

# Why are Korean American Physicians Reluctant to Recommend Colorectal Cancer Screening to Korean American Patients? Exploratory Interview Findings

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Published online: 8 July 2008  
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**Abstract** *Background* Korean Americans have one of the lowest screening rates for colorectal cancer. Although physician recommendation is one of the most important predictors of cancer screening across populations, only few Korean American patients receive such a recommendation. *Methods* We interviewed 14 Korean American physicians in Los Angeles area who primarily serve Korean Americans to explore why they are reluctant to recommend colorectal cancer screening to their Korean patients. *Results* Physicians identified barriers attributable to themselves (i.e., lack of knowledge, fear of medicolegal liability), their patients (i.e., patient's unfamiliarity with the concept of screening), and the health care system (i.e., lack of referral network, poor reimbursement). *Discussion* Our results suggest the need for multi-faceted interventions directed at the physicians, their patients, and the health care system. Further research is needed to validate our results and to assess the extent to which they apply to physicians from other racial/ethnic groups.

**Keywords** Colorectal cancer · Cancer screening · Korean Americans · Physician barriers · Physician recommendation

## Introduction

Korean Americans are one of the recently arrived and rapidly growing ethnic groups in the US, particularly in Southern California. The number of Korean Americans in the US has grown from less than 70,000 in 1970 to over one million in the year 2000, of which approximately 80% are foreign born [1, 2]. Los Angeles County is home to the largest concentration of Koreans outside of Korea (17% of all Korean Americans in the U.S.), followed by Queens County, NY (less than 6%) and Orange County, CA (5%). Korean Americans are an underserved group, with respect to health services, research, and policy. They are less well studied as a group than other minority populations, under-represented in cancer screening efforts [3], and research describing Korean Americans and cancer is limited [4–6].

Colorectal cancer is the most common cancer in Korean American males, followed by stomach and lung cancers; the second most common cancer in Korea American females, after breast cancer; and the incidence is rising in this population [7–9]. Although screening, using the Fecal Occult Blood Test (FOBT), sigmoidoscopy or colonoscopy, is well established as an effective means of reducing the burden of colorectal cancer [10], screening rates are low across populations, and even lower among Korean Americans [11–14]. According to the 2005 California Health Interview Survey, about 77% of Korean adults 40 and older have never received any colorectal cancer screening as compared to 55% of Asian Americans, 46% of the general population, and 39% of Whites living in California [15].

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Cancer screening is an integral part of primary care, and physician recommendation has been identified as one of the most important predictors of cancer screening among various racial populations including Korean Americans [16–23]. However, several studies have shown that compliance to colorectal cancer screening guidelines by primary care physicians is poor [24–27] and significant barriers to physician recommendation have been identified, including: lack of knowledge, poor patient–physician communication, perceived patient embarrassment or anxiety, perceived disinterest on the part of patients, limited patient encounter time, and inadequate reimbursement [28–31].

In our previous study with 151 Korean Americans in Los Angeles County, we found that less than 30% had ever received a colorectal cancer screening recommendation from their physician [32]. The majority of Korean Americans are foreign born [1] and approximately 54% of Koreans aged 18 and over living in California do not speak English well [15]. Thus, many seek care from Korean American physicians if they have the opportunity. Because research on physician barriers has primarily been conducted among non-Asian physicians, we do not know if Korean American physicians have similar barriers or if they have additional barriers that stop them from recommending colorectal cancer screening to their patients [19]. The aims of this study were to explore why Korean American physicians fail to recommend colorectal cancer screening to Korean American patients and to obtain their input regarding intervention strategies aimed at increasing colorectal cancer screening among Korean Americans.

## Methods

The study protocol was approved by the UCLA Human Subjects Protection Committee.

### Participant Selection and Recruitment

We compiled a list of 128 Korean American physicians who practice primary care in the Los Angeles area (33 family physicians and generalists and 95 internists with or without additional sub-specialty training) using two methods: (1) We contacted primary care physicians from two community based clinics serving low-income Korean Americans in Los Angeles and obtained contact information of Korean American physicians on their respective referral lists. (2) We also compiled primary care physicians from a directory published by the Korean American Medical Association of Southern California, an organization of Korean American physicians who serve the Korean American community at large. Only six of the 128 physicians (5%) were female.

