Barriers and enablers to participation in cancer screening programs

Formative qualitative research with Queensland General Practitioners

Report

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Barriers and enablers to participation in cancer screening programs: Qualitative research with Queensland General Practitioners
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Barriers and enablers to participation in cancer screening programs: Qualitative research with Queensland General Practitioners
Introduction & Method
Project background

In Queensland, three national population-based screening programs are available free for eligible Queenslanders:

1. BreastScreen Queensland Program:
   - BreastScreen Queensland provides mammogram breastscreening targeting women 50-74 years. Breastscreening has had a marked impact on improving breast cancer survival through the early detection of cancer, which is when treatment is most effective.

2. National Cervical Screening Program
   - Cancer of the cervix is one of the most preventable and curable cancers. Cervical screening (Pap smear) is recommended every two years for women over the age of 18-20 years who have ever been sexually active. Screening is the best way of preventing cervical cancer by detecting early cell changes caused by the Human Papillomavirus (HPV).

3. National Bowel Cancer Screening Program
   - Bowel cancer screening is effective in the early detection and prevention of cancer through removal of precancerous polyps and adenomas and is recommended for men and women aged between 50 and 74 years. The program uses the Faecal Occult Blood Test (FOBT) for screening.

Briefings from Queensland Health reveal participation of eligible Queenslanders in the three national population-based cancer screening programs is lower than national participation standards and/or has not increased in line with population growth and ageing population rates.

MCR was commissioned by Queensland Health in May 2015 to undertake formative qualitative research with Queensland General Practitioners (GPs) in order to further understand barriers, enablers and motivators to reminding patients to participate in applicable cancer screening programs, how Queensland Health might support GPs to remind patients to get screened and to find out GPs’ perspectives on cancer screening.

Objectives

Through in-depth interviews the aim of the research with GPs was to build on and update understandings of Queensland GP’s attitudes and behaviours regarding recommending breast, bowel and/or cervical cancer screening to eligible patients including:

- Identifying current barriers and enablers GPs have to reminding patients from the target groups to get screened and rescreened (e.g. cultural sensitivities, gender differences) and comparing these across cancers and to barriers found in previous research.
- Finding out how GPs could effectively be supported by Queensland Health to remind patients from the target groups to get screened and rescreened using the three national population-based cancer screening programs?
- Exploring GP perspectives on the barriers, motivators and enablers patients face in participating in cancer screening, and how this differs across the government’s cancer screening programs.
- Finding out what GPs think the barriers might be to patients getting screened through the three national population-based cancer screening programs rather than privately run or distributed screening services (e.g. private hospital mammogram screening services or over-the-counter bowel cancer screening kits).
- Understanding if GPs inform patients that the three national population-based screening programs are free services and what influence they think this has on participation.
- Exploring GPs opinions on the Queensland delivery of the three national population-based cancer screening programs in terms of quality, efficiency, client-centredness etc.
- Understand the volume of general communications received by GPs from Queensland Health and explore methods used to prioritise information and communication channel preferences.
Method
Qualitative research, in the form of individual in-depth interviews with GPs was undertaken to meet the research objectives. A total of n=31 in-depth interviews was conducted.

Sample profile
The sample included GPs in metropolitan, regional and rural and remote areas in Queensland; GPs working in areas of low, mixed and high disadvantage were included. The majority of interviews were conducted in person at the GPs office (n=27), while four (n=4) were conducted over the telephone. Table 1 below summarises the number of interviews achieved by location, by GPs with culturally and linguistically diverse patients (CALD) and by level of patient disadvantage. Table 2 provides further detail by suburb and level of patient disadvantage.

<table>
<thead>
<tr>
<th>Segment</th>
<th>Number of interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>LOCATION</td>
<td></td>
</tr>
<tr>
<td>Brisbane</td>
<td>16</td>
</tr>
<tr>
<td>Regional city</td>
<td>7</td>
</tr>
<tr>
<td>Township rural</td>
<td>3</td>
</tr>
<tr>
<td>Rural and remote</td>
<td>5</td>
</tr>
<tr>
<td>PATIENT CALD PROFILE</td>
<td></td>
</tr>
<tr>
<td>Indigenous patients</td>
<td>7</td>
</tr>
<tr>
<td>African patients</td>
<td>6</td>
</tr>
<tr>
<td>Islamic patients</td>
<td>3</td>
</tr>
<tr>
<td>Asian patients</td>
<td>3</td>
</tr>
<tr>
<td>PATIENT DISADVANTAGE</td>
<td></td>
</tr>
<tr>
<td>High disadvantage</td>
<td>9</td>
</tr>
<tr>
<td>Mix (low to high)</td>
<td>13</td>
</tr>
<tr>
<td>Low disadvantage</td>
<td>9</td>
</tr>
</tbody>
</table>

Table 1: Summary of interviews by location, CALD patients, level of disadvantage

<table>
<thead>
<tr>
<th>Location</th>
<th>Suburb</th>
<th>Patient disadvantage</th>
</tr>
</thead>
<tbody>
<tr>
<td>BRISBANE</td>
<td>Inala (n=3)</td>
<td>High disadvantage</td>
</tr>
<tr>
<td></td>
<td>Logan (n=2)</td>
<td>High disadvantage</td>
</tr>
<tr>
<td></td>
<td>Kippa-Ring</td>
<td>High disadvantage</td>
</tr>
<tr>
<td></td>
<td>Brookfield</td>
<td>Low disadvantage</td>
</tr>
<tr>
<td></td>
<td>Indooroopilly</td>
<td>Low disadvantage</td>
</tr>
<tr>
<td></td>
<td>Toowoong</td>
<td>Low disadvantage</td>
</tr>
<tr>
<td></td>
<td>New Farm</td>
<td>Low disadvantage</td>
</tr>
<tr>
<td></td>
<td>Camp Hill</td>
<td>Low disadvantage</td>
</tr>
<tr>
<td></td>
<td>Eatons Hill</td>
<td>Mix - low to high</td>
</tr>
<tr>
<td></td>
<td>Kedron</td>
<td>Mix - low to high</td>
</tr>
<tr>
<td></td>
<td>Sunnybank</td>
<td>Mix - low to high</td>
</tr>
<tr>
<td></td>
<td>Aspley</td>
<td>Mix - low to high</td>
</tr>
<tr>
<td></td>
<td>Newmarket</td>
<td>Mix - low to high</td>
</tr>
<tr>
<td>REGIONAL CITY</td>
<td>Kirwan Townsville (n=2)</td>
<td>High disadvantage</td>
</tr>
<tr>
<td></td>
<td>Gulliver Townsville</td>
<td>High disadvantage</td>
</tr>
<tr>
<td></td>
<td>CBD Townsville</td>
<td>Low disadvantage</td>
</tr>
<tr>
<td></td>
<td>Belgian Gardens Townsville</td>
<td>Low disadvantage</td>
</tr>
<tr>
<td></td>
<td>Toowoomba (n=2)</td>
<td>Low disadvantage</td>
</tr>
<tr>
<td>TOWNSHIP RURAL</td>
<td>Dalby (n=2)</td>
<td>Mix - low to high</td>
</tr>
<tr>
<td></td>
<td>Gatton</td>
<td>Mix - low to high</td>
</tr>
<tr>
<td>RURAL/REMOTE</td>
<td>Cape York</td>
<td>Mix - low to high</td>
</tr>
<tr>
<td></td>
<td>Thargomindah</td>
<td>Mix - low to high</td>
</tr>
<tr>
<td></td>
<td>Cloncurry</td>
<td>Mix - low to high</td>
</tr>
<tr>
<td></td>
<td>MT Isa (n=2)</td>
<td>Mix - low to high</td>
</tr>
</tbody>
</table>
Overall a mix of age, gender, size of practice and number of years at the practice was achieved. Table 3 details the profile of GPs interviewed.

Table 3: Profile of participating GPs

<table>
<thead>
<tr>
<th>Segment</th>
<th>Number of interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>AGE</td>
<td></td>
</tr>
<tr>
<td>Under 50 years</td>
<td>16</td>
</tr>
<tr>
<td>50 years or older</td>
<td>17</td>
</tr>
<tr>
<td>GENDER</td>
<td></td>
</tr>
<tr>
<td>Males</td>
<td>17</td>
</tr>
<tr>
<td>Females</td>
<td>14</td>
</tr>
<tr>
<td>SIZE OF PRACTICE</td>
<td></td>
</tr>
<tr>
<td>Solo or small/medium (1-3 doctors)</td>
<td>10</td>
</tr>
<tr>
<td>Large practice (4 or more doctors)</td>
<td>21</td>
</tr>
<tr>
<td>NUMBER OF YEARS AT PRACTICE</td>
<td></td>
</tr>
<tr>
<td>&lt;5</td>
<td>10</td>
</tr>
<tr>
<td>5-9</td>
<td>6</td>
</tr>
<tr>
<td>10 years or more</td>
<td>15</td>
</tr>
<tr>
<td>SOFTWARE USED</td>
<td></td>
</tr>
<tr>
<td>Medical Director</td>
<td>15</td>
</tr>
<tr>
<td>Best Practice</td>
<td>14</td>
</tr>
<tr>
<td>Zed Med</td>
<td>1</td>
</tr>
</tbody>
</table>

Recruitment and incentive

Q&A Market Research, MCR’s qualitative recruitment partner recruited the GPs for the study using a screening questionnaire developed by MCR. GPs were paid $200 for their participation. Most interviews were limited to 45 minutes, some GPs however were happy to discuss the issues for up to one hour.

Interviewers and discussion guide

Jane McLean (Managing Director) and Therese Coutts (Senior Project Director) conducted the in-depth interviews. At the completion of the fieldwork a thematic analysis of the data was undertaken and this report was prepared.

MCR designed a discussion guide after consulting with Queensland Health. Feedback from Queensland Health Marketing Unit and relevant program areas was incorporated into the final version of the guide used in interviewing (see Appendix A).

Limitations

Findings should be read keeping in mind the following limitations:
- The sample is qualitative and therefore is representative of the GPs interviewed rather than all GPs in Queensland.
- There is the potential for bias in the sample given that GPs who agreed to be interviewed may be more interested in cancer screening programs* and or may be more willing or more available to participate in research than other GPs.
  * A letter of endorsement from Queensland Health was used in the recruitment process (see Appendix B) and GPs were generally informed in the recruitment process that the project was about cancer screening programs.

