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Pap Test Quality:

Practitioners' Perceptions of Service  
Provision

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Prepared by:

Jenny Anderson  
Madeline Fernbach  
Robyn Mullins

for:

PapScreen Victoria

November 2004



Centre for Behavioural Research in Cancer  
Cancer Control Research Institute  
The Cancer Council Victoria

# **Pap Test Quality: Practitioners' Perceptions of Service Provision**

*Jenny Anderson, Madeline Fernbach and Robyn Mullins*

## **Summary**

This study aimed to assess practitioners' perceptions of quality Pap test provision. A total of 467 randomly selected Victorian practitioners participated in a telephone survey, including general practitioners (85%), gynaecologists (6%) and nurse Pap test providers (9%). Overall, 57.2% of practitioners indicated that they were "very satisfied" with the level of service they provided when last performing a Pap test and 39.0% indicated that they were "satisfied". In addition, 38.1% and 58.9% of all practitioners reported that they perceived women to have been "very satisfied" or "satisfied" respectively with the last Pap test provided to them. Areas in which quality could be improved are the provision of additional training for general practitioners so that they feel better prepared to conduct Pap tests, and the broadening of practitioner conceptions of quality so that they include non-medical components such as the provision of privacy to the woman.

## Introduction

Since the establishment of the National Cervical Cancer Screening Program in 1991 within Australia, mortality rates due to cervical cancer have fallen from 4.1 to 3.0 per 100,000 women per year (Hacker, 2003). Within Victoria, it is estimated that 64.4% of eligible women had undergone a Pap test during the two year period of 2001 to 2002, and 77% had done so during the three year period of 2000 to 2002 (Mitchell, Burrows & Scott, 2003). Maintaining a high quality Pap test service should contribute to ensuring that these positive trends continue.

However, the measurement of Pap test quality has been a fairly recent phenomenon and is narrow in focus. While considerable attention has been paid to the quality of the various cell sampling techniques, little attention has been paid to quality in terms of the subjective experience of the Pap test procedure. For example, the literature discusses various methods to improve the quality of cells removed from the cervix during the procedure, such as prior cervix cleaning (Kotaska & Maticic, 2003) and the move from conventional Pap tests to liquid-based cytology (Carter, 2003; Guidos, & Selvaggi, 1999). However few studies focus on the quality of the experience of the woman receiving the Pap test (an exception is the study by Tishelman, Lundgren, Skald, Tornberg & Larsson, 2002) and none, to the knowledge of the authors, focus on the experience of the practitioner conducting the actual test. The *Pap Test Quality - Women's Perceptions of Service Provision* study (Mullins, Fernbach & Anderson, 2004) and the current study have been conducted to address these deficits.

Studying the subjective experience of Pap tests and perceptions of quality from the perspective of both women and practitioners is important for several reasons. A study in Sweden found that there were low perceptions of quality in terms of several aspects of the subjective experience of the Pap test procedure. These authors suggested that more attention to psychosocial aspects might optimise cervical screening programs (Tishelman et al., 2002). In support of this proposal, a study in Mexico found that a previous experience of good screening quality was strongly associated with greater use of the screening program (Lazcano-Ponce et al., 2002). A recent study in Texas also found that women who rated the overall quality of their health care as excellent were more likely to receive an annual Pap test (Borders, Warner & Sutkin, 2003).<sup>1</sup>

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<sup>1</sup> The recommended screening interval in the USA is one year, compared to every two years in Australia.

This study sought to examine quality using several approaches. One approach was to document aspects of the practitioners' most recent Pap test provision to gain a better understanding of the contextual and individual factors that contribute to the quality of the experience for practitioners. In addition, we sought to establish whether the practitioners' impression of how women experienced the test was in line with the self reports from women themselves (Mullins, Fernbach & Anderson, 2004).<sup>2</sup> We also sought to determine whether practitioners followed a procedural routine for conducting Pap tests that included considerations of the subjective experience for women. Finally, we aimed to understand practitioner beliefs about what medical and non-medical (i.e., psychosocial) components constitute a quality Pap test. This included asking questions about perceived barriers to taking quality Pap tests.

