Is the quality of skin cancer screening in Germany related to the specialization of the physician who performs it?: Results of a nationwide survey among participants of skin cancer screening

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Abstract
Background: Skin cancer screening (SCS) is an important measure for secondary prevention of skin cancer, which is the most common cancer type worldwide. This study aimed to describe patient-reported quality of SCS in Germany according to the specialization of the performing physician and different patient characteristics.

Methods: Data from 1260 participants 35-65 years of age (54.4% female) who underwent SCS and participated in National Cancer Aid Monitoring in 2019 were evaluated using chi-squared tests.

Results: Waiting times for SCS from a dermatologist were significantly longer than those for other physicians (31.1 versus [vs.] 15.7 days; \( P < .001 \)). Each body area examined during the standardized inspection was examined significantly more frequently by dermatologists than by other physicians (eg, upper body, 96.6% vs. 91.7%; \( P < .001 \)). Dermatologists more often offered consultation for skin cancer prevention (74.0% vs. 67.6%; \( P = .026 \)) and provided written information (47.8% vs. 34.8%; \( P < .001 \)). Patients with statutory insurance had to pay more frequently for additional services during SCS from a dermatologist than from other physicians (24.7% vs. 17.1%, \( P = .012 \)).

Conclusion: Results of this study revealed differences in the provision of preventive information and the quality of visual examination during SCS between dermatologists and other physicians. These results highlight the need for quality assurance measures.

KEYWORDS
cancer screening, dermatologists, early diagnosis of cancer, general practitioner, Germany, skin cancer

1 INTRODUCTION

Skin cancer is the most common cancer type worldwide.1 This also applies to Germany, where nearly 230,000 new cases of non-melanoma skin cancer and 23,240 new cases of malignant melanoma were registered in 2016.2 However, when in situ carcinomas are also considered, the estimates are further increased,3 and the incidence of skin cancer is projected to rise.2

A measure for early detection of skin cancer(s) is skin cancer screening (SCS). In 2008, standardized SCS was introduced in
Germany as a standard benefit for individuals with statutory insurance. The nationwide SCS program was controversially debated both before and after its introduction in 2008. A recent literature review showed that after the implementation of SCS in Germany, the incidence of skin cancer (in situ and invasive) and rates of thin melanoma increased while rates of thick melanoma decreased. Only limited evidence on the impact of SCS on skin cancer mortality could be observed.

In Germany, statutory health insurance funds, which insure the majority of the population (88%), cover the costs for biennial SCS for all members >35 years of age. Some private health insurance funds also bear the costs for this preventive service. SCS comprises a standardized, visual, full-body examination for malignant melanoma and non-melanoma skin cancers that is performed with naked eye. Additionally, physicians are mandated to counsel patients on the risks of ultraviolet radiation and on sun-protective measures during the SCS. Moreover, patients with a high risk for developing skin cancer should be educated about how to perform self-examination of their skin. SCS can be provided by dermatologists, and general practitioners who have been trained for this examination. The SCS is generally free of charge for those who are entitled to this preventive service. However, some physicians use aids during the SCS (e.g., dermatoscope, photographic documentation of the pigmented moles). For these extra services, which are not included in the coverage of SCS by health insurance funds, additional fees may be charged by physicians.

In the past, several studies have explored the use of SCS within the German population, both from the perspective of those who underwent SCS and based on evaluation of data from health insurance companies. These studies reported SCS participation rates to range between 28% and 40%. In addition, regional differences in access to SCS have been revealed. One study focused on the provision of preventive counseling for skin cancer during SCS; however, the results were based on a relatively small sample size.

To date, little is known about the quality of SCS provided by physicians. Therefore, the present study aimed to explore differences in patient-reported quality of SCS according to the specialization of the physician who performed the most recent SCS, and to patient characteristics using a large, representative sample.

2 METHODS

2.1 Study setting

The present study was based on cross-sectional data from the fifth wave of the representative National Cancer Aid Monitoring. Overall, 4000 individuals 16–65 years of age participated in the survey (response rate, 28.9%). Interviewers, who were trained by the study team, collected data from October to December 2019 using computer-assisted telephone interviews. The multistage sampling procedure used for the random sampling of participants is described in more detail elsewhere. The study design and sampling procedures were approved by the Ethics Committee of the Medical Faculty Mannheim of Heidelberg University (Mannheim, Germany; 2017-662N-MA).

Data from a subsample consisting of 1260 individuals 35–65 years of age (originally, individuals ≥35 years of age were entitled to SCS), who underwent SCS at least once since 2009, were analyzed. All subjects provided informed consent to participate in this study.

