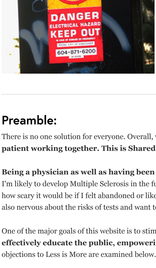

We wouldn't have to change the culture of medicine if there wasn't some controversy to overcome. Frequently Asked Questions (FAQs) and objections are discussed here.

There are lots of barriers to achieving a "Less is More Approach" to medicine. **Fear of taking this approach too far and winding up with "too little" medicine is probably the most common apprehension.**

Overall, it should be clear by now that the message is this: **we need to think twice before ordering a test or pursuing a treatment; the primary reason for being careful is that harm can come from tests and treatment, just as much as it can come from not ordering the right test or treatment.**

Preamble:

There is no one solution for everyone. Overall, **whatever the decision, it should be made with both the healthcare provider and the patient working together. This is Shared Decision Making (SDM) which is a part of patient-centred care.**

Being a physician as well as having been a patient with a serious condition myself – I was diagnosed with Transverse Myelitis and am told I'm likely to develop Multiple Sclerosis in the future (see my blog about it here) – **I feel I can speak from both sides of the experience.** I know how scary it would be if I felt abandoned or like my issues were not investigated or treated to the extent I thought was needed. At the same time, I am also nervous about the risks of tests and want to know what I'm, getting into before starting down any path.

One of the major goals of this website is to stimulate discussion. **Once we get talking about it, we can generate ideas about how to effectively educate the public, empowering patients and their providers to make wise decisions together.** Some of the (exaggerated) objections to Less is More are examined below.

Explore the headings below: [show all] [hide all]

From Patients:

1. "YOU HAVE TO ORDER THAT TEST! MY MOM HAD IT DONE AND IT FOUND HER CANCER!" + show/hide

- **There are lots of personal, anecdotal, and emotional reactions to suggestions in changing the way we deliver or receive care**. A great example is the range of responses to a Canadian paper showing that screening mammography does not reduce breast cancer deaths (as a sample, read the comments section of NPR's Diane Rehm's show which featured Dr. Shannon Brownlee discussing the subject). These kinds of responses are not invalid; rather, they must be acknowledged and worked through.
    - Some women are angry because they feel the screening has value, and don't want to be denied it for fear they'll develop breast cancer and not receive treatment in time to save their life
    - On the other hand, there are women who had 'DCIS,' a form of breast cancer than might not be cancerous at all; they said that had they known (before) that the DCIS was non-invasive and not likely to ever kill them, they would rather have not had surgery, radiation, and chemotherapy. They also state that they would rather not have had the mammogram in the first place, since it led to all this intervention which was in retrospect unnecessary.
    - A few of the reactions acknowledge the evidence including the idea that mammograms themselves may be harmful, but emphasize that each woman needs to have a discussion with her healthcare provider and needs to understand her risk.
    - Others focus on conflicts of interest, develop conspiracy theories, suggest the physician should be the one to make the call, misinterpret the word "screening," etc.
- **We have to be really careful about the phenomenon of Lead Time Bias** - this is "the bias that occurs when two tests for a disease are compared, and one test (the new, experimental one) diagnoses the disease earlier, but there is no effect on the outcome of the disease — it may appear that the test prolonged survival, when in fact it only resulted in earlier diagnosis when compared to traditional methods." (Wikipedia)
- **The variety of reactions make the case for Shared Decision Making (SDM), one of the key components of the Less is More approach**; healthcare providers can help patients separate goals for living from gut reactions, at the same time addressing the fears and unique thoughts of that individual, and interpreting the evidence in the context of that patient. Each woman needs a slightly different approach; if the goal is to avoid developing cancer, appropriate screening and counseling about lifestyle practices should be undertaken.
- Some women have an inherently higher risk of developing breast cancer, and should be tested. There may be other cases where mammography is optional, and women who want the test will, in being tested, have to accept the risks of false positives or of aggressive management of benign findings.
- Certain tests and treatments may be de-listed (no longer covered by health benefits) if they are shown to harm or not to help; **the costs and risks of pursuing these things privately will be up to the patient and the discussion with their caregiver.**

