Screening mammographies in Switzerland: what makes female and male physicians prescribe them?¹

Institute of Social and Preventive Medicine, Basel, Switzerland

Summary

Question under study: Physicians play a key role in motivating women to undergo mammography screening. In 1998 we assessed Swiss physicians’ attitudes to mammography screening and their prescription behaviour in this regard.

Methods: All female physicians and every second male physician aged 50–69 who were either not board-certified or board-certified in general practice, internal medicine, or obstetrics/gynaecology were sent a questionnaire. The response rate was 50% and thus 738 questionnaires were included in this study. Of the study population 39% were female and 61% male physicians. The distribution of professional backgrounds was: 27% board-certified general practitioners; 23% board-certified internists; 11% board-certified gynaecologists; 39% not board-certified.

Results: 55% of all study participants were in favour of a mammography screening programme for women aged over 50 in Switzerland, but breast self-examination and clinical breast examination were judged to have a more positive impact on breast cancer survival. Among clinically practising physicians, 22% reported generally prescribing biannual screening mammographies for women aged 50–69. Irrespective of other determinants, physicians from the Italian- and French-speaking parts of Switzerland prescribed screening mammographies more often than their colleagues from the German-speaking part (odds ratio [OR] 2.5; 95% confidence interval [CI] 1.5–4.2). Clinical practice in obstetrics/gynaecology (OR 2.4; CI 1.3–4.2) and a self-reported high level of knowledge concerning mammography screening (OR 1.9; CI 1.1–3.2) were also positively associated with the prescription of screening mammography.

Conclusions: Since mammography screening programmes exist in only three French-speaking cantons of Switzerland (VS; VD; GE), the gap in prescription of screening mammographies between French/Italian- and German-speaking regions must be narrowed to prevent a higher prevalence of side effects from opportunistic screening among German-speaking women. There is a need to educate physicians and the political community regarding the risks and benefits of mammography screening.

Keywords: mammographic screening; physicians; prescription; attitude

Introduction

Breast cancer is the most common cancer in women. One in twelve women in Switzerland will develop breast cancer over their lifetime [1]. Most breast cancer risk factors identified so far are poor targets for primary prevention of the disease [2]. Early detection therefore plays a crucial role in the fight against breast cancer. Mammography is the only screening method clearly associated with a reduction in breast cancer mortality in well-designed studies. Mortality reductions of up to 30% have been identified in eight randomised intervention studies in women aged 50 to 65 years who were screened at 1–3-year intervals [3, 4].

An effective reduction in breast cancer mortality associated with both an improved quality of life in breast cancer patients and a reduced risk of side effects [5, 6] in screened women can only be achieved with quality-controlled screening programmes. In Switzerland women aged 50 and over undergoing biannual mammographic screening in the context of a programme fulfilling the legal quality control criteria [7] are reimbursed by their health insurance schemes. Since such programmes are available in only three cantons (Vaud, Geneva, Valais), women from other cantons have access only to opportunistic screening and are thus faced
with an increased risk of side effects [8]. In fact, according to the data of the 1997 Swiss Health Survey, more women in the French-speaking part undergo mammography than in the German-speaking region [9]. Physicians in general – but most importantly physicians in cantons lacking screening programmes – who provide care to peri- and postmenopausal women play a crucial role in educating women about screening mammography. Their central role in motivating women for participation in mammography screening programmes has been demonstrated by several studies [10–15]. Asked for the two most common reasons why they had not had a mammography, women stated, first, that they did not know they actually needed an exam, and, second, that the exam was not recommended to them by their physician [14].

We therefore investigated how male and female physicians in Switzerland relate to mammography screening. First, we investigated their attitude to the procedure. We focused on the age group between 50 and 65, because our second interest was in the personal mammography screening behaviour of female physicians. Third and most importantly, we assessed the screening mammography prescription rate and how it was influenced by attitude, personal screening behaviour and other factors.

