CHOOSE WISELY

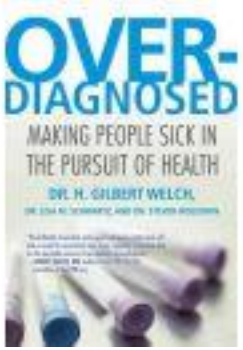
A COUNCIL OF MEDICAL COLLEGES IN NEW ZEALAND CAMPAIGN
and part of Choosing Wisely work internationally.

"Rationalising and Reinvestment, not rationing"
Sustainability in the health system

www.choosingwisely.org.nz

Dr John Bonning – Emergency Physician
President-Elect ACEM
Chair CMC

Over diagnosis



- Making people patients unnecessarily by identifying issues that were never going to cause them harm, or by (unjustified) over-medicalisation of ordinary life experiences through expanded definitions of disease #PODC2018
- Diagnosing people with “disease” that would otherwise not have been detected during their lifetime had the test/screening not been undertaken
- Incidentalomas initiating a diagnostic/intervention cascade
- *Primum non nocere*

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Choosing Wisely Canada

Choosing Wisely Australia

An initiative of NPS MedicineWise

Choosing Wisely

An initiative of the ABIM Foundation

ChoosingWisely UK

About Clinicians Patients & Carers Contact

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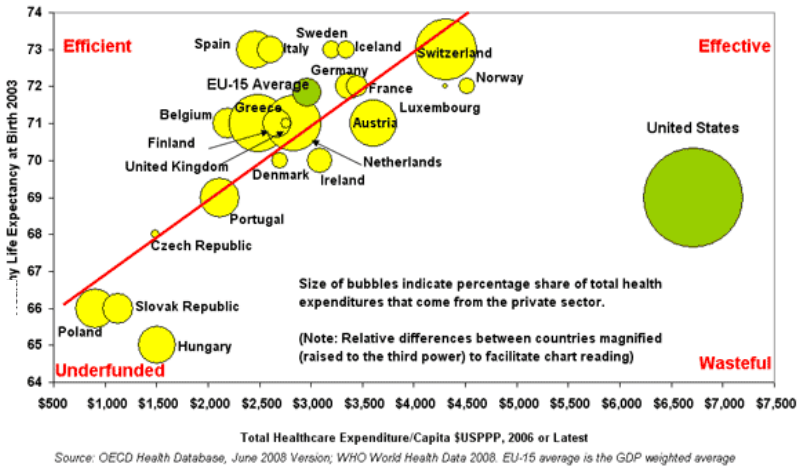
Launched in 2012 in response to increasing evidence of over utilisation of health care in the US

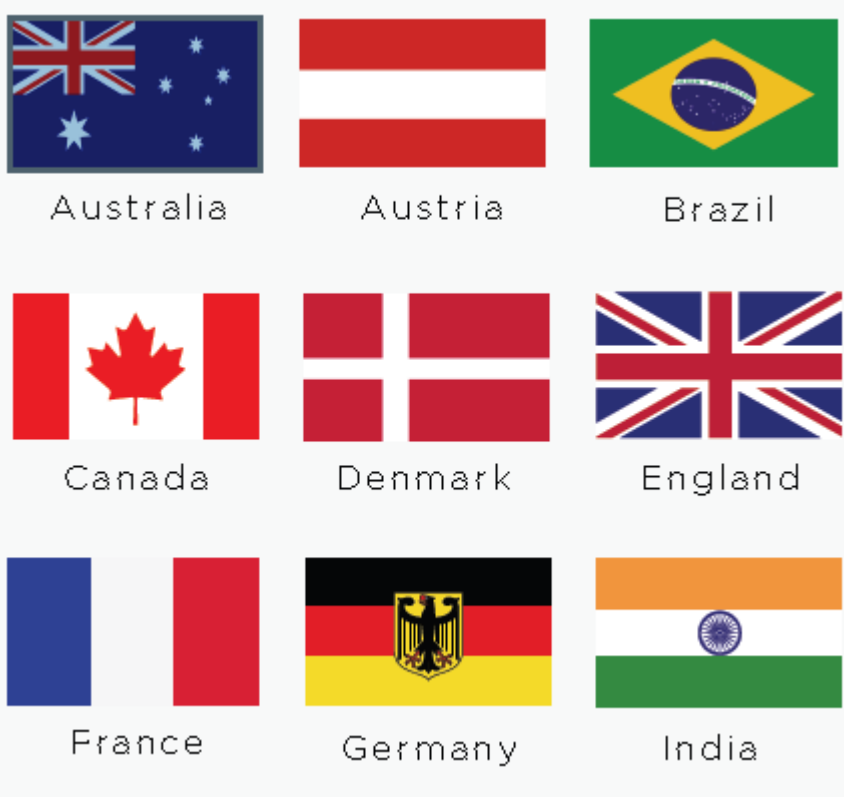
- Consumer engagement
- Healthcare quality
- Eliminating unnecessary TTPs
- Reduce over-diagnosis

