

From 17 June to 30 September 2002, 731 patients under the care of 29 GPs completed the questionnaire. Our findings are summarised in the Box.

GP-based opportunistic screening can reach significant numbers of people. Moreover, unlike other strategies (eg, distribution of test kits by pharmacies), review by GPs of patients' questionnaires ensures that cases unsuitable for FOBT screening (such as those with previously undeclared symptoms or family history) are appropriately assessed.

1. National Health Priority Areas report on cancer control 1997. Canberra: Commonwealth Department of Health and Family Services, and Australian Institute of Health and Welfare, 1998.
2. National Health and Medical Research Council. Guidelines for the prevention, early detection and management of Colorectal Cancer (CRC). Canberra: NHMRC, 1999. □

GP meets the psychiatrist

Greg A Lovell,* Phillipa J Hay†

*Medical Director, Adelaide Central and Eastern Division of General Practice, 1st Floor, Administration Building, Glenside Campus, 226 Fullarton Road, Glenside SA 5065; †Psychiatrist, Royal Adelaide Hospital, Adelaide, SA.

TO THE EDITOR: To achieve greater dissemination of mental health education to general practitioners, the Adelaide Central and Eastern Division of General Practice developed a program to be taken to GPs, based on individual need and using a medical expert/facilitator.

The "GP Meets the Psychiatrist Project" is an initiative of the Division in collaboration with the Eastern Mental Health Service, and supported by the Lundbeck Institute — a Danish foundation with a special interest in psychiatric education and pharmaceuticals (www.luinst.org). The specific objective of the project is to facilitate access by GPs to psychiatrist support, in the form of education and advice. This takes the form of a psychiatrist visiting a practice for a one-hour "open tutorial", on a topic preselected by the GPs in the practice. Lundbeck funded the psychiatrist's time. GPs were not funded, and no Continuing Medical Education points were sought for these sessions.

The project began in February 2001, and during the year 75 GPs from 22 practices were involved. Following the tutorial, both the GPs and the psychiatrist completed an evaluation questionnaire that covered issues such as the topics chosen by GPs, discussion of medications, referral for psychiatrist support, the need for further sessions and how they rated the sessions.¹

The main topics raised by GPs were depression, medication issues, difficulties

with access to psychiatry services, psychosis, and management of acute situations or angry patients.

GPs felt the sessions were very useful, and 87% were interested in having meetings with other specialists. From October 2001, 23 GPs rated the usefulness of the tutorial using a Likert scale of 1 ("no use") to 5 ("very useful"). The value of the tutorials was clearly demonstrated by the mean rating of 4.6.

Three psychiatrists participated and all found the experience of attending general practices and running the sessions very rewarding. They found their assumptions about the nature of family medicine were often wrong; for example, they were interested to find that practices were often focused towards particular areas of health.

The project has demonstrated the usefulness of tailoring education packages to the specific needs of GPs and has shown that this would be a suitable avenue to improve links between GPs and specialists. With specialist support, a similar session involving an endocrinologist discussing diabetes is now being run through the Division, with no funding, which suggests this type of program may be sustainable in the long term.

1. Allan D, Mueller V. GP Meets the Psychiatrist evaluation report. Adelaide: Adelaide Central and Eastern Division of General Practice, 2001. □

Medical Professionalism Project

Kerry J Breen

Gastroenterologist, Level 6, 6/55 Victoria Parade, Fitzroy, VIC 3065
kerrybreen@access.net.au

TO THE EDITOR: Your enthusiastic comments accompanying the publication of a "physicians' charter" prepared by the Medical Professionalism Project¹ do not acknowledge strikingly enhanced approaches to medical professionalism in Australia dating from the landmark Doherty Report in 1988.² One of the most noticeable changes since that time is the emphasis now placed on professional development throughout medical school curricula³ and in the preregistration year.^{4,5} In addition, our medical colleges are poised to do more in this area in their postgraduate training and continuing professional development programs.⁶ You fail to point out that the "physicians' charter" contains nothing new, as an examination of the Code of Ethics of the Australian Medical Association will reveal.⁷

We are probably fortunate that an equivalent process of developing such a

charter has *not* taken place in Australia. The document repeatedly speaks of a "contract with society", but it is an oddly one-sided contract, prepared without consulting members of the communities the authors purport to represent. The charter seems to be a response to frustrations and challenges caused by changes to healthcare systems, especially in the United States and Canada, and carries a tone of living in the past.

