Choosing Wisely: Evidence Based Practice

Gene Harkless, DNSC, APRN
• There has been no commercial support or sponsorship for this program.
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ACCREDITATION

Boston College Connell School of Nursing Continuing Education Program is accredited as a provider of continuing nursing education by the American Nurses Association Massachusetts, an accredited approver by the American Nurses Credentialing Center’s Commission on Accreditation.
SESSION OBJECTIVES

• Discuss the use of research in making clinical decisions.
• Summarize recent evidence that changes standard practice.
Less is More: Choosing Wisely 2015

Lessons for Nurse Practitioners

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Evidence-based medicine is an approach to health care that promotes the collection, interpretation, and integration of valid, important and applicable evidence.

The best available evidence, moderated by patient circumstances and preferences, is applied to improve the quality of clinical judgments.

McMaster University
US Health System Ranks Last Among Eleven Countries on Measures of Access, Equity, Quality, Efficiency, and Healthy Lives

Publication Date: June 16, 2014
## EXHIBIT ES-1. OVERALL RANKING

<table>
<thead>
<tr>
<th>Country Rankings</th>
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<tbody>
<tr>
<td><strong>Top 2</strong></td>
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<td><strong>Middle</strong></td>
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<td><strong>Bottom 2</strong></td>
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<table>
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<tr>
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<th>CAN</th>
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<td>Cost-Related Problems</td>
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<td>Healthy Lives</td>
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<td>2</td>
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<tr>
<td>Health Expenditures/Capita, 2011**</td>
<td>$3,800</td>
<td>$4,522</td>
<td>$4,118</td>
<td>$4,495</td>
<td>$5,099</td>
<td>$3,182</td>
<td>$5,689</td>
<td>$3,925</td>
<td>$5,643</td>
<td>$3,405</td>
<td>$8,608</td>
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</table>

*Notes: * includes free. **Expenses shown in $'s PPP (purchasing power parity); Australian data are from 2012.

Source: Calculated by The Commonwealth Fund based on 2011 International Health Policy Survey of Adults; 2012 International Health Policy Survey of Primary Care Providers; and 2013 International Health Policy Survey; Commonwealth Fund National Survey; 2012 World Health Organization; and Organization for Economic Cooperation and Development. OECD Health Data, 2012 (Paris: OECD, Nov. 2013).
A recent international study compared 11 nations on health care quality, access, efficiency, and equity, as well as indicators of healthy lives such as infant mortality.

### Overall Health Care Ranking

<table>
<thead>
<tr>
<th></th>
<th>Low</th>
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<th>High</th>
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<tbody>
<tr>
<td>U.K.</td>
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<tr>
<td>Switzerland</td>
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<td>Sweden</td>
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<tr>
<td>Australia</td>
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<td>Germany</td>
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<tr>
<td>The Netherlands</td>
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<tr>
<td>New Zealand</td>
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<tr>
<td>Norway</td>
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<tr>
<td>France</td>
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<tr>
<td>Canada</td>
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<tr>
<td>U.S.</td>
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## Distribution of Average Spending Per Person, 2009

<table>
<thead>
<tr>
<th>Age (in years)</th>
<th>Average Spending Per Person</th>
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<tbody>
<tr>
<td>&lt;5</td>
<td>$2,468</td>
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<tr>
<td>5-17</td>
<td>1,695</td>
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<tr>
<td>18-24</td>
<td>1,834</td>
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<td>25-44</td>
<td>2,739</td>
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<tr>
<td>45-64</td>
<td>5,511</td>
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<tr>
<td>65 or Older</td>
<td>9,744</td>
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</table>

<table>
<thead>
<tr>
<th>Sex</th>
<th>Average Spending Per Person</th>
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<tbody>
<tr>
<td>Male</td>
<td>$3,559</td>
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<tr>
<td>Female</td>
<td>4,635</td>
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</table>

Note: Population is the civilian noninstitutionalized population, including those without any health care spending. Health care spending is total payments from all sources (including direct payments from individuals and families, private insurance, Medicare, Medicaid, and miscellaneous other sources) to hospitals, physicians, other providers (including dental care), and pharmacies; health insurance premiums are not included.

Distribution of National Health Expenditures, by Type of Service (in Billions), 2010

- Hospital Care, $814.0 (31.4%)
- Physician/ Clinical Services, $515.5 (19.9%)
- Prescription Drugs, $259.1 (10.0%)
- Other Personal Health Care, $384.2 (14.8%)
- Home Health Care, $70.2 (2.7%)
- Nursing Care Facilities & Continuing Care Retirement Communities, $143.1 (5.5%)
- Other Health Spending, $407.6 (15.7%)

NHE Total Expenditures: $2,593.6 billion

Note: Other Personal Health Care includes, for example, dental and other professional health services, durable medical equipment, etc. Other Health Spending includes, for example, administration and net cost of private health insurance, public health activity, research, and structures and equipment, etc.

The 65 and Over Population Will More Than Double and the 85 and Over Population Will More Than Triple by 2050

Millions of Americans Experience Cognitive, Ambulatory, Self-Care, and/or Independent Living Difficulties, 2012

- With Self-Care Difficulty: 7.7 M
- With Independent Living Difficulty*: 13.6 M
- With Cognitive Difficulty: 14.3 M
- With Ambulatory Difficulty: 20.0 M

NOTE: Individuals ages five and over were assessed as having one or more difficulties due to “physical, mental, or emotional problems.”

*Independent living difficulty was determined only for individuals ages 18 and over.

Total Medicare Reimbursements per Decedent, by Interval Before Death
(Interval Before Death: Last Two Years of Life; Year: 2003–2007; Region Level: HRR)
<table>
<thead>
<tr>
<th>Test</th>
<th>Avg. U.S. Price</th>
<th>Canada</th>
<th>Switzerland</th>
<th>Spain</th>
<th>New Zealand</th>
<th>Netherlands</th>
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<tbody>
<tr>
<td>Angiogram</td>
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<td>$35</td>
<td>$655</td>
<td>$7,731</td>
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<td>M.R.I. scan</td>
<td>$124</td>
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</table>

Source: 2012 Comparative Price Report by the International Federation of Health Plans. The average prices shown for colonoscopies do not include added fees for sedation by an anesthesiologist, a practice common in the United States, but unusual in the rest of the world. The additional charges can increase the cost significantly.

Preference sensitive care

Proportion of Medicare Spending Attributed to Each Category of Unwarranted Variation

- Effective Care: 25%
- Preference Sensitive Care: 12%
- Supply Sensitive Care: 63%
“American healthcare is seriously broken. We have a system that under treats large numbers of people who need more and better care, and over treats equally large numbers of people with ill-considered, wasteful, unnecessary care. These are really two sides of the same coin.”