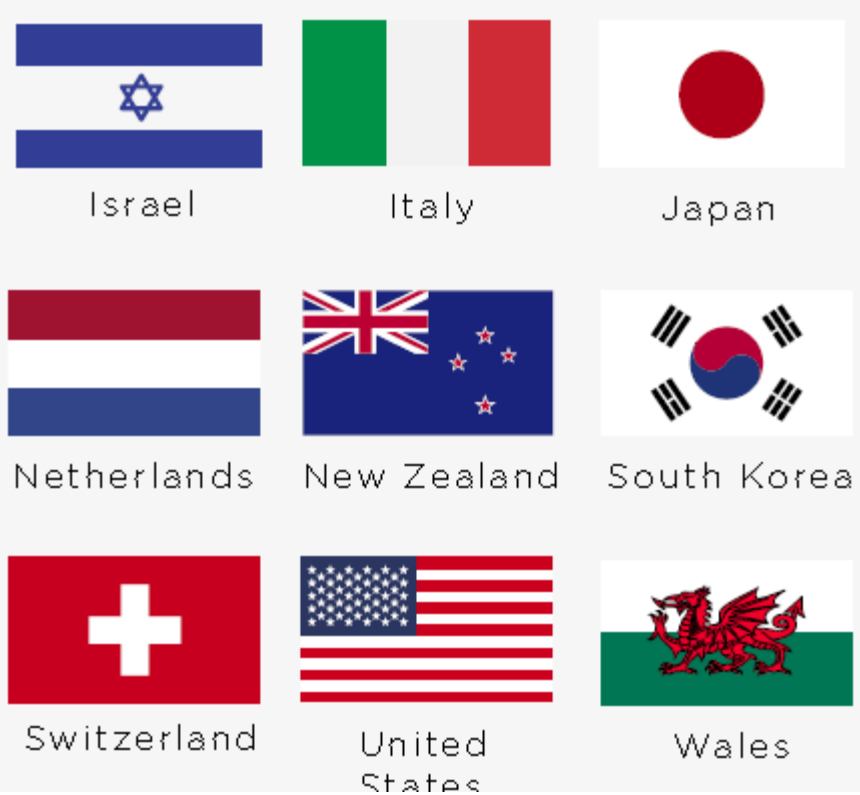
Figure 1: Healthy Life Expectancy Total Population and Total Healthcare Expenditure/capita, 2003/2006



Source: OECD Health Database, June 2008 Version; WHO World Health Data 2008. EU-15 average is the GDP weighted average

Part of an international campaign – now >20 countries





Choosing Wisely

- More is not always better
- Rationalising, not rationing
- Resource stewardship
- Reinvesting in better value healthcare
- Clinician-lead, patient-focussed

