Paying women to have mammograms is unethical, ethicist says

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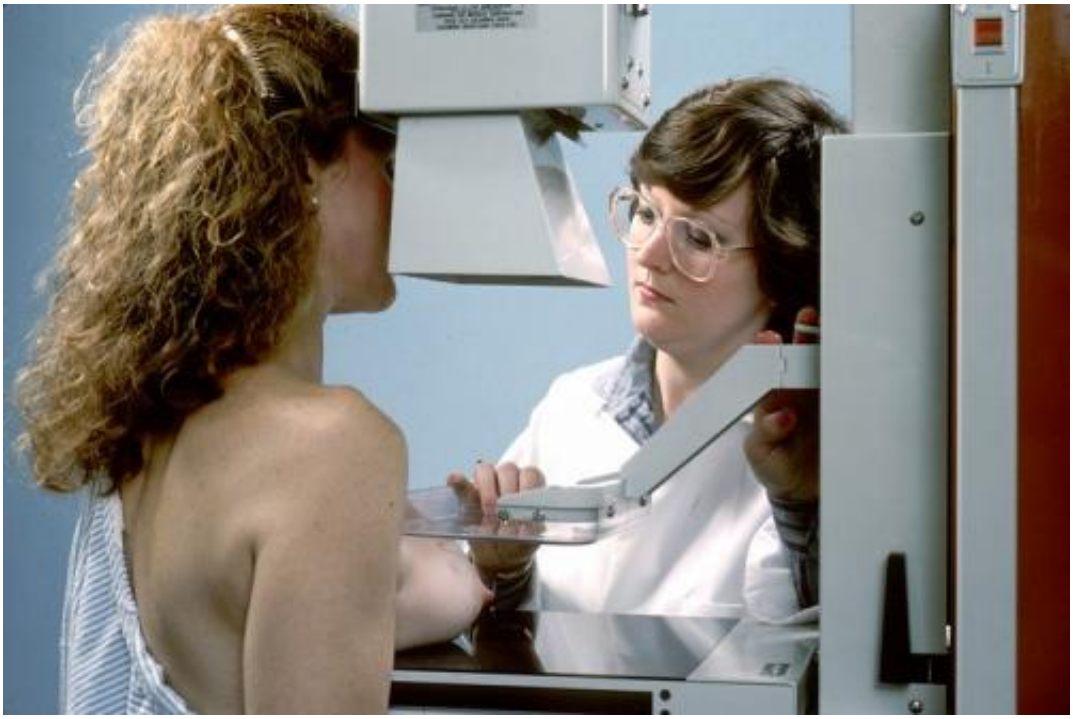

Credit: National Cancer Institute/public domain

The widespread practice of incentivizing mammogram completion via cash payments, typically by insurance companies and ranging from $10 to $250, is unethical according to a Viewpoint article published this week in *JAMA* by an expert from the Perelman School of Medicine at the University of Pennsylvania. Instead, incentives should be offered to women to use evidence-based decision aids to decide if they want a

mammogram, even if this policy likely averts fewer breast cancer deaths overall.

In the piece, Harald Schmidt, PhD, assistant professor of Medical Ethics & Health Policy, notes that cash payments are increasingly used to promote healthy behaviors such as quitting smoking and losing weight. In such cases, Schmidt says achieving the incentivized targets produces health and financial benefits without any risks. But other incentivized health behaviors, such as breast cancer screenings, are different.

"Incentives for having mammograms are ethically troubling," says Schmidt. "Women need to strike a delicate balance in assessing the benefits and risks of mammograms. In the case of smoking cessation or weight loss programs, providing incentives supports behavior change. But with breast screening, mammograms can unhelpfully short-circuit decision-making."

Schmidt points out that incentives can wrongly signal mammograms as beneficial only, and offers several reasons for concern. First, not all screened women benefit, since although screening reduces chances of dying from breast cancer, there are screened women who nonetheless die from the disease. Second, some cancers identified in screening never develop into lethal tumors. "These cases of over-diagnosis regularly lead to over-treatment," he said. This includes partial or full surgical breast-removal and hormone-, radio-, or chemotherapy. Third, all participants risk periods of worry due to false positives and biopsy complications.

There is general agreement that benefit-risk ratios differ significantly across age groups. The U.S. Preventive Service Task Force's screening guidelines recommend mammograms every two years for average-risk women aged 50- to 74 years with a "grade B" screening, due to "moderate certainty that the net benefit is moderate." For ages 40- to 49 years, a weaker grade C recommendation is made: "There is moderate

certainty that the net benefit is small." Broadly, the Task Force recommends making screening decisions on an individual basis.

Schmidt NOTED that in a study assessing decision aids, women receiving brochures which explicitly enumerated risks and benefits of mammograms (such as the actual number of false positives that patients received) were less inclined to have mammograms—74 percent vs. 87 percent—than women who received brochures simply discussing the risk of false positives, but without actual figures to illustrate the scope of overtreatment.

"Findings such as these can pose a dilemma for policy-makers," said Schmidt. "Informed decision-making is important. But since better-informed women are less inclined to be screened, fewer breast cancer deaths will likely be averted. The question is: should minimizing deaths from breast cancer be prioritized over maximizing informed decision making, or vice-versa?"

Schmidt writes that true consent demands an understanding of an intervention's risks as well as benefits. Consequently it is unethical to omit pertinent information, such as false-positive rates and information on overtreatment. And because of the complexity of the data, information should be conveyed in ways that are understandable by patients of all levels of literacy and numeracy.

"Incentives," he writes, "should support, and not distract—or worse, undermine—informed decision-making. Completion incentives that inevitably signal mammograms as inherently valuable are unhelpful in this regard and should be phased out, especially for ages younger than 50."

Furthermore, "Less educated, lower-income groups face greater challenges because incentives, especially larger financial ones, have

more salience for them and may unhelpfully shortcut informed decision-making … In addition to insufficient respect for their autonomy, the disproportionately higher economic and psychological burden associated with possible harms from screening must be especially concerning." The bottom line, he concludes, is that "[m]ammogram choices should be made by meaningfully informed women – not their physicians, health plans, policy makers, or other parties."

More information: "The Ethics of Incentivizing Mammography Screening." *JAMA*. 2015;314(10):995-996. DOI: 10.1001/jama.2015.8852

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