

Medicare rebates are currently available for these tests.

The additional cost of these new technologies should be considered in the context of the cost of diagnosis, treatment and subsequent cytological and clinical follow-up of biologically insignificant disease. The money saved from improved patient selection for treatment and reduced frequency and late commencement of screening would allow more resources to be allocated to enrolling women (who are currently under-screened) and to funding these new technologies.

1. Dickinson JA. Cervical screening: time to change the policy. *Med J Aust* 2002; 176: 547-550.
2. Cervical cancer screening in New South Wales. Annual statistical report 2000. Sydney: NSW Cervical Screening Program, NSW Pap Test Register, 2000.
3. Larsen NS. Invasive cervical cancer rising in young white females. *J Natl Cancer Inst* 1994; 86: 6-7.
4. Solomon D, Schiffman M, Tarone R. Comparison of three management strategies for patients with atypical squamous cells of undetermined significance: baseline results from a randomised trial. *J Natl Cancer Inst* 2001; 93: 293-299.
5. Williams GH, Romanowski P, Morris L, et al. Improved cervical smear assessment using antibodies against proteins that regulate DNA replication. *Proc Natl Acad Sci USA* 1998; 95: 14932-14937. □

Screening mammography and mortality

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TO THE EDITOR: Life expectancy in developed countries increased by an average of about 20 years during the 20th century. An editorial in the *Journal* by Rodger referred to mortality in populations having screening mammography.¹ Data quoted indicated that there had been only slight changes in breast-cancer mortality in Australia up to 1996.

Data for 1999 are available in the report of the Australian Bureau of Statistics *Causes of death*, published in December 2000.² The standardised all-causes death rate per 100 000 for all persons in 1989 was 758.9 and in 1999 was 584.2, a reduction of 23.0%. For women, the standardised death rate attributable to breast cancer in 1989 was 27.2 and in 1999 was 22.1, a reduction of 18.75%. Recent decreases in breast cancer mortality of similar magnitude have also been observed in the United Kingdom and the United States.³ However, screening mammography could only be responsible for a small portion of these changes, because population screening has been in place for little more than a decade and the benefits of earlier detection and treatment

would take more than five years to become evident. The causes of these dramatic reductions in death rates are not yet understood.

Regarding the effect of population screening mammography on mortality rates, this is limited to breast-cancer-specific mortality and cannot be expected to translate into a reduction in overall mortality. In a recent overview of the situation in Sweden,⁴ breast-cancer-specific mortality in the screened group was 22% lower than in the non-screened group. However, the age-adjusted relative risk for total mortality was 1.00 (95% CI, 0.98-1.02). In other words, the mammographically screened population died less frequently from breast cancer, but nevertheless died at the same rate as the non-screened population (from other causes such as heart disease and other cancers). If we consider that, in the age group 40-79 years, breast cancer accounts for about 3% of total mortality, a reduction in breast cancer mortality of 25% would be 25% of 3%, or 0.75%. This change is so small that it would probably never be possible to show an effect of breast-cancer screening on overall population mortality.

It is therefore realistic to regard the benefits of screening mammography as limited to early detection and treatment (possibly with improved quality of survival) and a reduction in breast-cancer-specific mortality.

1. Rodger A. Is it worth screening women over 70 for breast cancer — or indeed any women? [editorial] *Med J Aust* 2002; 176: 247-248. http://www.mja.com.au/public/issues/176_06_180302/rod10045_fm.html
2. Australian Bureau of Statistics. Causes of death, Australia, 1999. Canberra: ABS, 2000: 91 pp. (Catalogue No. 3303.0.)
3. Peto R, Boreham J, Clarke M, et al. UK and USA breast cancer deaths down 25% in year 2000 at ages 20-69 years. *Lancet* 2000; 355: 1822.
4. Nyström L. Assessment of population screening: the case of mammography. Monograph. Umeå, Sweden: Department of Public Health and Clinical Medicine, 2000: 106 pp. □

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IN REPLY: I agree with Gough and welcome the more recent data showing up to an 18.75% reduction in breast cancer mortality in Australia in the 10 years from 1989.

Obviously, this cannot be attributed solely to the now 10-year-old National Mammographic Screening Program, but it may result from a combination of the screening program, ad-hoc screening before the program, and the more rigorous use of adjuvant therapies based on the results of clinical trials. That breast screening is

unlikely to have an impact on overall population mortality gives the lie to the conclusions of Olsen and Göttsche's overview,¹ which are based only on overall mortality.

Nevertheless, Gough and I agree that screening mammography is likely to deliver other benefits through detection of earlier-stage disease and a reduction in deaths from breast cancer.

1. Olsen O, Göttsche PC. Screening for breast cancer with mammography. In: Cochrane Library, issue 4. Oxford: Update Software, October 2001. □

Communication loads on clinical staff in the emergency department

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TO THE EDITOR: I would like to compliment Coiera et al for their very interesting article about communication in an emergency department.¹ Nearly a third of communication events were classified as interruptions, thus having an adverse effect on communication within the department.

In trying to reduce this level of interruption, perhaps it is time to rethink the role of the on-call emergency physician in an emergency department. In most large Australian emergency departments, the emergency physician is also the admitting officer, who is responsible for coordinating the non-elective admissions of the day. This involves being readily available for external and internal phone calls, usually by mobile phone. Thus, as well as the normal clinical workload of an emergency physician, he or she needs to respond immediately to the summons of a mobile phone — a recipe for interruptions and less efficient communication.

It is not optimal for the person who has clinical responsibility for the emergency department to also be the person through whom most of the communication is channelled. One possible solution is to channel calls about patients whom the referring doctor considers definitely need assessment in the emergency department to non-medical clerical staff. They could enter the details in a computerised "expected patients" database, which would be available for viewing by emergency department staff. Only calls about patients where there is some uncertainty, and advice calls, would be channelled to the emergency physician on call. This would