PRACTICE OBSERVED

Practice Research

Quinquennial cervical smears: every woman's right and every general practitioner's responsibility

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Abstract

Out of 558 women aged 18 to 64 who were registered with one general practitioner, 450 were eligible to be screened for cervical cancer. Even though the practice had been taking cervical smears for many years, they were predominantly from women under 35. Of the eligible women between 35 and 64, 111 (25%) had never had a smear. After short term intensive screening the uptake rates, defined by a smear done within the past five years, rose to 100% for women under 35, 84% for those aged 35 to 64, and 96% for all eligible women. Screening was rewarding both in its clinical yield and in the income generated by item of service payment. The success of screening was largely due to the participation of practice nurses in taking smears, and to a new method of recording smear results and claims for them. Some women, however, refused to have cervical smears.

Introduction

Recent reviews on screening for cervical cancer in Britain all agree that cervical smears are not necessarily being taken from the women in the population who are most at risk.¹⁻³ The entire population of women over 35 has consistently had fewer smears taken than women under 35, and yet in 1980, of the 2068 women who died from cervical cancer, 95% were over 35.⁴

Although the doctors at our health centre believed that they were providing a good cervical cytology service, an audit of our

smear programme showed that the eligible women under 35 were being smeared frequently, whereas many over 35 were being missed. In addition, an analysis of our family practitioner committee payments for cervical cytology showed that we had been underclaiming by half. In July 1983 we began a campaign with two objectives: to identify all eligible women and invite them to have a smear, and to design a foolproof record system for results and claims.

Our policy on smears

Table 1 gives the policy on when offers should be done, which is based on recent expert views.^{1,5}

TABLE 1—How often smears should be done

Asymptomatic sexually active multiparous women	First smear within one year of starting coitus. Repeat smears every five years.
Pregnancy	One smear during every pregnancy or at the postnatal examination.
Apparent gynaecological or venereal symptoms	Do a diagnostic smear.
Asymptomatic women aged 35-64	Smear every five years.
High risk groups—for example, previous abnormal smears, recurrent pelvic infection, or repeated sexual partners	Plan individual programme for each woman concerned. Usually annual smears.

For several years the nurses in our treatment room have taken 90% of the routine cervical smears. They have been trained by a standard technique described in the excellent handbook of the British Society for Clinical Cytology.⁶ They have detected many abnormal smears and other gynaecological pathology. Of the 440 smears done in our study, only one had to be repeated because of an inadequate sample. Smears done by nurses have proved highly acceptable to our patients. Indeed, of those women who had never had a smear and who were reluctant to be screened, 60% expressed a preference for the smear to be done by a nurse. Apart from taking smears, nurses can also conveniently

for payment. The following were not eligible for payment: smears done on all 74 women aged 16-34 who had had one or two pregnancies, and all 60 women aged 16-64 who used contraception but had had no pregnancies. For both groups the total number of women was 450, of whom 440 (96%) had smears.

Results

Two women with abnormal smears were referred to hospital—the first aged 55 with a CINIII smear confirmed by biopsy, and the second aged 46 with a CINIII smear and clinically suspicious cervix. Neither had had a smear before. Five other women with minor abnormalities are being followed up in the practice. During the past five years screening has already resulted in two women having hysterectomies and four other women having cone biopsies. Future screening is bound to yield further abnormal smears. As with all screening studies, we uncovered many other problems apart from the one we were looking for. These included *Trichomonas* and *Candida* infections, cervical erosions and polyps, uterovaginal prolapse, and severe senile vaginitis.

Table 11 gives the details for the 188 smears that were eligible for payment. The expenses of the scheme worked out at roughly 33%, which is similar to the expenses element of a general practitioner's gross pay.

TABLE 11—Logistics of short term intensive screening

A total of 286 smears were taken of which 188 were eligible for payment. A rough estimate of the gross income generated is given below.	
Income from family smears	£ 4,071
188 smears at January 1984 rates of £4.70	
Expenditure on all smears	
Receptionist's salary—14 hours a week for six months after 70% reimbursement	£ 250
Treatment room nurse—allowing 10-15 minutes per smear. Cost after 70% reimbursement is approximately 20p per smear	£ 40
Typing, postage, telephone calls	£ 250

Why do women refuse to have cervical smears?

