagues [e.g. general practitioners, emergency medicine doctors, consultant surgeons, psychiatrists and geriatricians] to provide an overview of medical management that may be lost with exclusive care from physicians who practise single organ-system subspecialties.[32]

General physicians working with subspecialty physicians

It is important to stress that the roles of general physicians and other subspecialty physicians are, and should be seen as, complementary rather than competitive. Optimal patient outcomes can be achieved across a variety of clinical scenarios if general physicians are allowed to assume primary responsibility for co-ordinating and directing

care while, at the same time, consulting other subspecialty physician colleagues when appropriate.[33-35] Such collaboration will foster better consensus about clinical circumstances warranting referral of patients to subspecialty physicians, the content and feasibility of clinical practice guidelines, and the selection of subspecialist or general physician in the role of chief provider of chronic care.[36,37] Such 'on the ground' collaboration is even more important in circumstances where availability of general physicians and subspecialty physicians will vary from hospital to hospital, area to area, and specialty to specialty, and which require local solutions based on different specialty groups working together to the benefit of patients and the wider healthcare community.

3. The Internal Medicine Society of Australia and 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 promote hospital and community practice of general medicine. It seeks to articulate, advocate for, and sponsor the educational, training, research and workforce requirements of general medicine. Since its inception in 1997, from the merger of separate bodies on either side of the Tasman, IMSANZ has publicised these issues in the production of training guidelines, policy documents, newsletters, and journal articles. It has also developed databases containing information on hospital training programs in general medicine and the geographic distribution, skills base, academic interests, and subspecialty interests of its general physician membership.

4. The Current Status of General Medicine in Australia and New Zealand

Workforce shortfall

General physician practice is at risk of disappearing from both public and private practice. The numbers of practising general physicians in relation to population need are presently proportionately fewer than for any other subspecialty in adult medicine, and will continue to fall over time as the current general physician workforce, which is already older than that of other subspecialty physicians,[1] retires over the next 5-10 years. Currently there are only 400 physicians in Australia and 110 physicians in New Zealand who practise entirely or predominantly as general physicians.[1] The numbers of general physician vacancies in metropolitan and regional centres existing around Australia and New Zealand was

estimated in 2000 as being 160,[38] and in 2004, was estimated at being 180 (IMSANZ data). This number will continue to increase, particularly as the current total number of specialist trainee positions in Australia (approximately 1500-1700) exceeds the total annual number of medical graduates (approximately 1400). Compared to other subspecialties, fewer physician trainees are graduating from advanced training programs in general medicine and then progressing to practise in this discipline.[1]

As a result, the numbers of general physicians available to service the specialist medical needs of rural and remote centres has reached crisis point in some regions, with increasing dependence on overseas-trained physicians. Shortages in metropolitan areas exist as well. IMSANZ predicts approximately 5-7 full-time equivalent general physicians are needed per 100,000 population to provide adequate service, teaching and research capacity in general medicine. This compares to a current ratio of approximately 3 per 100,000 in Australia and 4 per 100, 000 in New Zealand.[1] In contrast the ratio for subspecialty physicians is 20 per 100, 000[1]. No more than 1 in 4 adult physcians practise any form of general medicine and, of these, only 50% regard their practice as being predominantly general medicine. The following table profiles general physician practice in Australia and New Zealand as of November 2004.

Contemporary profile of general physician practice in Australasia

Queensland

The major metropolitan Brisbane hospitals of Royal Brisbane, Princess Alexandra, Queen Elizabeth II, Redlands and Logan have established general medicine units. Large regional centres [Townsville, Cairns, Toowoomba, Nambour, Gold Coast, Ipswich, Redcliffe-Caboolture] have departments of general medicine staffed by general physicians. Provincial centres such as Mackay, Rockhampton, Bundaberg, and Mt. Isa have precariously low numbers of general physicians. Many regional centres have inadequate numbers of resident general physicians to cover leave and future retirements.

Estimated additional general physicians required: 40.

South Australia

General medicine units exist at the Flinders Medical Centre (FMC), Repatriation General (RGH), Royal Adelaide, Queen Elizabeth, Modbury and Lyell McEwin Hospitals, with combined general medicine/other subspecialty units at the remaining teaching hospitals.

Acute assessment units run by general physicians attached to emergency departments exist at FMC and RGH. Although there are many general physicians in private practice, there is a need to plan the succession of general physicians currently in practice in regional centres.

Estimated additional general physicians required: 8.

Victoria

General medicine units are well established at Royal Melbourne Hospital (RMH), Austin and Repatriation Medical Centre, St Vincent's, Alfred Hospitals and Monash Medical Centre. Outer metropolitan hospitals at Box Hill, Northern, Western, Dandenong, Sandringham, Frankston and Ringwood feature general medicine services. The major regional centres of Bendigo, Shepparton, Geelong, Ballarat, Warrnambool, Wangaratta and Traralgon-Latrobe Valley have general medicine units staffed by resident general physicians.

Estimated additional general physicians required: 20.

New South Wales

General medicine units exist in the major metropolitan hospitals of Royal North Shore, Liverpool, and Lidcombe-Bankstown, but many are underdeveloped. Smaller, outer metropolitan hospitals at Manly, Sutherland, Port Macquarie, Woollongong, and more recently Camden and Campbelltown have general medicine units. Prince of Wales, Woollongong and Port Macquarie Hospitals propose a networked advanced trainee position in general medicine. John Hunter and Mater Misericordiae hospitals in Newcastle have also retained general medicine units, with one Newcastle general medicine training program including a rural rotation. Wollongong Hospital also retains a general medicine unit with patients often triaged to local smaller hospitals. Regional centres such as Coff's Harbour, Armidale, Tamworth, Dubbo and Wagga Wagga are staffed mainly by physicians in subspecialties other than general medicine but who exercise a strong general medicine interest.

Estimated additional general physicians required: 18.

Australian Capital Territory

The Canberra Hospital has no general medicine unit, general physician appointments or trainees. Calvary Hospital has a general medicine 'take', and a general medicine training program in place.

Estimated additional general physicians required: 4.

Western Australia

Royal Perth, Fremantle and Sir Charles Gairdner Hospitals have general medicine units. Of the 60 general physicians in WA, only 7 are based outside of Perth, with rural centres being seriously under-serviced.

Estimated additional general physicians required: 20.

Northern Territory

Alice Springs and Royal Darwin Hospitals have general medicine departments with most subspecialty physicians maintaining a high degree of general physician practice, with scope for general physicians to practise in another subspecialty. However these units are understaffed in terms of required community outreach services.

Estimated additional general physicians required: 10.

Tasmania

Royal Hobart and Launceston Hospitals have general medicine units with advanced training programs in general medicine. Regional centres are in dire need of more general physicians with interests in various subspecialties.

Estimated additional general physicians required: 10.

New Zealand

General medicine units exist in all major metropolitan and regional hospitals in New Zealand. The general medical unit located at Auckland City Hospital comprises 12 general medicine teams with a total of 90 impatient beds combined with a newly-commissioned 45 bed Admission and Planning Unit directed by a general physician.

Smaller centres experience chronic shortages of physicians. Because of the lack of qualified general physicians, all centres have problems attracting locums. Tauranga has developed a stable pool of overseas locums (mainly North American) who return regularly although most locums comprise retired physicians.

Estimated additional physicians required: 50.

