PATIENT SAFETY BLOG

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"The Mammography Wars" and Doctor Conflicts of Interest

It was nearly a year ago that the U.S. Preventive Services Task Force caused a huge uproar with the mildest imaginable recommendation about mammograms, and now two physician researchers say it might be time to point out that certain emperors are wearing no clothes.

In their Sounding Board article in the New England Journal of Medicine, Drs. Kerianne Quanstrum and Rodney Hayward note that some of the harshest cries against the Preventive Services Task Force came from those doctors with the highest vested self-interest in maintaining the importance of

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mammograms, the Society for Breast Imaging. Yet nobody seemed to notice the obvious conflict of interest.

As the authors note:

When a given service is successfully extended to more people with more intensity, the profession providing that service tends to grow in importance and profitability. In the United States, where medical specialists often enjoy an exalted status in the minds of the public, if experts shout loudly that every woman 40 years of age or older must be screened annually for breast cancer, then breast cancer must be important, screening must be a basic human right, and doctors who provide this service must have great value and authority.

But what if those experts are basing their recommendations on more than the interest of patients alone? In any other industry, we accept the idea as natural that those providing a service or product hold their own and their shareholders' interests as a primary objective. Why have we failed to acknowledge that the same phenomenon occurs in health care? Although it is true that individual medical providers care deeply about their patients, the guild of health care professionals — including their specialty societies — has a primary responsibility to promote its members' interests. Now, self-interest is not in itself a bad thing; indeed, it is a force for productivity and efficiency in a well-functioning market. But it is a fool's dream to expect the guild of any service industry to harness its self-interest and to act according to beneficence alone — to compete on true value when the opportunity to inflate perceived value is readily available.

The objective facts, as Quanstrum and Hayward point out, are that the well known economics law of diminishing marginal returns applies in health care as much as anywhere. In mammograms, as the rareness of the tested condition increases, the cost of the test goes up.

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So for women between ages 60 and 69, you can save one life by subjecting only 400 women to mammogram screening (in the process of 5,000 screening visits and 400 false alarms in the same group over 13 years of follow-up). That's enough of a benefit to encourage everybody in the age group to get annual screening.

But in women between ages 40 and 49, the data show that to save a single life, you need to subject 1,900 women to screening and endure 20,000 screening exams with 2,000 false alarm tests during eleven years of follow-up. That puts the risk-benefit equation in more of a gray area where you cannot say definitely that no one should have it, or that no one should not have the screening.

And that was exactly the point of the Preventive Services' recommendation: To put the issue into the hands of individual doctors and patients and let them decide if family history or individual anxiety are enough to make the patient want to have the test. That's not a cop-out, it's a prudent bow to individual self-determination.

Here's another quote from the Sounding Board authors:

We must acknowledge that just as in any other profession or industry, self-interest is unavoidably at work in health care. Rather than even acknowledging practice guidelines offered by vested experts, we ought to borrow from the wisdom of sound governance and implement a system of checks and balances when it comes to the interpretation and application of medical evidence. At the same time, we need to recognize that these two tasks are distinct. Although the interpretation of medical evidence is (or ought to be) a scientific exercise, the application of that evidence, as in guideline formation, is ultimately a social exercise.

Decisions regarding practice guidelines can, and certainly should, be informed by evidence. But they will always require value judgments regarding how much evidence is sufficient to dictate care, for example, or whether and to what degree costs should be considered. By separating the processes of

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evidence review and guideline formation, fair disagreements about the quality or substance of the evidence can occur separately from, and before, disagreements about the implications for clinical care.

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