THE ORGANIZATION OF A CERVICAL SCREENING SERVICE*

J. DRUMMOND, *V.R.D.*, M.B., Ch.B., D.P.H.
Deputy County Medical Officer of Health, Buckinghamshire

R. P. C. HANDFIELD-JONES, B.M., M.R.C.P., D.Obst.R.C.O.G.
General practitioner, Haddenham

MARGARET R. WOLFENDALE, M.B.
Clinical cytologist, Stoke Mandeville
Aylesbury

MUCH is being talked and written about organizing a cervical screening service within the National Health Service. Sooner or later, in response to intense public demand, laboratories will be built and technicians trained. But this is only half the problem. Who should take the smears?

At the Nuffield Medical Centre for Combined Research at Stoke Mandeville we have been looking at the questions involved with the object of starting a screening service based on the general practitioner in the near future. It seems to us that there is much misunderstanding of what is involved and we hope that the conclusions we have reached from our experience may be of value to others.

1. Developing a cervical screening service in an area is an exercise in co-operation by the three branches of the National Health Service and can succeed only if workers from hospital, the local authority and general practitioners get together from the earliest stage of planning. Each has difficulties about which the others have little knowledge, and no room exists for competition or empire-building. "... all branches of the health service will have to work together without thought of vested interest if the service to the public is to be efficient." (Rivett, 1964).

2. The organization must have a headquarters from which everybody's efforts can be co-ordinated as there is an enormous amount of administration and office work. In the first instance it will be necessary to collect a central register of all the women in the appropriate age groups in the area; thereafter all data will be collected so

*From the *Nuffield Medical Centre for Combined Research*

that it can be stored and handled by modern mechanized techniques or computer. As all sources of smear-taking must be co-ordinated so that unnecessary re-duplication is avoided, the headquarters should be situated close to the laboratory. There must be close contact between the administration, the cytologist, the gynaecologist and histologist, so that the patient with the positive or doubtful smear is properly followed up and treated.

3. It will be necessary to offer alternative arrangements for taking smears. Different arrangements will be appropriate in different districts.

4. The patient's first inquiries about the service will be to the general practitioner and it is he who will have the care of the patient and her family when a smear is reported positive. He is in the strongest position to influence his patients on medical matters and it has been shown that the highest response rate is obtained when the general practitioner takes an active part in the service (MacGregor and Baird, 1963). If the general practitioner is unable to take smears himself he can play a useful role in persuading his patients to make use of facilities provided.

For these reasons the participation of the family doctor is essential to the success of a screening programme, and at best the service should be based on the general practitioner's surgery.

5. It is essential to distinguish between selective and comprehensive screening. Selective screening means taking smears from patients who have come to the doctor for advice, e.g. because they have gynaecological symptoms or are pregnant; or attending for postnatal examination or contraceptive advice. Taking a smear on such occasions adds little time or trouble to a pelvic examination. Indeed, every cervix exposed with a speculum should have a smear taken from it, particularly as the yield of positive smears from such selective screening is likely to be higher than from comprehensive screening programmes (*Lancet*, 1958). Laboratories should accept smears from general practitioners and general practitioners should be prepared to take smears from their patients as part of the medical services they provide for the capitation fee, without extra remuneration, just as they take blood for haemoglobin, or test urine. At the Nuffield Medical Centre for Combined Research here in Stoke Mandeville, within two years of a cytological laboratory being opened 23 general practitioners are sending in smears from their patients. One practitioner has reported that from a practice of 2,800 by selective screening he is sending smears at the rate of nine a month and estimates that in three years he will have examined half the women of 25–65 age group in his practice (Rivett, 1964).

6. With comprehensive screening, the approach is different. It

means encouraging well women who would not otherwise seek medical advice to come at regular intervals only to have smears taken. This will involve extra consultations, more time, correspondence, ancillary help—clerical and nursing—more equipment and, of course, more expense. Thus, at the present time, any general practitioner offering this service to his patients would be worse off as a result. It would seem to be unreasonable, therefore, to expect general practitioners to do this work without extra remuneration. Additional payment could be made either by way of an increase in the capitation fee, or on an item of service basis, or by the local health authority at their usual sessional rates. In existing circumstances the third method of payment would appear to be the most likely.

7. When a comprehensive scheme is first started there will be a rush of volunteers—the people who will have formed the forefront of the pressure groups.

Thereafter, it will become increasingly difficult to persuade the reluctant and disinterested to come forward. The group will most likely contain the high risk cases, i.e. high parity and low social and economic classes, and will take much hard work to achieve a satisfactory return. To do this will need the team work of all the medical and medicosocial agencies.

The success or failure of a comprehensive scheme depends on the return from this group. The cost of the service is high—not only financially but in professional skills—and a continual return of many negatives without a substantial fall in the number of new cases of cervical cancer will speedily bring it into disrepute.

8. Comprehensive screening is best organized on a sessional basis, organized by the local authority and general practitioners together. It is very important that the general practitioners who wish to take smears from their own patients should have the opportunity to do so. Sessions should be held in the doctor's surgery for preference, or if these are unsuitable, in some alternative premises which offer adequate facilities. As a large measure of success depends on patient acceptability, we must ensure that smears are taken under the best environmental conditions available. Some of this sessional work in the surgery could be done by part-time married women doctors, particularly as many patients would prefer to be examined by a woman.

What kind of response can be expected from general practitioners? We sent a questionnaire to 187 general practitioners in our area and received replies from 166 (Wolfendale and Handfield-Jones, 1964). Ninety-seven and a half per cent approved of cervical screening in principle and 76.5 per cent said they would take smears from their

own patients, given the necessary facilities. The difficulties that confront the general practitioner in taking part in a screening service arise from the unsuitable premises in which he has to work and the lack of nursing and clerical assistance. The pool system of payment acts as a positive deterrent. These shortcomings can be put right only if the administration consider it worth spending public money to modernize the general-practitioner service.

It is hoped that the present negotiations will lead to modern premises, adequate staff and a fair system of reward. Given these, many of the difficulties would disappear and the family doctor would be given the opportunity to play a part in the campaign of preventing invasive cancer of the cervix. Whatever the outcome, as the further development of medical care may well lie in screening procedures such as this, it is essential that the difficulties—of organization as well as of finance—be fully evaluated. While it would be possible to organize a screening service divorced from general practice, if any attempt is to be made to turn the emphasis towards the selection of high risk cases, or even to make sure that such cases do not default from a comprehensive scheme, the general practitioner, with his records, his knowledge of and his relationship with his patients are essential.

We are hoping, therefore, that our co-operative research will enable us to reach conclusions from which a system of cervical screening can be developed using all members of the health service team, with their varied skills and disciplines and from which it might be possible to obtain a blue-print for future schemes.

Acknowledgements

We are grateful to Dr G. W. H. Townsend, the medical officer of health for Buckinghamshire for his interest in our work and advice on the preparation of this paper; and to Mr G. Draper of the unit of biometry, Oxford University, for the advice on the collection and handling of data.

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