Cervical screening in general practice: a "new" scenario

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The new scheme

For many years government policy on remunerating general practitioners for taking smears was to pay for smears taken from women aged 35 or older. Only one smear between each successive fifth birthday qualified for payment. Smears taken from younger women qualified for payment only if the woman had had three pregnancies.

One of the aims of the new contract is to increase the uptake of cervical screening in women aged 25-64, who will be called for screening at intervals of five and a half years. There are two targets offering different rates of payment, a higher one if general practitioners manage to take smears from 80% of women in this age group and a lower payment if they reach 50%; there is no payment if the lower target is not reached. The difference in payment between the 50% target and the 80% target is substantial, so just missing the bull's eye can be very costly. The table shows an example of payments to a practice with 430 women in its target population.

Example of payment under new contract

Target population	Percentage (No) smeared (n=430)	Payment to doctors (£)* From 1 April 1990	From 1 April 1991
Women aged 25-64 in England (21-60 in Scotland)	<50% (<215)	0	0
	50%-<80% (215-343)	734	760
	≥80% (≥344)	2202	2280

*Details of the complex calculations of targets and payments are contained in the family practitioner committee statement of fees and allowances, paragraphs 28.1 to 28.13.

To qualify for payment, smears must have been performed on patients on the general practitioner's list and taken by any member of the practice who has been trained to take smears, including doctors, nurses, and locum doctors acting on behalf of the practice. Smears taken outside the practice by other authorities do count towards the target payment.

At present each practitioner must reach the targets on his or her list irrespective of the targets of other partners in the practice, but this may be changed to allow other partners' smears to be counted together towards the target. The family practitioner committee will request the general practitioner to provide details of smears performed on his or her patients, irrespective of where the smears were taken.

Setting up a screening service

General practitioners should aim to identify, reach, invite, and screen the eligible female population on their practice lists.[1] The target population can be identified from an age-sex register or a register held on the practice's computer. The family practitioner committee can provide names with details of the history of smears if these are not already in the practice system. It is then necessary to set up the cervical smear register to enable quarterly additions and deletions of the changing cohorts of women and to update smear details on those already in the system. This can be done using a Kardex system or a computer. Each eligible woman should have her surname, forename, date of birth, address, and smear details on this card or on a computer entry. Smear details should include date of sampling, name of laboratory, slide number, date of reporting by the laboratory, result, and date of next recall. All ineligible women (including those who have moved away from the area) need to be identified and deleted from the practice target, and the family practitioner committee should be informed of such actions.

Flagging or tagging records of patients who are on the cervical screening register is a useful technique in helping to identify other patients who have slipped through the net. It also helps in removing patients' names from the register when they move away from the practice.

The administration and documentation aspects of the smear register should be familiar to at least three members of staff but run mainly by one of them. This system allows good continuity: if one member is away then another can step in.

Ideally, doctors and nurses should be specially trained to take adequate smears and perform pelvic examinations at the same time. In addition, a good knowledge of family planning and contraception and well woman screening procedures, coupled with a good knowledge of menopausal and postmenopausal problems, is important.

Accommodation and equipment should include suitably equipped rooms that are warm, clean, well ventilated, and well lit and that provide privacy and have comfortable couches. There should be a suitable supply of equipment including spatulas, endocervical brushes, speculums, and sterilising facilities. The delivery system for transport of slides to and from the laboratory and the purchasing, ordering, and reordering of disposable items and their storage and distribution in the practice must be carefully organised. Good liaison with the laboratory is an important part of the process.

Who should be screened in an ideal service?

A woman should have her first smear taken within a year of first having sexual intercourse, and smears should continue at three year intervals (or earlier if suggested by the cytologist or if the woman is at high

Target groups

From 1 April 1990: women born between 2 April 1925 and 1 July 1965 inclusive.

From 1 July 1990: women born between 2 April 1925 and 1 July 1925 will be excluded from the target and women born between 2 April 1965 and 1 July 1965 will be included; subsequently, each quarter an older cohort will leave the target population and a new younger cohort will enter it.

Exclusions: women who have had a hysterectomy (general practitioners will need to notify the family practitioner committee that such patients on their lists are ineligible for "clinical reasons"); and patients who are registered temporarily.

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risk). Taking smears can stop if a woman has had three consecutive negative smears leading up to her 70th birthday and if she no longer has sexual intercourse. Women over the age of 70 who are sexually active should continue to have regular smears.

Squamous cell carcinoma is the predominant type found in cervical cancer. It is associated with being or having been sexually active and therefore unlikely to be present in virgins. However, virgins can have a much rarer variety of cervical cancer, adenocarcinoma, which is mostly found in women aged 60 to 70. It is vital that virginal women have a smear if they experience any unusual vaginal discharge or bleeding from the genital tract as this can be a sign of cancer anywhere in the genital tract.