**Methods**

The cross-sectional study was based on a self-administered questionnaire sent to all practising female (n = 529) and 50% of all practising male physicians (n = 1001) aged 50 to 65 years who were either not board-certified or board-certified in general practice, internal medicine, or obstetrics/gynaecology. Selection of this age category was based on our interest in assessing female doctors’ personal screening behaviour (age at which mammography screening is generally recommended). The professional backgrounds selected chiefly cover the medical service provided to peri- and postmenopausal women in Switzerland. Since many female physicians practice medicine without being board-certified, we included this group in the study. Name and address (n = 1530) were provided by the Swiss Medical Association (FMH). The first mailing was sent out in November 1998, followed by two reminders in December 1998 and January 1999. Questionnaires returned before May 1999 were included in the study. 36 participants had to be excluded from the study (address unknown n = 5; died n = 1; no longer practising n = 8; abroad n = 2; professional background different from those listed above n = 20). The response rate was 58% for women and 46% for men. 15 questionnaires were excluded (demographic information missing n = 2, or unrealistic n = 13). The study population is representative of the base population with regard to age, gender, region and board-certification (table 1). We collected information on demographic variables, workplace, attitude to and prescription of mammography screening and osteoporosis prevention (manuscript in preparation). Female physicians were also questioned about their personal breast cancer screening strategies.

Data was anonymised and abstracted in **Epi**

### Table 1 Comparison of base population and study population.

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>base population¹</th>
<th>study population</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>female</td>
<td>male</td>
</tr>
<tr>
<td><strong>Region</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>German</td>
<td>69.4%</td>
<td>69.1%</td>
</tr>
<tr>
<td>French</td>
<td>24.6%</td>
<td>26.2%</td>
</tr>
<tr>
<td>Italian</td>
<td>2.5%</td>
<td>3.3%</td>
</tr>
<tr>
<td>abroad</td>
<td>3.6%</td>
<td>1.4%</td>
</tr>
<tr>
<td><strong>Board-certification</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gynaecology/Obstetrics</td>
<td>11.3%</td>
<td>12.1%</td>
</tr>
<tr>
<td>General Practice</td>
<td>9.6%</td>
<td>29.8%</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>13.6%</td>
<td>27.6%</td>
</tr>
<tr>
<td>other²</td>
<td>0%</td>
<td>1.0%</td>
</tr>
<tr>
<td>total board-cert.</td>
<td>34.6%</td>
<td>70.4%</td>
</tr>
<tr>
<td>not board-cert.</td>
<td>65.4%</td>
<td>29.6%</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>–55</td>
<td>53.7%</td>
<td>52.1%</td>
</tr>
<tr>
<td>–60</td>
<td>30.4%</td>
<td>28.9%</td>
</tr>
<tr>
<td>–65</td>
<td>14.9%</td>
<td>17.4%</td>
</tr>
<tr>
<td>–70</td>
<td>0.9%</td>
<td>1.6%</td>
</tr>
</tbody>
</table>

¹ In order to assess the representativity of the study population the characteristics listed in the table were provided by the Swiss Medical Association (FMH)

² Infectiology n = 3, Child and Adolescent Psychiatry n = 1, Medical Genetics n = 1, Med. Radiology/Radio-Oncology n = 1
Info (Version 6.03, Januar 1996) and statistically analysed in STATA (Statistical Software, StataCorp 1997, Release 6.0). We first investigated the frequency distribution of answers related to attitude and personal behaviour with regard to mammography screening. **Attitude** refers to the question whether the participant is in favour of health insurance coverage for mammography screening for women in Switzerland after age 50 (Appendix, Question 1). **Personal screening behaviour** refers to the question whether female physicians undergo mammography screening themselves on a regular basis (Appendix, Question 2). **Prescription behaviour** refers to the question whether the participant routinely prescribes screening mammographies for patients in specified age categories (Appendix, Question 3).

