USPSTF Recommendations on Breast Cancer Screening: A Missed Opportunity to Save 10,000 Women Each Year

Healthcare Rationing Justified by Faulty Science

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This policy brief addresses a series of issues generated by the widely debated 2009 United States Preventative Services Task Force Recommendation on Breast Cancer Screening. While we fully support the application of evidenced-based medicine to achieve high quality equitable health care, we disagree with the assumptions, the methodology, and the conclusions which form the basis of the USPSTF recommendations on breast cancer screening for women between the ages of 40 and 50 and over the age of 75. We also disagree with many of the opponents of this recommendation, as both sides of the debate missed the enormous opportunity to save as many as 10,000 lives each year that are lost to breast cancer.

The recommendation attempts to apply a single standard (i.e., no routine screening) across a population of women for whom mammogram screening effectiveness varies significantly (from roughly 20% to 90% due to differences in breast tissue density). By averaging the effectiveness of mammogram screening (overall at 75%) across a population for whom effectiveness ranges widely, the task force failed to acknowledge or account for the root cause of mammogram ineffectiveness for much of the population. By failing to address this well-known, but little discussed issue, the task force missed the most significant and immediate opportunity to reduce deaths from breast cancer by 25%.

An equally serious flaw of the recommendation was the blatant introduction of healthcare rationing and age discrimination. This is especially disturbing given our current fiscal crisis.

When this kind of rationing becomes commonplace for ordinary individuals, the dangers to more vulnerable groups increases exponentially. People of color, people with disabilities, and the elderly – all groups with bitter histories of bias and discrimination – will experience greater adverse effects. This bias and discrimination, and the resultant degradation of quality and availability of medical services, have been noted by the USPSTF in other publications.

Our goals in advancing this policy brief are to:

1. encourage the USPSTF to revoke and revise its existing screening recommendation based on a thorough assessment of the issues, and
2. encourage the USPSTF to recommend screening practices – almost universally available today - which can slash the death rate associated with breast cancer by 25%.
Introduction

Thousands of women with breast cancer die needlessly each year due to ineffective screening practices. In October 2011, this Institute filed a Citizens Petition with the FDA requesting that the FDA Commissioner fully and adequately implement the patient notification statute of the federal Mammogram Quality Standards Act. This statute mandates that mammogram results be communicated directly to women patients in language easily understood by a layperson. Because this letter does not disclose the patient’s breast density or the impact of density on mammogram effectiveness in detecting cancer, critical health information is being systematically withheld from patients. More alarming is the fact that about 40% of women - those with dense breast tissue - receive false and misleading “normal” reports based on a screening tool which, for them, only detects an average of 27% (for film mammography) to 59% (for digital mammography) of cancers.

Because critical medical information is withheld from a large portion of patients who obtain mammograms, these patients are denied material information which is necessary for providing informed consent for their medical care. As a result, thousands of women each year who have breast cancer which is not detected by a mammogram will not seek additional or alternative screening, and the cancer will progress to more advanced stages. Many will die due to this delay in diagnosis. Many more will suffer through painful treatments which cause severe physical, mental, and emotional damage; the treatments themselves often result in death even if the women survive the initial cancer.

While we do not support sacrificing the lives of women to reduce the federal budget or healthcare costs, our analysis indicates that providing effective, individualized screening for all women is more cost effective than the exponentially higher costs of treating later stage cancers in the thousands of women whose cancers remain undetected by the existing, ineffective screening program.

Incidence and Impact of Breast Cancer on Women Ages 40 - 50
Breast cancer typically impacts women increasingly with age. The rate of invasive breast cancer per 100,000 in the 40-44 and 45-49 age cohorts are 120 and 188, respectively. This rate per 100,000 rises steadily to 450 for those between the ages of 75-79, and decreases thereafter. However, it is important to note that a full 1/3 of life years lost because of breast cancer are lost to women who were diagnosed with the disease between the ages of 40 and 50.

