

**The Honorable Tom Harkin**  
Chairman  
Health, Education, Labor and Pensions Committee  
United States Senate  
SD-428  
Washington, DC 20510

**The Honorable Michael B. Enzi**  
Ranking Member  
Health, Education, Labor and Pensions Committee  
United States Senate  
SH-835  
Washington, DC 20510

**The Honorable Max Baucus**  
Chairman  
Finance Committee  
United States Senate  
SD-219  
Washington, DC 20510

**The Honorable Charles E. Grassley**  
Ranking Member  
Finance Committee  
United States Senate  
SD-219  
Washington, DC 20510

Dear Senators:

The recent mammography recommendations from the U.S. Preventive Services Task Force have brought unprecedented attention to this quasi-governmental, independent body. For the last quarter century, the Task Force has played a vital role in determining which clinical preventive services are effective in improving health and saving lives while avoiding harms from unproven services. We are committed to ensuring that the Task Force continues to play this important role long into the future.

The recent revision of the mammography recommendations has resulted in numerous inaccurate and unfounded attacks on the Task Force. We want to set the record straight about the recommendations and about the Task Force itself. The three most common misstatements that have appeared in the media are that:

- The Task Force recommends that women aged 40 – 49 not receive mammograms.
- The Task Force recommendations were intended to reduce costs by reducing the number of mammograms women will receive.
- Members of the Task Force are not qualified to make scientific recommendations, or they have other agendas at play.

Allow us to address each of these.

**Misstatement #1: The Task Force recommends that women aged 40 – 49 not receive mammograms.**

The Task Force found that, for women in their 40s, weighing the health benefits against the health risks of mammography did not justify a broad recommendation that all women in that age group receive mammograms on a regular or routine basis. However, the Task Force realized that the balance between benefits and harms (physical and psychological) of mammograms will be different for each woman depending on family history, other illnesses, and levels of anxiety about her health. The reason for that is that the benefit-risk calculation for women in their forties is much less clear than it is for older women. Women in their forties with no identifiable risk factors are much less likely to have breast cancer than those aged 50 and above with no risk factors. Moreover, mammograms in this age group have a much higher likelihood of generating false positives than in older women. False positive tests result in additional x-rays, unnecessary biopsies and other invasive procedures and treatments, as well as significant anxiety among women and their families.

For this reason, the Task Force does not recommend that all women in this age group automatically start receiving mammograms at age 40. Rather, it simply recommends that those women and their healthcare providers have a full discussion about the potential pros and cons of screening. This allows the patient to incorporate information about her family history, overall health, and personal values and preferences along with the best scientific information into the decision-making process. The result is an empowered patient who is able to make an informed decision about whether or not to be tested. In fact, many women may choose to continue mammography because they value the small chance that they might benefit, but other women may choose to defer beginning mammograms until the balance of benefits and risks is more favorable.

The Task Force does support routine screening for women aged 50 – 74 because the evidence is strong that the benefits clearly outweigh the potential risks. For mammography as well as for other preventive services, the Task Force supports shared decision-making between women and their healthcare providers.

**Misstatement #2: The Task Force recommendations were intended to reduce costs by reducing the number of mammograms women will receive.**

The Task Force never uses cost as a reason to recommend against a service that has been proven to be effective. In its review of the evidence about breast cancer screening, the Task Force had a single objective – to determine how to maximize the health of women. Every medical procedure has benefits and potential risks. Any scientific review of a screening test must therefore carefully weigh the health benefits and harms, especially when applying it to a broad population of healthy people. The Task Force followed this well accepted approach in considering a variety of breast cancer screening strategies.

The Task Force uses explicit criteria to formulate its recommendations about the effectiveness of preventive services. These criteria are clearly delineated on the Task Force's web site, which can be viewed at <http://www.ahrq.gov/clinic/prevenix.htm>. For each preventive service it reviews, the Task Force assesses the quality of the scientific information, estimates the magnitude of benefits and harms, reaches consensus about each service's net benefit, and issues a recommendation.

**Misstatement #3: Members of the Task Force are not qualified to make scientific recommendations, or they have other agendas at play.**

The U.S. Preventive Services Task Force was first convened by the Public Health Service in 1984. Since its inception, it has been recognized as the authoritative source for determining the effectiveness of clinical preventive services, and its methods have been adapted by guidelines groups worldwide. Most members of the Task Force are experienced clinicians (doctors, nurse practitioners, and nurses) as well as experts in prevention research.

While this small group of distinguished health care professionals and researchers is largely unknown to the general public, its work is well known to clinicians in preventive and primary care practice. Because of the rigor and objectivity of its research, the Task Force's recommendations have often been endorsed by the major primary care specialty societies in the U.S., giving patients access to a wide range of effective preventive services. The preventive services recommended by the Task Force have prevented hundreds of thousands, if not millions, of premature deaths and averted needless harms.

Members of the Task Force are appointed by the Agency for Healthcare Research and Quality within the Department of Health and Human Services. Current members have been appointed under Republican and Democratic Administrations, and they were nominated because of their expertise in prevention, primary care, and evidence-based medicine without regard to political views or influence. They operate under strict rules to prevent conflict of interest.

The Task Force has no direct role, and has not sought a role, in setting policy such as insurance coverage. The timing of the current recommendation in relation to health care reform is entirely coincidental. All Task Force recommendations must be updated at regular intervals. The decision to update the previous Task Force recommendations was made several years ago before current reform proposals were even conceived. The timing of release was dictated by when the process of careful peer review of the recommendations and supporting scientific paper were completed.

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The U.S. Preventive Services Task Force was established as an independent body to apply rigor and objectivity to the analysis of clinical preventive care – even on issues that arouse passions and political posturing. The misstatements we have noted are evidence of both of these dangers, and the Task Force is our best defense against both. Our common goal is for preventive services to improve the health of all Americans. We believe the Task Force is the best way to ensure we're guided toward that goal by recommendations of experts who are guided by science, and only by science.

Thank you for the opportunity to share our views.

Sincerely,

American Academy of Family Physicians  
American Academy of Nurse Practitioners  
American Academy of Physician Assistants  
American College of Physicians  
American College of Preventive Medicine  
American Journal of Preventive Medicine  
American Medical Association  
American Public Health Association  
National Association of County and City Health Officials  
Partnership for Prevention  
Public Health Institute  
Trust for America's Health