

PRACTICE OBSERVED

Essays on Practice

Micros for GPs

F P HOWARTH

The pioneers of general practice computing have blazed the trail into the 1980s, and for the past five years it has been the "consumers' turn, culminating in the Micros for GPs scheme, which was launched by the Department of Industry (now Department of Trade and Industry) in June 1982.

Patient registration

For most practices patient registration was the starting point. The time given to prepare an accurate list before the computer was installed was well spent, and often underestimated, since the list is the core of the database.

Dyce Health Centre, Dyce, Aberdeen AB1 0NQ F P HOWARTH, MR, MRCP, general practitioner

changes in workload over the next 10 years. Such information is valuable for management planning.

Repeat prescribing

Repeat prescribing was usually implemented next. Before the computer was installed the doctors identified three main objectives of a repeat prescribing program: increased efficiency; improved safety, and the facility to monitor their prescribing patterns.

Recall and screening

For screening and recall there were no improvements. Doctors had been dissatisfied with existing manual systems and were expecting greater efficiency using a computer.

whereas the false negative rate is roughly 30%. The false negative rate, however, may be reduced to 10% by increasing the period of testing from three to four weeks.

Method

In January 1985 an up to date list of general practitioners in each practice in Portsmouth was compiled from Hampshire family practitioner committee lists. A telephone call was made to each practice to check that the list was correct.

A questionnaire, which was compiled specially for the survey and may be obtained from me, was adapted from one used in Victoria, Australia. It included items on the vital statistics of colorectal cancer, high risk groups, symptoms, investigations, and screening.

Results

Three of the 105 general practitioners were away or ill at the time of the survey; thus there were 102 potential responders. Table 1 shows the response rate by the survey method and the sex of the doctor.

The general practitioners' responses to the questionnaire were analysed initially by survey method, sex, interview or self completion. Where the responses differed greatly this is indicated, otherwise the data have been combined.

Experience of colorectal disease—The general practitioners were asked to estimate both the number of patients with intestinal problems whom they had referred to hospital during the previous month and the number of new cases of colorectal cancer whom they had seen during the previous year.

who mentioned the common symptoms of colorectal cancer. A wide variety of "other" symptoms were mentioned by five or fewer doctors: loss of appetite, lethargy, anorexia, haemorrhoids, nausea and vomiting, and general ill health.

Knowledge of the risk factors—No risk factor for colorectal cancer was named by over half of the doctors. Liver disease was mentioned by the highest proportion (43%), followed by inherited conditions (38%), a family history (30%), increasing age (29%), diet (27%), and the presence of bowel polyps (17%).

TABLE 1—Number (%) of responders/percentage by survey method and sex of general practitioner

Table with 3 columns: Sex of doctor, Interview, Self completion, Total No by sex. Rows include Male, Female, Total No by method.

\*Includes six out of eight singlehanded doctors. †See p 306, dl=1, p<0.025. Survey method (allowing for sex):  $\chi^2=6.99$ , df=1, p<0.025.

TABLE 2—General practitioners' knowledge of the vital statistics for colorectal cancer. Figures are numbers (%) of doctors

Table with 4 columns: (i) New cases, (ii) Deaths, Interview, Self completion. Rows include Mean common, Second most common, Third most common, Fourth most common, Don't know.

TABLE 3—General practitioners' knowledge of the symptoms of colorectal disease. (i) What do you consider are the symptoms of colorectal cancer? (ii) What symptoms should make you refer a patient to hospital for colorectal investigations? Figures are numbers (%) of doctors who mentioned each symptom

Table with 4 columns: (i) Symptoms of colorectal cancer, (ii) Symptoms for referral for colorectal investigation. Rows include Rectal bleeding, Change bowel habit, Abdominal pain, Night loo, Anorexia, Mucus discharge, Intermittent obstruction, Tenesmus, Unexplained weight loss, Other.

appointment can be entered onto the patient file, and thus the workload can be anticipated by using the search routine to find those patients who have recall dates in, for example, the following month.

Qualified success

The Micros for GPs scheme was timely and should be regarded as a qualified success. It has provided many doctors and staff with experience with computers, and the commercial sector now has a better understanding of the computer needs of general practice.