Impact on the current healthcare system of losing general physicians

The potential impact on the healthcare system of a loss of a general physician workforce includes:[39,40]

- Compartmentalisation of care by medical subspecialty, with the result that significant co-morbidities and patient concerns unrelated to particular subspecialties are at risk of being overlooked, misdiagnosed or inappropriately managed.
- Increased cost of care provided by subspecialty physicians compared with less resource-intense practice more characteristic of the general physician.[4]
- Increased cross-referral between different subspecialty physicians, and increased rates of transfer of sick patients in regional areas to tertiary centres, resulting in overcrowding in tertiary centres and more services from multiple providers with attendant increased costs.
- Increased potential for multiple subspecialty physician involvement to cause excessive polypharmacy, adverse treatment interactions, and uncoordinated care.
- Decreased access of patients, especially in rural and remote areas, to specialist medical care by a general physician. This may result in a greater burden of serious and costly disease complications, potentially avoidable by more timely intervention from a general physician.
- For surgeons, psychiatrists and other specialists, loss of, or reduced access to, advice from general physicians regarding medical aspects of their patients' illness.
- Patient inconvenience resulting from extra time required to visit several different subspecialty physicians and longer hospital stays due to multiple referrals.
- Concerns about quality of patient care if the practice of 'hospitalism'[41] was conducted by other disciplines with the exclusion of general physicians.
- Loss of continuity of care, teaching potential and opportunities for cross-disciplinary research.

Trainee recruitment

The total number of advanced trainees in general medicine has remained relatively static over the past 5 years, averaging 45-50 advanced trainees at any time throughout Australia, and 80-90 in New Zealand. Only 5% of adult physicians gaining fellowship in 2003 underwent advanced training in General Medicine.[1] As of March 2005, the number of registered advanced trainees in general medicine in Australia was 59 but these were unevenly distributed among the states and territories (Qld 13; NSW 9; SA 10; Victoria 22; ACT 0; WA 5; Tasmania 0). In New Zealand there were 91 registered trainees. While the total

numbers may appear potentially adequate to meet future demand, this number of registered trainees greatly exceeds the number who complete advanced general medicine training and become general physicians, as up to 70% switch to a subspecialty after the first year of advanced training.[42] In contrast, over 85% of all RACP subspecialty trainees complete training in their subspecialty.

The reasons why the majority of general medicine trainees choose another subspecialty as their primary vocation and do not become general physicians are many and complex,[24,43,44] and include the following:

- Expansion in recent decades of subspecialisation, driven by advances in technology.
- Historical inequity in remuneration between procedural and non-procedural subspecialists.
- Increased availability of full-time subspecialty physician appointments in teaching hospitals with comparatively smaller numbers of general physician appointments.
- Loss of academic departments of general medicine, and of role models in general medicine, as a result of closure or downsizing of general medicine units. This has often been driven by financial cutbacks and managerial changes, accentuated by increased competition with subspecialty units for funds from limited hospital budgets.[45]
- Limited research opportunities for general physicians because of enormous demands of clinical care and teaching combined with loss of academic research infrastructure.
- Redirection of an increasing proportion of patients presenting to teaching hospitals towards subspecialty units and away from general medical units.
- Trainee perception that the resultant dilution in variety and acuity of illness of patients admitted to general medicine units decreases the level of professional interest and challenge.
- Perceived lack of career prospects for general physicians based on the assumption that all clinical work in the future in most urban centres will be conducted by non-general subspecialty physicians.
- Inadequately structured training programs for advanced trainees in general medicine and less than optimal rigor in the determination and monitoring of training requirements.

- Difficulties faced by general medicine trainees in competing for coveted training positions in other subspecialties which would enable them to develop broader skills and interest.
- Trainee perception that the scope of knowledge required to practise as a competent general physician is overwhelming, leading to a perception of inadequacy in dealing with some areas compared to the expertise of a single organ-system subspecialty physician.
- Trainee perception that career opportunities (particularly hospital appointments and research positions) and professional development needs are more likely to be compromised if one chooses general medicine as one's main subspecialty.
- Negative labeling of general physicians by other consultants, professional societies and patient support groups.

General physician trainees wishing to practise in non-metropolitan sites and wanting to develop procedural skills in another subspecialty have very limited opportunities to acquire such skills as non-general subspecialty rotations are currently reserved for advanced trainees in that subspecialty or, if such rotations are available, require general physician trainees, for purposes of certification, to perform a minimum number of procedures which is often unattainable within the limited duration of the rotation.

Academic portfolio

Academic career opportunities for general physicians and general physician trainees are severely curtailed due to the absence of a research training infrastructure and limited number of research awards, grants and positions in sciences relevant to general medicine such as health service research, outcomes management and evidence-based medicine.[46]

Remuneration and indemnity issues

Rebates for general medicine consultations which involve considerable, time-consuming cognitive work and patient counseling are disproportionately low compared to procedural subspecialty physicians. There is also need for more funding from state and territory health authorities for more salaried or contracted positions in general medicine in public hospitals. General physicians practising in more isolated sites work long hours away from families and better remuneration and locum support are needed. General physicians who perform procedures (as so often happens in regional areas) are faced with high indemnity premiums, representing a significant proportion of gross income.

Continuing professional development (CPD)

General physicians need to maintain competence in many areas of medicine including cardiovascular and respiratory medicine, endocrinology, gastroenterology and renal medicine. In addition, general physicians need to find time and resources for undertaking peer review, practice-specific CPD activities, and clinical audit in maintaining professional standards. There is need for greater access, particularly on the part of rural and regional physicians, to discipline-specific decision support and CPD resources (such as clinical update and skill augmentation programs sponsored by tertiary hospitals, traveling subspecialty lectureships, and videoconferencing or videotaping of educational meetings).

Workload and conditions of service

At the same time as the number of general physicians and advanced trainees in general medicine declines, workload increases. Many trainees observe the rosters worked by general physicians, in particular (but not confined to) non-metropolitan settings, and see a life of long working hours with little relief and difficulties in procuring locum cover.[24]

5. An Action Plan for Advancing General Medicine

In January 2004, the RACP released a document summarising proceedings of the forum on the future of General Medicine held in March 2003.[25] The overall purpose of the forum, convened by the RACP, was to provide an overview of the key issues confronting general medicine in Australia and New Zealand, and to outline strategies that the RACP could implement, or recommend to other bodies, to address those issues. Training programs relevant to general physician trainees were also discussed and inevitably became intertwined with the demands of the College review of the entire training program undertaken by the Education Strategy Taskforce.

A number of recommendations for strengthening general medicine were expressed, including the need for the:

> 'college to work with relevant external agencies…. to maintain general medicine units in tertiary hospitals, maintain and support medical registrar positions in regional hospitals, and [to improve] working conditions in rural/regional locales.' (p. 10)

In relation to advanced training, it was stated that:

> 'the College will work with Specialist Advisory Committees (SACs) and subspecialty societies to ensure that 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 in regional/rural areas.' (p. 10)

The following sections present specific objectives that IMSANZ and RACP consider need to be achieved if the above broad objectives expressed at the Forum are to be realised. For each objective or set of objectives, a number of potential strategies are listed and an action plan is attached which outlines specific tasks, timelines, performance criteria, and responsible parties. Explanatory notes relevant to each set of objectives are also provided.

A. Hospital departments of General Medicine

Objectives

In all public hospitals >150 beds:

A1. Promote establishment (or re-establishment) of certified positions in general medicine

A2. Promote the establishment (or re-establishment), maintenance and enhancement of general medicine departments (or combined general medicine/other subspecialty departments)

A3. Promote the establishment of acute medical wards staffed by general physicians

Explanatory Notes:

Credentials of General Physicians

It is recognised that many consultant physicians who practise general medicine have also trained in another subspecialty and continue to practise in that subspecialty in addition to their practice in general medicine.

The training and experience required of a general physician equate to the standards of the RACP as formulated in consultation with IMSANZ. The Curriculum Writing Group of IMSANZ has formulated a list of competencies that general physicians are expected to demonstrate in order to practise independently,[47] and which lay the basis for any training or credentialing processes.