Choosing Wisely Alberta | Choosing Wisely Canada

Patient Poster Campaign

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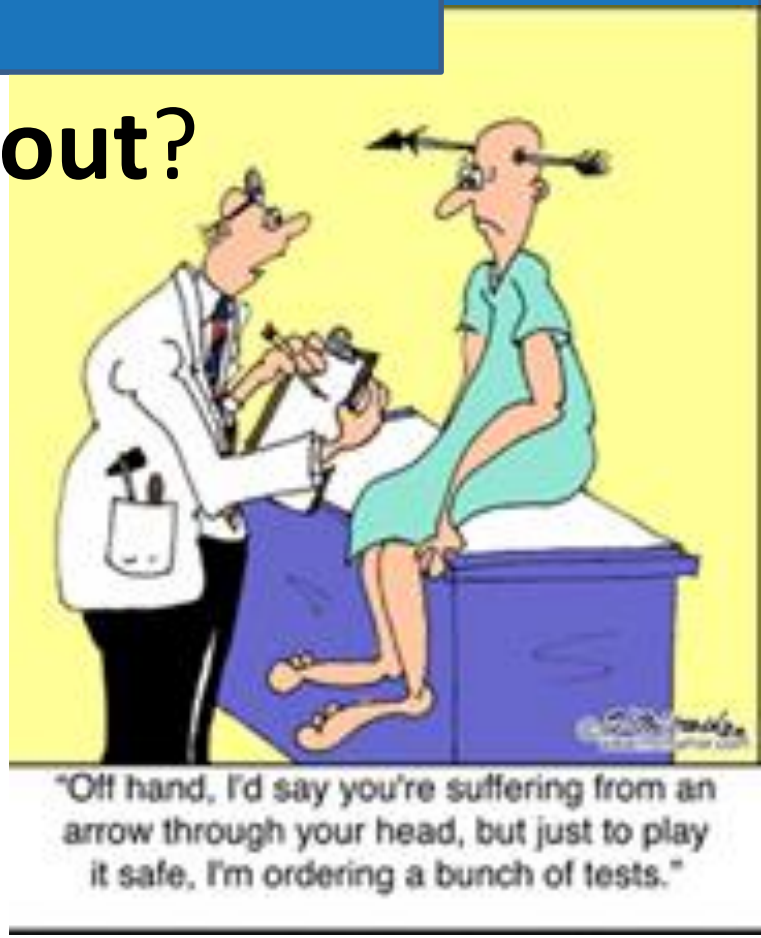
What care are we talking about?

- What “Care” are we talking about? “Care”
  - that gives little or no benefit to patients
  - where the risk of harm exceeds likely benefit
  - and costs do not provide proportional benefit



- Miles’ Law – “where you stand depends on where you sit”

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CHOOSE

As at 1 April 2019

MORE, ISN'T ALWAYS BETTER.
SO LET'S TALK BETTER CARE

Choosing Wisely promotes a culture where low-value and inappropriate clinical interventions
are avoided, and where patients and health professionals have well-informed conversations around treatment options – leading to better decisions and outcomes.

105 PROJECTS

31 COLLEGES & ASSOCIATIONS

18 DISTRICT HEALTH BOARDS

159 RECOMMENDATIONS

39 SUPPORTERS

48 PATIENT RESOURCES

6 SPONSORS and PARTNERS

62 PRESENTATIONS
TO GROUPS ACROSS THE SECTOR

8 SUMMER STUDENTSHIPS

4 PUBLIC and PROFESSIONAL EVENTS

Shared decision making: the 4 BRAN questions

- **Benefits** – do I really need this TTP?
- **Risks** – are there any harms?
- **Alternatives** – are there simpler/safer options?
- **Nothing** – what if I do nothing?

