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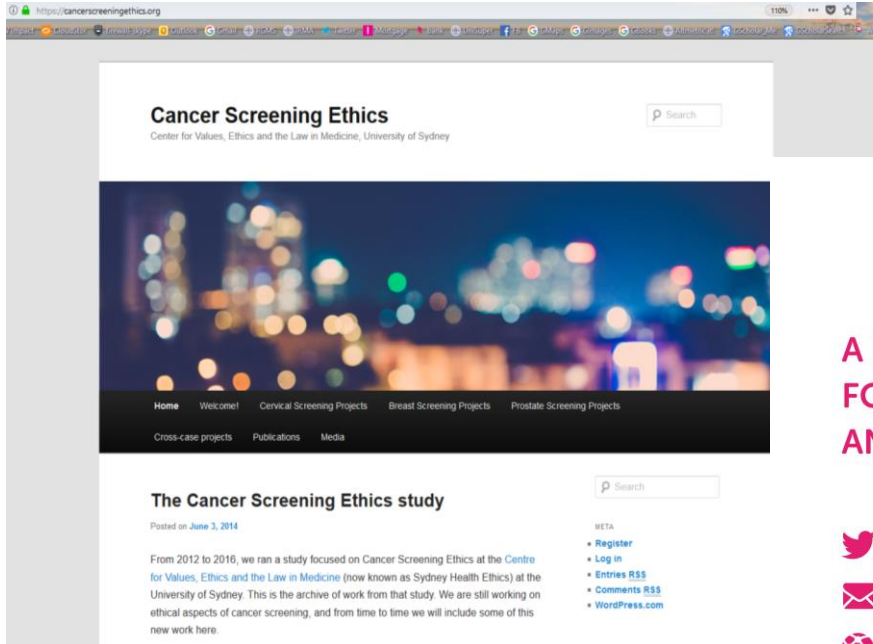
Ethical considerations in cancer screening programs

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A RESEARCH COLLABORATION FOR REDUCING OVERDIAGNOSIS AND OVERTREATMENT



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Outline

- The context: population screening & public health
- Core ethical issues (there are others!)
 - Minimising harm
 - Supporting autonomy
- Making ethically justifiable decisions



The context



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Population screening programs

- Initiated by health authorities rather than individuals
- Large number of people tested
- Testing asymptomatic, well people

- Stronger justification required



Population screening is not a good in itself

1. **Immediate objective:** To 'sort' populations into those who should receive diagnostic testing vs those who should not
2. **Intermediate aim:** *Support autonomy of participants*
3. **Ultimate aim:** Reduce suffering and lengthen life in populations

Not 'pure' public health

PUBLIC HEALTH

- Aim is to improve population health
- Public funding & promotion
- Standardisation and quality assurance

CLINICAL

- Implemented in clinic-like situations
- Implemented by a clinician
- Little common good arising from participation (unlike e.g. vaccination)



Minimising harm



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Possible harms (averted and caused)

- Cancer death
- Experience of metastatic disease

- Harms of Rx (e.g. immediate side effects of Rx, later cardiovascular complications of radiotherapy and chemotherapy)
- Psychosocial & financial effects of Dx & Rx

- Death from other causes

- Lost opportunities
- Intergenerational effects

Minimising harm

- Across the entire cascade (not just the test)
- Screening programs should reduce the number of people harmed by disease
- Screening programs should not increase the number of people who are harmed on balance
- Different people value different harms differently (but population level programs need to take a policy position)



Moral intuitions & cognitive biases

- Reasoning is hard when information is uncertain
- People will tolerate many injuries to save one life
- A feeling of having a 'right' to something is compelling
- Unintended harms may be discounted
- If we know the person harmed our concern is heightened
- We anchor to particular examples we have experienced
- Framing influences our reasoning

Carter SM. Overdiagnosis, ethics, and trolley problems: why factors other than outcomes matter—an essay by Stacy Carter. *BMJ*. 2017;358:j3872.

Scott et al. Countering cognitive biases in minimising low value care. *Med J Aust*. 2017;206(9):407-11.



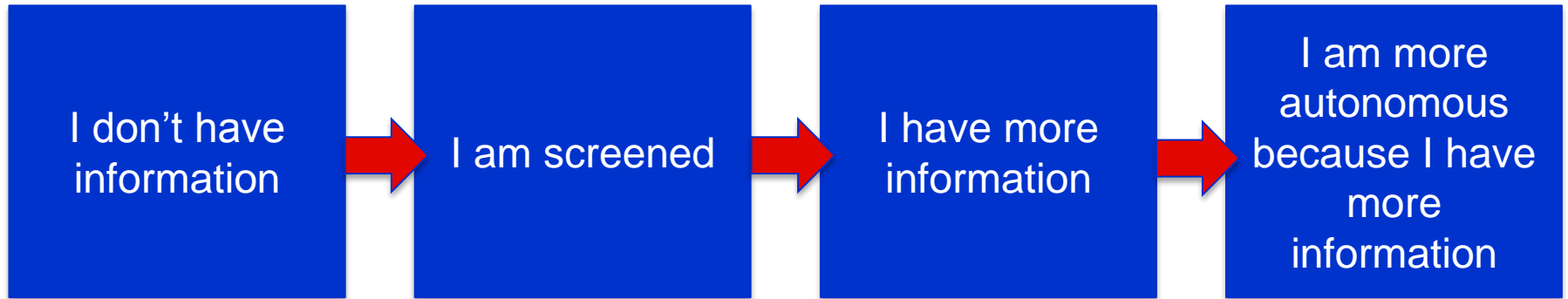
Supporting autonomy



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Does screening support autonomy?

ONE COMMON VIEW



But: depends on what and how

- Misleading information (e.g. relative rather than absolute risks; over-stating the value of reassurance or negative results)
- Selective information (e.g. about some outcomes and not others)
- Persuasive or manipulative communication, using guilt or fear
- Uncertain information
- Information that can't be interpreted or used meaningfully by the person, especially if this is likely to harm (e.g. undermine identity, cause anxiety)

How do we decide?



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No easy answers

- Deciding for public programs vs making clinical decisions
- Focus on outcomes (including full range of possible harms)
- Consider the practical value of information (*Can* this information support autonomy? *How* should it be communicated?)

- Attend to procedural justice
- Include diverse perspectives
- Recognise the effect of biases and intuitions (for everyone)

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