- ***Medical expert / clinical decision maker*** with the ability to:
  - undertake timely, comprehensive and systematic clinical assessments
  - efficiently formulate diagnosis and management plans in partnership with patients
  - prioritise care according to clinical circumstances and treatment goals
  - care for patients at all stages of life from adolescence onwards
  - care for a diversity of patients with multiple problems
  - care for acute and chronic undifferentiated illness and well-defined clinical syndromes
  - show willingness and capability to manage a diverse spectrum of clinical problems and patient casemix in a variety of clinical settings using innovative approaches to care
  - demonstrate cost-effective and appropriate use of interventions, investigations and medication
  - competently perform procedures according to current and future practice settings, patient needs, and credentialing requirements
  - manage patients in environments of clinical uncertainty
- ***Communicator*** who:
  - communicates with, and provides support for patients, families and carers
  - effectively communicates complex concepts in a wide range of settings
- ***Collaborator*** who:
  - consults and interacts with other specialists and health professionals in supervising patient care
- ***Manager*** who is able to:
  - form and lead health care teams
  - understand and navigate bureaucratic complexities associated with patient care

- ***Health advocate*** who:
  - accepts responsibility for patients who have difficulty accessing care
  - advocates for co-ordinated, patient-centred provision of health care
  - recognises social, economic, cultural, and psychological determinants of clinical problems and how they affect management
- ***Scholar / researcher*** who:
  - is a self-directed learner and facilitates the development of this in others
  - teaches, supervises and mentors other health professionals
  - understands and applies a knowledge of research methods and evidence-based medicine to clinical practice
  - is able to contribute to research in quality improvement, health service delivery or clinical medicine
- ***Professional*** who:
  - identifies his/her limits to knowledge and seeks additional knowledge and skills
  - respects and operates under the principles of patient autonomy, welfare and social justice
  - is committed to professional competence and honesty in dealing with others

Models of General Medicine Practice in Hospital Settings

It is recognized that at present the hospital practice of general medicine across Australia and New Zealand may take one of several forms:

1. ***General medicine departments*** wherein general medicine is practised by consultant physicians whose prime subspecialty is general medicine, but who may have training, and practise at least part-time, in another subspecialty.

2. ***Combined general medicine/other subspecialty departments*** staffed by consultant physicians who have training and interest in general medicine and another subspecialty and who practise both in almost equal proportion. Often these other subspecialties, such as Endocrinology, Renal Medicine and Geriatric

Medicine, focus on patients who have a high prevalence of active, chronic medical problems which affect more than one organ-system. Such departments can be appropriately named departments of Endocrinology/General Medicine or Geriatric/General Medicine. This is analogous to the situation in private practice where consultant physicians who practise both general medicine and another subspecialty call themselves 'endocrinologist/ general physician' or 'geriatrician/general physician.'

3. ***Subspecialty departments*** which do not carry the title of Department of General Medicine wherein consultant physicians predominantly practise within a non-general subspecialty but who, in certain circumstances, may practise a limited form of general medicine.

Each model is consistent with the concept of promoting 'the physician within' i.e. promoting skills in general medicine but at very different levels of intensity and expertise.[25] In some hospitals, especially tertiary hospitals in Sydney, geriatricians practise as general physicians, although undertaking this function has compromised their ability to provide the full range of geriatric assessment and rehabilitation services consistent with their subspecialty objectives (John Obeid FRACP, personal communication, 2005). In such circumstances the establishment of both general medicine and geriatric medicine departments should be endorsed and supported by hospital management and Divisions of Medicine.

IMSANZ wishes to promote practice more along the models of 1 and 2, and does not believe that a model in which university teaching hospitals have no Department of General Medicine, or combined General Medicine/other Subspecialty department, may be limited in ensuring best medical care to patients as previously described. This is reinforced by a recent study of 1294 consecutive admissions to a General Medical Unit in a 500 bed metropolitan hospital showing that 88% of presentations involved 18 separate conditions spanning all major specialties except for rheumatology, with the average number of separate diseases per patient being 4.8.[48]

The following discussion will focus on the requirements for establishing general medicine departments as envisaged in models 1 and 2.

Definition of a General Medicine department (or moiety)

In defining a functioning general medicine department (or general medicine moiety within a combined general medicine/other subspecialty department), IMSANZ adopts the following standards:

- Staffing by one or more general physicians (or combined general physicians and other subspecialist) who practises on at least a part-time basis, preferably 50% or more.
- Acute medical admission on-take averaging a minimum of 20 admissions per week across the spectrum of general medicine, with shared care models being adopted for those patients who may need to be admitted, in the first instance, to highly specialised units (eg coronary care unit, respiratory high-dependency unit, intensive care unit, dialysis unit, etc).
- Outpatient clinics averaging a minimum of 20 occasions of service a week for the whole department.
- Development of areas within general medicine where general physicians with a special interest may contribute to patient care (eg acute stroke medicine, perioperative medicine, obstetric medicine, chronic and complex care programs).
- Involvement in programs to improve the organisation and delivery of care.
- Time off from clinical service for full-time physicians and visiting or contracted medical officers to undertake research, teaching and service development.
- Active clinical partnership with the Emergency Department and Intensive Care Unit.

RACP training accreditation requirements for General Medicine or combined General Medicine/other Subspecialty departments

General medicine departments or combined general medicine/other subspecialty departments in hospitals (including private hospitals) should only be accredited for the purposes of RACP advanced training in general medicine, and of basic training, if all of the following criteria are satisfied:

- Each consultant unit in the department to which trainees are assigned is supervised by a consultant general physician, or a general physician with subspecialty interest provided that at least 50% of clinical service time is spent by that person undertaking general physician responsibilities.

- Each consultant unit within the department has a caseload which ranges between a minimum of 12 inpatients and a maximum of 25, with one medical registrar and one resident/intern position.
- Each consultant unit participates in an acute on-take roster at least once a week (whether these be sessional, daily or weekly rosters) for admitting acute medical patients directly from emergency departments.
- Each consultant unit has the ability to care for all acute patients presenting with any condition which does not require immediate admission to a specialised ward wherein care is mandatorily supervised by another specialist eg coronary care unit, dialysis unit, intensive care unit, high-dependency respiratory ward. (This qualification pertains to tertiary hospitals in which specialised units usually adopt 'closed' rather than 'open' policies to care delegation ie. the specialist administering the unit also assumes, together with his/her staff, exclusive responsibility for the direct care of patients within that unit).
- Each consultant unit provides an outpatient service comprising a minimum of 10 occasions of service per week, or the equivalent in ambulatory care experience (such as hospital in the home or outreach services to other health care institutions, or access to private practice consultations).
- Each consultant unit has access to those diagnostic and other ancillary clinical services deemed essential to the effective and safe practice of general medicine on the part of IMSANZ and its Specialist Advisory Committee (SAC) in General Medicine.
- Each consultant unit is situated in a hospital that provides or guarantees reasonable access to those subspecialty services deemed essential to the effective and safe practice of general medicine on the part of IMSANZ and SAC in General Medicine.

Definition of an Acute Medicine Unit or Ward
(or Acute Medical Assessment/Planning/Management Unit or Ward)

This is a designated in-patient ward with various synonyms to which all acutely ill patients are admitted for initial care by general physicians, in liaison with multidisciplinary health professionals, in the absence of clearly defined acute syndromes which mandate admission to highly specialised areas (eg CCU, intensive care, respiratory high-dependency unit, acute stroke unit, etc).[49]

The objectives of this ward are to streamline and expedite early comprehensive assessment of acutely ill medical patients presenting to emergency departments, facilitate timely consultant review (including review as indicated by other subspecialty physicians) and access to investigations, decrease need for admission and, for those patients who are admitted, to shorten length of stay. Experience in New Zealand suggest such units, compared to usual care, provide more cost-efficient care, decrease hospital admission rates, save hospital bed days and streamline care delivery (Dr John Henley FRACP, 2005, personal communication).

The acute medicine ward is preferably physically co-located with, or adjacent to, the emergency department (ED) and receives patients referred directly from ED or directly from external general practitioners or other specialists. The ward has formal admission and discharge processes, clinical management protocols, in-house ancillary clinical investigation facilities, and procedures for transferring patients as required to in-patient general medicine or subspecialty wards or, where available and considered appropriate, acute care of the elderly (ACE) wards. It is recognized that in some situations, clinical needs of acutely ill patients will require close liaison between general physicians and other subspecialty physicians, including emergency and intensive care physicians.

