




*Physician's Perspectives on Barriers to Appropriate
Colorectal Cancer Screening for Average Risk Patients:*

*Final Report of the High Mortality Counties
Colorectal Cancer Project
Genesee County, Michigan*

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Introduction

In 2004, the Genesee County Health Department (GCHD) received a grant from the Michigan Public Health Institute (MPHI) and the Michigan Department of Community Health (MDCH) through the High Mortality Counties project. This project allowed GCHD to examine barriers to colorectal cancer (CRC) screening adherence. Genesee County is one of several Michigan counties whose 10-year mortality rate (1992-2001) is greater than the State rate for the same period. Given that effective and sensitive CRC screening is available, and that CRC is the second most common cancer in the United States, behind lung cancer, early detection is of utmost importance. Early detection of CRC is known to increase survival rates and with some screening methods, curative intervention can actually be applied to prevent the development of cancer.

University of Michigan researchers recently published a population-based telephone survey of Black and White Genesee County residents ages 50-79 years. Results showed that the presence of specific barriers to colorectal cancer screening was significantly associated with a strong, negative influence on whether or not a patient underwent each of three screening procedures (fecal occult blood test, flexible sigmoidoscopy, colonoscopy). The study also showed that physician recommendation was a powerful motivator to screening behavior. The majority of respondents who reported that their physician had recommended undergoing a colorectal cancer screening reported that they had completed the screening. (Janz, Wren, Schottenfeld & Guire, 2003). Given that physician recommendation for colorectal cancer screening was found to be an important determinant of screening behavior, this focused on gathering the perspective of Genesee County physicians in regards to barriers and enabling factors to appropriate colorectal cancer screening for average risk patients.



Methods

From May to August 2005, three focus groups were conducted with Genesee County physicians. A standard focus group guide was used in all three groups. The same moderator conducted all three groups, ensuring greater consistency in which questions were asked and the manner in which they were asked. Focus group participants were recruited from two pre-existing physician associations in Genesee County, as well as by cold-calling, faxing, and mailing invitations to Gastroenterologists from a physician listing. At the focus group, prior to beginning data collection, each participant was asked to read and sign an informed consent form. After this was completed, participants completed a brief, anonymous demographic survey. At the conclusion of each focus group, participants received a small honorarium in appreciation of their participation. Each focus group was recorded by a notetaker and was audio-recorded for verification of the notes. This resulted in transcription of the notes from each group. The notes were then organized and analyzed using Microsoft Excel to reveal the most prevalent themes. A list of themes was developed based on 1) issues of interest to GCHD, MPHI and MDCH and 2) patterns and topics that reoccurred throughout the focus groups. This project and its activities were approved by the Michigan Public Health Institute's Institutional Review Board.

Participant Demographics

In total, 14 physicians participated in the focus groups. Eleven participants were male, while three were female. Participants identified themselves as the following race/ethnicity: 6 African American; 2 Caucasian; 3 Asian/Pacific Islander/Native Hawaiian; 1 Afro-Arab; 1 Middle Eastern; 1 Unspecified. The participants represented several types of medicine: 6 Internal Medicine, 1 General Practice, 2 Family Practice; 3 Gastroenterology; 1 Oncology; 1 Surgery. Twelve of the 14 physicians accepted HMO plans. They were also asked whether or not they accepted Blue Care Network and HealthPlus, the two largest HMO's serving Genesee County. Eleven participants accepted Blue Care Network while 12 accepted HealthPlus.

Following are the most prevalent themes that emerged in the focus groups. Themes are not listed in any particular order.

Importance

Physicians felt routine colorectal cancer screening for patients at average risk was extremely important. Nearly all participants mentioned that this type of cancer is the second most common cancer and that it is important because it is both “preventable” and “treatable”. Also, participants felt screening was particularly important because colorectal cancer often does not present with anticipated symptoms.

“The earlier you catch the cancer you can cure it. If you catch it late, then the survival rate diminishes so I think ‘extremely’ is would be the word I would use”.

“The interesting thing about colon cancer is that you can apply prevention; the early detection and you can have extremely cost-effective prevention and in some you can have a cure if you find it early”.

Priority

Colorectal cancer screening, for the most part, is not seen as a big priority during the patient's visit. Usually patients come in with other, often complex, problems. Participants felt that the standard of care in this County for primary care physicians because they have the most access to patients, should be for every patient in the appropriate age categories be screened. They also expressed that women were more aware and concerned of breast cancer and cervical cancer because it affected their sexual health and that men seemed more concern over prostate cancer, than they do about colorectal cancer.

“Unfortunately it [colorectal cancer screening] is not a big priority and that is a problem why there is a high incidence of colon cancer.”

