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Colorectal cancer screening: How to help patients comply

Strongly recommending that a patient be screened and addressing commonly held fears are among the 7 ways you may be able to improve compliance

Practice recommendations

- Be more assertive about the need for screening with patients at risk, and do not rely solely on patient-education materials to communicate the message.
- Address key issues such as fear of pain from colonoscopy, costs and comparative benefits of different tests, and safety of procedures—even if patients don't raise these issues.

Abstract

Purpose: We elicited patient opinions about how physicians can improve communications about colorectal cancer (CRC) screening.

Methods: We recruited 15 patients, ages 50 years and older, from an urban family medicine teaching clinic. All patients in the initial pool of candidates had been seen at the University of Arkansas for Medical Sciences Family Medical Center within the past 12 months. The recruits participated in 1 of 3 focus groups to discuss how to enhance the rate of CRC screening.

Participants watched a videotape that described the different approaches to CRC screening. We then asked them to comment on how patients could be encouraged to undergo CRC screening.

Results: Using a qualitative analysis of focus group data, we determined the most common reasons participants had not undergone CRC screening: fear, lack of information, and failure of the physician to strongly recommend CRC screening. Participants offered 7 recommendations for how physicians could address their concerns. Participants emphasized the importance of strong physician endorsement of screening, of frank and informative dialogue about patient's concerns, and of using educational materials to supplement personal advice.

Conclusion: A physician's recommendation for screening is the most powerful motivator in patients' decisions. However, other sources of information such as videotapes, written materials, and even endorsement of CRC screening by the clinic's office staff can help patients decide to undergo screening.

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It's well known that patients may avoid colorectal cancer (CRC) screening for fear of pain, embarrassment, lack of awareness of the importance of CRC screening, misperceptions about screening effectiveness, or lack of resources.¹⁻⁵ But how well do physicians address these concerns and misgivings to help patients make a different choice? Equipped with an understanding of patients' perspectives, physicians could reframe their counsel and likely increase the rate of CRC screening in their practices.

We conducted 3 in-depth focus group sessions to draw out details of patients' concerns regarding CRC screening and to solicit their thoughts on how physicians could address and even resolve these issues.

■ Methods

Patients randomly selected for focus groups

Our initial pool of candidates was approximately 500 patients who were at least 50 years old and had been seen at our Family Medicine Center during the prior 12 months. We stratified this population into 4 ethnic/gender groups: African American males, African American females, Caucasian males, and Caucasian females. Sixty percent of the patients were female; 50% were African American, 48% were Caucasian, and 2% were Latino.

After creating a database that listed these patients by number and concealed their identities except for race and gender, we sequentially selected participants for groups of 8 patients (2 drawn from each of the ethnic/gender groups). Our random selection process avoided such biases as choosing patients by name or age or whether they had been seen more recently.

The first group of 8 patients received a letter asking them to participate in the project. The invitation included the offer of an honorarium. Invitations were mailed every 10 days until we had recruited

4 to 6 volunteers from each ethnic/gender group. After enlisting 20 participants, we were finally able to assemble 15 of them into 3 groups roughly balanced by gender and race. We also had 4 stand-by groups of 8 patients, in case any of the original participants chose to leave the study. All patients who volunteered were assured that if they chose not to participate, their continuing care would be unaffected.

Sessions thoroughly explored patients' issues

The same experienced focus group leader (Caucasian, female) led all 3 sessions, adhering to a widely accepted structure for focus groups.⁶ This facilitator was familiar with the common barriers to CRC screening, as cited in the medical literature.^{1,7-9} She first asked an open-ended question and then probed specifically to determine why some participants or their family members had not received CRC screening. She solicited input from all attendees, sought clarification on points of view, and polled participants about their reactions to statements made by other members of the group. Participants were encouraged to discuss their experiences and their talks with family physicians about CRC screening.

How the sessions unfolded

After receiving instruction about the purpose of the session, participants viewed 2 patient-education videotapes that discussed CRC screening in an average-risk population. They also read a brief patient-education booklet about CRC screening before the facilitator engaged them in dialogue.

The videotapes—"Colon Cancer Screening: What You Need to Know," produced by Harris and Pignone¹⁰; and "Screening for Colorectal Cancer: An Easy Step to Save Your Life," produced by the Foundation for Digestive Health and Nutrition¹¹—gave all focus group members a common understanding of the rationale and importance of CRC screening. We chose these 2 tapes because of their

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Though educational videotapes were important, patients felt they were no substitute for a doctor's recommendation

widespread use in clinical practice, complementary messages, easy-to-read graphics, content aimed at a lay audience, good sound quality, and recommendations that followed the American Cancer Society guidelines for average-risk patients.¹²

After participants contemplated the information they had viewed and read, the facilitator asked, "What suggestions would you give to a doctor to encourage a patient to be screened for colorectal cancer?" This began approximately 1 hour of feedback from the focus group members.

