



Original article

General practitioners' preferences with regard to colorectal cancer screening organisation Colon cancer screening medico-legal aspects



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ARTICLE INFO

Article history:

Received 31 May 2016

Received in revised form 21 August 2017

Accepted 30 August 2017

Keywords:

Colorectal cancer screening

General practitioner

Preferences

Rights of patients

Discrete choice method

ABSTRACT

Objective: French health authorities put general practitioners at the heart of the colorectal cancer screening. This position raises organisational issues and poses medico-legal problems for the professionals and institutions involved in these campaigns, related to the key concepts of medical decisions and suitability of standards. The objective of our study is to reveal the preferences of general practitioners related to colorectal cancer screening organisation with regard to the medico-legal risk

Methods: A discrete choice questionnaire presenting hypothetical screening scenarios was mailed to 2114 physicians from 20 French different areas. The preferences of 358 general practitioners were analysed using logistic regression models.

Results: The factors that have significant impact on the preferences of general practitioners are the capacity of the primary care professional in the procedure, the manner in which pre-screening information is given to patients, the manner in which screening results are given to patients, the number of reminders sent to patients who test positive and who do not undergo a colonoscopy and the remuneration of the attending physician.

Conclusions: Our results reveals that current colorectal cancer screening organisation is not adapted to general practitioners preferences. This work offers the public authorities avenues for reflection on possible developments in order to optimize the involvement of general practitioners in the promotion of cancer screening programme.

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1. Introduction

In France, colorectal cancer mass screening has been implemented since 2008 [1]. The State and the health insurance Fund delegate the organization and the promotion of this screening to local associations. More precisely, these management structures are operational bodies under the authority of the Ministry of Health which are responsible for identifying the target population and inviting them by mail to carry out the screening. Decrees published in the French Official Journal of Legislation define the resources and tasks of the management structures, in particular in terms of programme evaluation and compliance with regulatory and ethical aspects (quality assurance, consent, confidentiality [2,3]). The

French colorectal cancer screening programme targets people in the 50–74 years old age group with average risk. The management structure invites people by a personal letter to go to their general practitioner to give them a screening test. The screening test for occult blood in faeces must be done at home. Once the test has been completed, it is sent to a laboratory using a prepaid envelope provided with the test. Patients, their doctor and the management structure are informed of the result by the laboratory. If the result is positive, a colonoscopy will be required to confirm. To reduce colorectal cancer mortality estimated at some 17,500 deaths in 2011 [4], French health authorities set a level of participation of the population concerned above 50% (with a European expected participation objective at 45%) [5]. During the period from 2011 to 2012, the participation rate was only 31.7% [6]. Several studies revealed numerous inequalities in terms of screening participation linked to socio-demographic variables [7,8] and showed that the level of screening participation is closely related to the degree of involvement of the general practitioners. This is not particular to France.

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An Australian study also showed that compliance was higher when patients received an invitation to screening signed by their general practitioner rather than receiving an invitation signed by the promoter centre without mention of the GP's name [9]. General practitioners appear to play a major role for improving participation in the screening programme by sending a final reminder to their patients. The 2009–2013 Cancer Plan launched by the French government in order to reduce cancer incidence and mortality and improve the care of the sick, therefore placed the attending physician at the heart of the cancer mass screening process [10]. Laid down in measure 14 of the 2009–2013 Cancer Plan, the involvement of attending physicians in colorectal cancer mass screening is aimed at fighting inequalities in access to and use of screening. Involving attending physicians in national screening programmes is even the core issue of measure 16 of the Cancer Plan, with the objective of facilitating inclusion of the target patients by general practitioners [11] and therefore increases screening participation.

The position of general practitioners at the heart of the system, however, raises organisational issues and poses medico-legal problems for the professionals and institutions involved in these campaigns, related to the key concepts of medical decisions and implementation and suitability of standards. Focused on the specific relationship between doctors and patients in preventive action, these issues refer to notions of terms and scope of information, obtaining the consent of patients, data confidentiality, professional liability. . . Indeed, given the fact that our society is becoming ever more litigious, there is reason to fear an increase in the questioning of the legal responsibility of doctors by patients detected false positives or false negatives or not detected but suffering from cancer on the grounds for insufficient information on screening.

