Balancing Diagnosis Error and Conservative Care: Principles of Conservative Diagnosis

APRN 2018 Roundtable Rosemont IL 4/11/18

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Disclosures

Primary-care Research in Diagnosis Errors (PRIDE) Learning Network

Project funded by the Gordon and Betty Moore Foundation

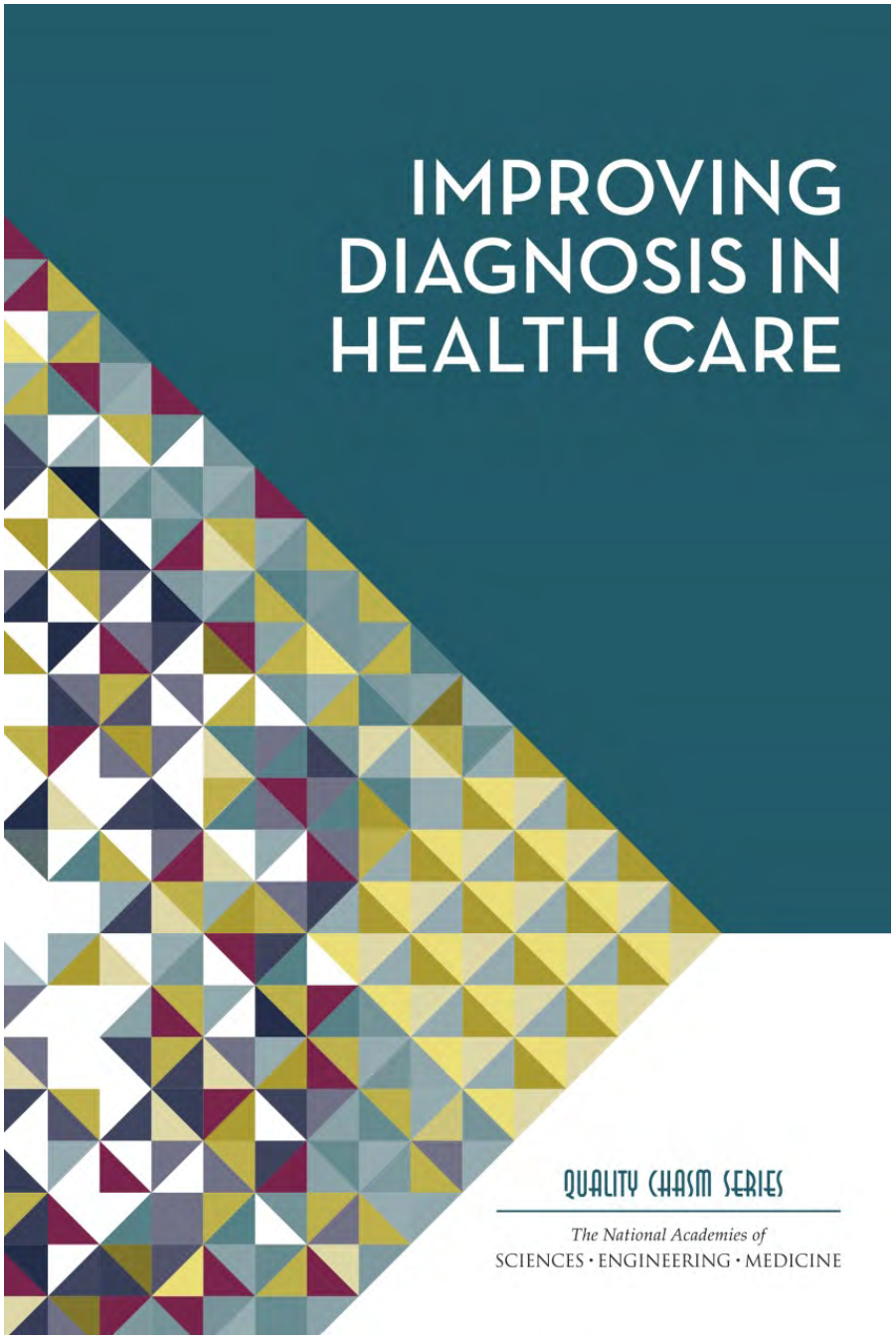
Learning Objectives

- Identify key issues that contribute to diagnosis error; brainstorm clinical and policy solutions.

- Illustrate new, more conservative/appropriate diagnosis paradigm embodied 10 Key Principles of Conservative Diagnosis," particularly as they apply to advanced practice nursing

Agenda

- Project Background/Overview
- Conservative Diagnosis: Why? What?
- Do you have “my back”
  - Gordy’s backpain
- Group discussion of ten principles
- Conclusions



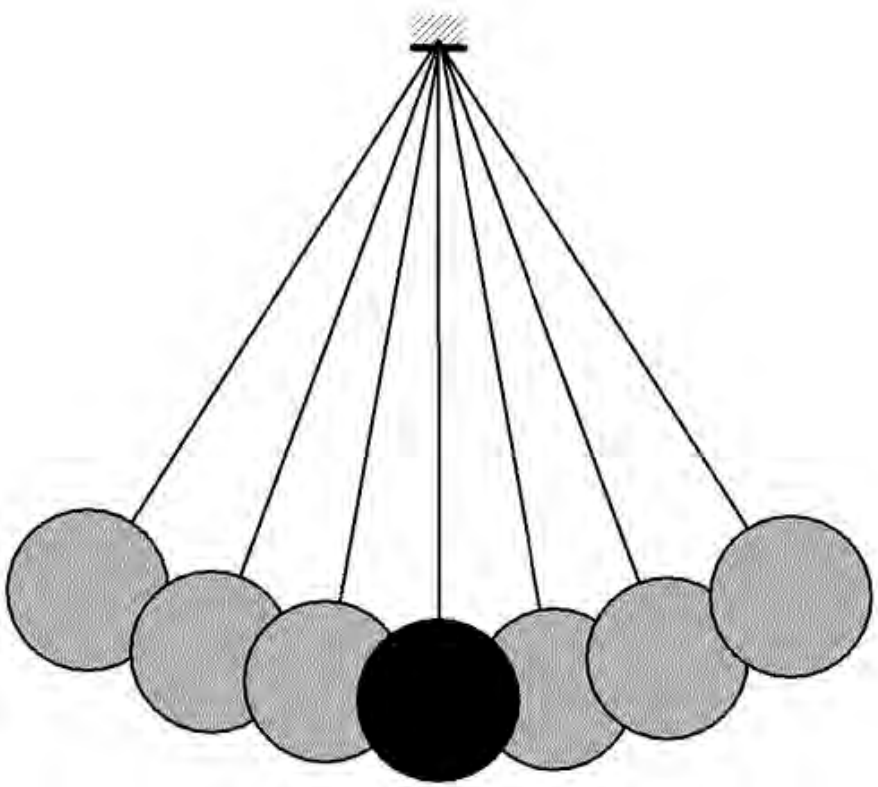
IOM Report
September
2015

Berwick, who also reviewed the report for the Institute, cited one crucial omission--the Committee decided not to address *over*-diagnosis, a diagnosis that is made that is not helpful to patients.