All 3 sessions were videotaped, but due to technical problems, video was available for only 2 groups. All 3 sessions were audiotaped.

Data analyzed promptly and rigorously

We systematically gathered and analyzed the qualitative data. The focus group leader and Dr. Goldsmith (principle investigator) together categorized the data by themes, which were structured so as to reduce overlapping. Disagreements on categorization were resolved by referring to transcripts and videos. We reassembled this information using an axial coding approach.

Though body language, gestures, and voice tone are important indicators of intent in communication, we did not classify data according to these non-verbal cues. However, we did note such cues during review of the videotapes, and also took into account the frequency and extensiveness of remarks (eg, how many people made a similar comment). Rapid transcription of the sessions and prompt review of the transcripts minimized the inaccurate interpretation of data that can occur when review is delayed.

We used 2 means of assessing the educational level of attendees. Patients in the first 2 focus groups were given the Rapid Estimate of Adult Literacy in Medicine (REALM) test,¹³ and members of the third group were asked for the highest grade level they completed in school.

Results

The average age of participants was 56 years. Few men volunteered to begin with. So to replace patients who dropped out on short notice, only women were immediately available from the standby groups. Thus, 13 participants were women and 2 were men. Two were covered by Medicaid, 6 by Medicare, 5 had private insurance, and 2 had no insurance. Eleven of the insured participants reported their insurance would pay for CRC screening.

Seven participants were African American, 7 were Caucasian, and 1 was Latino. Each focus group had approximately an equal mix of subjects by ethnic group, but only 2 groups had an uninsured subject. One man was part of each of the first 2 groups.

Reasons for low screening rate

Of the 15 subjects, 5 (at least 1 in each group) had undergone some type of CRC screening: colonoscopy (3), flexible sigmoidoscopy (1), or fecal occult blood testing (1).

Of the 10 subjects not screened, medical records lacked evidence that their family physicians had discussed CRC screening. The facilitator asked them why they had not been screened. The primary reason given was failure of their physicians to recommend screening; although on further inquiry, 1 patient said, "If the doctor did mention it [CRC screening], it was done in a fashion that didn't impress me enough to remember." Several other unscreened patients nodded in agreement. Other reasons given were costs, psychological issues (fear and embarrassment), belief that screening was unnecessary, and difficult logistics (time off and transportation) (TABLE).

Patients offered 7 suggestions for physicians

Our focus-group participants offered 7 recommendations for addressing issues that can hinder patients' decisions to be screened.

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Anticipate patients' fear of pain and explain what's done to minimize discomfort

1. Do not rely on educational materials alone. Though participants thought videotapes and written information were important, all of them strongly stated that the primary endorsement for CRC screening must come from their physicians. All 3 groups agreed that videos and written materials were helpful supplements to a physician's advice.

2. Address fear of pain. Anticipate patients' fear of pain from colonoscopy, and explain what is done to minimize discomfort.

3. Cite costs of tests. A common theme was the lack of knowledge about the costs of the CRC screening options. Let patients know they can opt for less expensive screening.

4. Discuss pros and cons of each test. A strongly held belief was that colonoscopy is the best, if not the only, test to have. If a physician had frankly discussed both costs and benefits of the options, patients might have been reassured enough to proceed with a screening procedure, even if it was not colonoscopy.

5. Challenge the "worst case" mindset. Focus group participants feared that if cancer is found, it may not be curable. They urged physicians to expect this apprehension and to counter it with a realistic assessment.

6. Emphasize safety of testing. Several participants who had not been screened feared being disabled by the test itself and said physicians should spend time to counter this belief.

7. Elicit concerns about logistics. Some group members had avoided colonoscopy because it required taking time off from work, which they could not afford to do. The solution is to match the screening test to a patient's needs and preferences.

Find a way to address the above concerns. Participants suggested that if a doctor's time is limited, then someone else in the office (a nurse or even a clinic staff member) ought to speak with patients—preferably someone who has undergone endoscopy screening and can

TABLE

How to improve CRC screening rates— focus group recommendations by theme

Strategies, other than physician communications, that could improve CRC screening rates

Most common responses in order of frequency:

- 1. Videotape on CRC screening similar to the ones shown to focus groups**
- 2. Print handouts on CRC screening**
- 3. Advice of friends and family**

Family physician communications that could improve CRC screening

Most common responses in order of frequency (and typical comments):

1. Delivery of advice to be screened: use a clear and forceful recommendation.

- "When I went to my doctor, he said 'Do you want a colonoscopy?' and I said 'Well, not really.' After all, who wants to have such a test? [Because] of the way it was presented, I just kind of blew it off."