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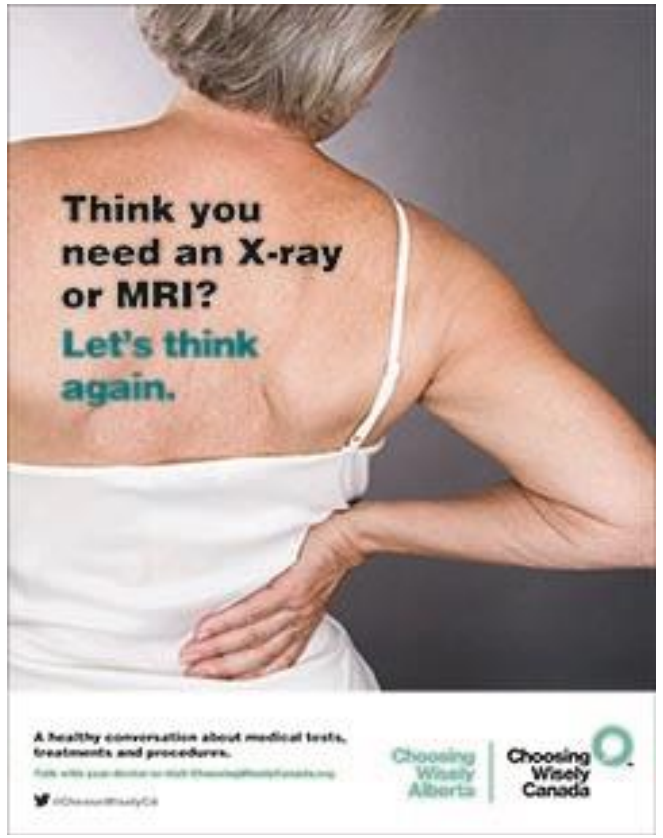
Enthusiasm for diagnosis

- More and more sensitive scanners/tests
- Living longer yet sicker… or being told you are sick.
- Treating people with no symptoms or consequences can only be harmed by treatment
- Screening low-risk populations - breast, prostate
- Incidentalomas - cost of pan scans in trauma



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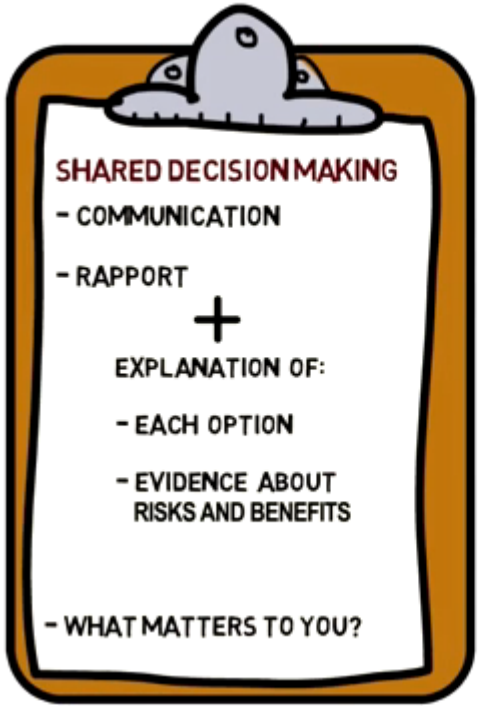
Factors/myths that encourage over-intervention

- Financial incentives - fee for service or activity-funded healthcare.
- The Pharmaceutical industry – new TTPs are always good
- Concern over errors of omission vs commission
- Medico-legal concerns
- Intollerance of uncertainty
- Patient wants the TTP - “more must be better.”
- Misunderstanding of risks by health professionals and patients
- Overestimating benefits and underestimating harms
- The “just in case” or “better exclude” test

Supporting patients with shared decision making

- Myths about shared decision-making
  - Takes more time
  - Patients feel abandoned
  - Patients don't want to make decisions
  - Information too complex
  - I already do it



- "What matters to you" not 'what is the matter with you'