We first investigated the determinants of attitude, personal screening behaviour and prescription behaviour in separate statistical models. In a second step we assessed the association of the major determinants identified in step 1, and of attitude and personal screening behaviour, with prescription behaviour in a multivariate logistic regression model. Separate models were run for all participants combined (general model) and for male and female physicians separately. The models were restricted to physicians reporting they were treating patients at the time of the interview. Independent variables included in the models were: age, gender (general model only), language region, board-certification, gynaecological activity, self-reported level of knowledge concerning mammography screening, attitude, belief in the life-prolonging effect of mammography screening, estimation of patient knowledge (general model only), and personal screening behaviour (model for female physicians only).

### Table 2

| Sociodemographic characteristics of male and female physicians. | female | | | male | | | total | | | significance |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | n | % | n | % | n | % | | | | |
| **Total** | 290 | 39.3 | 448 | 60.7 | 738 | 100.0 | | | | |
| **Region** | | | | | | | | | | |
| German | 218 | 75.2 | 334 | 74.6 | 552 | 74.8 | n.s. | 2 |
| French | 69 | 23.8 | 102 | 22.8 | 171 | 23.2 | | | | |
| Italian | 3 | 1.0 | 12 | 2.7 | 15 | 2.0 | | | | |
| **Age (years)** | | | | | | | | | | |
| <55 | 152 | 52.4 | 247 | 55.1 | 399 | 54.0 | n.s. | 2 |
| 55–59 | 93 | 32.1 | 127 | 28.4 | 220 | 29.9 | | | | |
| >59 | 45 | 15.5 | 74 | 16.5 | 119 | 16.1 | | | | |
| **Board-certification** | | | | | | | | | | |
| board-certified: | 97 | 33.4 | 357 | 79.7 | 454 | 61.5 | <0.001 | 1 |
| Obstetrics/Gynaecology | 24 | 8.3 | 59 | 13.1 | 83 | 11.3 | 0.04 | 4 |
| General Practice | 33 | 11.3 | 170 | 38.0 | 203 | 27.4 | | | | |
| Internal Medicine | 40 | 13.8 | 128 | 28.6 | 168 | 22.8 | | | | |
| not board-certified: | 193 | 66.6 | 91 | 20.3 | 284 | 38.5 | | | | |
| Practising medicine | | | | | | | | | | |
| yes | 257 | 88.6 | 432 | 96.4 | 689 | 93.4 | <0.001 | 1 |
| full-time | 122 | 42.1 | 415 | 92.6 | 537 | 72.8 | | | | |
| part-time | 135 | 46.6 | 17 | 3.8 | 152 | 20.6 | | | | |
| no | 29 | 10.0 | 14 | 3.1 | 43 | 5.8 | | | | |
| no reply | 4 | 1.4 | 2 | 0.5 | 6 | 0.8 | | | | |
| **Workplace** | | | | | | | | | | |
| private practice | 186 | 72.4 | 356 | 82.4 | 542 | 78.7 | n.s. | 2 |
| hospital | 52 | 20.2 | 79 | 18.3 | 131 | 19.0 | | | | |
| other | 49 | 19.1 | 35 | 8.1 | 84 | 12.2 | | | | |
| no reply | 9 | 3.5 | 46 | 10.7 | 55 | 8.0 | | | | |
| total | 257 | 100 | 432 | 100 | 689 | 100 | | | | |

1. p(χ²) for the comparison between female and male physicians  
2. n.s. = not significant (p ≥ 0.05)  
3. Comparison between board-certified vs. not board-certified  
4. Contrast between the specialties of board-certification  
5. the p-value is based on combining ‘no reply’ and ‘no’ in a single category  
6. these numbers only refer to participants who were practising medicine at the time of interview (n = 689). Multiple replies were allowed.
Results

738 questionnaires were included in the analysis. Of the study population 39% were female and 61% male physicians (table 2). Three-quarters of participants practised in the German-speaking region, about one quarter in the French-speaking region, and a very small percentage in the Italian-speaking region. The participants’ mean age was 55 years. 33% of female and 80% of male physicians were board-certified (p <0.001). Among board-certified participants 45% were general practitioners, 37% interns, and 18% gynaecologists. There was a statistically significant gender difference in the distribution of specialties among board-certified participants (p(χ²) = 0.04). 67% of female and 20% of male physicians were not board-certified. Their specialty area was chiefly general practice and psychiatry. Overall, 93% of participants and about half of all female physicians were practising medicine at the time of interview. Among those, 79% were in private practice.

