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Engaging Patients and Their Partners in Preventive Health

Behaviors:

The Physician Factor

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In 2008, approximately 62 480 people in the United States are expected to have developed melanoma, which is now the sixth most common cancer in men and women.¹ Men aged 70 years or older have the highest probability of developing melanoma, 1 in 64.¹ Of the 8420 anticipated deaths from melanoma in 2008, older men will be disproportionately represented.^{2,3}

MELANOMA: RISK FACTORS AND BARRIERS TO EARLY DETECTION

A growing body of sex-specific studies shows a trend among men, especially white middle-class men, of delaying seeking help when they become ill.⁴ By delaying seeking care, men present at a later stage of melanoma when it is no longer treatable. The benefit of early detection, which led to improvement in the mortality rate in women from 1991 to 2004 (from 1.82 per 100 000 to 1.70 in 2004), has not been realized with men, whose mortality rate of 3.80 per 100 000 in 1990 increased to 3.94 per 100 000 in 2004.¹ Among the possible reasons for the higher mortality rates in older men are sex differences in cognitive variables, such as lower knowledge and awareness of melanoma and less-favorable attitudes about preventive health care behaviors, which can lead to fewer skin self-examinations (SSEs) and regular physician visits. In addition, the anatomic location where melanoma commonly occurs in men, the back, as opposed to the lower extremity in females, is not easily seen by the person. This anatomical site difference makes opportunistic self-discovery of the lesion less likely for men⁵ and increases the need for men to either engage a partner to help do skin checks or have regular physician surveillance.

This editorial discusses the best practices of early detection of melanoma in relation to current research findings. The identification of gaps in the literature and the need for future research in relation to early detection through intervention efforts are also addressed. Specifically, 2 issues are highlighted: (1) the need to examine the impact of training patients on how to conduct SSEs on early detection outcomes and (2) exploring how enhanced physician-patient communication may facilitate patients' participation in their own care and improve health outcomes.

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THE ROLE OF SSEs IN THE DETECTION OF MELANOMA

The 3 publications by Swetter et al^{6,7} and Geller et al⁸ (hereinafter, the Swetter group) in this issue of the *Archives* explore intriguing patient factors regarding the discovery of melanoma by middle-aged and older men.⁶⁻⁸ As we consider these articles, we note that 73% of the patients were enrolled at the University of Michigan, and 74% had early stage IA or IB melanoma with a 5-year survival of 95%. Men with stage IIA, IIB, or IIC melanoma, who have an anticipated 5-year survival of 50% to 80%, represent 26% of the population in the Swetter et al⁶ study. Men presenting late in the course of the disease (stage III) with an expected 5-year survival of 10% to 50% were not enrolled in the study; therefore, it is not possible to explore the variables that may have contributed to presentation late in the course of the disease. One to 3 months after the diagnosis and prior to the consultation with the physician, male patients with melanoma and their accompanying spouses separately completed a self-report survey. Men who demonstrated a proactive interest in health matters, indicating that they paid attention to their health, regularly took an interest in reading or watching news stories about health topics, or carefully paid attention to information about skin cancer detection, were more likely to present with tumors less than or equal to 2.0 mm in thickness than those with tumors greater than 2.0 mm in thickness. In comparison, in those presenting with thicker tumors, the proactive health attitudes of the men with tumors less than 2.0 mm in thickness were not manifested as a statistical difference in seeking screening for skin cancer or carefully examining all moles.⁶ Thus, it seems that although these men have an interest in health issues, this interest is not being translated into personal preventive behaviors. Despite the evidence that such attitudes are related to presenting at a physician's office earlier, which has been associated with more positive long-term treatment outcomes, the mechanisms underlying the lack of impact of the same attitudes is less clear for those individuals with more advanced melanoma. These findings taken together underscore the complexity of cognitive influences on behavioral and treatment outcomes and highlight the need for further study prior to drawing definitive conclusions about their preventive value. Among the cohort of men with melanoma, 95% of the physician-detected melanomas of the back were less than 2 mm in depth compared with 63% of self-detected and 76% of partner-detected lesions among patients.⁸ The latter findings are consistent with an earlier report⁹ documenting that physicians had the most success finding thin, early-stage melanomas. However, in contrast to the articles by the Swetter group,⁶⁻⁸ the population-based study by McPherson et al⁹ found that melanomas detected in locations visible to the person during *deliberate skin examinations* by lay people were more likely to have more favorable depth than melanomas discovered incidentally.

