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PRACTICE OBSERVED

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An Ethical Dilemma

Who should be concerned?

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Mary is aged 20, the youngest daughter in a family of three. Her two elder sisters graduated with honours at a top university. She is resting her first year at a somewhat rundown polytechnic college...

It was arranged that she would be transferred to the "poly" sick bay. Her father, who "happened" to be in the town, brought her across the next day. He did not stay or discuss the matter...

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asked to see her father. During that week a terse phone call from mother asked the nurse on duty to readmit her next Monday. We did. Mary returned irritated and restless. She wished to leave at the end of the week and return to her flat even though she did not like her flat mates. I agreed. On Thursday afternoon she took a further overdose while in the sick bay...

Commentary by A V Campbell

This case is distinguished by its ordinariness. Many practitioners will recognise the outlines of similar cases in their own experience—patients who seem to need help, yet create effective barriers against receiving it, elusive relatives who nevertheless seem to be concerned when finally contacted, fuzzy boundaries between physical, emotional, and social problems, a sense of inconclusiveness, and a lack of clear medical functions to perform...

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The World Medical Association Geneva Convention Code of Medical Ethics states (in an article of the Hippocratic Oath): "The health of my patient will be my first consideration."

What should a doctor do in such circumstances? It is difficult to see what can be done effectively. The practitioner is at the boundary (if not over the boundary) of medical competence. General practitioners are not experts in family dynamics and do not usually have any specific skills in family therapy...

SUCIDE, ATTEMPTED SUICIDE, MANIPULATION

This leads us to the special feature of this case—Mary's use of suicide attempts to attract or regain attention. The case report makes it obvious that Mary's behaviour is highly manipulative. She creates disturbances in the general hospital, at the "poly" sick bay, and at home, all of which have the effect of forcing people to move her around from place to place without really helping her...

This type of manipulative behaviour creates considerable moral dilemmas for the people trying to help Mary. To rush to help Mary is to join her self-defeating game; but to refuse to do so might be to let a young, emotionally disturbed person kill herself. Neither alternative commends itself morally...

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for her own recovery. But it is obvious that she needs to cooperate with at least one of the several resources she has called on (college tutor, hospital staff, sick bay staff, general practitioner, parents) or attempts to help are pointless. Perhaps then it falls to the general practitioner not to be dissatisfied by her suicidal behaviour. But, one must repeat, what is he to do?

ENHANCING AUTONOMY

The moral philosopher's answer to this question is likely to be that the doctor should seek to enhance his own and his patient's autonomy, both of which are in jeopardy in their present interactions. Like most answers from philosophers this sounds too vague and generalised to be of much practical relevance. Yet, it is indeed autonomy which is the main value at stake in this case. We must first clarify what the term implies and then see what practical implications might be drawn regarding the medical care of Mary...

These general principles apply to the care of Mary in the following way. Mary, although of adult years and of at least normal intelligence, is acting in a way more consistent with a child who cannot predict the future and who seeks constant attention from others. This she is considerably less autonomous than she might be capable of being, were it not for her emotional distress. The medical task is to relieve her emotional disturbance by whatever therapeutic means are available, but more than this, to mediate a professional relationship which treats her as a responsible adult, capable of self-direction...

We will be pleased to receive from general practitioners reports of other cases posing medical problems. We will then ask an "expert" to comment.—Ed, BMJ.

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Practice Research

Screening for asymptomatic bowel cancer in general practice

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Abstract

General practitioners screened 4284 asymptomatic people aged over 40 to compare the incidence of large bowel cancer and polyps with a control general practice (4288 patients). Compliance was best in young women (60%), and overall it was 42%. Twenty six patients who had a positive Haemoccult test result (1.5% of those screened) were examined by colonoscopy and 10 had polyps. The incidence of cancers in the two groups was similar but in the control (unscreened patients) practice no polyps were found.

