AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

On the Radar

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On the Radar
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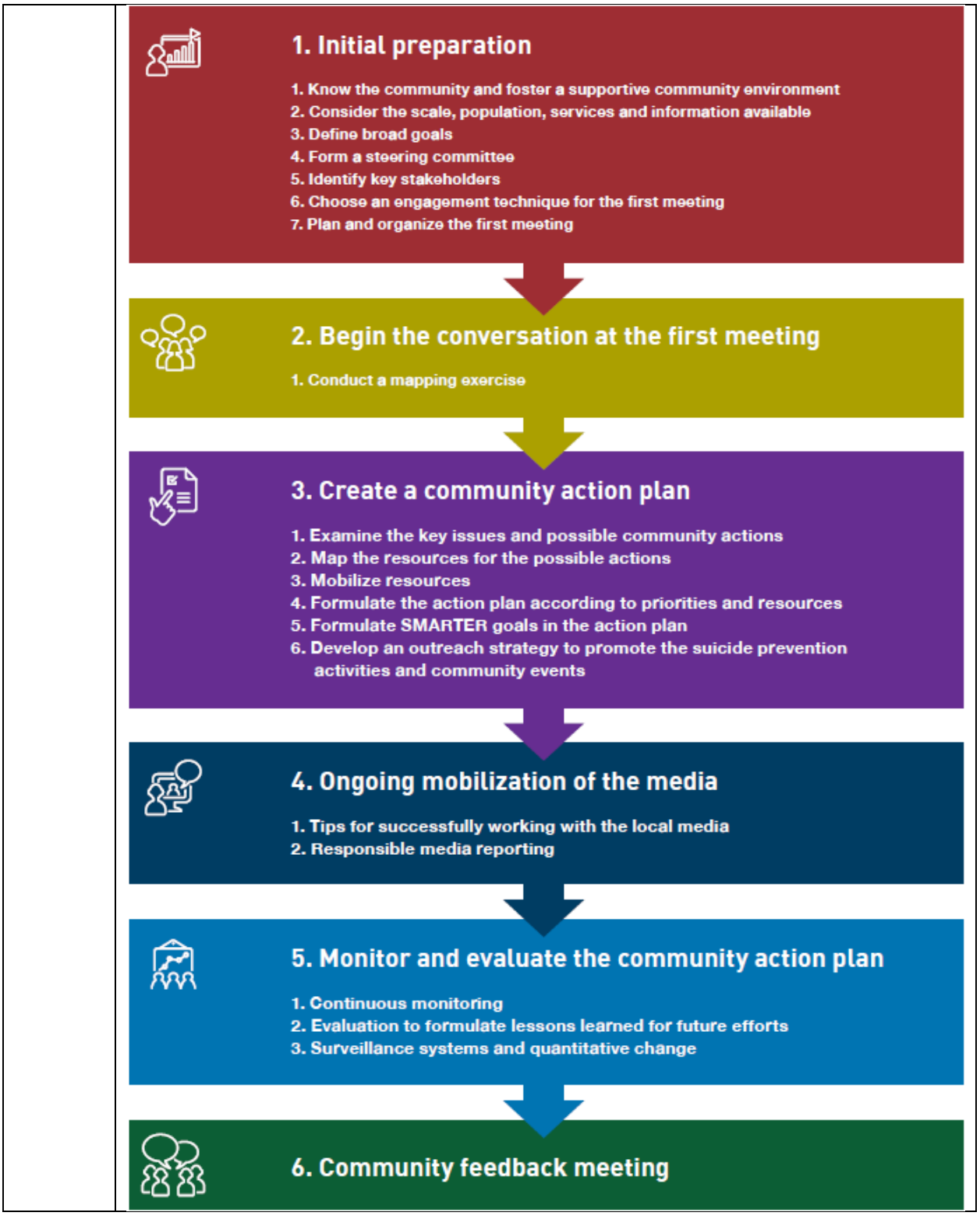
Reports

Suicide prevention: toolkit for engaging communities
World Health Organization
Geneva: World Health Organization; 2018. p. 99.

URL	http://www.who.int/mental_health/suicide-prevention/engaging_communities_toolkit
Notes	On World Suicide Prevention Day, 10 September, the World Health Organization released this toolkit. The toolkit a **step-by-step guide** for people who would like to initiate **suicide prevention activities in their community**. According to the WHO's website, it describes a participatory bottom-up process by which communities (including community leaders, health workers, parliamentarians, teachers, social workers, police and firefighters and business leaders) can work together to identify, prioritize and implement activities that are important and appropriate to their local context and that can influence and shape policy and services. Advice and practical tools to help with goal setting, stakeholder mapping and development of an action plan are included as are examples of successful initiatives in Canada, India, Kenya, Nepal, Trinidad and Tobago and the USA.