Breast self-examination and clinical breast examination ranked higher than mammography screening in the physicians’ judgement of the respective impact of different breast cancer screening methods on survival (table 3).

57% of female and 54% of male physicians were in favour of health insurance refund for screening mammography (table 4; Appendix, Question 1).

More female respondents had “no opinion” (17% vs. 10%), whereas more males were against refund (34% vs. 23%). Arguments against screening mammography were listed in the following order: (1) false reassurance in the light of a negative result, (2) unfavourable cost/benefit ratio, (3) too many follow-up procedures, (4) too many false-positive results. In bivariate analysis a statistically significant positive association with approval of mammography screening programmes in Switzerland was found for respondents practising in French- or Italian-speaking regions (83% vs. 46%, p <0.001); practising without board-certification (58% vs. 53%, p <0.001); practising in gynaecology (69% vs. 53%, p = 0.009); with a self-reported high level of knowledge of mammography screening (65% vs. 39%, p <0.001); and with a belief in the life-prolonging effect of mammography screening (88% vs. 2%, p <0.001).

All female physicians were at the age at which mammography screening is generally recommended by experts. 54% reported that they underwent regular screening mammographies (Appendix, Question 2). Differences were again noted between language regions (75% in the French/Italian-speaking parts of Switzerland vs. 38% in the German-speaking part; p <0.001); between different self-reported levels of knowledge concerning mammography screening (52% vs. 35% for high and low levels self-reported knowledge respectively; p = 0.002); between differences in belief regarding improved survival due to mammography screening (70% vs. 9%, p <0.001); and between differences in attitude to mammography.

Table 3

Percentage of female and male physicians who think of screening mammography, breast self-examination and clinical breast examination as having a life-prolonging effect.1

<table>
<thead>
<tr>
<th></th>
<th>female</th>
<th></th>
<th>male</th>
<th></th>
<th>total</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>1. Breast self-examination</td>
<td>222</td>
<td>76.61</td>
<td>332</td>
<td>74.11</td>
<td>554</td>
<td>75.1</td>
</tr>
<tr>
<td>2. Clinical breast examination</td>
<td>213</td>
<td>73.42</td>
<td>304</td>
<td>67.83</td>
<td>517</td>
<td>70.0</td>
</tr>
<tr>
<td>3. Screening mammography</td>
<td>205</td>
<td>70.74</td>
<td>299</td>
<td>66.74</td>
<td>504</td>
<td>68.3</td>
</tr>
</tbody>
</table>

1 Question “How effective is the life-prolonging effect of screening mammography, breast self-examination, and clinical breast examination?” Possible replies: “ineffective”, “potentially ineffective”, “potentially effective”, “effective”. The table lists the sum of “potentially effective” and “effective” replies.

2 p(χ²) for the comparison of female vs. male physicians = 0.11. The “(potentially) ineffective” replies were compared to the “(potentially) effective” replies.

3 p(χ²) for the comparison of female vs. male physicians = 0.005. The “(potentially) ineffective” replies were compared to the “(potentially) effective” replies.

4 p(χ²) for the comparison of female vs. male physicians = 0.32. The “(potentially) ineffective” replies were compared to the “(potentially) effective” replies.

