Is ‘routine screening’ for dementia in hospitalised cases justified?

The remit (2014)
The Chairman explained that a round robin request had been received from a CEC regarding routine screening for dementia in patients over 75 years admitted to hospital. The committee had concerns over the lack of choice patients were given in being screened for dementia (i.e. compromising autonomy), particularly because of the stigma/anxiety on receiving the diagnosis where there was a lack of proven beneficial treatments. The CEC was aware that this was a national initiative, but would be grateful for further opinions from other CECs about the ethical justification of such a practice.

Discussion

Background
The Chairman began the discussion by referring to the active debate in the BMJ which suggested that the screening initiative had been politically motivated rather than being based on sound evidence that screening was beneficial to patients. The purpose appeared to be that the government recognised the unrecognised dementia as a problem and was keen to show activity which demonstrated treatment and support. Screening was not a NICE requirement but was strongly encouraged by the Department of Health. As a result the National Council on Dementia Screening had attempted to rationalise and standardise requirements.

The screening process
The screening process used by medical staff in our Trust was as follows: when staff open the patient’s e-record, they gain access to the dementia screening menu-driven process, which starts with 3 questions:-

1. Does the patient have a known diagnosis of dementia?
2. Does the patient have delirium? - a flow chart was provided together with a protocol for delirium
3. Has the patient been more forgetful in the past 12 months? If the answer was yes then there were a series of medical steps to take followed by a brief mental screening test which, if positive, would lead to a referral to a psychiatrist or to a GP.

As suggested in the BMJ articles and letters, the question arises whether the Trust should continue with the screening programme or whether the resources may be used better in a different way (e.g. better support and diagnostic workup for those patients presenting with dementia). An ethical question also arises whether screening should have been implemented in the first place.

The Chairman referred to an open letter to the Prime Minister and Chief Medical Officer for England from a number of GPs which had been published in the BMJ and which stated there was no evidence-base for the proposed dementia screening. [Ref 1] The open letter also suggested that there was no evidence that the programme fulfilled the WHO established criteria for screening; the authors assert that screening could lead to harm to patients by way of over-treatment and a diversion of resources away from other services; and that before a screening programme was introduced it must be shown that the benefits outweighed any potential harm. The authors indicate that in June 2010 the UK National
Screening Committee advised against routine screening for Alzheimer’s disease. The diagnosis remained a frightening one and some patients might avoid seeking help from their GP when it was needed and the WHO had advised that no treatments were currently available to cure or even alter the progressive course of dementia.

By way of further background the Chairman referred to the article “Screening for dementia – is it a no brainer?” by C Fox et al [Ref 2] which stated that cognitive impairment was not synonymous with dementia, there was no effective treatment intervention and no reliable predictors identifying which patients with mild cognitive impairment would later develop dementia. It is asserted that the new initiative was effectively a mixture of population screening and case finding. There was no high quality research evidence showing benefit in diagnosing patients before the usual point of presentation. While “significant benefits” of “early” diagnosis was often cited as reasons for promoting this policy, the evidence supporting this view was from small numbers of individual studies which were limited in size.

Scepticism about the drivers for introducing screening

A member indicated suggested that the large pharmaceutical companies had a major interest in this programme – it would be of major economic benefit to them. The member queried who really benefited in the absence of any evidence. Another member supported this view, stating that if this process had been undertaken directly by the pharmaceutical companies there would be an outcry but it appeared that it was being done on their behalf.

In relation to Question 1 in the screening process, members acknowledged that it was good practice to establish from the medical records if the patient had a prior history of dementia. However, the hospitals Trust was not a public health body - patients were admitted for a variety of problems and that there should not be a routine checklist if it was not relevant to the patient.

Potential harm of screening

A member advised that the process of screening should not create harm e.g. false/positive results caused by depression and that there was a risk of causing harm especially if the patient misinterpreted the questions. The act of asking the question without consent or knowing why the questions were being asked could cause distress or harm which could cause significant distress.

A member referred to the knock on effects on families and the related issue of genetic testing which some relatives might feel they required.

The Chairman summarised the issue by stating that the discussants had outlined concerns that the duty to avoid harm (non-maleficence) was considerably greater than potential beneficence for the patient – since there was little or no evidence of identifiable benefit for patients who are screened.