"They might not define that as an error," he says, "But I think the task of addressing over-diagnosis is critical."

US News and World Report 9/22/2015

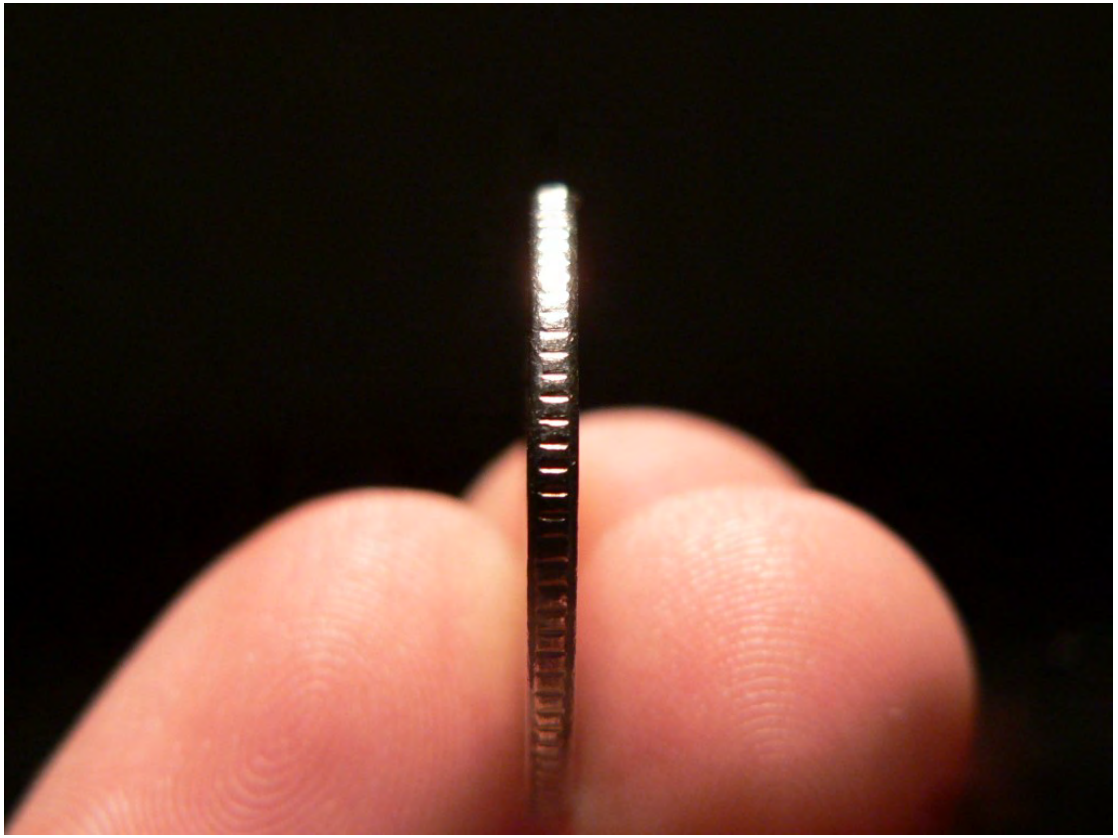
Trade-off Under vs. Over Diagnosis??



WSJ: *How can doctors avoid overdiagnosing and incurring unnecessary costs for overtesting?*

DR. SINGH: Doctors usually need to balance between ordering additional tests or procedures that often come with their own risks versus risking “underdiagnoses” by not investigating. There is so much national conversation now on overdiagnosis, overtesting, overtreatment and health-care costs. The midpoint of the pendulum is what we need to strive for, and that’s not going to be easy.

Diagnosis Errors and Over-diagnosis: Two Sides of Same Coin



What to Call This?
More…….Diagnosis

- Conservative Diagnosis
- Judicious “
- Mindful “
- Patient Centered “
- Shared “
- Listening “
- Relationship-based “
- Modest “
- Prudent “
- Caring “

- Realistic “
- Honest “
- Rational “
- Appropriate “
- Cautious “
- Skillful “
- Smarter “
- Effective “
- Safer “
- Optimal “
- Thoughtful “

Why Conservative Diagnosis

- Need general principles
  - Beyond just list of tests to avoid (eg Choosing Wisely)
- Need to do right thing for right reasons
  - Not about doing *fewer* tests,
    but *more appropriate* testing and better care
- Must be based on respect for clinical challenges, uncertainties, anxieties, and ways clinicians and patients can work together to improve care and outcomes.

JAMA®
The Journal of the American Medical Association

Promoting More Conservative Prescribing

Gordon D. Schiff, MD
William L. Galanter, MD, PhD

ALTHOUGH MEDICAL AND PHARMACY CURRICULA and journals are rich with information about drugs and treatment of specific diseases, there is a paucity of education on ways to become effective lifetime prescribers. Two recent reports from the Association of American Medical Colleges (AAMC) lamented the current state of pharmacology teaching[1] and the disturbing extent of pharmaceutical industry influence at all stages of medical education.[2] Given the well-documented prevalence of medication-related harm and inappropriate prescribing,[3,4] such educational reform is necessary but not sufficient to ensure that patients are optimally treated. Beyond improved training in pharmacology and minimization of unbalanced industry-sponsored education, trainees need guiding principles to inform their thinking about pharmacotherapy to help them become more careful, cautious, evidence-based prescribers.

In this Commentary, we offer 25 such principles (BOX), making no claims that they represent the definitive or comprehensive antidote to the many factors contributing to suboptimal prescribing. However, based on our experience educating physicians, pharmacists, and medical students, we believe these lessons are fundamental for teaching clinicians how to develop excellent prescribing skills, yet such fundamentals are absent or underemphasized in current medical and pharmacy education.

more skeptical approach to using drugs, prescribers will lack the will and the skills to resist ubiquitous promotional messages encouraging them to reach for newer and often more expensive medications.

Such skepticism needs to be grounded in historical and current lessons that offer reasons for precaution. Lessons from iatrogenic events related to agents such as thalidomide, phen-fen, or rofecoxib (Vioxx); recognition that new medications are tested in limited numbers of patients with few comorbidities, typically for a relatively short time; and disquieting revelations that promotional activities distort what prescribers learn about drugs[5] are lessons worth learning and incorporating into prescribing decision making. Although the attitudes and behaviors recommended in our principles should not be terribly controversial, taken together they represent a departure from current practice. If prescribers routinely heeded these principles, many patients could be spared the risk or expense of needless or harmful drug therapy.

Principles for More Conservative Prescribing

Think Beyond Drugs. More than learning to "just say no" to drugs, clinicians require confidence, time, evidence, and readily available options for alternate ways of helping patients. These include physical therapy, exercise, diet changes, counseling, stress reduction techniques, or even surgery where appropriate. Placing more emphasis on prevention will lead to a greater return for clinicians' investment of time and resources.