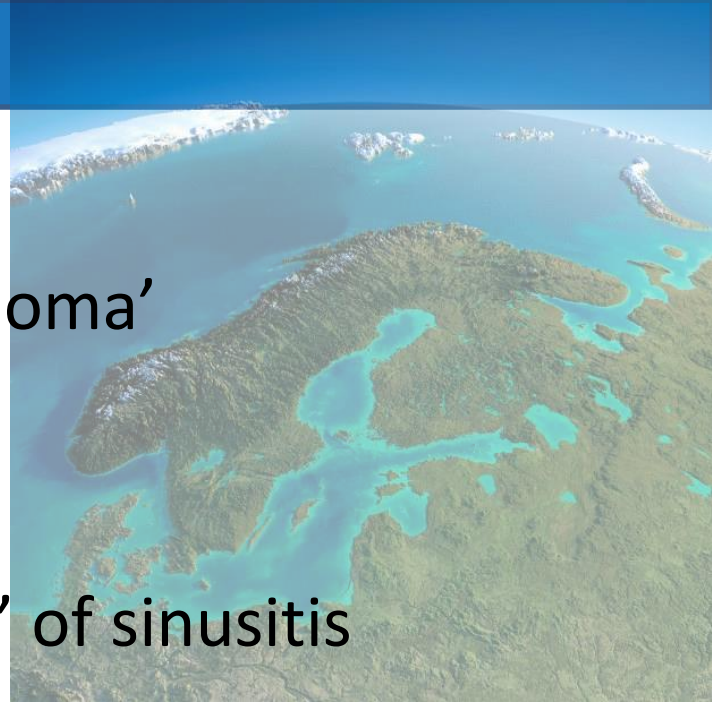
Legal issues

- Fear of being sued driving defensive practice, Australian courts & the HDC discourage defensive practice (Rights 5,6,7)
- Exercise “reasonable care & skill”
- Defensive approach of attempting “to rule out every possible sinister cause in every possible patient every time you see them” is not good medical practice
- “Tension between under-investigation, and missing serious diagnoses, and over-investigation, exposing the patient to unnecessary risk and unnecessary procedures”

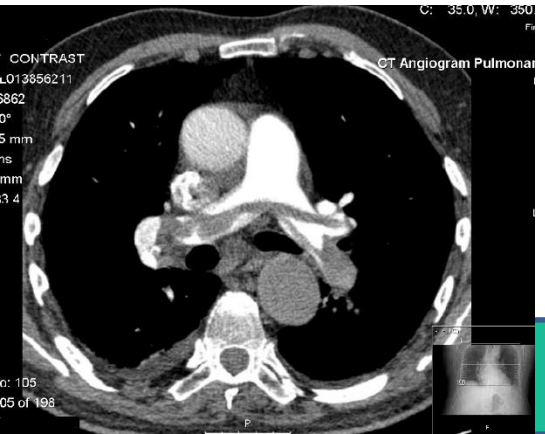
Some infinite NNTs www.thennt.com

- Antibiotics for
  - URIs, abscess, sinusitis, uncomplicated wounds
  - Complications: Resistance, diarrhoea, candidiasis, colitis, cost, allergy, pseudo-allergy
- Anything but analgesia, physical therapy & time for back pain that is due to degenerative disease
  - no evidence of benefit of epidural steroid injections or surgery in these cases
  - 500,000 back operations pa in the US
- Insulin infusions (outside of DKA/ICU settings)

CT scans



- 1000 subjects having pan-scans, 86% had an ‘incidentaloma’
- Current strategy of investigating/treating PEs in the US
  is killing 6x more patients than it is saving
- In 1 study 87% of subjects with a cold had 'CT evidence’ of sinusitis
- Radiation doses - 1 CT chest is
  - 400 CXRs, 40,000km highway driving, 700 cigarettes
  - 3.6yrs background radiation
    - Pan-scan is 1600 CXRs
    - PE positivity 15%



The CRP – the last bastion…

- Produced by the liver in response to inflammation
- Very low sensitivity and specificity for SBI
- <3yo fever – S & S 75%, PTP 20% gives PPV 44% & NPV 8%
- <28 day-olds sensitivity ranges 30-80%
- Appendicitis SR&MA, sensitivity 57% & NLR 0.5
- One week in Middlemore ED
  - 83 with pneumonia: 11 +ve CRP (87% -ve) & 74% afebrile
  - 35 UTIs: 4 +ve CRP (89% -ve) & 91% afebrile

What sort of test orderer are you?