As there was limited literature on which to base hypotheses, the expectations for the results from this study were also constrained. Thus, this study was viewed as primarily exploratory, especially in terms of understanding the context in which practitioners conduct Pap tests and in capturing the practitioners' experience of their most recent Pap test. However, as the results from the *Women's Pap Test Quality Study* (Mullins, Fernbach & Anderson, 2004) were very positive in terms of the overall very high satisfaction levels of women who had received a Pap test, the authors of the current study predicted that the practitioners would also reflect these high levels in their own estimations of the overall experience of women. Finally, whilst there are no published guidelines that refer to a set of standard psychosocial considerations that should be included in the Pap test procedure, general areas that practitioners should be aware of are suggested in at least one Government based publication (Commonwealth Dept. of Health and Family Services, 1998) in addition to a training manual that has been developed for medical students and current practitioners (Dept. of General Practice, The University of Melbourne, 2003). These sources recommend that a variety of psychosocial components form part of the Pap test routine, including open communication with each woman to understand her past experiences, beliefs and feelings, the maintenance of professional boundaries, an explanation of what is being done at each stage of the procedure, the maintenance of the privacy and comfort of the woman, and clear communication about how the woman will receive her results and when her next Pap test is due. Thus this list provides some indication of the content and number of psychosocial components the practitioners in the current study might include as elements of their Pap test routine or consider as elements of a quality Pap test.

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<sup>2</sup> Of the women surveyed, 96% rated "very high" or "high" levels of satisfaction with the level of service

## Method

### Sample

In order to obtain a final sample of approximately 500 participants, a total sample of 2082 Victorian practitioners was used, randomly selected from a database of Pap test practitioners<sup>3</sup> developed and distributed by AMPCo (Australasian Medical Publishing Company). Practitioners were defined as general practitioners (GPs), gynaecologists and nurse Pap test providers (NPTPs; nurses specifically trained to take Pap tests). Of the total sample of 2082, 535 practitioners could not be contacted (26%), which left 1547 potential participants. Of these potentials, 1080 (70%) refused to participate. Of these refusals, 237 (22%) were made directly by the practitioner, 549 (51%) were made via the practitioner's receptionist, 235 (22%) because of a standard policy not to answer surveys, and 59 (5%) for some other reason not specified. This resulted in a final sample of 467 practitioners, consisting of 396 GPs (85%), 29 gynaecologists (6%) and 42 NPTPs (9%), which equates to a 30% response rate. The distribution of the final sample across practitioner type was compared to that found in the community. The Victorian Cervical Cytology Registry (VCCR) estimates that of all Pap tests conducted in Victoria, 79% are conducted by GPs, 19% by specialists and 2% by nurses.<sup>4</sup> Thus our sample consisted of a similar proportion of GPs, but included a lower percentage of specialists and a higher percentage of nurses.

As with all studies that involve sampling a survey of the target population, the percentages are only estimates of the true percentage that would be obtained if the entire population were surveyed. Based on the sample size surveyed in each professional group, we estimate that our prevalence estimates are within  $\pm 5\%$  of the true population values for GPs, within  $\pm 18\%$  for gynaecologists, and within  $\pm 15\%$  for NPTPs.

Demographic details were collected from the practitioners. Of the final sample recruited, 221 (47%) were male and 246 (53%) female, however gender divisions differed markedly across the different types of practitioners. The gender ratio was similar for GPs and gynaecologists, with the GP group consisting of 206 (52%) males and 190 (48%) females, and the gynaecologists consisting of 15 (52%) males and 14 (48%) females. However, the 42 NPTPs were all female (100%). Participants were also categorised into six age brackets. The majority of GPs and NPTPs were aged 40 to 49 years (40.4% and 52.4% respectively) while

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provided during their last Pap test (Mullins, Fernbach & Anderson, 2004).