Practice More Strategic Prescribing. Smarter ap-

REVIEW ARTICLE

ONLINE FIRST | LESS IS MORE

Principles of Conservative Prescribing

Gordon D. Schiff, MD; William L. Galanter, MD, PhD; Jay Duhig, MA; Amy E. Lodolce, PharmD, BCPS; Michael J. Koronkowski, PharmD; Bruce L. Lambert, PhD

Judicious prescribing is a prerequisite for safe and appropriate medication use. Based on evidence and lessons from recent studies demonstrating problems with widely prescribed medications, we offer a series of principles as a prescription for more cautious and conservative prescribing. These principles urge clinicians to (1) think beyond drugs (consider nondrug therapy, treatable underlying causes, and prevention); (2) practice more strategic prescribing (defer nonurgent drug treatment; avoid unwarranted drug switching; be circumspect about unproven drug uses; and start treatment with only 1 new drug at a time); (3) maintain heightened vigilance regarding adverse effects (suspect drug reactions; be aware of withdrawal syndromes; and educate patients to anticipate reactions); (4) exercise caution and skepticism regarding new drugs (seek out unbiased information; wait until drugs have sufficient time on the market; be skeptical about surrogate rather than true clinical outcomes; avoid stretching indications; avoid seduction by elegant molecular pharmacology; beware of selective drug trial reporting); (5) work with patients for a shared agenda (do not automatically accede to drug requests; consider nonadherence before adding drugs to regimen; avoid restarting previously unsuccessful drug treatment; discontinue treatment with unneeded medications; and respect patients' reservations about drugs); and (6) consider long-term, broader impacts (weigh long-term outcomes, and recognize that improved systems may outweigh marginal benefits of new drugs).

Arch Intern Med. 2011;171(16):1433-1440.
Published online June 13, 2011.
doi:10.1001/archinternmed.2011.256

In striving to relieve suffering and prolong life, we often turn to medications. Drugs are the therapy physicians most fre-

messages and interests of the pharmaceutical industry, but there is an alternate paradigm that represents a radical shift in pre-

HARVARD MEDICAL SCHOOL

Harvard Health Letter

VOLUME 34 • NUMBER 8 | JUNE 2009

The principles of conservative prescribing

No matter what your politics, a conservative approach to medications is a good idea.

The old, jokey line was "take two aspirins and call me in the morning." But, of course, doctors prescribe a lot more than just aspirin these days. The medicine cabinet is crammed full: cholesterol-lowering statins, stomach acid–reducing proton-pump inhibitors, antidepressants, asthma drugs, diabetes drugs, sleeping pills, hormones. The amount of money that Americans spent on prescription drugs tripled between 1997 and 2007, although growth in our collective "pill bill" has slowed recently for many reasons (see sidebar on next page).

People who genuinely need medications should take them; indeed, getting

effects shouldn't be a concern? But saying and doing often diverge. Besides, the hope here is that by laying out a few principles, in contrast to a long list of dos and don'ts, a better balance between the risks and benefits (and costs) of taking drugs might be found.

1. *Consider alternatives to medication*

It's understandable that people want to leave the doctor's office with a prescription. A prescription sends the message that the doctor believes you've got a real illness—and, better yet, that there's something that can be done about it. But playing to this psychology can mean

that nondrug alternatives get

There's a lot of switching from one drug to another. Or people start taking several drugs all at the same time.

A more cautious, step-by-step approach can help you—and your doctor—figure out what's working, what's not, and whether certain medications might be causing undue side effects.

Dr. Schiff also has a somewhat contrarian view of individualizing therapy, which ordinarily is seen as something to strive for. In his opinion, individualizing therapy can sometimes (not always, by any means) amount to a blank check to try all sorts of treatments that stand very little chance of working based on the evidence from clinical

Conservative Diagnosis Principles

Combining

- Fundamentals of good diagnosis
  - Need for differential diagnosis
  - Listening to patient; obtaining good history
  - Careful exam
  - Need to match syndrome to findings
  - Understanding limitations diagnostic tests
  - Avoiding known biases
    - Premature closure, availability, hindsight
  - Bayesian probability weighing

With 4 Critical Paradigms….

- Precautionary Principle
  - Shifting burden of proof for new technology
  - Alternative to “risk-benefit” paradigm
- Primary care principles
  - Continuity of care, caring relationships
  - Lessons from evaluation of common symptoms
  - Teamwork
- Key patient safety lessons
  - Situational awareness of pitfalls
  - Safety nets to mitigate inevitable error, harm
  - Culture of safety (learning, systems, avoid blame)
- Critique of market medicine, mindset
  - Healthy skepticism (to counter biases favoring overuse)
  - Longer Term time horizons

"Precautionary principle" is a translation of the German *Vorsorgeprinzip*. *Vorsorge* means, literally, "forecaring." It carries the sense of foresight and preparation—not merely "caution."

When an activity raises threats of harm to human health or the environment, precautionary measures should be taken even if some cause and effect relationships are not fully established scientifically.

Wingspread Statement's definition

Placing the *burden of proof* on proponents of an activity

Erring on side of precaution rather than disrupting natural ecosystems

Exploring *alternatives* to possibly harmful interventions

Worrying, intervening at social and environmental causes of disease

Setting and working toward public health and longer term *goals*

More participation, *transparency* for decisions affecting health

- Precautionary Principle
  - Shifting burden of proof for new technology
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Walking Through A Real Time Personal Case *Against* Conservative Diagnosis Gordy's Severe, Radicular Back Pain

It is now agreed that, except under the circumstances of obvious structural pathology amenable to surgical intervention, conservative care is the initial treatment of choice for low back pain

Rosen N, Hoffberg H. Conservative management oflow back pain. Physical Medicine and Rehabilitation Clinics of North America 1998;9:435-72

Imaging Tests for Lower-Back Pain

You probably do not need an X-ray, CT scan, or MRI

DOWNLOAD PDF

X-rays, CT scans, and MRIs are called imaging tests because they take pictures, or images, of the inside of the body. You may think you need one of these tests to find out what is causing your back pain. But these tests usually do not help. Here's why:

The tests will not help you feel better faster.
Most people with lower-back pain feel better in about a month, whether or not they have an imaging test.

People who get an imaging test for their back pain do not get better

CR ConsumerReports

AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

ADVICE FROM CONSUMER REPORTS

How to treat lower-back pain

Many people get over lower-back pain in just a few weeks by following these self-care steps:

IMAGING FOR NONSPECIFIC LOW BACK PAIN

All 5 Clinical Societies recommend against use of imaging

Evidence Justification

Five clinical specialty societies recommend against the use of imaging for nonspecific low back pain. We summarize the reasoning provided by the clinical societies to justify the inclusion of this service, including assignment of this service into one of 5 evidentiary categories of "wasteful" services arising from the evidence on benefits, risks, and costs (Gliwa, 2014).

