



Prostate specific antigen testing for prostate cancer

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Prostate specific antigen testing for prostate cancer

Engaging with the public may address their concerns and produce workable solutions

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Medical screening is an example of “institutionalisation of risk.”¹ In practice this often entails imperfect tests, sometimes inappropriately presented to the public,² that discover diseases we do not fully understand and cannot adequately treat. Pressures for the establishment of national screening programmes are widespread, but we are now seeing countries seeking to learn from others’ experiences or from their own established national programmes.^{3,4} But attempts to resist public pressures for new screening programmes may be mistrusted as attempts to save money, betray the science, or fool the public, or as sex discrimination. Traditionally, the response to such apparent public ignorance or irrationality has been to argue that the public needs to be educated and people’s views corrected to align more correctly with what policy makers and scientists want them to believe. Perhaps what is needed now is not so much public understanding of science as understanding of the public by scientists.

In this issue we see contributions to the debates about risk in relation to prostate cancer.⁵⁻⁷ Yu-Lao and colleagues seem to bolster the arguments for caution in the debate on screening for prostate cancer by prostate specific antigen testing.⁵ Their findings show that more intensive screening and treatment with prostatectomy and external beam radiotherapy are not associated with lower prostate cancer specific mortality through 11 years of follow up.

Although the experts continue to argue about the evidence on screening, the public has come to different conclusions, as shown by Chapple and colleagues,⁶ who show that trial, epidemiological, or clinical evidence may play a small part in the public’s demand for screening for prostate cancer by prostate specific antigen testing. Instead, the irresistible logic of finding the cancer early, the drive to avoid regretting later the decision not to have the test, the right to obtain information about oneself by testing, and a perceived right to parity with women’s access to screening may all be more important arguments.

These lay arguments for prostate specific antigen testing have their own logic and validity. What they mostly do not recognise are the costs of screening.⁸ Screening is the business of changing identities; it is the business of producing patients. Becoming a patient is not a trivial matter. It has profound health, social, psychological, and economic consequences.⁹ Screening therefore raises important ethical problems. As

Cochrane and Holland pointed out three decades ago: “If a patient asks a medical practitioner for help, the doctor does the best possible. The doctor is not responsible for defects in medical knowledge. If, however, the practitioner initiates screening procedures the doctor is in a very different situation. The doctor should, in our view, have conclusive evidence that screening can alter the natural history of disease in a significant proportion of those screened.”¹⁰ Reconciliation between today’s risk conscious citizens demanding tests or pressing to initiate screening programmes and authorities becoming more cautious about their provision will come only through initiatives that engage with the public not through authoritarian insistence on the “rightness” of the science.

Donovan and colleagues make just such an important contribution.⁷ They describe how the use of an iterative and flexible approach to study design can help sensitise researchers to patients’ priorities and views. The qualitative embedding of the ProtecT (prostate testing for cancer and treatment) randomised trial allowed detailed investigation of the presentation of information about the study by recruiters and its interpretation by participants. Findings led to changes in ways that recruiters presented trials to prospective participants. These included amending the order of presenting treatment to encourage emphasis on equivalence in a more satisfactory, confident, and convincing consultation model, avoiding misunderstood terms, and coining new terminology for the non-radical arm. After these changes, rates of consent to randomisation increased from 30-40% to 70% in a year.

This approach shows that, by engaging with people and exploring their beliefs and priorities, much can be done to address public concerns and produce workable solutions to complex issues around the interface between individual risk and wider costs.¹¹ It also shows how easy it might be for this approach to be misused by those charged with the governance of risk: the science and methods of engaging with the public must be used only in a context of responsible and respectful partnerships about how risk is to be governed in our society. These newer and more satisfactory methodologies exploring the feasibility and acceptability of conducting difficult or contentious research might lead to fewer—but higher quality and more relevant—truly successful studies, and to better

ways of explaining the pros and cons of existing technologies to the public.^{11 12}

Stronger and braver governance is required to ensure that responsible decisions about risk management emerge for areas such as screening, which have such potentially enormous individual and societal consequences. These decisions must be based on sound research and proper partnerships.