2.2 Instrument and measures

All outcome variables regarding the most recent SCS and covariates used in this study are described in detail in the following sections. All questions and items were pretested in 15 cognitive interviews and slightly revised according to the results before the survey.

2.3 Aspects of SCS regarded as outcome variables

First, participants were asked about their waiting time for an appointment to undergo their most recent SCS. Participants could report waiting time in days, weeks, or months. For analysis, however, all responses were converted to days. Second, detailed information regarding the service participants received during the most recent SCS included:

1. Body areas examined during SCS (face and neck, scalp, upper body, arms, hands, genital area, legs, and feet);
2. Received counseling for skin cancer prevention during SCS (yes/no);
3. Received written information regarding skin cancer prevention (yes/no); and
4. Information about how to perform a self-examination of the skin (yes/no), which should be a part of SCS in at-risk patients according to the German guideline on skin cancer prevention.

Third, consistent with the study by Braun et al., 2 items were used to assess participant satisfaction with their most recent SCS: “How satisfied are you with waiting time for the appointment to undergo SCS?”, “In general, how satisfied are you with your physician regarding the time he has devoted to you during SCS? (very satisfied, rather satisfied, rather dissatisfied, or very dissatisfied).”

Fourth, participants were asked whether they had to pay extra for some additional services during the most recent SCS, consistent with the study by Augustin et al.

2.4 Variables regarded as covariates

In the present study, covariates included the following:
1. Specialization of the physician who performed the most recent SCS (dermatologist versus [vs.] general practitioner/other specialist);

2. Study participants provided sociodemographic information including sex, age, and characteristics needed to define their immigrant background. In accordance with established indicators, participants were defined as having an immigrant background if their mother and father were born abroad, if one parent was born abroad, or if the participant's mother tongue was not German. In addition, frequent sunburn during childhood, and a family history of malignant melanoma. According to the number of risk factors, participants were subcategorized as: "those without any risk factors"; "those with one risk factor"; and "those with two or more risk factors".

3. Participants who underwent SCS in a dermatological practice were more likely to be dissatisfied with the waiting time for an appointment (17.3% versus [vs.] 7.3% for other specialists; \( P < .001 \)) and to pay extra for some services during SCS (24.7% vs. 17.1% for other specialists; \( P = .012 \); Table 1).

Dermatologists examined all body sites that should be inspected during SCS significantly more frequently than other specialists (Figure 1). In general, however, the feet (84.4% vs. 72.2%), scalp (82.8% vs. 69.3%), and genital area (73.7% vs. 55.7%) (all \( P < .001 \)) were the least examined body sites by dermatologists and other specialists, respectively. The rate of abnormal ("positive") findings did not differ by physician's specialization: 13.1% of those who underwent SCS in a dermatological practice and 13.0% of those who underwent it with other specialists reported that abnormal skin alterations were identified during SCS (\( P = .999 \)).

4. Additionally, information regarding insurance status was also assessed during telephone interviews (insured via statutory or private health insurance).

2.5 | Statistical analysis

Data were weighted by age, sex, education, and federal state of residence to ensure a nationally representative sample. Descriptive analyses and the chi-squared test were used to explore and compare the distribution of covariates. Additionally, t-tests were performed to reveal potential differences in waiting times according to the specialization of the physician; differences with \( P < .05 \) were considered to be statistically significant. Statistical analyses were performed using SPSS version 25 (IBM Corporation).

3 | RESULTS

Overall, 54.4% of the subsample was female, and it was approximately equally distributed in terms of age: 35-45 years (34.9%); 46-55 years (33.5%); and 56-65 years (31.5%). Most of participants underwent SCS performed by a dermatologist (\( n = 933, 74.0\% \)), 23.8% (\( n = 299 \)) underwent SCS performed by a general practitioner and 2.2% (\( n = 28 \)) by other specialist. Women underwent SCS more often in a dermatological practice than men (77.2% vs. 70.2%; \( P = .005 \)). No further differences in sociodemographic characteristics of participants regarding the specialization of performing physician could be identified (data not shown).

The mean (±SD) waiting time for an SCS appointment was 27.4 ± 36.3 days (min: 0, max: 273.6 days) and differed according to physician specialty (Table 1). Participants had to wait significantly longer for an appointment with a dermatologist (31.1 days) than for an appointment with another specialist (15.7 days; \( P < .001 \)). Participants who underwent SCS in a dermatological practice were significantly more likely to be dissatisfied with the waiting time for an appointment (17.3% versus [vs.] 7.3% for other specialists; \( P < .001 \)) and to pay extra for some services during SCS (24.7% vs. 17.1% for other specialists; \( P = .012 \); Table 1).

