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Adherence to cervical cancer screening in France: factors influencing the healthcare professionals' decisions—a qualitative study

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ABSTRACT

Objective To understand what leads to the non-adherence to the cervical cancer screening (CCS) recommendations during a consultation.

Design For this qualitative study, in-depth semistructured interviews were carried out with French healthcare professionals. An interview guide was developed and tested. It included the following themes: CCS recommendations, patients' profiles, relationship with patients, emotional work, over-screening and under-screening. Interviews were carried out until data saturation (no new data, theoretical diversity reached). The grounded theory was used for data analysis.

Participants Gynaecologists, midwives and general practitioners (GPs). The sample diversity was achieved using the following criteria: place of work, type of healthcare profession, type of patients, private-sector or hospital professional.

Setting Interviews were conducted between July and December 2022 in six regions in France.

Results In-depth semistructured interviews were carried out with 15 midwives, 24 GPs and 11 gynaecologists from six French regions. Their analysis highlighted that the following factors contributed to the non-adherence to the CCS recommendation: burden of caring for family members for some women, adhesion to the principle of yearly screening by healthcare professionals and patients, need of negotiating the respect of the CCS recommendations, use of emotions, and arbitration to prioritise what is needed for good health maintenance. The search for mutual emotional comfort led some healthcare professionals to adopt attitudes towards the CCS that avoid positioning conflicts, even if this means departing from the recommendations.

Conclusion CCS can be correctly performed if healthcare professionals and patients agree on the need of actively taking care of their health, which is difficult for women from lower sociocultural backgrounds. During the one-to-one meeting with their patients, healthcare professionals may find difficult to apply the CCS recommendations, although they know and agree with them.

STRENGTHS AND LIMITATIONS OF THIS STUDY

⇒ This study focused on negotiation during a medical consultation to understand what leads to over-screening or under-screening, although healthcare professionals are aware of and agree with the recommendations on cervical cancer screening.
⇒ This study used rigorous methods and relied on rich accounts from a diverse sample of healthcare professional from different regions in France.
⇒ A limitation of the study is that patients were not interviewed. The analysis of their perspectives would have strengthened the credibility of our analysis.
⇒ The use of in-depth semistructured interviews allowed a deeper and more nuanced understanding of under-screening and over-screening.

INTRODUCTION

Cervical cancer is the fourth most prevalent cancer in women worldwide and the fourth leading cause of cancer-related death in women: 604 127 new cases and 341 831 deaths per year.[1] *Human papillomavirus* (HPV) is responsible for nearly all cervical cancer cases. It is one of the most common sexually transmissible viral infections, and its prevalence is particularly high among 20–24-year-old women in Europe (29% to 45%).[2] When cervical dysplasia is identified in a young woman, the probability of regression is 91% at 36 months.[3] Persistent infections by 13 high-risk HPV genotypes account for virtually all cervical cancers worldwide.[4] In May 2018, the WHO issued a call to action to eliminate cervical cancer as a public health concern. A draft global strategy in 2019 outlined three intervention targets: vaccination (primary prevention), screening and precancer treatment (secondary prevention), and invasive cancer diagnosis and treatment (tertiary prevention).[5] The WHO coverage target is to increase twice-lifetime cervical screening to 70% in order to achieve cervical cancer elimination by 2030.[6]

Several studies have shown the Papanicolaou (Pap) smear value to reduce cervical cancer incidence.[7] In France, before 2019, the smear test was carried out every 3 years and

from the beginning of sexual activity. Since 2019, many European countries (Belgium, Italy, Ireland, Greece, UK and France) recommend cervical cancer screening (CCS) from the age of 25 years to the age of 65 years, with two tests at 1-year interval for 25- to 29-year-old women and then every 5 years for 30- to 65-year-old women.[8] In France, Pap smears can be carried out by gynaecologists, general practitioners (GPs) and midwives, and there is no restriction on the number of tests per patient and their timing. For instance, a woman can have a Pap smears before the age of 25 years or more frequently than recommended if the healthcare professional agrees on its necessity. Neither patients nor healthcare professionals are monitored or sanctioned for not following the CCS guidelines, potentially leading to over-screening but also to under-screening. Therefore, despite the existing recommendations, over- and under-screening remain a challenge for health organisations in France and many other countries.[9–11] Over-screening exposes women to the detection of lesions that are likely to disappear spontaneously and is accompanied by unnecessary follow-up examinations and surgical procedures (eg, conizations) that can lead to premature birth.[12]Conversely, under-screening exacerbates health inequalities because the women least likely to undergo CCS are those most exposed to cervical cancer risks due to sociodemographic and socioeconomic factors.[13]

