

PSA testing in general practice: can we do more now?

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THE DEBATE OVER PROSTATE-SPECIFIC ANTIGEN (PSA) testing for prostate cancer has been prolonged, public, and sometimes acrimonious. Despite this, a common theme is present in most evidence-based guidelines produced to date: while population-based screening cannot be advocated currently, individuals considering a test should be fully informed about the pros and cons and make their own decisions.¹⁻³ The US Preventive Services Taskforce adds that individuals “be assisted in considering their personal preference and risk profile”.⁴ However, none of these guidelines address the issue of how to ensure such “informed choice”.

The Australian Prostate Cancer Collaboration* (APCC), with support from the National Cancer Control Initiative, convened a workshop on informed choice for prostate cancer testing. The meeting was part of the Conjoint 4th National Prostate Cancer Symposium and the 5th Annual APCC Meeting held at Royal Melbourne Hospital in August 2003. The workshop participants (about 50 people) comprised urologists, GPs, nurses, members of non-government cancer organisations, patients and consumers. The diverse views presented at the workshop suggested that an active approach to managing the PSA testing issue in general practice is needed.

What is currently happening?

Jeanette Ward (Director, Division of Population Health, South West Area Health Service) summarised the current status — that PSA testing is widespread in general practice (in a Western Australian study, 48% of men aged 45 to 60 years had ever been tested).⁵ Furthermore, men overestimate their risk and make decisions without being fully informed.⁵⁻⁷ Max Gardner (Chair, Prostate Cancer Foundation of Australia) and several workshop attendees made it clear that some men with prostate cancer felt they did not have an opportunity for informed testing when their cancer may have been localised. Paul Nisselle (Health-Law Consultant; formerly Chief Executive, Medical Indemnity Protection Society and general practitioner) described the medicolegal exposure arising from this situation, as well as when men feel that they have been harmed by unnecessary screening. A common theme was that a climate of anger,

frustration and, increasingly, litigation is arising from men feeling inadequately informed about prostate cancer testing.

Addressing this issue, speakers described barriers that prevent men being fully informed. These include:

- time constraints for the GP;
- lack of knowledge of the issues (Murray Barson, general practitioner with interest in men’s health; Debra Rowett, Chief Investigator, DATIS trial of academic detailing for PSA testing in general practice);
- lack of understanding of medicolegal obligations, particularly what is prudent and what is sufficient in terms of information provision (Nisselle); and
- wide ranges in patients’ awareness, concerns, levels of comprehension and life circumstances (Barson; Suzanne Steginga, Director, Community Services, Queensland Cancer Fund).

Lack of understanding of how to communicate the complex areas of risk and uncertainty (Barson; Rowett; Ward) is also a barrier to fully informing men.

What constitutes “informed choice”?

Nisselle revisited the medicolegal precedent set by *Rogers v Whitaker* and suggested that three tests are needed to determine if a patient has been fully informed:

- The reasonable patient test: information has been given that a reasonable person as a patient would think relevant;
- The reasonable doctor test: extra information has been given, which a reasonable doctor would add, having regard to the particular circumstances of the patient; and
- The individual patient test: additional information has been given, that that particular patient sought, having been given the opportunity to seek it.

“Informed refusal” is as important as “informed consent”. A patient needs to be made aware that there is information he should consider before deciding not to have a test.

How patients make decisions is crucial in determining how they should be informed. Steginga reported research which suggests that patients more commonly use non-systematic processes (eg, anecdotes or analogies, old beliefs, salient experiences and expert opinion) to make health-related decisions rather than systematic processing (the weighing up of the medical risks and benefits of the decision).

As a consequence of these issues, Nisselle and Steginga maintained that providing a patient with written material and telling him to go away and make a decision is not enough. A discussion between doctor and patient has to take place, in which the patient’s views and beliefs are elicited, medical information is individualised to the patient’s circumstances (eg, age, family history), and the patient’s specific information needs are responded to. In short, “shared decision-making”.

* The Australian Prostate Cancer Collaboration is a national organisation of clinicians, researchers, consumers and non-government organisations with an interest in prostate cancer. It receives project-based sponsorship from non-government organisations and commercial sources.

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Pinnock outlined effective communication strategies to support this shared decision-making. These include establishing the preferred amount of information, the preferred role in decision-making,⁸ graphical representations of risk, and checking patient understanding. Ward noted that preference for a shared decision-making has been found in studies of men and GPs alike.⁹

Rowett reported results from the DATIS trial (a three-state study of academic detailing, which is a form of educational outreach as a means of informing GPs about issues concerning prostate cancer screening). Unprompted comments from GPs suggested that, although secondary, written materials can be useful in supporting the discussion. This was reinforced by Ward,⁹ who found that written materials increased knowledge gain by patients, particularly in those who prefer an active decision role. Pinnock discussed quality criteria for decision aids,¹⁰ including neutral framing, explicit evidence base, and evidence of effectiveness. High-quality written materials may reduce the length of the consultation (Rowett), improve patient knowledge,⁹ and reduce decisional conflict,⁹ but their effect on the decision outcome is variable (Steginga).