4 | DISCUSSION

The aims of the present study were to describe the quality of SCS as perceived by participants with regard to the specialty of the performing physician; and according to patient characteristics. Results revealed that patients had to wait significantly longer
for an appointment to undergo SCS at a dermatological practice (31.1 days) than at other physician practices (15.7 days; \( P < .001 \)). This difference in waiting time may have led to significantly higher dissatisfaction with waiting time in patients who underwent SCS at a dermatologist compared with other physicians. However, no differences could be identified regarding the satisfaction with the length of time the physician dedicated to the patient during SCS across different specializations.

Longer waiting times for an appointment with a dermatologist were also reported in a previous survey of 359 individuals who underwent SCS \(^{15} \) and mirror the generally longer waiting times for an appointment in a specialized practice than at general practitioners. \(^{21} \) A study involving 681 dermatologists reported that other more acute reasons for presentation (eg, acute eczema, assessment, and excision of suspicious nevus) had a higher priority when setting appointments in dermatological practices. \(^{22} \) For these reasons, the longest waiting times, with an average of 5.7 weeks, were identified for SCS. Because waiting times among our data were shorter, we cannot exclude that some patients reported an alteration in a current nevus when they scheduled the appointment, which would make their need for an appointment more urgent. However, we did not get any information on how the appointments for SCS were scheduled.

In our study, we explored the provision of services during SCS in detail. Overall, 71.1% of participants reported receiving advice regarding skin cancer prevention during SCS. This figure is comparable to that recently reported by Krensel et al. \(^{16} \) Written preventive information and advice regarding self-examination of the skin were provided less frequently to approximately 40% of participants. Although there are guidelines specifying which body sites should be examined during a standardized visual examination, \(^{9} \) our results revealed that the feet, scalp, and genital area were examined much less frequently during SCS.

In our large study sample, we explored patient-reported provision of services during SCS according to the specialty of the performing
First, our results revealed that patients who underwent SCS at a dermatological practice reported more accurate standardized visual examination and, second, that they received more likely preventive counseling and written information about skin cancer prevention. One possible explanation for this finding is differing skills for provision of SCS. Dermatologists are trained in SCS and consultation for skin cancer prevention throughout their specialization, whereas general practitioners merely have to complete an 8-hour training course to qualify for SCS. Moreover, patients who underwent SCS in a dermatologic practice were more likely to pay extra for additional services during the SCS. A reason might be that dermatologists can routinely use a larger variety of instruments during SCS they have available in their practices (eg, dermatoscopy, photographic documentation), which, however, are not included in the coverage by health insurance funds. A future study involving physicians who provide SCS may clarify further reasons for these differences.

When comparing preventive counseling of dermatologists and general practitioners during SCS in Germany, it is important to note that SCS is often combined with a general health checkup at general practitioners, which is more aimed at early detection of hypertension, diabetes, and cardiovascular diseases. During such checkups, aside from physical examination and blood sampling, physicians comprehensively query individual health and provide advice on lifestyle behavior. Therefore, it may be difficult for patients to remember whether advice regarding the prevention of skin cancer was also offered. It is also conceivable that general practitioners have little time for a detailed consultation on skin cancer prevention due to other examinations they need to perform during a general health checkup.

Compared with women in our sample, men more frequently reported receiving preventive counseling (70.6% vs. 74.4%; \( P = .139 \)), written information (39.1% vs. 50.7%; \( P < .001 \)), and information about self-examination of the skin (44.0% vs. 51.4%; \( P = .010 \)). This finding is consistent with results from studies focusing on lifestyle counseling for the prevention of other diseases.23,24 The higher likelihood of preventive services/advice in men may be due to their