Generally though the sample was broad and covered a range of GPs by age, gender, size of practice, location and level of disadvantage.
Barriers and enablers to participation in cancer screening programs: Qualitative research with Queensland General Practitioners

Publication of Information

MCR is a member of AMSRO and abides by the AMSRS Code of Professional Behaviour. The Code of Professional Behaviour can be downloaded at www.amsrs.com.au. Under the Code of Professional Behaviour – information about Client’s businesses, their commissioned market research data and findings remain confidential to the clients unless both clients and researchers agree the details of any publications.

MCR has ISO 20252 quality assurance accreditation.

Disclaimer

In-depth interviews are a valuable means of identifying a range of attitudes and behaviours in the market. However they do not measure the extent to which these attitudes or behaviours are found throughout the market. As is our normal practice, we emphasise that any demand estimates or marketing recommendations in this report can be influenced by a number of unforeseen events or by management decisions. Therefore no warranty can be given that the information included will be predictive of a desired outcome.
Barriers and enablers to participation in cancer screening programs: Qualitative research with Queensland General Practitioners
findings
1.0 Breastscreening

1.1 Perceived role of General Practitioners in breastscreening

Most General Practitioners (GPs) consider themselves to have a moderate level of involvement in screening for breast cancer; activities of GPs are typically limited to encouraging women into the program to start with and organising follow-ups for women with abnormal results.

Reasons for a GP describing their role in breastscreening as moderate (and not central) are:

- The GP does not physically conduct the test
- The GP does not have to refer patients (women often do this independently)
- The issue of breast cancer is considered top of mind for many women in the target audience
- The BreastScreen Queensland program is considered to be well known among the target audience
- BreastScreen Queensland is considered to be highly effective, offering a high quality, widely available service with a reliable recall and reminder system (the success of the program removes the need for GPs to focus on this area).

<table>
<thead>
<tr>
<th>(Our role is) Just alerting them to the fact that it is available and because it happens on a 2 year cycle. People often ask when it is going to be back so you give them some advice about when it is coming back.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural and Remote, Dalby</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>I normally pick up the new people that have never screened before, but once they get in the system the government takes over, but I do check in with them from time to time.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mixed disadvantage, Sunnybank</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>It is an excellent program, we just remind people to go and get it done when they need to, it is the greatest program it really is.</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Disadvantage, Kippa-Ring</td>
</tr>
</tbody>
</table>

1.2 GP awareness and knowledge of BreastScreen Queensland program

The GPs interviewed typically have a very high level of awareness and knowledge about the BreastScreen Queensland program.

*Eligibility criteria*

While GPs are aware that the program targets women 50 years of age or older, understanding that women aged between 40 and 49 years are also eligible is not universal. GPs are also less certain about the upper age limit of eligibility (the extension of the service to women aged 70-74 years is not always known).

All GPs interviewed understand the difference between screening mammography and diagnostic mammography. They recognise that BreastScreen Queensland is only available to well women. Some GPs however note that not all women understand this difference.

*Referral process*

The referral process is understood by GPs; most had a referral pad or business cards to distribute to patients who have not used the service before. Many report their patients undertaking this process independently of the GP, even those attending for the first time.

*Location of nearest service*

For GPs located in areas with a permanent BreastScreen Queensland service, the location of the nearest service is well known. In regional or rural areas, details about the frequency with which the van visits, the location of the visiting van and when the van is actually in town are not well known by local GPs.

In small towns GPs comment that the women know when the van is in town via word of mouth.
1.4 Triggers to encouraging patients to participate in BreastScreen Queensland

In practices with a committed and active approach to preventive health it is routine to check whether a patient’s breast cancer screening is up-to-date (at least annually). This is more so out of doctor habit than as a result of a formal reminder mechanism. In practices with a less proactive preventive health focus the doctor will discuss breast screening opportunistically or when patients present with relevant symptoms.

Triggers to discussing breast screening are when:

- the patient approaches or has a milestone birthday (40 and or 50 years)
- taking a history of a new patient and uncovering the patients’ family history of breast cancer
- conducting a well women’s check-up (or the 45–49 years health check)
- conducting a Pap smear
- a woman is approaching or experiencing menopause
- another patient is diagnosed with or dies from the disease (this makes the disease and screening top of mind for the GP).
GPs report that patients will raise the subject of breastscreening in response to a celebrity or high profile (often young) person, a family member or a local community member (e.g. a school mum) being diagnosed or dying from the disease. The high level of community awareness of the disease and the recommended screening regime is helpful to GPs when it comes to encouraging women into the service.

**Reminder systems**
Most GPs do not have a formal reminder system in place for breastscreening. There are two key reasons for this:
- The preventive health section of both major software providers does not list breastscreening as an area for investigation.
- The view that BreastScreen Queensland’s recall and reminder system is highly effective. GPs do not want to duplicate a system that is working well, particularly when their own resources are limited.

<table>
<thead>
<tr>
<th>Someone they know, or in the media who has had some breast issue will often bring them in, I think that is the Kylie Minogue Syndrome.</th>
<th>Mixed Disadvantage, Aspley</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family history (is a trigger) you always ask for family history and most people will tell you and women are so well aware of breast symptoms these days, lumps, irregularity, nipple discharge and family history.</td>
<td>High Disadvantage, Kippa-Ring</td>
</tr>
<tr>
<td>You just opportunistically ask them about smoking and all those things especially if it is a fairly simple condition they come in with then you can address some of those other things.</td>
<td>High Disadvantage, Gulliver Townsville</td>
</tr>
<tr>
<td>It most commonly links to people presenting for Pap smears and that is often a trigger to looking at breast screening. Once people have started breastscreening of course they are on a recall system so that keeps them going back.</td>
<td>Rural and Remote, Dalby</td>
</tr>
<tr>
<td>Between 40 and 50 I would discuss it with them, I would say to them, and every time you do a pap smear you do a breast exam so you discuss it then as well. I will say to them once they have passed 40, ‘now listen are you going to start your mammograms now’ and they will say ‘I didn’t know I had to until I was 50’ and I say ‘they will take you any time from now on if you get a couple through your 40s that would be fine, what is your family history like’ and it just opens the discussion. Once they are 50, I will say ‘right have you had it, if you haven’t had it don’t come back until you have had it’.</td>
<td>Low disadvantage, Brookfield</td>
</tr>
<tr>
<td>Subconsciously you often will go through the investigation, make sure they have had a sugar and cholesterol and Pap smear and see that they have had a breastscreen but it is not a fool proof system, it depends on how you function on the day.</td>
<td>Rural and Remote, Dalby</td>
</tr>
</tbody>
</table>

### 1.5 Barriers to encouraging patients to participate in BreastScreen Queensland

Lack of time is the most common barrier to doctors discussing any of the screening programs with patients. Most patients are visiting for a specific reason (rather than a general health check-up) and doctors say that if they take the full consultation time to cover the presenting issue they are unable to spend extra time discussing preventive health issues.

Lack of financial incentive is another barrier for doctors. Some say they don’t want patients to have to pay for a double consultation in order to do additional preventive work, and if they go over the short appointment time limit the doctors receive no extra financial compensation.

Another barrier for GPs is that the topic of breastscreening does not appear in the software (Best Practice or Medical Director) under preventive health. Therefore no alerts are automatically set for this screening.
One GP expressed a view that population screening for women is unnecessary and while she does not actively promote this view, this doctor does not suggest breastscreening (private or via BreastScreen Queensland) to her patients.

The success of the BreastScreen Queensland program also represents another barrier in that some GPs assume their female patients are organising this independently; it reduces the need for GPs to focus on this issue.

The reader is also referred to section 4.0 of this report for a discussion of barriers that are present in relation to a range of cancer screening programs that relate to culturally and linguistically diverse groups.

<table>
<thead>
<tr>
<th>Comparison to past research</th>
</tr>
</thead>
<tbody>
<tr>
<td>Research conducted by Queensland Health with GPs in 2005 also revealed that time constraints were a barrier to GPs recommending BreastScreen Queensland. Not being heavily involved in the conduct of breastscreening is mentioned in 2015 as it was in 2005.</td>
</tr>
<tr>
<td>Limitations in recall systems mentioned in the 2005 research appear to be less pronounced in 2015 as GPs rely on the BreastScreen Queensland recall and reminder system. Issues with the referral pad or process in 2005 were not evident in 2015.</td>
</tr>
</tbody>
</table>

### 1.6 Patient barriers to participation in BreastScreen Queensland

Barriers for patients to screening are generally low; most women (according to doctors interviewed) are said to accept the test as important and undertake it as required.

Patient barriers according to GPs are:

- resistance to preventive health activities generally (i.e. poor health literacy, patient apathy, a sense of immortality, fear of uncovering a cancer death or a fatalistic perspective that ‘what will be will be’)
- perceptions of pain/discomfort of mammogram (and or a poor past experience)
- infrequent availability (rural/remote)
- embarrassment (indigenous)
- not wanting to go to an appointment alone (indigenous)
- not understanding the importance or reason for breastscreening (among immigrants)
- having breast implants; some women assume an ultrasound is needed to avoid rupturing the implant (even after reassurance from the GP)
- a lack of time (although many say because it takes only around 30 minutes this is only a minor barrier).

Distance to travel to be screened is a barrier for indigenous women if the service is not available in an easily accessible or well-known location. One doctor in Cape York says that if patients miss out on the BreastScreen Queensland van (which comes every two years), they will either have to wait another two years, or try to have a breastscreen in between time i.e. if they are eligible for a travel allowance to Cairns for treatment of a medical condition, they can access the breastscreen clinic at the same time. (There is no travel allowance just for a breastscreen to be done in Cairns).

Cost of transport can also be an issue in areas of high disadvantage even if the service is permanently located in the area. For example a woman may have to catch a taxi to the doctor’s surgery and then cannot afford a taxi to the BreastScreen Queensland service.
Regarding the fear of having a breastscreen on their own, one doctor with indigenous clients in Brisbane cites an example of a group screening day where a bus picked up and dropped off approximately 12 indigenous women for screening together. This group approach worked well in screening women who are open to a breastscreen but have a fear of doing this by themselves. The event was also felt to help the program be perceived as part of the cultural practice.