Our goal was to interview as many physicians as needed to obtain a comprehensive list of themes that address the aims of this study. We utilized an iterative process of subject sampling where we analyzed and compared the initial interviews and kept recruiting for additional interviews, until we were confident that saturation has occurred. From our pool of 128 physicians, we tried to recruit a diverse sample of physicians representing various specialties, practice locations and both genders. After we had interviewed 14 physicians, we determined that saturation had occurred and we stopped our contact attempts and recruitment.

In order to achieve recruitment of these 14 physicians, we had made contact attempts with 33 physicians (i.e. phone calls to the clinic or office and leaving a message with their answering service or staff requesting a return call). Three physicians had disconnected phone numbers and 13 physicians never returned our phone calls despite two or more messages asking for their participation in a UCLA research study. We were able to speak directly with the remaining 17 physicians, of which only three refused. We attempted to contact all of the six female primary care physicians on our list. Of them, one was out of the country, three never returned our calls, and one had a disconnected telephone number. We were successful in contacting only one female physician who agreed to participate.

### Interview Procedure

Immediately prior to the interview, participants were given written or verbal information regarding the study including the assurance on the confidentiality of the data collected. They were also told that the answers they provide will be used for research purposes only. Using the long interview method described by Crabtree and Miller [33, 34], we gathered in-depth information from each of the physicians through several broad, open-ended questions and follow-up prompts. Using a semi-structured interview outline, we obtained descriptive information on physician's knowledge and current practice on cancer screening, explored what are the barriers and facilitators to recommending colorectal cancer screening to their Korean American patients and gathered their input regarding intervention strategies to increase screening in this population.

All of the interviews were conducted one-on-one, in-person or via telephone by the first author who is a bilingual Korean American primary care physician with training and experience in qualitative research methodology. These interviews, lasting 30–60 min, were conducted in English with Korean clarification as needed, and were audio taped and transcribed for detailed analysis. No monetary incentives were given for participation, but physicians were told that their assistance will help in

developing future interventions aimed at increasing cancer screening in Korean Americans.

#### Data Analysis

A multidisciplinary team consisting of a family Physician (first author), a senior research scientist (co-author), a medical student (co-author), and an undergraduate student (co-author) analyzed the interviews using the editing method [33, 34] in which transcriptions were examined and dissected, identifying the information most pertinent to the research question and then categorized, cut, and pasted the interview content into a list of themes. To ensure that relevant items were not overlooked or misunderstood, team members individually scrutinized the data to extract pertinent themes. Themes were then compared and contrasted across investigators and synthesized into a final list. Any of the disagreements were discussed with the entire team until a consensus was reached.

#### Results

Below, we present a summary of our findings and a number of representative quotes that succinctly exemplify each of the themes.

##### Physician Characteristics

The sample of 14 Korean American physicians consisted of mostly male generalists, family physicians and internists. Slightly more than half are foreign medical graduates, most of whom have received their medical degree from South Korea. Many of these physicians practiced in Koreatown.

##### Physicians' Recommendation Patterns

Nine (64%) of the 14 physicians stated that they do not routinely recommend colorectal cancer screening in their practice. Seven of these physicians (50%) stated that they do not offer or discuss colorectal cancer screening even if patients who are aged 50 and over ask for a complete physical exam. One physician stated that he occasionally offers colorectal cancer screening only when his patients request it.

GP: I don't know exactly what percent of our patients come here wanting a complete check up, but we don't do or recommend sigmoidoscopy or colonoscopy to these patients.

Interviewer: Do you offer FOBT (fecal occult blood testing) to your patients?

GP: No, not unless they complain of rectal symptoms such as pain or bleeding.

Interviewer: If a patient doesn't have any symptoms at all... let's say you had a patient who is 50 years old with no symptoms...do you recommend that he get colorectal cancer screening?

FP: Without symptoms, no. But with continued poor appetite, weakness, and weight loss...I recommend endoscopy and sigmoidoscopy, and I send them to the specialists.

#### Barriers to Colorectal Cancer Screening Recommendation

##### *Physician's Lack of Knowledge*

Most of the physicians lacked knowledge on the prevalence of colorectal cancer in Korean Americans. Many also lacked knowledge of screening guidelines. They stated that the incidence for this disease among Korean Americans is much lower than the general population. Two physicians stated that the incidence among Korean Americans is about a tenth of that of the general population; while according to the 2000–2002 California Cancer Registry, the age-adjusted rates among this population is just slightly lower than Whites (57.8 vs. 59.1 per 100,000 for males and 33.1 vs. 42.8 per 100,100 for females) [35]. These physicians were not familiar with the available screening modalities and the time intervals recommended for these tests. Several physicians reasoned that because the prevalence of this disease among Korean Americans is very low, routine recommendation and development of any programs to raise screening rates are not warranted in this population.

