

Engagement of general practitioners in prostate cancer screening – learnings from PRAISE-U pilot sites

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Abstract

This article explores the engagement of family practices and general practitioners in prostate cancer screening in different pilot sites in the European screening implementation study PRAISE-U. Pilot sites showed variation in GP involvement, from central roles in patient invitation and counselling to more limited participation. These differences were associated with recruitment, patient trust, and continuity of care. The findings highlight that integrating primary care can enhance acceptability and uptake, but requires alignment with local workflows, incentives, and capacity. PRAISE-U demonstrates that tailored strategies for GP engagement are essential for implementing effective, context-sensitive screening programs across European healthcare systems.

Introduction

The Prostate Cancer Awareness and Initiative for Screening in the European Union (PRAISE-U) project started on April 1st, 2023 to evaluate how risk-based, population-based prostate cancer (PCa) screening can be implemented within national healthcare systems across five European pilot sites [1]. Understanding implementation in different healthcare settings is essential to ensure future PCa screening programmes are both effective and equitable. Here we review the role of general practitioners (GP) in the five pilot sites, their involvement in the PRAISE-U-screening pathway, and key lessons for future implementation.

Spain – Manresa/Althaia

In Manresa, the Althaia Foundation integrates primary and specialist care and serves approximately half of the local population. GPs are salaried, provide free healthcare based on a territory basis, and act as gatekeepers to secondary care.

The Manresa pilot adopted a GP-led approach. GPs promoted the study among the general population through videos, social media and posters, and also initiated recruitment by sending personalised invitation letters. They furthermore answered participant questions, guided men through the screening pathway and provided follow-up where the PRAISE-U algorithm stopped. Because most of the process was automated, the additional workload for GPs was limited.

The model proved successful, achieving a participation rate of 43%. Its strong integration with routine primary care and reliance on automation suggests that the pathway could be scaled up relatively easily in a future PCa screening programme, provided that sufficient GP capacity is available. [2]

Spain - Galicia

In Galicia, 97% of the population has public health insurance; GPs lead the primary care teams, the gateway to the healthcare system, combining active prevention with healthcare provision. Patients rely

heavily on their GP for information and shared decision-making. While GPs are not formally integrated into most cancer screening programmes -except for colorectal cancer-, they play a crucial role in informing, motivating and supporting participants.

Invitations were distributed centrally by CSG (regional government organization) through SMS and postal mail. GPs were not directly involved in the screening pathway but provided advice and follow-up outside the programme, helping many men decide on whether to participate. To support this role, GPs were provided with comprehensive information before the pilot began. In parallel, CSG reinforced the existing Programme of Preventive Activities and Health Promotion (PAPPS) recommendations on PSA testing to reduce opportunistic screening.

The pilot exceeded a 40% participation rate and demonstrated that a centrally coordinated screening model with a coordinative role by GPs is both realistic and scalable.

Poland

In Poland, GPs are the first point of contact for nearly all citizens, with almost all (97–98%) insured individuals registered in GP practices contracted by the National Health Fund. However, GPs do not formally manage cancer screening programmes.

GPs are involved in “Moje Zdrowie” (“My Health”), a national preventive programme including PSA testing for men over 50 every three years [3]. There is no nationally defined follow-up pathway after testing, and central systems record only that a PSA test was performed, not the results or subsequent care.

The PRAISE-U pilot introduced a structured screening model supported by GP practices and coordinated by the oncology center. A total of 93% of records received from GP practices are complete, compared with 72% from government data sources (Ministry of Digitalization).

Men contacted by the oncology center were often more receptive when informed that the invitation was issued on behalf of their GP. Most refusals were due to recent PSA testing rather than objection to PCa screening itself. Discussions with GP organisations resulted in a willingness to take responsibility for future screening activities.

Ireland

GPs play a central role in community healthcare and currently provide virtually all referrals to the country's eight Rapid Access Prostate Clinics (RAPCs) through an opportunistic pathway. As key stakeholders, GPs were engaged in the PRAISE-U pilot.

Nevertheless, GPs elected not to actively participate in PRAISE-U. Their main concern was that the project would create substantial additional workload related to surveillance of screened men without

adequate resources. The study protocol was therefore redesigned to implement direct invitations and home-based blood sampling sent in for PSA testing without GP involvement.

Experience suggests that programmes involving GPs are more successful in recruiting patients. Consequently, the future PRAISE-U+ program will involve a GP research body, allowing participants to choose between home PSA-blood sampling and GP-based testing. GPs will also be engaged in implementing the EU algorithm across their practices.

Lithuania

Lithuania has operated a national organised PCa early detection programme since 2006, with primary healthcare institutions responsible for identifying and inviting eligible men [4]. However, programme effectiveness has been limited by a lack of central coordination, insufficient monitoring systems and widespread opportunistic PSA testing outside the organised pathway.

The PRAISE-U pilot tested a centralised invitation model in two family medicine centers. Centers using personalised telephone outreach achieved almost twice the participation rate of centers relying solely on written information. This finding confirms that direct, proactive communication from primary care significantly improves screening uptake.

The pilot also highlighted the importance of a simple and efficient diagnostic pathway. As the most trusted point of contact in the healthcare system, GPs are ideally placed to encourage participation and support informed decision-making. The Lithuanian experience points to the need for three key investments: (I) coordinated infrastructure that supports practices according to capacity, (II) continuous GP education on programme benefits, and (III) meaningful financial incentives for outreach activities.

Conclusion

Pilots where the GP holds an active role demonstrate high participation rates. GPs can play a central role in organized PCa screening, acting as the primary link between the healthcare system and the male population. Their contribution extends beyond referral to include patient education, informed decision-making, motivation, follow-up and care coordination. The trust men place in their GP consistently improves acceptance of and adherence to PCa screening.

At the same time, successful integration requires organised, automated and adequately funded models that minimise administrative burden and reduce opportunistic screening. The evidence from PRAISE-U suggests that the most effective and sustainable screening programmes will combine centralised coordination with active GP involvement, leveraging primary care's unique ability to deliver equitable, efficient, and patient-centered PCa screening. Future research may focus on the drivers for active GP involvement.

Declarations

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Ethics approval and consent to participate

This article reports aggregated implementation findings from the PRAISE-U pilot sites and does not include identifiable participant data. Ethical approval and informed consent procedures for the individual pilot studies were obtained in accordance with the applicable national and institutional requirements. All pilot activities involving human participants were conducted in accordance with the Declaration of Helsinki. Details of the relevant ethics approvals are available in the documentation of each pilot site. No additional ethical approval was required for the comparative descriptive analysis presented in this article.

Consent for publication

Not applicable. The manuscript does not contain identifiable personal data, images or information relating to individual participants.

Availability of data and materials

The aggregated data supporting the findings of this article are presented in the manuscript and its table. Additional information regarding the PRAISE-U pilot sites may be made available by the corresponding author upon reasonable request, subject to consortium governance arrangements, applicable data-protection requirements and approval by the relevant project partners.

Competing interests

The authors declare that they have no competing interests.

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Author contributions

JV conceived the article, coordinated the comparative analysis and drafted the manuscript. AMTA, KT, DG and AP contributed information from the pilot sites and reviewed the manuscript for accuracy. HVP, SC, AC, MJR, RCNvdB and LDFV contributed to the interpretation of the findings and critically revised the manuscript. All authors reviewed and approved the final version of the manuscript and accept responsibility for its content.

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Tables

Table 1 is available in the Supplementary Files section.

Supplementary Files

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- [TABLE.docx](#)
- [AppendixA.docx](#)