Studies have focused on the factors influencing cervical cancer under-screening.[14–16] They found that healthcare professionals play a significant role in the adherence to health recommendations.[17 18] However, few studies explored the healthcare professionals' attitude during consultation and the influence of their relationship with women patients. Moreover, a study in the USA reported that only 23% of healthcare professionals implement the CCS recommendations, although they knew them and the groups at high risk of cervical cancer.[17] In addition, their capacity to promote CCS acceptability and adoption by their patients remains unknown. Therefore, to improve cervical cancer prevention, it is important to understand and address the healthcare professionals' perceptions and practices concerning CCS. We hypothesised that the healthcare professionals' characteristics, their knowledge and perceptions of CCS, and their patients' profile play a role in the correct CCS implementation.

The objective of this qualitative study was to understand what affect the healthcare professionals' attitude towards CCS in real life. Our findings could represent the starting point of future studies and outreach efforts to reduce cervical cancer burden in underserved populations.

METHODS

Study design and participants

For this qualitative study, two researchers (SM, JL) carried out face-to-face and telephone interviews to investigate the participants beliefs and experiences about CCS. Then, the grounded theory was used to determine why healthcare professionals may not perform or overperform CCS.[19] Then, the patient-healthcare professional interaction and its potential consequences were discussed and interpreted.

Three types of healthcare providers (gynaecologists, midwives and GPs) are involved in CCS in France, and this may be one of the factors influencing the adherence to this screening. Therefore, gynaecologists, midwives and GPs were sampled using a purposive and snowball sampling strategy. Recruitment was carried out in five French regions (Nouvelle Aquitaine, Occitanie, Ile de France, Haut de France, Pays de Loire). Participant recruitment was stopped when data saturation was reached (ie, no new theme emerged and theorical diversity of participants reached). The place of work, type of healthcare profession, sociodemographic characteristics of their patients, healthcare professional's status (private sector or hospital), age and gender were considered to obtain diversity of healthcare professionals' experiences concerning CCS. Ethics approval was obtained from the data protection officer at Poitiers University (number: 202352). Data were collected anonymously to protect the interviewees' privacy. Each interviewee was assigned a unique number. All audio recordings and transcripts were stored on a password-protected computer.

Data collection

In-depth semistructured interviews were carried out from July to December 2022. Each interview began with an explanation of the research aims, how the data would be used and the obtention of the verbal consent for participation and audio recording. The participants' age, career path, other professional characteristics and care offer in the geographical area where they worked were collected at the beginning of the interview. The interview guide (open-ended questions) was developed using previous literature data to discuss various aspects of cervical cancer over- and under-screening (online supplemental file 1). At the interview end, the healthcare professionals were encouraged to express their opinions with the following question: Is there anything else you would like to add?

This study followed the Consolidated Criteria for Reporting Qualitative Research (online supplemental file 1).[20]

Data collection and data analysis were carried out simultaneously. Two authors (SM, JL) transcribed the audio recordings within 24 hours after each interview. The NVivo 14 software was used for data coding.

Data analysis

The techniques of coding and thematic analysis were used in which 'codes' are ascribed to salient parts of the transcript text and are then organised into larger 'themes' that represent meaningful categories. Three authors (SM, JL, NN) simultaneously and independently coded three transcripts to establish a codebook and performed repeated readings of the transcripts for credibility. Then, they discussed the codes and content area discrepancies