Despite personal interviews, 19 (6%) eligible women over 35 still refused to have a smear. Of this group, 90% were over 50 and 74% had never had a smear before. 90% were married, and at least half were multiparous. All except one were infrequent attenders at the surgery, with only 0.5 consultations a year compared to a practice average of 2.3 attendances. The patients were evenly distributed across social classes (I to V). Five of the group had a husband or close relative die from cancer and had not been impressed with the medical profession's unsuccessful attempts at treatment. These findings support the results of previous studies.⁷

Broadly, the reasons for refusal or near refusal to have a smear were, in order of importance, fear of cancer, fear of becoming dependent on doctors, and fear of pelvic examination, or a combination of these. Two of the "near refusals" had been actively concealing symptoms and only time will tell whether the group of absolute refusals are hiding serious pathology. With more liberal attitudes to sexuality and greater public understanding of cancer it is likely that absolute refusal to have a cervical smear will become rare.

Future screening

We intend to convert gradually all women to having their routine smears done early in each quinquennium. This will greatly facilitate recall, which will depend on the following: (a) Self-recall—Quinquennial birthdays are easy to remember and we hope that some well motivated women will recall themselves for cervical smears. (b) Practice reminder-recall is based either on our Royal College of General Practitioner age-sex register using one box code to represent each quinquennium, or on the "treatment and recall" module of our micro-computer. These are updated every three months. (c) *Vax* patients are interviewed and so their names may be sorted out into a smear programme entered on a summary card. This sorting itself yielded one new case of cervical cancer, for another practice had managed to lose a malignant smear report in an overloaded record envelope and the patient had also been lost to follow up by the laboratory.

Discussion

Our smear uptake rates of 100%, for eligible women aged under 35, 84% for eligible women over 35, and 96% for all eligible women are the highest rates published from a British general practice. Three other comprehensive surveys have been undertaken by Rose in Dalbeattie, Scaife in Stockton-on-Tees, and McPherson in Oxford, and they reported uptake rates of between 88% and 90%.¹⁻³ The success of our scheme was certainly helped by having a stable, personal list of patients, most of whom were known to the general practitioner. Uptake rates in different practices are bound to vary according to the turnover rate of the patients on the general practitioner's list and their age and social class. As refusal to have a smear occurs predominantly in women aged over 50, general practitioners with young practice populations should easily achieve smear uptake rates of nearly 100%.

Local factors will also influence how best to get smears done. In our practice in a compact urban setting the nurses were backed up by the general practitioner and this proved to be an ideal method, and in other practices they are backed up by health visitors and midwives.¹⁻³ In inner city family planning clinics play a much greater part in screening than in outer city or rural areas. Some practices run special well woman clinics, an arrangement that may work well in a group practice where one or two doctors have a special interest in the subject.¹⁴

How successful are general practitioners at screening women for cervical cancer? In 1980 they took 1 252 000 smears: 43% of the total for England and Wales compared to 27% in 1973. The contribution that general practitioners make to screening practice may be assessed from family practitioner committee returns for FP 74 payment. In 1980 in Birmingham and Newcastle 13 claims were paid per 1000 women.¹⁵ In the same year Bury Family Practitioner Committee paid general practitioners for 1183 smears (also 13 claims per 1000 women), rising to 1831 smears (20 per 1000) in 1983. Bury Family Practitioner Committee has a population of about 31 000 women between the ages of 35 and 64, and it is possible for one doctor's screening to appreciably affect the FP 74 totals. For example, 14% (162 claims) of the 1983 total were from PS's list, and he has only 1% of the eligible women in Bury registered with him.

It is highly probable that many general practitioners underclaim for cervical smears. But even allowing for this it is clear that at present general practitioners do not adequately screen the eligible women in the population for cervical cancer. If all general practitioners had an uptake of 90%, family practitioner committee returns should be about 60 smears per 1000 women a year or 63 claims per "average" general practitioner. Receptionists can do a simple audit of smears by examining the records of the first 20 eligible women over 35 starting from a random letter of the alphabet. The percentage of women who have never had a smear, those who have not had one for over five years, and those who have not had one in the current quinquennium may easily be calculated. Circulating the results for different doctors in a group practice may stimulate friendly competition to improve any shortcomings in screening.

