Referral in Mild Cognitive Impairment: Subjectivity or Uncalibrated Prudence?

Referenciação no Défice Cognitivo Ligeiro: Subjetividade ou Prudência não Calibrada?

Keywords: Attitude of Health Personnel; Cognitive Dysfunction; Portugal; Referral and Consultation
Palavras-chave: Atitude do Pessoal de Saúde; Disfunção Cognitiva; Encaminhamento e Consulta; Portugal

I read with great interest the study by Fonseca *et al*,[1] which explores the barriers to referring patients with mild cognitive impairment (MCI) in Northern Portugal. The authors identify "subjectivity" in the application of referral criteria and a "lack of assertiveness" among primary care clinicians (PCCs) as critical barriers. This letter serves as an extension and alternative interpretation of their valuable findings.

From a bioethical and methodological perspective, I propose that this "subjectivity" should not be viewed merely as a lack of adherence to guidelines, but potentially as a manifestation of the "Prudence Gap" (Phronesis). In clinical ethics, prudence is the practical wisdom required to adapt abstract medical guidelines to the complex realities of individual patients. Unlike pure subjectivity — which implies arbitrariness — prudence is a deliberate moral calibration. In Primary Care, the decision to refer is a probabilistic exercise where the clinician must weigh the biomedical utility of a diagnosis against the patient's social determinants of health (SDoH), such as the low literacy correctly identified by Fonseca *et al*.

In line with recent European research highlighting marked ethical insecurity and heterogeneity in MCI disclosure practices,[2] as well as a limited contribution and lack of specific training for dementia management among Portuguese family physicians,[3] I recently proposed a Bayesian framework (a probabilistic model that integrates a patient's prior social context with new clinical evidence to guide decision-making) to evaluate this specific disconnection between theoretical ethical knowledge and prudent clinical performance.[4] When applying this analytical lens to Primary Care, it becomes clear that when PCCs hesitate to refer, they are often unconsciously drawing on a Bayesian prior: knowing that in a context of severe social frailty, an advanced diagnosis without downstream support might cause more harm (maleficence) than good. Importantly, this should never justify diagnostic nihilism or act as a barrier to appropriate referral; rather, severe social vulnerability must inform the need for shared decision-making and the