There are effective means of engaging with our community to ensure that essential aspects of medical professionalism are valued and maintained.⁸ Many of these are already being used in Australia. I refer to such developments as community membership of medical boards, community input into selection of medical students, establishment of independent health complaints commissions and widespread engagement with the health consumer bodies by most sections of the profession. Additional initiatives that will assist the community to trust and value medical professionalism in Australia include the increased expectation that all doctors will engage in continuing medical education and the establishment by medical boards of pathways to identify and assist poorly performing doctors.

Should the organised profession ever develop a similar charter for Australia, it is to be hoped that the authors will ensure that the concerns and needs of our broader community are taken into account and that we do not engage in the self-pity evident in the Medical Professionalism Project.

1. Medical Professionalism Project. Medical professionalism in the new millennium: a physicians' charter. *Med J Aust* 2002; 177: 263-265.
2. Doherty RL (chairman). Committee of Inquiry into Medical Education and Medical Workforce. Australian medical education and workforce into the 21st century. Canberra: AGPS, 1988.
3. Australian Medical Council. Guidelines for the assessment and accreditation of medical schools. Canberra: AMC, 1998.
4. Australian Medical Council. National guidelines for intern training and assessment. Canberra: AMC, 1996.
5. Association of Teachers of Ethics and Law in Australian and New Zealand Medical Schools (ATEAM). An ethics core curriculum for Australasian medical schools. *Med J Aust* 2001; 175: 205-210.
6. Breen KJ. Professional development and ethics for today's and tomorrow's doctors. *Med J Aust* 2001; 175: 183-184.
7. The Code of Ethics of the Australian Medical Association. Canberra: AMA, 1996.
8. Breen KJ. The patient-doctor relationship in the new millennium: adjusting positively to commercialism and consumerism. *Clin Dermatol* 2001; 19: 19-22. □

Keith V Woollard

Cardiologist, Suite 34, Murdoch Medical Centre, 100 Murdoch Drive, Murdoch, WA 6015
KeithWoollard@wacardiology.com.au

TO THE EDITOR: You recently lent your support to the "physicians' charter" produced by the members of the Medical Professionalism Project.¹

According to the document, the charter is part of the process of reforming healthcare systems. If the authors are hoping to use this document to change the way medicine is delivered, they should be prepared for criticism.

The simplest criticism is that they present no evidence. Sweeping statements are made, without supporting documentation, about the potential for dishonest behaviour by physicians. Even broader generalisations are made about the appropriate way to run healthcare, again without evidence.

The authors state that “physicians should never exploit patients for . . . personal financial gain or other private purpose”. While the word “exploit” has a pejorative flavour, it is reasonable for doctors to be paid for what they do. The “sackcloth and ashes” version of medical practice appeals to a small minority.

They then move deeper into socialist territory: “Medical professionalism demands that the objective of all healthcare systems be the availability of a uniform and adequate standard of care.” But the standard of healthcare can never be uniform, and vigorous attempts to make it so could conceivably undermine its quality.

“Political correctness” proceeds apace. “A commitment to equity entails the promotion of public health and preventive medicine . . .”. Why, for goodness’ sake? Preventive medicine is not always cost effective.

The authors then propose their own version of health economics. In their view “the provision of unnecessary services not only exposes patients to avoidable harm and expense but also diminishes the resources available for others”. This is not necessarily so. Some services will turn out to be superfluous. There are other areas of extravagance in our society (eg, fast cars, big houses, and all restaurants), but they still make an important contribution to the economy.