The content of the informed-choice discussion

Gardner (providing a patient perspective), Pinnock (from the perspective of published research), and Ward (based on her group's research) addressed the categories of information that should be presented in written materials. These include:

- Basic information on the prostate and its function, the individualised risk of developing prostate cancer and dying from it, and the way in which the man's age, health status and family history may modify these risks;
- The potential benefits of early detection (can detect disease at a stage when treatment is potentially curative) and uncertainties (not sure whether active treatment prolongs life); and
- The performance of the PSA test in detecting prostate cancer (sensitivity, specificity and positive predictive value).⁹

The outcome of informed choice

Pinnock suggested that the outcome of this process of discussion and decision support is not a decision whether or not to test, but a management plan, which may involve review only, a single test, or testing at specified intervals. It should be individualised to the patient's situation, sense of his risk, and preference when balancing the potential benefits, risks and uncertainties of early detection for prostate cancer.

Providing resources and skills to GPs

The DATIS study suggests that academic detailing is successful in reaching GPs (80%–90% penetration), acceptable to GPs, and effective in increasing knowledge and perceived ability to inform patients. Ward revealed that a NSW trial of a peer-led 3-month education program will also look for

improvements in understanding the evidence, perceived medicolegal risk and self-efficacy in promoting informed decision-making.

Improved health literacy schemes in the community may reduce GP time required to explain basic background information. Furthermore, improving prostate health literacy is likely to improve decision-making regarding lower urinary tract symptoms,¹¹ which are more common than prostate cancer. Sharing the educational task with non-government organisations, such as cancer councils, could spread the cost across sectors. These and other strategies to make the informed-choice discussion time-efficient need to be explored.

Addressing inequity in access

Workshop attendees raised the issue of men who are unconcerned about their health, who do not visit their doctor, and others (eg, rural men), who have poor access to medical services. These groups have an imposed, or default, uninformed refusal of prostate cancer testing. Education programs targeting general practice will not address this problem, but a community education program can reach such groups. Community education focusing on male reproductive and prostate health is also likely to promote a more active role for men in maintaining their health and reduce stigma associated with some of these disorders.

Should this wait until 2008?

Two speakers (Pinnock; Greg Neerhut, urologist, Victoria) addressed whether the need for informed choice will change once the results of the US and European randomised controlled trials on prostate cancer screening become available from 2008. Even if a screening benefit is detected in trials, the need for a man to make a fully informed decision will remain. This is because any survival benefit of active treatment of localised disease is likely to be evident only after 10 years or more.¹² It is also likely that the poor performance of the PSA test, in particular the high rate of false positive results, will continue or increase with widespread early detection.

In summary, the workshop established that there is a pressing need to support and resource GPs assisting men in making an informed choice about prostate cancer testing, to disseminate knowledge of how patients make these decisions, medicolegal issues, and provide access to decision support resources. A community education program on men's prostate or reproductive health will help to reduce the burden on the GP as the sole agent responsible for community and patient understanding of these issues.

References

1. Australian Health Technology Advisory Committee. Prostate cancer screening. Canberra: AGPS, 1996.
2. Screening for prostate cancer: the evidence. Information for men considering or asking for PSA tests. Centre for Reviews and Dissemination: University of York, York; 1997. Available at: www.urosoc.org.au/info/ainfo.html (accessed Feb 2004).

3. Smith R, von Eschenbach A, Wender R, et al. American Cancer Society guidelines for the early detection of cancer: update of early detection guidelines for prostate, colorectal, and endometrial cancers. *CA Cancer J Clin* 2001; 51: 38-75.
4. Harris R, Lohr KN. Screening for prostate cancer: an update of the evidence for the US Preventive Services Task Force. *Ann Intern Med* 2002; 137: 917-929.
5. Slevin T, Donnelly N, Clarkson J, et al. Prostate cancer testing: behaviour, motivation and attitudes among Western Australian men. *Med J Aust* 1999; 171: 185-188.
6. Weller D, Pinnock C, Silagy C, et al. Prostate cancer testing in South Australian men: influence of sociodemographic factors, health beliefs and lower urinary tract symptoms. *Aust N Z J Public Health* 1998; 22: 400-402.
7. Pinnock C, Weller D, Marshall V. Self-reported prevalence of prostate specific antigen (PSA) testing in South Australia: a community study. *Med J Aust* 1998; 169: 25-28.
8. Towle A. Framework for teaching and learning informed shared decision-making. *BMJ* 1999; 319: 766-771.
9. Gattellari M, Ward J. Does evidence-based information about screening for prostate cancer enhance consumer decision-making? A randomised controlled trial. *J Med Screen* 2003; 10: 27-29.
10. O'Connor AM, Stacey D, Entwistle V, et al. Decision aids for people facing health treatment or screening decisions [update of Cochrane Database Syst Rev 2001; (3): CD001431]. *Cochrane Database Syst Rev* 2003; (2): CD001431.
11. "Is it my Prostate, Doc?" A guide for general practitioners. Canberra: National Health and Medical Research Council, 1997. Available at: www.health.gov.au/nhmrc/publications/pdf/cp43.pdf (accessed Mar 2004).
12. Holmberg L, Bill-Axelson A, Helgesen F, et al. A randomized trial comparing radical prostatectomy with watchful waiting in early prostate cancer. *N Engl J Med* 2002; 347: 781-789.

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