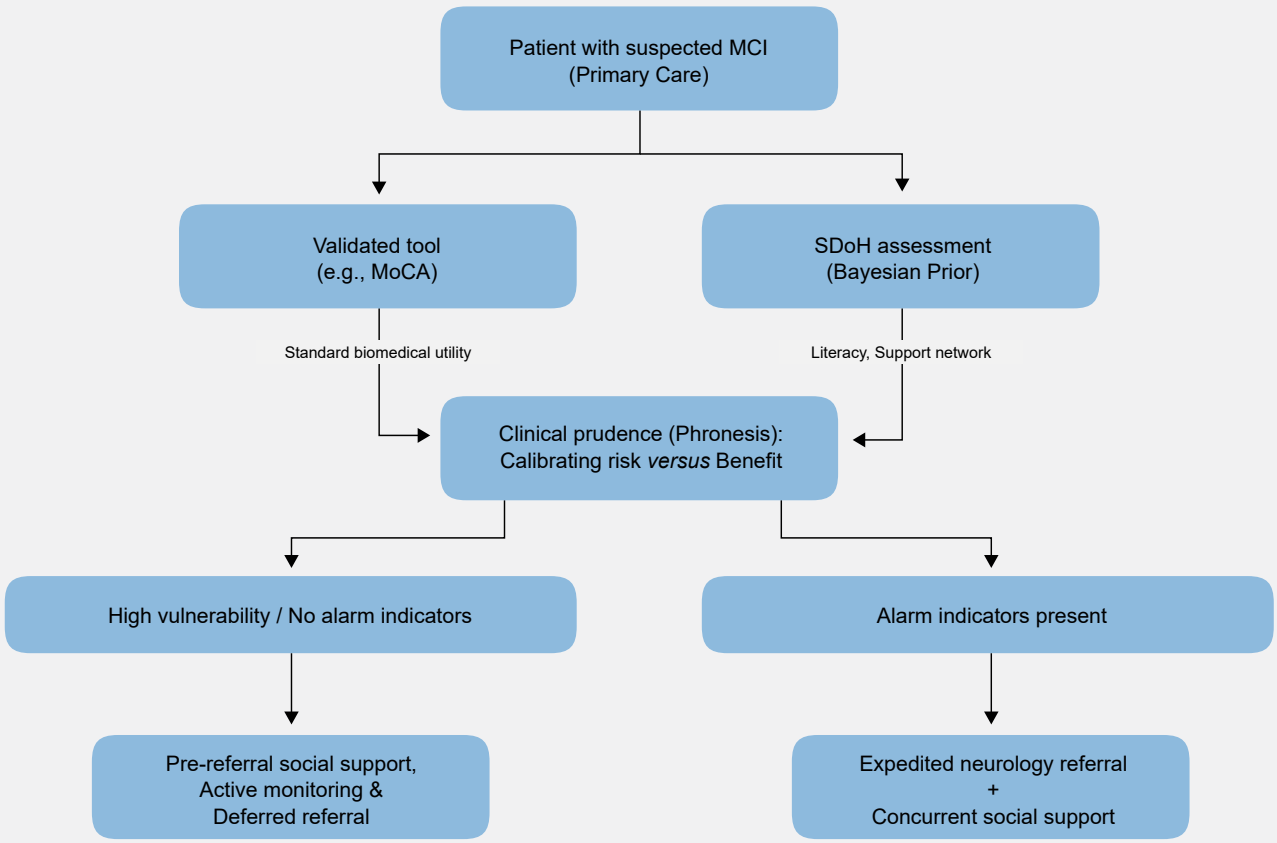

Figure 1 – Multicriteria Bayesian referral algorithm for mild cognitive impairment. The algorithm illustrates how Phronesis calibrates biomedical utility with social context to determine the safest patient pathway.
MCI: mild cognitive impairment; MoCA: Montreal Cognitive Assessment; SDoH: social determinants of health.

mobilization of tailored psychosocial support before and after the referral. However, without a formal framework for clinical judgment, this ethical intuition superficially manifests as inconsistency.

To strengthen the referral pathway and translate this conceptual reflection into practical action, solutions must evolve towards multicriteria referral algorithms (Fig. 1). Practically, this requires standardizing criteria by combining validated cognitive assessment tools (*e.g.,* MoCA) with structured "clinical red flag indicators" — such as rapid cognitive decline or severe caregiver burnout. In this algorithm, high social vulnerability does not preclude referral; instead, it acts as a critical contextual modifier that simultaneously shifts how the referral is discussed with the patient and triggers the immediate need for structured local support to ensure the referral's success. Furthermore, looking towards future operational feasibility, training PCCs to use Bayesian nomograms integrated into electronic health records could eventually serve as an aspirational tool to help visualize how SDoH modify the actual benefit of a referral.[5] This approach transforms "subjectivity" into "calibrated judgment," ensuring that referrals are both technically accurate and ethically sound.

ACKNOWLEDGMENTS

The author declares that no AI tools were used during the preparation of this work.

CONFLICTS OF INTEREST

The author has no conflicts of interest to declare.

FUNDING SOURCES

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

REFERENCES

1. Fonseca M, Araújo N, Ruano L, Amorim M. Health professionals' perspectives on the referral process in mild cognitive impairment: facilitators, barriers, and solutions. Acta Med Port. 2025;38:699-707.
2. Schweda M, Kögel A, Bartels C, Wiltfang J, Schneider A, Schicktanz S. Prediction and early detection of Alzheimer's dementia: professional disclosure practices and ethical attitudes. J Alzheimers Dis. 2018;62:145-55.
3. Balsinha C, Iliffe S, Dias S, Freitas A, Grave J, Gonçalves-Pereira M. What is the present role for general practitioners in dementia care? Experiences of general practitioners, patients and family carers in Portugal. Dementia. 2021;20:1988-2006.
4. Acosta-Batista C. Beyond clinical skills: assessing prudent ethical competence for underserved populations. Can Med Educ J. 2026;17:113-5.
5. Brush DR, Schwartz A. Bayesian reasoning in primary care. BMJ. 2017;359:j5614.

Carlos ACOSTA-BATISTA [1]
1. Primary Care - Research Initiative (PCRI). Miami Lakes. Florida. United States of America.
✉ **Autor correspondente:** Carlos Acosta-Batista. carlos.acosta@pcri-research.org
Revisto por/*Reviewed by*: Ana Rita Santos Mendes
Recebido/*Received*: 02/01/2026 - **Aceite/*Accepted*:** 26/06/2026 - **Publicado/*Published*:** 01/09/2026
Copyright © Ordem dos Médicos 2026
https://doi.org/10.20344/amp.24450