When they organised the bus they all went together and they felt more comfortable but it is really difficult because indigenous people tend to do things together more so than the general population would and for one individual to make an appointment that would be more difficult and they need a lot more support as far as group bookings and so they don’t feel alone and intimidated by the process.

High Disadvantage, Logan

No barriers but there are women who don’t like to do it and there are some women who have done it once and say it is too painful, I can’t go back, I don’t want to do it. There are also some women who say ‘no I will never do pap smear and mammogram’ (for no real reason).

Low disadvantage, Toowong

It hurts, it’s painful and they don’t want to have their boobs flattened like a pancake.

High Disadvantage, Logan

Sometimes some indigenous don’t have the transport and it costs them $50 to come here (to the surgery) and so they don’t want to spend another $50 to get to BreastScreen.

High disadvantage, Kirwan Townsville

Comparison to past research

2005 research with GP’s conducted by Queensland Health highlighted patient barriers similar to those noted in 2015. For example, a resistance to preventive health activities, lack of time and perceptions of pain.

The 2005 study also noted that patients had difficulty remembering to return for rescreening. This barrier was not raised in 2015 given the perceived efficacy of the BreastScreen Queensland reminder service.

Not wanting a male doctor to perform a breast examination was also mentioned as a barrier to women screening in the 2005 research. This was not raised in 2015, most likely because this activity is often linked with the Pap smear test which is now mainly conducted by female practitioners.

1.7 Perceived quality of service

All GPs interviewed have a very high opinion of the quality and service provided by BreastScreen Queensland.

Comparison to private providers (and reasons for recommending private screening)

Clinically, the BreastScreen Queensland service is considered to be on par with private providers. The main difference perceived between the two is that private services provide feedback and offer follow-up testing (ultrasound or biopsy) on the day if needed. GPs interviewed, even those located in the Western suburbs of Brisbane (close to the Wesley Hospital), do not report actively recommending a private provider over BreastScreen Queensland. Where a private provider is used, this is usually at the request of the patient (who feels the private service may be of a higher quality, or who prefers to have the all the tests available to them on the one day) or in instances where symptoms are present and BreastScreen Queensland cannot be used.

GPs also note that while the “full day of service” at some private providers is considered a positive by a few women, most women prefer the quick appointment provided by BreastScreen Queensland and are satisfied with the wait time for results – especially as they are asymptomatic and the screening is free.

GPs do not consider there to be any difference in the ease of referring to BreastScreen or a private provider.

As most referrals to private providers are at the instigation of a patient, GPs say there is little that BreastScreen Queensland can do to change this happening apart from continuing public education about the quality and effectiveness of the BreastScreen program.
Accessibility
In city areas, accessibility of the service is positively rated. One comment from a GP in Toowong, from her own personal experience, is that the new location at the Indooroopilly Shopping Centre can be difficult to find and is a long way to walk for older women with limited mobility.

In rural and remote areas the visitation of the van is considered to make the service generally accessible. GPs however tend to find out from the women that the van is in town and would benefit from prior advice from BreastScreen Queensland about the visitation schedule. A problem in relation to the mobile service is that a woman may have to wait four years to be rescreened if she misses the van’s biennial visit.

Communications from BreastScreen Queensland about patients
GPs report receiving letters from BreastScreen Queensland with normal results and phone calls (and follow-up letters) from the service in the case of an abnormality. GPs are satisfied with the timeliness and clarity of these communications.

Communications are generally received in hardcopy and in most surgeries the reception or practice manager scans the document into the patient’s file. Once the GP reviews the letter some may add a manual recall into their software so that a system reminder appears in two years’ time (or less if the patient has had an abnormal result).

| They are local and I am quite happy with the standard of their work and obviously it is free breast screening for women over 40 and as a result it is not that hard to persuade women to go and I think the standard of their work is fine, I am perfectly content with it as a screening tool. | Low disadvantage, Camp Hill |
| As a screening service I think it is fantastic, it is cheap and quite efficient. For a public service I think it is quite efficient, it is slow but it is screening and if you have an abnormality it will be picked up the week after you have had the imaging done. | Low disadvantage, New Farm |
| We don’t need anything more (communications from BreastScreen Queensland). (Yes women ask to go to the Wesley) I have told them the free BreastScreen Queensland service is good enough when they’re doing screening but if they want me to refer them to the diagnostic clinic at the Wesley or special clinics I will refer them there. | Low disadvantage, Toowong |
| I think it is a great program that people support very well compared to some others. | Rural and remote, Dalby |

1.8 Rescreening
Most GPs are of the view that once a woman commences with BreastScreen Queensland they are compliant in terms of rescreening.

| I think Breast Screen Queensland does a good job as well because they are very good, they send out reminders to patients even before due date. | Low disadvantage, Toowong |
2.0 Cervical screening

2.1 Perceived role of General Practitioners in Cervical Screening

Female General Practitioners (GPs) consider their role and level of involvement in Cervical Screening to be high. This is because they advocate for it as well as provide the service (take the smear, order pathology and follow-up on results). Male GPs consider their level of involvement to be moderate (similar to their role on the BreastScreen Queensland program) as most male GPs conduct very few (if any) Pap smears (see section 2.5 for more detail on this).

I think we have a huge role basically. I think we have a huge role because it’s different from the bowel screening where a patient can do it themselves. Obviously they need to come and see a doctor to do the Pap smear.

High disadvantage, Inala

We have a primary role in identifying relevant women and encouraging and performing the smear test.

Low disadvantage, Belgian Gardens Townsville

I do a lot of Pap smears but I don’t mind, I enjoy doing that kind of thing and I enjoy having the chat to them and looking after that side of things for women.

Low disadvantage, Toowoomba

I have to say certainly the females do far more than the males. Certainly with a lot of our refugee patients, I don’t know if they elect to but everyone just generally assumes that they would prefer a female so they are never booked in for a pap smear with a male. I am sure I do more pap smears than the male GPs here.

High disadvantage, Inala

2.2 GP awareness and knowledge of National Cervical Screening Program

The Pap Smear Registry and reminder services are the elements of the National Cervical Screening Program that are understood by GPs.

Inclusion on registry

GPs report that the vast majority of women agree to be placed on the registry. There is no need for the GP to encourage them to participate.

Eligibility

GPs generally believe that all women aged 18+ years who have been sexually active for one or two years are eligible for the National Cervical Screening Program.

Fees

Most GPs charge a consultation fee in line with their standard fee schedule, that is, if they are a bulk billing practice they will bulk bill the procedure, if not they will charge in line with the time taken. The pathology is universally bulk billed, with the exception of the Thin Prep test. If cost is a barrier for the patient the GP will not order the Thin Prep test.

The cervical screening one - that one is most efficient because they have the Pap smear register.

Mixed disadvantage, Aspley

I use it all the time. That is another very good service because it sends the reminder letter that the women have to go. That is another screen that women will put off, the letter forces them over the line and is a good system.

Low disadvantage, Camp Hill

I am familiar with that yeah. Now they start to do a Pap smear when they turn 18, or if they are sexually active for more than 2 years. And it’s every 2 years unless they have some clinical concern. But I know it is going to change from next year onwards. It is going to be every 5 years.

Rural and Remote, Mt Isa
2.3 Information received from the National Cervical Screening Program

GPs interviewed cannot recall receiving promotional or educational materials about the National Cervical Screening Program in recent years.

GPs do however recall reading about upcoming changes to the screening intervals, although most do not consider this information came directly from the National Program but rather from an association or medical journal. While it is understood that changes are being made, the details of these (commencement age, if the change in screening intervals has been confirmed yet) are not well known.

No (I haven’t received any information). (Do you need anything?) Probably, I went to an obstetric update in Melbourne in March and the Victoria Cytology institute came along and spoke and it was very interesting some of the things they talked about in terms of cervical screening and the fact that you could ring them on their hotline for advice about different things and how to manage it. So that was useful for me to have that as a contact number if I need to contact someone.

Rural and Remote, Dalby

2.4 Triggers to encouraging patients to participate in Cervical Screening

As was the case with breastscreening, in practices with a committed and active approach to preventive health it is routine to check if a woman’s Pap smear is up-to-date. While this is usually out of habit, Pap smear reminders are built into medical software so the patient’s chart is also a trigger for GPs to discuss cervical screening.

Other triggers to discussing cervical screening are:
- prescribing the pill
- the patient becoming sexually active or reaching 18-20 years of age
- recently giving birth
- the woman approaching menopause
- any gynaecological symptoms
- taking a history of a new patient and uncovering that the patient has a family history of cervical cancer
- conducting a well women’s check-up (or the 45-49 years health check)
- conducting a breast check or referring a woman to breastscreening.

Women of reproductive age, anything to do with anything gynaecological is a really good trigger, anyone who has had a baby recently, anyone who is coming in about contraception, those are really good triggers.

High disadvantage, Inala

Absolutely, anyone who asks for contraception, we have the discussion about pap smears. And that is between 20 and 30 year olds mostly.

Rural and Remote, Cloncurry

I just do it. For all the women I ask if they are on the pill, on hormone replacement, when the last breastscreen was done and when the last Pap smear was done and I make a record of it. If they are visitors I say ‘ok you go and see your doctor it is overdue’. Otherwise I say ‘it has to be done, keep it in mind, you have come for something else but I just wanted to remind you’.

Low disadvantage, Toowong

Any time a woman presents for the pill, or new patients, (we discuss it). It is almost routine.

High Disadvantage, Logan
2.5 Barriers to encouraging patients to participate in Cervical Screening

As already mentioned in relation to breastscreening, lack of time is the most common barrier to doctors discussing any of the screening programs with patients. Other barriers specific to Cervical Screening are discussed below.

While most women prefer that a female undertakes the Pap smear, male GPs do not find talking with women about this topic difficult and usually have someone to refer women to for the Pap smear (e.g. female colleague within practice, or a gynaecologist external to the practice).

Some male GPs are grateful not to have to do Pap smears; others consider it is a part of their practice that they are now missing out on. When a woman goes elsewhere for a Pap smear the main GP does not always receive this advice (or the results). This is a drawback.

