Dealing with uncertainty
The 21st century GP dilemma

- “The attempt to prevent illnesses has led to labelling of an ever increasing proportion of the population as being at risk and to over diagnosis and treatment”
- Iona Heath President RACGP UK BMJ 25 Aug 12
It’s all good?

- New York Times 2 June 2012: FOR decades, scientific research has shown that annual physical exams — and many of the screening tests that routinely accompany them — are in many ways pointless or (worse) dangerous, because they can lead to unneeded procedures. The last few years have produced a steady stream of new evidence against the utility of popular tests.
Overseas experience

- All preventive activities are associated with harm. Screening turns people into patients, and drags many into the system with over-diagnosis causing needless anxiety, needless appointments, tests, drugs and even operations. There needs to be evidence that demonstrates that benefits outweigh those harms for each preventive activity...there are international "standards" as to what is accepted as an effective screening programme...[WHO and UK National Health Services]
The evidence

- “a small number of periodic screening tests, which depend in part on a patient’s risk factors for illness may be of use “
- NYT 2 June 2012

- Preventative activities need to be based on best available evidence and where possible incorporate the use of clinical guidelines
I am Not Sick,
I am Just A Reflection
Of Your Society.
General practice provides person centred, continuing, comprehensive and coordinated whole-person healthcare to individuals and families in their communities.

There are over 125 million general practice consultations taking place annually in Australia: we see 86% of the population per year.

Prevention and screening is an inherent part of patient care [the ‘whole’ consult].
One of our challenges is to make the most of this opportunity to contribute to preventive health care which:

- Is opportunistic
- Anticipates preventative needs by reminders
- Proactively targets high risk individuals

We must be aware of the potential psychological consequences of a positive screening test: informed consent is essential
On 1 May 2010, changes to MBS: prevention now accepted as an inherent part of the consultation i.e. Level B, c or D consults ‘providing appropriate preventative healthcare’
Prevention

- **Primary:** the promotion of health and the prevention of illness, for example, immunisation and making physical environments safe
- **Secondary:** the early detection and prompt intervention to correct departures from good health or to treat the early signs of disease, for example, **cervical screening**, **mammography**, blood pressure monitoring and blood cholesterol checking
- **Tertiary:** reducing impairments and disabilities, minimising suffering caused by existing departures from good health or illness, and promoting patients’ adjustment to chronic or irremediable conditions, for example, prevention of complications
Screening involves asking questions of, or conducting tests on, patients ‘to identify those individuals who are more likely to be helped than harmed by further tests or treatment to reduce the risk of a disease or its complications’.

Involves assessment of the actual condition, the test itself, the treatment options and critically the outcome.
Screening activities in general practice are complex; they involve patients accessing care as well as general practices adopting systematic approaches to registering and recalling patients, and organising their efforts to maximise the effectiveness of each consultation in providing preventive care. Effective screening requires consideration of subgroups in the population who may have a higher prevalence of a disease or risk factor, or who may have difficulty accessing services.
Screening tests are not "case finding" or "diagnostic" tests.

The purpose of a diagnostic test is to establish the presence (or absence) of disease as a basis for treatment decisions in symptomatic or screen positive individuals (confirmatory test) E.g. taking a mid stream urine (MSU) for evaluation of a urinary tract infection, mammography for a suspicious breast lump.
Reminders

- Medical Director
- Best Practice
- Z med etc.

- Each have prevention prompts [level detail?]
- Each have potential to personalise prompts

- A major issue for practices: Accreditation: RACGP standards for prevention and recall/reminder systems
Guidelines for preventive activities in general practice (7th edition): 479 references!

- guide to who is most at risk and for whom screening or preventive care is most appropriate
- a reminder to check at a glance which preventive activities are to be performed in various age groups and how often
- a check list of preventive activities used according to an individual patient’s health profile
The Red Book 2

- Guidelines are based on current evidence based guidelines for preventive activities.
- New edition to be launched at GP 12 [fully updated]: 8th edition
- In addition: National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people [Second edition]
Whether a preventive activity is beneficial, harmful, or indeterminate (that there is not enough evidence to base a decision) requires a consistent unbiased evidence based approach.

No area typifies this more clearly than the area of cancer screening. “The even-handed interpretation of evidence, balancing harms and benefits, managing over-diagnosis and over-treatment, has been a goal of those drafting the prostate and breast cancer sections of the red book since the early editions. These screening activities have polarised different sectors of the health professions”.

New tools

RACGP PrimaryCare Sidebar®

Is an interactive panel which is displayed on the right hand side of the clinical desktop system.

Developed by PEN Computer Systems and operates with MD and BP (75% plus of the clinical desktop system market).

The PCSB is a platform that can host a range of eHealth tools which can help the practice team improve the effectiveness and efficiency of patient care.
The interactive version of the RACGP evidence-based preventative guidelines, which delivers web-based knowledge specific to the open patient record.

e-red book is the RACGP Oxygen e-health implementation that matches individual patient specific information from the clinical desktop system to the relevant Red Book guidelines to deliver recommended best practice advice appropriate to the presenting patient.

e-red book delivers specific actions that are recommended and due to be performed. Also links to online chapters of the guideline that are relevant for the patient, based on information available from GP desktop system.
Disclaimer: the software being used in this module is for the purposes of education and demonstration only. It does not constitute an endorsement of any particular product.
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Number crunching

- It is critical that each preventative/screening activity is based on sound research evidence of what is effective
- Time management for GPs
Health literacy

- Patient education and counselling contribute to behaviour change for primary prevention of disease. ‘Health literacy’ is the knowledge and skills patients require to maintain their own health including use of health services.
- Communicate!
- The use of behavioural techniques, especially for self monitoring has proven benefit: use written or other audio visual materials
Equity issues

- Making sure that preventive care services reach those who most need them and may be less likely to access them requires a population approach in general practice: **Access: Remoteness**.
- Another RACGP publication, “Putting prevention into practice: guidelines for the implementation of prevention in the general practice setting (the ‘green book’)”
Changing behaviour

- Patients need to develop their own understanding of the problem and what can be done about it.
- These benefits and costs may include answers to the following questions:
  - How big is the problem to the individual?
  - What are the consequences of not doing it?
  - What are the benefits?
  - What are the barriers?