Dr. Vikas Saini 2012
Unnecessary care as a maker of poor quality?

- [http://avoidablecare.org/](http://avoidablecare.org/)
- How much care in the US is avoidable?
- Can we quantify its consequences, in terms of financial impact and harms?
- What factors drive over utilization and inappropriate medical services, how can we curb it, and do nurse practitioners have an ethical duty to do so?
Why is there overuse?

- Magical thinking—convictions that individuals tend to hold despite evidence that should lead to contradictory or more nuanced beliefs.
  - New technology is good.
  - Natural is good.
  - Uncertainty is intolerable
  - Misunderstanding evidence
  - Misplaced trust
Cost of healthcare

Becky 26 yo

Makes $35000

Pays $2500 for health insurance/ co-pays

Company will pay $5700

This means she is actually worth over $43000 to the company

Pay stub: $35000

Taxes $7781

State $1276

$3827

SS $2170

Medicare $508

Other deductions

Medical $1932

Dental $114

Vision $66

More health spending in taxes

Becky pays $508 and company pays $508

Income tax – 20% of her taxes will go to health spending

State tax – 10% to health spending

So, out of the company’s real compensation of $43000 for Becky’s work, over $10,050 has gone into health spending.

23% of her gross income
If Becky…

Works for 30 years without a raise

Never marries or has kids

Never really gets sick

Health care prices do not rise

She will have paid out over $300,000 into our health care system during her working career. And, then she will pay Medicare premiums.
Becky gets married, her premiums will increase by $9225 per year

With kids, another $7231 per year

As her income grows, she will pay more into Medicare and taxes.

As a senior citizen she will pay about $1600 per year for Part B and D premiums in addition to a Medigap insurance policy of $2800 and $1200 in out of pocket expenses
Gets married at 30, has 2 children

Works until 65 and then dies at 80.

Income grows at 4% so that at retirement she is earning $180,000. For simplicity, husband has left and joined an ashram, she is responsible for her own Medicare premiums.

Her dependents stay healthy, no large out of pocket expenditures.
Health care only grows at 2%, half of Becky’s income growth. This has not been true for 45 years but we can hope.

Becky will earn $3.85 million over her career.

How much will Becky contribute into the health care system for her and her dependents over her lifetime? The answer is $1.9 million

If health care costs grow at 4% (still lower than recent growth), Becky will have contributed $3.2 million – one out of every two dollars she earns into our health care non-system.

Then let’s assume..
Too Little? Too Much? Primary Care Physicians' Views on US Health Care
A Brief Report
Brenda E. Sirovich, MD, MS; Steven Woloshin, MD, MS; Lisa M. Schwartz, MD, MS

Figure 5: In your own practice, is this a reason you sometimes end up ordering an unnecessary test or procedure? IF YES: Is this a major reason or minor reason?

Total n = 600

- Malpractice concerns: 52%
- Just to be safe: 36%
- Want more information to reassure myself: 30%
- Patients insisting on test: 28%
- Wanting to keep patients happy: 23%
- Feel patients should make final decision: 13%
- Not enough time with patients: 13%
- Fee-for-service system: 5%
- New technology in practice: 5%
Figure 8: How often do you talk with your patients about the costs of tests and procedures?

- Always/almost always: 20%
- Often: 21%
- Half the time: 13%
- Not too often: 25%
- Rarely/never: 19%
Figure 11: How effective would ______ be in reducing unnecessary tests and procedures? (Very effective, somewhat effective, not too effective, or not at all effective?)

- Malpractice reform: 66% Very, 25% Somewhat, 91% total
- Having specific, evidence-based recommendations in a format designed for patients that MDs could use for discussion: 45% Very, 40% Somewhat, 85% total
- Having more time with patients to discuss alternatives: 43% Very, 35% Somewhat, 78% total
- Changing the system of financial rewards for ordering tests/procedures: 28% Very, 33% Somewhat, 61% total
Editorial
Too much medicine: the challenge of finding common ground
Published 04 March 2015

Research
The impact of providing rapid diagnostic malaria tests on fever management in the private retail sector in Ghana: a cluster randomized trial
Published 04 March 2015

Filler
Myth busting in medicine
Published 04 March 2015

Analysis
The challenge of overdiagnosis begins with its definition
Published 04 March 2015

Analysis
Estimating overdiagnosis in screening for abdominal aortic aneurysm: could a change in smoking habits and lowered aortic diameter tip the balance of screening towards harm?
Published 04 March 2015

Analysis
Overdiagnosis in mammography screening: a 45 year journey from shadowy idea to acknowledged reality
Published 04 March 2015
Choosing wisely exemplars
Primary care
Don’t do imaging for low back pain within the first six weeks, unless red flags are present.

Red flags include, but are not limited to, severe or progressive neurological deficits or when serious underlying conditions such as osteomyelitis are suspected. Imaging of the lower spine before six weeks does not improve outcomes, but does increase costs. Low back pain is the fifth most common reason for all physician visits.

Don’t routinely prescribe antibiotics for acute mild-to-moderate sinusitis unless symptoms last for seven or more days, or symptoms worsen after initial clinical improvement.

Symptoms must include discolored nasal secretions and facial or dental tenderness when touched. Most sinusitis in the ambulatory setting is due to a viral infection that will resolve on its own. Despite consistent recommendations to the contrary, antibiotics are prescribed in more than 80 percent of outpatient visits for acute sinusitis. Sinusitis accounts for 16 million office visits and $5.8 billion in annual healthcare costs.

Don’t use dual-energy x-ray absorptiometry (DEXA) screening for osteoporosis in women younger than 65 or men younger than 70 with no risk factors.

DEXA is not cost effective in younger, low-risk patients, but is cost effective in older patients.

Don’t order annual electrocardiograms (EKGs) or any other cardiac screening for low-risk patients without symptoms.

There is little evidence that detection of coronary artery stenosis in asymptomatic patients at low risk for coronary heart disease improves health outcomes. False-positive tests are likely to lead to harm through unnecessary invasive procedures, over-treatment and misdiagnosis. Potential harms of this routine annual screening exceed the potential benefit.
5. Don’t perform Pap smears on women younger than 21 or who have had a hysterectomy for non-cancer disease.

Most observed abnormalities in adolescents regress spontaneously, therefore Pap smears for this age group can lead to unnecessary anxiety, additional testing and cost. Pap smears are not helpful in women after hysterectomy (for non-cancer disease) and there is little evidence for improved outcomes.