It can be difficult to opportunistically screen women (on the spot) for Cervical Cancer given the women often need time to ‘prepare’ themselves – either physically or mentally – for the procedure. This comment is most commonly made by GPs with indigenous patients.

For male GPs, the need for a chaperone when conducting procedures such as a Pap smear, while not specifically raised as a barrier, adds another level of complexity to the procedure.

A small number of doctors raise the ethical consideration of conducting Pap smears on women under 18 years who have been sexually active for some years. There is a concern about causing trauma for the child, but also uncertainty about the legal responsibility this could involve for the doctor.

The reader is also referred to section 4.0 of this report for a discussion of barriers that are present in relation to a range of cancer screening programs that relate to culturally and linguistically diverse groups.

<table>
<thead>
<tr>
<th>I think just a lack of time is certainly one because often we do just need to book in for a long appointment just to talk about all of that and see whether they want to have it or not.</th>
<th>High disadvantage, Inala</th>
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</thead>
<tbody>
<tr>
<td>Sometimes you don’t have time and you are there for 45 minutes or an hour and you can only deal with what they are talking about because it is a significant issue.</td>
<td>Low disadvantage, New Farm</td>
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<tr>
<td>I try and get out of it if I can, there are a lot of female GPs in this area and I try and persuade people to go to female GPs for that because I hate doing them.</td>
<td>Low Disadvantage, Camp Hill</td>
</tr>
<tr>
<td>Male GPs don’t like doing Pap smears and female patients don’t want men to do Pap smears on them for the vast majority, so it means the female GPs get a bit inundated with pap smears.</td>
<td>High disadvantage, Logan</td>
</tr>
<tr>
<td>It’s a very grey area (doing a Pap smear on a patient under 18 years), you are wandering into unchartered territory with inappropriateness of sexual assault or something like that and that is not a big part of the whole deal but it is happening more often than it ever was in the past.</td>
<td>Mixed disadvantage, Kedron</td>
</tr>
</tbody>
</table>
2.6 Patient barriers to participation in Cervical Screening

Barriers for patients to screening are generally low; most women (according to doctors interviewed) are said to accept the test as important and undertake it as required.

Patient barriers according to GPs are:

- resistance to preventive health activities generally (i.e. poor health literacy, patient apathy, a sense of immortality, fear of uncovering a cancer and death or a fatalistic perspective that ‘what will be will be’)
- perceptions of pain/discomfort of the smear test (and or a poor past experience)
  - pain or discomfort is especially a barrier for older women. Some doctors will prescribe an oestrogen cream to reduce pain for this segment.
- some women in the older age groups feel there is no need to continue with Pap smears as they are no longer sexually active or because they have had same partner for many years
- embarrassment of shyness among indigenous women or women of CALD populations
- not having access to a female to undertake the test is also a barrier; although most GPs interviewed have a female option for women, some patients may feel uncomfortable asking their GP about an alternate provider.

Cost is not perceived by GPs to be a barrier for women, particularly because the pathology is bulk billed, but also because those GPs with patients with high disadvantage bulk bill the procedure.

Some doctors also comment that with the upcoming changes to the screening recommendations and the advent of the Gardasil vaccination, some women are becoming less concerned about having a Pap smear. Some GPs feel that the change of screening interval to five years will make it harder to ensure compliance among women.

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<th>Quote</th>
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<tr>
<td>I think the young women under 25 are probably taking the law into their own hands at the moment, (because of) Gardasil but also because of the talk about changing it to a 5 year pap smear and while I think that will come, it hasn’t come yet but the 25 year olds are acting as if it is already here and choosing not to have cervical screening.</td>
<td>Rural and Remote, Dalby</td>
</tr>
<tr>
<td>Pap smear screening is a really good thing to do. It concerns me a lot that they are going to change it from 2 years to every 5 years.</td>
<td>Mixed disadvantage, Kedron</td>
</tr>
<tr>
<td>Some as any screening program, finding the time, family illness, that there is a screening program, then there is the cost maybe because we private bill here, generally some people don’t like screening, they don’t want to know. And previous bad experience when they went for a pap smear, it was very painful or very uncomfortable.</td>
<td>Rural Remote, Mt Isa</td>
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<tr>
<td>It is kind of an embarrassment type thing and particularly indigenous they are more sensitive to that kind of issue than the general population.</td>
<td>High disadvantage, Logan</td>
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2.7 Rescreening

GPs interviewed report that most women are compliant with rescreening. Exceptions are among:

- those with indigenous patients who, because of being private and shy, are harder to persuade to have the test or to rescreen as required
- Pacific Islander women (some of whom are said to regard the topic as taboo)
- older women who are not aware that despite being sexually inactive or having only one partner they are still at risk.
3.0 Bowel cancer screening

3.1 Perceived role of General Practitioners in Bowel Cancer Screening

Unlike breast screening or cervical screening, screening for bowel cancer (either through the National Bowel Cancer Screening Program (NBCSP), other private testing kits or an order for a FOBT) is not top of mind for GPs. Bowel cancer is widely recognised as a serious and widespread cancer and testing is routinely offered once a patient presents with a specific symptom or identifies a family history of bowel cancer. However, screening for bowel cancer does not routinely feature on a GPs preventive health checklist for patients who qualify for the program.

GP involvement is especially low in regards to the NBCSP primarily because the test is distributed, undertaken and submitted without their input. Many GPs suspect patient compliance to be low.

We (GPs) have kind of deferred to the program. I was thinking that it would almost be better if somehow the GP could endorse the test to the patient.

Rural and Remote, Dalby

We’re (GPs) only (involved) as much as we remind people that it is out there. From my personal point of view, I think the GPs have been cut out of the loop.

Mixed disadvantage, Aspley

What the government is doing is sending the patients directly a piece (in the mail), so GPs are not in that loop, patients and the government do that.

High disadvantage, Inala

I think with the screening, the idea is we are not meant to be that involved and it is meant to be a reminder here and there and I know I put reminders in for the breast cancer one, in case they miss their mammogram, but I have to say of all three, the bowel screening one seems to be the least well organised.

High disadvantage, Logan

3.2 GP awareness and knowledge of National Bowel Cancer Screening Program

While GP awareness of the National Bowel Cancer Screening Program (NBCSP) is high, knowledge of how it works is limited.

Familiarity with kit

Unless they have received a kit themselves through the mail, most GPs have not seen a kit or its contents and they are not aware of the specifics of the testing procedure.

Eligibility criteria

While most are aware that kits are sent to people at 50 years of age, few doctors can accurately recall the rescreening intervals or the cut off age on the NBCSP.

Referrals of +FOBT

The referral path recommended by GPs is directly influenced by whether the patient has private health insurance or not. If a patient has private health insurance (and is willing to pay the gap) the GP will refer to a private specialist. If not, the GP will refer the patient to the public system. There is a perception that the waiting time in the private system is only a few days compared to weeks or in some cases months to access the public service.

Very few GPs are aware of the NBCSP Gastroenterology Nurse; most just refer to the relevant hospital. There is some scepticism of the value of such a specialist nurse as this can be perceived as adding another layer of bureaucracy to the process.
3.3 Information received about the NBCSP

GP\s can recall receiving very little information on the NBCSP in recent years.

3.4 Triggers to encouraging patients to participate in bowel cancer screening

Bowel cancer is not usually proactively discussed by most GPs unless the patient has a specific symptom or has a family history of bowel cancer. Where family history or presenting symptoms are present, a colonoscopy is ordered rather than FOBT.

For those GPs who are proactively discussing bowel cancer screening, age is the key trigger. GPs in areas of low disadvantage will often refer a patient straight to a colonoscopy as they consider this to be the best standard. For proactive GPs with patients with high disadvantage a FOBT is normally used.

One GP in remote north west Queensland is highly alert to bowel cancer screening given he has a (relatively) large number of male patients who eat significant quantities of red meat.

Reactions to the idea of having NBCSP kits on hand to distribute are mixed. GPs working with CALD groups are more likely than others to be interested - especially those with indigenous patients as they believe the personal recommendation the GP would increase uptake. Those with patients from non-English speaking backgrounds suggest kits written in their patient’s language could be provided to them (e.g. Asian GP in Sunnybank) to distribute to relevant patients.

_Awareness of cost_

GP\s are aware that the NBCSP is free.

_Tests results_

GP\s are aware that they receive a letter advising a patient’s results if the patient has nominated them as their doctor. They assume patients are also sent a letter although few are certain about this issue.

<table>
<thead>
<tr>
<th>I am much, much more vague on this (bowel cancer screening) than on the women’s ones.</th>
<th>Low disadvantage, Brookfield</th>
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<tr>
<td>I didn’t know there were specific gastroenterology nurses who can take care of referrals; I just refer to colonoscopy clinic at the RBH.</td>
<td>Low disadvantage, Toowong</td>
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<tr>
<td>If the system was organised properly, why would you need them (gastroenterology nurses). You have protocols and people follow the protocols so why do you need to give somebody another $70k salary. They have the same thing going on at the Mater; they have a dedicated stones nurse for anyone that turns up in emergency with a kidney stone.</td>
<td>Low disadvantage, New Farm</td>
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If there is a strong family history, if they had a father who died of bowel cancer and they come in and say I am 40 years old and I am worried, I would send them for a colonoscopy. I would do an FOBT as well but I wouldn’t be reassured by a negative FOBT when it’s a first degree relative.

Rural and Remote, Cloncurry

If they have a history and they are bleeding, I advise them not to participate because they are going to be positive and then they’ll have to go for a colonoscopy anyway.

Low disadvantage, Toowong

Just start talking about it, just that they are here and they are over 50.

Low disadvantage, New Farm

Biggest (trigger to discussing bowel cancer screening) is family history. That would be number one; symptoms would be number two and age number three.

High disadvantage, Logan
3.5 Barriers to encouraging patients to participate in bowel cancer screening

Despite GPs being aware that bowel cancer is a common and life threatening disease, the main barriers to GPs encouraging patients to participate in bowel cancer screening are related to screening having a lower prominence in the minds of both GPs and the general public.