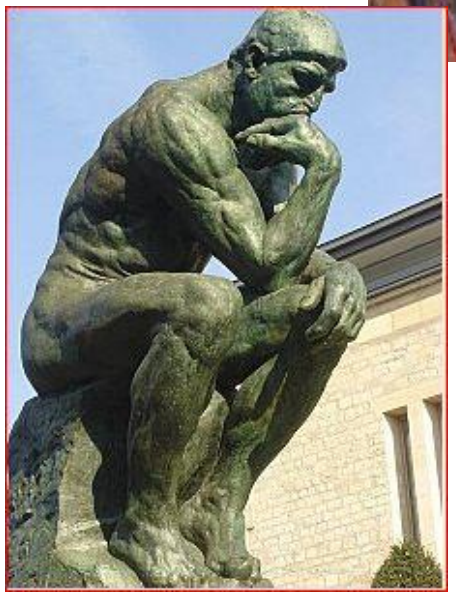
The money maker?

The litigation-phobic?

The lone wolf?

The technocrat?

The sleuth?



We want the Thinker!

5 determinants of health & longevity

1. Genetics
2. Lifestyle/Behaviour (alcohol, smoking, diet, exercise)
3. Social circumstances
4. Environmental exposure
5. Healthcare

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So don’t just do something – stand there!

STOP doing/giving/performing UNNECESSARY

- IV lines if they don’t need IV meds/fluids – *“one less prick”*
- blood tests on every ED attendance – *“NUTs”*
- urine tests when there is no chance of UTI – *“stop taking the piss”*
- other microbiological tests such as wound swabs & stool cultures
- low specificity blood tests on low risk populations
- CT scans in all trauma / uncomplicated ureteric colic
- antibiotics in viral URIs, sinusitis, uncomplicated wounds
- ubiquitous use of the CRaP as a measure of “unwellness” in everyone
- routine tests such as pre-op CXR & bloods in low risk patients

Choosing Wisely in EM

Use caution/avoid:

- CT/KUB for uncomplicated ureteric colic
- Cx spine imaging outside validated decision instrument
- CT brain in trauma outside a validated D.I.
- CXR in ACS patients unless other pathology suspected
- Routine blood cultures
- Coag studies without indication
- CRP outside occult inflammatory and infective conditions
- Imaging in low back pain without high risk features
- Antibiotics for asymptomatic bacteruria

RACP

evolve

evaluating evidence. enhancing efficiencies.

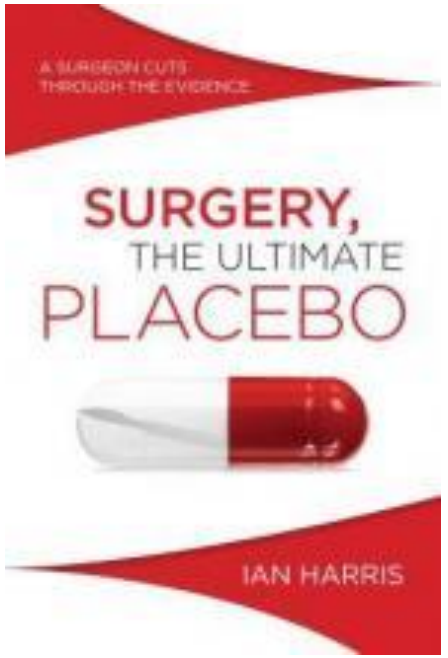
- Physicians – imaging in LBP, Abs for sinusitis & AOM, routine DRE/PSA
- Geriatricians – anti-psychotics or benzos as first line, Abs in bacteruria
- Paediatricians – antibiotics for viral illness, anything for bronch, PPIs, CTs
- Dermatologists – topical Abs on wounds
- Rheumatologists – arthroscopy, ANA testing
- Immunologists – antihistamines in anaphylaxis
- etc

THE ROYAL AUSTRALIAN COLLEGE OF GENERAL PRACTITIONERS

Choosing Wisely in Surgery – “I can, but should I?”