Purpose of Breast Cancer Screening
A key finding of breast cancer research is that the mechanism to reduce mortality is through the detection and treatment of the cancer at an early stage, when tumor size is small, localized, and responds more favorably to treatment. The fact that smaller tumors can often be discovered
through the use of mammography is important, but not sufficient. Mammography screening is generally cited to detect between 2.5 and 4.7 per 1,000 screening mammograms\textsuperscript{vii viii}. Any screening mechanism that enables earlier cancer detection (when the tumor is smaller, or “pre-clinical”) will achieve the important end result of mortality reduction\textsuperscript{ix x xi}. With a complex disease process as exhibited with breast cancer, it is natural that early detection may require multiple screening modalities. Mammography is the current standard baseline for breast cancer screening, but it does not work equally well for all women. For some women, those with dense breast tissue, mammograms are not effective, detecting an average of 27% of cancers at the low end; for others, those without dense tissue, mammograms are fairly reliable and may detect the majority of cancers.

**Impact of U.S. Preventative Services Task Force (USPSTF) Recommendation on Screening Objective**\textsuperscript{xii}

The USPSTF is an independent panel of non-Federal experts in prevention and screening protocols and evidence-based medicine. The task force plays an important role in US healthcare, as the recommendations from this organization guide policymakers, employers, healthcare insurance providers, and strongly influence the clinical preventive services that primary care clinicians provide to their patients. The 2009 recommendation on breast cancer screening was prefaced as follows:

> “The information in this report is intended to help clinicians, employers, policymakers, and others make informed decisions about the provision of health care services...This report may be used, in whole or in part, as the basis for the development of clinical practice guidelines and other quality enhancement tools, or as a basis for reimbursement and coverage policies.”

However, the USPSTF recommendation to deny routine breast cancer screening for women between the ages of 40 and 50 attempted to apply a one-size-fits-all medical care approach to a population of women (those between the ages of 40 and 50) with different physiologies, different medical needs, and different screening requirements.

**Recommendation Would Deny Routine Screening for Sub-Cohort Which Clearly Benefits From Mammograms**

For one third of women between the ages of 40 and 50, those without dense breast tissue, mammograms are an effective screening tool for the early detection of breast cancer. However, the USPSTF recommendation would deny routine screening for these women. The recommendation, therefore, would likely decrease the rate of early cancer detection in this group, increasing mortality.

**Wide Variation in Effectiveness is Averaged Across Entire Cohort of Women Aged 40-50**
For two thirds of the women in this age cohort, however, mammograms alone are not an effective screening tool\textsuperscript{xiii}. For these women, breast tissue with high radiographic density obscures cancers on a mammogram\textsuperscript{xi, xiv}. In order to effectively screen for breast cancer in this population, a supplemental or alternative technology is necessary\textsuperscript{xvi}.

By averaging the impact of mammograms across the 40-50 age cohort, for which there is such a well-documented and wide variation in mammogram effectiveness, the USPSTF developed a recommendation which:

- will likely increase the mortality rate among this group, and
- missed the opportunity to significantly reduce breast cancer mortality.

**Supplemental and Alternative Screening**

There are readily available supplemental and alternative screening tools for those women whose breast tissue density severely reduces the effectiveness of a mammogram. (See chart “Breast Tissue Density”) Ultrasound is widely available, relatively inexpensive, and does not present the danger of side effects associated other screening modalities\textsuperscript{xvii}. Automated Whole Breast Ultrasound is also increasingly available and relatively inexpensive\textsuperscript{xviii, xix}. In the recent ACRIN 6666 study, whole breast ultrasound increased the detection rate of cancers in high risk women with dense breast tissue by 55\%\textsuperscript{xx}.

**State Legislation**

Legislation was enacted in Connecticut in 2009 requiring that the patient notification report include density results and recommend adjuvant screening for those with dense breast tissue\textsuperscript{xxi}.

