

PRACTICE OBSERVED

Investigation of non-responders at a cervical cancer screening clinic in Manchester

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Abstract

Uptake of cervical cytology screening in a Manchester practice has been very low (14%) in spite of the family practitioner committee introducing a call and recall system. A questionnaire was used to investigate the attitudes of non-responders, who were all from social classes IV and V. Attendance was found to be inhibited by a high level of anxiety about the test and about cervical cancer, by erroneous beliefs, and by concurrent family difficulties. More than half the non-attendance was directly attributable to administrative errors, which resulted in appointments being sent to wrong addresses or to inappropriate people (four after hysterectomy, 10 who had had recent smears). These matters require urgent attention.

Several simple measures might improve attendance at clinics, follow up of patients, and attitudes toward screening: invitations to attend the clinic, a register of patients and results, a simpler version of the leaflet, use of well known personalities to promote cervical screening, health education campaigns, and regular evaluation of records.

Introduction

About 4000 cases of cervical carcinoma and about 2000 deaths occur each year in England and Wales.¹ Unfortunately, mortality has fallen only slightly since the start of the cervical screening programme in Britain. This disappointing result may be due to the fact that the women who are most at risk fail to attend for smear,^{2,3} particularly women in social classes IV and V,⁴ in whom cervical cancer is five times as common as it is in women from professional classes.⁵

To combat this failure Manchester Family Practitioner Committee recently set up a cervical screening call and recall system for all women aged 35-60, offering a smear test at their local family

planning clinic or their general practitioner's surgery. The response to these invitations has been poor—for example, at Beswick Health Centre, Manchester, only eight out of 58 eligible women (14%) attended for a smear. I therefore undertook this study to find out why so many women failed to attend at that particular centre.

Methods

The records of all 50 non-responders were obtained, and their addresses and details of any previous smears were checked with the family practitioner committee. Age and social class were recorded. A questionnaire was devised with five aims:

- (1) To determine the attitudes of the non-responders towards the invitation for the screening test and the accompanying explanatory leaflet.
- (2) To explore their knowledge about the test and about cervical cancer.
- (3) To elicit their reasons for not attending.
- (4) To find out whether there were any practical problems—for example, with the time or place of the appointment.
- (5) To ask about preferences regarding the sex and professional status of the person performing the test.

The intention was to interview all the non-responders in their homes, where the questionnaire would be administered and the screening test and cancer of the cervix explained. For various reasons (see below) only 17 women were finally interviewed.

Results

The age range of the non-responders was 35-66, and all came from social classes IV and V. Twenty seven had not had a smear previously.

WOMEN NOT INTERVIEWED

Thirty three women were not interviewed, for one of three reasons:

- (1) Several women failed to attend for a smear because of administrative error; the general practitioner had not informed the family practitioner committee of a patient's change of address (four), a recent smear (10), or hysterectomy (four) or the family practitioner committee had not acted on notification.

- (2) Fifteen women could not be traced: their house had been knocked down (four) or boarded up (one), there was no record of existence of the road

(two), they had moved away without leaving a forwarding address (six), or contact was not made after several visits at different times of day (two).

(3) Four women refused to be interviewed or to have a smear, though they all expressed anxiety and indeed seemed anxious and agitated. None of these four would discuss any aspect of preventive health care, nor could they apparently understand why appointments had been made for them.

RESULTS OF INTERVIEW

In the end 17 women were interviewed. Their attitudes to the invitation and the explanatory leaflet were as follows:

The invitation—Twelve of the women expressed terror at having received the invitation. They did not understand the reason for it, but all assumed that they had cancer of the cervix and that the doctor knew this.

The explanatory leaflet—Four women did not receive the leaflet through error, two had not looked at it, and 11 thought it self explanatory (but to have adopted this attitude some of them might not actually have read it). All women who had received the leaflet produced it. Two thought that the leaflet had increased their anxiety. Only one of the 17 women had never heard of the smear test or the screening programme.

Having read the leaflet, three women decided not to have a smear. These women, aged 55, 60, and 60, were all widows. They were well and content with their health. All believed that investigations usually showed abnormalities that required further tests that would cause unjustified anxiety. The 14 others were all in theory willing to have the test but decided not to for one or more of the following reasons: fear of discovery of cancer (nine) or other disease (two); embarrassment (seven); fear of the procedure (three); fear of objection after previous experiences (two); and other commitments (eight). In some cases these specific objections were linked with more general ones—for example, concurrent family problems (other cancers, recent bereavement)—and these women saw the smear test as something else to add to their list of troubles.

