

Health Insights Today

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EDITOR'S LOG

Attacking Unwelcome Evidence

By Daniel Redwood, DC

All health professions accept in principle that health care should be evidence-based. Elected and appointed officials at all levels of government profess to accept the evidence-based model. Health advocacy organizations of all types spend much of their time urging health policy makers to fund increased research and to apply its findings.

Undergirding this broad framework, there is presumed to be a shared understanding that: (1) where evidence exists, it should be evaluated by experts without conflicts of interest; (2) reports from such experts should play a central role in formulating public policy; (3) in some cases, available research is insufficient to use as the primary basis for clinical decision making and public policy, and; (4) in all cases, doctors can and should apply professional judgment as a significant part of the equation, balancing risks and benefits for each individual patient and also giving consideration to the patient's values and preferences.

When New Evidence Conflicts with Past Practice

The massive firestorm that erupted in November 2009, following the release of the U.S. Preventive Services Task Force (USPSTF) report on breast cancer screening, indicates that in many cases, people endorse the evidence-based model only if it supports their preconceived ideas, policies or bottom line. The white-hot reaction to the USPSTF guidelines strikes me as a situation akin to lawyers and lawmakers accepting an accused's right to a fair trial only in cases where they are unsure whether the accused is guilty, and dispensing with such formalities for those they have prejudged as guilty. That's not the way things are supposed to work.

So what is the USPSTF and what did its report on mammography screening actually say? The 16 members of the panel, appointed by the Agency for Healthcare Research and Quality, are an independent group of 16 experts who specialize in prevention and primary care. Members are not supposed to have any conflicts of interest on topics they evaluate (as would, for example, an officer or member of an organization representing radiologists who perform mammograms). Furthermore, the USPSTF was *expressly charged NOT to consider issues of cost-effectiveness, only health benefits versus health risks*. As reported in the *New York Times*, "in order to formulate its guidelines, the task force used new data from mammography studies in England and Sweden and also commissioned six groups to make statistical models to analyze the aggregate data."

The six groups of experts, working with separate models, apparently did a thorough job and arrived at remarkably consistent findings, mirroring recommendations of the World Health Organization and many European nations—that regular screening for all women should begin at age 50 rather than 40, and that it be performed every other year rather than annually. This would mark a significant change in current U.S. policy, which now recommends that all women receive annual mammograms once a year starting at age 40.

Probably the most informative, wide-ranging response I've seen is by Adrienne Fugh-Berman, MD, of Georgetown University Medical School, and Alicia Bell, of the National Women's Health Network (<http://www.thehastingscenter.org/Bioethicsforum/Post.aspx?id=4194>). The American College of Physicians has a detailed statement on the controversy (<http://blog.lib.umn.edu/schwitz/healthnews/2009/11/american-colleg.html>). The Century Foundation's

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Healthbeat blog has an insightful commentary (<http://www.healthbeatblog.com/2009/11/new-mammography-guidelines-hit-the-wall-of-public-opinion.html#more>). The full-text version of the USPSTF report that generated the firestorm is at <http://www.annals.org/content/151/10/716.full.pdf+html>.

How Do We Decide?

Most of the negative reactions to the new guidelines focus on one key point: that saving every life is important and therefore we must do everything possible to ensure that no case of breast cancer eludes detection.

The data analysis used to determine whether mammograms should be recommended for all women starting at age 40 or 50—and whether to recommend mammograms once a year, once every other year, or at some other interval—goes beyond the scope of this editorial. But the methods we use to reach such decisions are something that people on all sides of the controversy need to consider. Unless our society can arrive at a consensus on the proper way to make these policy decisions, we will continue talking past each other, generating far more heat than light.

So how do we decide? If your desire to help avoid even one unnecessary breast cancer death—a most laudable goal—leads you to reject the new guidelines and stick with the “once a year starting at 40” policy, please ask yourself the following question. Would you favor recommending mammograms twice a week for every female starting at age 15? *Remember, just like the USPSTF, you cannot consider financial issues, only health effects.* Now, assuming you say that twice a week starting at age 15 is overdoing it, how about four times a year starting at age 20? Once a year starting at 30? And, most importantly, why?

I think this is a very instructive exercise. It takes us straight down to the nitty-gritty of health benefits (lives saved) versus health risks (radiation exposure, false positives that lead to unnecessary surgery, aggressive treatment of tiny malignancies that would have disappeared without intervention, etc.). If you reject a proposal to perform mammograms twice a week starting at age 15, you are acknowledging that some kind of informed risk-benefit analysis ought to be used in determining guidelines. *That's the purpose of the USPSTF guidelines process.*

Last but by no means least, contrary to what numerous overheated commentators have recently written, nothing in the new guidelines requires or even recommends that women, particularly at-risk women, not receive mammograms prior to age 50. The guidelines explicitly point out that doctors should tailor patient care to the needs of their individual patients. The core issue is whether to recommend a nationwide policy under which *all* women are urged to have mammograms at a certain frequency, and at what age this should begin.

If we really believe in evidence-based healthcare, we have to be willing to look at new evidence with clear and open minds. The recent breast cancer screening controversy demonstrates that a great deal of public education is needed before we as a society can achieve that goal.

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