

Sense about mammography

consensus statement which addresses these urgent issues which cause considerable problems for researchers.² In our view Tudor Hart would be better expending his considerable experience and knowledge of research to addressing these types of problem rather than 'tilting at the windmills' outlined in his article!

Finally, there is the issue of the College's research committee which Tudor Hart describes as 'an occasional meeting between the three or four minor research empires scattered about the UK to divide whatever cake was available'. He will be interested to hear that the RCGP research committee ceased to exist in 2006 having done an excellent job over a number of years contributing to and influencing the strategic changes to research funding and infrastructure outlined in the earlier part of this article. It has been replaced by the RCGP Clinical Innovation and Research Centre (CIRC) whose remit includes 'developing clinical excellence through clinical audit and effectiveness, service development and research projects'. Contained under its umbrella is the RCGP Birmingham Research Unit which is one of the 'jewels in the research crown' of the College with a world class reputation for original research. In addition, we celebrate the prestigious RCGP Research Paper of the year award (now in its 14th year) and in 2009 we will be awarding the RCGP Discovery Prize for original research in general practice, of which Tudor Hart is a previous winner.

Any suggestion therefore that the College does not lead or play an important role in the conduct of research in general practice is incorrect. The RCGP is an academic organisation which exists to promote the highest standards of general practice. Research has always been and always will be an important part of our remit for improving the care of our patients.

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Since reading some 15 years ago an authoritative study which demonstrated that breast self examination was 'more effective at generating anxiety than detecting tumours', I have been trying to pass on this message to female patients who express concerns about breast cancer.¹ I have found that, rather than producing a sigh of relief or a gasp of liberation, this information is more likely to cause irritation, even indignation.

No doubt these responses are partly a result of exasperation at the experience of receiving contrary advice from different sources. A more important factor seems to be anger at being cheated of the alluring prospect offered by such screening tests — that early detection will confer a better chance of avoiding a premature death from breast cancer. I am often left with the feeling that I am the target of resentment, as though I had blurted out the truth about Santa Claus.

The recent controversy surrounding claims that 'women are still not given enough, or correct, information about the harms of screening' is likely to cause many more similar consultations in our surgeries.² Peter Gøtzsche and colleagues at the Nordic Cochrane Centre argue that the current promotion of mammography exaggerates the benefits and downplays the harms resulting from screening. On the basis of their earlier systematic review, the authors claim that if 2000 women are screened regularly for 10 years, one will benefit while 10 healthy women will become cancer patients and undergo unnecessary treatment.³ Furthermore, about 200 women will experience the psychological stress of a false alarm.

Here I should declare an interest. I was a signatory to the letter to *The Times*, published in the same week at Gøtzsche's article in the *BMJ*, which drew attention to the problems of overdiagnosis and overtreatment resulting from screening and pointed out that none of the official invitations for mammography 'comes close to telling the truth'.⁴ The immediate withdrawal of the leaflet used by the NHS breast screening programme marked a triumph for the campaign led by the breast surgeon Michael Baum and the patient advocate Hazel Thornton, as well as others over the past decade.

The popularity of screening tests for

breast cancer, from self examination to mammography, reflects the powerful commonsensical appeal of the notion that early diagnosis confers a better prognosis. But, according to Gøtzsche, 'it has not been proved that screening saves lives'. It may do, but it is clear that the benefit of mammography is relatively small, certainly much smaller than the public — influenced by a combination of wishful thinking and public health propaganda — believes. If the current controversy leads to a less paternalistic and manipulative presentation of health information then this will have much wider benefits.

Broadcaster Michael Blastland has shown how the statistics of breast cancer screening can be presented in such a way as to enable women to make an informed choice about mammography.⁵ He follows the approach recommended by Professor Gerd Gigerenzer of the Max Planck Institute, who favours presenting absolute rather than relative risks, 'natural frequencies instead of conditional probabilities'.⁶ In an inspirational summary of his approach, Gigerenzer and colleagues insist that 'statistical literacy' is 'a necessary precondition for an educated citizenship in a technical democracy'. Their conclusion emphasises the wider political and social significance of the accurate presentation of information about health:

'Understanding risks and asking critical questions can also shape the emotional climate in a society, so that hopes and anxieties are no longer as easily manipulated from outside and citizens can develop a better-informed and more relaxed attitude toward their health.'⁶

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