| TABLE 2 Provision of information on skin cancer prevention and self-examination of the skin during the most recent skin cancer screening |
|----------------|
| **Provision of preventive counseling** | **Provision of written information about skin cancer prevention** | **Information on how to perform a self-examination of the skin** |
| \( n \) | \( \% \) | \( P \)-value (Chi\(^2\)) | \( n \) | \( \% \) | \( P \)-value (Chi\(^2\)) | \( n \) | \( \% \) | \( P \)-value (Chi\(^2\)) |
|----------|----------|-----------------|----------|----------|-----------------|----------|----------|-----------------|
| Total | 941 | 71.1% | 571 | 43.1% | 620 | 46.8% |
| Sex |  |  |  |  |  |  |  |  |
| male | 424 | 74.4% | .139 | 290 | 50.7% | <.001 | 294 | 51.4% | .010 |
| female | 476 | 70.6% | 261 | 39.1% | 296 | 44.0% |
| Age group |  |  |  |  |  |  |  |  |
| 35-45 years | 333 | 76.9% | .002 | 205 | 47.1% | .138 | 206 | 47.0% | .071 |
| 46-55 years | 307 | 73.6% | 187 | 45.3% | 214 | 51.6% |
| 56-65 years | 261 | 66.1% | 158 | 40.4% | 171 | 43.5% |
| Immigrant background |  |  |  |  |  |  |  |  |
| no | 791 | 71.8% | .247 | 470 | 42.9% | .001 | 522 | 47.4% | .913 |
| yes | 107 | 76.4% | 81 | 57.9% | 67 | 47.9% |
| Education level |  |  |  |  |  |  |  |  |
| low | 88 | 68.8% | .388 | 53 | 42.1% | .048 | 60 | 46.9% | .028 |
| medium | 320 | 70.8% | 180 | 39.7% | 190 | 41.6% |
| high | 352 | 73.9% | 226 | 47.7% | 238 | 50.3% |
| Insurance status |  |  |  |  |  |  |  |  |
| statutory insured | 707 | 70.7% | .002 | 412 | 41.4% | <.001 | 456 | 45.6% | .014 |
| privately insured | 190 | 80.5% | 135 | 57.2% | 128 | 54.5% |
| Risk for skin cancer |  |  |  |  |  |  |  |  |
| no risk factors | 277 | 70.5% | <.001 | 165 | 42.2% | .002 | 178 | 45.4% | .077 |
| 1 risk factor | 302 | 67.1% | 180 | 39.8% | 204 | 45.1% |
| ≥ 2 risk factors | 316 | 80.4% | 201 | 51.7% | 205 | 52.2% |

Note: \( n = 1260 \) individuals 35-65 years of age who participated in National Cancer Aid Monitoring in 2019 and reported having been screened for skin cancer; data is weighted by sex, age, education level, and state of residence.
higher risk for developing skin cancer, their lower knowledge of sun-protection, and lower use of measures for skin cancer prevention.

The frequency of preventive counseling apparently decreased in older patients. Overall, 76.9% of participants 35-45 reported being advised on skin cancer prevention vs. 66.1% of those 56-65 years of age. Although not significant, we also found a lower likelihood of receiving information about self-examination in older participants. This is somewhat concerning because the importance of self-examination increases with age due to higher risks for developing skin cancer later in life.

We also noted that privately insured patients were more likely to receive all additional services we examined in our study. One possible explanation for these differences is the different ways in which physicians charge for patient consultations. For privately insured patients, higher fees can be charged for SCS than for those with statutory insurance. This finding contributes to the ongoing debate regarding social inequality in medical care in Germany.

4.1 | Limitations

In our large representative study, we explored differences in services provided during SCS according to physician specialty as well as a wide range of patient-related characteristics. However, some limitations should be considered when interpreting our results. First, we focused only on the perspective of subjects who underwent SCS and the perspectives of physicians who performed SCS were not be considered; thus, further studies among physicians are needed to confirm our findings. For example, quantitative and qualitative studies involving SCS providers or participatory observations during the SCS appointment would be helpful in gaining more insight to reasons explaining the identified differences according to specialization of the physician and patient characteristics. Second, because the data were based on self-report, possible recall and social desirability bias could not be ruled out, which could lead to inaccurate information regarding the examined body sites, or to an under- or overestimation of the frequency of services patients received during SCS. To determine the extent of the potential recall bias, we performed additional analyses focusing on the time point of the last SCS (data not shown). We revealed that only the proportion of visual examination of scalp, genital area, and feet differed significantly: Compared to those who had SCS before 2018, participants who underwent SCS in 2018-2019 reported that these body sites were inspected more frequently. The differences regarding the examination of other body sites, provision of preventive counseling, and extra payment were not significant.

5 | CONCLUSION

A detailed analysis of SCS was performed using a nationally representative sample. Although the majority of SCS participants received counseling on skin cancer prevention during an SCS, we found differences in the provision of counseling, written preventive information, and information regarding self-examination of the skin, as well as in the quality of visual examination between dermatologists and other specialists. These findings highlight the need for the implementation of quality assurance measures.

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CONFLICT OF INTEREST

The authors declare no conflicts of interest.

AUTHOR CONTRIBUTIONS

TG, KD, SS, and EWB designed the research study. TG, KD, and SS performed the research. TG analyzed the data. TG, KD, SS, and EWB interpreted the data. All authors contributed to the drafting, reviewing of the article, and have approved the final article.

DATA AVAILABILITY STATEMENT

Research data are not shared due to guidelines of funder.

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