A. Hospital departments of General Medicine or combined General Medicine/other Subspecialty

Strategic Action	Methods
1. Agree position descriptions in general medicine for full-time, part-time and visiting medical officer positions in general medicine (or combined general medicine/other subspecialty)	Consensus by IMSANZ Council and SAC in General Medicine
2. Agree key selection criteria and credentialing requirements in general medicine for physicians applying for positions in general medicine or combined general medicine/ other subspecialty	Consensus by IMSANZ Council and SAC in General Medicine
3. Assess the number and types of established positions and current vacancies in general medicine or combined general medicine/other subspecialty in all hospitals >150 beds	Analyse survey data from all applicable hospitals
4. Establish positions (full-time, part-time, visiting) in general medicine or combined general medicine/other subspecialty in all hospitals >150 beds	Campaign state health departments for positions in general medicine to be established in all applicable hospitals Establish positions in general medicine in all applicable hospitals by Jul 2006
5. Agree definition and accreditation requirements in general medicine for general medicine or combined general medicine/other subspecialty departments in hospitals >150 beds	Consensus by IMSANZ Council
6. Assess compliance of existing or to-be-established general medicine or combined general medicine/other subspecialty departments with accreditation requirements for general medicine	Survey of teaching hospitals undertaken by SAC General Medicine

Responsible parties	Timeline	Performance indicators
IMSANZ	Jul 2006	Position descriptions agreed
IMSANZ SAC General Medicine	Jul 2006	Key selection criteria and credentialing requirements agreed
IMSANZ RACP Workforce Committee	Dec 2005	Analysis completed
IMSANZ RACP Workforce Committee RACP State committees RACP Rural Taskforce ACHS State health departments IMSANZ	Jul 2005 Jul 2006	Campaign launched Establishment of positions in general medicine in all applicable hospitals
IMSANZ	Dec 2005	Definition agreed
IMSANZ SAC General Medicine	Dec 2005	Compliance analysis undertaken

Hospital departments of General Medicine or combined General Medicine/other Subspecialty, continued.

Strategic Action	Methods
7. Identify hospitals which do not have general medicine or combined general medicine/other subspecialty departments	Survey of teaching hospitals undertaken by SAC General Medicine Questionnaire survey of applicable hospitals not included in previous survey
8. Analyse reasons why hospitals do not have general medicine or combined general medicine/other subspecialty departments	Interviews/teleconference discussions with medical executives of identified hospitals
9. Propose incentives for hospitals to establish general medicine or combined general medicine /other subspecialty departments	Interrogate results of situational analysis
10. Mount campaigns to assist hospitals to establish general medicine or combined general medicine/other subspecialty departments	Mandate positions for appointment of general physicians in all applicable hospitals as part of hospital accreditation for both service requirements and physician training Mandate general medicine units for purposes of undergraduate, graduate and postgraduate medical teaching and interdisciplinary learning as from Jan 2006
11. Agree definition and accreditation requirements for an acute medical ward in appropriately sized hospitals	Consensus by IMSANZ Council
12. Mount campaigns to assist hospitals to establish acute medical wards staffed by general physicians	Establish acute medical wards in all applicable hospitals

ACHS=Australian Council of Healthcare Standards; AMC=Australian Medical Council

Responsible parties	Timeline	Performance indicators
IMSANZ and RACP	Dec 2005	Analysis and gap identification completed
IMSANZ and RACP	Feb 2006	Situational analysis completed
IMSANZ RACP State committees State health departments	April 2006	Incentives formulated
State health departments RACP ACHS State health departments RACP AMC	Late 2005	General physicians appointed Establishment of general medicine departments (or combined general medicine/other subspecialty departments)
IMSANZ	Dec 2005	Definition agreed
State health departments ACHS RACP	Dec 2006	Wards established

B. Physician Training and Continuing Professional Development in General Medicine

Objectives

B1. Implement a structured but flexible training curriculum and methods of assessment in general medicine which ensure acquisition of requisite skills necessary for independent practice as a consultant general physician, as a consultant general physician with another subspecialty interest, or as a consultant subspecialty physician with a general medicine interest

B2. Establish a system of mentoring and supervision from appropriately trained general physicians for all trainees who enter into general medicine training

B3. Provide training and certification for general medicine trainees in a subspecialty area of interest in addition to their qualifications in general medicine

B4. Establish state-based or region-based trainee selection and appointment

B5. Implement a program of continuing professional development in general medicine for consultant general physicians, consultant general physicians with another subspecialty interest, and consultant subspecialty physicians with a general medicine interest

Explanatory Notes:

Training Curriculum and Assessment

The RACP training program currently comprises two phases: 3 years of basic training at the end of which trainees must pass both a written and clinical examination, followed by 3 years of advanced training in whichever subspecialty the trainee chooses.[50] The requirements of advanced training are currently being redefined in light of the Education Strategy being undertaken by the RACP,[51] and the reader is advised that many other reforms in addition to those proposed below may be forthcoming as discussions of the various Education Strategy Taskforce Working Groups ensue.

The current training program stipulates that of the 36 months of basic training, only a minimum of 3 months has to be spent undertaking a general medicine rotation. Despite its importance as a core component of the basic training program, it is of interest that the minimum duration of general medicine training has progressively decreased from 12 months in 1980 to the present 3 months. This contraction has been driven by the progressive downsizing and loss of general medicine departments in Sydney tertiary hospitals leading to inadequate numbers of general medicine registrar positions through which basic trainees could rotate in order to satisfy the training program requirement.

IMSANZ and RACP advocate for advanced training programs in general medicine to satisfy the following requirements:

- A structured but flexible curriculum which includes formal training and assessment in acute medicine, chronic and complex care, perioperative care, clinical epidemiology and critical appraisal, clinical informatics, resource utilisation analysis, quality improvement and systems analysis;
- A curriculum which provides an appropriate balance between impatient medicine and ambulatory/outpatient care;
- The ability for each trainee to define a flexible training pathway which best equips him/her to meet the needs of their intended future practice, taking practice location and patient population characteristics into account;
- Protected access for advanced trainees in general medicine to special skills training including, but not confined to, procedural skills. Those trainees pursuing a cardiology, respiratory or gastroenterology interest, for example, should be able to receive training and credentialing in transthoracic echocardiography, bronchoscopy and gastroenterological endoscopy respectively;
- Provision of rural and regional experience as facilitated by consortia or networks of tertiary and regional hospitals (see Section C) in which trainees can undertake a number of varied rotations;
- The opportunity for advanced trainees to work in private hospitals and clinics, supervised by nominated private physicians, and remunerated under arrangements determined by the private hospital and the supervising private physician.
- The opportunity to gain experience and training in private consulting rooms with appropriate remuneration arrangements between state funded hospitals and the Department of Health and Ageing.

The option of dual training

This option refers to trainees undertaking full-course advanced training in two different subspecialties, one of which is general medicine. All advanced trainees undertaking this option, regardless of choice of second subspecialty, must acquire skills in communication, history-taking, physical examination and comprehensive assessment, evidence-based decision making, safety and quality improvement.

IMSANZ recommends that all advanced trainees of the RACP consider the option of dual training i.e. in general medicine and a subspecialty (which may include addiction medicine, palliative medicine or sexual health in addition to organ-based subspecialties). Those completing training in each subspecialty should receive credentialing in respects of such training and be eligible for dual medical board registration in general medicine and the other subspecialty. Each subspecialty SAC would be requested to draw up a training program for those who wish to pursue this option. The RACP may also need to consider some form of centralised planning such that general medicine trainees, subspecialty trainees and trainees from other societies/ faculties/chapters who wish to access subspecialty training (such as intensive care and occupational medicine) have equity of access to such positions.

Most regional centres need physicians who are good general physicians but also have the capacity to consult in another subspecialty. By having several physicians who can cover general medicine and who between them can also cover most of the other subspecialties, regional centres will become more self-sufficient. Currently 33% of advanced trainees in general medicine in Australia undertake dual training compared to 58% of those in New Zealand (IMSANZ data). The practice of dual training and dual appointments is widespread in New Zealand and the UK, and affords more equitable delivery of health services throughout both countries.

