

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