American Academy of Family Physicians
Don't do imaging for low back pain within the first six weeks, unless red flags are present.

American Association of Neurological Surgeons and Congress of Neurological Surgeons
Don't obtain imaging (plain radiographs, magnetic resonance imaging, computed tomography [CT], or other advanced imaging) of the spine in patients with nonspecific acute low back pain and without red flags.

American College of Occupational and Environmental Medicine
Don't initially obtain X-rays for injured workers with acute nonspecific low back pain

American College of Physicians
Don't obtain imaging studies in patients with nonspecific low back pain

North American Spine Society
Don't recommend advanced imaging (e.g., MRI) of the spine within the first six weeks in patients with nonspecific acute low back pain in the absence of red flags.

My Back Pain

*Choosing **Wisely*** or ...*Imposing **Miserly** Rules*

- Dismissive-
  - No need to be seen; nothing much to do
  - Just take NSAIDs and refer to PT
  - Don't you know how much I'm suffering
- What is "*nonspecific*" low back pain
  - How do we know not structural lesion
  - How good is exam in differentiating
  - Isn't nerve root symptoms a "red flag"
- Don't treatments differ depending on Dx?
  - If you are uncertain, why not know
- Isn't earlier vs. delayed Dx/Rx better?
  - Keeping acute pain from becoming chronic
  - How do you know it's not cancer?

My Back Pain
*Choosing **Wisely*** or ...*Imposing **Miserly** Rules*

- Why isn't care from specialist/expert better
- Do your exercises
  - Your own fault if don't/can't
- "Yellow flags"
  - Psychologic factors that drive outcomes
- Just focused on curbing costs
  - PCP monitored, incentivized on MRI for LBP
  - Back to work, avoiding disability claims central themes
- Guidelines -arbitrary, one-size-fits-all rules
  - What is evidence for 6 wk cutoff
  - > 50 y.o. vs. 25 y.o.
- Left on my own to learn from others

Walking Through Selected Conservative Dx Principles

Ten Principles

1. Promoting a New Model for Caring
2. Developing a New Science of Uncertainty
3. Rethinking symptoms
4. Maximizing Continuity and Trust
5. Taming time
6. Linking Diagnosis to Treatment
7. Tests: More Thoughtful Ordering and Interpreting
8. Safety Nets: Incorporating Lessons from Diagnosis Errors
9. Addressing Cancer: Fears and Challenges
10. Transforming Specialists and ED Physicians into Conservative Diagnosis Stewards

"Listen to your patient, he is telling you the diagnosis"

---Osler

I. Promoting a New Model for Patient "Caring"

1. Shift construct what it means to be thorough, attentive, cautious, careful, caring
2. Moving from "ordering lots of tests" as conception of thoroughness and taking concerns seriously
3. Center more on pt--concerns, outcomes, potential for benefit, harms-- rather than on diagnostic label
4. Hearing & engaging pt; recognition of pt's role in "co-production" of diagnosis
5. Hearing what matters most: fears, plans, impacts
6. Engaging pts in monitoring, reliable follow-up for safety net to enable practice of conservative dx
7. More meaningful shared decision-making

II. Developing a New Science of Uncertainty

1. Recognize, respect, master, become more comfortable w/ uncertainties, challenges, ambiguities
2. Collectively, as well as individual clinicians and patients
3. Appreciation of associated patient and provider anxieties
4. Redesigning care around these insights- systems for feedback and follow-up as key safety nets

III. Rethinking symptoms

1. Integrating evidence from studies on common sx - most outpatient encounters are for nonspecific sx
2. Recognition that many (even majority) of symptoms defy definitive medical diagnosis
3. Symptoms often self-limited (regardless of whether or not able to be explained)
4. Growing prevalence multiple unexplained somatic sx overlapping with “non medical” (psych, other) sx
5. Thus classification, evaluation, and management of common sx needs to be redefined, emphasizing organic causes may be inadequate; search for linkage to social etiologies warranted

Kurt Kroenke, M.D., Indiana University School of Medicine

Common symptoms in ambulatory care: incidence, evaluation, therapy, & outcome

- 14 common complaints, 1000 pts
- Total 567 new sx: chestpain, dizziness, fatigue, headache, edema, back pain, dyspnea, insomnia, abdominal pain, numbness, impotence, weight loss, cough, and constipation were noted, with 38 percent of the patients reporting at least one symptom
- Diagnostic testing performed in 2/3
- Organic etiology only 16%

Kroenke Am J Med. 1989

- “The classification, evaluation, and management of common symptoms need to be refined. Diagnostic strategies emphasizing organic causes may be inadequate”

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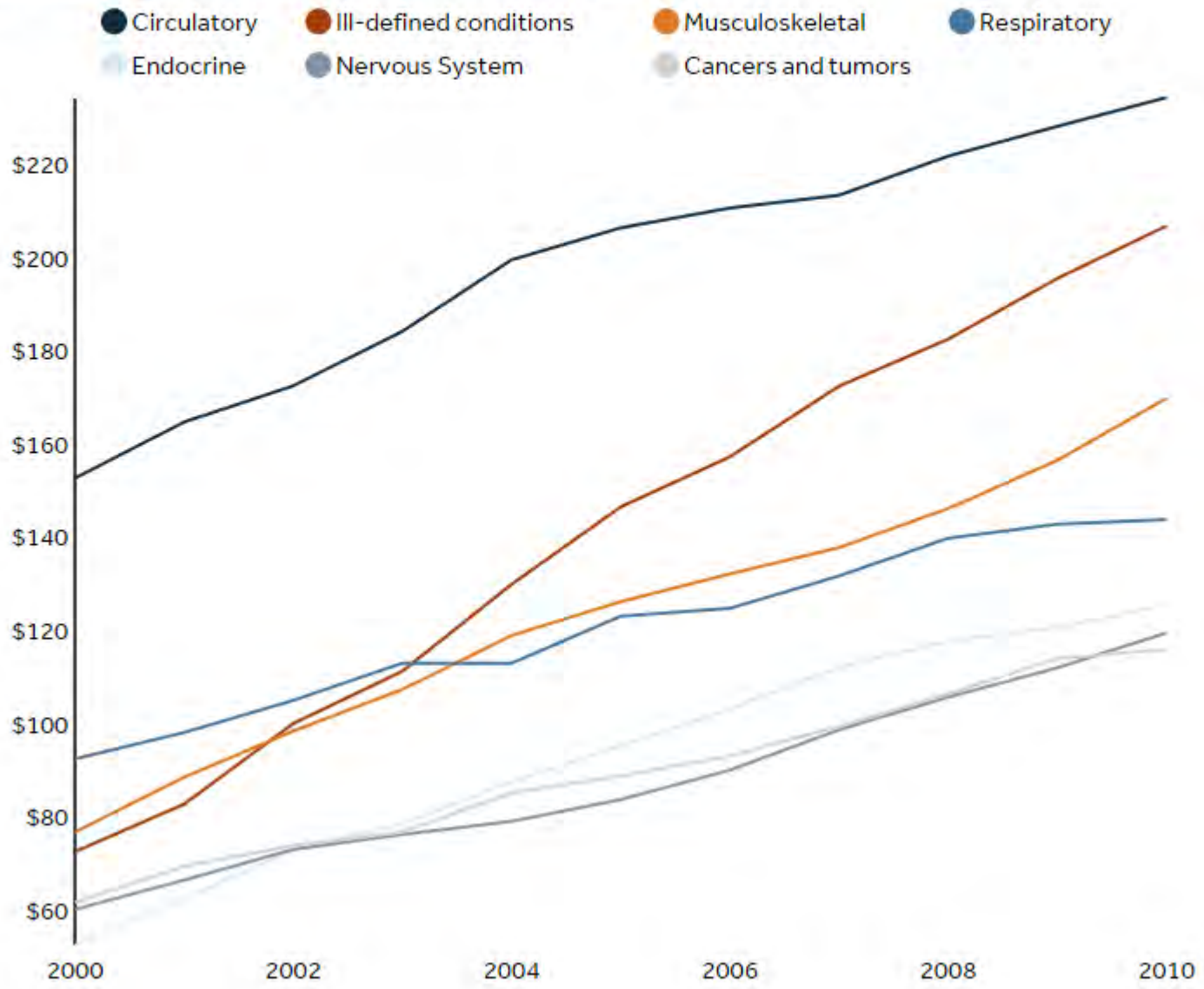
Kroenke Am J Med. 1989