FP: Well, for them (Korean Americans), it's not as big of a problem as for the Americans. The reason is that their diet is mostly vegetables, but as you go into the second generation, they're more likely to eat fast foods... They're eating more fat rich diet which could be the risk factor for colorectal cancer.

Interviewer: For Korean Americans, how big or small do you think is the problem of cancer?

FP: Well, of the patients that I've been seeing, the rate of cancer occurrence would be... colorectal wise...about a tenth of the Americans.

IM: Colorectal cancer is relatively rare among Koreans... for our population, I'm not sure if we need to go through it (screening).

### *Patients' Lack of Awareness of "Screening" and "Preventive Medicine"*

Several of the physicians stated that "screening" or testing in the absence of symptoms is a foreign concept to many Korean Americans, especially the elderly. They explained that although disease prevention and health maintenance are highly valued in this population, the concept of "Preventive Medicine" is relatively new and unfamiliar. They stated that their patients generally equate having no symptoms to having good health or having no disease. Therefore, recommending colorectal cancer screening to their Korean American patients requires much more on the part of the physician than just recognizing the need for screening and ordering appropriate tests at the right time intervals. Extra time and effort is needed to explain to their patients about screening and why routine examinations in the absence of symptoms are needed.

IM/GI: I think the concept of preventive medicine has been lacking especially in the elder Korean patients.

FP: You see, they (hold on to) this concept that you need testing (screening) only if there's something wrong. They're still not educated about the screening program.

IM: They (Korean patients) do not know the difference between a screening test and a diagnostic test...

FP: When I'm seeing Caucasian or American born patients, they are well aware of (the concept of) screening. So when I offer this test (sigmoidoscopy) they take it without much of a resistance. But the Koreans, especially the elderly, I have to twist their elbows to have them do it. I have to do a lot of talking, a lot of sales pitch before they accept to do it.

### *Lack of Referral Network for Low-Income and Underinsured Patients*

Three of the physicians explained that they lack adequate referral system for their low-income and underinsured patients who screened positive. Diagnostic testing and follow-up would therefore prove too burdensome for many patients. In light of relatively high false positive rates of FOBT, these physicians expressed reluctance to offer this test routinely to their underinsured and low-income patients.

IM: The referral network is not well worked out for the poor patients. If they end up testing positive on the FOBT, they have to get further testing with a colonoscopy usually. This can cost over a thousand dollars at private clinics in Koreatown. This amount is very burdensome for most...even for those who have jobs, it's a burden if they have to pay out of pocket.

FP: We often refer our patients to the county hospitals but...many patients don't like to go there...wait time is also very long...many are also lost to follow-up.

### *Perceived Patient Non-Compliance*

Several physicians expressed disinclination to recommend screening because they believed that many of their patients would not comply with recommended testing, noting several factors that they believed would likely contribute to patient non-compliance. These included a lack of understanding of FOBT directions; fatalism; reluctance or shyness to show their buttocks in order to be examined unless they have definite symptoms; the dietary restriction of cruciferous vegetables (i.e. cabbage, radish, cauliflower) recommended for FOBT may be unrealistic for Korean American patients because "Kim Chee", made with cabbage or radish, is considered a daily staple, eaten at almost every meal; fear that endoscopies are painful; and inability to comply with endoscopy preparation.

IM/GI: That is correct but also for them, especially elderly people, they think that showing...they feel that (laugh)...they're not comfortable showing their buttocks to their physicians perhaps.

Interviewer: Do you ever send out FOBT cards to your patients?

IM: Compliance rate would be probably close to zero if I do that. Again, that's due to lack of understanding in the importance of the test.

IM/GE: I give them (Korean American patients) explanation of the benefits of early detection and diagnosis (but) they were afraid that this is painful...(saying that) this procedure can hurt them...they said my friend had this procedure and they've been going to bathroom, having diarrhea and abdominal pain for one month... they don't want to have that.

GP: I would explain to patients (about FOBT) but they don't understand...maybe they understand about half of the direction. They rarely follow through, and so I don't want to waste so much of my time (with FOBT).