The option of modular, certifiable training in subspecialty medicine

Another option is for general physician trainees to construct a 3 year program of advanced training which comprises 6-12 month modules in those subspecialty areas best suited to equip them with the knowledge and skills required to practise as a general physician in the clinical setting (outer metropolitan, regional, rural or remote) in which they intend to practise. The RACP training program is moving toward a modular curriculum based on achieving competence at each stage.[51] Modules may comprise periods of time spent working in various organ-system subspecialties (such as cardiology,

respiratory medicine, or gastroenterology) and acquiring a requisite level of consultative and procedural skill in that subspecialty appropriate to the roles the trainee is likely to assume as a fully fledged consultant general physician with a subspecialty interest servicing the needs of particular patient populations.

For example, a trainee wishing to practise as a general physician with a cardiology interest in a regional centre may wish to develop skills in transthoracic echocardiography, Holter monitoring or transcutaneous pacing, but does not want (nor would it be appropriate) to acquire skills in invasive percutaneous coronary intervention or transoesophageal echocardiography. Similarly, a trainee wishing to practise in the same setting but with a gastroenterology interest may wish to develop skills in investigative gastroscopy and colonoscopy but does not intend to acquire skills in endoscopic retrograde cholangiopancreatography (ERCP) or capsule endoscopy.

This approach to differentiating skills that general physician trainees are capable of acquiring from skills which rightly remain the exclusive province of subspecialty trainees is applicable to all other subspecialties, including non-procedural subspecialties. IMSANZ recommends that conjoint committees involving representatives from IMSANZ and each of the other subspecialty societies, in liaison with their respective Specialist Advisory Committees, be convened to:

1. define subspecialty skills for purposes of advanced training in subspecialty medicine for general physician trainees;

2. define the minimum training curriculum that would be needed in order for general physician trainees to acquire the requisite level of selected skills;

3. devise a formal method of certification (eg diploma, certificate) that enables trainees to demonstrate that they have acquired the requisite level of selected skills;

4. define the methods of assessment by which suitability for certification would be determined; and

5. develop ongoing continuing professional development and maintenance of professional standards programs that ensure the requisite level of selected skills are maintained over time.

The above arrangements could act in reverse for those physicians who want to practise predominantly in a non-general subspecialty but who still wish, or require, to practise a certain level of general medicine, or who, in the future, may want to practise more as a full-time general physician. The RACP is keen to ensure that, as much as possible, fellows are competent to practise some level of general medicine even if their primary interest and training is in a non-general subspecialty. This aim is embodied in the concept of 'promoting the physician within.'[25] After completing the requisite core training program in the non-general subspecialty, an elective program in general medicine skills could be undertaken which leads to a certifiable demonstration of competence in general medicine at the completion of advanced physician training. A similar training program could be devised for those physicians practising in a non-general subspecialty who elect to now practise as a general physician.

In all situations described above, there would need to be established systems of continuing professional development and maintenance of professional standards in both general medicine and other subspecialties for all newly conferred fellows who wish to continue clinical practice in more than one subspecialty.

Mentoring and supervision

Advanced trainees in general medicine should be assigned a mentor, a supervisor and a system of peer support. General physicians who would act as mentors or supervisors would be expected to demonstrate a high level of knowledge and skill across the spectrum of internal medicine, be active participants of the College Maintenance of Professional Standards (MOPS) Program (all New Zealand physicians are enrolled in and participating in MOPS already), be committed to an individualised program of professional development and peer review, and to have attended mentor and supervisor workshops.

Trainee selection and appointment

While State-based selection and allocation of advanced trainees should be considered, the advantages and disadvantages of this process need to be compared. Region-based processes may be more efficient, feasible and responsive to local need. The Medical Training and Education Council (MTEC) of NSW is one attempt to make state- or health area-based recruitment workable and sustainable. The Victorian Department of Human Services is developing a system of hospital consortia and integrated medical rotations. Consideration should be given by RACP and state and territory health authorities as to

whether incentives are offered, or targets introduced, to actively support and encourage medical graduates from rural and provincial locales, or those committed to practising in such areas, to enter physician training. In addition, in order to prevent those with active interest in general medicine at enrolment from losing that interest during subsequent years, they should be accorded preference in the allocation of rotations to non-metropolitan hospitals during basic training, and provided with a transparent process for guaranteeing high-quality subspecialty experiences on return to metropolitan areas to undertake advanced training.

Role of consultant physicians in private practice

The role and importance of the private sector is rarely if ever mentioned in physician training. Most trainees see little or any private practice. Hospital based staff physicians dominate the training program with consequent diminution of the role of visiting medical officers in training programs, Special Societies and College committee activity.

At present, at least 50% of physicians spend over 50% of their time in private practice. Many trainees are unprepared for the multiple professional, practical, ethical and financial problems involved in conducting a full time private practice. It should also be recognised that consultant practice undergoes considerable evolution after becoming a Fellow of the RACP. Eventually a general physician may be conducting a practice principally in a limited area such as obstetric medicine, cardiac failure, or hypertension, and only undertaking truly undifferentiated work if on a general roster.

With the need for reduced demand on hospital beds and more emphasis on ambulatory and community-based care, the private consultation room setting provides interesting opportunities for training, especially as outpatient clinics in many southern hospitals have been privatised or disbanded. However, adequate teaching and training would require additional resources, including information technology facilities and remuneration to the private consultant for time taken to provide education. Trainees would also need access to a specific location provider number and be able to receive remuneration sufficient to compensate for reduction in hospital-based income. In advancing these ideas, it is important that private consultant physicians be adequately represented on training and similar committees, and, for those trainees intending to work primarily in the private sector, to receive training in this environment.

B. Physician Training and Continuing Professional Development in General Medicine

Strategic Action	Methods
1. Develop a list of competencies that must be acquired by end of training for advanced trainees in general medicine	Consensus and consultation Review of general physician competencies developed by other colleges/general medicine societies
2. Develop a structured curriculum in general medicine for: 1) basic trainees; 2) advanced trainees in general medicine	Tasking the Curriculum Writing Group Modular curriculum Review of curricula developed by other colleges/general medicine societies
3. Develop assessment methods for ensuring general physician skills have been acquired	Review of assessment methods developed by other colleges/general medicine societies
4. Promote trainee mentoring	IMSANZ mentoring program
5. Ensure all general physicians who supervise trainees have appropriate mentoring and supervisory skills	RACP supervisor training program Certification of all general physician supervisors Mentor scheme
6. Ensure all basic trainees and advanced trainees in general medicine have varied experience in general medicine	Training paths that include rotations in tertiary and regional hospitals, public outpatients, community health and other ambulatory care settings, and, where possible, private hospitals and clinics

Responsible parties	Timeline	Performance indicators
IMSANZ Council IMSANZ Curriculum Writing Group RACP Specialties Board	Mar 2005	Competencies defined and agreed
IMSANZ Curriculum Writing Group SAC General Medicine RACP Department of Education	Dec 2005	Curriculum developed
IMSANZ Curriculum Writing Group SAC General Medicine RACP Department of Education	Dec 2005	Assessment methods developed
IMSANZ	Dec 2005	Mentoring program established
IMSANZ SAC General Medicine RACP CPT IMSANZ RACP	Dec 2005	Register of general physicians certified as having attended supervisor training program Mentor program implemented
IMSANZ SAC General Medicine RACP CPT IMSANZ SAC General Medicine RACP CPT AACP	Jan 2006	Requirement of training paths to include tertiary and regional hospital rotations Models of supervised training in private hospitals and clinics developed

Physician Training and Continuing Professional Development in General Medicine , continued.