<sup>3</sup> The use of the term "Pap test practitioner" was current at the time of the survey (2001). Due to legislative changes, Pap test practitioners are now referred to as "Pap test providers" (2004).

<sup>4</sup> Communicated through a personal correspondence to the first author.

the majority of gynaecologists were a little older (34.5% were aged 50 to 59 years and 31% were aged 60 to 69 years).

## **Procedure**

An initial pilot study was conducted with 18 practitioners to test the validity of the questionnaire and to provide an indication of the refusal rate. The questionnaire developed for the *Women's Pap Test Quality Study* (Mullins, Anderson & Fernbach, 2004) was adapted so that the items were relevant to practitioners. The pilot study did not identify any issues in terms of the validity of questionnaire items, and produced a 25% response rate.

For the main study, practitioners were first sent a letter to introduce the study and inform them that they would receive a phone call during the following few weeks during which they would be invited to complete a survey. A telephone interviewer then attempted to contact each practitioner to gain verbal consent and either conduct the survey at that time or make a time that was more suitable. The survey took approximately 15 minutes to complete using a Computer Assisted Telephone Interviewing (CATI) system.

## **Measures**

Practitioners were asked approximately 80 questions related to the conduct of Pap tests. These included questions that can be categorised into seven broad areas: (1) the context of their provision of Pap tests, (2) the frequency of their Pap test provision, (3) the practitioner's general perceptions of the experience of Pap tests for women, (4) the practitioner's own experience of the last Pap test they provided, (5) the routine followed by practitioners when conducting a Pap test, (6) barriers to Pap test provision, and (7) practitioner beliefs about the components of a quality Pap test. Basic demographic information was also collected about the practitioner as reported above.

## **Results**

### **Context of Pap test provision**

Practitioners often operate within time-poor contexts in which they need to juggle many primary health care priorities. When asked how high on their agenda Pap tests were, 75.8% of GPs and 100% of gynaecologists answered "very high" (NPTPs were not asked this question). No practitioner answered "low" or "very low". When presented with the statement "I am often too busy to spend extra time with a woman who presents for a Pap test", GPs appeared to be the group most under time pressures, with 11.1% responding "strongly agree" or "agree", compared to 6.9% for gynaecologists and 2.4% for NPTPs. However, the majority

of practitioners indicated that they disagreed or strongly disagreed that they were too busy to spend extra time during Pap tests (GPs = 86.3%, gynaecologists = 93.1%, NPTPs = 97.6%).

Practitioners were asked to rate how well their training had prepared them to take Pap tests. On a scale of 1 to 10 (1 = “not prepared”, 10 = “completely prepared”), the gynaecologists’ mean rating was 8.79 (SD = 2.72), the NPTPs’ was 7.83 (SD = 1.72) and the GPs’ was 6.54 (SD = 3.00). To calculate group differences, the preparedness ratings were collapsed to create a dichotomous variable (1 to 5 = low preparedness, 6 to 10 = high preparedness). Chi square analyses revealed that GPs were significantly less prepared than both gynaecologists ( $\chi^2 (1) = 7.32, p = .007$ ) and NPTPs ( $\chi^2 (1) = 11.12, p = .001$ ). No differences were found in terms of preparedness between gynaecologists and NPTPs ( $p = 1.00$ , 2 sided Fisher’s Exact Test).

## Pap test frequency

The frequency with which practitioners provide Pap tests was measured by two questions: “On average, how many Pap tests would you perform in a six month period” and “How many Pap tests did you perform in the last week?” The results (see Table 1) revealed that gynaecologists conducted by far the highest self-reported number of Pap tests in the measured time intervals compared to the other two groups of practitioners. The large standard deviations within each group indicate the high level of variability in the self-reported number of Pap tests conducted by individual practitioners for each type of practitioner.

