

Let Guidelines Be Guidelines

There is almost nowhere to hide. Most physicians today have been asked to complete a survey investigating their practices. As concern about the costs of health care has grown, there has been an increased interest in understanding the people who order tests and control therapies.¹ Much of the work investigates ways to limit the use of unnecessary procedures.²⁻⁵ This issue of the *Journal* includes the results of the opposite kind of study, one seeking to promote a necessary procedure — screening mammography.⁶

The use of mammography is a curious problem in primary care.⁷ Physicians believe mammography is beneficial but have not implemented its regular use.⁸⁻¹¹ The reasons can be attributed to factors influencing both women and physicians.^{7,12} For physicians the performance of screening procedures is a very different behavior from the curative aspects of care.¹³ Prevention rarely happens spontaneously.¹⁴ Cancer screening in particular is most likely to occur when the physician is reminded to do it¹⁴ or in association with a well-care visit.^{15,16} Screening is fostered by group practice and by membership in a health maintenance organization or independent practice association and is somewhat more likely to be performed by women.^{14,17} The characteristics that lend themselves to change are the implementation of reminder systems or the more frequent scheduling of well-care visits. The others are not amenable to organized interventions.

The article by Costanza and colleagues in this issue identifies other factors that might contribute to the design and targeting of an organized intervention to influence physicians' use of mammography. Entitled "Physician Compliance with Mammography Guidelines: Barriers and

Enhancers," the article confirms the findings of others regarding practice characteristics.^{6,15,16} The authors also find that if physicians perceive either a benefit for screening or a community consensus regarding mammography, they are more likely to order the procedure annually.⁶ The authors conclude that a "multichannel approach" to influencing behavior should be undertaken and targeted at solo practitioners in middle-age groups.

Part of this intervention bears closer examination because it has important implications. As one component of the multichannel approach they propose to inform physicians that "their legal vulnerability can be decreased by complying with national guidelines." The meaning is clear. Do this or risk litigation. It is a potentially effective approach that may or may not be accurate. Failure to diagnose cancer was the third most common allegation in one malpractice insurance report and the seventh most costly settlement.¹⁸ The proportion that were failures to screen is not clear. According to one of the largest malpractice insurers in Washington State, they have had only one case in which payments were made for a failure to screen, and it involved a symptomatic high-risk woman who experienced a delayed diagnosis. Screening was not the principal issue. So, one question raised by an intervention, such as the one proposed by Costanza, et al., is the extent to which the liability risk of the physicians might actually be increased if a single guideline is endorsed.^{18,19} To what extent does such an intervention begin to establish the community standard for screening and therefore raise the level of vulnerability of those who do not accept the guidelines?^{18,19}

The answer to the question is not clear, but I think it is important for two reasons. First, there is evidence that those primary care physicians who perform screening more regularly read more medical journals.¹⁵ Reading might lead to scientific reasons to practice medicine in ways that vary from a specific guideline. The second reason is that, as Costanza, et al. report, alternative national guidelines that appeared during the course of their study differed from those of the American Cancer Society. So which national guideline is the one to which physicians are accountable, which represents the best inter-

Submitted 30 September 1991.

From Preventive Care Research, Group Health Cooperative of Puget Sound, Seattle, WA. Address reprint requests to Stephen H. Taplin, M.D., M.P.H., Preventive Care Research, Group Health Cooperative of Puget Sound, 1730 Minor Avenue, Suite 1600, Seattle, WA 98101-1448.

ests of the patients being seen, and which is the most current reflection of the literature?

In fact, several guidelines now exist, and they conflict in important ways. The recommendations promulgated by the American Cancer Society (ACS), the American Academy of Family Physicians, the US Preventive Services Task Force (USPSTF), and the American College of Physicians (ACP) are in conflict because of justifiably different interpretations of the literature.²⁰⁻²³ Each one argues that it represents the best interests of patients, but they can't all do so. So which one is the standard to which physicians could be accountable today? The ACS recommends screening procedures beginning at the age of 35 years⁹; others (USPSTF, ACP) wait until the age of 50 years except possibly in high-risk women.^{19,21} Two recommend annual mammography for all women more than 50 years of age^{9,21}; another states that every 2 years is sufficient.²⁰ These are all national guidelines, and they do not agree.

