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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 impor-

tant 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.

Graham B Turner, Visiting Fellow¹
 Marcus W Chin, Registrar¹
 Noellene M Foster, Clinical Nurse¹
 Jon Emery, Professor of General Practice²
 Geoff M Forbes, Gastroenterologist¹

¹ Department of Gastroenterology, Royal Perth Hospital, Perth, WA.

² University of Western Australia, Perth, WA.
 gbtturner@doctors.org.uk

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

Allan D Spigelman

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 Report⁵ 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.

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)

Allan D Spigelman, Professor of Surgical Science St Vincent's Clinical School, University of New South Wales, Faculty of Medicine, Sydney, NSW. aspigelman@stvincents.com.au

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Douglas R Taupin and Mike Corbett

TO THE EDITOR: The recent report by the Multicentre Australian Colorectal-neoplasia Screening (MACS) Group¹ offered some intriguing findings. Participation in bowel cancer screening was lower than expected,

despite a range of tests being offered. In addition, people offered a choice of different faecal occult blood tests (FOBTs) were less likely to participate than those not offered this choice. The accompanying editorial by Salkeld and colleagues concluded that "Informed consumers making smart choices about screening . . . would be a public health success".² We believe the available evidence indicates otherwise.

As the MACS Group study showed, participation in FOBTs was lower than in the Australian Government FOBT pilot program,³ and participation in screening by colonoscopy was lower than for other studies, including our recent Australian study.⁴ They suggested this may be because local general practitioners were not engaged in the project. Our study was designed to address this issue, and concluded that involvement of GPs had a small, non-significant effect on participation rates and no effect on response to invitation.⁴ This is not to say that involvement of GPs is undesirable.

The MACS Group study found participation in FOBTs of 27.4% when only an FOBT kit was provided and a significantly lower participation when a choice of four screen-

ing modalities was offered, with an FOBT kit provided (18.6%, $P = 0.03$). These data confirm the findings of a large multicentre study from the SCORE2 Working Group.⁵ In that study, participation in FOBT was 30.1%, while participation in either FOBT or flexible sigmoidoscopy, when a choice of the two was offered, was 27.1%. The authors did not offer this analysis, but the difference was again significant ($P = 0.015$, two-tailed Fisher's exact test).

The editorial by Salkeld et al suggested that the Australian bowel cancer screening program should incorporate decision-support systems to allow informed choice of screening options. The "choice paradox" reported by the MACS and SCORE2 studies argues against this. Further, there is no evidence that decision support improves rates of participation in screening, and some explicit evidence that it has no effect.⁶ This should not be troubling. At this time, most colon cancer screening is still performed after consultation between patient and doctor, and in this setting informed choice is possible and desirable. Decisionmakers such as the Australian Government Department of Health and Ageing use a different process, which is explicit and quantitative,⁷ in deter-

mining screening policy. With the evidence available, the Australian mass-screening program should offer and evaluate a single test modality.

Douglas R Taupin, Gastroenterologist

Mike Corbett, Gastroenterologist

The Canberra Hospital, Garran, ACT.

Doug.Taupin@act.gov.au

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Glenn P Salkeld, Jane M Young and Michael J Solomon

IN REPLY: Taupin and Corbett contend that the “choice paradox” reported by the MACS Group study argues against decision-support systems to allow informed choice of screening options. That would be true if the purpose of informed choice was simply to increase participation in screening.¹ Our point is that the purpose of informed choice is to support an ethical basis for individuals’ decisions about screening.^{2,3} This can occur within the single-test modality (faecal occult blood tests) of the national screening program. It would be desirable to have decision-support systems embedded in a doctor–patient consultation. But this may not be feasible in terms of screenee access to a general practitioner, nor affordable for the Australian Government — hence our call for a self-directed decision-support system as an adjunct to a doctor-guided system. This is one way of applying the principle that patients should be given unbiased information on the benefits and harms of screening that enables them to make an informed

choice about their own participation in screening.⁴

Glenn P Salkeld, Lecturer (Health Economics)¹

Jane M Young, Executive Director²

Michael J Solomon, Professor and Head²

1 Department of Public Health and Community Medicine, University of Sydney, Sydney, NSW.

2 Surgical Outcomes Research Centre (SOuRCe), Royal Prince Alfred Hospital, Sydney, NSW.

glenns@health.usyd.edu.au

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Skin cancer clinics in Australia: workload profile and performance indicators from an analysis of billing data

Alvin LK Chia and Stephen Shumack

TO THE EDITOR: We read with alarm the skin cancer clinic profile published recently in the Journal.¹ This article publicly states what has been privately suggested for some time — that doctors in skin cancer clinics provide a service no better than the average Australian general practitioner.

