Conclusion

After thirty-five years in medical practice I have attempted (I am afraid in a very muddled way) to paint a picture of a peculiarly difficult problem in human relationships—namely, the triangular one between the patient, the doctor, and the State. A perfect solution depends upon an agreed philosophy of life, but unfortunately that does not exist. Compromise is therefore essential. Now I must have said much with which you will not agree. I may have made statements which you positively dislike. You may think that I have painted the darker corners of medical practice in too sombre colours. But I have raised questions which must be faced. True that I have given you no answers to any of them, but I venture to hope that I have helped you toward a better understanding of the problems being raised by the power of medicine which, to adapt again Mr. Dunning's famous motion in the Commons, "has increased, is increasing and is likely to increase still further.

THE CANCER PATIENT: DELAY IN SEEKING ADVICE

BY

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AND

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Cancer of the breast, cervix uteri, skin, or mouth usually presents symptoms which a patient can recognize and for which early successful treatment is a practical possibility. Yet of 2,700 patients attending this hospital with cancer in these sites 45% had delayed consulting their doctor for three months or more, and 17% for a year or more, after the onset of symptoms. This article describes a study of factors which influence people with these cancers to delay seeking advice. The study is based on the interviewing of a series of 75 men and 239 women patients and their relatives, resident in Manchester, Salford, and Stockport, and attending this hospital. All the interviewing was carried out by one person (J.A.-S.).

Interpretation of facts obtained by these means is inevitably subjective. Sometimes more can be learned in a few minutes from a relative than from several interviews with the patient. Conclusions are not based, therefore, on the patient's statement alone, but on all the evidence available. In addition, 63 patients were tested by the Wechsler–Bellevue method of intelligence testing to ascertain the relationship between individual I.Q. and delay.

Early in the study it appeared evident that there were two clear-cut groups of patients: (1) those who "knew" they might have cancer, and (2) those who were genuinely ignorant of the possible significance of their symptoms. The mental processes of these two groups are entirely distinct. Nevertheless, it was sometimes far from easy to place individuals into the correct category, especially as those in the first group often tried to hide the truth. The degree of awareness of a symptom, and the extent to which people will consciously accept what they suspect to be the truth, are dependent on personal factors. Shands *et al.* (1951), describing three levels of knowing, say: "(1) A person may be in the possession of a number of facts that are not related to each other; he may know, for instance, that 'a lump may be a cancer,' and 'I have a lump,' without arriving at the conclusion, 'I may have a cancer.' (2) He may have taken the initial step of the relationship but stops short of translating the insight into action. . . . (3) A third level of knowing is that characterized by the integration of the pertinent information into the behavioural patterns of the individual."

In the present study a patient is considered to have known if there is evidence that at any level she thought of cancer in relation to her symptoms before consulting a doctor. Patients who "knew" can be subdivided according to a characteristic positive or negative response—those in whom fear is the dominating factor, and those who fatalistically accept the situation and mean to do nothing. The former group may offer a series of superficial reasons for their delay, and some of these are discussed later. Basically, these patients are motivated by fear, and their actions, wise or unwise, represent response to fear. As will be seen, fear may result in immediate action, as it ought to, but more often it leads to an only half-conscious policy of concealment and appropriate rationalization. The latter group, usually older people, are well adjusted to the situation which they do not deny.

Where there is genuine ignorance clearly no such factors operate, and delay, if it occurs, represents a normal response to the problems of health and illness which would take place regardless of the type of disease. At this point it may be noted that if education masters ignorance it may only result in a transfer to the other category.

It appeared later that the fraction falling into the two categories of "knowing" and "not knowing" varied greatly with the type of cancer, category 1 being dominant for breast cancer and category 2 for cancer of the cervix, skin, and mouth. This is, of course, an important finding in regard to the placing of emphasis in any educational campaign.

The average length of delay and numbers delaying three months or more are significantly higher among patients who knew than among those who did not know. This is not to say that they necessarily all delayed because they knew. Naturally, delay is also influenced by the degree of inconvenience suffered. The figures may therefore also reflect the fact that, generally, cancer of the cervix and mouth present troublesome symptoms earlier than cancer of the breast or skin.

