Psychodynamics of Late Diagnosis Cancer Patients

A note of caution needs to be made regarding the interpretation of Levy et al (1) of their findings on the psychodynamics of late diagnosis cancer patients. First, some of the conclusions appear to be inconsistent. For example, the "late" presenters appear to be engaging in both denial of illness and self-criticism. Given the number of statistical tests performed, ie, 24, it is possible that any findings are spurious.

At best, the data reflect patient adjustment and coping mechanisms in response to a diagnosis of cancer. It is not warranted to speculate that responses to the diagnosis reflect prediagnosis patient status; because a patient is currently anxious, we cannot assume that he or she manifested the same levels of anxiety before diagnosis, much less that this was the reason for seeking treatment for symptoms. Clearly, a prospective design is needed to provide solid data on the important question of motivations behind a patient's delay in seeking treatment.

Additionally, screening activities are directed toward a healthy population. Extrapolation from data based on a symptomatic population to asymptomatic groups is not appropriate.

In any case, additional hypotheses should be explored before interventions to increase public anxiety are contemplated. For example, the lower educational level seen among the late presenters is consistent with studies of patient delay, as the authors noted. This represents a tangible, if less psychodynamic, barrier that may guide the development of effective interventions.

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Reference


Response

We wish we could prospectively study the psychodynamics of a pure population of people who are destined to get cancer but who delay its diagnosis and therapy. In the absence of conducting a study of unapproachable magnitude (at least for us), we did what seemed to be the next best thing: We studied those who delayed seeking treatment and compared them with those who did not, trying to ferret out any differences between them. Our tests are not perfect, and it is possible that the diagnosis of cancer changed the psychodynamics we tested in the "late" population in a fashion different from that seen in the control population. We do not, however, have any reason to think this is the case, nor is any reason promulgated by Gotay.

Remember that the genesis of the study was our frustration with the problem of people who do not seek medical care, even when it is clear that it is needed. We assumed that these patients represented a group who were unscreened and who would have benefited if they had been screened, and thus could serve as a model. While lower educational levels or some cultural situation correlated with lower educational levels might explain why some people do not seek medical care, it is our empiric observation that this is not the case. When we perform the unscientific exercise of actually talking with these patients, they knew, and admit that they knew, that something needed to be done. We attempted to understand why the extant messages failed to motivate them to action, and we believe a viable explanation lies in their coping strategies. Emphasizing that this conclusion applies only to a subpopulation (after all, some people are now being reached), we suggest that educational efforts are on a flat part of the dose-response curve.

Consumer product producers, led by our hometown Procter and Gamble, have shown that marketing strategies can be developed, targeted, and tested. Our interpretation of our data led us to a hypothesis that we believe merits a test, and this is an easily achievable and assessable process. The "raison d'être" of publication, especially for country doctors like us, is to stimulate further work in this arena based on sharing experience and data. The reflex "no," which is accompanied by the idea that what we are now doing must be right because we are doing it or the caution to be so careful that nothing changes, has to be overcome. Testing different ways of improving on the now dismal compliance with early detection at least has the potential to improve results.

Human observation as the basis for scientific advancement can lead to either substantial intuitive progress or delusion. It seems abundantly clear from talking with the victims of delay and their families that something needs to be done differently to reach those who might delay seeking treatment. Our hypothesis is only one of many probably out there, and again we welcome alternative suggestions for doing something; joining as a reflex the "Flat Earth Society," which suggests caution and more of the status quo, however, has little appeal to us. People are dying out there.

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The Danger of Unrecognized Cancer Treatment Clinics

In November 1988 my son was diagnosed as having terminal cancer. In February 1989 he traveled to Athens, Greece, to seek treatment from a doctor who claimed to have found the cause and cure for cancer and who reportedly had cured patients with cancer by immunotherapy for 20 years. My son was accepted as a suitable candidate for the treatment and received daily injections of the doctor's serum for 21 days. He was then sent home with a set of instructions for diet and rest that he followed to the letter.