Surely, if these doctors are calling themselves skin cancer “experts”, the aim of their practice should be to reduce the skin biopsy rate. This is obviously not the case. They report a consultation to biopsy ratio of 1.79. Thus, 56% of all their consultations result in a skin biopsy. The biopsy to treatment ratio of 3.1 is also very high. In addition, they report that only 32% of all biopsies yield a non-melanoma skin cancer. This figure indicates either no additional diagnostic ability on the part of the skin cancer clinic doctors compared with the average Australian GP (who, according to a recent retrospective study, can clinically diagnose a basal cell carcinoma 34% of the time²) or an effort to maximise income.

Similarly, the article describes a number needed to treat (NNT) of 28.6. This means that for every 29 benign lesions excised and sent for histological examination to exclude melanoma, only one melanoma is detected. The authors concede that this figure is equivalent to that observed in mainstream

general practice. We therefore question the motives of doctors at these clinics in presenting themselves as skin cancer “experts”.

However, perhaps the greatest indicator of their seeming intent to maximise financial gain can be demonstrated by an analysis of skin flap item numbers. The article indicates that the total number of excisions was 8055, of which 116 were melanomas and 4709 were non-melanoma skin cancers (ie, 4825 cancers were excised). If one assumes that a suspicious or benign mole biopsy is never closed with a skin flap repair (standard clinical practice), then, of the 4825 skin cancers excised, 2651 (55%) were closed with a flap procedure, and of these, 55% were either “complicated” or “site-specific” flap repairs. There were only 111 skin grafts performed out of the 4825 cancers excised (2.3%). Thus, more than half of the skin cancers excised were closed with a flap repair! Moreover, more than half of the flaps used were “complicated” or “site-specific” flaps, with 24 flaps performed for every skin graft! Surely, no one can argue that these figures are reasonable or consistent with good clinical practice. In comparison, current Australian Medicare data indicate that dermatologists and specialist surgeons close large skin cancer excisions (lesions >2 cm on the trunk [item number 31290]) with skin flaps at rates of 15% and 17%, respectively (Andrew Miller, Australian Medical Association Skin Representative Group, personal communication). Large lesions normally require a higher skin flap closure rate than smaller lesions. Hence, a flap repair rate of 55% — for lesions of all sizes and sites — reported by the skin cancer clinic doctors is all the more extraordinary.

We believe that the above suggests that many skin cancer clinic practitioners are more concerned with maximising income than improving patient care.

Disclaimer: Stephen Shumack is Honorary Secretary of the Australasian College of Dermatologists. The opinions expressed here represent the personal views of the authors and do not necessarily reflect the views of the College.

Alvin LK Chia, Dermatology Research Fellow¹
Stephen Shumack, Dermatologist²

1 St George Dermatology and Skin Cancer Centre, Sydney, NSW.

2 Department of Dermatology, Royal North Shore Hospital, Sydney, NSW.

sshumack@bigpond.com

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David Wilkinson and
Deborah A Askew

IN REPLY: Our previous publications^{1,2} should calm Chia and Shumack's "alarm". We have urged for the development of education, standards, accreditation, research and audit for skin cancer clinics.¹ Over the past 12 months, the Skin Cancer Society of Australia has been formed (<http://www.skincancersociety.com.au>), standards have been developed, a process of skin cancer practice accreditation has been established, and a masters-level degree in primary care skin cancer medicine has been created (<http://www.som.uq.edu.au/skincancer/masters.htm>).

Our results described activities of a single network of skin cancer clinics.² They should not be viewed as a benchmark, and caution must be exercised in making any generalisations from them. They are simply the first such data to be presented for public scrutiny. It will be important to see results from other skin cancer clinics.

Regarding flap repairs, we were unable to confirm the findings alluded to by Chia and Shumack based on a personal communication. However, we are currently undertaking a detailed analysis of relevant Medicare Benefits Schedule data for general practitioners and specialists and we look forward to presenting this for rigorous peer review and publication shortly.

Skin cancer medicine is an established component of primary care. Whether this occurs in mainstream general practice, "special interest services" or skin cancer clinics, the same standards apply to all.

Competing interests: David Wilkinson works in a Skin Alert skin cancer clinic one day per week and is paid for this work in the same way as other doctors working at these clinics.

David Wilkinson, Professor of Primary Care and Deputy Head
Deborah A Askew, Postdoctoral Research Fellow
School of Medicine, University of Queensland, Brisbane, QLD.
d.askew@uq.edu.au

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