IMSANZ

Internal Medicine Society of Australia and New Zealand

January 1998

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From the President

Our New Zealand members deserve full marks for the recent IMSANZ meeting at Mt. Cook. A veritable smorgasbord of clinical vignettes and talks, long afternoon walks up glaciers and a most entertaining dinner, made most of us think we should have IMSANZ meetings more often. The rugged splendour of Mt.Cook was seen in the most favorable weather and even the local medicos said they had not seen the mountain looking so hospitable before. Plus snow right down to the end of the glaciers! The mountain claims three climbers' lives each year on average and the only skiing is down the glacier after you have been delivered to the top by helicopter. But the true value of these meetings lies in the chance to meet and to get to know other general physicians with similar problems to your own, to compare notes and to get a few new ideas. Our after-dinner speaker was a Mount Everest climber, Dr Dick Price, a pursuit that puts most other contemporary forms of masochism in the shade.

My impression is that our New Zealand members are well ahead of Australian members in the computer area. Most of them have e-mail addresses and are increasingly using the Internet to discuss clinical cases and problems.

IMSANZ now has an e-mail address - imsanz@racp.edu.au. Hopefully the slow learners as far as computers go (like me) will gradually catch up. Members should note that MEDLINE is now free on the Internet(http://www.ncbi.nlm.nih.gov/PubMed/).

IMSANZ now has a new Secretary at RACP headquarters - Ms. Cherie McCune. She's very happy to help with any enquiries that you may have. Cherie is starting to build an extensive data-base on our members, which should help us to know where our strengths are and who we can call on for expertise when problems arise. In the near future we will be conducting another survey of membership and it is my hope that subsequently an

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As you turn the pages...................

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IMSANZ Membership Directory will be published.

There is considerable concern that general physicians should be able to continue to perform procedures provided they have sufficient training. IMSANZ Council has decided that IMSANZ will formulate its own guidelines in relation to procedures. Under the able leadership of Dr. Michael Kennedy a committee is looking into this matter and a **procedures booklet** is taking shape. Council also believes that trainees should keep a log book of procedures performed throughout their training and requests that members discuss this with their trainees. This will be essential when guidelines are published in our booklet suggesting that each procedure must be performed a set number of times under supervision before a physician is considered to be competent in performing the procedure. Members who have views about accreditation procedures should contact Michael Kennedy as soon as possible.

IMSANZ is off to a good start - let's keep the energy riding high.

There are new guidelines for training in general medicine which have recently been approved by the RACP. These are contained in the **"Guidelines for Members"** booklet which will soon be circulated to all IMSANZ members. This booklet is in evolution and suggestions for the 1998 version would be welcome.

Council has prepared a **"What is a General Physician?"** pamphlet aimed at educating our patients about this tricky question! Currently it is being tizzed up a bit with some artwork but hopefully a copy will go out with the guidelines. It is hoped that members will then purchase quantities and display them in their waiting rooms.

Would members please encourage their Advanced Trainees to make presentations at the 1998 meeting in Melbourne for the "IMSANZ Clinical Investigator Prize"?

Council is keen to hear about the experiences of generalists and their problems, particularly in relation to retention and re-establishment of general medical units in hospitals.

The newsletter is an ideal way to put your point of view. Please support your newsletter editors by remembering to make contributions. With over 500 members, IMSANZ has plenty of talent but we all need to put in a bit if the maximum potential of the Society is to be achieved. We need your ideas.

The Australian Medical Workforce Advisory Committee is planning a survey related to requirements for sustainable practice for general physicians in rural areas. The commonly quoted "benchmark" figure is one general physician for 10,000 population but to some extent this figure has been plucked out of the air. Council would appreciate feedback from members as to whether or not this is realistic.

At its October meeting the IMSANZ council approved the following mission statement for IMSANZ:

"The society exists to foster the highest standards of training, practice, teaching and research in the field of Internal Medicine."

IMSANZ is off to a good start - let's keep the energy riding high.