Many GPs feel that the disease is not strongly in the public domain and feel that the public:
- underestimates the incidence of the disease in the community (because it’s not spoken about and not commonly heard of in public campaigns about preventive health)
- underestimates the severity of the disease/mortality rate.

A number of GPs do not have a high level of confidence in the FOBT and as such will refer straight to colonoscopy (in low disadvantage areas). Colonoscopy is considered the most definitive test and also provides a baseline measure, another potential benefit of the procedure. Further, a number of patients (in low disadvantage areas) request a colonoscopy believing this to be the recommended protocol for asymptomatic individuals.

A few GPs consider a colonoscopy to be the screening test.

Doctors, particularly in regional Queensland, mention that because the “45-49 years Health Check” is before the bowel screening age it is not included (or even discussed) during the health check. This is considered a lost opportunity.

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<th>Mixed disadvantage Kedron</th>
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<tr>
<td>You often don’t necessarily suggest the kit really, you might suggest that they go off for colonoscopies but the kit really doesn’t spring to mind as something to use.</td>
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<thead>
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<th>Mixed disadvantage Kedron</th>
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<tr>
<td>It is not routine (to discuss or recommend bowel cancer screening), it is not top of my mind but for some reason it is quite often discussed. But I would have thought probably in the discussion it is at least 50% started by the patient rather than by me, the other (screening programs) it might be me that initiates the discussion, but this one (bowel cancer) it might be someone else.</td>
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<tr>
<th>Low disadvantage, Brookfield</th>
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<tr>
<td>You try to be proactive but the reality is often patients when they are coming in for something in particular, you won’t have time.</td>
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<th>High disadvantage, Logan</th>
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<tr>
<td>I think there is a bit of stigma with bowel screening, people think it is a terrible test to do, they are not very keen on having it.</td>
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<th>High disadvantage, Inala</th>
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<tr>
<td>Anyone over the age of 50 should have a colonoscopy or if there is a family history, start screening colonoscopies 10 years before the person who has been diagnosed with colon cancer so there is a bit of wriggle room in there as well but for people over the age of 50 they are saying they should have colonoscopies. (Not the screening test?) The screening test, the one they send out in the mail, you don’t get a great response.</td>
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Mixed disadvantage, Kedron
3.6 Patient barriers to participating in NBCSP

A number of patient barriers are proposed by GPs:

- Not knowing enough about the program and not having the GP endorse or encourage them to complete it.
- Considering the sample collection process to be unpleasant.
- Considering a colonoscopy to be a better test (due to word of mouth from others or recommendation from GP).
- For Asians (and likely other NESB groups) the English instructions are too complicated to read and understand – doctor suggests providing kits with Mandarin instructions, YouTube instructional videos, or doctors in these areas could be provided with kits with instructions in Mandarin/other relevant languages.
- For rural and remote doctors or metro based doctors with indigenous patients- having kits on hand to distribute is suggested – doctors consider their personal recommendation may increase uptake among patients.
- Unlike breast and cervical screening, there is no other test that naturally fits with bowel cancer screening.

| I think maybe part of it is being patient driven, I don’t know that it should be but it’s just, often, it’s dependant on us thinking about it and saying, have you had your screen for bowel cancer. It’s rare that patients would bring it up with me so, I don’t know why that is, if they are just not aware of it or if they are not comfortable talking about it or they just don’t think it’s relevant to talk about it with your General Practitioner. |
| High disadvantage, Inala |

| Because people are just getting these kits in the mail, they haven’t been talked to about it, it is not being discussed, they don’t know the pros and cons. Obviously many people aren’t bothering to find out the pros and cons. A hell of a lot of people are going unscreened whereas when I suggest that someone has an FOBT, and I actually write out a request form they go and do it. |
| Rural and Remote, Cloncurry |

| Last week I had someone come in and say ‘do I need to do it, how do I do it’. So they should have it on the covering letter and some pictures to say it is not that difficult to do it (have this on the covering letter) rather than inside the actual kit because they won’t open it. |
| Low disadvantage, Toowong |

| I have a feeling that the majority of them haven’t done it; I have a feeling that most men and women throw it in the bin. |
| Mixed disadvantage, Aspley |

| I don’t have many people that take up the kits. You almost can’t give them away. |
| High disadvantage, Logan |

| Talking about my Chinese speaking patients that don’t read a lot of English, it would be good if they could get the kit in whatever language they speak because they bring the kit and everything in and say ‘what do I do with this’. I am sure others will just put it in the rubbish bin. |
| Mixed disadvantage, Sunnybank |

| The thought of having to play with your faeces doesn’t appeal to a lot of people and I think when you get a pack like that, I know what I am like, you get a pack like that and start to read it and it has what appears to be complex instructions, it is a turn off and you think ‘I don’t think I can do this, I don’t feel like reading it, I just need someone to tell me how to do it’. You couldn’t really run an ad on TV showing people how to do the test. |
| Rural and Remote, Dalby |

3.7 Rescreening

Once the first FOBT has been done GPs suspect patients are compliant with rescreening. GPs are however generally uncertain about patient compliance in the first place.

GP reports that patients who have had a colonoscopy are highly compliant in rescreening, usually because the hospital/specialist that performed the last colonoscopy is likely to have a recall and reminder system in place.
4.0 Segment specific barriers to cancer screening programs

Rural/remote
Time pressures are very high (especially for GPs who may only visit a destination one day a week/month) and acute presentations or urgent matters have to be dealt with in the first instance.

Indigenous
If the doctor does not have a long established relationship, indigenous patients can be reticent to talk about such personal matters, this being especially the case if the doctor is male. Another barrier pertains to the desire to be supported by someone (i.e. a liaison person or a friend) when having to go to a different location for a screening test. Other barriers for indigenous people specific to individual screening programs are detailed throughout the report.

Males in rural/remote areas
Males can be difficult to encourage into preventive health programs generally (only likely to come in with specific symptoms rather than for general check-ups).

Muslim patients
Some GPs note the difficulty they have in talking about women’s screening programs when they are unable to talk directly to the patient and have to talk through the woman’s husband (in some instances husbands will attend their appointments). The GP either feels uncomfortable or cannot be certain that the woman understands what the doctor is talking about.

Immigrants (Indian / Asian / African)
GPs need to educate women about preventive health as this is something they may not have any experience of in their country of origin. Once they understand the value of screening, these groups are reportedly highly compliant with participation in the screening programs.

Those in need of an interpreter’s service
For women who cannot speak or understand English, some GPs are reliant on the telephone interpreter’s service to help explain screening and other health matters. Unfortunately there are instances when delays are present with this service and GPs run out of time to include non-urgent topics in these interpreter assisted discussions.

Non-compliant population
According to GPs, for all programs there is a segment of patients who refuse cancer screening. Doctors say this is due to a combination of factors including poor health literacy, apathy, a sense of immortality, a fatalistic perspective, embarrassment or a fear of uncovering a cancer and death.

<table>
<thead>
<tr>
<th>Sometimes it is hard, especially if there is a husband there with them and they are answering for them. Then you find it quite hard to know whether this woman does want screening and the husband is saying, no, she doesn’t need it. And that is always tricky. There is no easy way to get around that unfortunately.</th>
<th>High disadvantage, Inala</th>
</tr>
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<tr>
<td>Dealing with women of a different cultural background, where the husband does all the talking for them, that is a very difficult consultation to have when the woman who is the patient for whatever reasons, looks to the husband before she makes any comment.</td>
<td>Mixed disadvantage, Kedron</td>
</tr>
<tr>
<td>In Vietnam for example there is no Pap smear system and certainly no breastscreening and so when you talk to them about these programs they look at you as if you’re an alien.</td>
<td>High Disadvantage, Logan</td>
</tr>
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</table>
(Having materials that) just explain it simply in their language the importance of breast screening, might be helpful, I am not sure whether they do have resources like that, if they do that would be good so we can print out and give out for them to read and understand.

Rural and Remote Mt Isa

Women of Indian background, culturally they are not even aware of it because I see a lot of Indian patients and it is completely new, they have never heard of it so then I have to tell them and they are the ones who are very shy.

Low disadvantage, Toowong

I would like different languages leaflet for what the heck is about to happen. There is a website that I have found, I don’t think it’s Australian, and it has some languages on it, but it doesn’t have a lot, we have a very wide range of clients.

High disadvantage, Inala
5.0 Other observations

5.1 Importance of public awareness campaigns

Government run cancer screening and reminder programs are welcomed by doctors who note that they can’t be expected to cover all preventive health issues with patients all the time.

Public awareness campaigns regarding the need for screening and information about the screening process are considered critical by GPs who would like to see patients take a more active role in their health (rather than relying solely on the recommendation of the GP).

Another reason for considering public awareness campaigns to be important is that a doctor’s recommendation has a limited reach:
- Not everyone goes to the doctor or wants to discuss these programs when they are visiting for a specific reason.
- Doctors who have a strong commitment to preventive health also recognise that their style can cost them patients because patients effectively self-select the doctor that suits their needs (i.e. for some patients, a doctor that provides a script or referral with little discussion of other non-relevant issues is preferred).

5.2 Well run government programs reduce the burden on GPs

Once there is a government reminder mechanism in place there is less likely to be a formal system utilised by GPs:
- A government reminder mechanism provides an opportunity for GPs/practices to reduce their workload in this area.
- This is especially the case for BreastScreen Queensland as doctors have experienced the reliability of this program and therefore have confidence in it.
- Formal written reminder processes are difficult for GPs to manage – especially those in smaller surgeries without dedicated resources. It can also be difficult for those in areas of higher disadvantage with a transient patient base; these doctors question when they should stop trying to contact people (how many attempts should they make?) (What is their duty of care in this area?).

Government programs that take over this process are therefore welcomed.