Although there are the customary concerns about recall bias and generalizability of the findings from the study populations, these studies beg the question of what contributes to delays in seeking help or why there is a lack of evidence suggesting that lay persons can detect melanomas of the back less than 2 mm in depth compared with high rates by physicians. There are many potential explanations for these outcomes. First, the lay individuals in the Swetter group⁶⁻⁸ and McPherson et al⁹ studies were not systematically trained to conduct SSEs. Therefore, it is possible to draw a conclusion that when individuals who are expertly trained, over the course of many years, with countless experiences supervised by other experts (eg, physicians), are compared with individuals who have no benefits of training, experience, and supervision (eg, participants) the former group clearly outperforms the latter. This conclusion would seem to be obvious in any other profession as well (eg, professional homebuilders do better quality work than weekend hobbyists). Should anybody find the results of the Swetter group⁶⁻⁸ and Mc Pherson et al⁹ surprising? A more compelling contrast would be to compare these same well-trained physicians with lay persons who have received moderate or minimal training, experience, and supervision. We would still expect the physicians to perform better under these circumstances, but would the

gap between the 2 groups change so that we would observe clinically significant increases in the numbers of individuals seeking earlier health care with treatment having more positive long-term health outcomes? Such studies have not been conducted but clearly should be before any conclusions can be drawn about the potential inadequacy of laypersons' SSEs.

Second, these studies were not designed to include measures on the quality or thoroughness of the participant-reported SSE to identify positive or negative decision-making approaches. Without a more thorough examination of the processes participants utilize, there is a missed opportunity to reinforce accurate SSEs and correct misperceptions that might improve future SSEs. Physicians have the benefit of supervision when being trained, which serves these purposes and effectively improves their diagnostic skills.

Third, participants were not encouraged to invite their partners to help with the skin check in hard-to-see areas. The literature^{10–13} is unequivocal about the benefits of having well-trained partners conduct skin checks in hard-to-see locations. Individuals cannot identify potential melanomas in areas of the body they simply cannot see, but well-trained partners may be able to. We still might expect physicians to perform better than trained partners, but again, only further research can answer the question of whether well-trained patients and partners result in clinically significant increases in the numbers of individuals seeking care earlier and who receive earlier treatment that may be life saving.

Swetter et al⁶ are commended for finding that men have limited awareness of melanoma warning signs as well as the practice of SSE and are not likely to request skin cancer detection materials from the physician. Wives are more likely than husbands to be aware of the ABCD rule, to have read about skin cancer detection, and to perform SSE. The women ensure that their husbands see a physician and help them with SSE.⁹ For male patients, the female partner may become the provider of health care in the home. An identified barrier to seeking health care is men's socialization to be independent and conceal vulnerability.¹⁴ The tasks associated with seeking help from physicians, such as relying on others, admitting a need for help, or appearing vulnerable, may be in conflict with some individuals' societal and normative beliefs that men are self-reliant, physically tough, invincible, and in control of their destiny. For example, some men may be thought of as the "strong, silent type"; thus, they are reluctant to make a fuss over a little mole or to admit their fear that something could be wrong, even to themselves. This latter issues leads to the question of how physicians can interact with their patients in a manner that overcomes some of these interpersonal and psychological barriers to improve treatment outcomes.

THE IMPORTANCE OF PHYSICIAN-PATIENT COMMUNICATION IN ENHANCING SSEs

The barriers to men developing positive preventive health care attitudes and regularly seeking mole checks with a physician make a compelling argument for involving the female partner in the continuing care of the man with melanoma. Because most dermatology care occurs in the office-based setting where patients and their partners play an active role, it is possible to interact with the couple during a brief educational and skills training intervention that enhances self-efficacy and promotes performance of SSE.^{10–13} Skills training helps "tune" lay visual perception to that of the dermatologist. For example, training may consist of pointing out an irregular border of a benign nevus to patients and their spouses, which affirms their perception and encourages them to check their moles. Patients recognize that physicians are authoritative sources of health advice and report a willingness to take a physician's advice.¹⁵