“Females...maybe the breast cancer or cervical cancer, cervical for example, because any treatments, any surgery, will affect their sexual health and with breast cancer, maybe she’s concerned that she doesn’t want to lose, you know, a breast or something.”

Benefit

Physicians expressed that colorectal cancer is a preventable disease and if it’s caught in the early stages it is treatable; so the benefits of screening are many.

“It still reflects on the community. If people are aware of it and you offer it and you do screenings. Certainly decrease the incidence of deaths from it at least. People not dying prematurely or cutting the morbidity, which is to benefit the community as a whole”.

Screening Practices

Many physicians felt that the “older” tests, especially fecal occult blood testing, digital rectal exam are not really useful in part because they are not very sensitive and if they show something then a colonoscopy will need to be done anyways. Colonoscopy was cited as the preferred screening method for colorectal cancer, because it is cost-effective and sensitive, and because it can prevent colorectal cancer in that many precancerous lesions can be removed, preventing the development of cancer. One participant noted that it was the golden standard in CRC screening. This sentiment was expressed by both Gastroenterologists and primary care physicians alike. Participants expressed a need for easier screening methods. Virtual colonoscopy, a newer screening method was referred to several times, but at this time, most participants felt it was not a reliable method in that it was costly and not very sensitive. Furthermore, Gastroenterologists were unsure where they might do a screening colonoscopy for people without health care coverage, especially those who come through the Genesee County Free Medical Clinic where several of them see patients.

“...everybody agrees that the most sensitive, the best test is colonoscopy”.

Guidelines

Physicians were aware of national CRC screening guidelines and seemed to adhere to the age recommendations, and recommendations about performing annual rectal exams. However, it was not clear how adherent physicians actually are to the screening methods and schedules outlined in the national guidelines. They were also aware of risk factors and various screening guidelines for high-risk groups such as those with a family history of cancer or those with a colon disease.

The American Cancer Society was cited most often as being a place where physicians obtained screening guidelines. Other venues included American Society of Gastroenterology and Endoscopy, American Academy of Family Physicians, American College of Family Physicians, American College of Gastroenterologists, and the Preventive Taskforce. Sometimes journals or the web are used for information-seeking as well. Participants said that most of the guidelines are all similar, although some are more stringent than others. Many physicians felt that it was more practical to send everyone for a colonoscopy at age 50 years instead of relying on tests such as the digital rectal exam or fecal occult. Most participants stated that they perform annual rectal exams starting at age 40 years. Very few participants were familiar with the Michigan Cancer Consortium, although those who were familiar felt that the screening guidelines of the MCC were more relevant for primary care physicians rather than specialists.

Education/Awareness

It is important to raise awareness and educate both physicians (particularly primary care because they have the best access to patients) and the public. One group felt that the main emphasis to increase screening should focus on the physicians. Patient awareness/education can be disseminated through many different venues, such as physician's offices, literature, and television. There was particular emphasis on utilizing the local newspapers to disseminate information. Educating on the benefits of colorectal cancer screening was identified as being important to convey. Others thought that emphasizing that screening can prevent a colostomy is important because many people fear this. In addition, participants felt as though women were more attuned to colorectal cancer screening and could be useful in getting family members, especially their spouses, in for screening. Participants expressed that there is more awareness of breast, lung, prostate, and cervical cancers than colorectal cancer. It was also mentioned that there does appear to be a lack of patient demand for colorectal cancer screenings compared to other cancer screenings. People with a family history of cancer or who have a colon disease tend to seek out screening more than any other group.

“The other thing when we’re educating the public is I find that it’s usually the female spouse is more diligent in, maybe you could direct some of the education to them and say, ‘make sure your family members keep their appointments’”.

“People are more aware with breast cancer, cervical cancer, lung cancer. People they come, they know about it. But colon cancer, no, not really. They don’t come and want to be checked for colon cancer at all. Even prostate [cancer] has more awareness than colon cancer”.

Physician Influence

Participants felt that physicians should advise their patients regarding colorectal cancer screening so that then patients can make their own decisions. The major problem/barrier regarding colorectal cancer screening is seen as getting physicians to recommend it. Participants felt that a doctor recommending something carries a lot of weight with patients, if they trust them.

“I would say the major problem is at that level, not at the patient. Once you explain to the patient, they can say yes or no, but it should be put to the patient first that this is what [physician is] recommending you do”.

Barriers

Participants recognized that there are both physician/provider and patient barriers to ensuring patients are appropriately screened.

“...One is the physician factor, why they are not promoting colorectal cancer when they should and why people are not conscious enough to come in and ask for it”.