8. Don’t screen for carotid artery stenosis (CAS) in asymptomatic adult patients.

There is good evidence that for adult patients with no symptoms of carotid artery stenosis, the harms of screening outweigh the benefits. Screening could lead to non-indicated surgeries that result in serious harms, including death, stroke and myocardial infarction.

9. Don’t screen women older than 65 years of age for cervical cancer who have had adequate prior screening and are not otherwise at high risk for cervical cancer.

There is adequate evidence that screening women older than 65 years of age for cervical cancer who have had adequate prior screening and are not otherwise at high risk provides little to no benefit.

10. Don’t screen women younger than 30 years of age for cervical cancer with HPV testing, alone or in combination with cytology.

There is adequate evidence that the harms of HPV testing, alone or in combination with cytology, in women younger than 30 years of age are moderate. The harms include more frequent testing and invasive diagnostic procedures such as colposcopy and cervical biopsy. Abnormal screening test results are also associated with psychological harms, anxiety and distress.
Don’t perform routine annual cervical cytology screening (Pap tests) in women 30–65 years of age.

In average risk women, annual cervical cytology screening has been shown to offer no advantage over screening performed at 3-year intervals. However, a well-woman visit should occur annually for patients with their health care practitioner to discuss concerns and problems, and have appropriate screening with consideration of a pelvic examination.

Don’t treat patients who have mild dysplasia of less than two years in duration.

Mild dysplasia (Cervical Intraepithelial Neoplasia [CIN 1]) is associated with the presence of the human papillomavirus (HPV), which does not require treatment in average risk women. Most women with CIN 1 on biopsy have a transient HPV infection that will usually clear in less than 12 months and, therefore, does not require treatment.

Don’t test for Lyme disease as a cause of musculoskeletal symptoms without an exposure history and appropriate exam findings.

The musculoskeletal manifestations of Lyme disease include brief attacks of arthralgia or intermittent or persistent episodes of arthritis in one or a few large joints at a time, especially the knee. Lyme testing in the absence of these features increases the likelihood of false positive results and may lead to unnecessary follow-up and therapy. Diffuse arthralgias, myalgias or fibromyalgia alone are not criteria for musculoskeletal Lyme disease.

Don’t routinely repeat DXA scans more often than once every two years.

Initial screening for osteoporosis should be performed according to National Osteoporosis Foundation recommendations. The optimal interval for repeating Dual-energy X-ray Absorptiometry (DXA) scans is uncertain, but because changes in bone density over short intervals are often smaller than the measurement error of most DXA scanners, frequent testing (e.g., <2 years) is unnecessary in most patients. Even in high-risk patients receiving drug therapy for osteoporosis, DXA changes do not always correlate with probability of fracture. Therefore, DXAs should only be repeated if the result will influence clinical management or if rapid changes in bone density are expected. Recent evidence also suggests that healthy women age 67 and older with normal bone mass may not need additional DXA testing for up to ten years provided osteoporosis risk factors do not significantly change.
Do not repeat colorectal cancer screening (by any method) for 10 years after a high-quality colonoscopy is negative in average-risk individuals.

A screening colonoscopy every 10 years is the recommended interval for adults without increased risk for colorectal cancer, beginning at age 50 years. Published studies indicate the risk of cancer is low for 10 years after a high-quality colonoscopy fails to detect neoplasia in this population. Therefore, following a high-quality colonoscopy with normal results the next interval for any colorectal screening should be 10 years following that.

Avoid using medications to achieve hemoglobin A1c <7.5% in most adults age 65 and older; moderate control is generally better.

There is no evidence that using medications to achieve tight glycemic control in older adults with type 2 diabetes is beneficial. Among non-older adults, except for long-term reductions in myocardial infarction and mortality with metformin, using medications to achieve glycated hemoglobin levels less than 7% is associated with harms, including higher mortality rates. Tight control has been consistently shown to produce higher rates of hypoglycemia in older adults. Given the long timeframe to achieve theorized microvascular benefits of tight control, glycemic targets should reflect patient goals, health status, and life expectancy. Reasonable glycemic targets would be 7.0 – 7.5% in healthy older adults with long life expectancy, 7.5 – 8.0% in those with moderate comorbidity and a life expectancy < 10 years, and 8.0 – 9.0% in those with multiple morbidities.

Don’t perform population based screening for 25-OH-Vitamin D deficiency.

Vitamin D deficiency is common in many populations, particularly in patients at higher latitudes, during winter months and in those with limited sun exposure. Over the counter Vitamin D supplements and increased summer sun exposure are sufficient for most otherwise healthy patients. Laboratory testing is appropriate in higher risk patients when results will be used to institute more aggressive therapy (e.g., osteoporosis, chronic kidney disease, malabsorption, some infections, obese individuals).
American Academy of Nursing
Five Things Nurses and Patients Should Question

1. Don’t automatically initiate continuous electronic fetal heart rate (FHR) monitoring during labor for women without risk factors; consider intermittent auscultation (IA) first.

2. Don’t let older adults lay in bed or only get up to a chair during their hospital stay.

3. Don’t use physical restraints with an older hospitalized patient.

4. Don’t wake the patient for routine care unless the patient’s condition or care specifically requires it.

5. Don’t place or maintain a urinary catheter in a patient unless there is a specific indication to do so.
<table>
<thead>
<tr>
<th>Health Care Service</th>
<th>Overuse Quality Indicator</th>
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<tbody>
<tr>
<td>Prostate cancer screening in men aged &gt;74 y</td>
<td>Visits by men aged ≥75 y who are ordered a PSA</td>
</tr>
<tr>
<td>Screening ECG in adults in GME</td>
<td>Visits by adults who present for GME and are ordered an ECG</td>
</tr>
<tr>
<td>Screening UA in adults in GME</td>
<td>Visits by adult men and nonpregnant women who present for GME and are ordered a UA</td>
</tr>
<tr>
<td>Screening CBC in adults in GME</td>
<td>Visits by adults who present for GME and are ordered a CBC</td>
</tr>
<tr>
<td>Screening x-ray in adults in GME</td>
<td>Visits by adults who present for GME and are ordered a chest x-ray</td>
</tr>
<tr>
<td>Cervical cancer screening in women aged ≥65 y</td>
<td>Visits by women aged ≥65 y who were ordered a Pap test</td>
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<tr>
<td>Mammography screening for women aged ≥75 y</td>
<td>Visits by women aged ≥75 y who received a mammogram</td>
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<tr>
<td>X-ray for back pain in adults aged 18-55 y</td>
<td>Visits by adults with acute back pain who received x-ray</td>
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<td>Abx for URTI</td>
<td>Visits by adults with uncomplicated URTI who received any antibiotic medication</td>
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<td>Abx for acute bronchitis</td>
<td>Visits by adults with bronchitis who received any abx</td>
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<tr>
<td>Abx for acute asthma exacerbation</td>
<td>Visits by adults with acute asthma exacerbation who receive any abx</td>
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USPSTF[^16]  
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USPSTF[^21]  
USPSTF[^22]  
USPSTF[^23]  
USPSTF[^24]  
NCQA[^25]  
ICS[^26]  
NCQA[^27]  
NAEP[^28]
"Yet some of the largest medical associations selected rare services or ones that are done by practitioners in other fields and will not affect their earnings. "They were willing to throw someone else's services into the arena, but not their own," Dr. Nancy Morden