varying rates

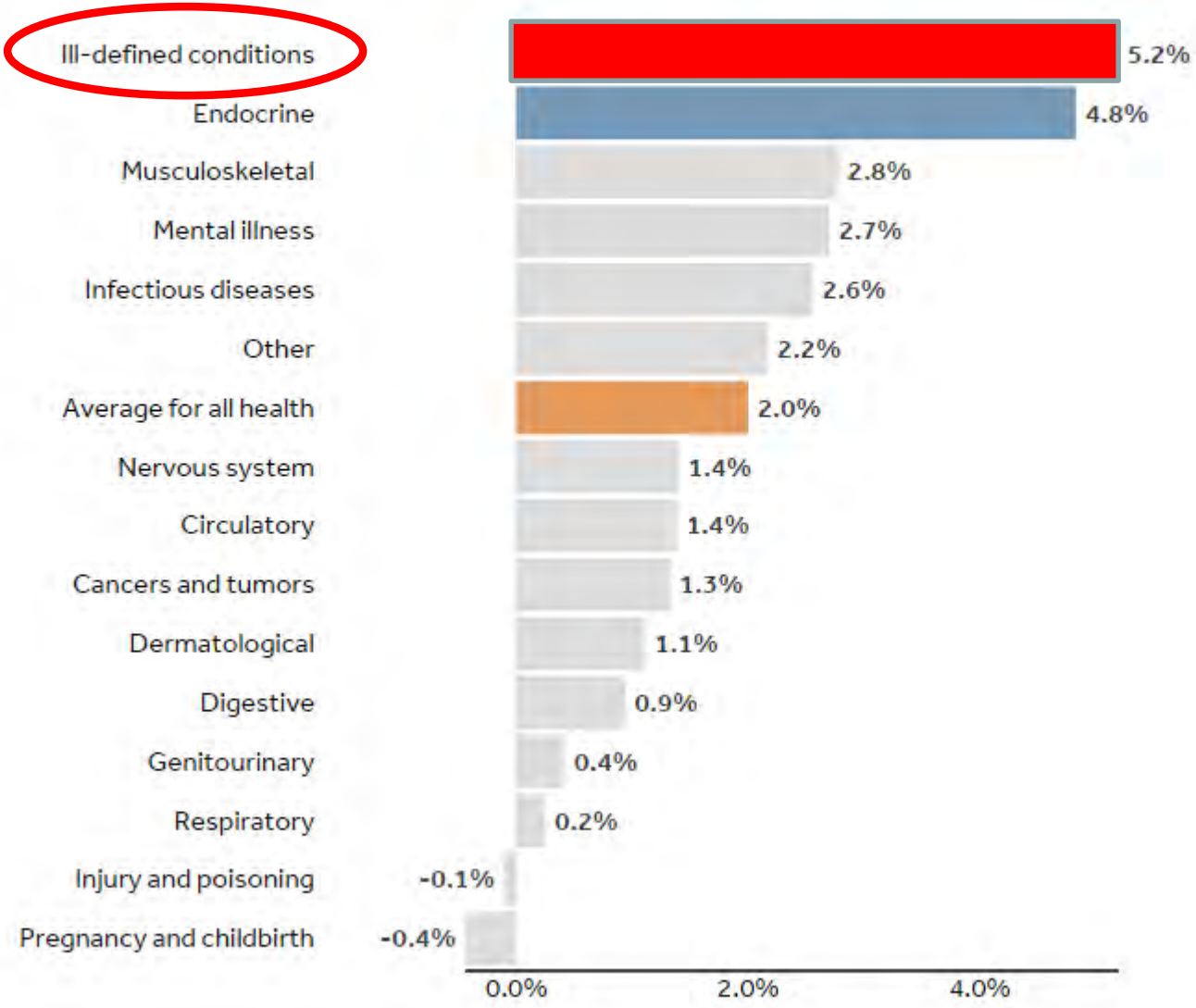
Total expenditures in $ billions by disease category, 2000 - 2010



Source: Bureau of Economic Analysis Health Care Satellite Account (Blended Account) Note: Expenditures on nursing home and dental care are not included in health services spending by disease.