Table I sets out an analysis of the whole material divided with as great accuracy as possible on these lines for the four diseases under review. In 19 cases it was impossible to determine on the evidence available whether the patient "knew" or not.

Action Related to Ignorance

Where the first symptom was not a lump in the breast women with breast cancer were apt to mistake the possible significance of their symptoms. Enlargement or swelling of the breast, a lump in the axilla, or retraction of the nipple was genuinely attributed to old lactation difficulties, menopausal disturbances, or recurrence of previous complaints. Even where the first symptom was a lump, in some cases the history was long and the lump unchanging. In addition, some put off through apparent indifference about their symptoms. They did not think the condition important, and allowed it to drag on owing to pressure of other events, and possibly low health standards and a low level of intelligence.

TABLE I.—*Delay of Patients who Knew they had Cancer and those who did not, by Site of Disease*

Site	Total	Knew	Did Not Know	Indeterminate	Delay								
					Under 3 Months			3–12 Months			12 Months and Over		
					Total	Knew	Did Not Know	Total	Knew	Did Not Know	Total	Knew	Did Not Know
Breast	127	92	31	4	52	32	17	36	27	9	39	33	5
Cervix uteri ..	80	18	51	11	47	9	32	22	4	15	11	5	4
Skin*	62	8	52	2	30	3	26	12	0	12	20	5	14
Mouth	45	8	35	2	26	3	22	12	5	6	7	0	7
Total ..	314	126	169	19	155	47	97	82	36	42	77	43	30

* Squamous-cell carcinoma and malignant melanoma only.

One case typifies this group.

A young woman did not bother about the lump in her breast until it began to "fester." Her husband agreed that they were not people to go to the doctor unless they had to. She complained of trouble with her eyes, he said, but she had not had new glasses for 20 years—she did not bother. She suffered from bad headaches, her husband suffered from stomach ulcers, and their little girl was delicate, with asthma and "nerves." Having been treated, this patient characteristically failed to respond to follow-up appointments.

Altogether one-quarter of the women with breast cancer did not realize the possible significance of their symptoms.

Almost two-thirds of the women with symptoms of cancer of the cervix were similarly ignorant. Naturally enough, younger women predominated in this group. Nineteen out of 20 pre-menopausal patients did not suspect cancer. Women of all ages from 35 to 65 attributed their symptoms to "the change," other reasons given being emotional upsets, strains, after-effects of confinement, and recurrence of previous gynaecological complaints.

Well over three-quarters of patients with skin and mouth cancer were ignorant of the nature of their symptoms. The patient with these symptoms had usually gone to his doctor (or dentist) before anxiety was aroused about the condition. Delay in these patients reflected their attitude to "doctoring," there being a general reluctance to seek advice for what seemed an exceptionally trivial matter.

Not all the 169 patients who were ignorant delayed—in fact, 46 had consulted their doctor within a month of the onset of symptoms. Further analysis showed that in over half these cases the reason for this prompt action was that the symptoms were too troublesome to neglect (flooding, painful mouth, etc.), relatives had insisted, the patient was under the doctor already or had gone about something else. Only 19 had gone within a month on their own initiative about symptoms which were not yet severe, and which they did not suspect to be cancer.

Action Determined by Fear

In essence the breast story exemplifies the fact that women do know as a matter of public knowledge that a lump in the breast is dangerous. Why the minority with cancer of the cervix, skin, and mouth suspected cancer while the great majority were ignorant can be broadly classified (Table II).