Table 4

Attitude of female and male physicians towards the introduction of mammography screening for all women after age 50 in Switzerland.1

<table>
<thead>
<tr>
<th></th>
<th>female</th>
<th></th>
<th>male</th>
<th></th>
<th>total</th>
<th></th>
<th>significance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>P2</td>
</tr>
<tr>
<td>Yes</td>
<td>165</td>
<td>56.9</td>
<td>241</td>
<td>53.8</td>
<td>406</td>
<td>55.0</td>
<td>&lt;0.0011</td>
</tr>
<tr>
<td>No</td>
<td>67</td>
<td>23.1</td>
<td>154</td>
<td>34.4</td>
<td>221</td>
<td>30.0</td>
<td></td>
</tr>
<tr>
<td>No opinion</td>
<td>50</td>
<td>17.2</td>
<td>43</td>
<td>9.6</td>
<td>93</td>
<td>12.6</td>
<td></td>
</tr>
<tr>
<td>No reply</td>
<td>8</td>
<td>2.8</td>
<td>10</td>
<td>2.2</td>
<td>18</td>
<td>2.4</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>290</td>
<td>100</td>
<td>448</td>
<td>100</td>
<td>738</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>

1 Appendix, question 1

2 p(χ²) for the comparison of female vs. male physicians

3 In calculating this p-value the categories ‘no opinion’ and ‘no reply’ were combined; p(χ²) for the comparison yes vs. no after exclusion of ‘no opinion’ and ‘no reply’: p = 0.011.
Table 5  
Prescription of screening mammographies in the clinically active study population.1

<table>
<thead>
<tr>
<th>General prescription of screening mammographies</th>
<th>female</th>
<th>male</th>
<th>total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Total</td>
<td>172</td>
<td>29.4</td>
<td>414</td>
</tr>
<tr>
<td>Yes2</td>
<td>70</td>
<td>40.7</td>
<td>150</td>
</tr>
<tr>
<td>for age category</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;40 years</td>
<td>18</td>
<td>10.4</td>
<td>67</td>
</tr>
<tr>
<td>40–50 years</td>
<td>35</td>
<td>20.3</td>
<td>99</td>
</tr>
<tr>
<td>50–70 years</td>
<td>69</td>
<td>40.0</td>
<td>142</td>
</tr>
<tr>
<td>Interval1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>annually</td>
<td>6</td>
<td>3.5</td>
<td>10</td>
</tr>
<tr>
<td>biannually</td>
<td>45</td>
<td>26.1</td>
<td>85</td>
</tr>
<tr>
<td>triannually</td>
<td>14</td>
<td>8.1</td>
<td>86</td>
</tr>
<tr>
<td>less often</td>
<td>4</td>
<td>2.3</td>
<td>10</td>
</tr>
<tr>
<td>no reply</td>
<td>0</td>
<td>0.0</td>
<td>1</td>
</tr>
<tr>
<td>&gt;70 years</td>
<td>42</td>
<td>24.4</td>
<td>106</td>
</tr>
<tr>
<td>No2</td>
<td>87</td>
<td>50.6</td>
<td>253</td>
</tr>
<tr>
<td>No reply</td>
<td>15</td>
<td>8.7</td>
<td>11</td>
</tr>
</tbody>
</table>

1 Appendix, question 3  
2 \( \chi^2 \) female vs. male physicians: <yes> versus <no> versus <no reply>: \( \chi^2 = 0.001 \) <yes> versus <no>: \( \chi^2 = 0.109 \)  
3 Screening interval for women between ages 50 and 70 years. The gender difference with regard to screening intervals is not significant.