The Society of General Internal Medicine recommended against the annual physical exam, a mainstay of American healthcare.

http://www.medpagetoday.com/PublicHealthPolicy/GeneralProfessionalIssues/45286
The overtreatment of mild hypertension

LESS IS MORE

Waste and Harm in the Treatment of Mild Hypertension

Iona Heath, MA, MB, BCh


The 2012 Cochrane Review on “Pharmacotherapy for Mild Hypertension”\(^1\) concluded that antihypertensive drugs used in the treatment of otherwise healthy adults with mild hypertension (systolic blood pressure [BP], 140-159 mm Hg, and/or diastolic BP, 90-99 mm Hg) have not been shown to reduce mortality or morbidity in randomized clinical trials. Will this landmark conclusion affect clinical practice and slow the inexorable expansion of disease categories? It certainly should because overdiagnosis and overtreatment are potent causes of both waste and harm and seem to be operating in the interests of the pharmaceutical industry rather than in those of the patients whom the industry claims to serve.

The overtreatment of mild hypertension

https://www.youtube.com/watch?v=cZCuJheVJA0&list=UUrkhryqZAYzGvfeAp0ulw
Lifestyle changes and effect on BP

<table>
<thead>
<tr>
<th>Modification</th>
<th>Recommendation</th>
<th>Approximate Systolic Blood Pressure Reduction (Range)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight reduction</td>
<td>Maintain normal body weight (body mass index 18.5-24.9 kg/m²)</td>
<td>5-20 mmHg/10 kg</td>
</tr>
<tr>
<td>Adopt DASH** eating plan</td>
<td>Consume a diet rich in fruits, vegetables and low-fat dairy products, with a reduced content of saturated and total fat.</td>
<td>8-14 mmHg</td>
</tr>
<tr>
<td>Dietary sodium reduction</td>
<td>Reduce dietary sodium intake to no more than 100 mmol per day (2.4 g sodium or 6 g sodium chloride).</td>
<td>2-8 mmHg</td>
</tr>
<tr>
<td>Physical activity</td>
<td>Engage in regular aerobic physical activity such as brisk walking (at least 30-45 minutes per day, most days of the week).</td>
<td>4-9 mmHg</td>
</tr>
<tr>
<td>Moderation of alcohol consumption</td>
<td>Limit consumption to no more than two drinks (e.g., 24 oz. beer, 10 oz. wine, or 3 oz. 80 proof whiskey) per day in most men and to no more than one drink per day in women and lighter-weight persons.</td>
<td>2-4 mmHg</td>
</tr>
</tbody>
</table>

*For overall cardiovascular risk reduction, stop smoking.
**DASH indicates Dietary Approaches to Stop Hypertension.
† The effects of implementing these modifications are dose- and time-dependent and could be greater for some individuals.
A model of gains in life expectancy with HTN treatment

<table>
<thead>
<tr>
<th></th>
<th>CHD</th>
<th>Stroke</th>
<th>CVE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>GLE (months)</td>
<td>RGLE (%)</td>
<td>GLE (months)</td>
</tr>
<tr>
<td>40 years Women</td>
<td>9.0</td>
<td>2.0</td>
<td>14.2</td>
</tr>
<tr>
<td>40 years Men</td>
<td>20.3</td>
<td>4.5</td>
<td>32.2</td>
</tr>
<tr>
<td>50 years Women</td>
<td>10.0</td>
<td>2.7</td>
<td>15.7</td>
</tr>
<tr>
<td>50 years Men</td>
<td>16.6</td>
<td>5.18</td>
<td>26.0</td>
</tr>
<tr>
<td>60 years Women</td>
<td>10.6</td>
<td>3.7</td>
<td>16.5</td>
</tr>
<tr>
<td>60 years Men</td>
<td>13.3</td>
<td>6.2</td>
<td>21.0</td>
</tr>
<tr>
<td>70 years Women</td>
<td>10.3</td>
<td>5.2</td>
<td>16.2</td>
</tr>
<tr>
<td>70 years Men</td>
<td>10.3</td>
<td>8.1</td>
<td>16.9</td>
</tr>
</tbody>
</table>

Table 3

Absolute and relative gain in life expectancy without events

<table>
<thead>
<tr>
<th>Age at treatment initiation</th>
<th>40 years</th>
<th>50 years</th>
<th>60 years</th>
<th>70 years</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Women</td>
<td>Men</td>
<td>Women</td>
<td>Men</td>
</tr>
<tr>
<td>CHD GLE (months)</td>
<td>9.0</td>
<td>20.3</td>
<td>10.0</td>
<td>16.6</td>
</tr>
<tr>
<td>RGLE (%)</td>
<td>2.0</td>
<td>4.5</td>
<td>2.7</td>
<td>5.18</td>
</tr>
<tr>
<td>Stroke GLE (months)</td>
<td>14.2</td>
<td>32.2</td>
<td>15.7</td>
<td>26.0</td>
</tr>
<tr>
<td>RGLE (%)</td>
<td>3.1</td>
<td>7.0</td>
<td>4.3</td>
<td>7.9</td>
</tr>
<tr>
<td>CVE GLE (months)</td>
<td>19.2</td>
<td>32.6</td>
<td>21.3</td>
<td>27.0</td>
</tr>
<tr>
<td>RGLE (%)</td>
<td>4.3</td>
<td>7.8</td>
<td>5.9</td>
<td>9.2</td>
</tr>
</tbody>
</table>

Abbreviations: CHD, coronary heart disease; CVE, cardiovascular events; GLE, gain in life expectancy without events; RGLE, relative gain in life expectancy without events.