“[E]ach mammography report provided to a patient shall include information about breast density, based on the Breast Imaging Reporting and Data System established by the American College of Radiology. Where applicable, such report shall include the

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**False Positives Don’t Kill; False Negatives DO Kill**

The term “false positive” is misleading. It simply refers to a result which indicates that further testing is necessary to determine if a finding is cancerous or non-cancerous. If a mass or lesion is detected on a mammogram, additional testing is required to determine if it is cancerous. The harms associated with a false positive are typically short term anxiety, and sometimes the pain of biopsy, as noted in the USPSTF report.

A “false negative” is a mammogram which misses any indication of cancer when cancer is, in fact, present. The harm associated with a false negative mammogram is a delay in diagnosis, which means detection at a later stage and generally a worse prognosis for survival. **False negatives often result in death**, either through the cancer itself, or because the treatment for the cancer impacts mortality in the long term, even if the cancer itself is initially survived.

False negative mammograms are not tracked and reported in the United States. However, this Institute estimates that up to 10,000 lives per year could be saved by informing women when a mammogram is ineffective – increasing the odds of a false result – and ensuring that effective breast cancer screening tools are available.
following notice: "If your mammogram demonstrates that you have dense breast tissue, which could hide small abnormalities, you might benefit from supplementary screening tests, which can include a breast ultrasound screening or a breast MRI examination, or both, depending on your individual risk factors. A report of your mammography results, which contains information about your breast density, has been sent to your physician's office and you should contact your physician if you have any questions or concerns about this report."

Outcomes of studies conducted to track the effects of this legislation indicate that, with adjuvant screening, an additional 3.2 cancers per 1000 patients are detected among women with dense breast tissue, in comparison with the average detection of 3.3 tumors per 1000 women using mammography alone xxii xxiii.

MRI is recommended for the 5% of women who have a very high risk of breast cancer, although there can be some serious side effects. Magnetic Breast Imaging, another available modality, is designed to distinguish cancer tumors from surrounding dense tissue, and is not limited by radiographically dense tissuexxiv. Other technologies are also available.

Mammograms are a fairly effective screening tool for about 1/3 of women between 40 and 50. Mammograms with adjuvant screening technology are effective for the remaining 2/3 of women. However, the USPSTF recommendation would deny routine screening across the entire population based on the average effectiveness of mammogram screening alone across the entire age cohort.

<table>
<thead>
<tr>
<th>Breast Tissue Density</th>
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<tbody>
<tr>
<td>For clinical purposes, breast tissue density on a mammogram is measured along a four point BI-RADS™ scale (4th ed.) developed by the American College of Radiology:</td>
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<table>
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<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
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<tbody>
<tr>
<td>Predominantly Fatty Tissue</td>
<td>Scattered Fibroglandular Densities</td>
<td>Heterogeneously Dense</td>
<td>Extremely Dense</td>
</tr>
<tr>
<td>Having no areas of tissue that obscure cancer.</td>
<td>Having at least one area of tissue that can obscure cancer.</td>
<td>Tissue may obscure cancer in 50-75% of the breast.</td>
<td>Tissue may obscure cancer in &gt;75% of the breast.</td>
</tr>
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For women with dense breast tissue (BI-RADS categories 3 and 4) both the dense breast tissue and cancer appears white on a mammogram, making cancer much more difficult to detect.

**Issue Analysis**

The USPSTF 2009 breast cancer screening recommendation failed to address several key issues. The Task Force was charged with weighing what they term the “harms” of mammography against the “benefits” of mammography for various cohorts of women according to age. This
policy report concentrates on those between the ages of 40 to 50, and those over the age of 75.

Inexplicably, the USPSTF analysis limited its attention to “false positive” findings, ignoring false negatives. By doing so, the task force (as well as their opponents) entirely overlooked the real opportunity to use screening protocols to significantly reduce the number of deaths associated with breast cancer.

The harms cited by this task force include different types of inconvenience, psychological stress at follow-up testing, and for a small number, the pain associated with biopsies. These were all outcomes of what the industry and the task force term “false positives.” However, this term is itself misleading, as it simply indicates that further testing is necessary, and does not mean that a woman has been falsely diagnosed with cancer. Nevertheless, for the USPSTF recommendation, these “harms” in the form of anxiety and inconvenience for some, outweigh saving the lives of thousands of other women.