A lay member reflected that prior to the discussion he had thought that the screening programme seemed to be a good thing epidemiologically - he had, on first reflection thought it to be analogous to HIV. However, this did not appear to be the case from the discussion so far and he could not see much merit in screening. The Chairman added that
there was also the question of misdiagnosis – since 50% of patient with Mild Cognitive Impairment (MCI) did not progress to dementia, their MCI was simply a phenomenon of ageing and the effect of screening is to ‘medicalise’ a normal ageing phenomenon.

A member referred to the inefficiency of the screening system and wondered even if there was a perfect screening test whether it would be appropriate to go ahead as it did not translate into effective intervention and there was no advantage in being screened earlier.

A member drew a parallel with the Breast Screening Programme and the difficulties which would ensue in discontinuing that programme.

**Inadequate and inconsistent consenting process**

The Chairman advised that he had sought the view of an F1 in the consenting process and it was evident that foundation doctors (who do most of the screening for dementia in our Trust) had not received training in the consenting process. In any event, seeking consent for dementia testing is a complex clinical and ethical challenge which could not be done without considerable preparation.

**Should we be screening in a different way?**

A member (who is a psychologist) suggested that patients who did have early stages of dementia might not have insight into their condition whereas relatives might well do – there may therefore be a case for initiating the screening process by interviewing relatives and carers about evidence of cognitive impairment. This would be best done by GPs.

On the other hand, another member suggested that a slow decline may not be noticed by very close relatives.

**Might it be best left to GPs to screen?**

A member commented that question 1 seemed to relate more to GPs rather than the Hospitals Trust and the Chairman reiterated the point that GPs were of the view that this was not proper screening, was opportunistic and a waste of resources. He went on to discuss the NICE guidance for screening for depression in hospitals (NICE Clinical Guidelines 90 & 91). He said that when the Trust explored the best way of introducing depression screening, meetings with GPs had demonstrated that they were not very keen on blanket screening in hospital (because of the risk of over-diagnosing patients who were simply distressed by an acute illness) and that only if a patient was under the Trust’s care for a prolonged period would a diagnosis and treatment be appropriate. There were similarities with dementia screening (except that dementia screening probably has very little benefit wherever it is done).

**The clinicians’ voice**

A member raised the possibility that consultants should perhaps challenge more strongly new ideas which were deemed to be inappropriate for patients.

**Informing GPs of positive screens**
The Chairman indicated that the discharge letters had been modified to prompt foundation doctors to inform GPs if patients had been screened for dementia and what the outcome was. However, there was a potential gap in that the screener might not be the person completing the discharge letter.

A member commented on the potentially huge additional workload being sent to GPs.

Futile interventions are wasteful and therefore unethical

A member suggested that as the outcome of Mild Cognitive Impairment cannot be changed (since there is no proven, effective medical intervention), the ethical issues of beneficence and nonmaleficence fell away – the argument stops at the level that one should not do something that is ineffective and wasteful (“an is not an ought”).

References

i. Brunet et al. There is no evidence base for proposed dementia screening BMJ 2012;345:e8588 doi: 10.1136/bmj.e8588 Published 27 December 2012


Summary

A UK Clinical Ethics Round Robin question had recently been circulated by another Trust’s clinical ethics committee, in which they queried the ethics of routinely screening for dementia. This screening programme had been introduced throughout the NHS last year and there were considerable financial incentives/penalties attached to adherence to the screening programme. The programme has been criticised in the medical literature by GPs and Mental Health and public health academics. It was noted that in June 2010 the UK National Screening Committee - whose remit is to advise the government on all screening programme - advised very clearly that screening for Alzheimer’s disease “should not be offered”. Thus there was no justifiable evidence base or expert-based imperative to do screening in hospitals. It was noted that the method being employed could not strictly be described as population screening, but rather a form of ‘case finding’.

The CEC considered the absence of evidence of any benefit in screening (no evidence of beneficence) and the fact that there were a number of potentially harmful consequences of screening (breaching the duty of nonmaleficence - including causing distress to the patient and their relatives), even though a significant proportion of patients who screen positive will never go on to develop dementia. There were concerns about the inappropriate consumption of resources to do the screening (the ethical principle of distributive justice), which resources could be better utilized elsewhere, e.g. in providing better diagnostic and psychiatric support for patients who have features of cognitive impairment as their presenting symptom. There were serious concerns about the consenting process, particularly since screening is left to junior trainees who may be unskilled in managing the consenting interview and the consequences of finding cognitive impairment.

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