Published online 2005 June.
Study: Tools That Calculate CV Risk Overestimate By Up To 154%

Tue, 02/17/15 - 13:32
This study looked at nearly 400,000 elective coronary angiographies performed in US hospitals over 4 years.

Although preliminary investigations had been done in 84% of cases, the pick-up rate for significant coronary stenosis on angiography was 37.6%. Even these patients may have had little benefit, since COURAGE tells us that in stable angina, people do as well with optimal medical treatment as with percutaneous intervention.

So 250,000 of these angiographies were definitely of no value to the patients, and that probably applies to most of the rest too. We need much better case selection for the catheter lab, with all its attendant risks of radiation and bleeding, not to mention cost in money and cardiologist time.
Statins and women

Jupiter study analysis 2010

- Introduction: “Statin therapy in women without CVD is controversial given the insufficient evidence of benefit.”

- Study: 6801 women 60 years of age and older with high-sensitivity C-reactive protein 2 mg/L and low-density lipoprotein cholesterol <130 mg/dL received either high potency statin or placebo.

- Findings: There was significant reduction in revascularization/unstable angina. Absolute CVD rates (per 100 person-years) in JUPITER women for rosuvastatin 20 mg was 0.57 per 100 person-years and placebo 1.04 per 100 person years for the two years of the trial.

Absolutely no difference in mortality.
EKGs and exercise stress tests for heart disease

Those follow-up tests can include CT angiograms, which expose you to a radiation dose equal to 600 to 800 chest X-rays, and coronary angiography.

Imaging tests for lower-back pain

One study projected 1,200 new cancer cases based on the 2.2 million CT scans done for lower-back pain in the U.S. in 2007.

ConsumerHealthChoices.org/choosing-wisely
<table>
<thead>
<tr>
<th></th>
<th>Vascular death (%)</th>
<th>Overall mortality (%)</th>
<th>Major vascular event (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No Dia</td>
<td>Dia</td>
<td>No Dia</td>
</tr>
<tr>
<td>Statin</td>
<td>4.2</td>
<td>6.4</td>
<td>7.9</td>
</tr>
<tr>
<td>No statin</td>
<td>5.3</td>
<td>7.2</td>
<td>9.1</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th></th>
<th>Relative risk reduction</th>
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<td>18</td>
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<tr>
<td></td>
<td>9</td>
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<tr>
<td></td>
<td>22</td>
<td>27</td>
</tr>
<tr>
<td></td>
<td>21</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>1.1</td>
<td>0.6</td>
</tr>
<tr>
<td></td>
<td>1.2</td>
<td>0.9</td>
</tr>
<tr>
<td></td>
<td>1.4</td>
<td>2.6</td>
</tr>
<tr>
<td></td>
<td>5.0</td>
<td>5.3</td>
</tr>
</tbody>
</table>

*4.3 years per mmol/L reduction*

*Lancet 2008;371:117-25*
Option Grids

Choose your region's dialect:

English (UK)   English (USA)

Angina

Atrial fibrillation – Medication

http://www.optiongrid.org/optiongrids.php
Lung cancer screening
Use this grid to help you and your healthcare professional decide whether or not to screen for lung cancer.

<table>
<thead>
<tr>
<th>Frequently asked questions</th>
<th>Screening using low dose computed tomography (CT)</th>
<th>No screening</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who is it offered to?</td>
<td>To high-risk smokers or ex-smokers, aged 55 to 80, who have smoked at least 1 pack a day for thirty years. It is not offered to those who have symptoms of lung cancer. Ex-smokers are offered screening if they have quit in the last 15 years.</td>
<td>Only those at high risk of lung cancer are offered low-dose CT for screening. People who are not at high risk of lung cancer are not offered screening because there is no proven benefit to them.</td>
</tr>
<tr>
<td>How is lung cancer found?</td>
<td>It is often found using low-dose CT: an x-ray offered once a year. It takes a few minutes and needs no special preparation.</td>
<td>Without screening, lung cancer is usually found after symptoms are present or when other tests are done. In these cases, lung cancer is more likely to be found at a later stage.</td>
</tr>
<tr>
<td>What are the benefits of screening?</td>
<td>Low-dose CT finds signs of possible lung cancer in roughly 1 in every 100 screened (1%), and at a time when treatment has a better chance of success. 65 in every 100 scans (65%) will not find any problems.</td>
<td>Does not apply</td>
</tr>
<tr>
<td>What are the harms or risks?</td>
<td>False alarms: Roughly 25 in every 100 people (25%) have small nodules found in their lungs. To make sure these nodules are not cancer, more tests are done, for up to 2 years. <strong>Unnecessary treatment:</strong> Some suspicious nodules might be treated even though they might never cause problems. <strong>Finding more problems:</strong> Low-dose CT sometimes reveals findings in other parts of the body. These may lead to more tests and possible treatment. <strong>Radiation:</strong> Consider the possible benefit of finding lung cancer early against the small radiation risk of many CTs.</td>
<td>If you know that you are at risk for lung cancer and do not get a low-dose CT, you might worry that you have missed a chance to find the cancer early. If cancer is found because of symptoms like unexplained weight loss and coughing up blood, then the cancer is probably more advanced, and treatment will be more difficult.</td>
</tr>
<tr>
<td>What are the possible results?</td>
<td>25 people in every 100 screened (25%) will be told they have nodules, but few of these will be cancer. More tests will probably be done. Roughly 10 in every 100 people screened (10%) will be told about other problems, such as infections or lung damage from smoking.</td>
<td>Does not apply</td>
</tr>
</tbody>
</table>
people each year die or have liver transplantations because of the disease.9 13

http://www.bmj.com.libproxy.unh.edu/content/350/bmj.g7809
Analysis

Is widespread screening for hepatitis C justified?

*BMJ* 2015; 350 doi: http://dx.doi.org/10.1136/bmj.g7809 (Published 13 January 2015)
Cite this as: *BMJ* 2015;350:g7809

Key messages

- The CDC and other major organisations are recommending birth cohort population screening for hepatitis C infection
- Only a minority of patients with chronic hepatitis C infection will ever develop end stage liver disease
- We cannot reliably identify those who will develop end stage liver disease
- Drug trials rely on surrogate markers such as sustained virological response, which is not a cure
- Physicians should resist screening until we have strong evidence that antiviral therapy is clinically effective and the benefits outweigh the harms
Overtreating Prostate Cancer
From Medscape Urology

Human Costs
Overtreating Prostate Cancer Takes a Toll
Prostate Cancer Tx Side-Effects: New 15-Year Data
Post-Prostatectomy Radiation Tied to Urinary Incontinence
Occult Mix-Ups Occur in About 1 of 100 Prostate Biopsies

Financial Costs
$32 Million: Cost of Overtreatment of Prostate Cancer
'Choosing Wisely' Targets 90 More Dubious Tests, Therapies
Comparing Costs of New Drugs in Prostate Cancer
Researchers presented 412 doctors with what appeared to be data from two tests.