We investigated the association of sociodemographic factors, attitude and personal screening behaviour with the likelihood of prescribing screening mammography in a multivariate model. The following variables were identified as independent and statistically significant predictors (figure 1): a positive attitude towards mammography screening (OR 4.40, 95% CI 2.6–7.5) and a belief in its life-prolonging effect (OR 3.43, 95% CI 1.8–6.9) were positively associated with the likelihood of prescribing screening mammography. Physicians practising in the French- or Italian-speaking region were more likely to prescribe screening mammographies irrespective of other predictors (OR 2.47, 95% CI 1.5–4.2). The same was true of physicians practising gynaecology, irrespective of board-certification (OR 2.36, 95% CI 1.3–4.2). Male and female physicians with a high self-reported level of knowledge concerning mammography screening prescribed it more often (OR 1.85, 95% CI 1.1–3.2), as did physicians who considered their patients to be well informed (OR 1.73, 95% CI 1.1–2.9). Female gender and younger age were both positively associated with likelihood of prescribing mammography screening, but not to a statistically significant extent. Stratification of the analysis by gender identified the same predictors of the likelihood of prescribing screening mammography. Female physicians who underwent screening mammographies themselves were more likely to prescribe them for their patients, but the result did not attain statistical significance (OR 2.6, 95% CI 0.8–8.4).
Only 38% of practising male and female physi-
cicians reported that they recommended screening
mammographies to women after a certain age.
Only 22% prescribed them in agreement with
Swiss guidelines in terms of starting age (50) and
screening interval (biannually). Only half of all par-
ticipants were in favour of mammography screen-
ing programmes and only half of all female physi-
cicians underwent mammography screening them-
selves. Impressive differences between the French/
Italian- versus German-speaking regions were ob-
served in all three areas investigated: attitude, per-
sonal screening behaviour and likelihood of pre-
scribing mammography. This difference between
language regions is also reflected in the results of
the most recent Swiss Health Survey (Schweiz-
erische Gesundheitsbefragung 1997): the percent-
age of women who had ever undergone mammog-
raphy (including diagnostic mammography) was
25% in the eastern and central parts of Switzerland
as opposed to 48% (region of Geneva) and 46%
(Ticino) in the western part of the country [9, 16].
These figures mask the positive association be-
tween frequency of mammography and social sta-
tus. To what degree these regional differences re-
fect differences in the prevalence of mammogra-
phy screening programmes (only available in the
French-speaking region) or more fundamental dif-
ferences of attitude towards prevention in general
cannot be determined on the basis of our results.
It is interesting, though, in this context that in 1996
more family planning services were available in the
French-speaking regions, reflecting a stronger
interest in sexual and reproductive health [17].

The low prevalence of screening mammogra-
phy prescription in the age-group of the Swiss
physicians included in our study may reflect their
uncertainty with regard to the benefit of this
screening method in the light of recurrent discus-
sions of this issue [4, 18–20]. The methodology
and results of the large randomised intervention
studies investigating the association between
mammography screening and breast cancer mor-
tality have again been criticised recently in a meta-
analysis including only 20% of the available data
[18]. The authors argue that small age differences
between the intervention groups may have been
the result of incomplete randomisation in many of
these studies. They thus question the accuracy of
the observed average 25% decrease in breast can-
cer mortality in these studies. Despite being widely
publicised, the conclusions of the metaanalysis
were immediately criticised by many national and
international experts [4, 19, 20].

All ORs other than for personal screening behaviour of female physicians refer to the general model, including all clinically
active female and male physicians. The OR for personal screening behaviour is derived from the model including clinically
active female physicians only.
duced mammography screening programmes several years ago statistically significant decreases in breast cancer mortality are now being observed, in agreement with the results of the intervention studies [21–24]. Practitioners must be made aware of this evidence. In our study we have shown that believing in the life-prolonging effect of mammography screening and having a positive attitude towards a Swiss mammography screening programme were positively associated with the likelihood of prescribing mammography, in agreement with the results of previous studies [25, 26].

Being well-informed about mammography has a positive impact on attitudes towards the benefits of this screening method and the likelihood that it will be prescribed [27, 28]. Among the participants in this study, an average of 37% self-reported poor or very poor knowledge in this area. This percentage was lowest for gynaecologists (11%). But both the self-reported level of knowledge and the fact of being a gynaecologist influenced the likelihood of prescribing independently. A higher mammography prescription rate [12, 29, 30] and greater knowledge of breast cancer epidemiology and the benefits of mammography screening [31] among gynaecologists, as opposed to internists or general practitioners, have been reported in previous studies. Since postmenopausal women are less likely to see a gynaecologist [32], they are less likely to have a screening mammography prescribed for them. According to Beaulieu, 30–40% of all postmenopausal women are either not seeing a physician or not willing to take his/her advice with regard to mammography screening [10]. These women could be reached by screening programmes with personal and regular invitations to all women after age 50. The situation could be additionally improved for these women by educating general practitioners and internists about the benefits of mammography screening. The central influence of physicians with regard to participation rates in mammography screening programmes has been reported in several studies [10–15].

