

1. Thompson PG. Injury caused by baby walkers: the predicted outcomes of mandatory regulations. *Med J Aust* 2002; 177: 147-148. □

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IN REPLY: The support for my study¹ is pleasing, especially the letter from Martin.

I agree with Hockey and Pitt that including Queensland data would have enhanced my study, as Queensland is the only other Australian State with a substantial injury database like South Australia's and Victoria's. However, when I analysed the Queensland data only around 1% of baby-walker injuries could be classified as "proximity", compared with 20%–25% in Adelaide and Melbourne.

Surveillance collection can very easily miss critical details. The SA questionnaire asks "What was the victim doing at the time of the injury?", then "What went wrong?" and, finally, "How exactly was the injury caused?". As an example, "a child in a baby walker accesses the fireplace and burns her hand". If one or two of the above questions are left out, or the coder does not capture all the detail, this narrative easily becomes "child burns hand on fireplace" and the detail that the baby walker facilitated the child's access to the fireplace is lost.

In 1995, after the Victorian Injury Surveillance System moved to a "minimum" dataset, their "proximity" component dropped to just 1%, the same as for Queensland. Analysts at the Victorian Injury Surveillance System recommended that these post-1995 data not be used for my study. In my opinion the Queensland system has the same systematic problem, and discussions with Hockey suggest that this is a possibility (Richard Hockey, Senior Data Analyst, Queensland Injury Surveillance Unit, personal communication).

My assertion — that the data I used are largely representative of baby walker injury events in metropolitan Australia — is

justified, as any variations in "proximity" rates (even if they do exist) caused by different architectural styles in Queensland would represent only a very small proportion of the events Australia-wide.

The presence of additional steps and higher steps would only explain a higher proportion of these types of injuries, and possibly increased severity, but not the almost total absence of "proximity" injuries, as there is no association between them.

The recent finding by the US Consumer Product Safety Commission² that steps and stairs injuries still occur with new-style walkers confirms the need to discontinue the proposed mandatory regulations and instigate an immediate ban.

The letter from Beard is disturbing in its attitude. Inadequate supervision is another name for victim blaming, and an unsafe environment is a perfect description of a baby walker. Moreover, to suggest that the ban would include any form of purpose-designed apparatus, including a commercial baby walker, to assist disabled children is nonsense.

1. Thompson PG. Injury caused by baby walkers: the predicted outcomes of mandatory regulations. *Med J Aust* 2002; 177: 147-148.

2. US Consumer Product Safety Commission. Briefing package: rulemaking proceeding on baby walkers. Washington, DC: US Consumer Product Safety Commission, 2002. □

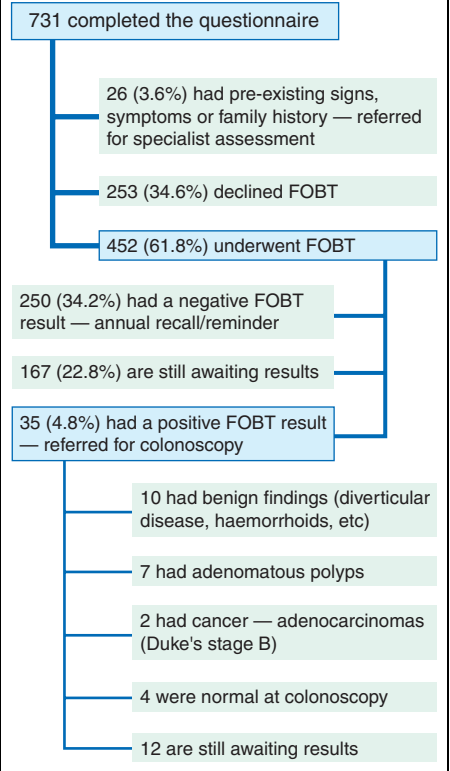
Opportunistic GP-based bowel cancer screening

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TO THE EDITOR: Colorectal cancer is, after skin cancer, the most common cancer in Australia, with 11 245 new cases diagnosed in 1997, and over 4600 deaths.¹ In clinical trials, screening programs using faecal occult blood testing (FOBT) have been

Data reported so far on patients who completed general practice questionnaires for eliciting family history or symptoms of bowel cancer



shown to reduce mortality. The Commonwealth Department of Health and Ageing estimates that implementation of effective FOBT screening programs would save around 400 lives per year.¹ However, such screening programs have not been widely implemented because of perceived difficulties with patient acceptance, funding, and the complexity of support structures.

General practitioners are in the front line of healthcare, and well placed to institute FOBT screening. Thus, we established an opportunistic screening program whereby patients over the age of 50 years attending surgery are asked by reception staff to complete a short questionnaire while in the waiting room. This questionnaire, developed locally to quickly establish whether a patient has symptoms or a family history of bowel cancer, is given to the GP by the patient during the consultation. If the questionnaire indicates colorectal symptoms, appropriate clinical assessment is undertaken. If a family history of colorectal cancer is elicited, the GP further defines the patient's risk by using the established National Health and Medical Research Council guidelines.² If there are neither symptoms nor a family history, the patient is offered annual FOBT screening.

Correspondents

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There should be no more than 5 references. The reference list should not include anything that has not been published or accepted for publication. Reference details must be complete, including: names and initials for up to 4 authors, or 3 authors et al if there are more than 4 (see mja.com.au/public/information/uniform.html#refs for how to cite references other than journal articles).

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

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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

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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. □

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