### *Lack of Trust in the FOBT*

Physicians expressed lack of trust in the FOBT as an effective means of screening owing to the fact that FOBT has high false positive and false negative rates.

GP: (Referring to FOBT) I don't know... I don't know if it's a good test. I believe it can have many false positives...I don't know.

IM: ...I don't trust FOBT...if you had too much red meat or if you have hemorrhoids, it would mess up the results...almost anything would mess it up.

### *Fear of Medicolegal Liability*

Three physicians stated that they personally do not perform sigmoidoscopies because of liability concerns or their lack of experience in this procedure. They explained that a diagnosis of cancer is a serious matter and they defer performing endoscopies to specialists who they deem to be more accurate in this procedure. However, these physicians said that they refer their patients to specialists only in the presence of symptoms.

GP: We don't do sigmoidoscopies here. I don't have enough experience...specialists are more accurate in this procedure.

GP: Cancer is a very delicate issue. If you miss one, you're in big trouble.

### *Hesitation to Deal with Upset Patient or Family Over Abnormal Test Results*

One physician stated that Korean American patients often get excessively distressed over abnormal test results, even after receiving an explanation that high false positive rates are inherent to screening tests. This physician explained that the news of an abnormal test result, especially if related to a diagnosis of cancer, can also create stress and concern in the extended family, due to the importance of the extended family among Korean Americans. This physician went on to explain that in these situations, the whole family can become distraught unnecessarily over false positive FOBT results.

FP: Oh, it becomes personal...it becomes personal...as soon as there is any mention of the word 'cancer,' the fear factor comes in. It's a whole family matter now. Americans have nuclear family. But Korean family is little more extended than American. The whole family (including the extended family), begin to worry...it causes a lot of hassle.

### *Administrative and Logistic Barriers*

Several physicians mentioned administrative and logistic barriers: lack of government funding for the underinsured and indigent populations, lack of interest on the part of clinic management, and pressure to see more patients in limited time. A few physicians also mentioned that reimbursement for FOBT is very low.

FP: The administration wants me to see many patients. They pressure us to see many patients...and I don't have much time educating patients on the importance of screening...

### *Preferred Interventions for Increasing Physician Recommendations*

Physicians suggested that information provided to them in the form of continuing medical education (CME) or physician detailing would be very helpful in keeping them up to date with screening guidelines. When asked whether or not they would take time off from their busy schedules to attend a CME or a dinner seminar on colorectal cancer screening and prevention, all replied affirmatively. Two physicians indicated that periodic reminders from trusted authorities such as the American Medical Association or the American Academy of Family Physicians would also help physicians pay more attention to colorectal cancer screening. In considering financial and practice barriers, many of the physicians commented that receiving government or fiscal support for the underinsured patients would greatly enhance screening, pointing to the relative success of breast and cervical cancer screening efforts since programs such as the California Department of Health Service's Cancer Detection Programs: Every Woman Counts that provide support for these tests and diagnostic services for qualified patients have been implemented.

FP: Cost would be very important factor so if the government could offer free screening then it will attract them more.

Interviewer: Anything else that you would suggest to increasing screening among Korean Americans?

GP: Yes, free programs like this clinic has (referring to the Cancer Detection Program)... Everything has to be low cost or free. How about vouchers for flexible sigmoidoscopy.

Finally, physicians explained that if their patients are aware and interested in getting screened, the recommendation and service delivery process becomes much easier and less time consuming. In order to raise awareness and interest among their patients, they suggested offering educational seminars at community venues such as churches, school, or work places; a media campaign; and print materials in their clinics.

FP: We have to emphasize the importance of early detection and prevention of this cancer rather than trying to fix it after it happens.

IM/GI: Newspaper advertisement or (other) mass media—radio and TV...all three modalities should be



used to educate (the Korean Americans) about prevention and preventive medicine.

FP: You know, I've been doing seminars for the senior citizens and at churches. Once they are educated and doctors strongly recommend it, they are likely to be open to the suggestion (of screening).

## Discussion

This is one of the first studies to qualitatively explore barriers to recommending colorectal cancer screening in a setting where both physicians and patients are of Korean American ancestry. Physicians are often hard to recruit into research studies, and interviewing physicians who are immigrants or international medical graduates poses additional challenges because they may not be fluent in English. In fact, in many of these interviews, English was predominately used but Korean clarification was needed frequently. Although we interviewed only 14 physicians, we were able to elicit detailed information using a common interview guide. After the first nine in-depth interviews, no new themes emerged in the data analysis, suggesting that saturation was achieved. Although we interviewed only one female physician who was an internist, she did not mention any themes that were unique from what was mentioned by others.

