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NICE guidelines and the treatment of Alzheimer's disease: evidence-based medicine may be discriminatory

Arshad *et al* (2001) raise important concerns that UK guidelines for the treatment of Alzheimer's disease (National Institute for Clinical Excellence (NICE), 2001) may be counterproductive for patients with learning disabilities. Potential for discrimination does not by any means stop here. A particular difficulty they highlight is the central role of the Mini-Mental State Examination (MMSE) instrument in determining treatment 'eligibility' and response. Scores on the MMSE are strongly influenced by previous education and cross-cultural validity is poor. The guidelines are, therefore, unhelpful for people with lower educational attainment or for growing numbers of older people from minority ethnic groups in the UK. Comorbid cerebrovascular disease will also be more frequent in people from more disadvantaged backgrounds and, in particular, minority ethnic groups such as African–Caribbean populations (Stewart *et al*, 1999). This reduces the likelihood of a diagnosis of Alzheimer's disease (and therefore eligibility for anticholinesterase treatment) according to standard diagnostic criteria (McKhann *et al*, 1984), despite growing evidence for overlapping pathological processes in dementia (Holmes *et al*, 1999).

For sub-populations who are underrepresented in clinical trial samples (minority ethnic groups, people with lower educational attainment, people with learning disability, people with comorbid cerebrovascular disease), the best that can be hoped for is that a considerably weaker evidence base might emerge some years in the future. By this time large numbers of people may have failed to receive potentially beneficial treatment. The problem does not lie with treatment guidelines themselves but with how they are applied at the level of individuals and services – in particular regarding groups with Alzheimer's disease for whom a 26-year-old cognitive screen and/or 17-year-old diagnostic criteria are unhelpful. Evidence-based medicine is a noble ideal. However, clinical practice that is restricted to the evidence base may amount to institutionalised discrimination.

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PTSD and stillbirth

The study by Turton *et al* (2001) on post-traumatic stress disorder (PTSD) in the pregnancy after stillbirth represents groundbreaking research in this area. It is a welcome addition to the world literature in a hitherto neglected field of enquiry. It is of serious concern, however, that they present their results in such a way as to implicate the practice of seeing and holding the dead infant as being related to the development of PTSD in subsequent pregnancies. Of those who had not seen the infant, one (17%) of 14 developed PTSD compared with 12 (26%) of 47 who had (P=0.26). This is a statistically non-significant correlation and as such no relationship can be assumed.

The current practice of encouraging mothers to see and hold their dead babies was initiated by Lewis's seminal work (Lewis, 1976, 1979; Lewis & Page, 1978) on the special difficulties of mourning a loss that frequently mothers had never seen and that often led to later psychological difficulties. Although in practice most maternity departments have developed protocols which give parents this opportunity, the nature of this service is extremely variable. Some units have specially trained bereavement midwives who offer support at the time of death and during subsequent pregnancies. Units may provide special suites to allow parents to spend time privately with their dead child. In other units a brief time in a delivery suite may be all the contact they are allowed. Staff may have little or no training in psychological care. Turton *et al* "presumed supportive management of the stillbirth itself" but do not discuss the nature of the service provided by any of the three centres included in the study. In future studies this is an important confounding variable that should be considered in examining the hypothesis that holding the dead infant following stillbirth is a risk factor for developing PTSD in subsequent pregnancies. What Turton *et al* assert as a clinical implication is nothing more than an interesting but, as yet, untested hypothesis. It would be a pity if policy-makers gave this research undue emphasis and abandoned current practice hastily. In establishing evidence-based best practice, longer-term outcome, morbidity in partners and views of maternity service users will be important areas of enquiry. It is disappointing that Turton *et al* have been tempted to emphasise a relationship between clinical practice and outcome that their own results did not demonstrate.

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