Robin Beattie
Hobart

With over 500 members, IMSANZ has plenty of talent but we all need to put in a bit if the maximum potential of the Society is to be achieved. We need your ideas.

THE LOGIC BEHIND OUR LOGO

Council is keen to create a corporate identity for IMSANZ and the search for a suitable logo has been one important aspect of this. In our last newsletter a request was made to all members to consider possible ideas for a logo and a few imaginative Fellows put forward interesting ideas which were discussed by Council at the Mt. Cook meeting in October, 1997.

It was decided to enlist the aid of renowned graphic artist, Linda Warner, who recently designed some of Australia's stamps. All of the ideas from the Council meeting were given to her and she was asked to creat a simple design for a logo which would go some way towards encapsulating the aspirations of the general physician.

The thrust of her final design is to create the wholeness of the practice of consultant general medicine by utilising stylised figures with outstretched arms to indicate the personal approach. These figures are arranged in a centrally focussed design as though in consultation. The arm gesture indicates the caring nature of our practice. The design also has emblematic qualities and a crestlike appearance, thus projecting the professionalism of our consultant practice. The logo was kept simple and direct without complicating the appearance, which allows it to work well at a small scale. Although it looks best in its colours of mauve and grey, it also works well in black and white and it will stand up reasonably well to the rigours of faxing. Council has yet to formally accept this logo but all Councillors have seen the logo and all of those who commented on it have expressed approval.

Rural Workforce and Training, RACP

The Royal Australasian College of Physicians has recently appointed Gary Disher as Executive Officer, Rural Training and Workforce Programme. Gary will be developing workforce profiles across rural Australia. He will also be involved in co-ordinating locum services for non-metropolitan areas and in developing advanced physician training and further opportunities for continuing education in non-metropolitan and rural areas.

As a result of a survey carried out before Christmas there are now locums available. Please contact Gary if you have need of a locum.

Phone: 02 9256 5421
Email: gdisher@racp.edu.au

IMSANZ Secretariat:
Ms Cherie McCune — ***Phone: 02 9256 5471***
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Sydney NSW 2000 — ***imsanz@racp.edu.au***

IMSANZ Scientific Meeting - February 1998 - Paihia, NZ

The IMSANZ Scientific Meeting for early 1998 will be held in Paihia, Bay of Islands, New Zealand on 27 and 28 February. This meeting promises to be a great success. The Bay of Islands is an idyllic spot and a great tourist attraction in the North Island. Australian delegates will find the trip worthwhile and are encouraged to come.

The scientific program will contain updates on: *Management of Veno-thrombotic Disorders, Transfusion Medicine* and *Hepatic Transplantation*. There will also be *Free Papers* and a *Medical Quiz* with attractive prizes to be won. The social program promises to be fascinating and will include a cruise around the Bay of Islands. The theme for the conference dinner is "*Laughter, the Best Medicine*".

For further information please contact : *victoria@voyager.co.nz* or *ramesh@igrin.co.nz*

RESURRECTION REQUIRED - CAN GENERAL INTERNAL MEDICINE SURVIVE?

Patrick J Fiddes, Wangaratta, Victoria

I was asked to speak at the Section of Medicine Meeting at the Royal Melbourne Hospital and chose to talk on the broad issue of rural consultant physician practice in general internal medicine. I particularly discussed the training requirements for physicians to practise as consultants in general internal medicine in rural areas, presented data on the workload of three physicians practising within the one rural city, and attempted to identify factors which attract physicians to practice in the country based on data from a personal survey of over 50 physicians in consultant practice in rural Victoria. In addition, I highlighted continuing deficiencies existing in the training available for such aspiring physicians.

The RACP and IMSANZ have spent a considerable amount of time in committee and debate, with various reports and publications, on issues concerning the role of the general physician and appropriate training. This effort has resulted in little benefit, as evidenced from the RACP Specialist Advisory Committee's report of the 27th August 1997, which shows a progressive decline in the percentage of registered advanced trainees choosing to undertake training in general internal medicine. Whilst with the passage of time, there has been an absolute increase in the number of general physicians who practice in rural Victoria, and presumably in Australia as a whole, the encouragement for such physicians to undertake training in general internal medicine with a view to a rural practice has been lacking.

