

THE LAY PERSON'S FEAR OF A DOCTOR

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WHEN A PRACTITIONER ATTENDS HIS surgery and finds his waiting-room crammed to capacity, he might be excused for saying "I wish they were more frightened of me". Nevertheless this fear is of great importance in one type of patient, namely the patient who has symptoms that might point to cancer, or who is suffering from 'cancer apprehension'. It is not so much that the patient is frightened of the doctor, but as of what he might say, or how he says it. It is probable that on the average a general practitioner may see about 15 cases of cancer per year, and most of these are already in a hopelessly advanced stage. He knows he will have to look after these people as they slowly die. No wonder he hates the word cancer and is not interested in the disease.

This fear of cancer dates back thousands of years, and still persists in spite of the better prognosis in these days when in this country over 30,000 patients are cured each year (using the five-year standard). This fear is interesting and has previously been called by the author 'cancer smog'. There are three types of this smog.

True cancerphobia. This is probably rare and may be defined as a conviction, on the part of the patient that he or she has cancer or will suffer from it, which is so great that it interferes with the ordinary life of the patient. They are difficult to diagnose as they never mention the word cancer. Many people who talk a great deal about cancer are called 'cancerphobes' but they are *not*, but probably do suffer from 'cancer apprehension' of the personal type i.e., if they experience some symptoms such as pain in the breast they immediately say to themselves "Can this be cancer?" They go on worrying until the pain disappears or, if they do have courage to see a doctor they complain of pain in their big toe, in the hope that the doctor will examine their breast. These patients are not easy to spot especially in a busy practice. It is a good rule to suspect '*personal cancer apprehension*' if the symptoms complained of are not accompanied by any signs.

Impersonal apprehension is very common, and exists among doctors and nurses. They have no fear of cancer themselves but believe that if they talk to a patient or other person about cancer they will instil fear into the person to whom they are talking. Of course this is complete nonsense, the only way of getting rid of fear of anything is to talk about

the origin of the fear, or as Emerson put it " Knowledge is the antidote to fear ".

Another mistaken idea is that by laughing at the patient's apprehension it can be removed. More than one person has said to me after a lecture, " I could not talk to my doctor about cancer. I hate being laughed at and he would not tell me the trouble in any case ". All this increases the 'hush hush' about the disease and diminishes the chances of 'early stage' diagnosis. Some medical people will point to the fact that in some cases the five-year survival is just as good in the patients who come late as those who come early. This is true because some growths are well differentiated and grow slowly, otherwise these patients would have been dead. There is no question but that 'early stage' growths when treated have a better prognosis, e.g. in cancer of the cervix (published in the Stockholm Report on Carcinoma of Cervix (1951)) of 14,346 cases in stage 1, 63.7 per cent were alive without signs or symptoms five years later, compared to 6.7 per cent in stage 4. The earlier the diagnosis the more likely the growth will be in an early stage. The terrible delay at present in diagnosis is well illustrated by the following figures published in 1957 by the Registrar General concerning cancer of the breast, uterus and rectum. The median delay before treatment in breast cancer was 6.2 months but 17.3 per cent of patients waited over two years. In the uterus the median delay was 5.7 months but 8.4 per cent wait over two years. Carcinoma of rectum mean delay 5.4 months and 25.0 per cent wait over one year.

Who is to blame for this terrible delay? Several surveys have been carried out in America to see to what extent the doctor is to blame or the patient, or both. In 1958 Kutner wrote an article in which he defined 'no delay' on the part of the doctor if diagnosed within one month, a very generous allowance; 'no delay' on the part of the patient up to three months. The percentage of delays due to the doctor varies widely in the different surveys from 5.9 per cent to 27.8 per cent but the mean for seven surveys was 17.7 per cent as the fault of the doctor. Why should there be any delay on the part of the doctor once the patient has reached him or her? Howson (1950) said that " the most important of many reasons is the absence of *cancer consciousness*, or a lack of diagnostic suspicion on the part of the doctor". Failure to examine the patient was found by Howson (1950) in an appalling number of cases (*see table*).