2. Emphasize that CRC screening is a routine part of preventive care.

- "My doctor never mentioned [CRC] screening to me and I thought I didn't need to be screened. If screening is important, the doctor has to say why."

3. Address patient psychological barriers and concerns.

- "Explain that by doing [CRC screening] we can prevent you from [having] some health problems that would be more embarrassing than CRC screening."
- "Find out why the patient is afraid. It might be the pain or that they can't pay the bill."
- "Tell patients about the IV medication given during colonoscopy... it made me feel real good and I had no pain at all."

4. Address barriers to access to care.

- "If money is a problem, tell the patient that a cheap test [such as fecal occult blood testing] is better than no test at all."

Preferred communication strategy for learning about the importance of CRC screening

Most common responses based on frequency (and typical comments):

1. Communication directly from the physician

2. Videotape viewing before seeing the doctor

- "I rely on my doctor's advice, but the videos would have helped me ask my doctor the right questions."

3. Written materials in the doctor's office

4. Written materials sent to the patient's home from the doctor's office

5. Someone in the medical office discusses endoscopy with the patient, including their own experience with the test

- "My doctor did something really smart. He told me of his personal experience [with CRC screening]. I appreciated him doing that."

talk about what it was like in “real terms we can understand.”

■ Discussion

Many factors keep the CRC screening rate lower than it ought to be. Physicians do not uniformly follow screening guidelines.^{7,14} Limited practice time, difficulty in identifying patients needing preventive services, and little financial incentive to provide preventive care in the ambulatory setting all hinder the effort to increase screening. And even when CRC screening is advised, patients are often reluctant to comply because of the reasons already discussed.

Effective communication between patients and physicians therefore becomes ever more important.¹⁵ Informed decision making about cancer screening is difficult for many patients to grasp, as evidenced by inaccuracies, distortions, and oversimplification of cancer-related beliefs.¹⁶ Patient-centered communications can give the physician a clearer understanding of the patient's perspective and influence health-seeking behavior.¹⁷

The suggestions offered by this study's participants can help family physicians improve communication about CRC screening, which should encourage more patients to opt for screening.

Participants unanimously recommended that physicians speak directly to well-known patient concerns about endoscopy, even if the patient does not bring them up during a visit.

Though participants spoke mainly about ways physicians could improve doctor/patient communications about CRC screening, they also expressed high regard for videotapes in patient education. The videos they watched taught them that CRC could be prevented or cured if discovered early, and they felt this message was not conveyed by their physicians. The value of video-based patient education observed in our study is consistent with the results of other studies.^{18,19} Given that primary care physi-

cians often have insufficient time to educate patients fully, using a videotape may be well received by patients and prove an efficient way to augment advice about CRC screening.

Shared decision making has many advocates these days, but the focus group population in this context preferred that physicians be more assertive in promoting CRC screening. Patients may more readily comply with screening recommendations if physicians convey a message that is persuasive rather than factual but emotionally neutral.

This study confirmed the findings of others: fear, lack of information, cost of testing, and the physician's failure to recommend CRC screening are all potential barriers to increasing screening rates.^{1,2,20,21} The study also showed the importance of physicians asking patients to clarify the origin of their fears about CRC testing.

Of the 10 focus group members who had not been screened for CRC, fully half said they would now consider screening given what they learned in the focus group. This encouraging finding implies that giving patients accurate information can improve screening rates. The remaining members of the focus group were still uncertain as to whether they would accept CRC screening if offered, and they did not give reasons for their indecision.

Limitations

The focus group participants may have been more assertive than most of the general population, given their willingness to freely express their feelings in front of others.

A sample of convenience was selected and most participants were women, despite efforts to recruit an equal number of men and women. Thus, our findings should be interpreted with caution for the male population.

The education level was higher than that of our urban, family practice clinic population. Thirteen of the 15 attendees had some type of insurance (Medicare,

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Let patients know they can opt for less expensive screening

Medicaid, or private insurance). Of the insured, 11 had insurance coverage for CRC screening. Lack of availability of insurance coverage for CRC screening undoubtedly affects purchasing behavior for CRC screening, but we did not specifically separate comments of the insured from the uninsured. We do not have data on response of the subjects by ethnic group or sex.

Although the sample size was small, comments about the inadequacy of doctor/patient communications that emerged in each of the focus groups were remarkably similar. ■

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Disclosure

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