**Table 1**

***Frequency of Pap test provision***

	Number of Pap tests provided:	
	Last 7 days M (SD)	Last 6 months M (SD)
GPs	4.95 (4.80)	101.11 (100.10)
Gynaecologists	19.72 (19.07)	331.52 (237.44)
NPTPs	3.74 (5.37)	88.00 (100.40)

*Note:* Range of responses across 7 days for GPs = 0 to 30, gynaecologists = 0 to 100, & NPTPs = 0 to 23. Range of responses across 6 months for GPs = 2 to 720, gynaecologists = 50 to 999, & NPTPs = 6 to 480.

## Practitioner perceptions of the woman’s experience of Pap tests

Practitioners were asked about their perceptions of how women experience Pap tests in general. Two of these items are listed in Table 2, including the percentage of each practitioner group that agreed or disagreed with each statement. There was a great deal of variability in responses to the item regarding Pap tests being uncomfortable for women, with approximately half of each practitioner group saying they agreed and half saying they disagreed. There were no differences found between the groups in regards to perceptions of uncomfortableness ( $\chi^2 (2) = 4.30, p = .117$ ). Responses for the second item regarding being embarrassed were very similar for GPs and NPTPs ( $\chi^2 (1) = .006, p = .941$ ), with the majority having perceived women as feeling embarrassed during Pap tests. Gynaecologists on the other hand were split evenly between whether they agreed or disagreed with this statement, and their responses were found to be significantly different from GPs ( $\chi^2 (1) = 9.50, p = .002$ ) and NPTPs ( $\chi^2 (1) = 5.08, p = .024$ ).

**Table 2**

*Perceptions about the woman’s experience of Pap tests, by practitioner type*

Belief	Practitioner	Agree or strongly agree %	In-between, disagree or strongly disagree %
Pap tests are uncomfortable	GPs	55.6	44.4
	Gynaecologists	41.4	58.6
	NPTPs	42.9	57.1
Pap tests are embarrassing	GPs	72.0	28.0
	Gynaecologists	44.8	55.2
	NPTPs	71.4	28.6

The third item that related to practitioner perceptions about the experience of Pap tests for women was whether the woman they had last provided a Pap test to was either relaxed or tense during the procedure. Although over 80% of all practitioner types had perceived the woman to have been “relaxed” or “very relaxed” during their last consultation (GPs = 80.1%, gynaecologists = 96.5%, and NPTPs = 83.3%), a significantly greater proportion of gynaecologists believed the woman to be relaxed or very relaxed compared to GPs and NPTPs combined together ( $\chi^2 (1) = 4.70, p = .030$ ). No differences were found between GPs and NPTPs ( $\chi^2 (1) = .26, p = .611$ ). Thus in summary, approximately half of all practitioners, regardless of practitioner type, perceived the Pap test to be an uncomfortable experience for

women. However, gynaecologists had somewhat different perceptions of the Pap test experience of women compared to GPs and NPTPs for the embarrassed and relaxed items. Gynaecologists tended to perceive women to be less embarrassed and more relaxed than GPs and NPTPs.

### Experiences of most recent Pap test provided

Practitioners were asked a set of questions specific to the last Pap test they had provided. On average, the last Pap test had been conducted 4.65 days before answering the survey (SD = 9.25, range = 0 to 90 days), and the majority of practitioners stated that they remembered this test either “well” or “very well” (GPs = 71.8%, gynaecologists = 93.1%, NPTPs = 76.2%). In the vast majority of cases, the most recent Pap test recalled by the practitioner had not been the first test ever for the woman concerned (GPs = 87.6%, gynaecologists = 86.2%, NPTPs = 92.9%). The majority of practitioners also indicated that this last test was either “very representative” or “representative” of their usual test standard (GPs = 90.9%, gynaecologists = 96.6%, NPTPs = 95.2%).

In terms of who had initiated the test, just over half of the gynaecologists had prompted the test themselves, whereas the woman had initiated the test for approximately half of GPs and NPTPs (see Table 3). A chi square analysis revealed that a significantly higher proportion of gynaecologists initiate Pap tests compared to GPs ( $\chi^2 (1) = 15.19, p = .000$ ).