Physicians aspiring to practice as generalists usually need to compete with aspiring subspecialists, for predominantly subspeciality training posts in the advanced training programmes of our major metropolitan teaching hospitals. Selection for such positions is predominantly allocated to those who elect to undertake training in such subspecialities. The aspiring general physician has to compete with such subspeciality trainees, to rotate from one training post to another and complete training with an appropriately broad exposure to a number of disciplines within internal medicine. This reflects a lack of specific general medicine training programmes and the RACP's inactivity in encouraging an increased allocation of such posts to aspiring general physician trainees.

The position in Australia compares unfavourably with the developing resurgence of generalism in New Zealand, Canada, United States and Great Britain. The position in the Great Britain may be reflected in the recommendations of a Royal College of Physicians' Committee on General (Internal) Medicine, published in its journal (May/June 1996) as follows:

1. *Acceptance of general medicine as a speciality with a major role in the management of acute medicine.*
2. *The designation of general medicine by a speciality number for higher medical training.*
3. *Co-ordination of higher medical training in general internal medicine together with training in a speciality.*
4. *Continuing medical education for the generalist with special reference to the management of acute medical emergencies.*
5. *Preparation by specialists of protocols and guidelines to help the generalist when handling a wide variety of acute medical cases.*
6. *Development of various models of practice for the organisation of general medical cover and responsibility for the management of acute medicine.*

The view of the Canadian Society of Internal Medicine is expressed in the report "General Internal Medicine, A Valued Resource For Canada's Health Care System", which specifies the place of general internal medicine in relation to community size and academic and non-academic settings.

......."The roles of general internists vary considerably with community size, and between academic and non-academic settings.

*In larger communities serving as **tertiary care centres** (population generally 250,000) there is usually a strong subspecialty presence, providing the opportunity for direct referral from primary care physician to subspecialist. In some of these communities, general internal medicine has found a more limited role,*

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dealing with pre-operative medical assessments, and those undifferentiated and/or complex problems for which a specific subspecialty is not readily apparent. In other larger communities however, General internists play a strong supporting role to subspecialists in managing patients with complex illness. In many such centres, general internists have been accorded larger responsibility for the management of clinical services and programs suited to their expertise, such as intensive care, eating disorders, palliative care, diabetes, etc.

*Medium size communities (population generally 50-250,000) lack the population base to support many of the subspecialties, but function as regional or **secondary care referral centres.** In these communities general internists often fulfil roles, such as endoscopy, which would normally be provided by subspecialists, as well as having a stronger presence in dealing with complex or undifferentiated problems such as myocardial infarction or acute respiratory failure, which would be referred to subspecialists in many larger communities.*

In some of these communities, solo subspecialists maintain an income and obtain cross-coverage by practising general internal medicine and participating in on-call call rosters, although not specifically qualified for this function.

*In small communities (population less than 50,000) general internists provide most, if not all, of the care in Internal Medicine. In these communities problems requiring tertiary medical care (e.g. coronary angiography, endoscopy) are usually referred out. Generally speaking however, general internists in small and many medium sized communities acquire special skills during their training which permit them to carry out many **secondary functions,** usually performed by subspecialists, which would otherwise require referral to larger centres.*

In academic centres general internists play unique roles in teaching and research. Their teaching roles include development of and participation in postgraduate residency programs, as well as participation in undergraduate and continuing medical education. The latter is especially important. As all physicians struggle to cope with the explosion of medical information, academic general internists have been at the forefront in understanding how physicians learn, and in developing innovative and effective methods to assist that process. Academic general internists, not surprisingly, also pay a prominent role in medical research in the fields of health technology assessment, clinical epidemiology, biostatistics, and medical ethics. Academic general internists serve as role models for the acquisition of skills in effective resource utilisation by future general internists ...."

