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Patient and clinical perspectives on changes to mammography screening guidelines

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Letter to the Editor

In 2009, the U.S. Preventive Services Task Force (USPSTF) updated its mammography screening guidelines to recommend screening every two years among women aged 50–74. The USPSTF now recommended against screening for average-risk women aged 40–49, citing evidence that while screening with film mammography reduces breast cancer mortality, there is “a greater absolute reduction for women aged 50 to 74 years than for women aged 40 to 49 years.” (1)

The updated guidelines sparked a firestorm of controversy. A media analysis following the updated guidelines reported that 52% of the media articles and posts were unsupportive and that only 18% supported the changes.(2) Unsupportive articles raised concerns that delaying screening would lead to later detection of breast cancer and more breast cancer–related deaths (23%), and some argued that the recommendations were evidence of government rationing of health care (22%). (2)

In response to this controversy and in light of concerns that the public had misunderstood its guidelines, the USPSTF issued a December 2009 amendment regarding mammography screening for average-risk women younger than 50. The amendment stated, “The decision to start regular, biennial mammography screening before age 50 years should be an individual one and take patient context into account, including the patient’s values regarding specific benefits and harms.” (1,2) Given these competing messages, the adoption of the updated mammography screening guidelines has arguably been marked by confusion as well as controversy.

To better understand how federal guidelines are received “on the ground”, we conducted qualitative interviews with clinic personnel and patients of a Federally Qualified Health Center in Western Washington.

Between April and September 2010, we interviewed a total of 18 providers, including 9 physicians (4 in their capacity as managers), 5 nurses, 2 medical assistants, and 2 program coordinators. The mean age was 37 years, and nearly three-quarters were female and two-thirds were non-Hispanic white. The mean number of years in practice was 6.5.

Between July and August 2010, we held 8 focus groups among 38 Spanish-speaking Latina patients (none had had a mammogram in the past 2 years). Their average age was 49, and 82% were born in Mexico. Half the participants had health care insurance, and slightly less than two-thirds had ever had a mammogram.

We generally found that providers were aware of the guideline changes but had little intention of changing their existing clinical practices; in fact, most providers recommended mammography screening beginning at age 40, and the most commonly reported screening interval was every 1–2 years. As for the Latina patients we interviewed, most were unaware of the guideline changes and those who had heard about them, had little understanding of the specific changes and the reasons behind them. Most patients believed that women should begin screening at age 40 or even younger if they have symptoms.

We identified three key reasons driving the reluctance of clinic personnel to adopt the new guidelines: mistrust in the quality of the evidence to support the revisions (scientific merit); the availability of low-cost or free mammography services (absence of structural barriers); and a desire to offer beneficial services to patients (perceived beneficence).

“I follow the old guidelines because I am still not convinced that starting at age 50 is more reasonable than starting at age 40. . . . [W]e still have patients diagnosed with breast cancer under 50 . . .”

—Family physician

“[Providing mammograms] helps patients feel that we’re focused on other aspects of the care and not just the current problem.”

—Nurse practitioner

Few clinic personnel supported changing their clinical practices to conform to the new guidelines, but those who did were generally motivated by a sense of duty to spend health care funds efficiently (responsibility to public), reduce patients’ indirect costs (e.g., lost time from work), and avoid physical harms associated with obtaining screening services and follow-up care (harm avoidance).

“[I]n primary care, we need to be considerate of the public dollar and who pays for these [services]. We also need to be considerate of time and loss of work, . . . cost, . . . and morbidity to the patient. So that’s why we try and follow every evidence-based guideline.”

—Family physician

Several clinic personnel desired an institution-wide clinical standard and consistency in standards across referring sites. Several providers noted that offering preventive services such as mammography communicated messages about caring for their patients and enhanced the patient-provider relationship. Finally, some providers expressed concerns about confusing patients who may receive health information or care from multiple sources and facilities.

Regarding patient perspectives, our interviews revealed an understandably different set of attitudes and beliefs. We noted a sense of mistrust among some patients for the reasons the guidelines were changed and skepticism regarding who made the changes. These attitudes are perhaps unsurprising, given the tone of much of the media coverage provoked by the

guidelines.(2) Nevertheless, several participants expressed unconditional trust in their doctors.

“[T]here was a debate between the government and the doctors; the doctors say that you have to do it at 40. And the government said no, that sometimes that costs too much money, and it is not worth it.”

“I think doctors have to . . . maybe they know what is best. Maybe it is better 50 and over. If they changed the age, well, I think it must be better.”

Our findings provide important insights into real-world responses to screening guidelines formulated at the federal level.

Acknowledgments

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References

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2. Squiers LB, Holden DJ, Dolina SE, et al. The public's response to the U.S. Preventive Services Task Force's 2009 recommendations on mammography screening. *Am J Prev Med*. 2011; 40(5):497–504. [PubMed: 21496748]

TABLE 1

Themes, Categories, and Codes Obtained from Narratives of Clinic Personnel and Latina Patients

Theme: Barriers to Adoption of New Guidelines
Category: Clinical Personnel Reluctance to Adopt Changes to Guidelines
Guidelines given low scientific merit
Insufficient evidence to recommend
Clinical experience contradicts guidelines
Ever-changing guidelines
Absence of structural barriers
The BCCHP* pays for screening mammography beginning at age 40
Perceived beneficence to patients
Women want it earlier / more often; providing it improves patient-provider relationship
Desire to avoid confusing patients with mixed messages
Category: Patients' Misunderstanding/Mistrust
Mistrust in reasons guidelines were changed and in who informed the changes
Government is saving money on health care (e.g. rationing)
Government takes too little care of us
Guidelines issued by men not women
Earlier is better, especially if symptoms (pain, lumps) are present
Theme: Facilitators to Adoption of New Guidelines
Category: Clinical Personnel's Willingness
Organizational standards of practice and guidelines
Consensus on guidelines within clinic system
Consensus across referral sites
Responsibility toward minimizing patient harms
Desire to avoid patient costs (time from work to attend clinic visits) and morbidity associated with screening and follow-up care
Responsibility toward use of public funds
Category: Patients' Willingness
Trust
Trust in providers' recommendations/opinions

* The Centers for Disease Control's Breast, Cervical and Colon Health Program