



Perspective

Screening Mammography and the “R” Word

Robert D. Truog, M.D.

The new recommendations from the U.S. Preventive Services Task Force on screening for breast cancer¹ were front-page news for several consecutive days, and they sent the Obama admin-

istration scrambling to reassure the public that these guidelines were not a prelude to the rationing of health care, notwithstanding Republican critics' assertions to the contrary.

The most controversial recommendation of the Task Force is to delay the onset of routine screening mammography from 40 to 50 years of age. Many observers were concerned that this move away from intensive screening might signal a shift away from the war on cancer, posing a threat to advocacy organizations such as the American Cancer Society. But at a deeper level, the recommendations raise concerns about access to potentially lifesaving care.

In the days after the report was released, supporters of the recommendations were challenged to justify the shift to more limited screening. For example, Susan Love, an internationally renowned breast cancer expert and women's health advocate, said, “I really don't think we should be routinely screening women under 50. There's no data showing it works.”²

Examination of the available data, however, suggests otherwise. The Task Force concluded that among women between 39 and 49 years of age, screening mammography results in a 15% reduction in the risk of death from breast cancer, with the prevention of a single death from breast

cancer requiring the screening of 1904 women. Clearly, screening mammography does offer an identifiable survival benefit to women in this age group.

But what about the risks associated with screening? They include a very low risk from the radiation exposure, along with pain, anxiety, and psychological distress related to the procedure. False positive results are particularly problematic in this age group, with one study suggesting that for every case of breast cancer detected in women 40 to 49 years of age, 556 women have mammography, 47 have additional imaging, and 5 have biopsies.³ Even so, one can argue that the magnitude of the harms associated with screening seems to be modest, particularly in comparison with the benefit of a life saved.

In the days following the publication of the Task Force report,

the airwaves were flooded with the personal stories of women who had breast cancer that was diagnosed with screening mammography when they were in their 40s. It seems undeniable that at least some of these women are alive today because they had access to this procedure. Although the outcry over President Barack Obama’s purported “death squads” reflected nothing more than political grandstanding, the new recommendation is a concrete example of a proposal that could, if it became policy, lead to the deaths of some women who would otherwise have survived.

It is interesting to compare these proposed guidelines with those that have been suggested for the prostate-specific antigen (PSA) test, another screening method for another cancer. In the case of PSA testing, a credible argument can be made that the test is often harmful for the individual patient. False positive results often lead to biopsies (which are themselves often unreliable) and then to invasive procedures such as surgery and radiotherapy that can leave patients impotent or incontinent, often to treat a prostate condition that never would have threatened their life. Mammography is different. Although abnormalities found on mammography generally necessitate additional imaging or a biopsy, the risks associated with these procedures are relatively limited.

Americans are deeply conditioned to think about health care decisions in terms of the benefits and costs to individuals, not to society as a whole. And from the perspective of an individual woman in her 40s, the claim that mammographic screening is without benefit is nonsense.

Indeed, the only way to make

sense of the Task Force recommendations is to introduce a new word into the conversation — a word that has been missing from the debate and the one word that the American public does not want to hear. It is the “R” word: rationing. Rationing is not a four-letter word. No health care system in the world, including our own, is free from the necessity of rationing. As long as a health care system has anything less than an infinite budget, there is a need to decide which types of health care will be funded and which will not.

Screening mammography for women in their 40s is clearly effective. The problem is that the benefit is tiny and expensive. A recent cost-benefit analysis showed that adherence to the current guidelines from the American Cancer Society costs more than \$680,000 per quality-adjusted life-year (QALY) gained, as compared with a proposed alternative costing only \$35,000 per QALY.⁴ Statistician Donald Berry has calculated that for a woman in her 40s, a decade’s worth of mammograms would increase her lifespan by an average of 5 days — and this survival advantage would be lost if she rode a bicycle for 15 hours without a helmet (or 50 hours with a helmet).⁵ The key issue here, however, is that these figures represent population averages. For the small number of women whose lives are saved, the difference is literally as large as that between life and death.

Unfortunately, this debate could not come at a worse time for the Obama administration and advocates of health care reform, since it highlights a necessity that most Americans want to deny. Yet critics of the Task Force recommendations and of health

care reform in general are offering a false choice. The choice is not between health care rationing and some undefined alternative, since there is no alternative. Rather, the choice concerns what principles we will use to ration health care. In the United States, we have traditionally rationed health care in the same way we ration expensive cars: those who can afford to pay for them are those who can have them. The alternative currently being considered in health care reform would involve a shift to other principles, such as those rooted in considerations of fairness, efficiency, and efficacy.

Unfortunately, many supporters of the new mammography guidelines have been reluctant to call a spade a spade. Efforts to disguise the guidelines under the cloak of false reassurances that mammographic screening for women in their 40s “does not work” only fuels suspicions that these experts are being evasive, or even misleading. In a November 18 interview on the *NBC Nightly News*, Susan Love candidly acknowledged, “This is rationing — but it’s rationing of the best kind.” If the debate about health care reform is going to progress with clarity, transparency, and honesty, we must lose our fear of the “R” word and discuss how, not whether, we should ration health care.

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From the Departments of Anesthesia and of Global Health and Social Medicine, Harvard Medical School; and the Division of Critical Care Medicine, Children’s Hospital Boston — both in Boston.

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