Practice Research

General practitioners' awareness of colorectal cancer

SALLY NICHOLS

Abstract

A survey was carried out in Portsmouth to find out what general practitioners knew about colorectal cancer and what their views were on screening. A random sample of general practitioners was interviewed by questionnaire and the remainder asked to complete the questionnaire themselves.

The level of knowledge of colorectal cancer varied according to which aspect was questioned. The general practitioners knew the symptoms well but were less aware of the vital statistics and risk factors.

Introduction Colorectal cancer is the second most common cancer in the United Kingdom in terms of both the number of new cases and the number of deaths.

Over 90% for patients with Duke's type A compared with less than 30% for those with type C.<sup>1</sup>

A wide range of symptoms may indicate colorectal cancer, notably a persistent change in bowel habit, rectal bleeding, abdominal or rectal pain, an abdominal mass, and weight loss.

Some groups in the general population have a greater risk of developing colorectal cancer: those aged over 40, those with familial polyposis or a family history, and those with Crohn's disease or longstanding ulcerative colitis.

Compliance rates for colorectal screening programmes in the United Kingdom have ranged from 27% to 45% when the test is received by post.<sup>11</sup> Compliance may be increased appreciably when the test is offered personally by a general practitioner (S Nichols *et al*, unpublished observations). With the Haemoccult test the false positive rate may be as low as 1.2%,<sup>12</sup>

Commonwealth Medical and Medical Statistics, South Block, Southampton General Hospital, Southampton SO9 4XY SALLY NICHOLS, MR, CRTD, research fellow

General practitioners' experience of delays in referring patients for investigation—Just over half of the respondents interviewed said that most patients and general practitioners were equally responsible for lengthy delays between onset of symptoms and referral to hospital; two thirds of the self completion group, however, considered that patients were mainly responsible for such delays.

General practitioners' knowledge and use of investigations—Almost all (97%) of the general practitioners said that they did a rectal examination on symptomatic patients, but most (98%) never did rigid sigmoidoscopy.

General practitioners' use of occult blood tests to manage symptomatic patients and attitudes towards screening—Table IV shows the doctors' use of chemical faecal occult blood testing for symptomatic patients and their attitudes towards the screening of asymptomatic people by this method.

Discussion It appears from the results of this survey of general practitioners that a higher response rate can be achieved from women doctors and by personal interview rather than by a self completed questionnaire.

TABLE 4—General practitioners' use of occult blood tests in managing symptomatic patients, and their attitudes towards screening for colorectal cancer. Figures are numbers (%) of doctors

Table with 4 columns: (i) Through a pathologist, (ii) As the surgery, Do you use chemical faecal occult blood tests to manage symptomatic patients? Do you think that faecal occult blood testing is a practical method of screening asymptomatic people for colorectal cancer? Do you think that faecal occult blood testing is a practical method of screening asymptomatic people for colorectal cancer?

Do you use chemical faecal occult blood tests to manage symptomatic patients? Do you think that faecal occult blood testing is a practical method of screening asymptomatic people for colorectal cancer?

Do you think that faecal occult blood testing is a practical method of screening asymptomatic people for colorectal cancer?

Do you think that faecal occult blood testing is a practical method of screening asymptomatic people for colorectal cancer?

Do you think that faecal occult blood testing is a practical method of screening asymptomatic people for colorectal cancer?

Do you think that faecal occult blood testing is a practical method of screening asymptomatic people for colorectal cancer?

Do you think that faecal occult blood testing is a practical method of screening asymptomatic people for colorectal cancer?

Do you think that faecal occult blood testing is a practical method of screening asymptomatic people for colorectal cancer?

Do you think that faecal occult blood testing is a practical method of screening asymptomatic people for colorectal cancer?

Do you think that faecal occult blood testing is a practical method of screening asymptomatic people for colorectal cancer?

Furthermore, different survey methods may produce different patterns of responses to the questionnaire, particularly to questions that require factual information. In cases where there is an opinion may be considered by the respondent to be less than "acceptable" to the interviewer. A good example is the question relating to the responsibility for delays in the referral of patients with colorectal symptoms.