Due to the small sample size and the qualitative nature of this study, our results are not generalizable. However, our primary intent was to gain an in-depth understanding of the characteristics and practice patterns of these physicians as well as barriers and facilitators to recommending colorectal cancer screening. Our results elucidate important themes that may be important in program planning and intervention development. These are discussed below.

Contrary to the belief that, among underrepresented populations, ethnic concordance between physician and patient should result in higher quality care, our study suggests that Korean physicians very rarely recommended colorectal cancer screening for their Korean patients. This is consistent with two previous studies that showed ethnic minority patients are less likely to receive certain preventive services such as pap smears, mammograms, and clinical breast exams from ethnic minority physicians compared to care received from Caucasian physicians [36, 37].

Physicians identified the following barriers for recommending colorectal cancer screening: barriers directly attributable to the physicians themselves (i.e., lack of knowledge, fear of medicolegal liability), barriers associated with their patient characteristics (i.e., patient's unfamiliarity with the concept of screening and preventive medicine), and barriers that result from the limitations of the health care system or local clinics (i.e., lack of referral network, poor reimbursement).

In addition to the barriers that have been described in prior research (lack of physician and patient knowledge, perceived patient embarrassment, perceived disinterest on the part of patients, limited patient encounter time, and inadequate reimbursement), our study elucidates themes that may be unique to this and perhaps to other immigrant or underserved groups. In particular, the lack of concept of "screening" may be common in immigrant populations from countries where preventive medicine is not widely practiced. Additionally, heavier involvement of the extended family in the patient's health practices and treatment decisions resulting in additional physician burden may be found more commonly in the Latin American and many of the Asian cultures. It may be of value to explore and compare our findings with physicians who serve other minority groups.

Physicians have suggested the need for a multi-faceted approach directed at the physicians, their patients, and the health care system to increase screening among Korean Americans. As suggested by the physicians, education in the form of physician detailing or CME courses may help address gaps in knowledge and lessen reservations regarding FOBT as an effective screening tool. A large body of research supports CME and physician detailing as effective means of changing physician behavior [38–43]. Regarding medicolegal concerns on performing sigmoidoscopy, a hands-on training with an experienced peer may be helpful. A map of referral network in the form of a physician tool, such as a poster or other visual aid in the physician's office or an interactive web page, may also be beneficial.

To address patient barriers, educational materials such as brochures, videos, or web-pages may be useful. A widespread educational ethnic media campaign on preventive medicine and on how patients can take advantage of this discipline to prevent diseases and maintain well-being may be effective. A media-based community educational campaign has shown to be effective in increasing breast and cervical cancer screening behaviors in other Asian communities such as the Vietnamese American community [36]. Because having a clear understanding of the concepts of preventive medicine and screening in the absence of symptoms can facilitate screening for other diseases as well, such effort on public education may have far reaching benefits beyond colorectal cancer.

For the health care system, in light of the fact that approximately a third of Korean Americans do not have health insurance [44], programs that support colorectal cancer screening and related diagnostic services may be needed. The above noted California Department of Health Service's Cancer Detection Programs: Every Woman Counts, where eligible women may receive breast and cervical cancer screening and diagnostic services free of

charge, resulted in services to nearly 190,000 qualified women in 2003 [10]. Advocacy is clearly needed to raise awareness and interest among policy makers in similar programs addressing colorectal cancer.

In summary, our findings suggest that Korean American physicians and their patients may need to be educated on colorectal cancer and the importance of screening. Physician education in the form of physician detailing and CMEs have been suggested. Patient education should focus on what preventive medicine is and how it can be utilized to prevent diseases and maintain well-being. Advocacy work is needed to help fund programs that link eligible patients to health insurance and to help subsidize colorectal cancer screening and diagnostic services for those who cannot afford or do not qualify for public programs.

**Acknowledgements** Sources of support for this research: grant number U01CA114640 from the Center to Reduce Cancer Health Disparities/National Cancer Institute; UCA Jonsson Comprehensive Cancer Foundation Research Fellowship grant; training grant R25 CA 87949 from the National Cancer Institute. The contents of this paper are solely the responsibility of the authors and do not necessarily represent the official views of the National Cancer Institute.

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