TABLE II

A disposition to worry about cancer, through having relatives or friends with the disease in same or other sites	10
Symptoms discussed with friends (in 3 cases a trained nurse) who suggested frankly the possibility of cancer	8
Mill-workers aware of danger of spinners' cancer ..	2
Patient a trained nurse	1
Read about cancer in paper	1
Other	12
	34

The reaction of seeking immediate advice appears to be related to age rather than to "knowing" or "not knowing," or to intelligence. Younger people predominated in this group. Of all those who acted immediately, 18 were psychologically tested, and in this group are to be found the highest and lowest scores obtained in the test. About the same proportion of patients who suspected cancer as of those who were ignorant sought advice immediately, or within one month of noticing symptoms—32 out of 126. These were mostly patients who had found a lump in the breast, and all but three went on their own initiative about symptoms which were not yet severe. Although these 32 had admitted to themselves the possibility of cancer it must be noted that not all sought advice with any sense of urgency. Two comments were: "It did occur to me afterwards that I wished I'd put it off a bit longer." "I thought people with cancer were wasted and ill. I wasn't ill and I wouldn't have bothered, but my daughter said if anything happens to you everything is going to come on me, so I went."

Only 15 more patients acted before the end of the third month.

The group which constitutes the main challenge to any public education project are the 79 who, though suspecting cancer, incurred substantial delay before seeking advice (three months and over). Four types of psychological reaction can be clearly seen in 68 of these patients (in 11 instances the data are inadequate). Almost half (36) had adjusted themselves psychologically in various ways to the threat of cancer. Thirty-two others delayed through a fear which inhibited action, and were in a state of conflict and anxiety. Usually some circumstance outside their own control had finally got them under medical care.

One patient in this later group, aged 59, delayed for a year after finding a lump in her breast. She "didn't tell a soul," for she knew her husband would insist on fetching the doctor. She fomented the discharging lesion and dressed it without looking at it—"I was terrified of it being something serious." Her husband, eventually noticing what was going on, fetched the doctor in spite of her insistence that the condition was improving. This patient had been an elder daughter and had nursed an ailing mother for 30 years. This experience of invalidism which had shadowed her life, and uncomprehending fear of the concept of cancer, were factors influencing her initial delay. Having delayed, feelings of guilt at "deceiving her husband" and wilfully neglecting herself made it increasingly difficult, as time passed, for her to take action.

Another patient, aged 40, found a lump in her breast and "didn't know what to do." She was "worried sick" and she readily admitted: "I concealed it from everyone." Faced with this calamity, for she never doubted it was cancer, she reacted on an emotional level and with no intellectual insight and therefore with no ability to work out the problem realistically. The emotional shock was too great and her personality a little too vague and ineffectual to integrate this new factor, and she was quite literally "ill with the worry of it." She was admitted to hospital for treatment for her stomach ulcer, and the breast condition was discovered then.

The following three common defensive reactions were noted.

Denial.—Seven patients denied to the interviewer and apparently to themselves that the condition could be serious, and they denied the implications of the disease, which were that it would not get better by itself, and that if left untreated it would kill them. They had ignored advice to see a doctor; their minds were already made up. Yet the very emphasis of their denial and the advanced stage of their disease belied their statements.

A single woman aged 43, pleasant and reserved, gave an impression of speaking with sincerity. She appeared to be on good

terms with the relatives with whom she lived. After being very fit for 12 years she developed a lump "like an abscess" in her breast. "I never thought it was anything I could not cure myself with lint and ointment, and I honestly never dreamed of worrying about it." The medical history described a huge, fixed cancer with wide skin involvement and ulceration. The smell from this lesion had become so noticeable that her relatives, to whom she had said nothing, insisted on fetching the doctor. Now here, she asked no questions, she was feeling better, and she presented an equable and completely blank front against any disturbing implications.

Suppression.—Eighteen patients did not deny that the condition was serious, but they rationalized it and did nothing. Two expressed this mechanism forthrightly. "I did think it might be cancer, but I shook it off." "I just put it right out of my mind. I didn't think of it and I didn't intend to until it hurt."

A retired ladies' companion delayed a year, when, instead of returning to her doctor as instructed, she delayed a further two years. She had always tended to put anything unpleasant away from her, she said. She felt that "cancer was a disease that people got who were dirty or who had done something wrong." The whole subject was distasteful to her and she did not wish to think of it. She had dismissed it from her mind while the lump in the breast caused no trouble, and she had two good reasons for doing so. First, she could not afford private care, and "objected to being put on show"; then, "and I don't tell this to everyone, there was no one but myself to look after my little dog."