**Table 3**  
*Who initiated the practitioner’s most recent Pap test*

	Practitioner %	Woman %	Practice Sent Reminder %	Other %	Don’t Know %
GPs	22.7	46.0	25.3	3.8	2.3
Gynaecologists	55.2	20.7	10.3	10.3	3.4
NPTPs	2.4	50.0	28.6	25.0	16.7

Practitioners were asked how satisfied they were with the service they provided for their last Pap test. Overall, 57.2% of practitioners responded that they were “very satisfied” and 39.0% responded that they were “satisfied” with their level of service provision. In addition, practitioners were asked to estimate how satisfied they thought the woman was with the Pap test provided. Once again, the majority of practitioners responded in the positive, with 38.1% estimating the woman had been “very satisfied” and 58.9% estimating that the woman had

been “satisfied”. The breakdown of these results for each practitioner type is listed in Table 4.

**Table 4**  
*Satisfaction regarding last Pap test service provision*

Item	Practitioner	Very satisfied %	Satisfied %	Total satisfaction %
How satisfied are you with your service provision?	GPs	55.6	40.4	96.0
	Gynaecologists	79.3	17.2	96.5
	NPTPs	57.1	40.5	97.6
How satisfied was the woman with your service provision?	GPs	35.4	61.6	97.0
	Gynaecologists	41.4	51.7	93.1
	NPTPs	61.9	38.1	100.0

### **Pap test routine**

Information about the Pap test routine of practitioners was collected by asking practitioners to spontaneously recall the procedural components of their normal Pap test routine (see Table 5). Of interest was to determine if practitioners included non-medical components in addition to medical components without prompting. A very high proportion of practitioners indicated they usually informed women that they were able to take their names off the VCCR register if they wished (91.4%), that the test is not 100% reliable (90.8%), and that they described the role of the VCCR to the woman (90.4%). A high proportion of practitioners indicated that they informed women that the test is designed to detect cell changes in the cervix (88.4%), what certain results would mean (83.5%), and how they would receive their results (77.7%). A high proportion also reported that they provided the woman with a fresh cloth to lie on (78.8%) and offered the woman additional information at the time of the test (81.2%). Just under half of the practitioners indicated they explained what the procedure involved before conducting the examination (46.7%). Considerations of privacy for the woman were less well addressed, with just over one third (37.3%) of the practitioners reporting that they provided privacy while the woman undressed or provided covering for the lower body while the test was being performed.

It is possible that the practitioner failed to mention some non-medical components even though they usually include them in their Pap test routine. The non-medical components may not be as salient as the as the medical components to practitioners. Alternatively, problems

with communication with the woman may prevent some practitioners from giving additional information. However, when asked if they had had any difficulties in communicating with the woman, 100% of gynaecologists and NPTPs said “no”, with only 1.5% of GPs responding that they had had difficulty. The reasons provided for these difficulties were cultural/language barriers (n = 3) and the perceived embarrassment of the woman (n = 3). Thus communication did not appear to be an issue for these practitioners.

**Table 5**

*Pap test routine components as listed by practitioners, by frequency and percentages of total practitioners.*

Procedural component	Frequency	% of total respondents (n = 467)
Explained she can opt off the VCCR registry	427	91.4
Explained that results are not 100% reliable	424	90.8
Described VCCR	422	90.4
Explained that Pap test detects cell changes	413	88.4
Explained what the results might mean	390	83.5
Offered other information	379	81.2
Provided a new cloth square on the exam. table	368	78.8
Explained how she will receive the results	363	77.7
Said when the test was finished	346	74.1
Said when OK to get dressed	316	67.7
Offered other services	300	64.2
Checked speculum was warm	242	51.8
Provided covering for the lower body	220	47.1
Explained what the procedure involves	218	46.7
Provided privacy for the woman to undress	174	37.3
Other	121	25.9

### **Barriers to providing quality Pap tests**

One possible barrier to the provision of quality Pap tests might be the priority that practitioners assign this screening test compared to other components of their work. As previously discussed, practitioners were asked to indicate how high on their agenda they placed cervical screening, using a five-point scale (“very high” to “very low”). NPTPs were

not asked this question, as a key component of their role is to perform Pap tests. Of GPs, 98.5% rated Pap tests as “very high” or “high” (1.5% indicated “in between”). One hundred per cent of gynaecologists indicated Pap tests were very high on their agenda. Thus the priority of cervical screening, in terms of practitioner perception, does not appear to be a barrier to Pap test provision, although there may be some self-report bias here due to a wish to comply with the researcher’s interests.

