Screening backlogs

How to move forward

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The COVID-19 pandemic has exposed weaknesses in our health system. We owe it to our patients to build on what we have learned and to think about where we go from here.

Cancer screening rates have decreased significantly during the pandemic.[1] As we reflect on screening backlogs, we need to ask ourselves: to what extent is this a problem, and how should we approach it?

"Earlier is better" is certainly an appealing phrase, and it can seem counterintuitive to think otherwise. But for this phrase to be true, we need effective screening. As physicians, we know that just because we can screen for something does not necessarily mean that screening does more good than harm.

Use evidence to guide decisions

Even when screening has been shown to be beneficial, we need to seek information about the magnitude of these benefits to best share this information with patients. It has been shown many times that patients and physicians alike tend to think the benefits are higher and the harms lower than they really are.[2,3]

Screening is an option, not an obligation, which individuals can choose to pursue or not once they know the facts about potential benefits and harms. They usually obtain this information through shared decision making with a health care provider. Deciding to undergo screening should not be seen as the only good decision.

If the lower screening rates we are seeing now were synonymous with patients being better informed, that situation would be acceptable. Unfortunately, these lower rates are more likely an outcome of difficulties in accessing care or patients' reluctance to access care, particularly during the early stages of the pandemic.[4] Still, providing better information to patients should be our aim, rather than just trying to decrease the backlog of screening procedures.

While screening has never been shown to decrease total mortality,[5] the number of cancer-specific deaths averted varies from about 1 per 1000 people screened (women 50 to 59 years old screened over 7 years for breast cancer)[6] to about 3 per 1000 (lung cancer screening over a decade).[7] The magnitude of harm differs based on the type of screen, but false positives and overdiagnosis are always concerning.

Strong recommendations for cancer screening issued by the Canadian Task Force on Preventive Health Care are few and limited to colon and cervical cancer screening in specific age groups.[8,9] Where screening is conditionally recommended and when benefits and harms are in equipoise, shared decision making is key. This judgment is increasingly informed by literature reviews on the values and preferences of patients, not only by opinions of expert panels.

To implement true shared decision making, we must recognize there is a decision to make, share pros and cons of each option, and support patients in their decisions.[10] However, existing screening programs are not designed with this in mind. One reasonable way forward in addressing the screening backlog is to implement trustworthy tools such as decision aids in our screening pathways and in our conversations with patients. We need to forgo counting numbers of screens performed and concentrate on what truly matters.[11] Having a patient undergo a screen when they have not been properly informed about its potential benefits and harms, or in the absence of high-quality evidence to support screening, in fact represents overscreening.

Resist overscreening

Also consider situations where people are screened for cancer even though they are unlikely to benefit from screening, such as those who are outside recommended age groups for screening. In younger populations benefits are improbable, and in elderly groups risks of harm are increased. To possibly benefit from screening, you need a life expectancy of at least 5 to 10 years, depending on the cancer for which you are screening. That is why life goals should be part of discussions about screening with patients in older age groups.[12]

A 2014 review by Royce et al showed that between 30% and 50% of individuals with expected high mortality rates were still screened, even for cancers for which screening is not recommended, such as prostate cancer.[13] Sadly, in Canada, this trend of overscreening seems to be continuing[14] and is likely, if we are not vigilant, to persist.

We need to seize this opportunity and not view the backlog as a problem we can solve only by doing more. If we really understand how screening works, we know that postponing screening slightly will not have a disastrous impact.[15] What is more difficult to understand is that when rates of diagnosis go down, that trend also partly represents decreased harm because less overdiagnosis occurs. The use of misleading statistics by the media, and at times by the scientific community, inflates the perceived benefits of screening,[16] which may unduly pressure us in our approach to care.

According to many sources, more cases of advanced cancer have been reported during the pandemic; unfortunately, these cases likely represent individuals with symptoms who chose not to consult their physicians or could not secure timely access to diagnostic testing because of disruptions in care owing to the COVID-19 pandemic.[17] It would take longer to see such a population impact from less screening.

Most interventions in medical practice achieve small to modest improvements, including cancer screening.[18] Hence, screening should not be prioritized above taking care of symptomatic patients or caring for those with unstable disease. Further, when addressing cancer-screening backlogs, we should probably start with screenings that decrease cancer incidence, such as colon and cervical cancer screening, and limit screening to proven and effective tests and procedures. This approach might alleviate some pressure put on family physicians in this unprecedented period.

The aim should be to share the best data we have with patients in a manner they can understand. Doing so means embracing shared decision making, as many screening recommendations suggest. Going back to screening as it was often done before the COVID-19 pandemic and seeing this as the only rational option are errors we should avoid.[19]

Conclusion

That individuals at high risk might not have access to appropriate care is of course concerning, but decreased screening in individuals with average risk might not be the bad news it initially appears to be in media reports. Shared decision making might reduce low-value screenings in patients for whom harms outweigh benefits, either because of their conditions or because of their personal values and preferences. We need to facilitate informed choices and respect individual decisions.

The current backlog in screening represents an opportunity to set clearer priorities in our health system. We need to prioritize symptomatic patients and unstable chronic disease. We also need to incentivize the integration of shared decision making in our practices and, ideally, in screening programs themselves. For these things to happen, we need a different approach.

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Competing interests
None declared

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