Acceptance.—These 11 patients were mostly elderly. The severity of their symptoms alone finally induced them to seek advice. They were not looking for cures.

A patient aged 78 said: "I didn't want to be upset about it. I'm not expecting to be cured, you know."

Another old lady, living alone, said: "At my age, what was the use of bothering?" She felt that to give in to illness meant dependence on others, and she said with great feeling: "I couldn't have people coming in and running about for me."

A patient aged 76, with five years' delay, summed up the views of this group: "It didn't hurt and I'd turned 70 and had my span of life."

Some had a hard attitude to illness, regarding it as a weakness and making a virtue of "not giving in." It was something to put up with and not to complain about. In most of the stories of these older patients, however, was anxiety about dependency, about "being sent away" and losing their rooms or houses. So much depended on their keeping going, and they saw no hopeful outcome if they let themselves get into the hands of the hospitals.

Whatever the defensive reaction, fear is probably at the bottom of all delay that is not due to genuine ignorance. It sometimes derives from something concrete, childhood experiences, cancer in relatives, etc., but more often it is the reflection of a kind of cultural fear—a herd instinct rooted in prejudice and ignorance. Patients naturally have not thought it out in terms of "fear of what?" The fear of cancer is vague and is therefore usually expressed in some more concrete, secondary (or rationalized) basis. "Reasons" for delay include fear of "doctoring" and hospitals, operations, dependency, leaving home, "being sent away," losing a job, leaving a young family or a sick husband. These are more immediate and tangible and more easily expressed. They are an important part of the total situation, but it is difficult to know, had there not been fear of cancer in the background, if the patient who "knew" would have delayed for these "reasons." They are mentioned briefly in the section that follows.

Other Factors Influencing Action

Fear of Doctors and Hospitals.—Practically all the patients spoke appreciatively of their general practitioner. Yet this did not prevent expression of strong prejudices against "doctoring" in general; this attitude, and a "dread" or "horror" of hospitals, played a considerable part in delay, especially among older patients. Sometimes this feeling derived from childhood or adult experiences, and the reasoning was simple: they were hurt or frightened in hospital and they would not go again. Those who were most afraid were often those who had never been in hospital but were full of alarming hearsay. Sometimes a patient's fears were not so much of going into hospital as of leaving home. Some housewives had become homebound, seldom going out on their own. They may have feared that their condition was cancer, but if it did not trouble them a much greater fear was of "being sent away." Another aspect of the dislike of "doctoring" was the patient's feeling that she would be found to be making a fuss about nothing. "They think you're mithering if you keep going," expressed a common attitude.

Fear of Operation and Treatment.—Mixed up with fear of hospitals was the fear of operations and treatment, allied with doubt about the value of such procedures. Patients would say that they knew that cancer is sometimes cured, but this theoretical knowledge did not affect their tendency to delay. Over a quarter of all the patients spoke of fear of operations in connexion with their delay. Most were speaking of operations in general; others were referring specifically to radical mastectomy. Some said this was no worse than any other operation, but to some the mutilation aspect was deeply disturbing. Age was not always a factor in this. Fear of operation "because it makes it spread" was frequently met with.

A patient aged 72 said: "I don't believe in cutting, and I was expecting this if I went to the doctor." She had had a slow-growing lump in the breast for six years, and thought it would not be much bigger by the time she was 80.

Another patient said: "I always feel that if you're cut there it just goes on and you have to have more done—the beginning of a long process leading to the end." She had known two women who had died following radical mastectomy. "People seem to think it best to leave anything that doesn't hurt, and not stir it up," said another. "People believe that even if they have this operation it is just the beginning of a lot of trouble."

Friends and Relatives with Cancer.—It is difficult to say what influence looking after or having relatives with cancer will have on the patient's own subsequent behaviour when symptoms occur. Most of the relatives and friends mentioned had died, but even when some had done well this fact does not seem to have helped. The fear of cancer is such that while a bad outcome may have an adverse effect a good outcome seems to give little encouragement.