Examples of low value care:

- Spinal fusion for degenerative conditions/back pain in older people
- Epidural steroid for back pain/sciatica
- Tympanostomy tubes for chronic otitis media
- Spinal cord stimulators for chronic back pain
- Surgery for lateral epicondylitis
- Knee arthroscopy for uncomplicated OA
- Stem cell injections for OA
- Appendicectomy in uncomplicated appendicitis



Other specialities

- CICM – ventilated patients should be trialled on light sedation
- ANZCA – day surgery should be the default & variation should be measured
- Cardiologists – avoid PCI for stable non-critical CAD
- RACGP
  - long term PPIs
  - Statins & BP control without CVS risk assessment
  - Screening low risk individuals with ECG/EST
- Midwives – no “routine” epidurals/fetal heart monitoring, USS recommendations
- Physios – imaging without DIs, CPM post TKJR, bed rest for DVT…

COLLEGE OF INTENSIVE CARE MEDICINE
OF AUSTRALIA AND NEW ZEALAND

RACGP
Royal Australian College *of* General Practitioners

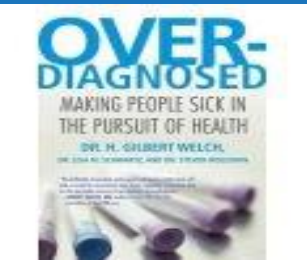
AUSTRALIAN AND
NEW ZEALAND COLLEGE
OF ANAESTHETISTS

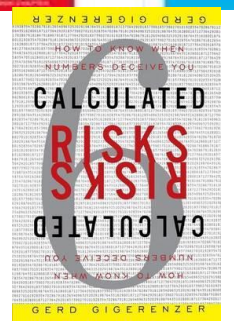
Challenges

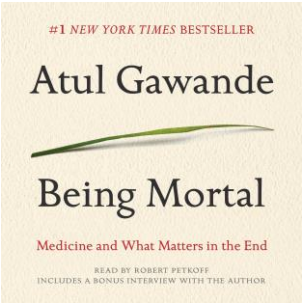
- Entrenched dogma
- Conflicts of interest, vested interests
- “Doctors often unknowingly rely on biased evidence, what others have taught them, what is common practice, what appears to work, and on studies that fit with their beliefs"
- “The fear of having someone harmed from a missed opportunity is a strong and emotive driver of over-treatment. So is the belief that non-operative management equates to neglect or no treatment”

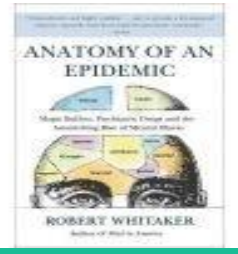
Practice-changing reading

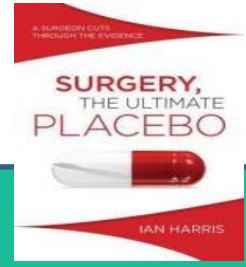
- *Over-diagnosed* – H Gilbert Welch
- *Bad Science* and *Bad Pharma* – Ben Goldacre
- *Anatomy of an Epidemic* – Robert Whittaker
- *Calculated Risk* – Gerd Gigerenzer
- *Surgery, the Ultimate Placebo* – Ian Harris
- *Being Mortal* and *The Checklist Manifesto* – Atul Gawande
- Others on metacognition
  - *Blink* and *Outliers* - Malcolm Gladwell
  - *Thinking, fast and slow* - Daniel Kahneman











Today's talk was brought to you by the word

- Rationalising
- Resource stewardship – re-investment
- We are harming patients
- Shared decision making
- The BRAN questions – benefits, risks, alternatives, nothing
- Decision instruments
- More is not always better
- Target high risk populations for TTPs
- Don't just do something – stand there!
- www.choosingwisely.org.nz