2. "THE OTHER DOCTOR DID AN X-RAY/GAVE ME ANTIBIOTICS/CHECKED MY THYROID, SO WHY WON'T YOU!?" + show/hide

- **There will definitely be variations in style of practice between healthcare providers** in this model. There already are. Some doctors test and treat things more, some others prefer to watch and wait. There are a lot of grey areas in medicine and there are often many right answers to how to do something. Even those who follow the "guidelines" follow different guidelines. For example, guidelines for managing osteoporosis from the Province of BC differ from those of Osteoporosis Canada; in BC, "Bone Mineral Density (BMD) is not indicated unless patients (men and women) are age > 65 years, at moderate risk of fracture (10 - 20% 10-year risk), and results are likely to alter patient care." In the Osteoporosis Canada guide, all adults over Age 65 or those who are younger and have risks - **regardless of whether it will change management** - should have a BMD scan.
- In keeping with a "Less is More" style, many physicians have begun to be quite careful about antibiotic prescribing. We use them according to guidelines and the latest evidence, avoiding over-prescribing given the risk of developing antibiotic resistant organisms (AROs). However, we know that some patients do not understand this practice and want antibiotics whenever they are sick, including when they have viral illness (where antibiotics are not indicated as they are not effective). They go and see a different doctor, and that doctor may prescribe them antibiotics. Some doctors are doing the "right" thing, others are doing what they think is "safest" and may not be aware of the harms, and still others are doing the "easy" thing.
- Some doctors are better at saying "no" than others. We want to help people and above all we do not want to do harm. When patients ask repeatedly for what is – according to the evidence and the guidelines – an unnecessary test, it is hard to keep saying no. We need to maintain trust and a good rapport in order to be effective partners in care with our patients, but it is hard to do this if the patient feels they aren't getting what they want.
- **There is proof that getting what you want actually does not mean you'll be healthier**; those who are happier with their care are sicker. That's probably because of greater use of discretionary care and the advent of medicalization. Here are a few articles about it:

"Adjusting for sociodemographics, insurance status, availability of a usual source of care, chronic disease burden, health status, and year t utilization and expenditures, respondents in the highest patient satisfaction quartile (relative to the lowest patient satisfaction quartile) had lower odds of any emergency department visit, higher odds of any inpatient admission, 8.8% greater total expenditures, 9.1% greater prescription drug expenditures, and higher mortality." (A National Study of Patient Satisfaction, Health Care Utilization, Expenditures, and Mortality, JAMA; see also How Patient Satisfaction Can Kill, the Kevin MD reaction to the JAMA article)

"The push to deliver patients who report being satisfied is changing how the principle of patient autonomy is interpreted; self-determination (the patient's right to accept or reject proposed treatments) in some contexts is evolving into patient-directed care (where patients demand specific tests or treatments). The struggle between true patient-centred care (patient engagement within the process of evidence-based medicine) and patient-directed medicine is readily apparent in the internet age where patients increasingly have specific requests for care based on their own information gathering, which may not be evidence-based or clinically warranted. In our attempts to increase patient satisfaction, we may be establishing frameworks that actually cause harm." (Incentives to increase patient satisfaction: Are we doing more harm than good?, CMAJ)

3. "WHAT ABOUT PREVENTATIVE HEALTH? ISN'T THAT THE MOST EFFECTIVE INVESTMENT?" + show/hide

- Good point! **Yes, preventative health care is underfunded and underpracticed, despite being shown to be quite effective at improving health and wellness.** Milstein & Co. argue it well with a simulated scenario in Why Behavioral And Environmental Interventions Are Needed To Improve Health At Lower Cost(Health Affairs). That said, we have so far had a very hard time convincing government to invest up front for a healthcare redesign that targets preventative health and social determinants. Part of the problem is that such an investment would take 25 years to show great effect, and in a situation where governments are continually campaigning in 4-year cycles, getting political leaders onboard is extremely difficult.
- One hope for Less is More medicine is that **by showing 1) that physicians and patients can be stewards of the healthcare system & 2) good care can result in financial savings as well as improved health and wellness, perhaps we can convince governments** that healthcare transformation does work.
- If there are savings from a system that focuses on judicious use of resources and evidence-based care including preventative screening where appropriate, those savings could be earmarked for preventative health and tackling social issues that greatly impact health, like poverty and illiteracy.

4. "I FOUND THIS THING ON THE INTERNET. AND I WANT YOU TO DO IT." + show/hide

- **Being educated about your symptoms, condition, and treatment is very important.**
- **Where you get that information from is also very important! So is the way that you present it to your healthcare provider**. A printout from the Internet detailing a radical new treatment is not a bad thing. It is a good place to start a discussion. One thing to remember is that in bringing information to your physician, for example, you are inviting them to discuss it with you, to lend their expertise, and to provide an opinion or recommendation. If it does not fit with your expectations, that should also be discussed. If you present an idea with an open mind, or have questions about what has already transpired or what is being recommended for you, that is wonderful! Sometimes healthcare teams learn about new treatments, support groups, or ongoing research from keen patients.
- On the other hand - **if you tell a physician what test you want and that you will not leave the office until it is ordered - that is usually seen as a pretty hostile approach to 'partnering' in care.**
- There is quite a debate about the continuum from paternalist (doctor knows best), to patient-centred (shared-decision making, focusing on patient's goals), to consumer-demand-based (patient gets exactly what they ask for) care. Whereas most physicians and patients are working toward the patient-centred model, there are many who prefer other styles.
- **One of the things doctors do best is a critical appraisal of information.** We are not just walking medical encyclopedias, we have been trained to integrate evidence, context, and experience to form recommendations tailored to each individual. That's why **we'll be less inclined to take seriously a printout from WebMD** entitled "Fighting Hair Loss in Women" with a tagline *"This content is selected and controlled by WebMD's editorial staff and is brought to you by Pantene"* (Pantene is a shampoo company, in case you don't know!) versus one from the Mayo Clinic entitled "Ca 125 Test" which includes the caveat *"A CA 125 test isn't accurate enough to use for cancer screening in all women — especially premenopausal women — because many benign conditions can increase the CA 125 level"*
- **You can ask your doctor about where to get more information regarding a specific condition**. They should be able to print you handouts or suggest evidence-informed, physician-reviewed websites that will have good quality information.
- **Check out the Act section for some ideas about how you can advocate for the right amount of care**. There are some really good books that deal with how doctors think and how to talk to them which may help with encouraging them to see things from your perspective.