A patient had accompanied to hospital a friend who had found a lump in her breast. She had thought at the time how sensible her friend was to see to it at once. The lump was removed and the friend had no further trouble. A few years later our patient found a lump in her own breast, which she concealed from everyone until it ulcerated.

Another patient, whose mother and sister had both died of cancer of the breast, claimed complete ignorance of the significance of a lump she had found in her breast. Later, she gave away unintentionally the fact that she had known. Her sister had lived for ten years after treatment, but our patient considered it a failure. She was not prepared "to go through such painful treatment for nothing."

Domestic Difficulties.—In many cases where the reason for delay was said to have been domestic difficulties other factors were clearly involved, but in some this did appear to be an overriding consideration. Apart from domestic crises causing delay there were the housewives who had never before left their families. They felt that the accustomed pattern of life could not be upset.

"It is easy to tell other people, but it's so difficult when it comes to yourself. If it had just been myself to think of, or if it had been painful, I'd have seen to it sooner, because I did know it was dangerous to leave lumps. But I've been thinking too much of the family. I just couldn't go off and leave them to manage on their own."

Not Realizing the Need for Early Treatment.—Many patients knew in theory that they should not delay with a "lump," but there was much ignorance about whether it

was safe to delay so long as it did not hurt. Other patients, thinking the condition ultimately incurable, saw no reason to hurry.

A brisk, talkative patient of 40 had heard cancer education talks, which she thought most useful. Her father had been successfully treated for cancer of the mouth, and was now "wonderful." This patient developed a lump in her breast. "Of course, naturally your thoughts fly right away to cancer, don't they?" She delayed nine months. "I kept it to myself because I didn't want to worry my mother. I've had to tell her now, of course, but I was attending classes and I'm an active club worker—you know how you keep putting off. I definitely knew I mustn't leave it too long, for then perhaps nothing could be done. I just became conscious of the lump and made up my mind one night that it was time to see the doctor."

"I believe something can be done if things are taken in time" (delay of three months). "I knew I must get it seen to, as otherwise it might spread" (delay of one year).

Ending of Delay

Delay here is arbitrarily defined as three months or more, and this analysis concerns the 79 delayers who suspected cancer and the 72 who did not. One point stands out. Patients who "knew" tended to seek advice only when forced to do so by the severity of their symptoms. Most of those who did not know had sought advice before that stage was reached. Nevertheless, a quarter of the latter came under medical care only when their symptoms were severe. It was not, therefore, through fear of cancer that they delayed. Other factors were present—fear of "doctoring" and hospitals, waiting to see, shyness, "elderly neglect," etc., which contribute to delay whatever the disease. In a considerable number of cases the action of others ended the delay, the patient being unwilling to seek advice. The main circumstances in which delay was ended are given in Table III.

TABLE III

	Knew	Did Not Know
Patient's initiative, symptoms too painful or troublesome to ignore longer	39	18
Patient's initiative, symptoms not severe	11	21
Action of relatives or friends	19	18
Condition found by doctor, patient intending to conceal it or not bothering	6	5
Other	4	10
	79	72

Shands *et al.* (1951) mention the element of chance in the circumstances which finally decide the patient to seek advice—the "magic" intervention for which he waits. This is a very real thing. A number of patients in this series mentioned such chance happenings. From the point of view of cancer education it is an important aspect of the delay problem, for it would appear that a patient may have heard talks about the danger of "lumps" and do nothing about her own, yet months later she may go to her doctor suddenly because of a chance remark by a stranger in a queue, or because "I happened to be passing a gate with a doctor's name on it, and I just thought I would go in and ask him if he would tell me what it was." Chance stimuli are effective when the patient is already predisposed to act but is procrastinating. Education may help in the process of predisposing without necessarily providing the stimulus—this may come on a more personal level.

Relation Between Delay and Intelligence

To see if there was any relationship between delay and intelligence as measured by an accepted test an additional investigation was carried out among 63 women with breast and cervix cancer, aged under 60, who were up and about. Out of 68 asked there were five refusals (Table IV).