Another possible barrier to quality Pap test provision may be factors associated with the cultural background of the woman. Practitioners were first asked if they provided cervical screening to women of different cultures. Only 4.3% (n = 20) indicated that they never saw women of a different culture. Of the remaining practitioners, 37.7% (n = 176) indicated that they saw women from different backgrounds “often”, 34.9% (n = 163) indicated “occasionally” and 23.1% (n = 108) indicated “rarely”. The 447 practitioners who see women from different cultures at least “rarely”, were then asked to describe the impact, if any, the different cultural background of the woman had on the Pap test consultation. The open-ended responses to this question were analysed and coded into categories depending on the theme or themes of the comment (see Table 6). Some responses were brief and just indicated the degree of impact (e.g., no impact, made things difficult), while other responses were more detailed and described the outcome of the consultation (e.g., suggested a female practitioner should conduct the test). The most common response was that the woman’s cultural background made no impact on the consultation (31.8%, n = 142). The impact mentioned most frequently was that the time of the consultation was increased (23.5%, n = 105). Factors related to coping with language difficulties (language barriers, more explanations required, and used an interpreter) were also mentioned frequently by the practitioners. Thus although approximately one third of practitioners reported that the cultural background of the woman had no impact on the consultation, factors such as language barriers and the need for increased consultation times when practitioners are generally time poor, may have an impact on the quality of Pap test provision.

**Table 6**

*Impacts of the cultural background of the woman, by frequency of practitioner response and percentage of total practitioners*

Impact	Frequency	% of respondents (n = 447)
No impact	142	31.8
Consultation time increased	105	23.5
Language barriers	74	16.6
More communication/explanations required	72	16.1
Interpreter used	71	15.9
Impact depends on the woman's religion and culture	45	10.1
Very little impact	36	8.1

Note: responses < 5% have not been reported

To determine what other factors may influence the quality of Pap test provision, practitioners were asked to list the circumstances under which they may feel uncomfortable when performing a test. These open-ended responses were analysed for similar themes and coded into categories accordingly. A wide range (n = 23) of categories was found and these are presented in Table 7 along with the frequency with which each circumstance was listed and the per cent of the total practitioners. About one quarter of respondents said that they would not feel uncomfortable in any circumstance (24.4%). The predominant circumstance that made practitioners feel uncomfortable was if the woman was perceived as being tense, unwilling or uninformed about the procedure (37.7%). The circumstance mentioned next most often was if the practitioner was seeing the woman for the first time or for their first Pap test (12%). The remaining circumstances were mentioned by less than 10% of the sample. Thus ensuring women are informed, relaxed and willing to undergo the procedure would remove some barriers to test provision.

**Table 7**

*The circumstances under which practitioners may feel uncomfortable when performing a Pap test, by frequency of response and percentages of total practitioners.*

Uncomfortable circumstance	Frequency	% of total respondents (n = 467)
Woman is tense or unwilling or uninformed	176	37.7
Would not be uncomfortable in any circumstance	114	24.4
New woman or first Pap test or woman is young	56	12.0
Practitioner knows woman personally or has personal conflict	39	8.4
View of cervix is obstructed (e.g., in obese woman)	35	7.5
Woman has been sexually abused	28	6.0
Woman is a virgin	25	5.4
Time restraints	22	4.7
Husband or boyfriend or child is present	18	3.9
Woman has intellectual disability or psychological disorder	18	3.9
Other	17	3.6
Woman has had a bad past experience of a Pap test	16	3.4
Woman is menstruating	14	3.0

Note: Responses < n=10 have not been reported

### **Beliefs about quality Pap tests**

Practitioners were asked to define what components they thought constituted a quality Pap test. The multiple, unprompted responses from each practitioner were recorded and analysed by allocating each response to one of ten commonly mentioned component categories (plus one category for “other”). The frequencies for which practitioners mentioned each component are listed in Table 8, with corresponding percentages of the total sample size.