Physician Barriers

Participants expressed the sentiment that it is difficult to force primary care physicians to do the screenings because the screenings are not always covered by a patient’s insurance. Another barrier is simply that a lot of physicians just forget to recommend the colorectal cancer screening. All groups mentioned the use of reminder systems/tools as a vital way to better ensure physicians recommend CRC screening. Computer reminder systems were mentioned by all, but it seems that primary care providers are less likely to have these systems. Gastroenterologists, however, felt that such a system was standard for gastroenterologists. Although reminder systems exist and were cited as being important, it appears that coordination between who is sending reminders to patients is lacking. Gastroenterologists said that they are willing to send reminders to patients for primary care doctors, but that often primary care providers and/or managed care ask them not to. Even if a physician does make a recommendation for screening, participants felt that they may not give patients enough information on why they are ordering certain tests, which may be a factor in why patients do not follow-up with screening even when it is physician-recommended. Physicians also often are complacent when patients refuse and do not follow-up in addressing reasons a patient may refuse. Lack of time during office visits was also cited as a barrier to physicians recommending CRC screening.

“With managed care, I’ve had some primary care tell me, ‘do not send a reminder to my patients.’ They said, ‘we will remind them’. They are telling you directly that they’ll send them to you when they think the time is right, and there’s not much you can do about it”.

Physician Differences

Participants believed that whether a physician recommends colorectal cancer screening is dependent on the personality of the physician as well as the physician’s age. Participants felt that younger physicians were more attuned to screening than older physicians. It was also suggested that physicians in private practice may be less apt to recommend screening because they don’t have anyone monitoring them.

Patient Barriers

There were many patient barriers to appropriate colorectal cancer screening identified by participants. They include:

Various Populations

Participants noted that there is variance among different patient populations in terms of barriers to colorectal cancer screening. These differences include health care access, race, gender, and suburban vs. urban populations. Physicians reiterated that they take care of all people, but that they do have to understand that there are different populations. Men, in particular, were mentioned as an important population to target for screening because they are perceived to seek health care much less than women. Educational status was also cited as influencing whether or not a patient comes in and requests screening.

“Think we’re all very cognizant of addressing males in particular because males don’t come to the doctor unless they’re very, very ill. So we’re cognizant of screening and getting them when we can”.

Preparation

The preparation for colorectal cancer screening methods, especially for flexible sigmoidoscopy and colonoscopy, was cited as one of the most salient barriers to patient colorectal cancer screening behavior. This type of preparation is not required for other cancer screenings, making colorectal cancer unique.

“Compliance you get from patients is not good because the preparation is something they hate. I have talked to a few people, some doctors too, and...they said, ‘if the preparation could be avoided, I would have no problem’”.

“I found it really interesting that if I get cancellation of patients, I don’t get it for colonoscopy after they get prepped. Because after they’ve been prepped, they do it at all costs.”

Cost

Participants did not have a clear understanding about what colonoscopy might directly cost a patient if he/she does not have health care coverage or if a colonoscopy is not covered under their policy. Lack of health care coverage, having to take one to two days off of work and needing transportation after a procedure where the patient has been sedated, were cited as significant patient barriers to colorectal cancer screening. Participants recognized the high monetary cost of colorectal cancer screenings compared to other cancer screenings.

“Insurance issues, depending on patient, would be a major issue. They may have the money to come to your office for hemocult screening, but don’t have the money for a colonoscopy or more invasive screening”.

“Let me make this clear, it is recommended no matter what type of insurance they have. Now we can recommend it all day long, but if the patient doesn’t have the money or the means of transportation, then it’s not going to happen”.

Fear

People fear what might be found if they undergo screening for colorectal cancer and so this influences whether or not they are tested.

“They live in denial. They’re afraid of the outcome.”

Unpleasantness of Screening

Physicians also stated that patients think that colorectal cancer screening methods are unpleasant and embarrassing.

“A lot of patients they find it quite repulsive to do the stool and the smearings and bring it back. You know it’s not something pleasant to do and they don’t do it.”

Health Care Access

Participants expressed that it was also important to consider those parts of the population that do not have access to health care. Most of these people are those that are indigent or uninsured. Special attention and other approaches to increasing screening are important to reach this population.

“...there are patients out there or individuals who do not have contact with a physician... We need other means to reach these patients. That can be also something to be looked at”.

Perceived Susceptibility

Participants emphasized that everyone is susceptible to colorectal cancer and that every American has some chance of getting it in their lifetime. It was expressed that denying susceptibility is human nature.

“...because of the human nature that is denial, they think that they are not at risk or they feel they are healthy, they’re not in the age group”.

Perceived Severity

Participants felt that most people underestimate the seriousness of colorectal cancer. They felt that people were not aware that it's treatable in the early stages and that catching it early is better both for quality of life and survival.

Enabling Factors

Physicians mentioned many factors that enable, or support, CRC screening adherence. These factors include: having systems/tools that will help remind physician to recommend screening to patient; having it as a covered service under health coverage plans, including managed care and Medicare; supportive office staff; and physicians who have nurse practitioners or physician assistants on staff. All were said to help increase physician/provider recommendation as well as patient compliance.