Physicians counseling patients to check their moles may raise awareness of the need to do so, but teaching the skills to be able to perform SSE builds self-efficacy and results in performance. The dermatologist, who monitors performance of skills and provides repetitive education over a series of patient visits, reinforces the message using consistent images and words, actively engages the patient, and provides support for sustained behavior changes. Including the patient's partner in discussions is informative for the partner, who is listening to the interaction between the physician and the patient. The partner may clarify concerns during the visit, support implementation at home, and help the patient to cope with having a potentially life-threatening disease and being at risk to develop new melanomas.¹⁶ Communication of clear directions is especially important when the patient is fearful, anxious, or depressed, as may be expected when he or she is dealing with having a melanoma.¹⁷ For elderly patients, it is helpful to provide written directions with large print and to encourage the accompanying partner to jot down important instructions so they are carried out at home. At some point in the visit, it is important for the physician to check with the patients to find out if they are able and willing to check their skin. If the patients decline to state they are able or willing to perform SSE, then the physician can terminate SSE education.

How physicians communicate with patients and their partners may be as important to the therapeutic outcome as diagnosing the disease and recommending appropriate care. Physicians frequently fail to recognize the emotional and social problems their patients face, like depression, anxiety, and fear (Table).¹⁸ Dermatologists, who diagnose and treat a patient with an early melanoma, see an outwardly healthy-appearing person. Some may counsel patients by saying there is "nothing to worry about." Our attempt to provide reassurance has the unintended consequence of shutting off discussion of the patient's concerns and relevant questions. By failing to address the possible future deterioration of the condition, we do not provide information about how to check for a return of the melanoma at the site of the resection. Furthermore, the diagnosis of melanoma has the potential to change all aspects of the individual's life, including his or her self-identity, perceived sense of well-being, and social relationships. One of the consequences of the resection can be a change in body image. Even when the scar is imperceptible by medical standards, patients may feel a psychological impact and perceive themselves as disfigured.

Physicians who fail to recognize the importance of the way in which information is conveyed do not engage and empower the patient with the necessary skills to become active participants in their care. The lack of information about their condition often leaves patients unable to make informed decisions, which can demoralize them and hinder treatment. If the patient is told to check the skin for changes in moles but not told what changes should prompt a visit with the physician, then there is the potential for needless visits to the physician or failure to seek care if a change is noticed. Another barrier to the physician-patient relationship may arise in the event that the melanoma returns at the site of the resection. Out of frustration with an inability to cure the patient, the physician may label the patient as noncompliant because she or he did not properly follow the care plan, which included SSE. It is very difficult for physicians to perceive themselves as being partly responsible for non-adherence; however, in some cases "nonadherence" is not an accurate description of patient behavior, and misunderstandings can be avoided with enhanced physician-patient communication.

The importance of establishing a strong, trusting physician-patient relationship and using patient educational materials that are designed to motivate without overly stressing risks in promoting adherence to a care plan was recently discussed by Ali et al.¹⁹ We have observed practicing dermatologists expressing interest in patients by inquiring about their families or vacation plans to establish a physician-patient relationship. Physicians can build rapport

with their patients by asking questions relevant to patients' dermatological care. Some examples include, "Tell me your thoughts about doing skin self-examinations," "What do you do to protect your skin?", and "What concerns you about your skin?" By asking these types of questions, physicians can gain valuable information in an efficient manner while expressing genuine interest in their patients. Patients' answers to these types of questions may provide physicians with an opportunity to educate patients about SSE, sun-protective behaviors, and/or increased risk factors relevant to patients' needs. By asking about concerns, the physician may uncover fears that can be dispelled or depression that can be treated. A strong, trusting physician-patient partnership can be established by demonstrating empathy for the effect of the disease, difficulty performing SSE, and anxiety about the future. Our care of the patient with melanoma can be improved by delivering:

The right message, one that empowers the patient

At the right time, when the patient is ready to learn

By the right person, the physician or some other well-trained individual

To the right people, the patient and the partner.