The analysis conspicuously failed to address several issues including the relative effectiveness of mammogram screening for women with differences in radiographical density. This variation in effectiveness was not adequately accounted for in the analysis, but was instead averaged across the entire age cohort of women 40 – 50.

A related shortcoming of the analysis was the absence of the uncounted, but significant, number of false negative mammograms. While the alleged harms of “false positive” results – results which simply indicate additional screening is necessary - were given more than adequate mention in the analysis, false negative results were largely ignored. Each false negative is a woman with an undetected breast cancer. Even by the accounts of the task force, false negatives occur at least once for every thousand mammograms. The very grave impact of false negative results (often death) was dismissed without a footnote.

While there was ample debate for and against the 2009 recommendation, the USPSTF failed to meet its obligation to American taxpayers by overlooking the most critical issues. Neither side of the debate addressed the root cause of false negatives, thereby missing the opportunity to rapidly and significantly reduce breast cancer mortality.

The reasons advanced by the Institute for Health Quality and Ethics (IHQE) for complete reconsideration and recall of this report are numerous and are organized around the most critical issues:

1. Health Care Rationing
2. Age Discrimination
3. Faulty Analysis
1. Health Care Rationing

The recommendation of the Task Force introduces government sponsored health care rationing by using mathematical formulas for determining the allocation of resources. The formulas utilized are not medical decisions, but are political and social decisions.

How was the formula of 1 life saved for every 1900 tested determined to constitute an expenditure that should not be made, and by whom?

What is the basis for the claim that one life saved for every 1300 mammograms is justified (for women over 50), but one life saved for every 1900 mammograms is not (for women aged 40 to 50)?

2. Age Discrimination: Double Jeopardy

This report veers dangerously toward a serious violation of medical ethics by discriminating against older patients. As an example, the argument advanced in favor of not screening those over the age of 75 is that these individuals will most likely die of causes other than the cancer. This may have been true in the past, but as recent US Census data indicates, it is not true for many today and will certainly not be true for many in the future.\textsuperscript{xxv}

This argument flies in the face of contemporary demographics. It is well understood that soon 20\% of all Americans will be 65 or older. Today, nearly 2 million individuals are over the age of 90. This number of individuals is projected to increase dramatically, with many in this population in good health. This Institute believes that the decision should be made by the individual patient based on her own health and other considerations.

How does a doctor tell a healthy person at 75 that he or she will no longer be tested for certain diseases or, if a disease is discovered, that it will not be treated?
Does the USPSTF expect older Americans to accept the fact that they do not have the right to know that they have cancer?

With a potential life expectancy of more than 15 to 20 years after the age of 75, what is the justification for consigning women over this age to an early death?

3. Faulty Analysis:

Failure to Analyze False Negatives Misses the Most Significant and Immediate Opportunity to Dramatically Reduce Breast Cancer Deaths

Analysis conducted by this Institute indicates that of the 40,000 women each year who die of breast cancer, as many as 10,000 of these deaths (25% each year) may be attributed to false negative mammogram results\textsuperscript{xxvi}. Astonishingly, although it is kept at the facility level, the federal government does not collect this data, and it is not made available to the public. It has certainly not been acknowledged within the debate on screening. The lack of information and reporting on false negative results has created a severe knowledge gap that should have been identified and widely publicized by the USPSTF, an organization tasked with assessing screening protocols and developing effective guidelines.

This USPSTF analysis seemed to deliberately ignore contemporary evidence with regard to the pressing issue of false negatives and their grave impact on the lives of thousands of women and their families each year. The USPSTF dismisses false negatives as inconsequential without a single citation as justification, stating in its 2009 report that “Few studies evaluate the effect of negative mammography results\textsuperscript{xxvii}”.