1. Initial preparation
1. Know the community and foster a supportive community environment
2. Consider the scale, population, services and information available
3. Define broad goals
4. Form a steering committee
5. Identify key stakeholders
6. Choose an engagement technique for the first meeting
7. Plan and organize the first meeting
2. Begin the conversation at the first meeting
1. Conduct a mapping exercise
3. Create a community action plan
1. Examine the key issues and possible community actions
2. Map the resources for the possible actions
3. Mobilize resources
4. Formulate the action plan according to priorities and resources
5. Formulate SMARTER goals in the action plan
6. Develop an outreach strategy to promote the suicide prevention activities and community events
4. Ongoing mobilization of the media
1. Tips for successfully working with the local media
2. Responsible media reporting
5. Monitor and evaluate the community action plan
1. Continuous monitoring
2. Evaluation to formulate lessons learned for future efforts
3. Surveillance systems and quantitative change
6. Community feedback meeting

Journal articles

Focusing on overdiagnosis as a driver of too much medicine
Brodersen J, Kramer BS, Macdonald H, Schwartz LM, Woloshin S
BMJ. 2018;362:k3494.

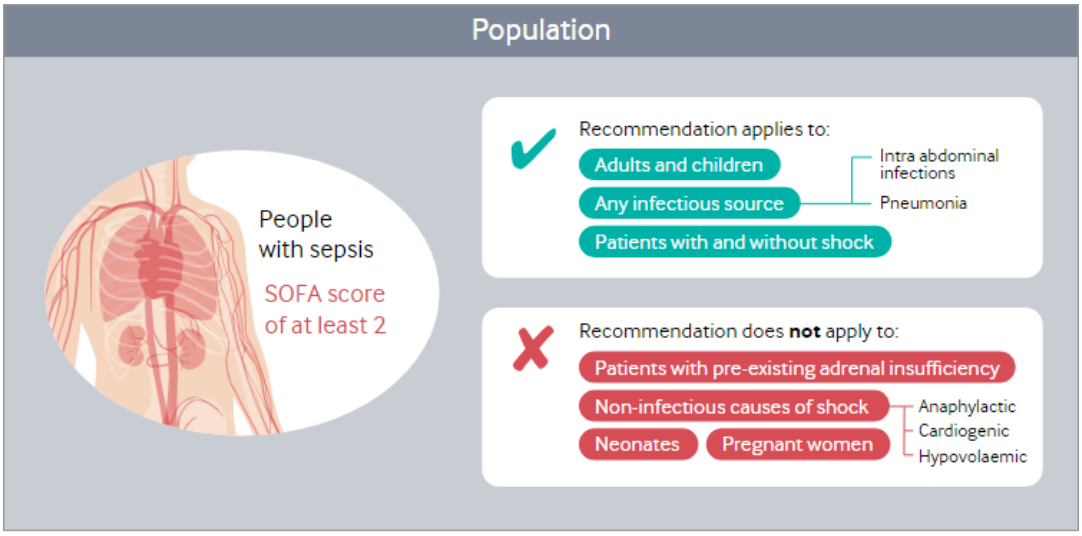
Overdiagnosis in primary care: framing the problem and finding solutions
Kale MS, Korenstein D
BMJ. 2018;362:k2820.

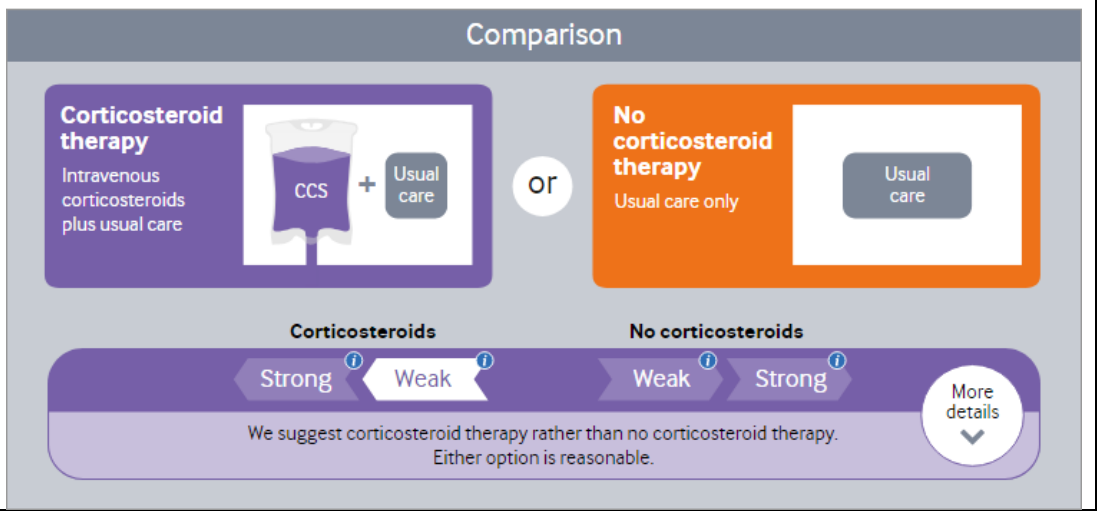
Improving diagnosis by improving education: a policy brief on education in healthcare professions
Graber Mark L, Rencic J, Rusz D, Papa F, Croskerry P, Zierler B, et al
Diagnosis. 2018;5(3):107-18.