TABLE
FAILURE TO EXAMINE (HOWSON)

<i>Site</i>	<i>No. of cases delayed</i>	<i>Cases not examined</i>	<i>Per cent not examined</i>
Corpus	108	50	46.3
Cervix	265	132	49.3
Ovary	48	31	64.6
Vulva	19	11	57.9
	<hr/> 440	<hr/> 224	<hr/> 50.9

Suggested causes of this omission are:

(1) Doctor is reluctant to examine when bleeding is present. (2) Reluctance to do pelvic examination upon the patient's first visit. (3) Ascribing symptoms to the menopause. The phrase "only the change of life" has killed thousands of women. (4) Lack of time to conduct a complete examination. (5) Fear that the patient will not return if a pelvic examination is done. (6) Reluctance to examine elderly women. (7) Feeling it is not safe to undertake gynaecological examination except in hospital. (8) Inadequate apparatus in consulting room.

Harnett (1952), in a survey of cancer in London, has some interesting figures for the most important of the accessible cancers:

Breasts (2,152 primary cases): 4.8 per cent were kept under observation for more than three months and given symptomatic treatment; 3.6 per cent were reassured and told there was nothing serious.

Cervix uteri (859 primary cases): 7.7 per cent were kept under observation for over three months; 3.4 per cent had no vaginal examination during the first three months.

Corpus uteri (288 primary cases): 6.6 per cent were kept under observation and given symptomatic treatment for over three months; in 2.3 per cent, patients were told it was due to the menopause and there was no need to worry.

Robbins *et al.* (1950) tried to see if the type of examination made any difference to the delay time but in the case of those growths that only required superficial examination, e.g. skin, lip, mouth and tongue, the delay was nearly as high as in the more difficult examinations. "It is possible that the temptation to treat an ulcer without diagnosis was too great."

No survey has been made in this country but there can be no doubt that the majority of the delays are due to the patient, but I regret to say not all. For this, the overcrowded surgery must be blamed, but very often the patient who comes up time after time and is called a 'neurotic' and 'hyperchondriac' and is a blasted nuisance, is really a 'cancer apprehensive' and five minutes talk about cancer will keep the patient away for a long time.

There is little doubt that if the Papanicolaou test can be carried out all over the country, deaths from cancer of the cervix will drop to nil.

Cancer education among the public advocating 'self examination of the breast' will reduce the delay in treatment of breast cancer. Likewise education concerning rectal bleeding will help diminish that terrible delay in 25 per cent of cases.

It is perhaps unnecessary to remind practitioners that certain symptoms *must* be considered to be due to cancer, until proved otherwise.

Any lump in the breast can only be proved by removal and section. The doctor who thinks he can diagnose a cyst or fibroadenoma by palpation is indeed an optimist and may be responsible for the death of his patient. Chronic mastitis does not exclude cancer but some risk may have to be taken in such cases. They should be examined at frequent intervals. If a doctor waits to see 'if it grows' he had better save time by ordering the coffin.

Irregular uterine bleeding must be investigated, and never put down to the menopause until such investigation has been carried out.

Rectal bleeding must be investigated before treatment. As Sir Stanford

Cade said " the first finger is better employed by doing a rectal examination, than by writing a prescription for pile ointment ".

The greatest evil arising from the ' hush hush ' about cancer is the fact that the public has lost confidence in the medical profession if they themselves suspect the possibility of cancer, and it is even difficult to persuade a patient of a negative report.

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CONTINUING EDUCATION

GROUP DISCUSSION

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NOW THAT OUR GENERAL-PRACTITIONER discussion group has held its 36th meeting, it is time to review its progress and achievement. Those of us who originated the idea have been pleasantly surprised by the group's continued existence. We felt that an account would be of interest to other practitioners running or planning similar groups. As the spontaneity of the group is one of its characteristics the plan of development can only be seen in retrospect.

The origin of the group was a feeling among local practitioners that existing medical meetings did not cater for some of the needs of the general practitioner. The unfulfilled need was for a forum in which to discuss problems peculiar to general practice. Meetings of the local medical society usually followed the pattern of a specialist speaker addressing a mixed audience of practitioners and hospital staff. Local B.M.A. meetings are poorly attended except in times of crisis when emotional speeches and lack of constructive thought seem to be the order of the day. It was noticed that useful discussion often took place at refresher courses in the lunch intervals when practitioners from different areas were able to exchange views.

In May 1959 an inaugural meeting was held in the waiting room of one of us. Seventeen practitioners were invited from three neighbouring towns covering the same area as the local medical society. Our choice of names was directed towards young-in-spirit practitioners who were known to have expressed an interest in any method of improving general practice.

At this meeting it was felt that there was sufficient support for the idea