THE STAGES OF CHANGE MODEL
The new red book: same

- sections containing evidence statements and recommendations on preventive activities in general practice
- a child lifecycle summary chart listing activities recommended at each age group from 0-19 years
- an adult lifecycle summary chart listing activities recommended at each age group from 10 years
The new book: different

- there is increased information about what should be covered in health assessments or health checks for particular groups
- levels of evidence and recommendations are now presented alongside “what should be done” and “how often”. References are listed in a separate column
- the amount of guidance has increased but brevity has been maintained to improve clarity
Cancer

- ~ 40% cancers possibly prevented by interventions: e.g. SNAP screening
- 1 in 4 women will develop cancer
- 1 in 3 men will develop cancer
- Risk increases with age
Most common cancers

- Prostate 1/7
- Breast 1/11
- Colorectal 1/19 men: 1/33 women
- Melanoma 1/22 men: 1/35 women
- Lung 1/27 men: 1/42 women

- SKIN cancer remains the commonest cancer
- Thinking prevention...thinking screening...
- Separate sections in Red Book
So, the new Red Book! 1.

- little has changed in the recommendations for screening for most cancers.
Skin cancer

- General population screening for melanoma or non-melanoma skin cancer is not recommended as the prerequisite (evidence to show this reduces death) is not available. Providing education that raises awareness of early detection of skin cancer or its prevention is recommended.

- Assess people opportunistically or when the patient is concerned (about skin lesions or their skin cancer risk) and plan appropriate strategies for their level of risk. People generally should be encouraged to become familiar with their skin, including skin not normally exposed to the sun, and be alert for new or changing skin lesions, particularly those over 40 years of age.
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- Assess people opportunistically or when the patient is concerned [about skin lesions]
Cervical cancer

- Pap smear screening is recommended every two years for women who have ever had sex and have an intact cervix starting from 18-20 years of age (or up to two years after first having sexual intercourse whichever is later). These recommendations are under review because evidence is challenging some of the following recommendations, and may change in the next National Cervical Screening Program renewal.
Breast cancer

- It is recommended that women aged 50-69 years attend the Breast Screen Australia Program every 2 years for screening mammograms (A).
- Women should be aware that a recommendation for clinical breast examination is not possible because there is insufficient evidence that this offers benefit to women of any age (C).
- However it is recommended that all women, whether or not they undergo mammographic screening, are aware of how their breasts normally look and feel, and promptly report any new or unusual changes (such as a lump, nipple changes, a nipple discharge, change in skin colour, or pain in a breast) to their general practitioner.
Ovarian cancer

- Routinely screening for ovarian cancer using blood tests for Cancer Antigen (CA) 125, or trans-abdominal or - vaginal ultrasound provides no benefit
Oral cancer

- There is insufficient evidence to recommend screening by visual inspection or by other screening methods
Organised screening by faecal occult blood testing (FOBT) is recommended for the asymptomatic average risk population from 50 years of age every two years (A) until 75 years of age with repeated negative findings (522, 523). Increased risk is determined by family history and this should include determining the number of relatives affected by colorectal cancer, side of family and age at diagnosis. Digital rectal examination (DRE) is not recommended as a screening tool (D) (but is important in evaluating patients who present with symptoms such as rectal bleeding).
There is insufficient evidence to routinely screen for testicular cancer using clinical or self-examination. Those performing testicular self-examination (TSE) are not more likely to detect early stage tumours or have better survival than those who do not (C).
Routine screening for prostate cancer with digital rectal examination (DRE), the prostate-specific antigen (PSA) or trans-abdominal ultrasound is not recommended. DRE has poor ability to detect prostate disease. Yet some cancers missed by PSA testing alone are detected by DRE, which is why those recommending screening advocate DRE as well as PSA.

The recommendation is contentious. Two large randomised controlled trials (552, 553) found no or marginal benefit. However analysis of the data from one centre contributing to one of these (554) showed an increased survival from prostate cancer (but not mortality from any cause) beyond 10 years. Two recent systematic reviews conclude that screening is not effective.

Even if one were to conclude there was a survival benefit (from current or future trial data), this survival would have to be balanced against the harms of cancer over-detection and treatment.
Prostate cancer

• Our updated recommendation is to not raise the issue with every eligible man, but wait until we are asked about screening. In light of many other proven preventive activities that could be more usefully addressed in men, we believe that prostate cancer screening remains low on the priority list.

• If men ask about prostate screening, they need to be fully informed of the potential benefits, risks and uncertainties of prostate cancer testing. When a patient chooses screening, both PSA and DRE should be performed.
No benefit from screening

- AAA screening
- Vaginal exam
- Ovarian cancer
- Coronary CT scanning
- EST
- Lung cancer
- TSH etc.
Be alert

- The history
- Clinical contemporaneous notes
- Medical software packages
- Recalls and reminders
- RACGP Red Book as a guide
- Think about the sidebar