In conclusion, based on research to date, we know physicians are most likely to detect melanomas in the earliest stages. It is important for individuals, particularly those at an increased risk of developing skin cancer, to have regular skin examinations conducted by their dermatologist. However, more research is needed to evaluate the impact of training patients on how to conduct SSEs in relation to improving early detection of melanoma among laypersons. In addition, examining physicians' ability to educate, train, and promote self-efficacy among their patients through brief interactions is also a promising area of future investigation. Overall, a multifaceted approach is the most promising way to improve the early detection of melanoma and in turn, optimize outcomes.

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Table

Physician-Patient Communication: Helping the Patient to Hear What You Mean

While Doing a Mole Check, the Physician Says:	Patient Perception	Rephrasing Example	Why Rephrasing Is Beneficial
"Don't worry about that mole, it's OK."	"The doctor dismissed me. I feel stupid for asking. No need to think about it anymore. No need to do skin self-examination."	"This mole is not skin cancer. It is actually called a benign nevus, which is not harmful. Benign nevi do not turn into skin cancer. Even benign nevi can have a bit of an irregular border. Since this is the only unusual feature of the mole, you can be confident that it is benign."	Inform patient it is not melanoma or NMSC. Identify the characteristics of the mole that make it benign. Inform patient what potential changes (if any) would be concerning. The patient will most likely feel relieved he or she does not have cancer and it is a helpful SSE teaching opportunity.
"I think it's OK. If the mole starts to change, we can do a biopsy then."	"What can be done to be sure? How will I know it changed? Who is watching it? What are we watching? I want to do the biopsy now to be sure it is not bad."	"This mole is most likely not melanoma, but I can't be sure. I would like to monitor it for change during the next 3-4 months. Come back to let me check it in 3 months. If it changes (gets larger, more shades of color, or seems to "grow legs" from the edges), I recommend doing a biopsy. A reason not to do a biopsy now is the possibility that the biopsy will create an unsightly or uncomfortable scar. In the meantime, examine and measure it each month and call us if it gets larger, etc."	Involve patient in monitoring plan and explain the course of action. Try to be specific when describing "changes to look for." Give the patient a rationale for decisions (eg, reasons to wait to do a biopsy). Patients who can participate in their care (ie, SSE) and understand the course of action are likely to feel more empowered rather than helpless.
"Let me do the worrying for both of us."	"I do not have to take responsibility for my health."	"You seem very worried. Feeling concerned is natural, but as we continue to monitor the mole (receive information about the biopsy results) we will develop a plan based on the information we have instead of worrying about the unknowns."	Trying to protect the patient isn't helpful to him or her. Patients need to be informed of their risks so they can make informed decisions about their health. In addition, patients can become an active participant in their own care if given the opportunity. Acknowledging patients' concerns and involving them in the care plan, whether it is SSE for monitoring the mole, waiting for biopsy results, or discussing treatment options for melanoma may provide them with a sense of control.
"The chance of the mole ever turning bad is very small."	"What does the doctor mean by "bad"? What is very small?"	"The chance of the mole turning into melanoma is about 5%. While it is not likely, it is still a good idea to look for changes during your regular skin exams. If you notice changes during SSEs, call our office."	Words and phrases like "bad" and "very small" may lead to confusion and anxiety, in patients. For example, "very small" may be a 5% chance to a physician, but the patient may interpret it as a 25% chance. Communication between you and the patient can be improved if less ambiguous words are used.
"You want me to give you the chances of you surviving this melanoma. I do not like to put numbers onto things. The numbers give estimates for lots of people, but there is only 1 of you. Either it will be OK or it won't. There is no need to live your life by some number."	"Give me a range. Is it 2%, 20%, or 80%? If I am not going to make it, I need to be able to make plans for my family."	"It seems like it would be helpful for you to make sense of everything if there were percentages to go along with your diagnosis. Your melanoma is classified as a stage IIA and has not spread to your lymph nodes. The average 5-year survival rate for a similar diagnosis is 70% to 80%. It is important to understand that this is an average number and individuals vary on preexisting health conditions and other factors that may impact those rates."	Some patients may want percentages, while others find them overwhelming. Framing the message in terms of survival is generally preferable. While it can be hard to deliver less than optimal results about patients' health, patients need to know the information in order to plan and choose from treatment options. Providing patients with accurate information in a way they can process it best and learn from it can be helpful. If you are not sure, ask patients what they prefer.

Abbreviations: NMSC, nonmelanoma skin cancer; SSE, skin self-examination.