Table 1 Characteristics of the population

ID number	Work type	Work area	Gender	Interview duration (min)
M1	GP	Urban	Woman	26.11
M2	GP	Urban	Woman	25.53
M3	Mw	Urban	Woman	37.57
M4	Gyn	Semi-urban	Man	31.25
M5	Gyn	Urban	Man	39.48
M6	Gyn	Urban	Woman	39.42
M7	Gyn	Urban	Woman	38.45
M8	Gyn	Rural	Woman	42.44
M9	Mw	Rural	Woman	46.12
M10	GP	Urban	Woman	48.22
M11	GP	Rural	Woman	43.45
M12	Gyn	Urban	Woman	44.09
M13	Mw	Semi-urban	Woman	59.13
M14	Gyn	Urban	Man	58.24
M15	Mw	Urban	Woman	47.27
M16	GP	Urban	Woman	34.44
M17	Gyn	Urban	Man	51.56
M18	Mw	Rural	Woman	43.3
M19	Mw	Urban	Woman	49.18
M20	GP	Rural	Man	32.09
M21	GP	Urban	Woman	28.39
M22	GP	Urban	Woman	31.19
M23	GP	Urban	Woman	34.19
M24	Mw	Urban	Woman	46.55
M 25	Mw	Rural	Woman	51
M 26	GP	Semi-urban	Man	38.33
M27	GP	Rural	Woman	35.39
M28	GP	Semi-urban	Woman	39.04
M29	GP	Urban	Woman	34.44
M30	GP	Semi-urban	Woman	59
M31	GP	Rural	Woman	39
M32	GP	Rural	Woman	48.33
M33	GP	Semi-urban	Woman	38.18
M34	GP	Semi-urban	Woman	52.04
M35	GP	Semi-urban	Woman	32.04
M36	Gyn	Urban	Woman	60.02
M37	Mw	Urban	Woman	52.45
M38	Mw	Urban	Woman	42.2
M39	GP	Rural	Man	38.33
M40	GP	Rural	Man	35.14
M41	GP	Rural	Woman	46.16
M42	GP	Urban	Woman	31.2
M43	Mw	Urban	Woman	41.37
M44	Gyn	Urban	Woman	53.04
M45	Mw	Urban	Woman	36.42
M46	Mw	Urban	Woman	45.24
M47	Mw	Urban	Woman	34.02
M48	GP	Urban	Woman	43.24
M49	Mw	Urban	Woman	43.34
M50	Gyn	Urban	Woman	40.47

GP, general practitioner; Gyn, gynaecologist; Mw, midwife.

that arose until they reached a consensus on the codebook. Transferability was obtained with a secondary coding. NN and XF reviewed the transcripts for completeness and accuracy. Any discrepancies or changes to the coding scheme were discussed, and then transcripts were updated to incorporate all changes made throughout the analysis process. Lastly, all authors discussed the findings and clustered the codes into broader themes to interpret them.

Patient and public involvement

None

RESULTS

Participants' characteristics

In total, 50 healthcare professionals (42 women and 8 men) were interviewed: 11 gynaecologists, 15 midwives (all women) and 24 GPs. Their mean (SD) age was 43.3 (10.9) years. The mean duration of each interview was 49.67 (10.07) minutes (table 1). They all knew the most recent CCS recommendations from 2019 and the targeted populations.

The interview data analysis identified four themes.

Theme 1: An implicit agreement on the need of a gynecological examination

Some healthcare professionals, particularly gynaecologists, expressed the need to systematically examine the cervix of their patients (table 2, 1.1). They said that if they found something abnormal, they had to carry out a Pap smear in order not to 'miss something'. For them, changes in sexual practices and longer life expectancy were reasons for a larger application of Pap smears. These changes were also put forward by healthcare professionals to explain why they tended to perform a precautionary Pap smear outside the recommended schedule. In addition, some healthcare professionals said that for them, it was easier to examine the patient than to ask questions about her sexuality, which is why some preferred to perform Pap smears more often than necessary (table 2, 1.2). This seemed easier also because in France, many