The Wechsler–Bellevue intelligence scale has been very much used in England for testing adults and has been standardized separately for people of different ages. This means that a 50-year-old patient is being compared with a wide variety of other people of 50, and not directly with younger or older people. The construction of the test does not draw too heavily on educational achievement or the ability to use words.

TABLE IV

	Group Tested	Total Group Under 60
No delay or under 1 month	23	44
Some delay, 1–3 months	15	26
Delay of 3 months or more	25	59

There is no evidence that the patients with the highest scores did not delay while those with the lowest scores delayed the longest. Scores obtained by patients who had delayed a year or more are spread over the middle of the range, with perhaps a slight tendency to have higher than average scores. Results expressed in terms of the product-moment coefficient by Pearson's method give a figure of 0.18, which is not significant. It is concluded, therefore, that there is probably no significant relationship between delay and intellectual level as measured by this test.

Discussion

It has been shown that over half the patients with cancer of the breast, cervix uteri, skin, and mouth did not suspect cancer when they first sought advice. Some of these sought advice only when the symptoms were severe or troublesome. Action, therefore, depended on individual standards of fitness and the level of ill-health they were prepared to put up with. They delayed through ignorance, and we do not know what they would have done had they suspected cancer.

We do know, however, what a group of patients who suspected cancer from the beginning actually did. Nearly two-thirds delayed three months or more, while one-third delayed a year or more. This delay is greater than that found among those who did not suspect cancer. More patients who suspected cancer sought advice only when the symptoms were severe.

Prima facie, it might be argued from this that people are better left in ignorance. This might be so if they were in the habit of going to their doctor promptly with symptoms which are not troublesome and which they do not take seriously. However, it has been shown that this is not a sufficient stimulus in a large enough number of cases.

Harms *et al.* (1943), discussing causes for delay of cancer patients attending an American hospital, say that it is noteworthy that fear of cancer played a minor part. "The major cause for the patient delay is primarily lack of proper information on the cancer problem. . . . Thus the failure of the educational programme to furnish the patient with sufficient information may be held responsible for delay in at least 85% of the cases." Earlier they say: "The median delay for patients who thought they had breast cancer was 3.25 months, while the median delay for all breast cancer was 6.5 months. This suggests that the delay could be halved if all patients were aware of the significance of their symptoms." If this is so education in America has succeeded in reducing the fear of cancer which is so largely responsible for the delay of patients who "knew" in the present series. Our study has shown no ground for assuming that, given adequate information on the significance of symptoms, people in this area—particularly women with cancer of the breast—would as yet react "rationally." Cancer education here, in addition to its purely informative role concerning significant symptoms, still has the more fundamental task of convincing those who suspect cancer that ultimately they will be better off if they seek treatment soon. It has also to influence the deeper and more primitive level of thinking, with its "magical," moral, and retributive elements.

Lack of confidence in what can now be done for them is clearly an important factor in the delay of patients who suspect cancer. Two things which appear to contribute to this lack of confidence are the fate of the advanced patient and the policy of medical silence about cancer.

From the point of view of influencing people to come earlier for treatment the fate of the advanced patient has an adverse effect. As Donaldson (1952) points out, an enormous number of people are brought into direct contact with cancer every year through nursing relatives dying at home. Their attitude and that of the group around them are influenced by these experiences. At the time of increasing anxiety when the patient begins to go downhill the hospital may give him a longer appointment, and his own doctor, it is sometimes alleged, "doesn't seem to take the same interest now." Perhaps he cannot get a bed in hospital, and living conditions may be unsuitable or squalid. He may be inadequately sedated. Worst of all is the feeling that nothing is now being done for him. This is cancer as the general population knows it—unpleasant, incurable, and rejected. These are not entirely welfare considerations; they have a direct bearing on the public's lack of confidence in what can be done for the cancer patient.