The questionnaire explored knowledge of cervical cancer and attitudes to the screening test. Five women thought that cervical cancer was incurable, and one knew nothing about it at all. Four thought that it was not a problem in Manchester. Four others had read about cervical cancer in magazines or newspapers and accused the media of an overly sensational approach. A high proportion (10/17) would not have been prepared to have the test done at home, even supposing they were persuaded of its value. Five would have agreed only to have the test performed by a female doctor; one would have preferred a male doctor; six would have preferred their general practitioner to another doctor; and four would have been happy for the test to be done by a nurse or midwife.

After their interview eight women accepted new appointments and six of them attended for smears, all of which were normal. Three women said they would like to make their own appointments, and, of these, one attended for further discussion, but none had smears. Three women developed minor illnesses after having the smear taken and ascribed these to the test in each case.

Discussion

In this study the initial response of 14% to postal invitations for cervical screening was increased to only 42% by personal interviews. These results are in striking contrast to those of other studies—for example, the uptakes of 88-96% recorded in Bury and Stockton on Tees.⁵⁻⁷ More than half of the poor response was the direct result of administrative errors on the part of the practice or the family practitioner committee or due to incorrect addresses—an important factor in Beswick, where slum clearance and rehousing are rife. Rehousing has previously been found to be the cause of non-response in one fifth of all cases.⁸

The families registered with the Beswick practice were predominantly from the lower socioeconomic classes. There was a high level of anxiety and of concurrent social and medical problems within this group, and it was common for women who received invitations to attend for screening to assume that they had cancer. Fear that cancer might be discovered was an important factor in the failure of many women to respond to the invitations. The accompanying leaflet did little to allay these fears and in many cases may not have been read. Simpler leaflets are needed, designed specifically to dispel these misunderstandings. They should be freely available, and it would be a good idea to distribute them with the leaflet that is given to new patients registering with the practice.

The screening test for cervical cancer is an intimate examination,

so the preferences of patients are important. There was some evidence of preference for a female doctor, but, surprisingly, only four women said that they would be prepared to have the test done by a nurse or midwife and 10 women rejected the idea of having it done at home. These findings suggest that arranging for a midwife or nurse from the practice to do the test in the patient's home is unlikely to improve the response rate.

Several recommendations arise from this study:

Firstly, in practices with low attendance at cervical screening clinics a simple letter should be sent by the general practitioner requesting attendance at the surgery. The colour of the invitation should be pink; this was found in a study in West Sussex to be the most appealing colour.⁹

Secondly, a cervical screening register is required. This would contain all results of smear tests and the relevant information about notifying patients. Patients should be asked to telephone or visit the surgery four weeks after their smears to obtain the result. Information about abnormal results would not be given over the telephone, but the patient would be asked to visit the general practitioner. Should the patient not call to ask about the result within two months notification would be sent by post. The register must be in a form that readily allows forward planning of smear clinics. Abnormal results need to be tagged in some way to ensure that they are not overlooked, and the course of action should be clearly shown in the record. A register of non-attenders would facilitate follow up visits by staff in the practice to increase uptake by persuasion.¹⁰

Thirdly, notes of women not responding to the invitation to attend the clinic for a smear test should be flagged to allow screening whenever the opportunity arises.

Fourthly, a simpler version of the leaflet about cervical screening should be produced. It should be one page long and in itemised form. A Medicaid, issued by the general practitioner and showing smear state and other important medical information, might help to increase the perceived importance of the test.

Fifthly, well known personalities can change attitudes. For example, the photograph of a well known female television personality has been used with success to promote cervical screening in Nottingham. This idea should be extended and efforts made to use other popular television personalities with whom this group of women could identify. Their photographs might be reproduced on the leaflets about cervical smears.

Sixthly, to change attitudes basic knowledge about cervical cancer and the screening test must be improved. This could be achieved by a health education campaign aimed at school leavers, college students, health centres, and community centres. Simple leaflets should be freely available in the waiting rooms of surgeries.

Finally, the general practitioner should be encouraged to evaluate the records carefully and regularly to ensure that they contain the correct information and that this information is promptly imparted to the family practitioner committee, which must act on this information efficiently.

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