The first showed a five-year survival rate that improved from 68 percent to 99 percent; the other, that the mortality rate dropped from two deaths per 1,000 people screened to 1.6 deaths.

The doctors were three times more likely to recommend testing based on the first set of data than the second.

But here’s the kicker: The data applied to the same test, PSA screening for prostate cancer. Many doctors didn’t understand that the five-year survival rate could make a test look better than it really was.
Breast cancer screening

**ORIGINAL ARTICLE**

**Effect of Three Decades of Screening Mammography on Breast-Cancer Incidence**

Archie Bleyer, M.D., and H. Gilbert Welch, M.D., M.P.H.


**CONCLUSIONS**

Despite substantial increases in the number of cases of early-stage breast cancer detected, screening mammography has only marginally reduced the rate at which women present with advanced cancer. Although it is not certain which women have been affected, the imbalance suggests that there is substantial overdiagnosis, accounting for nearly a third of all newly diagnosed breast cancers, and that screening is having, at best, only a small effect on the rate of death from breast cancer.
Survival statistics also tend to be inflated by overdiagnosis or by finding cancers that won’t become deadly.

The more cases detected, even harmless ones, the more people are designated as survivors.

That leads to the popularity paradox. “The more overdiagnosis, the more effective a test appears and the more popular it becomes,”.

“It’s a vicious cycle.”
Consider this message from a 2011 promotional campaign run by the breast-Save your life;
Cancer screening is oversold. Know the tests to get--and those to skip. Consumer Report March 2013.cancer nonprofit Susan G. Komen for the Cure: “Early detection saves lives. The 5-year survival rate for breast cancer when caught early is 98%. When it’s not? 23%.”

Imagine that 100 women receive a diagnosis of breast cancer after feeling a lump at age 67 and die at age 70. Their five-year survival rate is 0 percent. Now imagine that their cancer is detected at age 64 but they still die at age 70. Their five-year survival is now 100 percent, “even though,” Woloshin says, “no one lived a second longer.”

“Just because you are diagnosed earlier doesn’t mean that you will ultimately live any longer,”
From a health perspective, the annual physical exam is basically worthless.

http://www.marketplace.org/topics/life/money-health-care/how-necessary-annual-physical
**Conclusions** General health checks did not reduce morbidity or mortality, neither overall nor for cardiovascular or cancer causes, although they increased the number of new diagnoses. Important harmful outcomes were often not studied or reported.
<table>
<thead>
<tr>
<th>Component of Visit</th>
<th>PHE Data</th>
<th></th>
<th></th>
<th>PGE Data</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Applicable, Million</td>
<td>% With This Service&lt;sup&gt;a&lt;/sup&gt;</td>
<td></td>
<td>Applicable, Million</td>
<td>% With This Service&lt;sup&gt;a&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td>Examination feature</td>
<td>Blood pressure measurement&lt;sup&gt;b&lt;/sup&gt;</td>
<td>44.4</td>
<td>82.9 (78.2-87.6)</td>
<td>19.4</td>
<td>85.7 (80.5-90.8)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Full physical examination</td>
<td>44.4</td>
<td>81.3 (77.8-84.8)</td>
<td>19.4</td>
<td>71.2 (66.0-76.5)</td>
<td></td>
</tr>
<tr>
<td>Routine test&lt;sup&gt;c&lt;/sup&gt;</td>
<td>Complete blood cell count</td>
<td>44.1</td>
<td>32.6 (28.7-36.5)</td>
<td>19.3</td>
<td>9.4 (6.9-11.9)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Urinalysis</td>
<td>44.0</td>
<td>24.9 (21.1-28.8)</td>
<td>19.2</td>
<td>25.1 (18.4-31.7)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Serum electrolyte level&lt;sup&gt;d&lt;/sup&gt;</td>
<td>44.1</td>
<td>15.4 (11.4-19.4)</td>
<td>19.4</td>
<td>2.6 (1.2-4.0)</td>
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</tr>
<tr>
<td></td>
<td>Electrocardiogram</td>
<td>40.3</td>
<td>11.0 (8.1-13.8)</td>
<td>19.2</td>
<td>0.1 (0.0-1.0)</td>
<td></td>
</tr>
<tr>
<td>Preventive test&lt;sup&gt;b,c&lt;/sup&gt;</td>
<td>Papanicolaou smear</td>
<td>16.0</td>
<td>26.6 (22.2-30.9)</td>
<td>16.9</td>
<td>79.3 (75.8-82.8)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Prostate-specific antigen level&lt;sup&gt;e&lt;/sup&gt;</td>
<td>8.8</td>
<td>36.5 (30.6-42.4)</td>
<td>NA</td>
<td>NA</td>
<td></td>
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<tr>
<td></td>
<td>Mammogram</td>
<td>14.1</td>
<td>20.9 (16.0-25.8)</td>
<td>10.5</td>
<td>54.6 (48.1-61.1)</td>
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<tr>
<td></td>
<td>Lipid/cholesterol level</td>
<td>34.5</td>
<td>33.6 (28.8-38.4)</td>
<td>8.5</td>
<td>10.5 (6.9-14.1)</td>
<td></td>
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<tr>
<td>Counseling service&lt;sup&gt;b&lt;/sup&gt;</td>
<td>Weight reduction counseling</td>
<td>13.7</td>
<td>43.7 (31.1-56.4)</td>
<td>0.3</td>
<td>20.6 (7.2-34.1)</td>
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</tr>
<tr>
<td></td>
<td>Tobacco use counseling</td>
<td>5.7</td>
<td>32.5 (25.8-39.2)</td>
<td>2.2</td>
<td>31.4 (21.0-41.8)</td>
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<tr>
<td></td>
<td>Diet/nutrition counseling</td>
<td>9.7</td>
<td>36.5 (30.9-42.1)</td>
<td>0.8</td>
<td>44.3 (27.8-60.7)</td>
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<tr>
<td></td>
<td>Exercise counseling</td>
<td>9.7</td>
<td>25.6 (20.1-31.0)</td>
<td>0.8</td>
<td>38.2 (24.6-51.8)</td>
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<tr>
<td>Any preventive test or counseling service&lt;sup&gt;f&lt;/sup&gt;</td>
<td>44.4</td>
<td>52.9 (48.8-57.0)</td>
<td>19.4</td>
<td>83.5 (80.7-86.3)</td>
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<td></td>
</tr>
</tbody>
</table>