5.3 Impact of large clinics and irregular patients

The opportunity for discussing cancer screening programs and encouraging participation are reduced when a GP doesn’t have regular long-term patients:
- For transient patients or patients who see multiple doctors it can be difficult for relationships to be built. The advent of larger clinics as well as the increase in doctors working part time appears to be contributing to this situation.
- Having an existing relationship with a patient means that a doctor can spend more time talking about preventive health measures – rather than spending the time familiarising themselves with the patient’s history or building a rapport. It also allows the doctor the opportunity to bring up preventive health issues (including sensitive issues such as Pap smears) even though the patient may be presenting for an unrelated issue (e.g. a sore throat).
- Trust and relationships are especially important in rural or remote areas and for indigenous patients.
5.4 Information received on screening programs
According to GPs interviewed, few can recall receiving information or educational resources about any of the Cancer Screening Programs in recent times.
- Most feel they do not have a need for such information and would prefer general public awareness campaigns rather than GP targeted information.
- Some GPs would however like to be updated on these programs, especially on issues such as eligibility, statistics about the programs and the latest research about these forms of cancer.
- Some suggest segment specific educational information could be useful (e.g. communications tailored to indigenous, or language specific material). There is a preference expressed however to have this in electronic format so that it can be easily accessed and printed out as the need arises.

5.5 Evaluation of patient screening via software
The generation of data on the proportion of patients who are not up-to-date on various preventive health issues helps to focus GPs on these areas and give them a goal to work towards. Most GPs do not however use their surgery’s software for this purpose.

The exception to this is in regional Queensland (Townsville mainly) where Medicare Local has been actively helping practices by installing software and analysing results. In metropolitan areas the practice of analysing the proportion of patients who are screened is noted in a small number of larger, modern practices with a proactive practice manager. These surgeries audit this information as part of retaining their practice accreditation.

5.6 Inconsistent approach within a practice
Within the same practice (particularly in larger practices without a proactive practice manager), doctors often say they are unaware of what procedures are followed by other doctors when it comes to screening.

5.7 Use of practice software
Approximately one half of interviewed GPs use Best Practice (n=14), the other half uses Medical Director (n=15) (n=1 doctor uses Zed Med). Both Best Practice and Medical Director have a preventive health field or section. While the Pap smear appears to be standardly highlighted as an item for completion, breast screening and bowel cancer do not.
6.0 Information handling

Generally speaking GPs report being inundated with information from pharmaceutical and professional organisations. Most deal with this information manually by scanning and discarding those information pieces not immediately relevant.

They report however only receiving a limited amount of information from Queensland Health. The exception is Health alerts (i.e. communication of a Measles alert or changes to the immunisation schedule from the Communicable Diseases Unit) received from Queensland Health which are regularly received. This type of information is deemed very important and likely to be read and retained.

There was some reference to receiving promotional materials in the past about the cancer screening programs however this information was typically targeted at patients more so than GPs. Pamphlets about nutritional advice among GPs working with disadvantaged patients was also mentioned.

Most doctors advised that if they needed specific information from Queensland Health, they would firstly google the topic to try to locate a relevant phone number and then make phone contact with the relevant section of Queensland Health.

Preferred channels
There is still a preference for hardcopy materials among at least one half of the GPs interviewed. Reasons for this preference are habit and portability (i.e. they can take hardcopy information with them to read when time permits). Some doctors do prefer email or web based communications though to reduce paperwork and allow easy access as required.

Web portal
An easily accessible web portal where GPs could source the most up-to-date recommendations or information about a screening program is welcomed by most. This type of portal could include easy access to other infrequently used information pieces such as translated communications or age specific communication pieces.
Conclusions and recommendations
General reactions to programs

Overall, GPs are strongly supportive of cancer screening and keen to play a role in encouraging their patients to commence participation in screening programs and to rescreen. The role of the GP and their level of knowledge however varies across the three cancer screening programs discussed in this research.

BreastScreen Queensland has a strong level of support from GPs across the state. The service is considered to be of a high quality, is generally well understood by GPs and there is a strong level of community awareness and support for the service. GPs have faith in the recall and reminder system and consider this to be a key element to the program’s success. GPs do not however see themselves as being central to this program; the effectiveness and pervasiveness of the program means that women often take ownership of this process themselves and this reduces the need for a high level of involvement from GPs. GPs assume patient compliance with this screening program is high.

GP support is also very high in regards to the National Cervical Screening Program. The Registry and reminder service is considered to work well and GPs report the vast majority of women are happy to be included. Because they conduct the test, GPs consider themselves to be central to this program. Pap smears feature in the preventive health section of the software used by GPs and of the three programs discussed, this is the one where GPs are most likely to have their own formal reminder for women to return when due for a Pap smear. GPs are generally aware that changes to the screening protocols are coming into effect, although a detailed understanding of these changes is not universal. GPs assume patient compliance with this screening program is high.

Compared with the other screening programs, the National Bowel Cancer Screening Program has a lower level of prominence in the minds of GPs who do not perceive participation in the program to be high. While bowel cancer is recognised as a relatively common and serious cancer, many GPs tend to only promote screening (via FOBT or colonoscopy) for patients with a family history or symptoms. While GPs have a basic understanding of the program, they are uncertain about when and how often the kits are sent, what is contained within the kit or how users complete the test. There is a view among some GPs that relying on a FOBT is not optimal and they prefer to send patients with a family history or symptoms straight to a colonoscopy. Most however say that as a screening tool, especially for patients from areas of higher disadvantage, the program is valuable. After discussing the issue in the interview, most GPs express an intention to now include this program when talking with patients about other preventive health issues.

While GPs understand the importance of their role in encouraging people into screening programs, especially the newer NBCSP, they all stress the importance of continued public awareness campaigns to help create an interest in participation among the general public. It is important, from a GPs perspective, that people accept responsibility for their own health and prevention activities rather than solely relying on others.

Recommendations:
There is a clear need to increase awareness and understanding of the National Bowel Cancer Screening Program among GPs.

While GP awareness and understanding of the BreastScreen Queensland and National Cervical Cancer Screening Programs is generally strong, there is an opportunity to refresh GPs on the finer details of these programs and the technological improvements that have been made in recent years.
Triggers and barriers to encouraging participation in cancer screening programs

MEMORY AND REMINDERS
The primary trigger to GPs encouraging their patients to commence participation in cancer screening programs is habit, GPs relying on a list of memorised questions to ask during a consultation.

Computer software is another key trigger alerting GPs that a patient is due (or overdue) for a Pap Smear, however the main software programs in use do not (according to most doctors) automatically cover breastscreening or bowel cancer screening. The exception to this is if a doctor manually adds a recall for breastscreening or bowel cancer once the results of a screening test are received.

Recommendation:
Consider strategies to reduce the reliance of GPs on their memory and revert instead to software tools, written checklists and visual reminders. Visual reminders could include:

- a digital photo frame for a GP’s desk that rotates through information on the three programs
- a display case of business cards to hand out to patients – one holder with three business cards could be used - each card could have details of program, phone numbers, locations, websites
- a QR code that patients can scan with their mobile devices to access web pages with relevant details.

Note that while posters/brochures may be useful for patients they are less likely to be noticed by GPs.

There may be an opportunity to work with software providers to include (or increase prominence) of cancer screening programs/reminders on the preventive health section of software.

The RACGP’s Red Book is referenced by some doctors; this guide offers a checklist of preventive health issues to discuss with patients at key age milestones and includes mentions of cancer screening tests. Reference to this checklist in other communications with doctors may therefore be worthwhile.

AGE
A patient reaching the age where screening becomes relevant is another important trigger to GPs discussing cancer screening with patients. Because the “45-49 years health check” is completed prior to the 50 year milestone, bowel cancer screening is not included at this health check.

Recommendation:
Consider incorporating bowel cancer screening as a discussion point in the 45-49 years health check.

LINKING WITH OTHER COMPLEMENTARY ISSUES/TESTS
Breastscreening and Pap smears are closely tied in the minds of GPs, whereas bowel cancer screening is not currently associated with other preventive health activities.

Recommendation:
Consider grouping all screening tests together in a general cancer screening communication piece and or developing a mnemonic device that references all major cancer screening tests (e.g. Breast, Cervical, ColoRectal, Skin, Prostate – BCCRP).
PATIENT LED TRIGGERS AND BARRIERS
Having a patient raise the issue of cancer screening is another prompt for the GP to discuss the various programs. The importance of public awareness campaigns is therefore noted by doctors as another way of encouraging discussion about cancer screening.

Public awareness campaigns can provide GPs with more confidence to raise these issues with patients, especially for those seeing patients with whom they do not have an established relationship.

Recommendation:
Keeping GPs up-to-date with general population awareness campaigns would be useful.

PROGRAM SUCCESS
The perceived success of the BreastScreen Queensland program can cause some GPs to consider it less important to raise this program with women on the assumption that women are already going independently.

Recommendation:
If participation rates are lower than desired communicate this to GPs.

LACK OF TIME
Not having time or a perception that patients do not want to spend the time discussing cancer screening is a barrier to GPs discussing the issue.

This issue is exacerbated in large clinics where GPs do not have the opportunity to build a relationship with patients; GPs with established relationships are more easily able to raise issues even when the time is tight or when the patient’s presenting issue is unrelated.

Recommendation:
Other recommendations may help in this regard. For example: community awareness campaigns, visual reminders on the GP’s desk, business cards or QR cards that can be quickly referenced may assist in enabling the doctor to succinctly address these issues and lead to more in-depth discussion in future consultations.

If patient research (i.e. the quantitative study being conducted in partnership with the University of Wollongong) reveals that patients are open to discussing these issues, even when presenting with another condition, communicate this to GPs.

PREFERRING A FEMALE PRACTITIONER
There is a widespread trend for women to prefer a female GP or nurse to take the Pap smear. For male GPs without a female on staff, patients will go elsewhere for this procedure. While male GPs are accepting of this trend, there is a risk that the results of the test are not fed back to the patient’s main GP and questions arise as to whether the GP conducting the Pap smear is able to adequately follow up and or recall a patient they may have only met once.

Recommendation:
Consideration of ways to ensure the main GP is informed of test results may be needed.

LACK OF CONFIDENCE IN FOBT
A number of GPs do not have a high level of confidence in the FOBT and as such will refer their patients straight to a colonoscopy (in low disadvantage cases). Further, a number of low disadvantage patients request a colonoscopy believing this to be the recommended protocol for general screening.

Recommendation:
Communication with GPs about the efficacy of the FOBT for screening and the statistical population benefits from the NBCSP would be worthwhile.
GP RECOMMENDATION AND PATIENT RESISTENCE

Patient resistance to screening is considered by GPs to be strongest in relation to the NBCSP. Patients find the kit difficult (and potentially unpleasant) to use and according to GPs are unlikely to undertake it without GP endorsement. GPs generally feel disconnected from the NBCSP process.