Introduction

Colorectal cancer is the second commonest cause of death from cancer in the British Isles. Five year survival rates of 90% after treatment for lesions limited to the mucosa suggests that colorectal cancer is potentially curable. Survival figures for this condition of slowly increasing incidence, however, have not improved over the past three decades despite advances in diagnostic and surgical techniques.

Most patients continue to present with advanced disease, where survival for five years is expected to be less than 30%. Indeed, it is doubtful whether the results of treatment could be improved among symptomatic patients. It therefore seems reasonable to seek to improve cure rates by searching for pre-symptomatic patients with colorectal tumours. Morson showed a strong association between a benign adenoma and the incidence of cancer, suggesting an evolution from adenoma to cancer, although the lead in time for the development of malignant change in an adenoma is not certain. Gilbertson showed that early tumours can be found by screening when compliance is high. Studies in Britain have shown a disappointingly low compliance rate when screening for occult blood in the stool, and the yield of early tumours has been correspondingly low.

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Patients and methods

In this pilot study 4284 people aged over 40 who were registered with two adjacent general practices were invited by their family doctor to do a Haemoccult test. A letter was sent to each person explaining the reason for the survey and in one practice also enclosing the Haemoccult test kit with detailed instructions. In the second practice people were asked to collect the test kit from the doctor's surgery; those who did not were subsequently sent the kit by post (table 1).

TABLE 1—Response to letter of invitation to Haemoccult screening

Table with 4 columns: Response to invitation in practice A, Sample size, Returned without examining kit, Total returned after letter of reminder. Practice B data is also included.

Patients were asked to take a high fibre diet and abstain from taking iron and vitamin C for three days before and while performing the test. For this they were asked to take two separate samples from each of three consecutive stools, putting the samples on a Haemoccult test card before returning it to the practice for testing. The practice nurse put a drop of peroxide reagent on the test card and observed the colour change.

One or more positive test results indicated referral to hospital, where the patient was seen by one of three surgeons. A routine history and examination were carried out in outpatients and explanation given of the need for colonoscopy. The existing outpatient and colonoscopy services were used.

Patients for colonoscopy examination were admitted for the day after a 24 hour preparation consisting of dietary restriction, copious fluid intake, and two doses of Picosal, which usually induced diarrhoea. Three hours before colonoscopy examination an enema was given, consisting of 300 ml phosphate in twice the volume of water. This preparation was well tolerated and the bowel well cleared of stool. After a bolus dose of intravenous diazepam total colonoscopy was carried out and, where appropriate, polypectomy performed. Biopsy material was submitted for histological examination. Those found to have a polyp had colonoscopic examinations yearly.

The incidence of symptomatic large bowel tumours was recorded for the patients in the practice offering screening (4284 patients) and in a neighbouring control practice consisting of 4288 people aged over 40, chosen for similarity of social class, age, ethnic origin, and sex. Names were obtained from the age-sex register in each practice but screening was not offered to controls. Sources of information on colorectal tumours were the hospital pathology department and general practitioner reporting.

Results

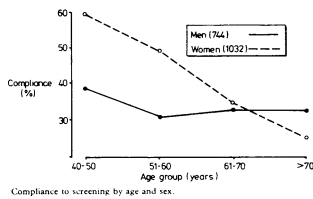
COMPLIANCE

The invitation to test the stool using the Haemoccult kit was accepted by 1776 people, a compliance rate of 42% overall. No

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difficulty was reported interpreting instructions and 40% of non-compliers returned the unused Haemoccult kit when asked in a letter of reminder. The figure shows the compliance rate by age and sex. In contrast with men, among whom compliance was steady at 35-40% for all age groups, compliance was as high as 60% in younger women but diminished with advancing age.



The site of the polyp in seven cases lay beyond the reach of a rigid sigmoidoscope and five were 45 cm or more from the anal verge. Two adenomas of 1.5 and 3 cm showed histological changes of epithelial dysplasia. Two patients also produced further adenomas at subsequent yearly colonoscopic examinations.