That dense tissue obscures tumors in a mammogram and results in false negatives has been known for years. Five states have attempted to enact legislation mandating density reporting\textsuperscript{xxviii} in the patient notification letter, recognizing that an inadequately implemented federal statute resulted in critical information being withheld from women patients. However, professional and medical organizations responsible for developing the language in the patient notification letter have conspicuously lobbied against reporting density in all of these state efforts\textsuperscript{xxix}.
Legislation requiring information on density and mammogram effectiveness has been introduced in Congress by Representatives Rosa DeLauro of Connecticut and Steve Israel of New York (The Breast Density and Mammography Reporting Act of 2011) with a growing number of co-sponsors. As the first state to pass legislation in 2009, Connecticut has had the opportunity to test the benefits of density reporting and adjuvant screening in practice. Jean Weigert, MD, who initially opposed the legislation, was involved in a study of 78,778 screening mammograms and 8,651 screening ultrasound exams. She found an additional 3.2 invasive cancers per 1,000 women with dense breast tissue among those with negative findings on the screening mammogram. Kathryn Greenberg, MD, a Yale oncologist who did not participate in the Weigert study, documented similar results.

Information regarding the practice of withholding material medical information is included in the attached Petition filed by this Institute with the FDA. Because tumors are frequently obscured by dense breast tissue, mammogram effectiveness for women with dense breast tissue is actually very low. However, these results are routinely reported as “normal.” A radiologist cannot truthfully claim that results for a woman with dense breast tissue are “normal” simply because there is no visible sign of a tumor on the mammogram. A patient with very dense tissue and no evidence of a tumor requires further testing to provide results with any reasonable degree of certainty.

The U S Preventative Services Task Force recommendation on breast cancer screening ignored entirely the issue of false negative reports and concentrated solely on false positives.

Why was the lack of information on false negative results not addressed in this report?

How can the report be considered rigorous with such a high number of women omitted? Are their deaths assumed to be a “given” and acceptable?

Why have women and their allies been forced to resort to their elected officials to obtain truthful mammogram results instead of the medical community and government organizations tasked with supporting effective medical and screening practices?

Section 354 of the Public Health Service Act, commonly referred to as the Mammography Quality standards Act (MQSA) of 1992, mandates that results of mammograms be provided to each patient in terms easily understood by a layperson. Because full and accurate information has been withheld from patients, they are denied the ability to make informed medical decisions, violating a key underpinning of our healthcare system. States such as Connecticut and Texas have enacted legislation requiring that women receive full and accurate information on their mammogram results. The bill recently introduced by Congress would also require that every mammogram report provided to patients contain a summary of the patient’s breast density and a statement concerning the benefit of supplementary screening tests for patients with dense breast tissue.
It seems inconceivable that the USPSTF (and medical professionals involved in screening) could so thoroughly dismiss such a crucial issue that women have had to resort to their elected officials to assist them instead of the medical profession.

“Numbers Needed to Invite”

There are other serious scientific deficiencies associated with this report. For purposes of this policy brief, the average reader not conversant with the medical literature may question some of the language used in determining the number and eligibility of women who warrant screening/treatment or no screening/no treatment. In their 2009 report, the authors used the expression “numbers needed to invite.” This is a term of art in the area of research, used notably in randomized and controlled trials; it is not reflective of actual clinical practice. The number of invitees required for research is inflated to offset the number of individuals who drop out of the trial or who discontinue due to other reasons. By using the numbers one would use for a research trial, the authors miscalculate the benefits of mammography screening for women aged 40 to 50.

Replacing “numbers needed to invite,” with “number needed for screening,” the actual number would be approximately 25% lower than the 1900 indicated in the report. The evidence, therefore, appears to contradict the Task Force’s own recommendation. In fact, much of the available evidence demonstrates that many women between the ages of 40-50 do benefit from annual mammogram screening.

Wide Variation of Mammogram Effectiveness Ignored

As detailed above, screening mammograms are effective for women who do not exhibit radiographically dense breast tissue. To eliminate screening in the population of women for whom mammograms are effective is senseless and would increase mortality due to breast cancer. For the 2/3 of women between the ages of 40 and 50 for whom dense breast tissue decreases the effectiveness of mammograms, the recommendations again fail by missing an opportunity to significantly reduce mortality by assessing the use of alternate or adjuvant screening. Significant reduction in mortality is a goal which has not yet been achieved with current screening practices.
Averaging outcomes and applying one recommendation to a population for whom there is such a wide variation in mammogram effectiveness is not just scientifically unsound, it would decrease the benefit across the entire population.