The gender gap with regard to mammography prescription was observed both bivariately and multivariately, but reached statistical significance only in the bivariate analysis. We also observed that female physicians more commonly believed in the life-prolonging effect of clinical breast examination than their male colleagues, but no information is available with regard to gender differences in the prescription of clinical breast examinations in this study population. A greater likelihood of prescribing screening mammography among female physicians is in agreement with previous studies demonstrating a greater likelihood of having a cancer screening exam among female patients seeing a female physician, especially if the physician is a general practitioner or internist [29, 11, 33, 34]. Female physicians were found to prescribe screening mammographies more frequently than their male colleagues [27].

The gender gap has also been observed in the prescription of clinical breast examinations in some [35] but not all studies [36]. Regular self-examination of one's own breast was found to predict the likelihood of a female physician's prescribing clinical breast examinations, possibly due to improved confidence in accurately performing the procedure [37, 38]. The more favourable attitude of female as opposed to male physicians towards prevention in general has been documented by several studies [26, 28].

The prescription rate of screening mammography for postmenopausal women may be underestimated in this study focusing on 50- to 65-year-old physicians. The younger generation of physicians is absent from the study population and gynaecologists are underrepresented. It is unknown what percentage of postmenopausal women are being counselled with regard to breast cancer prevention by groups of physicians not represented in this study population. Two investigations in the Canton of Geneva in 1991 and 1995 revealed that 90% of all mammographies (including diagnostic mammographies and mammographies for women under 50) were prescribed by gynaecologists, as compared to only 3% by general practitioners [39]. In our study, the likelihood of prescribing mammography was only 60% even among gynaecologists. Overestimation of the prescription rate for screening mammography by our study is a more likely scenario, given the fact that the negative attitude towards this screening method was probably greater among non-participants. In addition, several studies of male and female physicians have documented “physician overreporting” [25, 40, 41]. Finally, the differences between diagnostic and screening mammographies were often misunderstood, as evidenced by indications listed as reasons for recommending screening mammography (i.e. follow-up of positive clinical exam).
Conclusions

Most women after age 50 have no access to quality-controlled mammography screening programmes in Switzerland. Given the current lack of political and financial support for the establishment of such programmes it is crucial to educate male and female physicians, in particular general practitioners and internists, as well as the political community, on the subject of mammography screening.

References

Appendix

Question 1: Attitude towards mammography screening

“It is planned that after 1.1.1999 biannual screening mammographies for women above age 50 will be refunded by basic health insurance coverage. Do you think that the benefits of mammography screening (reduction of breast cancer mortality; greater likelihood of breast conserving therapy) outweigh its side effects (unnecessary biopsies; prolongation of the time a woman knows about the presence of breast cancer in the absence of a life-prolonging effect) and that regular screening mammographies are justified for women aged 50 and over?”

– Possible replies: yes – no – no opinion

Question 2: Personal screening behaviour

“Do you undergo screening mammographies at regular intervals (i.e. preventive mammography in the absence of any symptoms or palpable lesions)?“

– Possible replies: yes – no

– if “yes”: starting at what age, and at what screening intervals?

– if “no”: for what reasons?

Question 3: Prescription behaviour for screening mammography

“For patients without any indication of breast disease, without palpable lesions, and without a family history of breast cancer, do you generally recommend screening mammography after a certain age?”

– Possible replies: yes – no

– if “yes”: for what age categories and at what screening intervals?

– if “no”: for what reasons?
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