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Doing more does not mean doing better: the FADOI contribution to the *Slow Medicine* program for a sustainable and wise healthcare system

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ABSTRACT

Consistently with its own vision on the necessity to implement a sustainable and frugal medicine, in 2013 the Italian Federation of Associations of Hospital Doctors in Internal Medicine (FADOI) decided to adhere to the Slow Medicine program entitled *Doing more does not mean doing better*, launched in Italy in late 2012, following the Choosing Wisely® campaign of the American Board of Internal Medicine (ABIM) Foundation started in the USA in 2010. According to the program, FADOI has now produced a list of ten evidence-based recommendations of the *do not* type, regarding different practices whose benefits for the patients are questionable at least, if not harmful at worst. The list was obtained from a questionnaire submitted to 1175 FADOI members, containing a purposely selected choice of 32 pertinent recommendations already published by Choosing Wisely®, and reflects the qualified opinion of a large number of Italian internists. These recommendations are now endorsed by the FADOI, as a contribution to the discussion among doctors, health professionals, nurses, patients and citizens about what is worth choosing in medicine; they are also meant to promote a shared decision making process in the clinical practice.

Introduction

In 2013 the Italian Federation of Associations of Hospital Doctors on Internal Medicine (FADOI) has published a position statement on the ways to implement a sustainable and frugal hospital policy, oriented to the real needs of the patients admitted to internal medicine wards,[1] and, subsequently, *the FADOI ten points for a Slow Medicine*,[2] which condensate its vision on this topic. More recently, the FADOI agreed to formally adhere to the Slow Medicine program entitled *Doing more does not mean doing better*, launched in Italy in late 2012.[3]

Slow Medicine (http://www.slowmedicine.it) is an association of doctors, nurses, other health professionals, patients and citizens founded in 2010 in Italy, aimed at promoting a patient-centered medicine and measured, respectful and equitable health care, to be pursued through a high standard of communication between the doctors and their patients, for a shared decision making.

Following the Choosing Wisely® campaign of the American Board of Internal Medicine (ABIM) Foundation started in the USA in 2010,[4-6] Slow Medicine decided to undertake a similar task in Italy, in order to disseminate the same culture (improving quality and appropriateness of care, while ensuring safety) and to promote the reduction of medical procedures whose necessity should be questioned by patients and physicians. The *Doing more does not mean doing better* program is underway, with a growing list of Italian societies of different medical specialties and associations of physicians, nurses and patients being involved (Table 1). In the meanwhile, the Choosing Wisely® campaign is spreading throughout the world, in many European countries, as well as in Canada, Australia and Japan.

Within early 2014, Choosing Wisely® had pro-

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duced a comprehensive repertoire of recommendations of the *do not* type, sustained by 56 American medical societies (the *top five* list of each society), accessible on-line (http://www.choosingwisely.org). This material covers the most relevant areas where appropriateness is put under discussion in the daily activity of an internist. All the recommendations are evidence-based and vouched for by the proponent scientific society. Now, they expect to be endorsed and propagated by the local authorities (*e.g.*, the national scientific societies and other organizations), transferred to the clinical practice and - which is mostly challenging - verified as to application, impact and clinical outcomes.

Overtesting, overdiagnosis, overtreatment as a problem

Overprescription of undue procedures and treatments, which brings about questionable benefits as to health but increased risks as to harms,[6] is a well-recognized phenomenon, which encompasses all specialties. This phenomenon is sustained by increasing expectations by the general population, defensive attitudes by the physicians worried by malpractice claims,[7] occult influence by the stake holders; it produces medical futility,[8] and unjustified expenses. The World Health Organization (WHO) estimates than 20 to 40% of the expenditures for health is due to some forms of wasting. As a consequence, it is recommended that the financial sustainability of the health care systems becomes part of the medical responsibility and education.[9-13]

An exceedingly large series of pertinent examples could be given, in the field of both preventive and curative medicine, pharmacological and surgical therapy, and laboratory and instrumental diagnosis. As to Italy, we have robust data on radiology (where 44% of the outpatient requests result inappropriate after revision[14]), and cardiology (where 14% of the noninvasive procedures and many implantable devices for resyn-

Table 1. The list of the Italian scientific societies and organizations currently involved in the *Doing more does not mean doing better* program of Slow Medicine.

