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Choosing Most Wisely

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Our Evidence-Based Medicine Task Force has worked hard to combine the reality of the evidence, the lack of evidence, and feedback from SGIM members. Reading the fine print is essential to understanding the nuances of the recommendation.

Tomorrow morning I'll be seeing patients in my primary care practice. I have 10 patients scheduled—nine of my own and one urgent care visit of a colleague's patient. The scheduled patients range in age from 48 (the urgent care patient) to 94; in addition to the 94-year-old, four are in their 80s (87, 85, 83, 81), two in their 70s, and one more youngster of 51.

The 94-year-old, Ms. T, is actually the healthiest. She has incredibly stable hypothyroidism and some osteoarthritis but is otherwise remarkably well. Ms. T has few relatives, lives alone, takes one medication, and declines all preventive health options, except the flu shot. She is upbeat, energetic, involved in the lives of her neighbors. She bristles at her protective, condescending niece.

I've known Ms. T for 16 years; I've met her landlord who is her healthcare proxy, have talked with her about her dying brother, and know a lot about her end-of-life preferences. How often do I need to see her? What is the value of our regular visits—on top of the every-once-in-a-while TSH check to prove she should remain on the same replacement dose? Should she have an annual visit? She doesn't want preventive measures. She doesn't have much in the way of medical problems. Her last visit was 6 months ago; at that time her TSH was normal. I suggested hearing aids. She is scheduled for a "check up" tomorrow morning.

The 51-year-old is a nurse manager, Ms. M. She has hypothyroidism as her only real medical problem and takes one medication. I've known her for about a decade and a half. Some years she sees me and some years she doesn't, mostly depending on how busy her life is. I know about her kids, her ex-husband's tragic death, and her concern about living a long life to be there for her children. Ms. M. is completely up to date with her preventive measures and has had the flu shot, but she is scheduled to see me for an annual physical tomorrow.

Does either of these patients need a "check up" tomorrow? Well, it depends on what you mean by a check up.

SGIM has a love-hate relationship with the annual physical. In 2013, the Evidence Based Medicine Task Force (EBMTF) agreed to create five "Choosing Wisely" recommendations for the ABIMF Foundation (ABIMF). Choosing Wisely is an effort to control utilization. Launched in 2012, Choosing Wisely® aims to advance a national conversation about avoiding wasteful or unnecessary medical tests, treatments, and procedures. More than 70 medical societies have joined the movement and have identified things that "providers and patients should question"[1]

The ABIMF required that the recommendations be highly structured—SGIM was to present them as negatives (things *not* to do) with a bolded sentence leading a very short initial paragraph. After a work group drafted the five recommendations, SGIM's council voted to approve, and the recommendations were published on the Choosing Wisely Web site. Four were very straightforward (don't use urinary catheters for provider or patient convenience; don't screen for cancer in patients who have short life expectancy; don't do pre-operative testing before low risk procedures, don't use finger stick monitoring in Type II diabetes).[2]

The fifth reads "*Don't perform routine general health checks for asymptomatic adults*" in the bolded first line. The fine print summarizes the available evidence that routine checks and screening (annual physical examination and blood tests) have not been shown to reduce mortality, morbidity, or hospitalizations, and that they may increase the potential for harm from unnecessary testing.

Although the evidence-based recommendation garnered substantial positive public attention, was lauded by Consumer Reports, and reported in the *NEJM*, the recommendation didn't sit well with a sizable group of SGIM's members.[3,4] Then-President Eric Bass summarized initial reactions in two *Forum* columns, one of which was accompanied by Letters to the Editor.[5,6,7,8] One letter, signed by 27 SGIM members, spoke of the value of relationship-building in regular visits, independent of improvements in morbidity and mortality: "Time spent getting to know patients as human beings may not yield readily measurable improvements in disease outcome but is essential to the art of healing".[7] Many members felt that SGIM was holding the core of its interactions with our patients—to build relationships and develop regular opportunities to communicate about health—to an impossible standard of evidence for benefit. Based on old studies that often did not reflect modern practice, the evidence

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base for or against "general health checks" is of poor quality and those studies typically do not gauge harder-to-measure outcomes, such as trust, communication, and behavior. After a well-attended, passionate, and somewhat acrimonious town hall event at the Annual Meeting that year, the SGIM council voted not to rescind the recommendation.

Fast forward to 2016 (and, by the time of this publication, 2017). This year, SGIM is required to "update" our original five recommendations. The EBMTF updated the literature reviews, made a few improvements to the non-controversial four other recommendations, and tackled the white elephant in the room—general check ups. The EBMTF process has been very thoughtful, incorporated multiple rounds of revision, and included an e-mail to the entire membership soliciting input.

First, the EBMTF presented its new draft to the Executive Committee of Council: The officers gave feedback, and, as a result, a second version was presented to the full Council a few weeks later. More active discussion ensued. Marshall Chin, Immediate Past President, collected this second, extensive set of comments and summarized it for the EBMTF to consider. The EBMTF approached the ABIMF to ask whether the word count and other parts of the required structure could be flexible. Then, yet a third draft was shared on GIM Connect in late September, inviting all SGIM members to reply to the post with comments. At least 18 members commented, and again the passion of our members about the importance of regular visits as opportunities for relationship-building with patients was palpable. Finally, the EBMTF incorporated the comments from GIM connect into one final version and presented it to Council for approval at our recent winter retreat.

Council approved the final version unanimously, and it has gone to the ABIMF for final approval. There is a chance that ABIMF will ask us to shorten the initial sentence and paragraph or make other edits, so I don't want to promise final wording; however, the bolded first sentence we submitted reads:

> *For asymptomatic adults without a chronic medical condition, mental health problem, or other health concern, don't routinely perform annual general health checks that include a comprehensive physical examination and lab testing. Adults should talk with a trusted doctor about how often they should be seen to maintain an effective doctor-patient relationship, attend to preventive care, and facilitate timely recognition of new problems.*

I hope you will read the fine print of the entire recommendation when it becomes finalized and posted. Our Evidence-Based Medicine Task Force has worked hard to combine the reality of the evidence, the lack of evidence, and feedback from SGIM members. Reading the fine print is essential to understanding the nuances of the recommendation.

What will I do for Ms. T. and Ms. M.? For Ms. T., the 94-year-old with hypothyroidism, I'll assess her housing, social connections, cognition, fall risks, and reassess her end-of-life care preferences. I'll do a very limited physical examination—vital signs, mental status, and a get-up-and-go test. I'll check her TSH but no other blood work, unless directed by symptoms and signs. For Ms. T., I am abiding by the Choosing Wisely recommendation—I'm not doing an annual general health check with lab tests. And I do always discuss with her when she should come to see me next. I err on the side of suggesting regular visits despite any medical problems besides hypothyroidism. I can't measure the value of those regular visits nor really support them based on her medical history, but I do believe that they have value to her health *and* to my own satisfaction as her doctor.

For Ms. M., the 51-year-old with hypothyroidism, I probably won't be strictly abiding by the recommendation. She is due for cervical cancer screening, so I'll have her get fully undressed and do a pretty complete physical examination. She does need a pap smear, but doesn't really need me to feel her lymph nodes or listen to her heart and lungs (assuming she is asymptomatic). I'll order her TSH but also cholesterol and glucose tests (when she doesn't strictly meet criteria for screening for diabetes) since I'm drawing blood. But, at the end of the visit, when it's time to decide when her next appointment should be, I'll engage her in the conversation and tell her that I don't know the right answer—but that probably she doesn't need this all over again in just one year.

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I'll keep trying to Choose Most Wisely, just like SGIM's EBMTF.

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