Growth in healthcare expenditure expands the whole economy, and I am not aware of any evidence that spending in one area of healthcare necessarily deprives others. It could well be the reverse.

Politically correct attitudes are widespread in the medical community,² but should not be imposed on others, as the Editor was perhaps suggesting.

Russell L Gruen

Harkness Fellow in Health Care Policy and Advanced Trainee in General Surgery (RACS), Department of Health Policy and Management, Harvard School of Public Health, Kresge Building, 4th Floor, 677 Huntington Avenue, Boston, MA 02115, USA
rgruen@hsph.harvard.edu

TO THE EDITOR: Young doctors and medical students are acculturated into healthcare systems in which governments, corporations, consumer groups and other stakeholders have an increasing presence. These forces have so significantly altered medical practice in the United States, for example, that many doctors have questioned the applicability of traditional patient-centred values. Whether or not Australian doctors have faced such adversity, medical practice is becoming increasingly complex, and the Medical Professionalism Project’s charter¹ encourages us to consider how we might best serve the future needs of patients, families and the community.

To this end, the charter upholds traditional patient-centred values while embracing less familiar civic responsibilities. It challenges us to think outside the doctor-patient dyad about what it means to be a doctor in contemporary Australian society. The inevitable rationing of finite health budgets, inequalities in access to and quality of care, and growing recognition of social determinants of health are all compelling reasons for engagement with social processes. The Australian medical profession has served us well through its health policy leadership. We have no reason for complacency, however, given the appalling state of Indigenous health, the challenges posed by rural and refugee populations and the progressive infiltration of for-profit interests into the Australian healthcare system.

Upholding the principle of social justice will require skills not often called upon in medical practice. If we are to remain respected public advocates we will need heightened awareness of population health issues and the ability to effectively collaborate with other players. We will need ways of translating time-honoured virtues such as altruism and compassion into public arenas. Partnerships may open new opportunities in a publicly responsive and outward-looking profession, while retaining the inherent worth of patient care.

By its social orientation, the charter does more than exalt old values in the face of modern healthcare challenges. It helps to articulate the aspirations of a more broadly engaged profession. The charter will be valuable to those of us near the start of our careers, for whom professionalism will be as

much characterised by its engagement with the future as it is by its links with the past.

1. Medical Professionalism Project. Medical professionalism in the new millennium: a physicians’ charter. *Med J Aust* 2002; 177: 263-265. □

Martin B Van Der Weyden

Editor, *Medical Journal of Australia*, Locked Bag 3030, Strawberry Hills, NSW 2012.
editorial@ampco.com.au

IN REPLY: I welcome the comments on the physicians’ charter. The purpose in publishing the charter was to promote a dialogue on medical professionalism, as, in contrast to the continuing discussion and debate on professionalism in North America¹⁻³ and the United Kingdom,⁴ interest in the subject in Australia is virtually absent. Enter the terms “medical professionalism” and “Australia” in PubMed and the search yields eight publications in the Australian literature over the past 30 years. Despite this meagre tally, Breen informs us that all is well, through the efforts of bodies such as the Australian Medical Council (AMC). While the AMC’s efforts are commendable, its recommendations for instilling professional attitudes in medical students and interns must compete with other priorities in an already crowded curriculum and with the pressures of the intern year. Under the daily stresses of real life, abstract concepts of professionalism are likely to be given low priority. Breen also suggests that the medical colleges are “poised to do more in this area”. This may be so, but a search of college websites reveals that most are silent on matters of professionalism. Finally, Breen laments that the physicians’ charter contains nothing new — but no one really expects revolutionary concepts in precepts of professionalism, which have evolved over hundreds of years. Besides, what harm is there in being exposed to the views of our colleagues in the northern hemisphere? As the comments of Gruen suggest, the charter is one of the more broad-ranging contemporary expositions of medical professionalism.