conditions and endocrine disorders

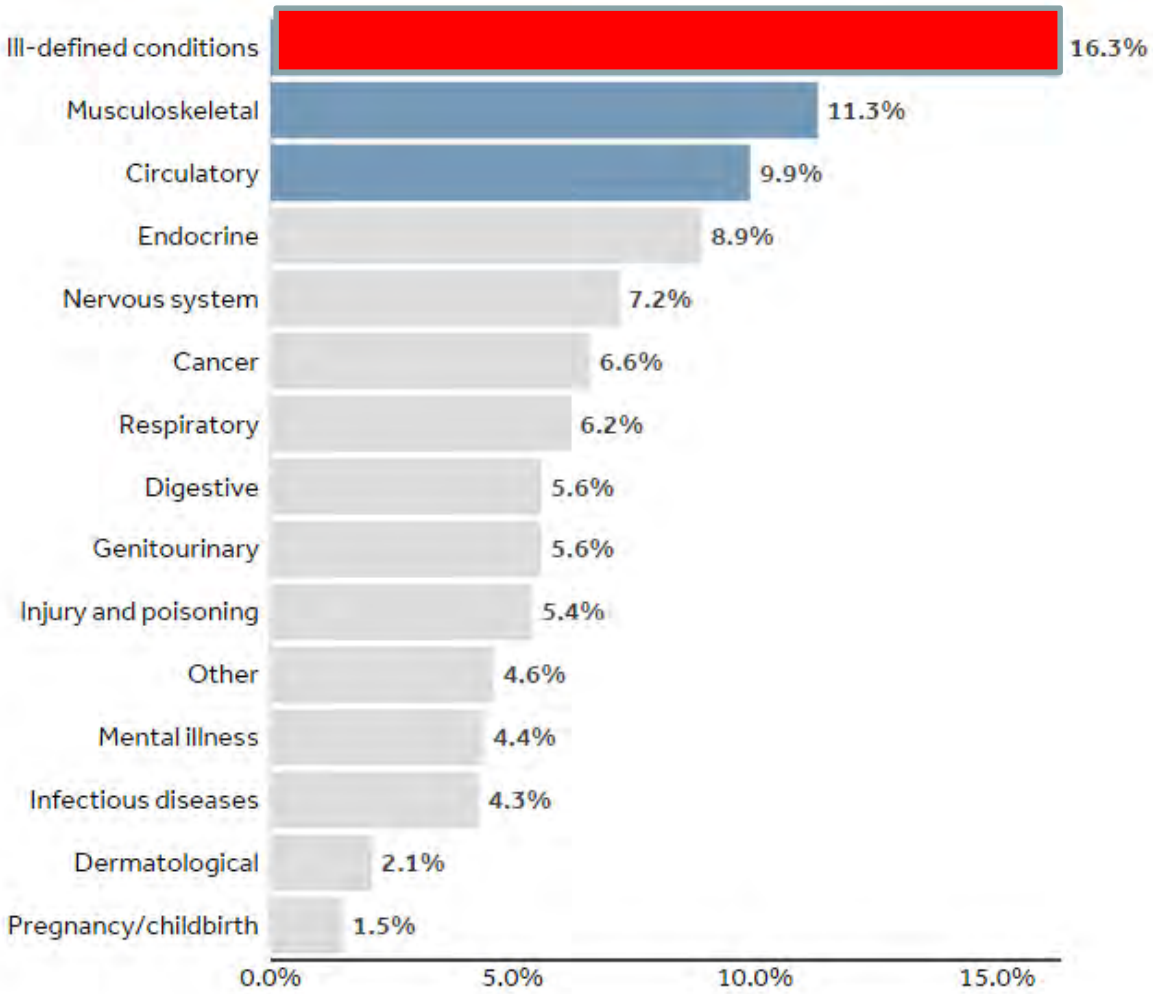
Average annual increase in real expenditures by disease category, 2000 - 2010



Source: Bureau of Economic Analysis Health Care Satellite Account (Blended Account)

About a third of medical services cost growth was from ill-defined, musculoskeletal, and circulatory conditions

Contribution to medical services expenditure growth, by disease, 2000 - 2010



IV. Maximizing Continuity and Trust

1. Continuity, longer term, trusting, relationships
2. Longitudinal primary care relationships-foundation building better, conservative diagnosis
3. Informational continuity – to avoid needless repeat work-ups
4. Shared decision-making partnerships
5. Trusting non-conflicted relationships require *financial neutrality* of clinical decision-making
6. Avoiding incentives to order more tests (imaging in offices); as well avoiding rewards for ordering fewer tests as they poison conversation, trust, create conflicts of interest with patients.
7. Easy access if ongoing concerns/worsening (even including MD/NP cell phone) for reliable follow-up, is key

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V. Taming Time

1. Adequate time for clinical encounters; better use of time; shifting to longer horizons
2. Weighing medium and longer term outcomes (benefits; risk) rather than just shorter term focus
3. Designing more efficient encounters based on process redesign and optimized teamwork
4. Engineer watchful waiting into common dx situations
5. Systematic, reliable vs current ad hoc f/up, monitoring
6. Understanding when early definitive diagnosis represents best/most conservative strategy
7. Better matching pt's course with known evolution and expected response to treatment

VI. Linking Diagnosis to Treatment

1. Waltz between diagnosis & treatment; limited value dx don't change rx, or where no effective treatment exists
2. Though recognize/acknowledge/balance other benefits of dx (avoiding needless rx, reassurance, prognosis)
3. Targeting high risk patients and diseases; Identifying pt at increased risk, or dx requiring urgent treatment
4. Coupled with restraint in low risk, non-urgent situations
5. Understanding, measuring, weighing *marginal benefit* of various strategies
6. Incorporating population-based perspectives

VII. Tests: More Thoughtful Ordering and Interpreting

1. Especially in low prevalence/probability situations. Bayes/predictive value +, - for beginners/masses
2. Appreciating surprisingly high testing error rates
3. Suboptimal/errors test choice, sequencing, performance, interpretation
4. Recognizing (often hidden) harms from testing: radiation, procedures' harm, excess anxiety, cascades
5. Distraction from more beneficial activities
6. Parallel vs. serial testing
7. Role of testing in creating "overdiagnosis" (this is not simply false + tests)
8. Understanding how tests tested, approved, marketed; limited rigorous testing; commercial biases

BMJ Quality & Safety Online First, published on 21 September 2013 as 10.1136/bmjqs-2013-00242

Diagnosis and diagnostic errors: time for a new paradigm

Gordon D Schiff

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Received 22 August 2013
Accepted 22 August 2013

It looks like diagnosis triggers may be gaining traction. Building on their earlier efforts,[1 2] a team of investigators based in Houston reports on their latest effort to apply electronic screens—so called 'triggers'—to large clinical databases, to identify cases of potential diagnostic errors.[3] They searched nearly 300 000 patients' records over a 12-month period at two large health systems with comprehensive electronic health records. They sought patients who had one of four 'red flag' findings for prostate or colon cancer—elevated prostate specific antigen (PSA), positive fecal occult blood test (FOBT), rectal bleeding (haematochezia), and iron deficiency anaemia. They then used a refined electronic algorithm to cull out patients who (1) were already known to have prostate or colorectal cancer, or (2) had evidence of appropriate follow-up did not. Since there is no reason to believe their findings are not broadly representative of ambulatory care in general (and the fact that both the institutions had advanced electronic systems should, in theory, put them in a better position for reliable follow-up than those lacking such capability);, the findings mean that healthcare diagnosis, as measured by this one metric at least, is a long way from *six-sigma* quality (defined as one defect per 3.4 million). This study's rate translates into roughly 13 600 defects per 3.4 million patients. While one could quibble with some of the arbitrary cut-off intervals chosen for this study—a colonoscopy 61 days after a positive FOBT was failed care, whereas, one after 59 days was not; similarly with 91 vs 89 days for follow-up of an elevated PSA—the study unquestionably highlights undesirable delays that

