Patient Factors Limiting Success of Cancer Detection*

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The American College of Obstetricians and Gynecologists has established as one of its goals for the next decade the reduction of mortality from breast and pelvic cancer by 50% (1). Radiation therapy and surgery are the main modalities of treatment for most genital cancers. These modalities have advanced to the level of diminishing returns. Immunotherapy is in its infancy, and chemotherapy is presently used mainly for palliation and for prolongation of life except for a few malignancies, choriocarcinoma being the classic example.

Barring a monumental breakthrough, it appears that any major advance in improving mortality statistics will be the result of early cancer detection. Cancer detection involves many factors, but basic units in the scheme include the patient, the physician or his representative, and the facility in which detection procedures are carried out. It is safe to assume that most people do not need to be convinced that early cancer detection is a desirable goal. Many facilities exist such as physicians' offices, hospital facilities, and public clinics, all of which can figure prominently in cancer detection. One of the major unfulfilled objectives of cancer detection programs is the inclusion of all eligible patients. This requires motivation of patients in such a manner that they will seek out and utilize the available cancer detection facilities.

The Papanicolaou smear and routine pelvic examination have been shown repeatedly to be simple, reliable, painless, and widely available. Yet, only an estimated 50% of the eligible women in our community have ever had a Pap smear. There is an even higher proportion of post-menopausal women who have never had a Pap smear. It is precisely from this population that we see patients who have far-advanced tumors of the cervix at the time of their first admission.

What are the reasons for this apparent discrepancy between the availability of the means for early detection and the lack of utilization? This is the problem I would like to explore and make some suggestions for improvement.

If women are to participate in programs for early detection of cancer, there are several steps that must be taken. First, they must know about the program and its value. The dissemination of cancer information is a worthwhile endeavor, but education of the patient takes place in different ways. Certainly the cancer education program of the American Cancer Society, our public health agencies, our medical societies, and universities should not be abandoned, but to a great extent we are preaching to the "already converted." The women's clubs and PTA groups that often sponsor education programs by the local Cancer Society are composed largely of women who are already convinced of the value of early cancer detection. Most gynecologists in private practice are very concientious about performing regular pelvic examinations including Pap smears on their patients. Commendable as this may be, the number of positive smears obtained in this manner is not great, and occasionally one may wonder if it is worth the effort and expense to do smears once or twice a year on women who have had several previously negative examinations. Asymptomatic women who come regu-

* Presented by Dr. Goplerud at the 46th Annual McGuire Lecture Series, December 6, 1974, at the Medical College of Virginia, Richmond.

larly to the private gynecologist's office are basically a low-risk group for the development of cervical cancer.

One of the proven ways to screen patients is to combine screening procedures with services that the patients need and want. Mature women are either in the child-bearing years or post menopausal. We need to look at these groups separately.

The sexually active young woman is likely to be seen in a private office or a public clinic for either contraception or prenatal care. At that time she is very likely to have a Pap smear and pelvic examination done; in fact, it would be difficult for her to avoid it. Consequently, these patients have cancer-screening tests done as an ancillary service, not because this is their primary motivation for seeking care. In order to continue to get the care she wants, this type of patient is given return appointments and will have repeat examinations and smears done.

If these young, sexually active women have an abnormal smear, follow-up examination is usually recommended. Consequently, the patients referred to our Anaplasia Clinic are most commonly drawn from this group. It is not difficult to do effective cancer screening if you are providing a service that patients desire and will seek out.

The post-menopausal woman of 65 who comes in bleeding from a Stage III-b cancer of the cervix does not fall into any of the categories related to pregnancy. All too often she gives a history of having her last encounter with a physician at the time of her last delivery some 30 or more years previously. Why don't these patients come in for examination? We must examine the motivation and understanding of the medically-indigent, middle-aged, and post-menopausal woman, since this is the group that has the greatest need for cancer screening and also shows the poorest utilization of cancer-screening services.

Sociologists tell us that motivation in medically-indigent patients is related to many factors (2, 3). Fear of surgery, fear of cancer, and ultimately, fear of death are important. The pressing problems of immediate day-to-day life such as obtaining sufficient food, clothing, and adequate shelter often preclude concern for a possible future problem which could be prevented by such measures as cancer screening. Lack of knowledge about the availability of screening procedures and their possible significance is important, but although patients often are aware at some level of these measures, they still do not take action. If patients are to be convinced that they should seek medical care when they do not have symptoms, they must be made aware that the disease in question can affect them. They must also be convinced that the disease is curable and prevention is better than treatment for the active disease, even though cure is likely.

One of the common reasons given for not seeking a Pap smear is that the patient feels well and equates the lack of symptoms with good health. Most patients in this age group are aware that cancer-screening examinations are available. However, some patients are afraid that if cancer is found, an operation may be recommended. In one survey, many of the patients interviewed felt that cancer was essentially incurable and therefore there was little to be gained by finding out the bad news earlier than necessary. Other patients feel that the test may be painful or that they will be subjected to indignities in a clinic situation. Fear that surgery will cause some interference with sexual function is a common concern. These beliefs and attitudes have been found consistently in ghetto populations by numerous surveys (3).