The attention given to the role of general internal medicine specialists in Australia has reflected the debate overseas, but has not yet resulted in any tangible increase in the number of positions available in major metropolitan teaching hospitals, or of training positions. In the majority of metropolitan teaching hospitals there is, I believe, only lip service paid to the role of the generalist. In the majority of teaching hospitals, if general medical units exist, they are staffed by subspecialists who attempt to provide a general perspective on the management of the patients with conditions which do not fall within the boundaries of their particular sub-speciality interest. The perpetuation of the predominance of sub-specialists subserving a generalist function within teaching hospitals reflects a lack of understanding on the part of the teaching hospitals, and indeed the RACP, as to the role generalists can play in the management of complex illnesses within a tertiary institute. Generalists do have a more significant established role in smaller metropolitan hospitals, and indeed in rural base hospitals where they provide the predominant internal medical services.

It is difficult to see what more can be done at this stage without the active encouragement of the RACP and its positive affirmation of the need to increase training positions for generalists, and to address this particular Australian trend away from generalism, in contrast to the resurgence occurring in the remainder of the English speaking world.

Dr G T Ey Travelling Fellowship for Isolated Physicians

The G T Ey Travelling Fellowship for Isolated Physicians is offered by the Royal Australasian College of Physicians to commemorate the life and work of Dr. Geoffrey Ey.

The purpose of the Fellowship is to support isolated physicians who are Fellows of the College or its Faculties, seeking to further their own continuing education through a short-term study tour of institutions outside Australia and New Zealand.

Applicants must supply a proposed itinerary and budget.

Approved grants will be for a sum up to $5,000. The amount of the award will be determined with reference to salaries and funds available from other sources and preference will be given to those in receipt of no other endowment for this particular purpose.

For further details contact:

RACP NZ
5th Floor St John House
99 The Terrace
WELLINGTON
Phone: 04 472 6713
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Email: jo.jones@racp.org.nz

RACP Sydney
145 Macquarie Street
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Phone: 02 9256 5444
Fax: 02 9252 3310
Email: racp@racp.edu.au

Dr Geoffrey Ey

Geoffrey Thomas Ey graduated from the University of Adelaide in September 1947. Following a period of residency at the Royal Adelaide, he practised in the Northern Territory for 2 years during which time he became aware of the difficulties and relative isolation of rural medical practitioners.

On his return from England, he worked as a registrar at the new QE Hospital in Adelaide and obtained the MRACP around 1961. He practiced in private and as assistant physician to the QE Hospital.

He worked as a relieving physician for several months in remote areas of the NT. The excellence of the QE Hospital's Thoracic Medicine Department is a tribute to his dedication and excellence.

He died in April 1991 at the age of 66 years following a long battle with secondary malignant disease.

The proposal to create a Travelling Fellowship for Isolated Physicians was supported strongly in his memory. Donations came from many of his colleagues in Australia and major donations from his widow and daughters.

He was a compelling teacher with innovative ideas, who always treated the whole person.

Dr Allan Kerr Grant

The Dr Ey Travelling Fellowship is awarded every 2-3 years by the RACP. The last recipient was Dr Wayne Spring, Ballarat, Victoria, who studied "Sleep Medicine" in Palo Alto, California, in 1996.

Dr Spring writes.......

A solitary Australian joined 29 Americans and 2 Canadians at the School of Sleep Medicine 14th Annual Physicians Sleep Medicine Course at Palo Alto. The 7-day course was intensive with lectures and workshops from the international leaders in sleep medicine. I found the course stimulating and it made me wonder how many patients with sleep disorders I had "fobbed off" over the years.

On my return I have gone ahead and set up a Sleep Disorders Centre in Ballarat in conjunction with the St.Vincent's Hospital Sleep Disorders Centre in Melbourne, which provides back-up expertise to both me and my sleep technologist.

