

***Physician-Patient Partnership:
Overcoming Barriers to Breast Cancer Screening***

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RURAL APPALACHIAN CANCER DEMONSTRATION PROGRAM

ABSTRACT

The CD, "Physician-Patient Partnership: Overcoming Barriers to Breast Cancer Screening," was designed to address breast cancer-related disparity in Appalachia. The CD's content was developed based on survey results ($N=400$), qualitative methodology (e.g., Lincoln & Guba, 1985), and themes recurrent in existing literature. Design of the CD took over eight months, including over 100 hours for graphics development (Lise Cutshaw, Department of Communication, ETSU) and nearly 300 hours for digital production (Daniel Santiago, Department of Communication, ETSU).

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METHODS: IDENTIFYING BARRIERS

A survey exploring attitudes, beliefs and experiences regarding breast cancer and breast cancer screening was conducted at a remote area medical (RAM 2004) fair in southeastern Virginia (N=400). Field notes (Lincoln & Guba, 1985) were also taken during RAM 2004 to form a better understanding of population needs, attitudes, beliefs, and behaviors. Existing literature was used to contextualize survey results. To address the "why" behind the survey data, informal semi-structured interviews were conducted with Appalachian women who had not had regular mammograms. These interviews were **not** to gather additional data; rather, they served as a means of *auditing* (Lincoln & Guba, 1985) our conclusions about barriers based on survey results and existing literature.

SURVEY RESULTS

Survey results indicated that the sample population (women, 40 years and older) was already participating in the healthcare system. While nearly 90% of survey participants had received care at a doctor's office or clinic within the last year, there still appeared to be some resistance to participating in breast cancer screening. Nearly 30% of the population was underscreened (rarely or never screened).

Is Fatalism a Barrier?

Current research still points to the existence of cancer fatalism and providers' belief that such fatalism is a barrier to screening (e.g., Shell & Tudiver, 2004). The RAM survey results, however, cast doubts on the traditional cancer-fatalism explanation. Additionally, other scholars have emerged, writing about the over-simplification and over-used of fatalism (see Lewis & Billings, 1997; Powe & Finnie, 2003).

Well over half of the RAM 2004 survey participants indicated that they believed early cancer detection resulted in lives saved. The vast majority of the underscreened subset believed that most women survive breast cancer beyond five years. These results, then, suggested the presence of optimism, not fatalism, regarding screening and breast cancer survival.

In the end, the RAM data repeatedly suggested the presence of understanding about the importance of breast screening; therefore, we explored other possible barriers to screening behavior.

The barriers ultimately identified were:

- 1) Low perceived risk
- 2) Low life priority (e.g., "My health isn't a high priority")
- 3) Poor access to screening facilities

OVERVIEW OF LITERATURE

Rural populations have often been identified as being underserved in breast cancer screening (e.g., Schootman, et al., 2000), helping to explain the breast cancer disparity in Appalachia (Appalachian Regional Commission; ARC, 2004). In addition to social and economic barriers to screening, there are also communication barriers. Klassen et al. (2002) argues that traditional screening recruitment techniques (e.g., mailed reminders) have limited effectiveness, giving rise to increased focus on interpersonal compliance-gaining techniques to overcome barriers.

In Schootman et al.'s (2000) research, women who felt a lump were more likely to receive adequate follow-up services than asymptomatic women. This may help explain why nearly 90% of the RAM survey participants regularly (i.e., once per year) sought medical care, but there was still resistance to carrying that health-seeking behavior into the area of breast cancer screening. Without some sort of “tangible” evidence, the costs (e.g., time and money) of seeking screening are often perceived as being too high.

The Barriers

In risk communication, interpersonal physician-patient interactions are vital. Research continues to emerge about the difficulty women have with understanding personal risk (Lipkus et al., 2001), particularly relative vs. lifetime risks. Women may also overestimate the rewards of mammograms (Lewis et al., 2003).

Existing literature helps elucidate the following RAM 2004 finding:

- almost 70% of the underscreened participants reported having an “average” risk of developing breast cancer. Regardless of health behaviors (e.g., smoking), many of the underscreened population perceived a low risk for developing cancer.
- Approximately 10% of “rarely” and 25% of “never” estimate that their risk is lower than other women in their age group.
- Approximately 30% of “never” participants report that they have had “about the right number” of mammogram screenings.

Interestingly, there was a subset of the women who stated that they were “Never” screened, however, also believed that they had **“too few” screenings**, suggesting the presence of barriers other than perceived low risk. For example, a woman’s social network, access to provider recommendations, and income level can also affect screening compliance (e.g., Allen et al., 1999). Because of the complicated world Appalachian women live in, particularly those in rural regions, underscreened population may simply forego screening due to access challenges (ARC, 2004). For example, the lack of public transportation, lack of insurance, and distance to health care facilities can further complicate screening behaviors. The auditing interviews conducted and field notes collected helped underscore that rural women can perceive they are taking away family resources (e.g., time and money) by engaging in screening.

CD "CLIMATE": PHYSICIAN-PATIENT PARTNERSHIP

Participative decision making is repeatedly mentioned in literature as a necessary element in compliance-gaining. Regarding breast health, both patient involvement (e.g., Bruyninckx et al., 1999; Sapir et al., 2003) and provider involvement are critical (e.g., McMilliam et al., 2000), with physician recommendation still viewed as the most important predictor of screening compliance (Allen et al., 1999).

Healthcare partnerships between physician and patient may be improved by helping primary care physicians form new scripts (communicative guidelines) about how to urge underscreened populations to have regular screening. These scripts must address and help reframe perceived and actual barriers. Such provider/physician scripts should draw on various verbal and nonverbal communicative techniques to increase patient trust, respect, and compliance (Geist-Martin et al., 2003; Parrott, 2000).

Since a primary goal of this CD was to personalize the breast cancer screening experience, three techniques were used to emphasize the spirit of participative engagement.

- Use of testimonials and scenarios drawn from the actual stories of underscreened women (standardized patients portraying the women);
- Use of photographs to capture diverse images of women living in this area;
- Use of research to demonstrate the vital role providers play in gaining screening compliance.

DISSEMINATION

Dissemination will primarily take place at rural CME/medical conferences, as this CD is an approved CME activity, East Tennessee State University James H. Quillen College of Medicine CME activity.

A total of 200 CDs will be initially distributed at conferences, including the following:

Event: Primary Care Research Day.

Date: September 10, 2005

Location: Johnson City, TN

Purpose: Interactive demonstrations of the breast cancer screening communication CD and distribution to target audience.

Event: Head for the Hills: A Retreat for Family Medicine Residents and Faculty

Date: October 6-8, 2005

Location: Breaks, VA

Purpose: Interactive demonstrations of the breast cancer screening communication CD and distribution to target audience.

Other events for the purpose of distribution are being reviewed at this time.

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