The point here is not that the organizations should get together and make a single recommendation. A single recommendation was tried once, and the result was a consensus statement by 11 organizations that is still controversial and not universally endorsed.²² The differences in recommendations for mammography are based on different judgments about the science of breast cancer screening. Guidelines are simplifications, and they cannot capture the nuances of the science or be adapted to new findings if they are endorsed as the final word. If a single recommendation is to prevail, it should be conservative and allow for new information and a range of interpretations. The science of breast cancer screening is complex and ambiguous, but it is the basis upon which we should be making choices about medical practice. As a surgeon recently reported from an American College of Surgeons' committee discussion, "The precise scope of screening mammography merits intense national examination before guidelines become mandates that are enshrined as the standard of practice despite an absence of hard scientific data and a detailed understanding of the economic implications."¹⁹ Let the guidelines be guidelines, not ironclad dictates for medical practice.^{18,19,24}

The guidelines should also assist women. There is a growing concern that we are raising

women's expectations beyond the findings of the data.^{18,19,23} What evidence exists that a baseline mammogram at the age of 35 years contributes to any reduction in morbidity or mortality? There simply are no well-controlled trials involving women aged 35 to 40 years, so what expectations are being created by advocating a baseline mammogram for this age group?

Breast cancer can be a tragic disease and now affects 1 in 9 women during their lifetime. That means that 8 of 9 women do not get the disease. To care well for both groups, physicians must be able to operate within the range of reasonable medical judgments. Conflicting recommendations actually assist this process. Physicians can still read, still make judgments, and still work with women to choose a plan within the range of reasonable scientific interpretations that exist.²⁰⁻²⁵

What physicians cannot choose, however, is to do nothing about screening mammography. Conflicting guidelines should not detract from the reality that increasing the use of mammography leads to reduced breast cancer mortality for women, the real motivating force. All groups agree that mortality reductions have been shown in women aged 50 through 75 years, so the goal to achieve regular screening among these women is without controversy. The controversy over the definition of "regular" is a relatively minor detail compared with the goal of reaching all women in the age group.

Physicians are essential to achieving this goal. Women who have not had mammograms say physicians never recommended it.¹⁰ Physicians report that they are recommending it more now,⁹ but as Costanza, et al. point out, there is a clear difference between what physicians say they do and what women report was accomplished. The question Costanza, et al. raise is whether the fear of litigation will effectively motivate physicians to recommend mammograms. It is a sobering question that deserves careful reflection. In the meantime, physicians should consider implementing a system that reminds them to perform mammograms according to whatever reasonable guideline they choose based on the science they understand.¹⁴

Stephen H. Taplin, M.D., M.P.H.
Seattle, WA

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Improving The Quality Of Care For Nursing Home Patients

There are 19,100 nursing homes in the United States with nearly 1.6 million residents. Nursing home patients are characterized by being old (mean age 80 years or older; almost 90 percent are older than 65 years), female, and physically and cognitively impaired. These statistics can mask the true heterogeneity of the nursing home patient. Forty-five percent of patients discharged from nursing homes had stays of fewer than 90 days. These patients are admitted for short-term rehabilitation, acute illness, or terminal care. Long-stay patients have significant impairments of cognitive or physical functioning.

Submitted 19 November 1991.

From the Office of Geriatric Medicine, College of Medicine, University of Cincinnati Medical Center, Cincinnati. Address reprint requests to Gregg Warshaw, M.D., Office of Geriatric Medicine, University of Cincinnati, 231 Bethesda Avenue, Cincinnati, OH 45267-0582.