Table 2 Theme 1: themes and subthemes

Themes and subthemes	Identifier	Illustrative quotations (GY, gynaecologist; MW, midwife; GP, general practitioner)
An implicit agreement on the need of a gynaecological examination		
The need to examine patients	1.1	*I do a clinical examination with a speculum. If there is something that seems not normal, if I have an ectropion that is suspicious or if it seems to me that there are abnormal things, I do the Pap test earlier. In the framework of CCS, it is done less frequently, but in patients with abnormalities it can be done more often*. M13 MW *I examine the cervix from the moment patients come for a gynaecological examination, never at the first appointment when they are 15, 16 or 17-year-old, but from the moment I examine them, I really examine them*. M36 GY
The patients' sex life	1.2	*When they absolutely want a regular Pap test, I tell them: "If there are changes in partners, then it's worth mentioning it, so that we can have Pap tests perhaps a little more regularly". However, I never ask directly about their sex life. I don't ask them: "Do you have a single partner?"*. M36 GY
The gynaecological norm	1.3	*Patients with a good standard of living obviously all have their check-up every year or every year and a half. So, in fact, we see them very regularly and this allows us to examine their cervix regularly and easily*. M50 GY *Oh yes, it must have happened, that she goes back to see her gynaecologist to continue her follow-up as she sees fit*. M21 GP
The introduction of the gynaecological norm	1.4	*These are young women who have heard by word of mouth or from their mother, aunt, close friends or family who tell them: "yes, you're this age, you have a sex life, you need to have a Pap test*". M43 MW
The end of the gynaecological norm	1.5	*The worry with this screening and this change in screening recommendations is that after the age of 65, "what happens if they abandon me?"*. M33 GP
Choosing their healthcare professional	1.6	*Overall, the socioeconomic profile of my patients, in any case they are not really destitute, so women of at least average level and particularly in the higher socio-economic categories, lawyers…I have patients who come from far away*. M36 GY

women are used to see a gynaecologist once per year (ie, 'gynaecological norm'), especially if they belong to a privileged social category (table 2, 1.3). This norm might be transmitted to younger women by their mothers, female family members and friends and maintained by healthcare professionals who encourage them to have a yearly check-up. According to some participants, these patients, who are used to gynaecological examinations and who associate this examination with a Pap smear, might find hard to accept that the CCS will stop (table 2, 1.4 and 1.5). Furthermore, patients with a higher socioeconomic level could more easily choose the type of healthcare professional whom suited them from the point of view of this norm, even in a context of healthcare professionals' shortage (table 2, 1.6).

Theme 2: Having the opportunity to look after themselves

According to the participants, under-screened patients might be overwhelmed by their family responsibilities and sometimes by the burden of financial difficulties (table 3, 2.1). In these circumstances, they would go to a doctor only if they had symptoms or if their loved ones needed care (table 3, 2.2). The result was that even when CCS was the initial focus of the consultation, it was supplanted by more urgent health problems in the family. It was no longer a priority (table 3, 2.3). Some healthcare professionals thought that these patients were negligent and passive because they did not comply with the follow-up recommendations. According to them, these women did little in the way of prevention and were more focused on treating the disease. They were fatalistic and not proactive (table 3, 2.4).

Theme 3: The negotiation, an emotional cost

The emotional cost of disagreeing on CCS could be important. For example, some patients posted unpleasant comments on social networks following the refusal of a Pap smear (table 4, 3.1). This might have negative consequences on the professional life (eg, fewer patients choosing to be followed by this person). Practitioners reported that patients used their emotions as a negotiation tool. Anxiety, threat and guilt were the emotional levers most often used (table 4, 3.2). They also said that women can choose their healthcare professional in France. Patients can change practitioners as often as they wish, depending on availability. They thought that patients who do not wish to be examined may go to their GP, who in France is considered the least legitimate healthcare professional to carry out gynaecological examinations (table 4, 3.3). Women who want more consultation time might go to a midwife who listens to women more in terms of care/well-being than treatment (table 4, 3.4). Patients with higher income might prefer to see a

Table 3 Theme 2: having the opportunity to look after themselves

Having the opportunity to look after themselves		
The burden of family and social commitments	2.1	*I see it in some large families from fairly high sociocultural backgrounds. The women are so busy looking after their family that they don't look after themselves at all. They know it has to be done, but they don't come. Well, at the last minute they can't come because of the children. Well, that's often the case. We find them back when the children are older and they're finally looking after themselves. They forget themselves, so we also have some who aren't up to date with the screening. They know that, so she says in a small voice: "Yes, I know". But there you go*. M15 MW *They look after their children, they look after the people around them, but they don't take much care of themselves. That's more like that. Quite frankly, because of their precarious situation, they're basically in survival mode, so I'd say they don't have the time or the energy to look after themselves. For them, their bodies don't really exist*. M25 MW
Relationship with their body	2.2	*A woman who has pain in her lower abdomen obviously thinks it's her ovaries, so that's how women were recruited for a consultation in the suburbs. In the city centre, on the whole, they come for a check-up, even if they don't have any problem, even if they're not in pain, they come*. M44 GY *It is this very precarious population for whom taking care of oneself is not the priority. To look after oneself, to take care of oneself, I think one has to be already well*. M24 MW
Patients who are not screened	2.3	*When women come here, they come for a new pill prescription, for shoulder pain, for the kid's prescription, for the grandfather's prescription, and so I try to frame things. To say, no, the gynaecological examination will be done in another consultation, but it's still difficult and I find that it is a difficult consultation*. M27 GP
A fatalistic attitude	2.4	*In disadvantaged areas, women tend to be either passive or negligent. It's the same for teeth, it's the same for everything*. M2 GY *There's also a lot of fatalism in these cultures, so if something happens I feel like saying, well, that's just the way it is. Well, it is awful*. M24 MW

