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Review

Clinicians' attitude towards changes in Australian National Cervical Screening Program

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ABSTRACT

Background: Australian guidelines for cervical cancer screening are being revised under the "renewal program". Physicians' willingness to accept these changes will play a pivotal role in its success.
Objective: To understand the willingness and acceptance of, as well as barriers and facilitators for Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) affiliates to screening using human papillomavirus (HPV) testing, starting at 25 years of age, every 5 years.
Study design: An electronic survey of RANZCOG affiliates was undertaken April–June 2014, while renew was announced April 28th 2014. Responses used a 7 point Likert scale, which was dichotomized as ≤4, indicating 'unwilling' and >4, indicating 'willing' to adopt revised practices.
Results: Response rate was 22% (n = 956): 60% were obstetricians and gynaecologists (OG); 27% general practitioner diplomates; 13% OG trainees. Overall, 60% (n = 526/874) were willing to revise their screening practice. This correlated with awareness of new guidelines (p = <0.001). Fifty percent (n = 438/869) of respondents were concerned about delaying to 25 years, and 48% (n = 421/869) concerned cervical cancers would be missed. Reasons respondents gave for wishing to continue screening from 18 years contrary to guidelines included: women not being vaccinated (65.6%), immunosuppressed women (92.2%) and women who had been victims of childhood sexual assault (73.9%).
Conclusions: The majority of RANZCOG affiliates were willing to change screening practice however, a number of barriers to delaying onset of screening age to age 25 years were reported. Effective change management strategies will need to be implemented to address the concerns raised to ensure best practice for cervical screening.

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1. Background

The Australian National Cervical Screening Program (NCSP) has enabled organized screening for cervical cancers and pre-cancers since 1991 with great success [1]. Compared to other countries with cancer registration systems, Australia now has the second lowest incidence rate of cervical cancer in the world at 9.6 per 100,000 women and one of the lowest mortalities at 2.0 per 100,000 women [2].

The advent of high-risk human papillomavirus (hr-HPV) DNA testing is anticipated to profoundly change the efficacy of cervical cancer screening [3–5]. In April 2014, as part of the renewal program, 5 yearly HPV testing commencing at 25 years was recommended by the Australian Medical Services Advisory Committee (MSAC), with a planned implementation date of 1st May 2017 [6].

The success of the new program is dependent on compliance, acceptability and willingness to change for both cervical screening providers and women undergoing screening. Major difficulties can arise when introducing evidence and clinical guidelines into routine daily practice [7–9]. Change generally requires comprehensive approaches at different levels (doctor, team practice, hospital, and wider environment), tailored to specific settings and target groups. Plans for change should be based on characteristics of the evidence or guideline itself and barriers and facilitators to change [10].

Physician's compliance with guidelines is essential to a successful public health program [11,12]. A physician recommending cervical cancer screening plays the strongest role in whether a woman decides to be screened or not [13,14]. Previous international literature demonstrates a poor adherence by health providers to cervical screening guidelines, despite changes made for better practice [14–16]. In Australia, 80% of cervical cancer screens are performed by general practitioners (GPs), 14.4% by obstetrician and gynaecologists (OGs) and 5.6% by Pap nurse providers [17].

2. Objectives

This paper aims to assess the attitudes and acceptance, barriers and facilitators of affiliates of the Royal Australian and New Zealand College of Obstetricians and Gynecologists (RANZCOG) who are largely OGs and GP diplomats, (GPs undertaking a diploma in obstetrics and gynecology), regarding the potential new recommendations for cervical screening. Specifically, 'willingness' to perform HPV DNA testing every 5 years from 25 years of age was assessed. The results can help inform effective change management strategies to ensure a successful implementation.

3. Study design

This was a cross-sectional observational study of RANZCOG affiliates. An electronic survey (SurveyMonkey®, Palo Alto, CA, USA) with a brief cover letter was distributed to 4725 RANZCOG affiliates on 4th April 2014, with two reminders sent out 17th April and 26th May 2014. Revised cervical screening guidelines had been announced April 28th 2014 to commence in 2016 (while the survey was active). The survey closed on 13th June 2014.

Potential participants included all RANZCOG fellows, members, trainees and diplomats from all states and territories in Australia and New Zealand. Duplicate surveys were avoided by manually checking the data and using the SurveyMonkey® feature that allowed only one response per computer. Questionnaires that were not completed beyond demographics were excluded.

The questionnaire was adapted from Ogilvie et al. [18], who assessed Canadian women's beliefs on HPV testing; and Perkins et al. [7] who assessed compliance with cervical screening guidelines in members of the American College of Obstetrics and Gynecology (ACOG). It took an estimated 10 min to complete. Demographic characteristics and scope of practice were obtained. Most of the questions were on acceptability of HPV DNA testing; delaying screening age and intervals; and willingness to perform new guidelines if the Australian National Health and Medical Research Council (NHMRC) or New Zealand National Cervical Screening Program (NCSP) suggested it. Barriers and facilitating factors for screening at 25 years were explored. Physician awareness and beliefs encompassed whether they:

(1) reported access to reliable HPV vaccination guidelines,
(2) reported awareness of potential new cervical screening guidelines and
(3) Regarded national NHMRC and NCSP guidelines to be important.

4. Data analysis

Analysis was performed using Statistical Package for the Social Sciences (SPSS) (IBM SPSS Statistics Desktop V22.0, New York). The answer to the statement 'For my patients, I would be willing to perform an HPV test to screen for cervical cancer at/after the age of 25 and every five years instead of a Pap smear every two years after onset of sexual activity, if the NHMRC or NCSP guidelines recommended' was used to determine physicians' willingness to adhere to potential new guidelines revisions. Responses were on a 7-point Likert scale (1 = strongly disagree to 7 = strongly agree). This was dichotomized and defined as 'willing' (score > 4) and 'unwilling' (score $\leq$ 4) to adhere to potential new guideline recommendations. Of those that answered '4' for guideline importance, the majority of affiliates (74.1%) responded <4 for 'willingness to perform potential guideline revisions'. Therefore a '4' response was interpreted as 'unwilling' to perform guideline changes.

To determine significant factors $p \leq 0.05$ associated with physician willingness to undertake potential new guidelines, chi-squared tests for categorical data and Students *t*-test for continuous variables were performed. A multivariate binary logistic regression model was used to determine the predictors of physician's willingness to adhere to new guideline changes. Variables that achieved significance in univariate analysis were included, with the adjustment for participants' age and response date.

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