Reminder Tools

Participants felt that a computerized system that flagged patients who were due for colorectal cancer screening would be helpful and increase physician recommendation of the appropriate screening. Gastroenterologists felt it was the standard of care for their specialty to have a computerized reminder system, especially because they felt that they may be held legally liable if they did not remind a patient when he/she was due for screening. Cost of such a system was cited as a significant barrier for most physicians. Participants said that currently some HMOs, PHOs, Gastroenterologists and other physicians are sending reminders. Gastroenterologists are willing to send reminders to patients and/or primary care physician. However, Gastroenterologists also said that in some cases, certain physicians and HMO's have told them not to remind their patients. Other reminder tools currently being used included having a flow chart based on patient gender and age, in the patient chart as well as having reminders/screening schedules distributed to new patients.

"I tell the patient that I'll forward to primary care and that my office staff will follow-up, so hopefully between the three, one is good enough; the patient won't fall through the cracks".

"I think the second thing is to get some kind of system, like software for medical records that can flag. Can flag that the patient needs colorectal screening. That will help so immediately you know that you need to refer them for colonoscopy. That immediately will improve the physician side. It will increase the level of detection and the level of treatment".

Enforcement

Trying to increase colorectal cancer screening rates was compared to the model for immunizations where there is enforcement involved. For example, children cannot enter school

without immunizations, and awareness is so greater that everyone knows that kids have to have immunizations. Participants also suggested that having a colorectal cancer screening would be necessary to renew your driver's license or that a person who did not adhere to screening recommendations would have increased health insurance premiums. It was discussed that this would be difficult to enforce given that immunizations essentially protect the entire community, while colorectal cancer screenings benefits are mostly limited to the individual.

Managed Care

Managed care was mentioned as a good way to increase screening; especially if managed care organizations urge their primary care doctors to screen appropriately. Managed care was also mentioned as being good at providing health information to their patients. Gastroenterologists felt that they see more managed care patients for at least an initial screening and that some managed care physicians do really well in terms of having their patients screened appropriately. It was mentioned that in some cases, managed care can help facilitate screening, as well as hinder appropriate follow-up.

“If we could urge them [HealthPlus and Blue Care Network] to urge their primaries [physicians] to do the standard guidelines, that’ll help our County”.

“...in terms of follow-up sometimes you wonder, is it managed care, financial incentives to the primary care to withhold care, is that playing a factor? So, managed care can help to do the screening, but sometimes they can hinder the follow-up”.

Prevention

Physicians mentioned that many of them also try to talk about primary prevention of colorectal cancer including factors such as diet, such as eating a high-fiber diet, lifestyle, overweight, red meat consumption, smoking, saturated fat intake, and promotion of a vegetarian diet.

“...the bottom line is just to improve morbidity and mortality....Let us focus on prevention factors”.



Discussion

In many aspects, the main themes revealed from the three focus groups with Genesee County physicians were consistent with the most salient findings from the Janz, et al. study conducted with Genesee County adults. The focus groups identified *cost* and *preparation* of colorectal cancer screenings as the two most salient patient barriers to adhering to colorectal cancer screening recommendations. Like the University of Michigan study, this study indicated that patients find colorectal cancer screening unpleasant. This study attempted to identify barriers for physicians in recommending colorectal cancer screening for average risk patients. Many physician barriers were identified by participants, a lot of emphasis on needing to educate physicians on the importance of colorectal cancer screening, as well as ways to reduce the barriers they experience through methods such as the use of reminder tools. If these do in fact increase the number of physicians who make appropriate colorectal cancer screening recommendations to patients, then given the findings of the Janz, et al. study, it is likely that an increase in colorectal cancer screening would follow.

Although it was not as salient of a barrier as others, the current American Cancer Society and Michigan Cancer Consortium colorectal cancer screening guidelines are somewhat incongruent with beliefs physicians hold about what screening types are most effective. This lack of consensus between the groups may have an impact on how physicians are recommending CRC screening.

Furthermore, the findings of this study reveal that it is important to find ways to reduce physician barriers. Ways to do this include increasing the communication between Gastroenterologists and primary care physicians, in particular, regarding the best way to ensure patients are being reminded when they are due to undergo colorectal cancer screening. This may include evaluating the feasibility of creating and implementing computerized reminder systems for physicians who do not have access, and/or implementing a less expensive, less technical, reminder system that will be effective.

Overall, it appears that there is a lack of awareness of the importance and impact of colorectal cancer screening, especially on the patient side, that is inconsistent to the magnitude of the problem. Lastly, in addressing both patient and physician barriers, it is important to recognize that various sub-populations (by gender, race, etc.) experience different barriers to screening adherence that must be addressed in any intervention.