Bad Guidelines and Overtreatment in Primary Care

Workshop
Preventing Overdiagnosis Conference 2013, Dartmouth College

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Abstract

Introduction: Doctors might wish to practice in a more patient centered way, testing and treating less, but work within cultural and regulatory frameworks which strongly discourage this. Standard guidelines for practice and treatment steer us towards testing, diagnosing and treating our patient populations. The evidence to support an alternative course of action is difficult to access in a time limited environment and tends not to be promoted by official bodies. We therefore have a dual problem of inadequate access to information and barriers to using it, if and when we find it.

Aims: To examine where and how we find our evidence base for daily practice, consider if it is adequate for our purposes and how we can improve on this.

Methods: Presentation looking at the nature of current commonly used guidelines followed by active discussion.

Output: To produce a summary statement commenting on the nature and quality of evidence presented to primary care doctors within guidelines, and to propose or design solutions to drive improvement.

Workshop Report

The workshop was attended by 80 or so delegates at the conference. A short presentation was given by JT using a clinical case of polypharmacy resulting from strict guideline adherence, to stimulate debate.

Participants were asked to share their views on the problem and then to discuss together and suggest what features they would like to see in an ideal evidence resource for generalists.

Results

There was complete consensus about the problems that arise with guideline driven practice – tending to lead to overtreatment and polypharmacy, and a risk of failure to take individual patient considerations into account.

It was acknowledged that some good information resources already exist, but information needs to be more accessible in terms of speed of access and relevance to generalists.

A recurrent theme in discussion was the differing perspectives of specialists vs generalists and a desire for generalists to have a greater sense of freedom to individualise treatment plans. The challenges of multi-morbidity and the application of trial based evidence to different populations were frequently expressed.

The summary points below were collected from the discussion and follow up emails following the conference.

Basics

"Give us the evidence" – use quality assessed summary resources for decision-making to complement guidelines.

There was discussion about whether another guideline is what is needed – the overall feeling was "no", but rather a new **evidence resource** to use to complement existing knowledge and guidelines.

It should be Generalist Led.

Generalists have a unique perspective regarding the use of EBM and the kind of information we want will differ from specialists and those interested in population based outcomes.

Free from special interests

Balanced, well sourced information. No pharma funding, no special interest groups. Draw on existing good quality EBM.

Free and accessible to all.

Produced by a reputable, trustworthy organization.

Clinicians need to feel they can trust the information available, from a clinical and medico-legal point of view. This is important to empower clinicians to deviate from guidelines when appropriate without the sense of fear that they are breaking some kind of rule. i.e. to give a real sense of *permission* to practice in a patient centred way.

What Information do we want?

Clinical trial and meta-analysis results need to be presented in a way that is relevant to patient centered decision making.

This means that "front page" information needs to be expressed as:

ARR, NNT then RRR - in that order.
> NNTs in context of time frame
> Baseline risks explored as much as possible

Harms and NNH clearly expressed where possible.
> Potential mounting harms of poly-pharmacy considered.

End point data first and clarity about use of **surrogate outcomes**.

Breakdown of **composite endpoints**
> e.g. Cardiac vs stroke vs total mortality/morbidity in CV risk modification
> Fracture NOF vs radiologically detected vertebral fractures in osteoporosis treatment.

> This would allow doctors to target treatment according to what the patient wants to achieve.

Information about **trial populations and trial limitations.**
> Extending from this – the question of applicability of trial data to real life patients.

Consideration of **special groups**
> Age, ethnicity, co-morbidity.

Non-pharmacological measures presented with equal weight as drug interventions.

Openness about controversies
> There was much discussion about the "grey areas" where evidence is weak. Rather than producing prescriptive, fudged, best-guess guidance, give us the information and let us decide along with our patients where the evidence is not clear.

Other Considerations

Retaining/reclaiming freedom to deviate from guidelines where clinically appropriate.

Can we address the problem of normal **ageing**?

Can we present the information in such a way that assists tailoring treatment in **multi-morbidity**?
> This will be to do with the layout of the resource.

Importance of **shared decision making** .
> Take your time in decision-making around chronic disease.
> Use tools for shared decision making in primary health care and continue to improve these.

Patient input into development of the resource.

Patient values – **the right to decline.**

Think about when and how to stop long term treatments where appropriate.

Use of **risk engines** – could they be embedded into the resource?

Guidelines - one concern: they create **performance measures**. Ideal performance measures would reflect good quality decision making rather than relying on numerical scores of guideline compliance.

> The need to change metrics / payment by results i.e. focus on patients goals - what matters to patients.

Potential to embed electronic resource in EMRs/ Clinical systems (long term goal)

Another subject for an evidence resource : Investigating symptoms : what do we need to know?
> e.g. investigating PR bleeding in an elderly patient : best value and minimally harmful investigations?
> Perhaps a "second wave" theme for an evidence resource

Next Steps

JT and IH plan to take these workshop outcomes forward and engage with relevant organisations in the UK, the RCGP and NICE to either create such a new evidence resource or promote change or development within existing guidelines and resources.

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