Payment for cervical smears is intended to be an incentive for general practitioners to screen the women who are most at risk of cervical cancer. It is therefore a curious paradox that general practitioners take many smears that are not eligible for payment and fail to take ones they could be paid for. Some doctors argue that smears in women aged under 35 should receive payment. We can see no logical reason for this except perhaps in the case of sterilised women. Cervical smears in the under 35s should be considered to be a routine part of contraceptive or maternity care, activities that already generate item of service payments far in excess of FP 74 income. Since screening in the over 35s is clearly inadequate greater financial incentives may be necessary to persuade general practitioners to start intensive screening. An increased fee for a first smear in a woman over 35 could be useful. The greatest obstacle, however, is not money—it rests in the attitudes of general practitioners to practice organisation, record keeping, and preventive medicine.

screen for hypertension and diabetes, teach about breast self examination, and after suitable training examine for breast lumps. General practitioners are paid for certain cervical smears after submitting Form FP 74 to their family practitioner committee. A thorough knowledge of the Department of Health and Social Security's *Statement of Fees and Allowances* (the Red Book) is crucial to our new record system. The key to understanding these regulations is to divide the woman's life into quinquennial spans as soon as she becomes eligible for paid cervical smears (table 11).

TABLE 11—Eligibility for item of service payment

Quinquennial span (age in years)	Eligible for item of service payment
15 to the day before 20th birthday	Yes
20 to the day before 25th birthday	Yes
25 to the day before 30th birthday	Yes
30 to the day before 35th birthday	Yes
35 to the day before 40th birthday	Yes
40 to the day before 45th birthday	Yes
45 to the day before 50th birthday	Yes
50 to the day before 55th birthday	Yes
55 to the day before 60th birthday	Yes
60 to the day before 65th birthday	Yes

Payment for a smear may be claimed at any time in the quinquennial span but only once. Although it would be clinically stupid to take a smear the day before the 40th birthday and the day after it, a GP could in theory be paid for both if no previous smear had been taken since the 35th birthday. This example illustrates that smear payments are not due five years from the date of the last smear, a commonly held but mistaken view.

Apart from showing the clinical results of cervical smears, general practice records need to alert the doctor that a woman's smear is due again and record whether payment has been claimed. To meet these needs we have developed a simple flexible system of quinquennial boxes recorded on a summary card.

1. Women born on 4 July 1963 with no pregnancies

Quinquennial span (age in years)	Eligible for item of service payment
15 to the day before 20th birthday	Yes
20 to the day before 25th birthday	Yes
25 to the day before 30th birthday	Yes
30 to the day before 35th birthday	Yes
35 to the day before 40th birthday	Yes
40 to the day before 45th birthday	Yes
45 to the day before 50th birthday	Yes
50 to the day before 55th birthday	Yes
55 to the day before 60th birthday	Yes
60 to the day before 65th birthday	Yes

If a woman needs more than one smear in one quinquennium there is usually a good clinical reason and this is therefore recorded as part of the clinical record. The box system, however, may easily be adapted for triennial or any other time interval of screening. If the patient has a hysterectomy or is over 65 her ineligibility for further screening may be recorded.

ELIGIBLE POPULATION OF WOMEN

Bury has a stable, predominantly working class population and PS's list size is 1945 patients with an annual turnover of 6%. The figure shows that PS has well above the average number of women

patients aged 50 to 64, the age group that is most reluctant to be screened. To identify those women who were eligible for smears we listed all women whose ages lay between the first day of the 10th year and the last day of the 40th year on 1 October 1983 from our age-sex register. Of these 558 women, 20 proved to be "ghost" patients, people who could not be traced and who had not consulted for over five years, leaving a total of 538.

Women eligible for smears—In the age group 35-64, total hysterectomy (except for cancer) 31, and lifelong abstinence from intercourse 1.

In the age group 16-34: single women who had never had a pregnancy or any family planning contact with general practitioner or clinic 47. The total number of ineligible women = 79.

Age structure of the women aged 15-64 on one general practitioner's list compared with women aged 15-64 in Bury, whose figures are closely similar to those for England and Wales.

Although it is possible that some of the 47 ineligible women under 35 had had unprotected intercourse or used barrier contraception, the risk of cervical cancer in this group as a whole must be very low. It is ethically debatable how far to pursue these patients, but those at risk will in due course present with a pregnancy or for contraception. Women eligible for smears—Age 35-64 with uterus 266; age 35-64 with hysterectomy for cervical cancer (vulv) smear 3; age 16-34 with three or more pregnancies 26; age 16-34 with one or two pregnancies 74; age 16-34 with contraception but no pregnancies 60. The total number of eligible women = 459.