Strategic Action	Methods
7. Promote dual training for all advanced trainees in general medicine	Protected positions for general medicine trainees who wish to undertake dual training in other subspecialty training programs
8. Consider modular, certifiable training in selected subspecialty skills for advanced trainees wishing to practise both general medicine and another subspecialty interest, but who prefer not to undertake dual training.	Convene conjoint committees with representation from IMSANZ and each of the Specialty Societies to: 1) Define selected subspecialty skills 2) Define minimum training curriculum necessary for general physician trainees to acquire requisite levels of selected skill 3) Devise a formal mode of certification of skills acquired 4) Define the methods of assessment by which suitability for certification would be determined 5) Develop ongoing CPD and MOPS programs to ensure maintenance of selected skills over time
9. Promote state-based or region-based trainee selection and appointment	Establish regional or state-based interviewing and selection panels for basic trainees and advanced trainees in general medicine
10. Implement programs of continuing professional development (CPD) for all consultant physicians who continue to practise general medicine	Develop programs of CPD for consultant physicians practising general medicine Promote enrolment into General Medicine CPD programs of all physicians practising general medicine

MTEC=Medical Training and Education Council; CPT=Committee of Physician Training; AACP=Australian Association of Consultant Physicians; BOCPD=Board of Continuing Professional Development

Responsible parties	Timeline	Performance indicators
IMSANZ RACP CPT Specialties Board	Jan 2006	Dual training programs ratified by RACP as training goal
IMSANZ SAC in General Medicine Other Specialty Societies SAC in other subspecialties • Cardiology • Thoracic Medicine • Gastroenterology • Renal Medicine	Jul 2006	Conjoint committees convened for: Cardiology Thoracic Medicine Gastroenterology Renal Medicine Selected subspecialty skills defined Minimum training curricula defined Formal mode of certification agreed Methods of assessment for determining suitability for certification agreed CPD and MOPS programs for maintaining selected subspecialty skills developed
IMSANZ and RACP State government health departments Statutory bodies (eg MTEC in NSW)	Dec 2006	Selection panels and procedures established throughout Australia and New Zealand
IMSANZ SAC in General Medicine RACP BOCPD IMSANZ SAC in General Medicine RACP BOCPD	Ongoing Dec 2005	Development of CPD programs in General Medicine Establish a register of all physicians practising general medicine who have enrolled in IMSANZ-sponsored CPD programs

C. Outer Metropolitan, Regional, Rural and Remote Services in General Medicine

Objectives

C1. Establish regionalised hospital networks throughout Australia and New Zealand for purposes of integrated service delivery, staffing and training.

C2. Increase government funding and support of schemes designed to enhance medical specialist service infrastructure within rural and remote communities.

C3. Implement locum and continuing professional development support schemes for isolated physicians in rural and remote communities.

Explanatory Notes:

Needs of physicians in rural and remote locations

A number of issues must be confronted if the delivery of high-quality medical specialist services outside the setting of major tertiary hospitals is to be guaranteed. These include:

- Existing numbers of consultant general physicians are inadequate to provide adequate coverage to local constituencies, particularly those spread across large, sparsely populated areas. This problem will worsen as the current workforce retires.
- Inadequate support infrastructure for non-metropolitan physicians in terms of proximity of, or established linkages with, secondary or tertiary hospital services providing subspecialty support, pathology, imaging and other ancillary services.
- Absence of locum support to allow rural and remote physicians to take recreational or professional development leave, combined with few opportunities for isolated or non-tertiary physicians to participate in skill augmentation courses or clinical attachments within large tertiary hospitals.
- An increasing proportion of general physicians in rural and remote locations comprise overseas-trained physicians, who may require additional opportunities

to acquire the necessary lingual, cultural or clinical skills required for optimal professional practice in Australia and New Zealand.

- Limited access to trainee registrars on the part of non-metropolitan physicians because of absence of rotational schemes from larger hospitals and negative perceptions held by trainees (and perhaps their tertiary mentors) of community practice.
- Problems of social and professional isolation, environmental adversity, financial disadvantage, and long-term job insecurity that are common to all clinical disciplines in rural and remote centres.
- Many area of need appointments involve overseas trained physicians who may have specific cultural and ongoing educational needs which currently may not be realized through current professional development programs of the RACP.

Regionalised hospital services and training programs

IMSANZ and RACP seek endorsement of the following recommendations for enhancing delivery of medical specialist services to rural and remote areas:

- Resident rural physicians should be supported by regionalised ('hub and spoke') hospital and service networks, wherein teaching hospitals (of 150 beds or more) with on-site personnel would support those physicians working within a geographically-defined catchment area.
- Regionalised networks would provide clinical services at various levels: a major tertiary hospital providing subspecialty physicians services to general physicians working in large community hospitals within say a 200km radius (including outer metropolitan hospitals); or a large community hospital providing general medicine and some subspecialty services to physicians working in smaller district hospitals within a 200km radius.
- Similarly, in terms of registrar recruitment and training, these networks would comprise a number of community hospitals affiliated with one major tertiary hospital, the latter providing the former with trainee registrars on a rotational basis of at least 3 months. Increasingly, with the limited supply of overseas trained doctors and the need to ensure a minimum level of quality in registrar performance, community hospitals will require staffing by competent and committed physician trainees who have a secure training path centred on their attachment to the tertiary hospital.

- The RACP working with IMSANZ would ensure that throughout Australia and New Zealand, regional networks would be set up, covering all medium sized hospitals and population centres in which general physicians work. The College, working with relevant State committees and State health departments, would register, monitor and accredit these networks, and in so doing ensure that: 1) the tertiary hospital employed sufficient numbers of registrars to provide all necessary rotation positions to community hospitals; 2) the tertiary hospital provided the necessary administrative and human resources support to their directors of physician training for purposes of overseeing the training needs of all trainees involved; 3) the community hospitals provided necessary levels of trainee supervision, clinical experience and educational support as recommended by the College and IMSANZ; and 4) those trainees desirous of practising as general physicians in regional centres be afforded access to subspecialty rotations in the tertiary hospital sufficient for the acquisition of appropriate levels of skill in specific procedures.
- The RACP would, in Australia, request each State committee, in consultation with Directors of Internal Medicine in all state hospitals, State IMSANZ councillors, and representatives from State health departments, to define, for the entire state, regional networks comprising a tertiary hospital and a suitable number (but no more than 5) of affiliated community hospitals selected on the basis of geographic proximity, established referral patterns, or particular service needs. In New Zealand this dialogue would occur with the Ministry of Health and District Health Boards.
- The RACP would request State and New Zealand branches (or executives/councillors) of Specialty Societies to liaise with their members in tertiary hospitals and advise them to support the appropriate provision in community hospitals of subspecialty services (in the form of visiting specialists from tertiary hospital or from local community, or, where deemed necessary, full-time appointments).
- The RACP would request that physician trainees in tertiary hospitals (all basic trainees and all advanced trainees in general medicine) rotate to community hospitals for a minimum of 6 months in either of the two phases of training.
- The RACP would register each regional network and record activity and demographic details of participating hospitals, number of secondment trainee

posts and subspecialty physician appointments in community hospitals, and other relevant details about referral and transfer procedures and ancillary services provided by the tertiary hospital to its affiliated community hospitals.

- Each regional network would establish a regional committee or advisory group, comprising the staff general physicians in each hospital of the network, whose brief would be to oversee recruitment, training and service functions relating to general medicine and submit recommendations for reform, as appropriate, to chairs of 'hub' hospital Divisions of Medicine, health district managers, and state health departments. The Medical Training and Education Council (MTEC) of NSW provides an example of how such networks, and the training infrastructure contained within them, could be developed and supported (more details available at: www.mtec.nsw.gov.au).

Outreach specialist services to remote communities

In Australia the Medical Specialist Outreach Assistance Program (MSOAP) is a federally funded program which pays for specialists to visit remote communities to provide both secondary medical care and education of clinical staff working there. General physicians are encouraged to be involved in these programs. Physicians involved in MSOAP may be: 1) fly-in, fly-out (FIFO) specialists who reside in a major but distant centre and provide one-off clinics or procedural sessions; 2) physicians who reside in, and provide full-time services to, a remote locality for a specified, albeit temporary period of time but who are based elsewhere; or 3) physicians employed at a large hospital (tertiary or community) who are contracted to provide outreach clinics on a regular, ongoing basis to geographically proximate but still remote communities.