Woollard wants evidence for the principles of the charter and its purpose. He also suggests that it is tinged with socialism and “political correctness”. But the medical ethics that underpin our professionalism are dependent not on evidence but on humanistic principles. He hints that making the objective of all healthcare systems “the availability of a uniform and adequate standard of care” smells of socialism. Perhaps so, but I prefer to think of it as embodying the Australian ethos of a “fair go”. Finally, “political correctness” is a subjective rather than an objective concept.

1. Medical Professionalism Project. Medical professionalism in the new millennium: a physicians’ charter. *Med J Aust* 2002; 177: 263-265.

2. Satel S. How political correctness is corrupting medicine. New York: Basic Books, 2000. □

I thank my colleagues for their insightful comments and for starting the debate on new professionalism. Long may it continue.

1. Cruess SR, Cruess RL. Professionalism: a contract between medicine and society. *CMAJ* 2000; 162: 668-669.
2. Wynia MK, Latham SR, Kao AC, et al. Medical professionalism in society. *N Engl J Med* 1999; 341: 1612-1616.
3. Rothman DJ. Medical professionalism — focusing in on the real issues. *N Engl J Med* 2000; 342: 1284-1286.
4. Irvine D. Doctors in the UK: their new professionalism and its regulatory framework. *Lancet* 2001; 358: 1807-1810. □

Developing a core clinical data set for cancer

Margaret P Staples,* J Mark Elwood,†
Alan S Coates,‡ Lizbeth M Kenny§

*Senior Project Officer, †Director, National Cancer Control Initiative, 1 Rathdowne Street, Carlton South, VIC 3053; ‡Chief Executive Officer, The Cancer Council Australia, Sydney, NSW; §Senior Radiation Oncologist, Division of Oncology, Royal Brisbane Hospital, Herston, QLD
Margaret.Staples@ncci.org.au

TO THE EDITOR: Optimising the management of cancer patients requires objective decisions about “best treatment” strategies, based on high quality data collected systematically from all treated patients (or at least a representative sample of them). Relating treatment and stage at diagnosis to individual outcome can allow monitoring of whether treatment is consistent with best practice, and can provide a systematic foundation for evidence-based care. Clinical cancer data collection also allows treatment services to be evaluated, as institutions can monitor throughput and endpoints. However, institution-based data collections may not be representative of all cancer patients, and aggregation of data from several institutions is needed to obtain a comprehensive picture.

Population-based cancer registries, which operate in all Australian States and Territories, include data on the site and morphology of cancers. Notification of cases to the registries is mandatory for hospitals and pathology providers, and survival of patients is assessed by linkage to mortality data. The registers do not routinely record stage or treatment data. Until recently, there have been no nationally agreed data items or standard data definitions to facilitate the collation of clinical cancer data across institutions.

In 1999, the National Cancer Control Initiative (NCCI) commissioned a nationwide consultation process to seek expert advice on developing a core clinical cancer data set. Representatives from the State and Territory population-based cancer registries, the Australian Institute of Health and Welfare and many large cancer treatment

centres were consulted.¹ A workshop was held in Melbourne in July 2000 to identify key items for inclusion in the data set, and a group was established to work on data definitions. These are now available on the NCCI's website (<<http://www.ncci.org.au/projects/data/dat01.htm>>). The data set is designed to be compatible with, and expand on, data currently collected by State cancer registries. Definitions are consistent with the New South Wales clinical cancer data set,² and we acknowledge the input from this source. Items would be collected by treatment centres. Some institutions would need to standardise information already collected for ongoing patient management, while others would need to establish and maintain new collections. The Faculty of Radiation Oncology of the Royal Australian and New Zealand College of Radiologists has recommended incorporation of the NCCI data set into its proposed quality assurance program. Collation of data across institutions requires careful attention to patient identification issues in order to protect privacy and avoid duplication of data from multiple sources.

