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Cancer Screening in Primary Care: Obstacles for Physicians

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Cancer Screening in Primary Care: Obstacles for Physicians

While a high level of agreement exists for the majority of cancer screening guidelines, debate continues to be generated in two principal areas: breast cancer screening with mammography for women 40 to 49 and prostate specific antigen. Even in other areas of cancer screening, numerous studies demonstrate that many individuals have not received indicated screens, and increasing attention has been given to the identification of factors which impede primary care-based screening—often called screening barriers. Recognition of barriers is a key first step to designing interventions to increase primary care based screening rates. A recent study in the Department of Family Medicine at Jefferson was designed to delineate correlates of cancer-screening in an academic Family Practice Center.

Charts of women ages 40-75, enrolled in the Family Practice Center at Jefferson for at least 5 years underwent comprehensive abstraction. Recommendation and performance of PAP smears, mammography, flexible sigmoidoscopy, and fecal occult blood tests were recorded in addition to detailed information on many aspects of each visit, including whether the physician listed "health maintenance", or an equivalent term, or made entries on preventive health checklists, the type of visit (scheduled or acute), number of chronic health problems, patients' ages and type of insurance.

Performance rates for each test varied significantly. Of the 89 patient charts, the percentages for each targeted test that had at least one screening done were 72% for mammography, 64% for PAP smears; 43% for hemocults, and 2% for flexible sigmoidoscopy. Significantly more sigmoidoscopies and hemocults were recommended than were actually done. This suggests that important barriers to implementation following physician recommendation exist. Difficulty in scheduling sigmoidoscopy and a lack of acceptance by patients are two likely barriers.

Several studies of mammography utilization have suggested that physician forgetfulness is the leading barrier to utilization. In this study, recommendation for mammography occurred at a high rate; 87% of 94 charts revealed at least one recommendation for mammography. Of interest, however, is that only 72% of charts included evidence that a mammogram was actually performed. This unexpectedly large gap between physician recommendation and final implementation suggests that important patient and health care system barriers adversely impact mammography screening rates.

An analysis of the 12 charts with no recommendation for mammography over a 5-year period also suggests that characteristics of the patient and the encounter are important. Several of these individuals had multiple chronic health care problems or had made very few scheduled visits. In fact, the number of scheduled visits was significantly related to the total number of all types of screens performed. As the number of acute visits went up, the number of screens performed lessened. In addition, patients' charts included prevention aids such as health maintenance checklists had a higher number of successful screens.

Barriers to preventive care are key impediments to successful practice. The current study highlights the complex interaction of patient, physician, and health care system that results in or blocks successful screening. Future strategies should target acute care settings, settings in which preventive practices are rarely recommended. Other interventions that should be tested include chart-based prevention aids that employ checklists and reminders. Finally, patient-related barriers for mammography in patients presenting to a family physician may have been underestimated and demand additional implementation approaches.

About the Author

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