Associazione Italiana di Neuroradiologia - AINR
Associazione Italiana di Psicogeriatria - AIP
Associazione Medici Diabetologi - AMD
Federazione delle Associazioni dei Dirigenti Ospedalieri Internisti - FADOI
Associazione Dermatologi Ospedalieri Italiani - ADOI
Associazione per un'assistenza appropriata in ostetricia e ginecologia - ANDRIA
Società Italiana di Genetica Umana - SIGU
Società Italiana di Allergologia, Asma e Immunologia Clinica - SIAAIC
Associazione Italiana di Medicina Nucleare - AIMN
Collegio Italiano dei Primari di Chirurgia Vascolare
Società Italiana di Cure Palliative - SICP
Federazione Italiana Medici pediatri - FIMP
Associazione Culturale Pediatri - ACP
ISDE Medici per l'Ambiente
Società Italiana di Pedagogia Medica - SIPeM
Collegio Italiano dei Primari Medici Oncologi Ospedalieri - CIPOMO
Cochrane Neurological Field - CNF
Società Italiana di Radiologia Medica - SIRM
Associazione Italiana di Radioterapia Oncologica - AIRO
Associazione Italiana di Dietetica e Nutrizione Clinica - ADI
Società Italiana di Medicina Generale - SIMG
Associazione Nazionale Medici Cardiologi Ospedalieri - ANMCO
Società Italiana di Allergologia e Immunologia Pediatrica - SIAIP
Altre Società scientifiche di IPASVI: ANIARTI, AISLEC, AICO, AIOSS, AIUC, ANIMO

chronization therapy are deemed inappropriate[15,16]). Also the TEMISTOCLE study, a cooperative observational study conducted by the FADOI (Italian internists) and the ANMCO (Italian cardiologists), showed that, in hospitalized patients with heart failure of the same degree of severity, the larger use of diagnostic procedures observed in the cardiological setting (echocardiograms, electrocardiogram monitoring, catheterisms, *etc*.), did not produce better outcomes as compared with the general ward setting:[17] a clear example that doing more does not necessarily mean doing better. Nowadays, the scientific community has shifted from questioning whether *too much* is done in medicine,[18] to stating that *less is more*[19,20] and *choosing wisely* a urgent need.[21]

To a certain extent, overprescription can be deterred by administrative actions (discouraging tickets or disadvantageous payment systems), but medicine doctors should be interested in pro-active measures, oriented towards appropriateness (not merely cost cutting purposes), such as adherence to the existing evidence-based guidelines and consensus statements. It must be underlined that fighting overprescription is not simply a matter of spending containment: in fact, from the doctor viewpoint, appropriateness is the essence of a medical choice and sparing resources not more than a desirable byproduct. As a matter of fact, we must admit that prescribing extra examinations and hopefully curative treatments is much easier than spending more time with the patients, in order to better comprehend their problems, and share with them more judicious choices.[22] Unfortunately, although meritorious, such a performance remains largely unrewarded.

The *Doing more does not mean doing better* program

This Slow Medicine program is ongoing. It aims at improving the quality and the safety of health care, through the reduction of unnecessary medical practices (diagnosis or therapy). Slow Medicine is establishing a partnership with all the scientific societies and other organizations interested in the program.

Each partner is asked first, to determine its own list of the pertinent practices deemed to be not obviously beneficial for the patients, commonly requested, potentially harmful (those already included in the Choosing Wisely® repertoire, but not necessarily restricted to them), and second, to formulate coherent recommendations of the *do not* type, accompanied with the most relevant references and the methodology through which the internal consensus is obtained. The recommendations are to be harmonized by a panel of designated experts, before being diffused to health professionals and citizens, and, subsequently evaluated in terms of impact and final results (http://www.slowmedicine.it).