Getting patients to the surgery

The wording of invitations to women due for a smear needs to be carefully thought out to enable them to understand the importance and benefit of being screened at regular intervals and to encourage other women to do the same. An invitation that has met with some success is one that coincides with a woman's birthday and is sent as a congratulations card offering a well woman check as a "birthday present" from the practice. Each invitation contains a definite appointment date (which should be entered in the appointments book) and requires the patient to confirm that she is coming or to contact the practice to change the date. The envelope containing the information should be stamped with the practice's name and address so that the letter can be returned if the patient has gone away or changed address. This also helps to identify those patients lost to follow up. This invitation technique of a ready booked appointment is more likely to trigger some kind of positive response than simply a recall invitation, which the patient may put off indefinitely.

Offering and recording smears

When a woman of appropriate age newly registers with the practice the doctor should take a full case history, identify the date and result of the last smear, and enter the patient into the smear register whether she is due for a smear or not. If the patient is due for a smear, offer to perform one straight away or make a firm appointment for one to be done in the near future.

A woman attending for reasons unconnected with cervical cytology should have the date of her last smear checked and if appropriate be offered a smear on the spot or a future appointment. The details should be entered in the register or computer and the patient's record flagged. Opportunistic cervical smears can also be offered during health promotion clinics for women such as a well woman clinic or preconceptual planning service or a hormone replacement therapy clinic.

Smear details should be entered into a register that includes the patient's full name, date of birth, date of smear, which member of the practice performed the smear, and the address to which to send the result. The smear should have a serial number, which should also be written on the smear report form: thus when the results are returned they can then be easily entered into the register as well as the patient's records. A regular check through the register will also show which results have not come back.

Slides should be labelled with the patient's surname, forename, and date of birth and the date the smear was taken. Accompanying forms should also have the patient's address, date of last menstrual period, and relevant history of hormones given, contraception, and cervical intraepithelial neoplasia, if any. These details are important to the cytologist, who sees the cells and not the patient and yet has to make recommendations for recall.

Informing women of their results

Women should always be informed of their smear results. Patients should be given a date by which to expect written notification of their results. After this date they should call the surgery if the results have failed to arrive. The patient's present address should have been registered at the time of taking the smear and an addressed, stamped envelope left in her records. The envelope should also bear the practice's address in case the patient suddenly changes her address without notifying the practice and the result fails to reach her.

The format and content of the results need careful wording. If the result is normal it should be clearly and immediately stated that "The result of your cervical smear taken on ... showed NO EVIDENCE OF CANCER." This should be followed by a date on which the patient should book an appointment or the practice will send for her.

If the result is abnormal but not precancerous (for example, due to thrush or inflammation) the letter can begin similarly and then include the exact wording of the laboratory report followed by an explanation of what the words actually mean. If the smear is positive a similar explanation should be given, along with a request for the patient to see the doctor and have the results properly explained and follow up action taken.

Problems in meeting the target

There may be an inflation of the general practitioner's target as a result of women who are on the list but who have changed their address and cannot be traced by the general practitioner. Smears taken outside the practice (at hospitals, private clinics, the workplace, or other screening services) will reduce the effective target still further. Women who refuse to have smears (including virgins, those who are afraid or embarrassed (especially in the presence of male doctors), or those who believe themselves to be immune to the disease) pose further problems in meeting the target.

Smears performed for no remuneration

Smears for which the general practitioner receives no remuneration include those on women within the target group who will need more frequent smears, at intervals of three years or less; on women outside target groups who are under 25 years or over 64 years and who are at risk and need to be smeared (see box for recall recommendations); and on temporary patients, who present a mobile at risk group and who may be lost to recall and follow up. Such women should be offered opportunistic smears when they present as temporary residents at the surgery for whatever reason. At present, one in 20 smears taken in our north London practice are from temporary patients, which indicates a large group of migrating patients at risk.

Furthermore, if a smear is described as "inadequate" as a result of there being too few cells for the cytologist

Approximate time required per patient per smear	
Booking an appointment	2 minutes
Taking a smear in the practice	15 minutes
Administration, processing, documentation	10 minutes
Laboratory processing and documentation	90 minutes
Processing result on its return to the practice	8 minutes