Approximately three-quarters of the practitioners indicated that taking a good smear or having a good smear-taking technique was the first priority in performing a quality Pap test. The next highly mentioned group of categories (23.3 % to 46.9%) included both medical and non-medical components. While being able to clearly see the cervix was viewed as important to quality, so too were the non-medical components of making sure the woman was relaxed, experienced a minimum of discomfort and that she understood the procedure. Providing privacy to the woman again received a fairly low percentage of responses (9.9%). The

satisfaction of the woman with the service was not generally considered to be a component of test quality (1.5%).

**Table 8**

*The components listed by practitioners as those that define a quality Pap test by frequency of response and percentages of total practitioners.*

Procedural component	Frequency	% of total respondents (n = 467)
Good smear or good smear technique	350	74.9
Relaxed woman	219	46.9
Lack of discomfort for woman (e.g., no pain, warm speculum)	164	35.1
Good visualisation of cervix	162	34.7
Woman understands procedure	109	23.3
Privacy	46	9.9
Other	43	9.2
Good rapport	40	8.6
Good lighting	28	6.0
Good interpretation of results	13	2.8

Note: Responses < n=10 have not been reported.

## Discussion

Overall, our sample of Victorian practitioners believed they provided a high quality Pap test service. They reported that they were satisfied or highly satisfied with the service they provided for their last Pap test, and that the woman they provided their last Pap test to was also satisfied or highly satisfied.

We felt it was important to consider the context in which Pap tests are provided in order to gain a better understanding of quality from a practitioner's point of view. Although practitioners are often presumed to work in time-pressured environments, our sample of practitioners indicated that Pap tests were high on their agenda and that they almost always made extra time to spare for Pap test appointments. However, GPs reported that they were less prepared than gynaecologists or NPTPs to conduct Pap tests in terms of the training they had received. This deficit could be addressed by providing a more comprehensive coverage of Pap tests in medical training and perhaps refresher courses for established GPs. In fact,

since this data was collected in 2001, this deficit has been at least in part addressed by the Department of General Practice at the University of Melbourne who now provide subjects designed specifically to train medical students in the conduct of Pap tests.

In addition to the context in which Pap tests are provided, we were interested in how practitioners perceived the experience of Pap test quality from the woman's perspective. Three measures of quality were used: (1) how uncomfortable tests are for women, (2) how embarrassed and (3) how relaxed women feel when having a Pap test. Practitioner groups tended to respond quite differently to the three questions. For the measure related to being uncomfortable, all practitioner groups were divided in how they perceived women to be feeling, with approximately half of each group believing Pap tests are uncomfortable for women, and half believing they are not. However for the measure of embarrassment, GPs and NPTPs had similar views, with approximately 70% of these groups reporting they thought Pap tests were embarrassing for women. Whereas, gynaecologists were evenly split again on whether they agreed or disagreed with this statement. For the measure of how relaxed the woman felt during her last Pap test, the majority of all practitioners reported they believed women felt relaxed or very relaxed, although a significant higher proportion of gynaecologists perceived the woman to be relaxed or very relaxed, compared to GPs or NPTPs. Thus in general, the practitioners perceived women as being able to relax despite feeling embarrassed and sometimes uncomfortable during a Pap test. However it is interesting to consider why a much greater proportion of GPs and NPTPs believed women to be embarrassed by the test compared to the gynaecologists. If women really are embarrassed by the test then perhaps gynaecologists are less likely to empathise with them. However if the converse is true, and women are not particularly embarrassed by the procedure, then perhaps the GPs and NPTPs are over compensating for the women's response. An alternative explanation is that perhaps women who are less prone to embarrassment tend to go to gynaecologists rather than GPs or NPTPs for Pap tests, especially as gynaecologists tend to see women who would be familiar with internal examinations due to pregnancies or abnormalities.