The woman who is asymptomatic must first learn about the availability of cancer screening. The commonly used mass media such as radio, television, and the press are not particularly effective in reaching the ghetto population which is at highest risk. These women are more often influenced by personal contact with friends and relatives and by their own personal experiences in health facilities (3).

The patient should then be made aware that she is a possible candidate for the development of cancer. Subsequently, she must be convinced that treatment is effective and that she could benefit from such treatment if it were necessary.

Utilization of services will be improved if the clinic facilities are located in areas close to where the patients live. Convenient hours must be arranged. This often means having clinics open in the evening.

Finally, let us consider the woman who has symptoms which might logically suggest the possibility of cancer but who delays seeking care. We have recently attempted to interview some of the patients who were admitted with cancers which obviously have been present for long periods of time in an effort to learn more about the reasons why the delays occurred.* Fear of learning the diagnosis and fear of the

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consequences of treatment rank high on the list of reasons for patient delay. One nulliparous patient stated, "I think if I had had a baby I would almost have had to go to a doctor then, and maybe I would have continued to go after that. I guess I just have always been scared to go to the doctor because of what he might find." At this point the patient described some of her relatives who had died from malignant disease. She went on to say, "My friends and neighbors have been after me for a long time to have an examination and so had my doctor. I have been going to see him every three months for blood pressure examination. He would offer to do a pelvic examination each time I would go for my yearly physical, but I would say no. My friend had told me how painful the exam was and I would get nervous when I went to the doctor. He was young and I just didn't feel right. He would examine me otherwise and I always had no problems. It is all my fault. If only I had listened to my friends and my doctor."

Another example is that of a patient who had bleeding for many months before seeking medical attention. This patient was a very religious woman who felt that her faith would heal her and probably interpreted the presence of symptoms as some sort of punishment. The patient stated, "When your time comes to die, you must go. If the Lord had taken me two weeks ago I would have been ready." There is a fatalistic attitude here as well as religious fervor.

Interestingly enough, the patient underwent surgery with complete removal of all visible tumor. She had an uneventful recovery and was assured that she had a good prognosis. In spite of the outcome and the long delay on her part, she was very reluctant to give any credit to the people who cared for her in the hospital.

In the 1974 edition of its Manual of Standards for Obstetrics and Gynecologic Services in Accredited Hospitals, the American College of Obstetricians and Gynecologists makes the following recommendation. "Good medical practice clearly warrants the establishment of cytologic screening as a hospital routine. It is therefore recommended that regardless of the service to which she is admitted, every female hospital patient who is age 18 or over or is sexually active should have a pelvic examination and a cervical-vaginal cytologic smear unless a negative smear has been recorded within a year. To implement this program, it is essential that hospitals make smears readily available and make every effort to encourage their routine use."

Along this same line, there are now three states, New York, Illinois, and Hawaii, that have passed legislation making the Pap smear mandatory for all women who are admitted to the hospital who fit into the categories outlined in the ACOG recommendations (4). It seems likely that similar legislation may be forthcoming in other states. There is no reason why departments of obstetrics and gynecology in any given hospital cannot exert pressure on the hospital administration and the rest of the medical staff to incorporate requirements such as these in their hospital bylaws. Certainly a voluntary action of this type would be more acceptable to most physicians than to have it forced upon them by legislative decree.

The question immediately arises as to who shall perform these Papanicolaou smears on women who are admitted to services other than Gynecology. The nurse practitioner programs which are developing in several medical centers may provide one answer to this problem. A number of hospitals have employed such individuals to do routine Pap smears on all female admissions with good patient acceptance and good results. Any patient is given the opportunity to refuse to have a smear performed if she has some personal objection. In addition, any woman who has had a smear performed by her private physician within the year prior to admission is not required to have a smear done provided the cytology was negative (4).

A program of this kind would not solve the entire problem, but it could be a significant step in the right direction. Patients admitted to hospitals constitute the captive population that is most accessible and the one over which we as physicians have the most control.

Summary. Patient education is an important part of preventive measures and is most likely to be effective when provided in a health-related setting. Cancer-screening services are best utilized when they are combined with other health services that the patient needs or desires. Convenience of health services such as location of clinics, convenient hours, and the attitude of health workers are significant factors. Captive populations such as hospitalized patients, inmates of institutions, individuals who must take employment physical examinations, etc., may be utilized to achieve more complete screening of the population at risk. The influence of friends,

neighbors, and relatives can not be overestimated. Efforts must be made to utilize these influences in a positive way. Finally, all physicians are urged to push for routine Pap smears on female hospital admissions as a voluntary program in their own hospitals.

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