The objective of our study was to reveal the preferences of general practitioners related to colorectal cancer mass screening organisation especially with regard to the medico-legal risk. This work deals with the balance of the current screening organisation modalities (such as patient information before and after screening, the number of reminders to undergo a colonoscopy sent to patients . . .) and the general practitioners requirements concerning both the respectful of the rights of patients and their degree of professional liability exposure.

2. Material and methods

2.1. Sample selection

The study population was selected from the 216,450 general practitioners registered with the French Medical Association in 2011. The sample size was based upon a rule of thumb usually applied in discrete choice experiment. It was determined on the basis of the analysis of sub-groups with a minimum figure of between 30 and 100 individuals for each sub-group of interest i.e. in this study for each socio-professional characteristics of respondents [12]. Then, estimating between 15 and 20% the a priori proportion of questionnaires accepted and exploitable among the persons contacted, we have fixed the population to be contacted at 2114. A sample of 2114 general practitioners broken down by gender, French *département* and locality of practice was selected. 20 départements (9 in the south of France, 9 in the north of France, 1 in the Paris region and 1 overseas département) were selected based on the density of general practitioners in the département: low (LD), medium (MD) or high density (HD). Depending on the locality in which their practice was located, the doctors were broken down into three zones: rural (population below 2000), intermediate or urban (population of over 10,000), based on the census taken by the French statistics office INSEE as of 1 January 2010.

2.2. Method of analysis

The method of analysis chosen to reveal the preferences of general practitioners was the discrete choice method [13]. Initially used in environmental economics and marketing, this method has been applied to health for some twenty years now as a decision-making support tool for public health choices and as a tool to prepare best practice recommendations [14]. It refers to a set of experimental methods making it possible to determine the preferences of an individual for different alternatives. Observing the choices made by individuals makes it possible to deduce an estimation of utility (i.e. economic indicator of the individuals' satisfaction) derived from consumption of a product, use of a service or taking a given action. The value of these methods is that they make it possible to estimate the contribution of each component to the choice made (still called attribute). Applied to ethical aspects of colorectal cancer mass screening, the discrete choice method indicates, for example, the utility of doctors associated with means of providing information, medical monitoring of the patient, or the remuneration of doctors.

2.3. Attributes and scenarios

By means of questionnaires, use of the discrete choice method leads to presentation of a series of scenarios for organisation of screening to each doctor, so that the practitioner can choose the alternative that offers the highest level of utility.

Each hypothetical scenario was composed of specific levels of each attribute representing a specific CRC screening organization modality. The choice of attributes was based on the work done by the French National Institute of Cancer Research Group on Ethics in Screening aimed at identifying ethical issues related to cancer mass screening in France [15].

Five interest attributes were chosen corresponding to the most debated modalities related to ethical aspects of the colorectal cancer mass screening procedure and general practitioners practice (Table 1).

The first attribute was the manner in which pre-screening information is given to the patient. . . Screening information is currently given to the patient by a brochure sent by post by the management structure. This mode of information is certainly quick and economical but does not guarantee the patient's good understanding of the benefits and risks of screening. This is why some doctors claim in France that the information must be issued exclusively by a healthcare professional during a dedicated consultation.

The second attribute was the way in which screening results are given to the patient. The current organization of screening provides that the results are communicated to the patient by standard mail. This method carries a double risk: that the patient does not receive the mail and that he does not understand the contents of the mail. Other modalities such as communicating the results in an interview with a health professional would provide better information for the patient and protection of the physician against possible legal action by an uninformed patient.

The third attribute was the capacity of the primary care professional from the screening procedure to the diagnosis. Currently in the hands of the management structures, it could be transferred to the general practitioner or the gastroenterologist. However, the medical shortage that is waiting for France is also pushing some politicians to consider entrusting this mission to nurses.

The fourth attributes was the remuneration of the attending physician. This attribute does not deal directly with the ethical aspect of screening but is concerned with a highly debated modality. Indeed, French fee-for-service system favours consultations for curative treatments rather than prevention. Therefore, when French general practitioners provide faecal occult blood tests, they

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