

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

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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?

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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.

- Boyd RN, Morris ME, Graham HK. Management of upper limb dysfunction in children with cerebral palsy: a systematic review. *Eur J Neurol* 2001; 8 (Suppl 5): 150-166.
- Boyd RN, Bach T, Morris ME, et al. A randomised trial of botulinum toxin A (BTXA) and upper limb training — a functional magnetic resonance imaging and resonant frequency study. *Dev Med Child Neurol* 2002; 44 (Suppl 91): B9. □

- 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.
- 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. □

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IN REPLY: We thank Graham et al for their response to our article.¹

It is important to understand that the clinician who posed the question regarding botulinum toxin A injection wished to find the “best available medical evidence”. We were not asked to take account of the historical context of previously published articles, nor were we asked to exclude specific types of RCTs. If we were to exclude specific RCTs based on the preference of an author, then the strong methodological principles that surround the evidence-based practice movement would be open to extreme forms of bias.

We also disagree that our conclusions were incorrect. Our reading of the article by Corry et al² differed from that of Graham et al. We do not consider that their study showed that botulinum toxin injection significantly improved the function of the hemiplegic upper limb. Together with the results of the study by Fehlings et al,³ indicating a significant improvement in weight-bearing at four weeks (part of the QUEST assessment), our conclusion — that we could not support or refute the efficacy of botulinum toxin injections for improving upper-limb function in cerebral palsy because of differing opinions — remains unchanged.

- 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.

Generalists and gerontology

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TO THE EDITOR: I read with interest and alarm your comments on generalists and gerontology in the 16 September 2002 issue of the Journal.¹ I believe the role of the general internal medicine physician in managing patients with complex multisystem disease is still important and will expand in the future. General physicians remain passionate about general medicine.²

General medicine has been threatened over the past 20 years by the emergence of the medical subspecialties. However, there is increasing recognition of the need for general medicine specialists, especially in North America and Europe. In Australia, general medical units are being established in the major teaching hospitals in capital cities. Sydney remains a unique exception — all of its general medical units were closed prior to the 2000 Olympics (for reasons that are unclear), and only one has subsequently been re-established (at Royal North Shore Hospital).

The Internal Medicine Society of Australia and New Zealand (IMSANZ) has been active in promoting the role of the general physician. IMSANZ provides support for the professional profile and culture of general physicians throughout Australasia. We would welcome enquiries from trainees and physicians (<<http://www.racp.edu.au/imsanz>>).

The Royal Australasian College of Physicians has recognised the necessity for a strong general physician workforce and will be holding a General Medicine Forum in March 2003 to examine the key issues confronting general medicine in Australia and New Zealand.

By 2010 the majority of “baby boomers” will be in their sixties, or older, and will require the services of well trained general physicians to provide integrated, cost-effective, whole-of-patient specialist health-care.

- Van Der Weyden MB. From the Editor's desk. Generalists and gerontology. *Med J Aust* 2002; 177: 281.
- General medicine Australia and New Zealand: the way forward. Sydney: Royal Australasian College of Physicians, December 2000. □

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