A policy of silence regarding a diagnosis of cancer is maintained in general in this country in the supposed interests of the patient. Is this done at the cost of diminishing public confidence in the value of treatment? The fact of palliative treatment is not understood, and hospitals appear to be trying to cure all their patients and failing in a high proportion of cases. If the patient does well the condition "cannot have been cancer." The known cured cancer case is a rarity. This is not the place to discuss what should be done about it, but the fact is entirely relevant to the findings of this study. It is clear that one of the causes of delay is lack of confidence in the efficacy of any treatment. In some way or other it must be brought home to people that some types of cancer are not only curable but are being cured in early cases.

Summary

A study, based on detailed interviewing of 314 patients with cancer of the breast, cervix uteri, skin, or mouth showed that approximately one-half delayed seeking advice for three months or more, and a quarter for a year or more, after first noticing symptoms. Most of the patients with breast cancer suspected they had cancer; patients with the other three types of cancer were, in the main, ignorant of the significance of their symptoms. There was greater delay among those who suspected cancer than among those who did not. Two quite distinct processes operate to cause delay.

1. *Ignorance.*—Here, delay in seeking advice clearly reflects the patient's general attitude towards "doctoring" and has no special relationship to cancer as such.

2. *Fear* (of cancer).—This is clearly indicative that, in some degree at least, the patient really "knows" the probable nature of the disease. Such fear may trigger a reasonable response and make for "immediate" action. Much more often, in the group analysed, it inhibited rational action and was the underlying factor causing delay, although this was camouflaged behind a variety of more superficial ostensible reasons. Testing by the Wechsler–Bellevue intelligence scale indicated that there was no significant relationship between delay and intellectual level as measured by this test.

These distinct and mutually exclusive attitudes to the different diseases must be recognized in any schemes for public education in this field.

We are indebted to Mr. J. C. Kenna, lecturer in clinical psychology, University of Manchester, for advice on psychological testing, and to Miss E. F. May and Mrs. P. F. R. Venables for carrying it out.

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EARLY CANCER DETECTION AND EDUCATION: A PILOT TRIAL

BY

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Every clinician in the field of cancer finds that a large proportion of patients coming for treatment at present must be classed as "late" cases, in which radical cure cannot be expected. Our thesis is that many of these cases could and should have been diagnosed and treated at a much earlier stage. Efforts to reduce the delay have been on two main lines: (1) education of the public by suitable propaganda, and (2) medical examination.

Present Investigation

The Ministry of Health, in a recent circular, considers public propaganda inadvisable at present but favours local exploratory schemes to enlarge our knowledge of the possibilities.

We have sought to combine some of the advantages of both the above methods—education and examination. We feel that cancer education is desirable, but should be conducted as personally as possible between physician and patient. Education and medical examination can and should be carried out together.

It was decided to offer all the patients between the ages of 40 and 70 on the National Health Service list of one of us a brief examination conducted specifically to detect early accessible cancer and to combine this with an effort at education in the cardinal symptoms of malignant disease. The women were invited first.

Circular letters were sent out in batches, offering free medical examination; stamped envelopes and reply forms were enclosed. The word "cancer" was avoided at all times, if possible, as being in itself a potent agent of distress.

Female Patients

Invitations were sent to 766, and 422 (55%) accepted. This, we felt, was a very satisfactory response. The examinations were carried out in batches of about 20 at one session a week, lasting about 2½ hours. The patients' National Health Service cards were available to assist rapid visualization of their histories.

After taking a careful menstrual history, with special reference to heavy or irregular bleeding and discharge, leading questions were asked concerning the following: regularity of bowels, unusual constipation or diarrhoea, blood in motions, piles, abdominal pain, sore places in mouth or throat, dysphagia, dysuria, haematuria, cough, hoarseness, moles or warts, lumps or swellings, usual weight, smoking habits.

If the answers appeared unsatisfactory, further inquiry was made and all the facts were noted. The mouth, tongue, pharynx, and larynx were then examined, including indirect laryngoscopy, and the neck was inspected and palpated. The patient then passed into the undressing-room, where she was instructed to take off *all* her clothes and to put on a dressing-gown provided. She then passed on into the examination room, where the body was inspected, the