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EDITORIAL:

Screening mammography requires informed consent

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One day I was describing how health systems ignore research evidence and harm patients, asking out loud, “Where are all the doctors?” One of my colleagues said, “I don’t understand why doctors don’t say anything.” A different colleague replied, “That’s easy—they don’t want to get fired.” I know from personal experience that my colleagues were describing reality. As a social scientist, I know the cultural values, political economy, and sociocultural theories to explain why doctors are afraid to speak the truth about evidence-based medicine, even though they acknowledge patients suffer the burden.

Medical students also bear the burden of this cultural dynamic. In my many years as a medical educator, I have learned to follow a few simple rules, one of which is to never ask a medical student or resident to do something that I would personally never do myself. My job is not only to teach, but also to create a learning environment where individuals maximize their potential, which requires humility and a sense of intimacy, trust and safety. During one of my small group sessions with first year medical students, a student stood up in front of his classmates, looked at me and said: “Dr. Meza, your generation of doctors [expletive deleted]-up medicine and my generation of doctors has to pay the price.” I looked back at him and said, “You’re right.”

At the Wayne State University School of Medicine white coat ceremony in 2013, I said: “A student from the Gold Humanism Honor Society asked me what I wanted to tell her generation of doctors. I replied, ‘I want the next generation of doctors to find it’s voice—society needs you.’” I have been feeling guilty ever since I made that comment because I broke my own rule. Of course, I am scared to speak truth to power, but the student contributors to this first issue of Clinical Research in Practice: The Journal of Team Hippocrates have demonstrated the courage necessary to heal society, healthcare, and provide exemplary care for their patients. See the above reflection by Stephen Simmer.

So, here is my confession: the Healthcare Effectiveness Data and Information Set (HEDIS) published by the National Committee for Quality Assurance (NCQA), the Center for Medicare Services (CMS), Accountable Care Organizations (ACO), and commercial insurance agencies establish reimbursement plans and define quality standards including recommendations for screening mammography^{1,2}. Yet, the Nordic Cochrane Centre leaflet “Screening for Breast Cancer with Mammography” makes the following comment regarding screening mammography: “It therefore no longer seems beneficial to attend for breast cancer screening... Screening does not reduce the overall risk of dying, or the overall risk of dying from cancer (including breast cancer)”³. For those women who are over-diagnosed, Cochrane further states: “Screening produces patients with breast cancer from among healthy women who would never have developed symptoms of breast cancer. Treatment of these healthy women increases their risk of dying, e.g. from heart disease and cancer”³. Cochrane produces the highest standard of evidence-based review. It bothers me that doctors are not more aware of the jarring inconsistency of guidelines and incentives with evidence. Other countries have made adjustments to medical practice: The Swiss medical board also found no evidence to suggest that screening mammography reduced overall mortality⁴. We are now at the one year anniversary of the publication of more high quality evidence that magnifies the inconsistencies between the medical research literature and clinical practice guidelines: the twenty five year follow-up for breast cancer incidence and mortality of the Canadian National Breast Screening Study, a randomized screening trial that confirms the

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above Cochrane summary through its conclusion that in the current clinical context, screening mammography does not reduce mortality⁵.

This evidence calls into question the definition of quality care. The clinical epidemiology of overdiagnosis means that providing what we currently label “quality care” will worsen health outcomes. Yet, physician and healthcare institutional financial incentives contradict what the available evidence tells me is in the best interest of my patient. In the privacy of the exam room, I share the evidence with my patients and allow them to decide what is best for them. This reinforces Gordan Guyatt’s statement, which is found on this journal’s website that “different patients use the same evidence differently.” Obviously, different doctors interpret evidence differently, but at a minimum I ask my colleagues to “join the conversation” at grand rounds, in hallway conversations, or online at websites like <http://theconversation.com/us>.

This is an open letter to all medical directors of insurance companies and healthcare organizations. You were doctors before you became physician administrators and I ask you to heed the oath from this journal’s namesake: “I will willingly refrain from doing any injury or wrong from falsehood...” My generation of doctors owes it to those that come after us to teach by our actions, not our words. The students that make this journal possible deserve nothing less. This editorial is reflective of my opinion, however, as an educator, if I ask medical students to use their voices, I am obligated to use mine.

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