The MSOAP to date has several disadvantages:

- It does not directly and permanently raise local levels of infrastructure and workforce.
- It may add to the workload of local primary care providers if specialist services are provided by people who do not have local knowledge.
- It may impede local infrastructure development by relieving pressure on the local health authority to commit to sustained service improvement.

- There are relatively limited numbers of funded MSOAP positions.

IMSANZ proposes the following strategies:

- Outreach services should be built in liaison with local service providers, with appropriate cultural and clinical orientation, and ongoing close professional collaboration.
- Specialists involved in providing such services should have an appropriate skill mix that emphasises self-sufficiency, and be committed to providing a continuing service over an agreed period of time.
- Medical registrars in advanced training as well as qualified specialists should be provided greater support from MSOAP than exists at present, in the form of joint positions with tertiary hospitals, given that an increasing proportion of such positions would incorporate an obligatory rural component. MSOAP could be used to increase exposure of trainees to non-tertiary practice and return of these people to rural sites to practise as fellows.
- Resident physicians in rural practice who have to assume the role of supervisors without the same level of administrative support that is available to their counterparts in large urban academic centres should be remunerated for their participation in such schemes.
- In cases of outreach services provided by regional hospitals to sparsely populated areas, incentives for building a critical mass of physicians in those hospitals should be present to prevent the demands of delivering the outreach service compromising the quality of acute hospital care. This is critical to avoiding physician burn out and loss of morale.

Achieving a sustainable number of physicians in a region will require political will, appropriate funding, and more exposure of trainees and young physicians to the professional satisfaction of caring for patients across a wide spectrum of clinical medicine. Although there are similarities, these recommendations will require some modification for the New Zealand context.

Locum and CPD support

IMSANZ recommends the following forms of locum and CPD support:

- MSOAP in collaboration with the RACP Workforce Committee initiate reliever terms (leave cover, sabbaticals, long service leave, backfill) to allow more isolated physicians to take holidays, do more outreach visits, write up papers or conduct original research.
- Arrange job swaps or exchanges between remote and tertiary-based physicians to enable remote physicians to refresh/acquire new knowledge/techniques, or undertake a clinical attachment, within a state-of-the-art tertiary setting. This could be part or wholly funded through MSOAP.
- Reintroduce clinical skill enhancement schemes whereby tertiary or large regional hospitals implement and advertise an annual (or bi-annual) clinical training program of 3-5 days involving all or a selected number of subspecialties from which remote physicians can select those sessions which most interest them to attend.
- Implement telehealth links and videoconferencing of education sessions, journal clubs, grand rounds and college lectures which would be bidirectional i.e. a physician in Alice Springs could present a case to an audience in Royal Darwin Hospital, and vice versa.
- Promote development of clinical practice guidelines, update courses and workshops, clinical decision support tools, quality improvement resources, and self-directed learning packages on the part of both IMSANZ and subspecialty societies.
- Provide self-learning formats of CPD accessible in electronic form which have embedded self-assessment methods.
- Establish reciprocal or conjoint registrar training programs whereby, on a 2 year rotation, one registrar from a tertiary site works in a more distant community hospital while a registrar from the community hospital works in the tertiary hospital.
- Expand the Cottrell Traveling Fellows scheme to enable more specialists based in tertiary or large regional hospitals to travel to remote centres for lecture tours, workshops and seminars, or practice reviews and demonstrations.
- Establish a mentoring scheme for overseas trained physicians which links such physicians with RACP-trained general physician peers in local catchment areas for the purposes of providing practice advice and review.

C. Outer Metropolitan, Regional, Rural and Remote Services in General Medicine

Strategic Area	Methods
1. Establish regionalised (hub and spoke) hospital networks throughout Aust/NZ for purposes of integrated service delivery, staffing and training.	Consensus and consultation between tertiary, regional and district hospitals within geographically defined regions
2. Establish rotations (minimum 3 months) of medical registrars from tertiary to regional/rural/ remote hospitals sufficient to fill vacant non-tertiary registrar positions	Rotational schemes incorporated into appointment contracts
3. Implement schemes for attracting physicians to practise in rural/remote areas	Conjoint or rotational registrar training programs involving tertiary/large regional hospital and more remote regional/rural hospital Revise RACP accreditation criteria for overseas trained physicians Consider preferential selection into training programs of basic trainees from rural/remote areas Increase exposure of physician trainees to rural/ remote practice
4. Direct more state and federal funding to establishing more resident physician positions and expanding local specialist service infrastructure in rural/remote communities	Undertake needs analysis of rural/remote communities Formulate operational plan for directing health funding to communities with greatest need
5. Expand the levels of MSOAP funding to support rural and remote positions for trainees and recently graduated fellows	Lobby Federal health department for more MSOAP funding Lobby for increased MSOAP funding for registrar positions

Responsible parties	Timeline	Performance indicators
IMSANZ RACP Rural Taskforce RACP State Committees State health departments State health area authorities Statutory bodies (eg MTEC in NSW)	Dec 2006	Register of regionalised networks established and monitored by RACP
RACP CPT HRM personnel, Division of Medicine administrative staff and DPT in tertiary hospital	Jan 2007	Rotational schemes endorsed by RACP State committees and RACP CPT
IMSANZ RACP Rural Taskforce RACP AMC RACP CPT RACP Rural Taskforce RACP CPT	Jan 2007	Conjoint registrar programs implemented Accreditation criteria revised Preferential entry or quota schemes developed
DHA RACP Rural Taskforce IMSANZ State area health authorities IMSANZ RACP Rural Taskforce State area health authorities	Dec 2006	Funding allocation procedures revised Needs analysis undertaken Agreed operational plan formulated
IMSANZ RACP Rural Taskforce IMSANZ RACP Rural Taskforce	Dec 2006	Register of MSOAP positions occupied by physician trainees

Outer Metropolitan, Regional, Rural and Remote Services in General Medicine, continued.

Strategic Area	Methods
6. Implement locum and CPD support schemes for isolated physicians	Lobby urban living physicians to undertake locum sessions Lobby tertiary hospitals within regionalised hospital networks to undertake job swaps/exchanges Lobby tertiary hospitals to provide upskilling courses, clinical attachments for isolated physicians Lobby MSOAP to provide more funding of CPD programs for isolated physicians
7. Establish mentoring scheme for overseas trained general physicians	Identify all overseas trained general physician Appoint a RACP-trained general physician trainee for each overseas trained general physician within local catchment areas
8. Promote educational/CPD linkages between tertiary and regional/rural/remote hospitals within hospital networks	Videoconferencing of grand rounds, journal clubs, college lectures between tertiary and non-tertiary hospital

BOCPD=Board of Continuing Professional Development; CPT=Committee of Physician Training; DHHS=Department of Health and Ageing; AMC=Australian Medical Council; MTEC=Medical Training and Education Council; MSOAP=Medical Specialists Outreach Assistance Program; HRM=Human Resource Management

Responsible parties	Timeline	Performance indicators
IMSANZ RACP Rural Taskforce IMSANZ RACP State Committees State health authorities RACP Rural Taskforce RACP Rural Taskforce RACP State Committees State health departments RACP Rural Taskforce	Jul 2006	Register of locum and CPD support schemes
RACP IMSANZ IMSANZ RACP BOCPD	Dec 2005 Dec 2005	Register of overseas trained physicians Mentors scheme implemented
IMSANZ RACP BOCPD RACP CPT	Dec 2005	Register of videoconferencing programs serving rural/remote hospitals

D. Remuneration and Private Practice in General Medicine

Objectives

D1. Promote greater recognition by the Commonwealth government (and District Health Boards and health insurance funds in New Zealand) of the value of cognitive, non-procedural work undertaken by all physicians, including general physicians.