The FADOI contribution

After its adhesion to the Slow Medicine program (September 2013), the FADOI[23] was asked to contribute with a list of ten recommendations.

In early 2014, the National Council of the FADOI committed two of its component (L.L. and R.F.) to elaborate a questionnaire containing a selection of the available recommendations already published by Choosing Wisely® (270 from 56 scientific societies by February 2014), to submit it to a sample of its members (those affiliated to Piemonte, Veneto, Trentino Alto Adige, Friuli Venezia Giulia, Lazio, Campania) in order to further select the *top ten* list, and to present the results at the FADOI National Congress (May 2014). This method, as an alternative to the establishment of a restricted panel of experts, was meant to encourage disclosure and sharing, at the possible expense of more qualified discussions.

A list of 32 Choosing Wisely® recommendations, those judged to be most relevant for an internist by the committee, was sent, along with an explanatory letter, to 1175 members in March 2014 (Table 2). The order of presentation reflected the timing of their publication by Choosing Wisely®, with no regard to the putative relevance.

Each member was asked to indicate the 5 recommendations considered to be most relevant for his/her own practice, leaving ranking out of consideration. The response rate was 18.1% (213 responders, for a total number of 1037 indications), by April 2014. All recommendations received at least one indication. No substantial differences were observed among regions.

The final *top ten* list is shown in the online Appendix, according to the format requested by Slow Medicine, that is, accompanied by an explanation, bibliographic references, and a note illustrating the applied method. In addition, foreseeing the necessity to monitor both adherence and clinical impact in the future, although not requested, the committee suggested an indicator of performance and an indicator of outcome, to be used for evaluation purposes for each recommendation.

Final remarks

Far from being exhaustive, the FADOI *top ten* recommendations, like others, should promote discussions among doctors, health professionals, nurses, patients and citizens about what is worth choosing in medicine. Being provocative, the *do not* recommendations imply question marks, not new dogmas, and should prevent doctors from uniform choices. By no means they are meant to amend existing guidelines in internal medicine, even though it must be admitted that in this area evidence based decisions are the exception rather than

Table 2. The list of the 32 Choosing Wisely® recommendations of the questionnaire submitted to the FADOI members.

1	*Do not prescribe acid suppressive therapy to hospitalized patients, unless there is a high risk of bleeding*
	it should be reserved to intensive-care patients
2	*Do not prescribe transfusion of red blood cells for arbitrary Hb levels, in the absence of symptoms of heart ischemia, heart failure, stroke*
	in stable patients, accept Hb levels of 7-8 g/dL
3	*Do not use benzodiazepines in elderly patients, as a first choice for insomnia, agitation, delirium*
	high risk of accidents, falls, fractures; keep BZD for alcohol withdrawal and anxiety
4	*Do not treat bacteriuria in elderly patients without urinary symptoms*
	screening for and treatment of asymptomatic bacteriuria are recommended only when procedures with possible mucosal bleeding are anticipated
5	*Do not use NSAID in subjects with arterial hypertension, heart failure, renal insufficiency from any cause, including diabetes*
	prefer safer drugs such as paracetamol, tramadol, short term narcotic analgesics
6	*Do not recommend percutaneous feeding tubes in patients with advanced dementia*
	offer oral assisted feeding, instead
7	*Do not delay palliative care*
	they do not accelerate death
8	*Do not perform carotid artery imaging for simple syncope without other neurologic symptoms*
	it does not identify the cause of the fainting
9	*Do not perform brain imaging (CT/MRI) for simple syncope without other neurologic symptoms or signs*
	except for skull trauma
10	*Do not screen for renal artery stenosis in patients without resistant hypertension and with normal renal function, even if atherosclerosis is present*
	no proven benefit
11	*Do not screen for hypercoagulable conditions after a first episode of deep vein thrombosis with a known cause*
	no proven benefit
12	*Do not recommend carotid endarterectomy for asymptomatic stenosis unless the risk of surgical complications is below 3%*
	restrict indications to >70% stenosis and life expectancy above 3 years
13	*Do not recommend for percutaneous or surgical revascularization of peripheral artery stenosis in patients without claudication or critical limb ischemia*
	no proven benefit
14	*Do not image for pulmonary embolism without a moderate or high pre-test probability*
	consider clinical criteria and D-dimer first
15	*Do not perform PET/CT for cancer screening in healthy subjects*
	it leads to unnecessary biopsies and surgery
16	*Do not prescribe white cell stimulating factors for primary prevention of febrile neutropenia systematically*
	restrict indications to high risk patients (based on age, history and other characteristics)
17	*Do not routinely order US imaging of the thyroid in patients with abnormal functional tests but without palpable abnormalities*
	it identifies a lot of non-relevant nodules
18	*Do not order T3 levels (total or free) to assess levothyroxins (T4) substitution therapy in hypothyroid patients*
	T4 is converted to T3 at cellular level
19	*Do not screen for carotid artery stenosis in asymptomatic patients*
	it leads to undue surgery
20	*In patients with low pre-test probability of venous thromboembolism, use D-dimer measurement as initial diagnostic test, not imaging*
	using the Wells prediction rules, a negative D-dimer excludes VTE
21	*Do not image for uncomplicated cefalea*
	imaging does not improve outcomes, while visualizing incidental findings
22	*Do not repeat DXA scan for osteoporosis more often than once every 2 years*
	minute changes fall within possible errors
23	*Do not use sliding scale insulin for the long term treatment of institutionalized diabetics*
	prefer *basal-bolus* therapy