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1 Giddens A. *Modernity and self-identity*. Cambridge: Polity, 1991.

2 Dixon-Woods M, Baum M, Kurinczuk JJ. Screening for breast cancer with mammography *Lancet* 358:2166-7.

3 Ciatto S, Zappa R, Bonardi G, Gervasi G. Prostate cancer screening: the problem of overdiagnosis and lessons to be learned from breast screening. *Eur J Cancer* 2000;36:1347-50.

4 NHS Cancer Screening Programmes. The prostate cancer risk management programme. www.cancerscreening.nhs.uk/prostate/index.html (accessed 26 Sep 2002).

5 Lu-Yao G, Albertson PC, Stanford JL, Stukel TA, Walker-Corkery ES, Barry MJ. A natural experiment examining the impact of aggressive screening and treatment on prostate cancer mortality in two fixed cohorts from the Seattle area and Connecticut. *BMJ* 2002;325:740-3.

6 Chapple A, Ziebland S, Shepperd S, Miller R, Herxheimer A, McPherson A. Why men with prostate cancer want wider access to prostate specific antigen (PSA) testing: qualitative study. *BMJ* 2002;325:737-9.

7 Donovan J, Mills N, Brindle L, Frankel S, Smith M, Jacoby A, et al. Improving the design and conduct of randomised trials by embedding them in qualitative research: the ProtecT study. *BMJ* 2002;325:766-70.

8 Giris S, Thomson C, Ward J. "The courts expect the impossible": medico-legal issues as perceived by New South Wales general practitioners. *J Law Med* 2000;7:273-80.

9 Thornton H. Consequences of screening. *Lancet* 2000;356:1033.

10 Cochrane AL, Holland WW. Validation of screening procedures. *Br Med Bull* 1971;27:3-8.

11 Thornton H, Dixon-Woods M. Recruitment of women into trials. *Lancet* 2002;359:164-5.

12 Ward J, Giris S. GPs' estimates of men's risk of prostate cancer and screening expectations. *Austr N Z J Public Health* 1999;23:219-20.

Treating violence as a public health problem

The approach has advantages but diminishes the human rights perspective

In every country, to a greater or lesser extent, violence blights lives and undermines health. Acknowledging this, in 1996 the 49th World Health Assembly adopted a resolution (WHA49.25) declaring violence a major and growing public health problem across the world. The resolution ended by calling for a plan of action for progress towards a science based public health approach to preventing violence. The World Health Organization defines violence as the intentional use of physical force or power, threatened or actual, against oneself, another person, or a group or community, that either results in, or has a high likelihood of resulting in, injury, death, psychological harm, maldevelopment, or deprivation.¹ In 2000, an estimated 1.6 million people died as a result of violence. Many more suffered injury. Of the deaths, nearly half were suicides, almost a third were homicides—of whom 57 000 were of children—and about a fifth were related to war. This week, the WHO published the *World Report on Violence and Health*.² The report includes sections on youth violence, child abuse, violence by intimate partners, abuse of elderly people, sexual violence, self directed violence, and collective violence. Underlying the bleak statistics in each chapter is a terrifying amount of pain and suffering.

Bringing all forms of intentional violence together in one volume makes very clear how much the different forms of violence feed on each other. People who were subjected to child abuse or violence from an intimate partner are much more likely to harm themselves. Collective violence fractures normal social bonds and often leads to sexual violence and heightened violence in young people. Almost every form of violence predisposes to another. Wherever power is distributed unequally across divisions of socioeconomic class, race, or sex, violence flourishes, and the more unequal the distribution the greater the

flourishing. All social classes experience violence, but people with the lowest socioeconomic status are consistently at greatest risk. More than 90% of all violence related deaths occur in low and middle income countries. Inequality always compounds inequality, and, as Wilkinson points out, the distributions of violence and of death from non-violent causes are closely related.³

The fundamental premise of the report is that violence is both predictable and preventable. The authors argue that more can be achieved by regarding violence as a problem of public health rather one of crime, and that politicians and decision makers in all countries and at all levels of society have a responsibility to make changes that will prevent violence and so protect health. A science based public health approach has considerable strengths. The painstaking collation of the available statistics from countries across the world

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