The advent of a sleep centre in Ballarat has led to an increasing number of referrals, many with severe obstructive sleep apnoea, as well as patients with narcolepsy.

The Fellowship has taught me a lot, both medically and about health in the USA, and has improved the delivery of sleep services in rural Victoria........

IMSANZ Annual Scientific Meeting - Tuesday 12 May 1998

The provisional program for the IMSANZ Annual Scientific Meeting, which will be held in Melbourne on the first day of the RACP Annual Scientific Meeting is outlined below.

Theme

Medicine at all ages: diseases of women

Workshops

The workshops are designed to be based on clinical vignettes, to be interactive and to separate *evidence* from *opinion*. Relevant references will be circulated beforehand.

Lunchtime Quiz

A series of stations with clinical details and investigations which can be visited during lunch.

Trainees and Members Presentations

For the first time members are also invited to submit abstracts of clinical cases, research projects and quality activities. Please encourage trainees to submit abstracts for presentation. $1,000 will be awarded to the trainee judged to make the best presentation. Abstracts should be sent to the local organising committee (see below).

Provisional Programme

0730 - 0800 Registration and Breakfast
0800 - 0845 Lecture: Screening for Cancer in Women
0900 - 1030 Opening RACP Annual Scientific Meeting by The Hon. Robert Knowles MP.
Cottrell Lecture: Prof. John McNeil.
1030 - 1100 Morning Tea and Trade Display Opening
1100 - 1215 Workshop 1 - "A 48 year old obese taxi driver falls asleep at the wheel"
1220 - 1325 Lunch and Quiz
1330 - 1500 Trainees and Members Presentation
1505 - 1615 Workshop 2 - "A 30 year old nurse with a DVT in the third trimester"
1620 - 1730 Workshop 3 - "A 50 year old engineer with menopausal symptoms asks about prevention of heart disease and stroke"
1730 - 1830 IMSANZ Council Meeting
1800 - 2000 RACP Welcome Reception
2000 IMSANZ Dinner

IMSANZ Dinner

This is expected to be the highlight of the week. Superb food, drink and company enhanced by the wonderful views of night-time Melbourne from the 57th Floor Observation Deck of the Rialto Tower.

Local Organising Committee

Dr. Robert Lodge, 219 Gore Street, Fitzroy, Vic, 3065. Fax: 03 9416 1944
Dr. Les Bolitho, 6 Dixon Street, Wangaratta, Vic, 3677. Fax: 03 5722 1781

Registration for the IMSANZ Meeting is included in the RACP ASM registration. Further details will accompany the February edition of Fellowship Affairs.

Late extra:

The RACP Annual Scientific Meeting has plenty to interest the general physician. If you're afraid of Clinical Epidemiology, come along to the workshops on "Choosing a new test" and "Does the treatment do more good than harm?"!!

Registration for the IMSANZ Meeting is included in the RACP ASM registration. Further details will accompany

RACP - NZ Meeting, Nelson, 1998

IMSANZ NZ meeting will be associated with the RACP NZ meeting to be held in Nelson, in the South Island of New Zealand, from 2 - 4 September 1998. Proceedings on the 2nd and 3rd of September will be held conjointly with the Thoracic Society and the Oncology/Haematology Society.

Topics include "Distant thrombolysis", "Acute transfer of cardiac patients", "AIDS", "Clinical and Theraputic Update" and Symposia on Pulmonary Thrombo-embolic Disease.

The IMSANZ Meeting on the 4th will be based on "Controversies" akin to Neurology Society meetings. This format involves allocation of topics and a short reference list to members, who are then asked to review the literature, present a dissertation of the evidence, and draw a conclusion in 10 minutes, with 10 minutes for discussion. Stressful? Yes! Enjoyable? Probably. Educational? Absolutely! (for both presenter and audience).

Dr Malcom Clarke and I are compiling a list of controversies - offerings are welcome.