Abbreviations: See Table 1.
<sup>a</sup>Data are given as rate (95% confidence interval).
<sup>b</sup>Applicable PHEs and PGEs are defined by the target population in the US Preventive Services Task Force. These are listed in eFigure 1 (available at: http://www.archinternmed.com).
<sup>c</sup>Visits in which a diagnosis code or reason for the visit would make the test clinically indicated were removed from the numerator and denominator. Criteria are listed in eFigure 1.
<sup>d</sup>Data are limited to 2003 and 2004.
<sup>e</sup>The US Preventive Services Task Force states evidence for routine prostate-specific antigen screening in men is mixed. If beneficial, it would be in men aged 50 to 70 years.
<sup>f</sup>Includes Papanicolaou smear, prostate-specific antigen, mammogram, cholesterol screening, weight reduction counseling, tobacco use counseling, diet/nutrition counseling, and exercise counseling.
### Table 4. Estimated Costs of PHEs and PGEs

<table>
<thead>
<tr>
<th>Service</th>
<th>Medicare Reimbursement, $</th>
<th>PHE Data</th>
<th>PGE Data</th>
<th>Combined Yearly Cost of PHEs and PGEs, $ Million</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. With Service, Millions</td>
<td>Yearly Cost of Service, $ Million</td>
<td>No. With Service, Millions</td>
<td>Yearly Cost of Service, $ Million</td>
</tr>
<tr>
<td>PHE or PGE</td>
<td>98.37</td>
<td>44.4</td>
<td>4369.5</td>
<td>19.4</td>
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<td>Examination feature</td>
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<tr>
<td>Blood pressure measurement</td>
<td>0a</td>
<td>36.8</td>
<td>NA</td>
<td>16.7</td>
</tr>
<tr>
<td>Complete physical examination</td>
<td>0a</td>
<td>36.1</td>
<td>NA</td>
<td>13.8</td>
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<td>Clinical testing</td>
<td></td>
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<td></td>
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<tr>
<td>Complete blood cell count</td>
<td>8.84</td>
<td>14.4</td>
<td>127.0</td>
<td>1.8</td>
</tr>
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<td>Urinalysis</td>
<td>3.10</td>
<td>11.0</td>
<td>34.0</td>
<td>4.8</td>
</tr>
<tr>
<td>Serum electrolyte level</td>
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<td>4.4</td>
<td>41.1</td>
<td>0.4</td>
</tr>
<tr>
<td>Electrocardiogram</td>
<td>27.18</td>
<td>4.4</td>
<td>120.1</td>
<td>0.1</td>
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<tr>
<td>Papanicolaou smear</td>
<td>14.76</td>
<td>4.3</td>
<td>62.8</td>
<td>13.4</td>
</tr>
<tr>
<td>Prostate specific antigen level</td>
<td>25.54</td>
<td>3.2</td>
<td>81.8</td>
<td>0</td>
</tr>
<tr>
<td>Mammogram</td>
<td>86.51</td>
<td>2.9</td>
<td>254.6</td>
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<td>Lipid/cholesterol level</td>
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<td>69.6</td>
<td>0.9</td>
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<td>Counseling service</td>
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<td>Weight reduction counseling</td>
<td>0a</td>
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<tr>
<td>Tobacco use counseling</td>
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<td>1.8</td>
<td>NA</td>
<td>0.7</td>
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<tr>
<td>Diet/nutrition counseling</td>
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<td>3.5</td>
<td>NA</td>
<td>0.4</td>
</tr>
<tr>
<td>Exercise counseling</td>
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<td>0.3</td>
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<tr>
<td><strong>Total</strong></td>
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<td>NA</td>
<td>5160.5</td>
<td>NA</td>
</tr>
</tbody>
</table>

Abbreviations: See Table 1.

*a* No additional reimbursement for this service beyond payment for visit.
Key Question #1. How accurate is the screening pelvic exam for detection of malignancy (other than cervical), pelvic inflammatory disease (PID), or other benign gynecologic conditions?

We identified three studies that investigated the diagnostic accuracy of the pelvic examination for detecting ovarian cancer and one for bacterial vaginosis. There were no diagnostic accuracy studies of other malignancies, PID, or any other benign gynecologic conditions in this population.
Is there any value in bimanual pelvic examination as a screening test.

Grover SR, Quinn MA.
Department of Obstetrics and Gynaecology, University of Melbourne, Royal Women's Hospital, Carlton, VIC.

Abstract

OBJECTIVES: To assess the place of bimanual pelvic examination as a routine procedure in healthy women.

METHODS: 2623 healthy, asymptomatic volunteers (mean age, 51 years; range, 25-92 years) underwent pelvic examination as part of an ovarian cancer screening program. The presence of a bulky or fibroid uterus and adnexal abnormality was noted. Pelvic ultrasonography was used to investigate adnexal abnormalities and was also performed in all women with an elevated serum CA-125 antigen level (> 35 U/mL). Laparoscopy or laparotomy was performed as clinically indicated.

RESULTS: A bulky or fibroid uterus was detected in 12.9% of women. The prevalence of abnormal adnexal findings was 1.5%, with a positive predictive value for a subsequent diagnosis of benign adnexal abnormality of 22%. The specificity of vaginal examination for malignancy was 99.9%. No ovarian malignancies were identified at initial screening.

CONCLUSIONS: This "routine" procedure is undertaken in the belief that it serves a screening purpose. The detection of benign uterine abnormality is of no clear benefit as progression to malignancy is rare. Bimanual pelvic examination is of questionable value as a screening strategy in view of the low incidence of ovarian cancer in healthy women, and the relatively high prevalence (1.5%) of relatively unimportant adnexal abnormalities.
Pap tests

When you need them—and when you don’t

It's important for women to get regular Pap tests, which check for abnormal cells in the cervix that might lead to cervical cancer. But many teenage girls and some women have the test when they don’t need it. Here’s why:

Pap tests usually don’t help low-risk women.

Cervical cancer is rare in women younger than 21, even if they’re sexually active. Plus, abnormal cells found in these younger women usually return to normal, making follow-up treatment unnecessary and possibly harmful. Similarly, cervical cancer rarely occurs in women older than 65 who have had regular Pap tests with normal results. Continued testing doesn’t help them but can produce misleading results that lead to unnecessary treatments. And Pap tests aren’t useful for women of any age who have had their cervix removed during a hysterectomy and have no history of cervical cancer or pre-cancer.