VIII. Safety Nets: Incorporating Lessons from Diagnosis Errors

1. Patient safety-–applying lessons; safety culture: understanding systems; blame-free accountable care
2. ↓ reliance on memory for remembering to ask key questions, considering/weighing diagnoses
3. Anticipating where safety fails: processes and handoffs; reliable systems trump brilliant dx
4. Situational awareness: learning from failures
5. Transparency to uncover, facilitate learning from errors; to build/reinforce trust and collaboration
6. Defining, being on look-out, hard wiring prevention of diagnostic pitfalls; don't miss diagnoses/red flag situations

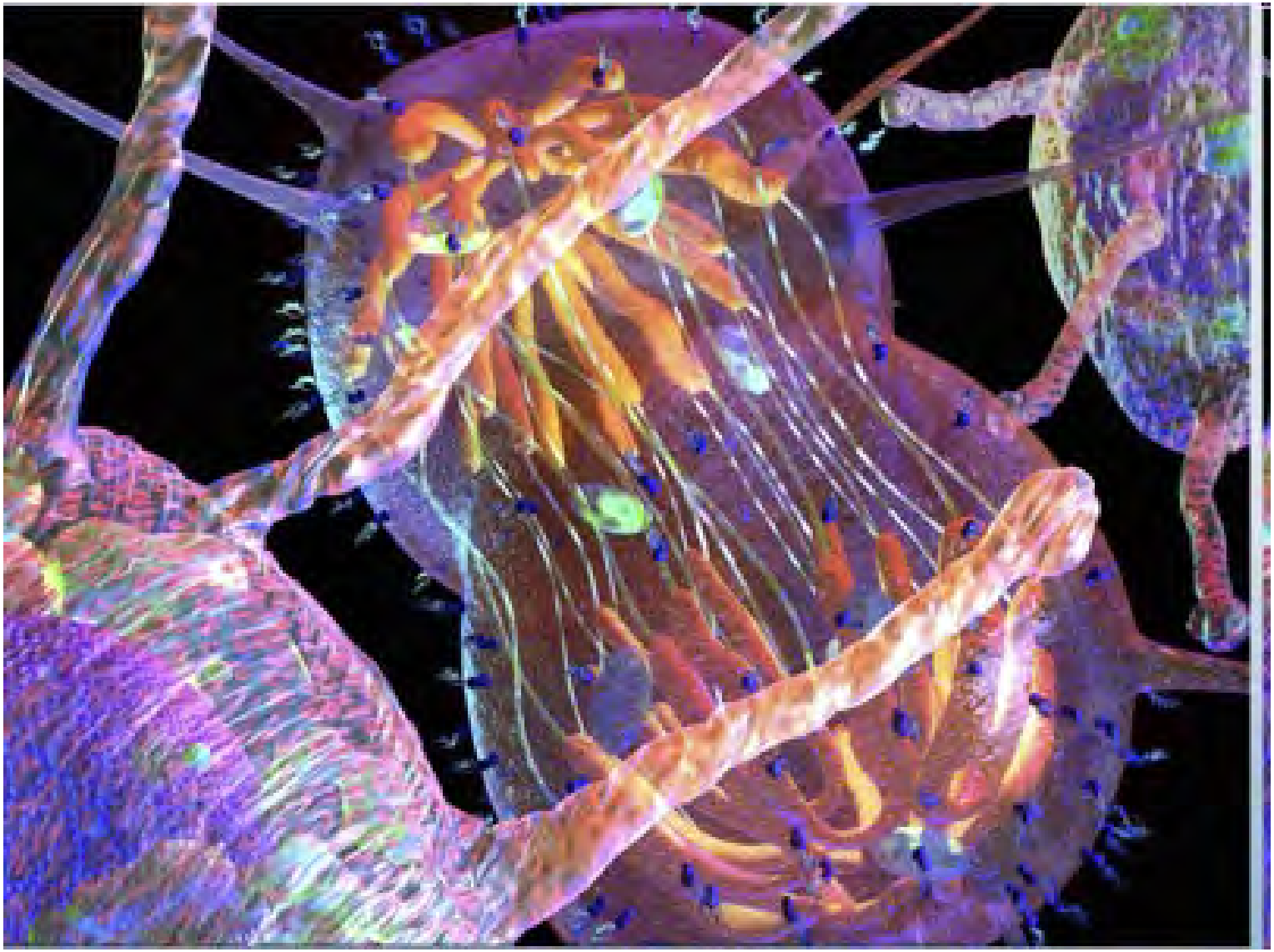
What is a **Diagnostic Pitfall**?

Clinical situations where patterns of, or vulnerabilities to errors leading to missed, delayed or wrong diagnosis

IX. Addressing Cancer: Fears and Challenges

1. Recognize that never diagnosed at moment 1st abnormal cell mitosis
2. Easily overlooked since can present with virtually any symptom, and any symptom can be cancer
3. Leading malpractice allegation– delayed cancer dx; further complicates
4. Cancer fears; developing new ways to address understandable dread
5. “Early diagnosis” central to paradigm, though not always true, possible, or shown to be worthwhile in various dx
6. Making more productive: upstream & downstream interventions


CANCER
BREAST
METASTASIS
SMOKING
LUNG
CELL
TUMOR
COLON
DOCTOR
BIOPSY
TOBACCO
COLONOSCOPY
CHILDREN
INSTITUTE
ULTRASOUND
HOPE
CURE
BONE
PAP TEST
TRANSPLANTATION
THROAT
BLOOD
LEUKEMIA
HEALTH
RESEARCH
CERVIX
CHEMOTHERAPY
BRAIN
LIFE
OPERATION
SCIENCE
DANGEROUS
SEDIMENTATION
THERAPY
MARKER
BODY
RNA
CARCINOGEN
PATHOLOGIST
LABORATORY
RADIOLOGY
TOMOGRAPHY
APPREHENSION
MALIGNANT
DRUG
ADULT
PROSTATE
ENDOSCOPY
LIVER
ATTENTION
REPORT
CARCINOMA
CYST
RESECTION
HOSPITAL
DEFINITION
UTERINE
EARLY DIAGNOSIS
SYNDROME
HORMONES
RADIOLOGIST
THORACOSCOPY
CHEMICAL
SERUM
CLOT
SARCOMA
CAUSE
THERMOGRAPHY
DNA
PANIC
TEST
X-RAY
POLYPS
RADIOTHERAPY
LYMPHOMA
RISK
LESION
ALOPECIA
VAGINAL
PILLS
BARIUM
HEMATOLOGY
TOXIN
ORGANS
ILL
RADIATION
SKIN
MAMMOGRAM
ACHE
ONCOLOGY
SURGERY
FEAR
MEDICINE
VULVA



The New York Times

Opinion

WORLD | U.S. | N.Y. / REGION | BUSINESS | TECHNOLOGY | SCIENCE | HEALTH | SPORTS | OPINION

The Great Prostate Mistake

By RICHARD J. ABLIN
Published: March 9, 2010

Tucson

Enlarge This Image

EACH year some 30 million American men undergo testing for prostate-specific antigen, an enzyme made by the prostate. Approved by the Food and Drug Administration in 1994, the P.S.A. test is the most commonly used tool for detecting prostate cancer.