Getting the smears done

At the start of the campaign 111 (37%) of the eligible women over 35 had never had a smear and a further seven (2%) had not had one for over five years. In addition, the results of our survey showed many women who had had a smear in the past five years but who had since entered a new quinquennium and were therefore eligible for another paid smear. We decided to invite these women to have a repeat smear if the previous smear had been done more than three years before.

Letters to all these women produced a brisk response, with about half attending. Contact with the defaulters was continued through more detailed and personal letters or telephone calls until we reached an uptake of 90%. Most of the remainder were visited at home by one of us and a few agreed to come to the surgery for a smear. One woman who was schizophrenic and two who were alcoholic had smears at home.

Of 296 women aged 35-64 with a uterus, 277 (94%) had a smear. The three women aged 35-64 with a hysterectomy for carcinoma of the cervix had a smear. All 28 women aged 16-34 who had had three or more pregnancies had a smear. All of these smears were eligible

General practitioners are ideally placed to implement screening for cervical cancer, but they are not, of course, the only people with a role. Screening might be coordinated by local committees with representation from gynaecology, pathology, general practice, family planning, community health, and family practitioner committees.

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GPs and Their Staff

Discrimination in employment

NORMAN ELLIS

Few general practitioners will have experienced any difficulties with the race and sex discrimination laws. Indeed, for any employer avoiding discrimination per se is good management practice. It may seem unlikely that an employer with only a handful of staff (most of whom are already women) could be affected in any way. But the Race Relations Act applies to any employer, irrespective of the size of his undertaking, and the Sex Discrimination Act applies to all employers apart from those with five employees or fewer (including any part time staff). Do not forget that your trainee is also an employee.

There is a growing awareness among the public of these anti-discrimination laws. This has been heightened by the present economic climate and the efforts of various organisations (including local councils and voluntary agencies) to inform people of their rights and to encourage and help them in pursuing these. Various public bodies, including the Commission for Racial Equality, the Equal Opportunities Commission, and local community relations councils have been particularly active in this sphere. It is therefore more likely than before that an unsuccessful applicant to a vacancy in your practice (or someone quite unknown to you who has not even applied for the vacancy) could seek redress on the grounds that your recruitment and selection procedures were discriminatory.

Fortunately, the small employer can greatly reduce any risk of an unjustifiable claim of discrimination if he takes a few essential precautions. Any claim of discrimination involves the time and costs of attending an industrial tribunal hearing. If successful, there are the additional costs of the compensatory award. Irrespective of its outcome the claim may lead to unwelcome local publicity.

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Extent of anti-discrimination law

There are two aspects where legislation requires an employer to act (and to be able to show that he has acted) in a manner which is not discriminatory: (i) on the grounds of sex (including equal pay) and marital status; (ii) on the grounds of colour, race, nationality (including citizenship), or ethnic or national origins. If your recruitment and selection procedures, together with your employment practices, are properly conducted no difficulties should ever arise. Although employers with five employees or fewer (including any trainee and part time staff) are excluded from the provision of the sex discrimination law, the racial discrimination law is applicable to all employers. The sex discrimination legislation was primarily intended to raise the opportunities and status of women in employment; however, men do have equal rights under this Act.

Fortunately, the scope and structure of both the sex and racial discrimination laws are similar. Both include two types of discrimination, direct and indirect, and require employers to take essentially the same action to ensure that their behaviour is neither discriminatory in practice nor capable of being seen as such.

Direct discrimination occurs when a person treats another person less favourably on grounds of race (or sex, or both) than he treats (or would treat) someone else. It is not necessary to show that the person openly expressed an intention to discriminate; it is possible in many instances to infer that his motive was discriminatory in the light of the circumstances of his actions.

Indirect discrimination occurs when the treatment may be seen in a technical sense as between different racial groups or between persons of different sex, but is discriminatory in its effect on one sex or particular racial group—for example, the unnecessary stipulation that a cleaner should have certain educational qualifications.

When assessing whether or not an employer has acted in an indirectly discriminatory manner an industrial tribunal is required to consider whether his actions, although formally