From Healthcare Providers:

1. "I DON'T CARE WHAT IT COSTS, I'M GOING TO ORDER THAT TEST. I DON'T WANT TO GET SUED! IT'S BETTER TO DO SOMETHING THAN NOTHING!" + show/hide

- This approach is called "Defensive Medicine," wherein healthcare providers more likely recommend the test or treatment that will protect them from legal action brought by the patient, than the care that is necessarily the best for the person.
- It's also called CYA-medicine. Cover your ... you can guess the rest.
- Forbes has an article explaining the harms of this way of practicing: Defensive Medicine: A Cure Worse Than The Disease. They share that "75 percent of doctors say that they order more tests, procedures and medicines than are medically necessary in an attempt to avoid lawsuits." Fortunately, they also offer a solution for the excessively litigious United States, in the form of a no-blame Patients' Compensation System.
- The problem can't be better summarized than in this title: "Defensive Medicine Not Only Costs, It Kills."
- Every healthcare provider has the freedom to give care how they see fit, provided that they are practicing within their medical scope, the bounds of their certifying body, the 'reasonable standard of care,' the law, and whatever codes of ethics their professional body has recommended.
- If you are a physician who chooses to order tests that have been shown to be harmful or of no benefit for patients, there are no particular disciplinary consequences, however this site details some of the reasons for moving away from that style of practice. **The tide is shifting; the expectation of "doing no harm" will include avoiding harm from overtesting and overtreatment, as much as it will include negligence or failure to provide the basic standard of care**.
- Physicians are a self-regulating professionals; in Canada, this means that we pay fees annually to national organizations representing either Family Physicians or Specialists. These bodies require us to pass exams and to engage in Continued Medical Education (CME) to ensure our knowledge remains up to date. More importantly, we pay fees to provincial and territorial licensing bodies who provide us a license, accept and pursue complaints against us, and audit us as needed.
- There is a growing movement to have more accountability and even performance indicators of physician practice, including some suggestions of monitoring our effectiveness. As this is an emerging topic, it will not be developed in depth on this site.
    - a taste, one example: B.C. questions whether doctors provide good value for money
- Eventually, physicians will be more closely monitored for their ability to practice to a reasonable standard of care.

2. "THERE WAS THIS ONE CASE, AND THE LADY HAD A (INSERT RARE DIAGNOSIS), AND IT WAS HORRIBLE. I'M NEVER GOING TO MISS THAT DIAGNOSIS AGAIN! ANY PATIENT WITH (INSERT A SYMPTOM) GETS (INVASIVE, EXPENSIVE, NOT VERY ACCURATE TEST), AND THAT'S MY STANDARD OF CARE." + show/hide

- Rare diseases are rare. **Unusual presentations of common diseases are still more common than rare diseases.** Just because you saw a case once, it doesn't mean every labile blood pressure case after that will be due to a pheochromocytoma.
- Yeah, you caught that rare thing once. I've done it too. I have even published two case reports (one pending) about rare presentations; an atrial myxoma (heart tumour causing heart failure) and a case of coccidioidomycosis (Valley Fever, fungal lung infection) in Canada. Despite the fact that it was surprising and interesting, **it would be unreasonable to believe that every patient with heart failure I saw after that also had a tumour in their heart!** Usually, it's just heart failure. But many clinicians suffer from the availability bias, in that something they've recently seen sticks in their mind and influences the decisions they make, simply because it is fresh in their memory.
    - If you let one odd case dictate how you practice for the rest of your career, you are letting the zebras (rare things) get the better of you. Likewise, if you ignore the possibility of zebras at all costs, you will miss a zebra or two!
    - Occam's razor, Anchoring, Gambler's Fallacy. . . there are many decision-making tools and many kinds of cognitive bias in medicine. Being aware of them can change how you work.
- Practicing "Less is More" may lead to some missed findings. All medical standards of practice - including our existing guidelines - will lead to some missed findings. However, for the few things missed from not ordering a test, there will be many more false positive and "incidentalomas" avoided. Overall, if you discuss the "why?" with your patient, enjoy the challenging questions, and stick to evidence-based care (including screening things for which there is demonstrated benefit of screening), you will be doing a good job!

What do you think? Are there reasons to fear a Less is More approach? Is it a slippery-slope? Do we have it all wrong? Email your thoughts or tweet them to @LessIsMoreMed