GP, general practitioner; GY, gynaecologist; MW, midwife.

gynaecologist who is considered an expert by women and also by the other healthcare professionals (table 4, 3.4).

Theme 4: Facilitating the negotiation

Some participants said that they had mainly patients who were similar to them and recognised their skills (table 5, 4.1). This generally avoid disagreements and when necessary reduce the emotional cost of the negotiation. According to the participants, patients were reassured by explanations and were happy to see a healthcare professional who wanted them to understand things. However, when there was a strong disagreement about the principle of screening, often the relationship ended (table 5, 4.1). Other participants said that education and repeated explanations could be useful in the case of disagreement over CCS (table 5, 4.2). Negotiation was learnt through experience. Healthcare professionals also said that they could move away from the strict application of the CCS recommendations and adopt a more flexible attitude closer to the patient's view (table 5, 4.3).

DISCUSSION

This study presents the experience of healthcare professionals involved in CCS. Although they were aware of and agreed with the recommendations on CCS, they could not always apply them during the consultation with their patients. During the healthcare professional-patient interaction, the search for mutual emotional comfort led both protagonists to adopt attitudes towards the CCS that avoided conflicts, even if this meant deviating from the recommendations.

Finding an agreement on cervical cancer screening (CCS)

Our results suggest that according to the healthcare professionals, the choice of healthcare professional to carry out a Pap smear is determined not only by proximity or ease of access, but also by the shared opinion (between practitioner and patient) concerning the intentions of care and screening. This attitude seems to be different among the healthcare professional types involved in the gynaecologist follow-up (ie, GP, gynaecologist and midwife). A previous work showed that patients with higher income use specialist doctors more often than patients with lower income.[21] Moreover, patients from higher socioeconomic levels are more likely to arrive at a consultation with prepared questions and requests.[22] Our hypothesis is that women from more privileged backgrounds may take this step because of the integration of the gynaecological norm (ie, social injunction for women to have an annual visit to a gynaecologist) but also for reasons of perceived control over their lives. It was previously shown that a feeling of empowerment can be associated with better health status, success and social integration.[23] People with limited resources are more likely to lose control over

Table 4 Theme 3: the negotiation emotional cost

The negotiation emotional cost		
The emotional cost of the negotiation	3.1	*She took her revenge, she didn't appreciate at all what I said to her and so she showed her displeasure on the internet, but I didn't see any point in lowering myself to her level of attack on the consultation; anyhow, we had different points of view*. M13 MW *And it's also the first reaction when you're aggressive, there will be inevitably an automatic reaction of aggression, in return; one has to be able to step back, one must not be too tired, must not be overwhelmed, one has to be available. It's not always easy*. M25 MW
Emotions as a negotiation tool	3.2	*If it's not in the recommendations than they say "yes, but it reassures me" because whatever, we do it. So no, I haven't had to deal with conflicts.* M45 MW *There's one lady to whom I think I did a Pap test earlier than recommended, but because she was hyper-anxious, stressed, I said: "Well then, let's do it", but yes, she did influence me a bit.* M19 MW *In any case, women from the upper social classes are going to start by telling me that I am taking risks with them, there's going to be an argument like: I am not following them. I am playing with their lives, that's it, there may be a little bit of that "yes it's the recommendations but my life is my life*". M5 GY
Legitimacy	3.3	*I was even told: "Well, you're not a gynaecologist, MY gynaecologist did it, so I think he knew more about it than you do". So if he did it, it was better*. M9 MW *There are those who come for their contraception and we update the CCS. And sometimes it's very convenient for them to do a new pill prescription at the GP's, without really having a gynaecological consultation*. M20 GP
Determined patients	3.4	*And they talk, they talk and they're really happy about it, they say, "I feel listened to". They're pretty active, they know what they want*. M3 MW *In socioeconomic terms, the profile is going to be quite varied, but more likely to be middle- to high-income patients*. M50 GY *The very rich, the very educated, I don't know if they go to midwives*. M37 MW