What about Nelson? Sun and Fun city of the South. Easily accessible by air and sea. Excellent accommodation and a huge opportunity for post conference week-end recreation with or without family. Biking through forest tracks, fishing in idyllic river valleys, sailing in the bay or sounds, walking or kayaking the Abel Tasman, tours of the wineries.

Sounds sooooo good!!!

For Details : Contact Bruce King (*bzknn@nn-hosp.nmhs.co.nz*)

Int Med List - Sidewalk Consultations at your fingertips!

This is an Electronic **Email list**, maintained by the RACP. Sadly the list has not been frequented as often as it should be. It is a great way of communicating with hundreds of colleagues. **Subscription is free** and undertaken through the RACP homepage on the worldwide web. After having subscribed, it is easy to post messages.

Type the message or a case report or a question (or whatever) to the "list address" (***intmed_int@medeserv.com.au***) and click the "send" button on your Email. Bingo! That's it! Other subscribers receive your message when they download their Email next time. This is a great way for instant communication and is especially suitable for busy souls like us. Come on Physicians! Awake! Stop Not!

EVIDENCE-BASED MEDICINE

How to practice and teach EBM *BOOK REVIEW*

D.L.Sackett, W.S.Richardson, W.Rosenberg, R.B.Haynes

Churchill Livingston 1997

This pocket-sized volume is very much, in the words of the preface, "short, lean and highly practical". The authors write in a pithy style which cannot but convey to the reader the enthusiasm and excitement which they have experienced in the practice of evidence-based medicine. The reasons behind this enthusiasm are clearly outlined and the benefits of enhancing clinical experience and diagnostic skills by the conjoint practice of EBM becomes very apparent as one is taken through the various aspects of formulating answerable questions, searching for best evidence, appraising evidence and applying it at the bedside.

There are useful hints and guides for the clinician and the student as to how to formulate answerable questions based on day-to-day clinical problems. The authors take one through approaches to obtaining evidence with discussion of the relative merits of information sources and the formulation of research strategies.

Appraisal of the evidence deals with the quality of literature and trials with emphasis on diagnosis, prognosis, treatment benefits, treatment harm and the relevance of evidence to clinical practice. Different presentations of diagnostic tests in terms of sensitivity, specificity and likelihood ratios are dealt with and the concepts of pre-test and post-test probability are expanded. Cost benefit analyses are considered. Methods of instruction in techniques of obtaining and applying evidence are outlined. The application of evidence to the day-to-day practice of medicine is considered at some length, as is deep self-evaluation of clinical performance, a useful tool for those considering "quality assurance" activities in their own practice.

Useful plastic cards are supplied with the book, printed with the important, most frequently required tables, nomograms etc.

This book does not expound the theoretical bases of various statistical methods as the interest is strictly on practice and teaching.

At A$45 this is a very cheap way of having one's approach to medical practice dramatically changed.

John S Penington
Victoria

RACP:
http://www.racp.au/

QA Activities
http://www.racp.edu.au/clickit/ci_qagow.htm

Monthly Newsletter
http://www.racp.edu.au/clickit

Free MEDLINE
http://www.ncbi.nlm.nih.gov/PubMed/

IMSANZ Newsletter

Contributions to:
ramesh@igrin.co.nz
or
PeterG@nursing.medrmh.unimelb.edu.au

General Physicians - Vacancies

Kempsey District Hospital
North Coast, NSW
Two Positions
Contact : Dr David Douglas
Phone: 02 6583 0716

Toowoomba , Queensland
St.Andrews Private Hospital
contact Mr Luke Hughes
Phone: 076 314 666

Further details:
IMSANZ Secretariat

USEFUL INFORMATION SOURCES FOR GENERAL PHYSICIANS

Ian Scott (Queensland)

Critical Reading Skills

Fletcher, R.H.,, Fletcher, S.W., Wagner, E.H. *Clinical Epidemiology: The Essentials.* 3rd ed. Baltimore, Md: Williams and Wilkins, 1995.

Sackett, D.L., Richardson, W.S., Rosengerg, W, Haynes, R.B. *Evidence-based medicine: how to practice and teach EBM.* London: Churchill-Livingstone, 1997. (See review page 8.)

