Attitudes of Western Australian general practitioners to colorectal cancer screening

Graham B Turner, Marcus W Chin, Noellene M Foster, Jon Emery and Geoff M Forbes

To the Editor: A nationwide colorectal cancer (CRC) screening program will commence in 2006. It has been shown that general practitioners can influence their patients in the decision to have CRC screening.[1,2] There are several screening test options in Australia, and the relative geographical isolation of rural centres may influence attitudes and participation.

We sought to determine the attitudes of GPs towards CRC screening and test preferences. Between January and September 2005, all GPs in Western Australia ($n = 1837$; 1298 metropolitan, 539 rural) were sent a questionnaire, which was completed by 801 (43.6%). Overall, 62.8% of respondents believed that asymptomatic average-risk subjects should have CRC screening (67.1% of metropolitan GPs v 54.2% of rural GPs; $P = 0.003$).

The questionnaire revealed major differences between which test GPs would recommend for their patients and which test they preferred for their own personal screening (Box). These differences were related to the factors GPs believed were most likely to influence choice of screening test. For colonoscopy, accuracy and speed of result were considered most important; for faecal occult blood testing, no need for bowel preparation or time off work and no discomfort were considered the strongest determinants. Previous studies that included patients' views have found that physicians may incorrectly perceive certain factors in screening to be important to their patients.[3] There were no significant differences in choice of test between rural and metropolitan GPs.

Although the target age group for the Australian pilot study and the national screening program is 55–74 years,[4,5] two thirds of GP respondents felt screening should be offered from the age of 50 years, and a quarter believed it should continue beyond 80 years. Many GPs (65%) indicated they would like further education on CRC screening.

In summary, there is good support for CRC screening among Western Australian GPs, but the availability of different screening tests and variations in GPs' opinions are likely to significantly influence clinical practice.

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1 Salkeld GP, Solomon MJ, Short L, Ward J. Measuring the importance of attributes that influence consumer attitudes to colorectal cancer screening. *ANZ J Surg* 2003; 73: 128-132.
2 Thomas RJ, Clarke VA. Colorectal cancer: a survey of community beliefs and behaviours in Victoria. *Med J Aust* 1998; 169: 37-40.
3 Ling BS, Moskowitz MA, Wachs D, et al. Attitudes toward colorectal cancer screening tests. *J Gen Intern Med* 2001; 16: 822-830.
4 Australian Cancer Network Colorectal Cancer Guidelines Revision Committee. Clinical practice guidelines for the prevention, early detection and management of colorectal cancer (CRC). 2nd ed. Sydney: The Cancer Council Australia and Australian Cancer Network, 2005. http://www.cancer.org.au/content.cfm?randid=408243 (accessed Jun 2006).
5 Australian Government Department of Health and Ageing. Australia's bowel cancer screening pilot and beyond. Final evaluation report. Bowel Cancer Screening Pilot Monitoring and Evaluation Steering Committee, October 2005. Canberra: Commonwealth of Australia, 2005. http://www.cancerscreening.gov.au/bowel/pdfs/eval_oct05.pdf (accessed Jun 2006). ❑

Colorectal cancer screening methods and general practitioners' recommendations and attitudes

	Test recommended by GP for patients	GPs' perception of patients' choice of test	GPs' preferred test for their own screening
Faecal occult blood testing	430 (53.7%)	396 (49.4%)	236 (29.5%)*
Colonoscopy	285 (35.6%)	278 (34.7%)	479 (59.8%)*
Flexible sigmoidoscopy	37 (4.6%)	20 (2.5%)	20 (2.5%)
Computed tomography colonography	18 (2.2%)	69 (8.6%)	32 (4.0%)
Barium enema	0	2 (0.25%)	3 (0.4%)

* $P = 0.004$ (χ^2) ◆

A comparison of colorectal neoplasia screening tests: a multicentre community-based study of the impact of consumer choice

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To the Editor: Australia's imminent bowel cancer screening program will revolve around the general practitioner,[1-3] whereas, in the United Kingdom, the GP will have virtually nothing to do with the national screening program now underway.[4] It is curious that two programs with the same evidence base regarding effectiveness should be so fundamentally different. One explanation could be the differing health care systems in each nation. However, they are more alike than not, so the true explanation for the Australian methodology could rest with the outcome of the Australian pilot studies.

If that is the case, then perhaps one should be both alert and alarmed. Given the inequity in access to GPs in Australia, it is not surprising that the Final Evaluation Report[5] of the pilot national screening program stated that:

> Some GPs interviewed in Woolcott's Qualitative Research focus groups … expressed concern over access to FOBTs [Faecal Occult Blood Tests] for people without a fixed address. It was mentioned that this group, particularly Aboriginal and Torres Strait Islander people and people in low socioeconomic groups, particularly homeless people, did not receive invitations to participate in the Pilot. Some GPs commented that the information packs, in both English and the translated versions, were too complicated for people with low literacy and those from culturally and linguistically diverse backgrounds.[5]

The same report noted that 38% of people overall (men, 42%; women, 34%) and 52% of non-English speakers did not visit their GP after a positive FOBT. Nevertheless, the report favours the continued central role of the GP.[5]

This is not the case in the UK screening program, which has a more direct approach, with program hubs and associated screening centres — all with defined accountabilities. The Australian approach is to simply add to the workload of GPs — a more pragmatic approach in the short term, but less imaginative. Our program will undoubtedly be a step forward in colorectal cancer prevention. The question is how large that step will be. Reliance on the existing system threatens to reinforce existing health care inequities.