GP, general practitioner; GY, gynaecologist; MW, midwife.

their lives and finally on their health. Some of the interviewed healthcare professionals considered that patients who did not undergo regular CCS were 'passive' and did not understand their fatalistic attitude.[24 25] This fatalistic attitude is associated with negative health outcomes due to more frequent late recourse to healthcare professionals in the event of a disease and reduced adherence to screening programmes. Therefore, it is not the income level in absolute terms but rather the social positioning that is a vulnerability factor.[25] Healthcare professionals should see this fatalism as a lever on which they can act.[26]

Avoiding conflicts by choosing each other

Our results suggest that healthcare professionals have patients who are similar to them in background and attitudes. In France, this is facilitated by the fact that patients can freely choose their physician until they find one who suits them. This choice may be based on criteria other than the quality of care. For instance, the interviewed healthcare professionals suggested that some patients prefer a professional who is attentive to their perceived needs. Follow-up with a healthcare professional can take place only if both partners agree that CCS is an approach of prevention and not the consequence of a disease. A previous work showed that all healthcare relationships occur in the context of reciprocal influence.[27] Reciprocity and mutual influence strongly affect interactions: more positive (or negative) communication from one participant leads to a similar response from the other. Healthcare professionals are less in conflict and more satisfied with patients with whom communication is easy and when they think that patients are satisfied with the care they receive.[28] Therefore, it is not surprising that patients return to see the healthcare professional with whom they had the most satisfying relationship. One study found that the least socially advantaged patients go back to the GP who is seen as a 'dominant' figure, close and accessible, and more familiar to them.[29] A meta-analysis demonstrated that patients reported more beneficial health outcomes, fewer symptoms and higher quality of life when they had a higher level of trust in their healthcare professionals.[30] Consequently, the women's choice of healthcare professionals allows reducing the tensions resulting from disagreement over the CCS benefits that may arise during a consultation. Likewise, in order to maintain a good relationship, healthcare professional may not follow the CCS recommendations, although this might be prejudicial for underprivileged women who are more susceptible to refuse screening.

In some countries (eg, UK), Pap smear samples from women under 25 or over 65 years of age are rejected.[31] This avoids negotiations between healthcare professionals and patients in the event of disagreement over a request outside the CCS guidelines. It can also limit medical nomadism because all patients are treated in the same way by all professionals concerning screening. In countries where patients can choose their practitioner,

Table 5 Theme 4: facilitating the negotiation

Facilitating the negotiation		
Continuing the relationship	4.1	*In most cases, they are friendly, lively and dynamic. They want to understand, they're looking for answers. I think my patients are nice. I'm delicate and gentle when I examine them, but I'm quite dynamic in a consultation. This means that I drive them a bit and try to explain everything, the imaging, I show them, I draw them diagrams. They're quite keen to have explanations, and I think that they like it*. M12 GY *I think that my patients, in fact, I think that those who don't like how I work, they don't necessarily come back to see me, I imagine. Because overall, I can't say, well, I don't have many patients who pester me for things I don't want to do. I don't have many in fact*. M44 GY *I think that I select because women who are naturally very worried about their gynaecological check-up they don't go to a GP, they go to a gynaecologist and they find the gynaecologist who suits them because I think there are plenty of gynaecologists who offer the recommended check-up, but there are few, there are few, who do the check-ups according to their own liking*. M21 GP
Educating patients	4.2	*I try to teach this to people a little bit, at my level so that they themselves can repeat this to others and so that it creates a bit of a snowball effect. I try every time to make sure that people understand why I'm talking about that, I give a lot of scientific explanations, so I use a lot of content for popularisation of medical information to explain with a bit of detail to people how it works and so that people know what it's all about*. M 43 MW
Developing communication skills	4.3	*After 15 years, I find myself in much less difficulty than before, although I don't feel I'm a better doctor than before, but I feel I'm in less difficulty because I have the feeling of having answers that suit people and of leaving them the choice*. M33 GP *Like all healthcare professionals, in fact, I had a hard time at the beginning, when I was a young doctor, it wasn't easy; but after a while things started to come together. And then, I think that one must say things sincerely. It's true that I make a lot of use of internet, which they also can access, to say that the recommendations are well done, they're really well done. I've kept the charts, I use them, we look at them together and that's it. It's going well, I think overall*. M32 GP