To be continued on next page

Table 2. Continued from previous page.

24	*Do not routinely prescribe lipid-lowering medications in patients with a limited life expectancy*
	above 85 years the risk of cognitive impairment, falls, neuropathy, muscular damage due to statins increases
25	*Do not prescribe transfusion of red blood cells in young heathy patients without overt bleeding and with Hb >6 g/dL, unless synptomatic or hemodynamically unstable*
	the decision to transfuse should be based on clinical and hemodynamic parameters
26	*Do not routinely prescribe colloid (albumin, dextrans, starches) for volume replacement*
	prefer christalloid (saline)
27	*Do not order transesophageal echocardiography (TEE) to search for embolic sources if a source has already been found and management will not change*
	tests whose results will not change management should be avoided
28	*Do not prescribe erythropoiesis-stimulating agents to chronic kidney disease patients with Hb >10 g/dL, without symptoms af anemia*
	normalizing Hb is not a target, since it does not benefit survival or cardiovascular disease, and may be harmful
29	*Do not place or leave in place peripherally-inserted central catheters (PICC) for patient or providers convenience*
	they should be removed as soon as the original indication ends, for the risk of infections and thrombosis
30	*Do not repeat chemistry testing in the face of clinical and laboratory stability*
	useless repetition augments expenditures
31	*Do not test for thrombophilia in patients with venous thromboembolism occuring in settings of transient high risk (surgery, trauma, prolonged immobilitation)*
	the therapeutic strategy does not change, while its duration risks to be inappropriately prolonged
32	*Do not administer plasma or prothombin complex concentrates for reversal of vitamin K antagonists, besides emergency situations (major bleeding, intracranial hemorrage, emergent surgery)*
	in non-emergent situations, withhold anti-vitamin K and/or administer vitamin K

Hb, hemoglobin; BZD, benzodiazepines; NSAID, non-steroidal anti-inflammatory drug; CT, computed tomography; MRI, magnetic resonance imaging; PET, positron-emission tomography; US, ultrasonography; VTE, venous thromboembolism; DXA, dual energy X-ray absorptiometry.

the rule. They also should help doctors to discern what is health oriented from what is disease oriented, providing them with a patient-centered mind.

In spite of being sparing in terms of money, the *do not* policy, requiring relationship, is demanding, and it is certainly expensive in terms of time.

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