Even for the application of health care “rationing,” which this Institute does not support, the USPSTF recommendation does not provide an optimal outcome. Maintaining or increasing the number of women who are diagnosed with breast cancer at a later stage will continue to put pressure on the healthcare system. While a cancer detected at an early stage is easily treatable at a relatively low cost and with little personal impact, treating later stage cancer becomes exponentially more costly and exacts a much larger toll on the individual and the individual’s family, even if that individual survives the initial cancer.xxxiv.

1/3 of Life Years Lost Occur in Women Aged 40-50

Perhaps the most egregious failure of the USPSTF was the failure to account for the one-third of the life years lost to breast cancer by women between the ages of 40 and 50. Rejecting not only screening mammograms, but also clinical breast examination and self-breast examination, the Task Force left women in this age group with, literally, no hope for early detection during the years in which they have the most to lose.

While screening mammograms are not effective for the two thirds of women with radiographically dense tissue, there are alternative and supplemental technologies which have been demonstrated to improve cancer detection at early stages, when mortality and quality of life can be impacted. The USPSTF recommendation to eliminate screening for these women assumes that the loss of these lives are a given, and resigns these women to an early death. Through this assumption, they have missed a valuable opportunity to have a significant and immediate impact on breast cancer mortality.

Discussion

Rationing of Health Care

The Institute was launched to identify and publicize practices in our healthcare system which needlessly sacrifice human life for the financial gain or convenience of special interests. Health care rationing is not a threat from the future, but a present day catastrophe that requires quick and thoughtful response.
The USPSTF is officially prohibited from using cost or resources as an argument to restrict screening or treatment in their recommendations. However, the recommendation on breast cancer screening demonstrates that this prohibition is a fiction in practice. Given the history of bias and discrimination in medicine, it can be predicted with some certainty that those most vulnerable will be among the first to be targeted. People with disabilities, people of color, and older Americans will surely be near the top of the list. Our underfunded Medicaid program is testament to this.

We are also on the verge of selecting an age around 75 at which to bar both screening and medical treatment, taking the astonishing position that these individuals do not even have the right to know if they have cancer.

Behind the door of this kind of rationing lies an ethical theory called utilitarianism. It is “ethical” to sacrifice some for the many once we accept that “the end justifies the means.” This concept, which is seeping into medical literature and clinical practice, constitutes the most lethal of all justifications for medical care rationing.

The recommendations in the Task Force report have the effect of severing the trusting relationship between doctor and patient necessary for good medicine. The recommendations render informed consent based on all available information and individual and personal choices between doctor and patient a meaningless concept. Is this an intentional byproduct of serious rationing? How is the patient to know that she can have complete trust in her doctor or in the medical establishment under such a system?

**Follow-up Screening Assessed as a “Harm”**

There is scant data in the report that would lead any organization to make a recommendation to withhold mammogram screening. What passes for “evidence” here could easily lead an objective observer to the opposite conclusion of the Task Force.

The USPSTF report contradicts itself regarding the “harms” (due to follow up screening, termed “false positives”) that they purportedly weigh against the benefits of routine screening. At one point the report asserts that follow-up requirements should not be a barrier to screening mammograms because they are mostly inconveniences. The authors later conclude that they are in fact a “harm” that outweighs dying. Women patients themselves are not allowed to weigh in on this issue. If the harms mentioned in the report that outweigh the benefits are all related to how women “feel” when follow-up screening is indicated, there should at least be a survey among these women to establish some data, let alone concrete evidence.
A small number of doctors and researchers appear to have concluded that women would prefer to forego screening (based on the prospect that they might undergo further testing to confirm a potential lesion) rather than participate in screening which would prevent the deaths of thousands of other women.