Result of cervical smear	Recommendation
Inadequate specimen (lack of cells, unclear smear, air dried smear)	Repeat smear immediately
Normal smear: endocervical cells present	Recall in three years; recall in one year if: first ever smear in postmenopausal woman; previous smear reported as abnormal, positive, inflammatory, or dyskaryotic; previously treated cervical intraepithelial neoplasia; genital warts present on patient or partner; promiscuous sexual history of either partner, particularly if drug abuse is involved; immunosuppressive treatment given; hysterectomy for cervical malignancy; heavy smoker (>20 cigarettes per day)
Normal smear: no endocervical cells present	Recall in one year
Inflammatory smear	Treat infective organism in patient and check for presence in partner; repeat smear within one year after treatment.
Persistent inflammation	Refer for colposcopy (one in five such smears may hide cervical intraepithelial neoplasia)
Atypical smear	Repeat smear in six months: if persistent, refer for colposcopy
Atrophic smear	Indicates oestrogen deficiency (hormone replacement therapy may be needed). Recall in three years. If atrophic changes are severe treat with oestrogen (10 μg ethinyloestradiol orally for 10 days); repeat smear after treatment. If atrophic changes persist, refer for colposcopy (changes may hide or be a sign of cervical carcinoma)
Dyskaryotic smear (mild, moderate, severe)	All dyskaryotic smears should be referred (urgently if severely dyskaryotic) for colposcopy
Carcinoma in situ	Urgent referral for colposcopy
Endometrial cells	If present during the second half of menstrual cycle or in postmenopausal women, refer for colposcopy and dilatation and curettage to exclude endometrial carcinoma.
Glandular endocervical cells	Refer for urgent colposcopy
Glandular neoplasia	Refer for urgent colposcopy and dilatation and curettage
Herpesvirus	Yearly recall
Human papillomavirus (wart virus)	Yearly recall

to make a report or the smear being air dried or obscured by blood (which may not be the general practitioner's fault) the general practitioner will not be remunerated for providing a repeat smear.

If the cytology laboratory is understaffed, by the time the general practitioner gets results back it may be too late to include them for submission in his or her target results. Abnormal or positive smears may take longer to be reported because they may be examined by three people in the laboratory, which can lead to further delay.

Recall suggested by the cytologist will often be more frequent than that qualifying for target payments; these smears are done solely for the benefit of the patient with no remuneration involved.

Cessation of recall

There is no need to recall a patient who has had a hysterectomy for a non-malignant condition if before that hysterectomy she had a normal smear and if the removed uterus and appendages were also non-malignant. Recall can also cease in a woman of 65 years and older if she has ceased having sexual intercourse and since the cessation has had three consecutive negative smears, the most recent one being in the previous three years, and if she has no undiagnosed irregular vaginal bleeding. There is no upper age limit for screening a woman who has never had a cervical smear.

Conclusion

The difficulties in setting up an efficient screening service and reaching the practice targets means that many general practitioners will be unable to meet the government targets for payments for smears. Yet these general practitioners may still be performing many smears and providing a valuable service for which they will now find themselves out of pocket in comparison with their remuneration before the target payments were introduced.

Given that a screening service costs the practice a great deal in terms of time and money, the new targets may act as a disincentive to some general practitioners, who reason that they will be unable to reach the new targets and therefore will not bother to perform any cervical screening at all. The situation could be improved by paying general practitioners for all smears performed, with bonus incentive payments given to general practitioners who manage to reach the two target tiers currently suggested.

The government is to be applauded for trying to improve the efficiency of the cervical screening service, but whether general practitioners—and, most importantly, the patients—actually benefit in the long run remains to be seen.

1 Chomet J, Chomet J. *Cervical cancer*. Wellingborough: Thorsons, 1989.

THE MEMOIR CLUB

It has become the fashion to concentrate attention on people who show recurrent social failure. These people deserve our help, but they are, relatively speaking, a dull lot, providing little scope for profitable pattern analysis. At the same time fashion dictates that we should look with something approaching scorn on the successful achievers. This is bad natural history and bad social science. First, effective compassion can only be built on a great body of positive achievement. This achievement provides the bricks and mortar for all effective humanitarian action. Secondly, the whole of human progress depends on striving after excellence in an infinite variety of areas. It is thus both more interesting and more useful to study the natural history of those who have made or are making a major contribution to humanity. The achievers show up their characteristics much more clearly than do the passive, the enfeebled, and the opters out.

At one point in my career I was able to identify a small but coherent group of manifest achievers. As under secretary of state for commonwealth relations and colonies in Harold Wilson's first government, it was part of my job to meet and see off visiting commonwealth premiers and prime ministers at London Airport, so I had many good opportunities for gossiping with the great. I soon found that whereas premiers and prime ministers vary greatly in interests, intelligence, and education, they have three things in common—energy, toughness, and a delight in talking about themselves. So the long hours passed pleasantly enough and I learnt a good deal about the holding and exercising of power.

Of my collection of approximately 20 commonwealth premiers and prime ministers, three were doctors (two of them general practitioners and one an orthopaedic surgeon), over half were lawyers, and a third had been university teachers. Though some were exceedingly intelligent, all except one found it wisest to hide their light under a bushel. Political leaders are almost always selected by their colleagues, and politicians are suspicious of choosing those they consider "too clever by half."

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