Sackett, D.L., Haynes, R. B., Guyatt, G., Tugwell, P. *Clinical Epidemiology: A Basic Science for Clinical Medicine* 2nd Edition. Boston, Mass: Little, Brown and Company, 1991

Gehlbach, S. G. *Interpreting the Medical Literature* 3rd Edition. New York, NY:McGraw-Hill, 1993.

1 User's Guide to the Medical Literature Series from the Evidence-based Working Group in *JAMA*:
2 How To Get Started. 1993: 270; 2093-5
3 How To Use an Article About Therapy or Prevention. (A) Are the Results of the Study Valid? 1993; 270; 2598-2601.
4 How to Use an Article About Therapy or Prevention. (B) What Were the Results and Will They Help Me in Caring for My Patients? 1994: 271; 59-63.
5 How to Use an Article About a Diagnostic Test. (A) Are the Results of the Study Valid? 1994: 271; 389-91.
6 How to Use an Article About a Diagnostic Test. (B) What Are the Results and Will They Help Me in Caring For My Patients? 1994: 271; 703-7.
7 How to Use an Article About Harm. 1994: 271; 1615-1619.
8 How to Use an Article About Prognosis. 1994: 272; 234-7.
9 How to Use an Overview. 1994: 272; 1367-71.
10 How to Use a Clinical Decision Analysis. (A) Are the Results of the Study Valid? 1995: 273; 1292-5
11 How to Use a Clinical Decision Analysis. (B) What are the Results and Will They Help Me in Caring for My Patients? 1995: 273; 1610-3.
12 How to Use Clinical Practice Guidelines. (A) Are the Recommendations Valid? 1995: 274; 570-4.
13 How to Use Clinical Practice Guidelines. (B) What are the Recommendations and Will They Help You in Caring for Your Patients? 1995: 274; 1630-2.
14 A Method for Grading Health Care Recommendations. 1995: 274; 1800-4.
15 How to Use an Article Reporting Variations in the Outcomes of Health Services. 1996: 275; 554-8.
16 How to Use an Article About a Clinical Utilisation Review. 1996: 275; 1435-9.
17 How to Use Articles about Health-Related Quality of Life. 1997: 277; 1232-7.
18 How to Use an Article on Economic Analysis of Clinical Practice. (A) Are the Results of the Study Valid? 1997; 277: 1552-7. (B) What Are the Results and Will They Help Me in Caring for My Patients? 1997; 277: 1802-6.

Other key articles on evidence-based medicine.

Evidence-Based Medicine Working Group. Evidence-based Medicine: A New Approach to Teaching the Practice of Medicine. *JAMA* 1992: 268; 2420-5.

W C Rosenberg, A Donald. Evidence-based Medicine: An Approach to Clinical Problem-Solving. *BMJ* 1995: 310; 1122-6.

P Glasziou, L Irwig. An Evidence-based Approach to Individualising Treatment. *BMJ* 1995: 311; 1356-9.

D L Sackett. Applying Overviews on Meta-Analyses at the Bedside. *Journal of Epidemiology* 1995: 48; 61-6.

D L Sackett, W C Rosenberg, J M Gray et al. Evidence-based Medicine: What It Is and What It Isn't. *BMJ* 1996: 312: 71-2.

C D Naylor. Gray Zones of Clinical Practice: Some Limits to Evidence-based Medicine. *Lancet* 1995: 345; 840-2

Evidence-based Care Resource Group Series in *Canadian Medical Association Journal*:

1. Setting Priorities: How Important Is This Problem? 1994; 150: 1249-54.
2. Setting Guidelines: How Should We Manage This Problem? 1994; 150: 1417-23.
3. Measuring Performance: How Are We Managing This Problem? 1994; 150: 1575-1579
4. Improving Performance: How Can We Improve The Way We Manage This Problem? 1994: 150; 1793-1796.
5. Life Long Learning: How Can We Learn To Be More Effective? 1994; 150: 1971-1973.

