Silence about Screening

Peter H. Schwartz MD, PhD
Indiana University Center for Bioethics
Indiana University School of Medicine

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1.

Whitney and McCullough (in press) present an important argument that it is ethical in some situations for doctors to make "silent decisions," i.e. to fail to mention a possible test or treatment due to "such considerations as patient benefit or economy of time" (p. 2). The authors show that respecting patient autonomy may not require as much disclosure as is sometimes supposed, and they advocate an improved balance between this ethical ideal and other important goals, such as beneficence.

In the three cases that the authors discuss, the doctor decides, first, that it would be unethical to offer a certain test or treatment, and then decides not even to mention it. Whitney and McCullough (in press) don't explicitly extend this argument to cases where the test or treatment has not been ruled out *a priori*, i.e. where the intervention is "not likely to produce a net clinical benefit" (p. 9) but the physician might provide it if an informed patient requested it.

For example, they defend a doctor's decision not to mention the possibility of prostate cancer screening to a 55-year-old man with Alzheimer's disease, due to his reduced life expectancy and the increased burden of any follow up tests and treatment (p. 8). But what if the man did not have Alzheimer's disease? Even for healthy men in this age group, it is unclear that screening for prostate cancer has a net benefit (Harris and Lohr 2002, American Urological Association 2000, Smith et al. 2006), and so it seems that the clinician might make a similar silent decision not to mention the possibility to a healthy 55-year-old man.

Whitney and McCullough approvingly cite a comment by Sheridan et al. (2004, p.58) that appears to support such an approach to unproven preventive interventions (Whitney and McCullough, p.14). But Sheridan's comment is unusual in the literature concerning screening: most guidelines regarding unproven tests say that the doctor should have an in-depth discussion with each eligible patient to allow him or her to make an individualized decision.

In this piece, however, I will consider an argument that the same considerations that Whitney and McCullough use to support silent decisions in other areas may also support silent decisions about unproven screening tests. I cannot fully explore or defend this possibility here but the discussion helps demonstrate the complex questions and far reaching implications of trying to balance patient autonomy and beneficence in medicine.

2.

While digital rectal exam (DRE) and prostate specific antigen (PSA) testing are commonly performed in men ages 50-70 to screen for prostate cancer, these tests have unproven benefit. Many cancers are identified that would never have caused a problem, and the follow up tests and treatments carry impressive morbidity of their own (Harris and Lohr 2002, American Urological Association 2000, Smith et al. 2006). In short, while prostate cancer screening can identify cancers early, it is unclear whether doing so improves health outcomes. A large study funded by the National Cancer Institute will help answer this question, but the results will not be known for several years.

Because of this uncertainty, guidelines do not recommend screening all men in the target group. Instead, three major organizations – the United States Preventive Services Task Force (USPSTF), the American Cancer Society (ACS), and the American Urological Association (AUA) – recommend that doctors describe the tests' risks and benefits to patients and help them make individual decisions (Harris and Lohr 2002, American Urological Association 2000, Smith et al. 2006). The USPSTF, for instance, writes, "Clinicians should inform men of the gaps in the evidence and should help them to consider their personal preferences and risk profile before deciding whether to be tested" (USPSTF 2002). The ACS similarly recommends that patients should be informed "about the benefits, limitations, and harms of early detection and treatment of

prostate cancer so that they can make an informed decision about testing." (Smith et al. 2006, p. 17). The ACS goes one step further, however, specifying that "Men who ask their doctor to make the decision on their behalf should be tested. Discouraging testing is not appropriate. Also, not offering testing is not appropriate." (ACS 2007)

The recommendation of discussion and patient choice is based on the ideal of *patient autonomy*, i.e., the idea that the patient's values and desires should guide his care, preferably through shared decision making with a physician. For patients who want to know about any developing cancer and are willing to run the risk of impotence or other side effects, for instance, prostate cancer screening would be appropriate. In contrast, patients who would prefer to avoid unproven tests and possibly unnecessary and unpleasant treatments should forego testing.

3.

But despite the initial attractiveness of such reasoning, there are important problems with it. Most patients do not fall clearly into the first or second category: they want screening if it has a reasonable chance of reducing their risk of disability or death, as long as the testing and follow-up treatment isn't too burdensome. And for a patient to decide whether PSA and DRE screening for prostate cancer falls in this category for him requires him to learn and consider a large amount of information regarding the possible benefits – mostly those stemming from finding a cancer early enough to make a difference – versus the dangers associated with testing and treatment, including impotence and urinary incompetence. To come to a fully informed decision, the patient must understand the probabilities of the many different possible outcomes and reflect on his feelings about them.

Given the current reality of the typical doctor's visit and of the typical patient's abilities, such complete consideration is unlikely. Doctor's visits are already overpacked with activities including addressing acute problems, encouraging healthier habits (such as quitting smoking), and implementing an ever growing list of preventive measures (Yarnell et al. 2003). Studies of patient abilities to handle numbers – i.e. "numeracy" – show that many have difficulties with even simple mathematics, much less the complex statistical information involved in probabilities (Sheridan, Pignone, and Lewis (2003).

In many cases, the patient may simply ask the doctor, "What do you recommend?" The ACS directs that such men should be tested (as quoted above.) But the ethical basis for such a recommendation is unclear. It can't be based on a judgment of beneficence, since there is no proof of net benefit, and it can't be based on patient autonomy, since the patient has not made a decision. Fully 57% of men over 50 years old have had PSA testing in the USA in the last year (ACS 2006, p. 43): if a significant percentage of them did not make an informed decision, this adds up to a questionable use of a lot of healthcare resources. There is some hope that interactive computer-based programs (Patient Decision Aids) could someday help patients learn about and make decisions regarding such screening decisions, but they aren't available yet, and it is unclear if they can do the job.

4.

Given this situation, it seems that a reasonable case can be made for doctors to make a "silent decision" in some cases not to mention PSA or DRE screening to healthy men in the target group. As in other justifiable silent decisions, the doctor may judge that it is more important to spend the available time on another activity, such as reviewing possible side effects of a new medication, recommending quitting smoking, or discussing a better supported preventive intervention. The doctor may guess, based on his interactions with the patient, that he does not have values that would favor screening. The doctor may also simply put off discussion to another visit, perhaps repeatedly.

The clinical judgment that goes into this decision may be criticized and may even be demonstrably mistaken, for example if the doctor is wrong about the patient's values. But as Whitney and McCullough say about other silent decisions, the fact that the decision may be mistaken does not make it unethical: all decisions calling for clinical judgment are fallible (pp. 13-14).

As discussed above, though, this silent decision differs from the ones that Whitney and McCullough discuss at length, since the doctor *would* provide the screening to an informed patient who requested it. Because of this, the possible cost of the silent decision is greater. A patient is not just deprived of information about the doctor's reasoning, but also of a test that possibly could have saved his life.

On the other hand, the same considerations that supported silent decisions in those other cases apply here: doctors must make judgments, given the time available, about what activities have the highest chance of helping the patient. And if the lack of time means that the doctor must choose between ordering prostate-cancer screening after only a cursory discussion, versus not mentioning it at all, it seems possible that the latter is the more ethical course. As mentioned above, there are serious ethical problems with providing an unproven test to a patient who does not understand it.

Admittedly, legal concerns may lead doctors to choose the former course, since a patient who is not tested and later develops prostate cancer could be litigious. But practicing this sort of "defensive medicine" leads to relatively irrational ways of apportioning healthcare resources, and may even injure more patients than it helps. In the end, an ideal medical system would make sure that all patients make informed decisions in such situations, but given the real limitations of the current system, a silent decision may be the ethical one.

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