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Re: It's Time to Retire the Term "Provider" from *JABFM's* Pages

There is information in the *JABFM* Information for Authors on the use of terminology for various health professionals: www.jabfm.org/content/information-authors.

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Re: The Prevalence of Low-Value Prostate Cancer Screening in Primary Care Clinics: A Study Using the National Ambulatory Medical Care Survey

To the Editor: Gillette et al analyze how PSA screening for age 70 and over, a low-value service, is being implemented in the United States.[1]

For PSA screening, the United States Preventive Service Task Force (USPSTF) assigns grade C to those aged 55 to 70 and grade D to all other age groups. By definition, D is not recommended to be done, with solid evidence that the harm outweighs the benefit. In other words, Grade D means that the service should not be performed because it will cause harm to the subject. In addition, C is that the service can not be recommended because insufficient level of certainty of evidence that the benefits outweigh the harms, that is, experimental medicine rather than evidence based medicine. So, in accordance with the Declaration of Helsinki, it is a condition of implementation that subjects are fully informed about the benefits and harms and consents to undergo the service. Grade C is uncertain or zero value and Grade D is negative value. Therefore, if we apply this USPSTF grade to the definition of The Centre for Value-Based Insurance Design (V-BID), PSA screening for aged 55 to 70, grade C, would barely qualify as low value care, but would be out of the question for aged 70 and older, grade D. The authors are not responsible, though, as the V-BID center describes PSA screening for aged 70 and over as low-value care. However, true to the authors' original research intention is a study to analyze how PSA screening for aged 55 to 70 is actually performed in the US.

The authors states, "Currently, it is thought that PC screening confers the most benefit between the ages of 55 to 69 years with the lowest risk of overdiagnosis and overtreatment" In fact, the USPSTF considers PSA screening for aged 55 to 70 as a small possible benefit, many harms (overdiagnosis and complication of tests and treatments), which is essentially a negative value. The USPSTF upgraded from Grade D to C in 2018 but remains Grade D in content.[2] Although there seems to be a negligible benefit when evaluated in terms of cancer-specific mortality, early detection and treatment of prostate cancer does not lead to an improvement in overall mortality because of the overwhelming frequency of other-cause mortality. The only RCT that showed the benefit had an age range of 55 to 70 years, so PSA screening for that age-group was assigned Grade C and the rest were assigned Grade D. The problem of overdiagnosis remains the same for all ages. Overdiagnosis does not mean that there are too many cases diagnosed as cancer, but that the expression "cancer" is overdone. Even if the number of cases can be reduced by excluding indolent cases, this does not mean that the situation will improve. Overdiagnosis is caused by problems with the diagnostic tests: pathologic examination.[2] In addition, the USPSTF also states that the decision to perform PSA screening should be an individual.[1] This means that PSA screening for aged 55 to 70 should be funded by private health insurance or research funding and not by public health insurance. The VHA and Medicare in the US are also public to some extent. It is possible that being covered by these public insurances may mislead subjects into believing that there is evidence of benefit with regard to PSA screening. Strictly speaking, this violates the Declaration of Helsinki.

The authors state as limitation, "First, we only examined primary care PC screening, so we did not include urologists' PC screening behaviors." In practice, screening by urologists would be still very active. Their conclusions are remarkably modest.

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Response: Re: The Prevalence of Low-Value Prostate Cancer Screening in Primary Care Clinics: A Study Using the National Ambulatory Medical Care Survey

To the Editor: We have read Dr. Takahashi's letter and appreciate the invitation to respond. We also thank Dr.

Takahashi for the thoughtful letter and observations. We agree with Dr. Takahashi's overall concern about the known harms associated with PSA screening. However, we believe the letter illustrates some common misconceptions regarding the United States Preventive Services Task Force (USPSTF) Grade definitions and practice implications, and below we attempt to correct some of these.

First, Dr. Takahashi states a USPSTF C Grade indicates "insufficient level of certainty of evidence that the benefits outweigh the harms." In fact, the Task Force issues an "I Statement" (rather than a C Grade) when it finds that "current evidence is insufficient to assess the balance of benefits and harms of the service."[1] Second, Dr. Takahashi states a Grade C means "the service cannot be recommended." In fact, for Grade C recommendations, the Task Force's suggestion for practice is to "offer or provide this service for selected patients depending on individual circumstances." In the case of PSA screening, the 2018 Task Force recommendation states that

> "*In determining whether this service is appropriate in individual cases, patients and clinicians should consider the balance of benefits and harms on the basis of family history, race/ethnicity, comorbid medical conditions, patient values about the benefits and harms of screening and treatment-specific outcomes, and other health needs.*"

Research has shown that prostate cancer screening is a highly preference-sensitive decision and that many men prefer to receive screening, even when informed of potential harms.[2] Third, although Takahashi is correct that the Task Force recommends clinicians discourage routine screening in men 70 years and older, the blanket statement that "Grade D means that the service should not be performed because it will cause harm to the subject" oversimplifies the issue when it comes to caring for individual patients. The USPSTF statement is more nuanced and allows for individualized decision making:

> "*Harms are greater for men 70 years and older. In determining whether this service is appropriate in individual cases, patients and clinicians should consider the balance of benefits and harms. . .Clinicians should not screen men who do not express a preference for screening and should not routinely screen men 70 years and older.*"[3]

Other organizations that issue screening recommendations, such as the American Urologic Association (AUA) also leave room for individualized decision making. The AUA early prostate cancer detection guidelines recommend that men over the age of 70 not be routinely screened for prostate cancer,[4] but also state that men who are 70 years and older who are in excellent health may benefit from prostate cancer screening. In practice at the individual patient level, clinicians must use their judgment and use shared decision making with their older patients about prostate cancer screening so that the patient can make the decision that is right for them.[3,4]

Finally, although we share Dr. Takahashi's view that screening men with PSA *without* discussing benefits and harms or elicitation of patient preferences is not ethical, we disagree that public insurance coverage of PSA screening "violates the Declaration of Helsinki." Moreover, the suggestion that public insurers, such as Medicare or the Veterans Health Administration, should stop covering cover PSA screening is impractical on many accounts, including that these US public insurers cover many services for which there is uncertainty regarding net benefit.

In conclusion, our study found substantial use of prostate cancer screening tests in men 70 years and older, and we agree that this generally reflects low value care. However, there are also complexities that involve risk factors, comorbidities, and preferences that determine the appropriateness of prostate cancer screening in the care of individual patients, including those 70 years and older. There are some men who might benefit whereas most men may not. We should not forget that medicine is a profession in which professional judgment is paramount to ensure that patients receive the best possible care that aligns with their preferences. Such judgment is created by the clinician's past experiences and their knowledge of the specific patient.

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