Selection of Best Published Articles

ACP Journal Club

Selects by explicit criteria the most scientifically strong and clinical relevant articles in the world's internal medicine literature and presents them as structured abstracts and commentaries in a journal published every 2 months by the American College of Physicians.

Evidence-based Medicine: Linking Research to Practice

Similar to ACP Journal Club but includes paediatrics, family medicine, obstetrics/gynaecology, surgery and psychiatry. Published every 2 months jointly by the American College of Physicians and the British Medical Journal.

Both ACP Journal Club and Evidence-Based medicine are now available on CD-ROM or disk, and are available through the American College of Physicians, Independence Mall West, 6th Street at Race, Philadelphia.

Journal Watch

Selection of the best articles in major journals, summarised into brief paragraphs for each. Published in 24 issues per year as a newsletter by the Massachusetts Medical Society. Now also on Internet. To subscribe write to Journal Watch, 1440 Mains Street, Waltham, Massachusetts 02154-1649.

The Cochrane Library.

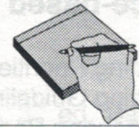
Systematic reviews of the best randomised controlled trials on specific clinical questions prepared by teams all over the world, updated regularly and published electronically. Available on CD-ROM or disk. Available in Australia through AMA Medical Products, Western Australia, PO Box 133 Nedlands, WA 6009. Phone 09-2733000. For further information on the Cochrane collaboration, see the article by Bero L and Rennie D JAMA 1995: 274; 1935-38 .

Some Useful Internet Addresses

Agency for Health Care Policy & Research Clinical Guidelines	*http://text.nlm.nih.gov/ahcpr/list.html*
New England Journal of Medicine	*http://www.nejm.org/*
British Medical Journal	*http://www.bmj.com/*
The Lancet	*http://www.thelancet.com/*
Journal Watch	*http://www.jwatch.org*
Evidence-Based Medicine, McMaster University	*http://hiru.mcmaster.ca/ebm*
Centre for evidence based Medicine, Oxford	*http://cebm/jr2.ox.uk/*

From the Editors

Peter Greenberg & Ramesh Nagappan



We are pleased to bring you this Newsletter to you on behalf of IMSANZ, with best wishes for 1998!

The Melbourne RACP Annual Scientific Meeting from 12 - 15 May 1998 will include the first IMSANZ meeting on Australian soil. **12 May 1998 will be IMSANZ day.** We hope many generalists will congregate in Melbourne for what promises to be an exciting event. See you there.

The IMSANZ Newsletter will be published *twice a year.* We welcome contributions from physicians and advanced trainees. Anything of potential value to general physicians will be considered. Job vacancies and advertisements for locums will be published. Please feel free to contact us with your thoughts and comments, even if they seem trivial to you.

When submitting material for consideration for the IMSANZ Newsletter please send your submissions in **IBM PC format** in Microsoft Word, Excel or Publisher applications. Please feel free to e-mail your submissions to either Peter Greenberg (*PeterG@nursing.medrmh.unimelb.edu.au*) or to Ramesh Nagappan (*ramesh@igrin.co.nz* or *ramesh@nhl.co.nz*).

Should you wish to mail a diskette please do so in a 3.5" IBM format.

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Wanting to join IMSANZ?

It appears that a considerable number of general physicians in Australia and New Zealand have not yet joined IMSANZ. Perhaps this is largely due to physicians feeling "over committed" with specialist societies and other professional activities? We wish to invite all physicians practising general medicine to seriously consider joining IMSANZ. Please feel free to contact a Councillor near you (see list on page 1) or the Secretariat to obtain an application form.

IMSANZ came into existence on 6 May 1997, at the Auckland RACP Meeting. It was formed by the merger of SCPIM (NZ) and ASCPIGM (Australia). There are now over 500 Members. **Its strength lies in its membership.**

Please give this Newsletter to a colleague who has not yet joined.