



**John Hickner, MD, MSc**  
Editor-in-Chief

## Catching up with the evidence

**E**arly last year, the US Preventive Services Task Force (USPSTF) and the American Cancer Society, among other medical groups, jointly issued guidelines for cervical cancer screening.<sup>1</sup> In November, the American College of Obstetricians and Gynecologists followed suit,<sup>2</sup> and the Canadian Medical Association jumped on the bandwagon early this year.<sup>3</sup>

For the first time, all agreed that no Pap smears are needed for women younger than 21 years; no testing for human papilloma virus (HPV) is necessary for women younger than 30; and for low-risk women, combined Pap smear and HPV testing can safely be done every 5 years, instead of every 3.

This is not the first time the USPSTF has told the public that less cancer screening is better. Remember the furor that accompanied its announcement that mammograms were no longer routinely recommended for women ages 40 to 49 and the downgrading of PSA screening to a D (not recommended) rating?

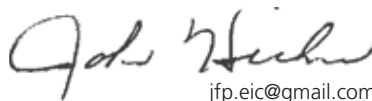
There is mounting evidence that more is not better in many aspects of health care. Research has shown, for example, that there is little relationship between dollars spent and quality of care for Medicare beneficiaries,<sup>4</sup> and studies by the family physician-led

Ambulatory Sentinel Practice Network have long since established that more CT scans of the head (*J Fam Pract.* 1993;37:129-134) and more D&Cs (*J Am Board Fam Pract.* 1988;1:15-23) do not lead to better outcomes. And I'll never forget the patient—a sturdy farmer referred by a pulmonologist for cardiac catheterization—who was found to have normal coronary arteries but died of an arrhythmia on the cath table.

I doubt that we can convince our patients that less is best for cancer screening, as well as many procedures. But we can practice shared decision making, taking the time to talk to patients about the pros, cons, and trade-

offs of tests and treatments and to elicit their preferences (which often differ in surprising ways from what we might guess). This approach, particularly when it's paired with easily understood patient education material, is likely to result in fewer unnecessary—and potentially harmful—tests and treatments.

1. ACOG announcement. March 14, 2012. Available at: [http://www.acog.org/About\\_ACOG/Announcements/New\\_Cervical\\_Cancer\\_Screening\\_Recommendations](http://www.acog.org/About_ACOG/Announcements/New_Cervical_Cancer_Screening_Recommendations). Accessed February 12, 2013.
2. ACOG Practice Bulletin No. 131: screening for cervical cancer. *Obstet Gynecol.* 2012;120:1222-1238.
3. Canadian Task Force on Preventive Health Care. Guidelines. Recommendations on screening for cervical cancer. January 2013. Available at: <http://www.cmaj.ca/content/185/1/35.full?sid=9cf0e8c7-74ae-45de-8c3a-80dca60bc136>. Accessed February 19, 2013.
4. The Dartmouth Institute for Health Policy and Clinical Practice. Health care spending, quality, and outcomes: more isn't always better. February 27, 2009. Available at: [http://www.dartmouthatlas.org/downloads/reports/Spending\\_Brief\\_022709.pdf](http://www.dartmouthatlas.org/downloads/reports/Spending_Brief_022709.pdf). Accessed February 21, 2013.

  
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