CONSUMER REPORTS’ ADVICE

How can you protect yourself against cervical cancer?

- Get vaccinated against HPV. Girls age 11 or 12 should consider the vaccine, which is given in three shots and protects
Clinical Breast and Pelvic Examination Requirements for Hormonal Contraception
Current Practice vs Evidence

Felicia H. Stewart, MD; Cynthia C. Harper, PhD; Charlotte E. Ellertson, PhD; David A. Grimes, MD; George F. Sawaya, MD; James Trussell, PhD

“The extent to which beliefs are based on evidence are very much less than believers suppose.”

Bertrand Russell 1927
Empowering patients through shared decision-making.
The DECISIONS Study:
A Portrait of How Americans Make
Common Medical Decisions

Brian J. Zikmund-Fisher, Ph.D.
Health Behavior & Health Education, U. of Michigan Public Health
Internal Medicine (General Medicine), U. of Michigan Medical School
Center for Bioethics & Social Sciences in Medicine (CBSSM)

Funding:
Foundation for Informed Medical Decision Making
(www.fimdm.org)

DECISIONS Study Findings

• Patients often not knowledgeable about the basic benefits and risks of their treatment
• Patients usually not asked for their preferences about treatment
• Providers discuss pros of treatments more than cons
• Providers advise “do it” 65-95% of the time
# Top three goals and concerns for different breast cancer decisions

<table>
<thead>
<tr>
<th>Decision: Goal</th>
<th>% top 3 Patient</th>
<th>% top 3 Providers</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery: Keep your breast</td>
<td>7%</td>
<td>71%</td>
<td>P&lt;0.01</td>
</tr>
<tr>
<td>Reconstruction: Look natural without clothes</td>
<td>59%</td>
<td>80%</td>
<td>P=0.05</td>
</tr>
<tr>
<td>Chemotherapy: Live as long as possible</td>
<td>33%</td>
<td>96%</td>
<td>P=0.01</td>
</tr>
<tr>
<td>Reconstruction: Avoid using prosthesis</td>
<td>33%</td>
<td>0%</td>
<td>P&lt;0.01</td>
</tr>
</tbody>
</table>

Lee et al HEX 2010
“Studies also illustrate the potential for wider adoption of shared decision making to reduce costs.

Consistently, as many as 20% of patients who participate in shared decision making choose less invasive surgical options and more conservative treatment than do patients who do not use decision aids.3

In 2008, the Lewin Group estimated that implementing shared decision making for just 11 procedures would yield more than $9 billion in savings nationally over 10 years.

In addition, a 2012 study by Group Health in Washington State showed that providing decision aids to patients eligible for hip and knee replacements substantially reduced both surgery rates and costs — with up to 38% fewer surgeries and savings of 12 to 21% over 6 months.4

The myriad benefits of this approach argue for more rapid implementation of Section 3506 of the ACA.”
Improving Practitioners’ Decision Support Skills

Faculty Developers

Annette O’Connor, RN PhD  
Emeritus Professor, University of Ottawa  
Visiting Scholar, The Dartmouth Institute for Health Policy and Clinical Practice, NH, USA

Dawn Stacey, RN PhD  
Associate Professor, University of Ottawa

Mary Jane Jacobsen, RN MEd  
Adjunct Professor, University of Ottawa

Target Audience

The Ottawa Decision Support Tutorial (ODST) is intended for health professionals and others involved in counselling and supporting people making decisions about health or social situations.

Participant Objectives

Upon completing the ODST, participants should be able to:

- describe concepts of decision support
- identify complex decisions requiring decision support
- explain how to assess patients' decisional needs
- tailor decision support to patients' needs
- explain how to use patient decision aids
- discuss how to evaluate decision support interventions

How to Proceed Through the ODST

1. Complete the 10 Sections (1 to 2 hours).  
The first 9 sections are followed by self-assessment tests that provide you with feedback on your comprehension; tests may be reviewed or retaken as often as you wish. Section 10 is a case study that shows an example of providing decision support incorporating a patient decision aid. If you do not complete the ODST in one sitting, you can log back in at any time and resume the ODST where you left off.

2. Write the final quiz to attain certification.
Decision Aids Shown (Again) to Improve Decision Quality

Posted on April 4, 2012 by IMDFoundation

The updated Cochrane Collaborative review of 86 randomized control trials (in six countries), involving 34 decisions, set out to determine how well decision aids prepare people to participate in decisions that involve weighing benefits, harms and scientific uncertainty. What the authors found was that decision aids not only improve the individual’s knowledge of their options, including the benefits and harms of those options, but decision aids also assist people in reaching choices that are more...
You are seeing this video because you are making medical decisions for a person with advanced dementia. Davis intones the words in a calm, uninflected voice. I’ll show you a video of a person with advanced dementia. Then you will see images to help you understand the three options for their medical care.
Process for Motivational Interviewing

- Develop Discrepancy - between actual and ideal behavior; between behavior and larger values
- Roll with Resistance – never meet force with force; avoid “righting reflex”
- Express Empathy - even (especially?) in the face of resistance
- Support Self-efficacy - actively support and affirm client strengths; allow maximum freedom and choice
Microskills

- Affirmations - to support strengths, convey respect and appreciation, deflect resistance
- Reflective listening – to explore concerns, convey understanding, deflect resistance; elicit change talk
- Open-ended questions – to explore concerns, promote collaboration, understand client’s perspective
- Summaries - to organize discussion, clarify motivation
- Elicit change talk – get the client to tell you what the target problem is

Adapted from: Jonathan Krejci, Ph.D., Princeton House Behavioral Health Version 01/24/06
How to empower consumers

- http://decisionaid.ohri.ca/
- https://decisionaid.ohri.ca/ODST/odst.php
- Health coaching / applying motivational interviewing skill building
- http://healthcarebluebook.com/
  (very MD oriented – we need an NP friendly video of the same quality…)
- http://www.healthnewsreview.org/
- http://www.healthwise.org
- http://www.youtube.com/user/InformedChoiceTDI/videos
More resources


- http://www.ithinkwell.org/can-patients-get-research-they-deserve/
- http://www.youtube.com/watch?v=Ij8bPX8llNg&feature=youtu.be
- http://www.optiongrid.org/
- http://www.bmj.com/multimedia/video/2012/10/03/harms-overtreatment
- http://www.preventingoverdiagnosis.net/
- http://sellingsickness.com/final-presentations/
- http://www.tdi.dartmouth.edu/
Thank you!
Thank you!

geh@unh.edu