Use of the data set by clinicians and health planners and evaluators at a national level is the ultimate aim. This would require funding and commitment, and attention to issues of privacy, confidentiality, and data ownership. At present, adoption of the data set on a voluntary basis by treatment centres is the best way forward.

1. Coates A. A clinical cancer registration common data set. Melbourne: National Cancer Control Initiative, 1999.
2. NSW clinical cancer data collection for outcomes and quality. Data dictionary. Version 1. Sydney: Public Health Division, NSW Health, 2001. □

Does intramuscular botulinum toxin A injection improve upper-limb function in children with hemiplegic cerebral palsy?

H Kerr Graham,* Roslyn N Boyd,†
Darcy Fehlings‡

*Professor, and Director, Department of Orthopaedic Surgery, †Senior Research Physiotherapist, Hugh Williamson Gait Laboratory, Royal Children's Hospital, Parkville, VIC 3052; ‡Developmental Paediatrician, Department of Paediatrics, Bloorview MacMillan Centre, The Hospital for Sick Children, University of Toronto, Toronto, Canada
grahamk@cryptic.rch.unimelb.edu.au

TO THE EDITOR: We applaud the efforts of Wasiak et al to apply the principles of evidence-based medicine to answer clinical questions.¹ However, it is important to understand the historical context of clinical trials reported in the literature, and, when

necessary (eg, when conducting a meta-analysis or when the results of trials appear to conflict), to seek additional information from the authors.

One of us (H K G) designed the randomised-controlled trial (RCT) reported by Corry et al.² It was a pilot study and not a definitive clinical trial. The primary outcome measure was resonant frequency, an objective measure of muscle stiffness. This trial was conducted before the introduction of validated outcome measures for assessing upper limb function in children with cerebral palsy, and it was not possible to perform any sample size calculation for functional outcomes. At 12 weeks in the group receiving injections of botulinum toxin A, there was a significant difference in grasp and release but not in the ability to pick up coins. It is not surprising therefore that this study found significant decreases in muscle stiffness, but the functional results were inconclusive.

The other RCT identified by Wasiak et al also involved one of us (D F).³ It was designed specifically to investigate functional outcomes, a sample size calculation was performed from pilot work, and a specific functional outcome measure (QUEST) was used. This study reported significant functional improvements after the use of botulinum toxin combined with occupational therapy.

These two studies, when understood in their historical sequence, should therefore be considered complementary and not contradictory. It is important to assess the quality of randomised clinical trials as well as their conclusions (eg, using the Physiotherapy Evidence database PEDRO scale <<http://ptwww.fhs.usyd.edu.au/pedro>>).^{4,5} The smaller study by Corry et al² had insufficient power and inadequate methodology to investigate functional outcomes. On the other hand, the conclusions of the study by Fehlings et al³ should be taken as the current level of evidence. We therefore submit that the conclusion drawn by Wasiak et al is incorrect. We support further research to evaluate and strengthen the evidence relating to botulinum toxin A and upper-extremity function.⁶

1. Wasiak J, Hoare BJ, Hender KM. Does intramuscular botulinum toxin A injection improve upper-limb function in children with hemiplegic cerebral palsy? *Med J Aust* 2002; 177: 158.
2. Corry IS, Cosgrove AP, Walsh EG, et al. Botulinum toxin A in the hemiplegic upper limb: a double-blind trial. *Dev Med Child Neurol* 1997; 39: 185-193.
3. Fehlings D, Rang M, Glazier J, Steele C. An evaluation of botulinum toxin A injection to improve upper extremity function in children with hemiplegic cerebral palsy. *J Pediatr* 2000; 137: 331-337.
4. Verhagen AP, de Vet HC, De Bie RA, et al. The Delphi list: a criteria list for quality assessment of randomised clinical trials for conducting systematic reviews. *J Clin Epidemiol* 1998; 51: 1234-1241.