This Institute believes women are both smarter than that and more generous.

**False Negative Reports Dismissed**

This same report deliberately dismisses and removes from consideration the women who die needlessly as a result of false negative mammograms. Thousands of women who die from a cancer that was discoverable but remained undetected are not included in the evidence when weighing the “harms” versus the benefits of screening for this population.

No serious evidence-based report would exclude such a large number of subjects and dismiss them without even a footnote. This Institute for Health Quality and Ethics report includes two documents as an addendum: 1) our analysis on the prevalence and impact of false negatives on mortality, and 2) the Citizen’s Petition this Institute filed with the FDA for their refusal to adequately implement existing law, thereby jeopardizing the lives of thousands of women.

The definition of “harms” on which the recommendation is based is imprecise and would be given little weight among reasonable people, even if the psychological “harm” was greater. Even the reduction in costs achieved by eliminating screening within this population (which this Institute does not support) has not been thoroughly assessed against the enormous expense of continuously increasing treatment costs for later stage cancers. Our analysis indicates that an effective screening program, based on an approach which is tailored to individual needs, is more cost effective than either the existing screening program, or the one recommended by the task force.

**A Final Word**

Rigorous science, evidence-based research, and best practices are all terribly important to the advancement of medicine. It is only when these principles become perverted by special interests that they are used to justify rationing and the sacrifice of human life. The Institute’s mission is to identify and remediate these unethical practices which so often violate medical evidence.

The Institute believes that high quality care is not necessarily more expensive than a low standard of care, and that high quality best practice solutions are most often cost effective
solutions, particularly in an environment in which all parties have equal access to information. We believe that using adjuvant screening to detect cancer across the population most at risk for false negatives is economically superior to treating these cancers at later stages with their exponentially higher costs. We also believe that insufficient resources have been devoted to the prevention of breast cancer, an approach which would have greater long-term positive impact.

While the USPSTF may have utilized existing research as the basis for their recommendation, they failed to conduct a simple assessment of industry dynamics to determine how those who benefit financially shape the breast cancer screening industry, the funding available for research, and the individual’s access to material health information. Even when faced with a dearth of information on false negative reports (*each report a woman with a cancer that remains undetected*), they simply elected to exclude this population from the analysis rather than questioning current practices.

Federally sponsored groups are working on the development of guidelines for many of the diseases we all recognize including various forms of dementia, obesity, hypertension, and cholesterol. There are already heated discussions taking place regarding the members of these groups over potential conflicts constituting various forms of payments from both pharmaceutical companies and medical device manufacturers.

The world of scientific research is filled with conflicts of interest. As we pause to consider the dangerous effects of rationing we must also contemplate the conflicts of interest which currently mold the breast cancer screening industry. We request that the US Preventive Services Task Force step up to their self-described challenge of developing “…recommendations based on comprehensive, systematic reviews and careful assessment of the available medical evidence.”

The Institute for Health Quality and Ethics is a non-profit organization dedicated to protecting the rights of all people to make fully informed medical decisions. We seek to promote a system of quality healthcare which supports the dignity and rights of all individuals based on ethical considerations.

The Institute is not affiliated with any political party or religious persuasion. We welcome your thoughts and feedback.

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End Notes

i Mammography Quality Standards Act §900.12(c)(2) (Communication of mammography results to the patients).


xii The U.S. Preventative Services Task Force; www.uspreventiveservicestaskforce.org


Yen, Hope, Associated Press, “More Americans likely to reach 90”, October, 2011


USPSTF Breast Cancer Screening Update 2009

Connecticut, New York, California, Texas, and Florida. To date, legislation has been enacted in Connecticut and Texas. Additional states such as Virginia have also recently proposed legislation.

Julie Marron, Conflicts of Interest and Faulty Reasoning in Mammogram Reporting, IHQE


This Institute has developed and is in the process of publishing a comparison between the utilization of effective adjuvant screening tools for those with dense breast tissue versus the high cost and of treating late stage cancer. To be published at www.inhqe.com in March, 2011.