D2. Promote greater equity between procedural and non-procedural physicians in the level of remuneration provided under Medicare.

D3. Encourage state governments to adequately compensate general physicians in private practice for time spent in undertaking public hospital duties comprising committee work and teaching roles in addition to clinical work.

D4. Encourage state and federal authorities to provide financial incentives to general physicians to practise in rural and remote areas.

D5. Encourage state and federal authorities to consider incentive payment systems that reimburse general physicians in private practice for their involvement in establishing or maintaining community or public health programs.

D6. Encourage government and private health funds in Australia, and insurance companies in New Zealand, to introduce alternative methods of remuneration that complement traditional fee-for-service methods to cater for work performed at a group, community or population level.

Explanatory Notes:

Increasingly in the future, most general physicians will practise in diverse settings in teams, often in the role of clinical leader. General physicians will continue to play an increasingly central role in programs of disease management, quality improvement, teaching and research. This will require greater flexibility in work schedules and methods of remuneration. More recognition and reward needs to be given to the non-procedural, cognitive work that general physicians undertake amongst other non-procedural physicians. For these reasons, changes are required in the current structures by which general physicians are funded and/or employed throughout Australia and New Zealand.

Further compounding this inequity between procedural and cognitive consultant, the experience of most general physicians would suggest that the work involved in performing a new consultation exceeds an hour, and is therefore not adequately

remunerated by the current rebate levels. Many of the patients seeing general physicians are older, have multiple organ-system problems, and comprise complicated cases. Completing the history and examination and reviewing all received correspondence could total 75 minutes. Ordering investigations, treatments and communicating the management plan to the patient would add at least another 15 minutes. Dictating and editing letters to the referring clinician, and comparing notes with colleagues about various aspects of care, would consume yet another 10 to 15 minutes. Thus a complicated new case may require more than the standard 60 minute consultation.

It is currently estimated that general physicians in private practice bear practice costs, including superannuation, equivalent to $100 per hour, assuming a 40 hour practice week, 45 weeks per year working practice, and rooms that are owned, not leased or rented (Dr Andrew Gordon FRACP, personal communication, 2004). As a considerable portion of general physician private practice comprises outpatient visits, this fixed practice overhead needs to be compared, in Australia, with the current Medicare Benefits Schedule (MBS) rebate for an initial outpatient consultation (MBS item 110) of $128.05, and that of a review consultation (MBS item 116) of $64.10. Therefore, the non-procedural general physician would need to see at least one new consultation and one review consultation each hour to gain an appropriate income if he/she chooses (or is required by virtue of patient circumstances) to charge a fee no more than 15% above the rebate. If one new consultation only can be seen in an hour, then a patient co-payment of $74.60 (59% of the rebate value) would need to be charged to provide the same income. This limited income generating capacity is further constrained by the previously mentioned reality of most consultations requiring additional work which consumes more time than is adequately remunerated under existing MBS items.

It is further estimated that physicians spend 20%-25% of their working day in non-patient contact care such as answering phone calls, talking to carers, relatives, and other health professionals, manageing the practice, teaching students and trainees, and being involved in community or public health initiatives. It is difficult to quantitate this work, and even harder to estimate its value, most of which must be performed during working hours which further limits consulting time and income generation. Being 'on-call' also constitutes a form of unpaid work, which is particularly relevant to rural and remote physicians. Physicians in private practice who choose to perform paid sessions at public hospitals also receive sessional rates in all states and territories which are substantially less than remuneration generated in private consulting practice for the same time commitment.

The economists contracted to the Medicare Schedule Review Board (Relative Value Study [RVS]) from 1995 to 2000 presented data to the Board which showed that in 1999 dollar values, the average consultant physician had hourly practice overheads of $82 per hour.[52] To adjust this to 2005 values, and including increases in medical equipment costs, room overheads, and other costs linked to the rises in consumer price index experienced during this period, hourly practice costs are now over $100 per hour. Both the accounting firm KPMG and the Australian Association of Consultant Physicians (AACP) conducted independent studies of average time taken in performing initial and follow-up physician consultations - MBS items 110 and 116 respectively (Dr Geoff Metz FRACP, personal communication, 2005). The studies showed remarkably similar results with approximately 47-51 minutes for initial consultations and 20-22 minutes for follow-up consultations. Added to both consultations was 'non face to face time' of 20% (consumed by dictating letters, speaking with radiology/pathology colleagues and family members, etc.) which, on 2005 Schedule fee values, is equivalent to $128.05 plus $64.10 = $192.15 for 88 minutes, or $131.00 per hour.

Thus non-procedural consultant physicians, after a minimum of 13 years of tertiary study and physician training, and a lifetime of continuing medical education ahead of them, can look forward to an after-cost net income of $31 per hour. This economic fact goes a long way to explaining why trainees are currently reluctant to train in general medicine, geriatric medicine, neurology, haematology, immunology, endocrinology, paediatrics and all other non-procedural subspecialties of consultant physician practice. A review of current rebates and their relativities is urgently needed if the ongoing loss of private general physicians from the workforce, especially in regional and rural centres, is to be reversed.

The RACP, in its recent submission to the Productivity Commission's Health Workforce Study,[53] recognises that remuneration is a major determinant of choice of specialty. The submission endorses the need to train more consultant physicians with a range of generalist skills who are able to provide the necessary care for an ageing population, and who can provide equity in workforce distribution among outer urban, regional and rural health services. IMSANZ will work with the AACP, the Australian Medical Association (AMA), the Health Insurance Commission (HIC), Specialty Societies and the RACP in an effort to convince government of the necessity of raising rebates for cognitive consultations performed by all physicians.

D. Remuneration and Private Practice in General Medicine

Strategic Area	Methods
1. Promote greater recognition by the Commonwealth government (and District Health Boards and health insurance funds in New Zealand) of the value of cognitive, non-procedural work undertaken by all physicians, including general physicians.	Consider submissions to Commonwealth government (and District Health Boards and health insurance funds in New Zealand) to increase levels of remuneration for cognitive physician consultations Assist AACP to lobby government for rebate increase
2. Encourage state governments to adequately compensate general physicians in private practice for time spent in undertaking public hospital duties comprising committee work and teaching roles in addition to clinical work..	Present business case to state government health departments to increase remuneration levels accordingly
3. Encourage state and federal authorities to provide financial incentives to general physicians to practise in rural and remote areas.	Present business case to both levels of government to provide various incentives (such as pro-rata rebates for relocation expenses and practice set-up costs, remoteness incentive grant or debt relief) to fellows who wish to practice in rural and remote locales
4. Encourage federal government to provide incentive payment system that reimburses general physicians in private practice for their involvement in establishing or maintaining community or public health programs.	Present business case to federal government to provide incentive payments for time consumed in working hours by general physician involvement in community or public health programs

AACP=Australian Association of Consultant Physicians

Responsible parties	Timeline	Performance indicators
IMSANZ AACP	Feb 2006	Formal submissions developed and submitted
IMSANZ AACP	Dec 2005	Joint communiqué from AACP and IMSANZ issued
IMSANZ AACP	April 2006	Business case development and submitted
IMSANZ AACP	April 2006	Business case developed and submitted
IMSANZ AACP	April 2006	Business case developed and submitted

Conclusion

The RACP and IMSANZ will attempt, in collaboration, to further refine and implement the objectives and strategic actions contained within this document over coming years. Representation from government (both state and federal) and the wider community, as well as from fellows of RACP, is invited in providing comment and feedback to the statements contained herein. We also encourage all concerned to attend meetings and forums where these recommendations are discussed. In particular IMSANZ will continue to forge partnerships with other generalist disciplines such as geriatric medicine, emergency medicine, intensive care medicine, and palliative care medicine. The RACP and IMSANZ hope that such collective action will enhance the quality of specialist services in general medicine as well as other medical subspecialties for the betterment of health of all Australians and New Zealanders.

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Australasian Chapter of Sexual Health Medicine
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