For some aspects of colorectal cancer, such as the symptoms, the general practitioners showed a high level of knowledge, but less well known were the risk factors, the relatively low survival rate (all stages combined), and the limited extent to which tumours can be detected by rigid sigmoidoscopy.

Attitudes of the general practitioners were not in favour of screening by testing for faecal occult blood. Interestingly, over three quarters of those who were against screening gave a high false positive rate as a reason. In four major screening programmes in the United Kingdom nearly 8000 persons have been tested using Haemoccult and 20 cases of cancer and 42 cases of adenoma have been detected in the 259 patients who were positive.<sup>13</sup> The false positive rate is taken to be the number of positives minus the number of cases of cancer and adenoma divided by the total number of persons tested then the false positive rate from the studies was 2.5%.

I thank the general practitioners in Portsmouth who participated in the survey, Mark Mullie and Lindsey Izzard for computing; members of the Westcoast colorectal screening advisory group, particularly David Machin for statistical advice and Eileen Koch for coding the questionnaires; and Doreen Nash for typing the paper.

This survey is part of a project on compliance in screening for colorectal cancer funded by the Cancer Research Campaign.

References

1 Cancer Research Campaign. Facts on cancer. London: Cancer Research Campaign, 1985. 2 Cancer Research Campaign. Trends in cancer incidence in Great Britain: cancer registered between 1960 and 1979. London: Cancer Research Campaign, 1982. 3 Gill PG, Morris PJ. The survival of patients with colorectal cancer treated at a regional hospital. Br J Surg 1979;67:120. 4 Williams C. All about cancer: A practical guide to cancer care. Chichester: John Wiley and Sons, 1981. 5 Ormiston AM. Large bowel cancer: diagnosis and staging. Gut 1983;24:119-22. 6 Wong C. Carcinoma of the colon and rectum. J Clin Pathol 1982;35:164. 7 MacArthur C, Smith A. Factors associated with speed of diagnosis, referral, and treatment in colorectal cancer. Br J Surg 1982;69:121. 8 Holladay HW, Hancock JD. Delay in diagnosis and treatment of symptomatic colorectal cancer. Cancer 1981;51:113. 9 Hancock JD. Screening for colorectal cancer. Update 1982;24:189-96. 10 Hancock JD. Screening sequence in the large bowel. Proc of the Royal Society of Medicine 1982;75:166. 11 Hancock JD, Fairhead P, Balow TV, Chantler J, Jones SS, Siddons MG. Coordinated trial of faecal occult blood testing in the detection of colorectal cancer. Lancet 1981;ii:14. 12 Schemm A, Hancock JD. Accuracy of non-invasive methods of screening for colorectal cancer. Community Med 1984;6:11. 13 Fairhead P, Hancock JD, Anderson DC. The Frame experiment—value of screening for colorectal cancer. Lancet 1981;ii:1312. 14 Doreen L. Screening for colorectal cancer: a colorectal cancer: the effect of spirit and the complications for faecal occult blood testing. Br J Surg 1982;69:711. 15 Fairhead P, Hancock JD. Accuracy of faecal occult blood testing. Clin Oncol 1983;5:27-29. 16 Doreen L, Hancock JD. Knowledge and attitudes of gastroenterologists in colorectal cancer. Ann Surg 1979;189:351-4. 17 Hancock JD, Fairhead P, Balow TV, Chantler J, Jones SS, Siddons MG. Coordinated trial of faecal occult blood testing in the detection of colorectal cancer. Lancet 1981;ii:14. 18 Schemm A, Hancock JD. Accuracy of non-invasive methods of screening for colorectal cancer. Community Med 1984;6:11. 19 Hancock JD, Anderson DC. The Frame experiment—value of screening for colorectal cancer. Lancet 1981;ii:1312. 20 Hancock JD, Anderson DC. The Frame experiment—value of screening for colorectal cancer. Lancet 1981;ii:1312. 21 Hancock JD, Anderson DC. The Frame experiment—value of screening for colorectal cancer. Lancet 1981;ii:1312. 22 Hancock JD, Anderson DC. The Frame experiment—value of screening for colorectal cancer. Lancet 1981;ii:1312.

(Accepted 18 December 1985)