**Recommendation:**
Incorporating GPs more strongly in the NBCSP process (by encouraging their endorsement to patients) is recommended.

VISITING BREASTSCREEN QUEENSLAND SERVICE

GPs in rural or remote areas tend not to have prior awareness of when the BreastScreen Queensland van is visiting town.

**Recommendation:**
Prior advice from the service to GPs may be useful so that GPs can pre-warn relevant women that the service is about to be or is currently in town.

Information

**INFORMATION FOR GPs**

Generally, GP’s cannot recall receiving much, if any, information from Cancer Screening Programs in recent times. While first reactions are often to assume they are up-to-date and generally well informed about each of the cancer screening programs tested, upon reflection most agree they could benefit from an update.

Information of interest includes current eligibility criteria, latest technologies in imaging, advances in pathology methods and statistics detailing the benefits of the program.

**Recommendation:**
Because of their own presumption that they are well informed it may be difficult to reach GPs with information unless it appears significantly new or different at first glance.

Some suggestions for information delivery are provided below:

- Case studies – as GPs get a sense of satisfaction from positive outcomes, consider developing case studies (if possible using real GPs and patients) about early detection via screening.
- Face to face – consider face to face presentations at seminars or functions organised by professional associations or organised presentations delivered in the surgery to larger well organised clinics. The availability of CPD points for attending such sessions increases the appeal for GPs.
- Familiarity sessions/tools - for example, a visit to a breastscreen Queensland van or clinic (and meeting staff) or providing a NBCSP demonstration kit for GPs to use in the surgery when discussing the FOBT with patients.

Keeping in mind that not all GP practices have a dedicated practice manager, communications should standardly be targeted towards all GPs, not just the principal GP or practice owner.
INFORMATION FOR SPECIFIC SEGMENTS

Indigenous and CALD groups are reportedly less well informed about preventive health issues compared with other groups and therefore have specific needs. The most common finding is that GPs generally need to spend more time explaining and persuading these groups to participate in cancer screening programs.

Recommendation:
If not already available, consider the following:
- Developing NBCSP kits with instructions specifically for indigenous/CALD groups (pictures may be needed as well as text). Provide these to relevant GPs to distribute to patients. GP recommendation and endorsement of the NBCSP kit is considered especially important for indigenous and CALD people.
- Consider offering group breastscreening days (including transport) for indigenous women who prefer to undertake these tasks as part of a group.
- If not already in place, consider developing information pieces that reflect the culture of the group (use language and imagery that reflects indigenous or CALD groups).

Analysis and comparison of databases

The provision of data on the proportion of patients who are not up-to-date on various preventive health issues helps to focus a GP’s attention on these areas and gives them a goal to work towards.

Recommendation:
Continued assistance to help GPs understand the screening profile of their patients would be recommended.
GP Personas

Personal style and the workplace environment impact a GPs propensity to discuss cancer screening programs with patients.

During the study four broad doctor personas emerged (as described in the adjacent chart). The personas vary on two dimensions: personal style (proactive/reactive) and the size of practice (larger/smaller).

The motivations and needs of each persona are identified over the following pages and could be referenced when designing new materials or approaches to doctors.

It should be noted that these personas are based on the qualitative research only. The size of each segment is not known.
Doctor Sam is highly engaged and proactive in relation to preventive health. She’s seen the benefits first hand of catching things early (she can give a number of examples where because of her early intervention she’s saved someone’s life). Her patients thank her for it and privately she gets a sense of satisfaction knowing she’s made a difference.

Dr Sam has worked in the practice for a long time, her surgery isn’t modern or state of the art, files aren’t always well organised but it’s well liked – children’s drawings, thank-you cards and pictures of babies adorn the walls. She’s part of the community; she and the receptionist know everyone well (and often their children and their grandchildren). If patients can afford it Dr Sam charges them, if not she bulk bills. Working as the main practitioner, sometimes supported by a second doctor, Sam feels an obligation to look after her patients; she’d like to retire but her patients need her and she enjoys it. Besides, what else would she do?

Dr Sam has built up a level of trust with patients so doesn’t mind having the hard conversations with them. She’ll push them if needed – taking the risk of a patient going elsewhere if they don’t like her style. She doesn’t mind going over time either and her patients understand that sometimes their appointment time will be delayed.

Dr Sam uses electronic patient files, but with limited administration support and nursing staff, the time to organise formal reminder systems for cancer screening is just not available. Fortunately she makes it a habit of checking that her patients are up-to-date with things. For Dr Sam, government run population screening programs are well regarded for their effectiveness and because the input required from her is minimal.

Old habits die hard, so hardcopy materials about preventive health are preferred when dealing with medical issues. Plus she can take them home and read them in her “spare” time. She’s been around a long time and is too time poor to attend organised seminars or the like. Nor is she impressed by the excess at some of the GP functions and conferences these days. If there’s something she needs to know she’ll ring and ask – she’s been around so long everyone knows her.

Doctors like Sam are decreasing in numbers. Some are closing their solo practices and transitioning to part time work at one of the bigger clinics. While the work is less satisfying it gives them freedom to do other things.

**Doctors like Sam need:**
- assistance of government-run recall/reminder services (e.g. like that employed by BreastScreen Queensland or Pap Smear Registry)
- help remembering to prompt patients with preventive health questions (visual reminders – posters/checklists/business cards/brochures/desk items)
- a refresher information piece, via a simple one page hardcopy document.

*Please note: While each persona description is written from the point of view of one gender, each persona could be either male or female.*
Dr Shannon is a highly proactive and engaged doctor at the early to mid-stage of his career. Working at a large practice, he has access to other doctors for advice, the support of a nurse at all times and an organised practice manager. Protocols and systems are in place to ensure standardised and high quality service for patients, reduced risks for doctors and a stimulating work environment. He hopes to stay at this practice for some time.

Dr Shannon has some long term regular patients, but on any given day will see a number of new patients. This can make it hard for him; patients sometimes get frustrated talking about issues not related to the reason for their presentation on the day. But he persists; it only takes a minute to raise the issue of cancer screening. He relies on the software to alert him when something is not up-to-date.

He doesn’t perform Pap smears as he feels that most women prefer a female. There is a nurse on staff trained in the procedure and other female GPs and he openly informs his patients about this.

The practice manager that Dr Shannon works with is highly organised and effective; she regularly runs information sessions for doctors and produces reports that give the doctors an overview of their patients as well as how well each doctor is going in regards to different preventive health areas. The practice has a high level of accreditation meaning that all the doctors and their files are audited. Dr Shannon likes this as it allows him to focus his attention on preventive health areas of greatest need.

The practice has a number of formal reminder systems in place – both for the GP and for patients – things don’t fall through the cracks very often. Standardised procedures can at times work against his attempts to provide a preventive approach to medicine (i.e. not being allowed to go ‘over time’ without having to bill a client for a screening service).

While a lot of information comes through in hardcopy, Shannon prefers digital information. Generally well informed about the cancer screening programs, Shannon is still interested in staying up-to-date and learning more about the programs.

**Doctors like Shannon need:**

- data on local, state and national averages (in terms of patient participation rates in screening programs) to provide comparative benchmarks to their own patient database
- one page information sheets that they can hand out to patients with further details to back up a short discussion
- visual reminders to prompt them to discuss cancer screening and prompt clients to ask about it
- to stay up-to-date – they therefore welcome general information, seminars, visits from cancer screening service personnel or the option to visit cancer screening services such as BreastScreen Queensland.
Dr Ashley has worked in a variety of locations and has seen a wide range of patient types during his working life. He’s currently at a large and busy clinic. It works well for him; he can work long days or weekends and then take off time through the week as needed.

The focus of the clinic he is currently at is to deal with as many patients as possible each day. The practice manager and patients expect the doctors to run on time. He hasn’t developed too many long term relationships. Most patients are there for a single issue and really just want to get in and out. There’s usually little time left to talk about anything else, so unless the patient raises the issue or is there for a general check-up he doesn’t get around to talking about cancer screening.

Dr Ashley believes this style of medicine suits his patients; they’d probably go elsewhere if he started raising issues with them that are outside the reason for their visit on that day.

Overall the clinic does not have a strong focus on preventive health, dealing with acute presentations take up the majority of the time. They’re currently without a practice manager so reminder and recall systems are not in place. There are many doctors at the surgery, all working different days and times, so it can be difficult to get together with colleagues to discuss practice issues or medicine generally.

Despite not being very clear on the finer details of the screening programs, he’s unlikely to attend seminars or information sessions or do any in-depth reading on these programs. Any communication needs to be short and sharp to get his attention and time.

Doctors like Ashley need:

- inspiration to discuss cancer screening programs – e.g. case studies of GPs and patients who have benefited from cancer screening
- ideas on how to fit the discussion into a busy appointment
  - one page information sheets that they can hand out to patients with further details to back up a short discussion
- support to the practice generally to encourage more of a practice-wide preventive health focus
- data on local, state and national averages (in terms of patient participation rates in screening programs) to provide comparative benchmarks to their own patient database
- help remembering to prompt patients with preventive health questions (visual reminders – posters/checklists/business cards/brochures DESK items)
- a refresher information piece, via a simple one page hardcopy document
- assistance of government-run recall/reminder services (e.g. like that employed by BreastScreen Queensland or Pap Smear Registry).
Doctor Alex would like to be proactive about preventive health but in reality it’s difficult. She’s working for a small practice part-time, providing support to the main GP who has owned the practice for many years. She often sees the same patients but hasn’t had an opportunity to build a lot of strong relationships; she only works two days and a half days a week and patients would prefer to see the main GP. Dr Alex is really their back-up doctor.

With a young family, time is limited and Dr Alex doesn’t get to do much professional reading or attend conferences. This is something she wishes she had more time for. She’s not as time‐pushed with her appointments as some of her peers in the bigger clinics, but patients typically come to her with basic complaints or issues and are keen to get in and out, so most consultations are short.

From time to time she will discuss preventive health issues. She’s not shy about it, but it’s just not always top of mind. She has a fairly good understanding of the screening programs but is open to being kept up-to-date (however she just may take some time to get around to reading materials).