GP, general practitioner; GY, gynaecologist; MW, midwife.

such as Sweden, Germany, Belgium, the Netherlands and Italy, women may choose a practitioner who allows them to remain in their comfort zone,[32] as described here for France. These practitioners may find it difficult to negotiate because of the fear of losing a patient or of bad publicity. Therefore, they may, as in France, deviate from the recommendations to maintain their emotional comfort.

Negotiating through emotions

In our interviews, healthcare professionals reported that their emotional state and that of their patients were used to reach a consensual attitude. Some healthcare professionals investigated their patients' views about Pap smears, whereas others used guilt or threats as a negotiating tool. Emotions can be used strategically by healthcare professionals during their interactions with patients.[33] Physicians should promote good understanding with their patients. A previous study showed that physicians who are especially empathic with patients and engage more in emotional labour have higher job satisfaction levels.[34]

Social identities profoundly shape emotional experience and the feeling rules that people are expected to follow.[35 36] For this reason, patients may prefer to go to some healthcare professionals rather than to others who do not occupy the same level in the social hierarchy. As a result, interpersonal efforts to manage emotions in line with such social expectations can reproduce and reinforce inequality.[37] Patients with higher socioeconomic level and/or education, who have better integrated the gynaecological norm, go to the healthcare professionals who perform Pap smears more frequently. Conversely, women with lower socioeconomic level and/or education, but at greater risk of cervical cancer, consult the GP. Unfortunately, the GP is often the family physician, and it might be more difficult for such women to broach personal or intimate questions.[38 39]

Strengths

The use of in-depth semistructured interviews allowed a deeper and more nuanced understanding of under-screening and over-screening. The triangulation between healthcare professionals and a sociologist allowed developing a theorical framework that integrated sociological points of views and the quality of the method used. Our results highlight the need of interventions or changes in training that could help healthcare providers better manage the balance between maintaining the emotional comfort and adhering to medical guidelines. For example, recommendation guides may include strategies for handling emotional comfort effectively. This could involve structured communication techniques that help practitioners engage in honest, transparent conversations with their patients while being sensitive to their emotional needs. Based on these findings, we advocate the need of policy

changes or improved healthcare training programmes that emphasise emotional intelligence, conflict resolution and patient-centred communication as core competencies for healthcare providers.

Limitations

An observational study in the consultation rooms would have enriched the observations, but the intimacy required by this procedure prevented the presence of a third party. A larger sample of healthcare professionals could have increased the generalisability of our findings.

As our aim was to understand the behaviour of practitioners and not of patients, this study focused only on healthcare professionals. However, this choice limited our interpretation of the results. Indeed, interviews with patients could have helped to corroborate the healthcare professionals' perceptions and experiences, particularly when exploring emotions as a negotiation tool. This mirror study would have required considerably more time, which is another reason for not including patients in this study.

Some of our observations may not be generalised to countries that apply strict CCS guidelines rejecting samples from women under 25 and over 65.

Therefore, we consider the perspectives set out here as exploratory, and more detailed work is necessary to better investigate the raised issues.

CONCLUSIONS

This qualitative study highlighted that in France, the awareness and adherence to the CCS recommendations by healthcare professionals do not always stand up to the emotional and social interactions that take place during the interaction with patients. These factors influence the choice of healthcare professionals and reinforce rather than decrease inequality in health. Recommendation guides should include effective negotiation support models, such as the Health Behavior Model that facilitates mutual understanding, particularly when patients and healthcare professionals are from different social backgrounds.[26]

The use of emotions as a negotiation tool should be better taken into account to understand non-compliance with the screening recommendations; otherwise, social inequalities in health will not be reduced.

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