As mentioned in the introduction to this paper, whilst there are no official guidelines that refer to a set of standard psychosocial considerations that should be included in the Pap test procedure, at least two sources provide information on important psychosocial components of the Pap test procedure (Commonwealth Dept. of Health and Family Services, 1998; Department of General Practice, The University of Melbourne, 2003). The results from the current study suggest that a good proportion of practitioners include some of the psychosocial components as recommended by the two sources. Thus, practitioners reported

that they communicated with the woman with regards to aspects of the procedure (the test detects cell changes, results are not 100% reliable) and how the woman will receive her results and what they might mean. In addition to these, practitioners also indicated they included components concerned with comfort (fresh cloth square, warm speculum) and information (regarding VCCR and additional related issues).

However, some of the recommended components were absent from the reports of the practitioners. These included understanding a woman's past experiences of the Pap test procedure, checking with her how she was feeling or thinking about the test, gaining consent and maintaining professional boundaries. Although none of the practitioners specifically indicated that they talked the woman through the procedure, step-by-step, almost half of the practitioners did report that they explained what the procedure involved beforehand and almost three quarters indicated to the woman that the test was finished. Compared to other components, the provision of privacy to the woman was reported by a substantially lower proportion of practitioners, with just over one third of the practitioners reporting that they provided the woman privacy while she undressed, and just under half of the practitioners reporting that they provided covering for her lower body during the test.

The absence of some components in the Pap test routine may in part be due to the way the question was asked. Rather than reading out a predetermined list of possible components against which the practitioner could indicate whether they included each or not, the practitioners were asked to describe the components of their own routine, without any further prompts. Thus, practitioners may have failed to mention some of the components related to the subjective experience of women, even though they do include these in their routine on a regular basis. However, the failure to mention these components, unprompted, suggests that these non-medical components are less salient to the practitioner than perhaps the medical components, and thus less easy to recall when asked to describe the whole routine. The question did not allude to the fact that "describe your routine" may incorporate both medical and non-medical components. This was left up to the interpretation of the individual practitioner.

Possible barriers to quality Pap test provision were explored. The impact of the cultural background of the woman appeared to not have any great impact on the quality of the consultation however it did impact on the time required to consult with these women, due to the extra time required to ensure the woman clearly understood the procedure. The key barrier indicated by practitioners was if the woman was tense, unwilling or uninformed about the procedure. Clear communication with the woman, about her concerns or understanding of

the procedure, would appear to be a way of removing this barrier. About one quarter of the practitioners reported that they would not be uncomfortable to conduct a Pap test under any circumstances, which leaves three quarters of the practitioners who would experience some feelings of discomfort connected with conducting a Pap test. The wide range of responses provided by practitioners to this question make it difficult to pin point particular issues that could be targeted in addressing their level of discomfort. However, acknowledging that practitioners experience some level of discomfort when conducting Pap tests is important, even if it is only in general terms. This knowledge may be incorporated into the development of practitioner training programs, so that practitioners are provided with the skills to cope with such discomfort, should it arise.

Finally, we considered the beliefs practitioners might have about what constitutes a quality Pap test. On the top of the practitioners' list was the ability to take a good smear. However, a high proportion of practitioners also listed components related to the subjective experience for women. These included ensuring that the woman was relaxed and understood the procedure. The majority of practitioners had indicated that they believed the woman to whom they had last provided a Pap test was either relaxed or very relaxed, however, only half of the practitioners had indicated that explaining what the procedure involves is part of their regular routine. The provision of privacy was only reported by approximately 10% of the practitioners as a component of a quality Pap test. Why practitioners do not associate the provision of privacy with quality is unclear, but this finding again provides an opportunity for improvement in the quality of Pap test provision via training programs that emphasise this component.

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