She can’t access her work emails from home, so hardcopy information is usually best. At least she can take it with her and read it later if she gets time.

**Doctors like Alex need:**

- help remembering to prompt patients with preventive health questions (visual reminders – posters/checklists/business cards/brochures/desk items)
- ideas on how to fit the discussion into a busy appointment
  - one page information sheets that they can hand out to patients with further details to back up a short discussion
- a refresher information piece, via a simple one page hardcopy document.
Barriers and enablers to participation in cancer screening programs: Qualitative research with Queensland General Practitioners
Appendix A - interview guide

Guidelines to be emphasised to participant at the start of each interview

- Introduce self and researcher role.
- All information discussed remains confidential and will only be used for market research analysis.
- The discussion is audio recorded (with respondent’s permission).
- Information is collected and reported in aggregated form and no individual names are included.
- Signature on sign-in sheet required
- Provide copy of QH letter

Thank you for agreeing to be interviewed today. I wanted to firstly let you know that I’m not a clinician nor do I have a clinical background in cancer screening. I’ll be using everyday terms to describe processes and I may need to clarify some of your answers just so I can be sure I’ve understood your response accurately.

- It can be helpful in the first instance if I can ask some background questions to understand a little about your practice. Can you tell me how long you’ve been practicing here?
  As you know I’m here today to talk about cancer screening in general and three national population-based cancer screening programs:
  - BreastScreen Queensland
  - National Cervical Screening Program
  - National Bowel Cancer Screening Program.
  Given each has a different target audience and process I thought we should talk about each program separately.

  Let’s start with (rotate between interviews)...

BreastScreen Queensland

- What role do you consider General Practitioners have in recommending breastscreening?
  - Is preventative health an area of focus for this practice? Would you say you discuss breastscreening and the process proactively (look for opportunities to discuss issue/formal reminder or recall mechanisms) or reactively (wait for patients to raise issue/present with symptoms) or does it vary (how/when)?
  - If not already covered: Does this practice have a formal reminder or recall system in place for such breastscreening? If so, How does this work (practice software/diarised)?
- How familiar are you with how the BreastScreen Queensland program works currently?
  - What is the referral process?
  - What are the eligibility criteria?
  - Do you know where your nearest BreastScreen Queensland services are located?
  - Do you understand the difference between screening mammography for well women (services offered by BSQ) and diagnostic mammography for the investigation of women presenting with symptoms (services offered by private radiology clinics)
  - Would you know how to contact clinical staff at BreastScreen Queensland if needed? Do you ever have such a need?
- What information/resources have you had from BreastScreen Queensland in the past?
  - How beneficial (or otherwise) were each of these in assisting you to recommend the program in your practice?
- What are the triggers to you encouraging patients to participate in BreastScreen Queensland (if GP does not refer to BSQ then ask questions about breastscreening generally)?
- What are the barriers to you encouraging patients to participate in BreastScreen Queensland?
  - How can these barriers be removed or lessened? (practice-wide focus on preventative health, software improvement e.g. PenCAT, resources for patients – info sheet, reminder card, brochures)
Thinking about BreastScreen Queensland, from the perspective of your female patients aged 50-74 years:
  o What do you believe are the barriers to them participating in BreastScreen Queensland?
  o Are there certain patients who are more difficult to encourage to participate in the BreastScreen Queensland program? (probe on: cultural, access barriers) What, if anything, could be provided by BreastScreen Queensland to assist you in encouraging them to participate in the BreastScreen Queensland program?
  o Do you remind patients that the service at BreastScreen Queensland is free? Why/why not?
  o And, what’s your own impression of accessibility of the BreastScreen Queensland service? EG: Ease of booking, ease of attending, patient view of the mobile vans?

What is your perception of the quality of service at BreastScreen Queensland versus private providers? (quality, efficiency, client-focus, facilities, feedback from BreastScreen Queensland to GP post-screening etc.)
  o Are there instances where you recommend private screening over BreastScreen Queensland? Why?
  o Do patients request private screening over BreastScreen Queensland? Why?
  o Is it easier to refer a patient to one type of service over the other (BreastScreen Queensland or private providers)? How/why?
  o How can you be encouraged to refer your patients to BSQ (rather than going private)?

What communications, if any, do you receive from BreastScreen Queensland about your patients?
  o How would you rate this? Any improvements?

Apart from what we have already covered, is there any other support (e.g. information/resources/clinical tools or software) that could be provided to assist you to encourage your patients to participate in BreastScreen Queensland?

Rescreening (going back for a screen every 2 years):
  o Do you remind patients to rescreen every 2 years?
  o What support could be provided to help you remind patients every two years after their previous screen?

National Cervical Screening Program

What role do you consider General Practitioners have in Cervical Screening?
  o Would you say you discuss Cervical Screening and the Pap smear process proactively (look for opportunities to discuss issue/formal reminder or recall mechanisms) or reactively (wait for patients to raise issue/present with symptoms) or does it vary (how/when)?
  o If not already covered: Does this practice have a formal reminder or recall system in place for such Cervical Screening? If so, How does this work (practice software/diarised)?
  o Do you encourage your eligible patients to enrol with the Pap smear Register (which provides a back-up system of reminder letter to prompt women who are overdue for their Pap smear, provide a safety net to ensure the appropriate follow-up of women if they have an abnormal smear, and keep a history of women’s results to assist in the assessment of Pap smears)?
    ▪ If not, why? (e.g. didn’t know about it?)

How familiar are you with how the National Cervical Screening Program works currently?
  o What are the eligibility criteria?
  o What fees apply for patients? (see notes over page)

What information/resources have you received about the National Cervical Screening Program in the past?
  o How beneficial (or otherwise) were each of these in assisting you to recommend the program in your practice?

What are the triggers to you encouraging patients to participate in the National Cervical Screening Program?
  o What are the barriers to you encouraging patients to participate in the National Cervical Screening Program?
  o How can these barriers be removed or lessened? (practice-wide focus on preventative health, software improvement e.g. PenCAT, resources for patients – info sheet, reminder card, brochures)
  o Is there a female GP or female non-medical Pap smear provider (nurse) available at the practice?
    ▪ If so ask, Do you think women prefer to attend a female practitioner for their Pap smear? Why?

Thinking about the National Cervical Screening Program, from the perspective of your female patients 20-69 years:
  o What do you believe are the barriers to them being screened?

Are there certain patients who are more difficult to encourage to be screened? (probe on: economic - cost, cultural, access barriers) What, if anything, could be provided by the program to assist you in encouraging them to be screened?

Do you discuss the cost of screening with patients (e.g. consult fee / what pathology is bulk billed)? Why/why not?

Apart from what we have already covered, is there any other support (e.g. information/resources/clinical tools or software) that could be provided to assist you to encourage participation in the National Cervical Screening Program?
• Rescreening (going back for a screen/Pap smear every 2 years):
  o Do you remind patients to rescreen every 2 years?
  o What support could be provided to help you remind patients every two years after their previous screen?

National Bowel Cancer Screening Program

• What role do you consider General Practitioners have in Bowel Cancer Screening?
  o Would you say you discuss Bowel Cancer Screening proactively (look for opportunities to discuss issue/formal reminder or recall mechanisms) or reactively (wait for patients to raise issue/present with symptoms) or does it vary (how/when?)
  o *If not already covered:* Does this practice have a formal reminder or recall system in place for such Bowel Cancer Screening? *If so, How does this work (practice software/diarised)?

• How familiar are you with how the National Bowel Cancer Screening Program works currently?
  o What are the eligibility criteria?
  o Do you think there are fees for patients using this program?
  o What involvement do GPs have?
  o Who receives test results (individual and or GP)?
  o When referring NBCSP (National Bowel Cancer Screening Program) participants with a +FOBT (Positive Faecal Occult Blood Test) for colonoscopy where do you usually refer your patient and what influences this decision?
    ▪ Are you aware of the most suitable free public option in your area where there is the NBCSP Gastroenterology Nurse who will manage NBCSP referrals and ensure your patient receives a timely colonoscopy?

• What information/resources have you received about the National Bowel Cancer Screening Program in the past?
  o How beneficial (or otherwise) were each of these in assisting you to recommend the program in your practice?

• What are the triggers to you encouraging patients to participate in the National Bowel Cancer Screening Program?

• What are the barriers* to you encouraging patients to participate in the National Bowel Cancer Screening Program?
  o How can these barriers be removed or lessened? (practice-wide focus on preventative health, software improvement e.g. PenCAT, resources for patients – info sheet, reminder card, brochures)

• Thinking about the National Bowel Cancer Screening Program, from the perspective of your male and female patients 50-74 years:
  o What do you believe are the barriers to them participating in screening/completing the FOBT?

• Are there certain patients who are more difficult to encourage to participate in bowel cancer screening? *(probe on: economic, cultural, access barriers)*
  o What, if anything, could be provided by the program to assist you in encouraging them to be screened?

• Do you know the phone number to advise patients to call to obtain a new kit if they have discarded or lost theirs? Would this be useful?
  o Would it be useful to have extra kits on hand for you to distribute?

• And, what are your impressions of the process patients go through on this program?

• Do you think patients prefer to use the kits provided by the National Bowel Cancer Screening Program or buy kits over the counter/via pharmacies?

• For what reasons would you advise a patient to either not participate in screening or to have a colonoscopy rather than a screening test?

• Do patients request a colonoscopy (without a screening test)? Why do they tend to do this?

• Apart from what we have already covered, is there any other support (e.g. information/resources/clinical tools or software) that could be provided to assist you to encourage participation in the National Bowel Cancer Screening Program?

• Rescreening (going back for a screen every 5 years/ at 50, 55, 60, 65, 70 & 74 years):
  o Do you remind patients to rescreen every 5 years?
  o What support could be provided to help you remind patients every 5 years after their previous screen?
Stakeholder engagement - information prioritisation

- More generally now, how often do you receive information/resources on programs or initiatives from Queensland Health and its program areas?
- What type of information do you tend to prioritise or regard as most useful?
- How could the coordination of information/resources from Queensland Health be improved?

Thank and close
Appendix B - Queensland Health letter of endorsement used in recruitment