Two patients positive for the Haemoccult test refused investigation and in two no cause for bleeding was found. Among the remaining 22 patients, 26 sources of gastrointestinal bleeding were identified. Two patients with diverticular had coincident piles and another a coincidental fissure. The source of bleeding was identified as a duodenal ulcer in a fourth patient. The patient who had epistaxis remembered having nose bleeds during the test period.

SYMPTOMATIC PATIENTS

Instructions with the kit advised that if symptoms were present the doctor should be told. Five patients from the practice screened presented in this way and were therefore not screened. Four had adenocarcinoma (three Duke's C and one Duke's B), and one woman aged 45 bled from a retractor polyp.

During the study period of two years, six patients from the control practice (unscreened) presented with symptomatic large bowel cancer. All had a Duke's stage C tumour and three have died of the disease. No polyps have been diagnosed in the control practice. Since screening ceased just over a year ago one woman aged 64 has presented with a Duke's stage C rectal cancer palpable on digital examination. She had a negative result on the Haemoccult test and remained negative on repeated testing after presentation with symptoms. Table III compares the total yield of colorectal neoplasia in study and control practices.

During the two years no undue strain was felt in general practitioner or hospital services. Haemoccult testing took two hours of the nurse's time weekly. Secretarial time was estimated at three hours weekly. No attempt has been made at costing hospital time owing to complexity of accounting.

TABLE III—Two year incidence rate of colorectal neoplasia per 1000 people (Numbers in parentheses)

Table with 5 columns: Cancer, Adenoma, Found by screening, Interval, Saw general practitioner with symptoms, Total, Control practice. Data for 4284 patients and 4288 controls.

Discussion

Gilbertson et al showed that early detection of asymptomatic rectal cancer by sigmoidoscopy can alter cancer incidence, and that screening for occult blood in the stool will show early colorectal cancer. They did not find barium enema x ray examination reliable and recommended colonoscopy. All Haemoccult positive compliers in this study had a colonoscopic examination.

We have shown that general practitioner screening detected two asymptomatic adenomatous polyps per 1000 screened. No polyps were seen in a matched control practice whose patients were not offered screening. In both screened and control practices 1-4 symptomatic cancers per 1000 were found. These figures are slightly lower than Hardcastle et al's who screened almost five times more patients but with only 36.8% compliance, compared with our 42%. Ours was a feasibility study to look at both patient compliance and incidence of polyps.

Compliance to screening was improved by a letter of reminder (table 1), but initial compliance was better when the Haemoccult kit was sent out with the letter of invitation than when the kit had to be collected from the surgery (practice B). A 42% compliance rate in this study was poor but no published report has yet shown better results. Better compliance was expected from women; the fall off with advancing age is attributed to diminishing less exposure to health education. Adult health education programmes have been available only in the past 20 years.

NUMBER OF POSITIVES

Table 1 shows that 26 patients (1.5% of those who did the test) had positive Haemoccult results. One case among an apparently asymptomatic rectal ulcer of 10 cm diameter, was found in a woman of 70.

TABLE II—Results of investigation of 26 patients positive for the Haemoccult test

Table with 2 columns: Lesion, Number. Categories include Adenoma, Hyperplastic polyp, Diverticular fissure/piles, Ulcer, Ulcer/gastrointestinal tract, Polyp, Diverticulum, Incoloured investigation.

After resection this was shown to be a Duke's stage B tumour. The yield of cancer was thus 0.6 per 1000 screened. The commonest cause of bleeding was a hamartoma, but the other nine all had one or more adenomas, giving a yield of potentially pre-malignant neoplasia of 5 per 1000 screened. Two patients had multiple adenomas (three each) without any family history. Seven had a single adenomatous polyp, six of a diameter 1 cm or less. One patient aged 72 had a polyp 3 cm in diameter in the transverse colon. He had had a right hemicolecotomy for cancer six years earlier but no follow up examination. Of these nine adenoma bearers, four were under 49 and three under 45.