The test's popularity has led to a hugely

The test's popularity has led to a hugely expensive public health disaster. It's an issue I am painfully familiar with — I discovered P.S.A. in 1970.

As Congress searches for ways to cut costs in our health care system, a significant savings could come from changing the way the antigen is used to screen for prostate cancer.

So why is it still used? Because drug companies continue peddling the tests and advocacy groups push “prostate cancer awareness” by encouraging men to get screened. Shamefully, the American Urological Association still recommends screening, while the National Cancer Institute is vague on the issue, stating that the evidence is unclear.

I never dreamed that my discovery four decades ago would lead to such a profit-driven public health disaster. The medical community must confront reality and stop the inappropriate use of P.S.A. screening. Doing so would save billions of dollars and rescue millions of men from unnecessary, debilitating treatments.

Prostate Cancer Early Detection

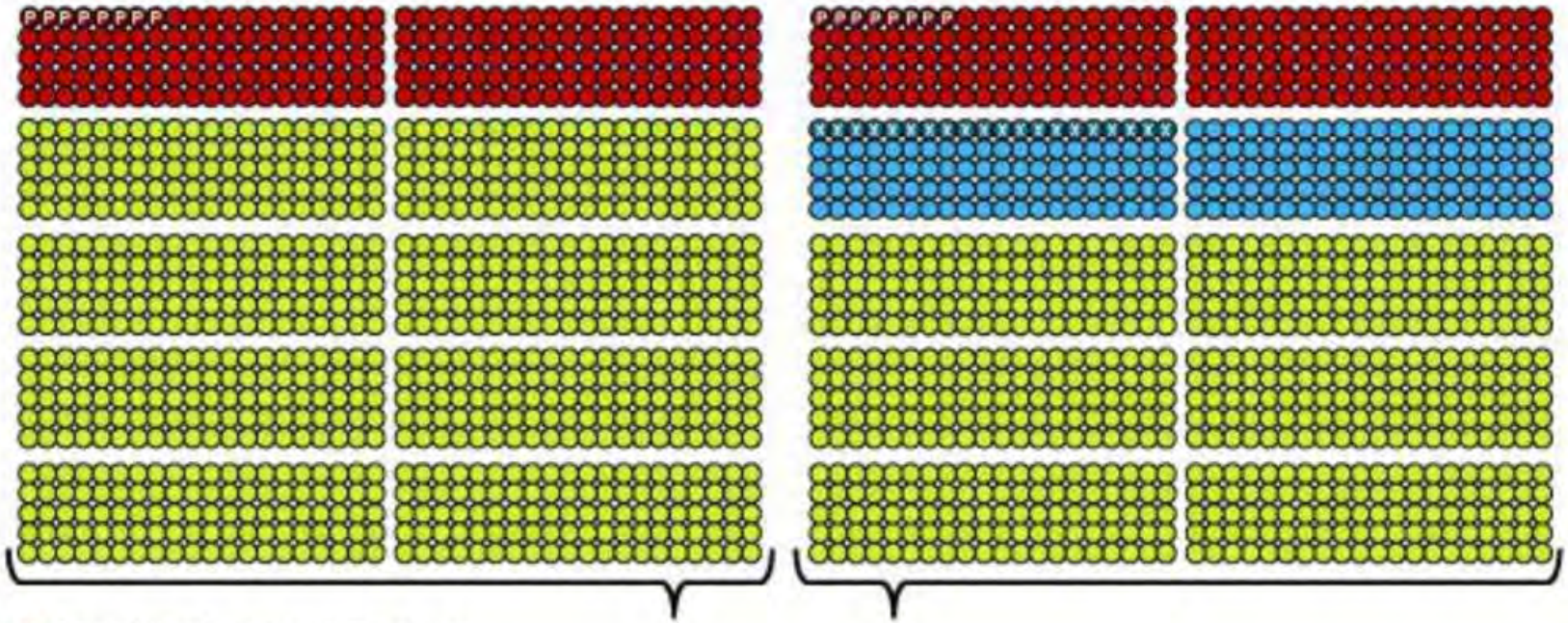
HARDING CENTER FOR RISK LITERACY

by PSA screening and digital-rectal examination.

Numbers are for men aged 50 years or older, not participating vs. participating in screening for 10 years.

1,000 men without screening:

1,000 men with screening:



	1,000 men without screening:	1,000 men with screening:
Men dying from prostate cancer:	8	8
Men dying from any cause:	200	200
Men that were diagnosed and treated for prostate cancer unnecessarily:	–	20
Men without cancer that got a false alarm and a biopsy:	–	180
Men that are unharmed and alive:	800	600

X. Transforming Specialists and ED Physicians into Conservative Diagnosis Stewards

1. Role of specialists as drivers of non-conservative dx; re-engineer roles as stewards for conservative dx
2. Growing #s ED visits; US has worst after hours 1^{o} care access of any nation
3. Understanding imperatives/special nature of diagnosis in ED: need to exclude urgent diagnosis
4. Poor knowledge and often unreliable f/up of pt as drivers; build in ways to offset

Misguided approaches

- High deductible, co-pay, coinsurance, multi-tier
  - "Skin in the game" false formulation
- Utilization review/prior authorization
- Blame patients for anxieties
- Blame physicians for uncertainties
  - Diagnosis uncertainties
  - Lack clarity/evidence about indications
- Cutting access, time w/ MD, blocking consults
- Malpractice caps

- Most countries found that bringing cost into the discussion diminishes both physician and patient engagement.

  However, the financing in different countries may diminish how the message is received; for example in some countries, the concept of value or waste reduction many be acceptable or desirable to the public.

Levinson, Choose Wisely Working Group BMJ QSHC 2015

HealthAffairs
At the Intersection of Health, Health Care and Policy

RATIONING

Muddling Through Elegantly: Finding The Proper Balance In Rationing

Explicit rationing at the clinical level is likely to cause more harm than good.

BY DAVID MECHANIC

THE INCREASING TENSIONS between the possibilities of medical intervention and the need for economic constraints place the rationing of health care squarely on the agendas of most nations. Although medical care has always been rationed by the location and availability of practitioners and facilities and by the ability to pay for care, we are clearly entering a new era in which it is more difficult to balance the possibilities of medicine and public expectations against the willingness to finance them.

■ **Levels of decision making.** Rationing is always a blend rather

COMMENTARY

Conclusions

- Conservative diagnosis- first and foremost a way of respecting patients, our limits
- Not fundamentally about saying no to people
  - Can't ignore legitimate fears, uncertainties
- Rather it is saying yes -enabling helping, supportive worrying, safety nets
- Creating new science of collaboration around uncertainty
- Rather than less is more…More is less
  - More support for pt; more careful watching, more hearing from patient, more understanding of tests, more focused testing, more worry-free lives, and diagnostic fewer errors

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