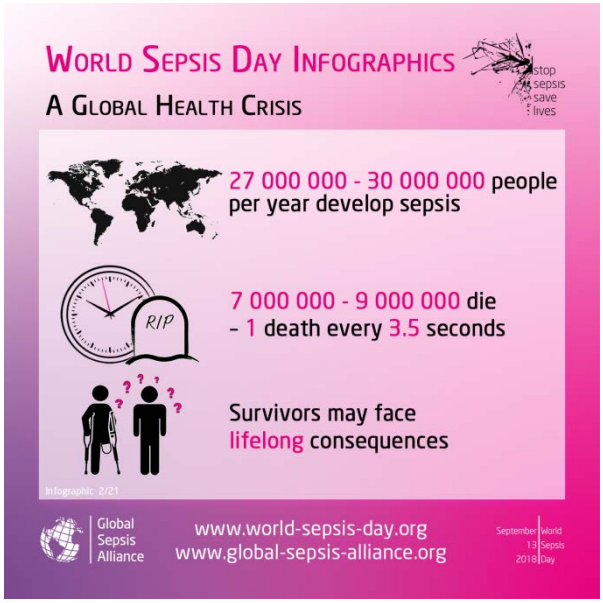
DOI	Brodersen et al https://doi.org/10.1136/bmj.k3494 Kale and Korenstein http://doi.org/10.1136/bmj.k2820 Graber at al https://doi.org/10.1515/dx-2018-0033
Notes	Issues around diagnosis, including misdiagnosis, diagnostic error, overdiagnosis and underdiagnosis, have emerged in recent years. These three pieces all look at important aspects. Brodersen et al look at how diagnosis, particularly **overdiagnosis**, can be driving the 'over use' of the health system or what may be considered as **inappropriate or even unnecessary care** (that can expose patients to unnecessary harms). [As an aside, I saw a tweet from Victor Montori that described overdiagnosis as "a bunch of true positives for whom detection means medicalization not better health"] But overdiagnosis can be hard to identify at the individual level and, indeed, "the effects of overdiagnosis look like benefits. People with disease that is overdiagnosed do well because, by definition, their disease was non-progressive. They are "cured" when cure was not necessary in the first place." Further, these then bolster the apparent benefit of screening. The piece suggests that improving prognostic methods and tools to recognise overdiagnosis in individuals should be prioritised. Kale and Korenstein looks at how overdiagnosis may be encouraged and faced in the primary care setting. They recognise that "**Overdiagnosis** can **harm patients** by leading to **overtreatment** (with associated potential toxicities), **diagnosis related anxiety** or **depression**, and **labeling**, or through **financial burden**." Some of the factors seen as contributing to overdiagnosis include how primary care is remunerated/funded and the perennial innovation of diagnostic technologies. As preventive care is a major component of primary care, and overdiagnosis is often related to screening, overdiagnosis in primary care is thought to be "an important problem from a public health perspective and has far reaching implications". The authors suggest **greater awareness** of what **overdiagnosis** is and of the **deleterious consequences** of inappropriate testing (and treatments) along with working to change our **expectations of care** could contribute to reducing overdiagnosis and its impacts. Graber et al look at how some of these issues around diagnosis, particularly **diagnostic error**, may be addressed or ameliorated by how clinicians may be educated and equipped so as to improve their diagnostic abilities and appropriateness. The piece identifies five key areas/objectives: 1. Acquire and effectively use a relevant knowledge base 2. Optimize clinical reasoning to reduce cognitive error 3. Understand system-related aspects of care 4. Effectively engage patients and the diagnostic team, 5. Acquire appropriate perspectives and attitudes about diagnosis.

Corticosteroid therapy for sepsis: a clinical practice guideline
Lamontagne F, Rochwerg B, Lytvyn L, Guyatt GH, Møller MH, Annane D, et al
BMJ. 2018;362:k3284.

DOI	https://doi.org/10.1136/bmj.k3284
Notes	Sepsis is a common, all but ubiquitous, complication that affects vast numbers of patients. World Sepsis Day fell on 13 September https://www.world-sepsis-day.org/. This week the *BMJ* published a 'rapid recommendation' The 'What you need to know' points are: • **Sepsis** is a **syndrome of life threatening infection with organ dysfunction**, and most guidelines do not advise use of corticosteroids to treat it in the absence of refractory shock • **Two new trials of corticosteroid treatment** for sepsis came to **differing conclusions** • **Corticosteroids may reduce** the **risk of death** by a small amount and increase neuromuscular weakness by a small amount, but the **evidence is not definitive** • This **guideline** makes a **weak recommendation** for **corticosteroids** in patients with sepsis; both steroids and no steroids are reasonable management options • Fully informed patients who value avoiding death over quality of life and function would likely choose corticosteroids.







Getting more health from healthcare: quality improvement must acknowledge patient coproduction—an essay by Paul Batalden
Batalden P
BMJ. 2018;362:k3617.

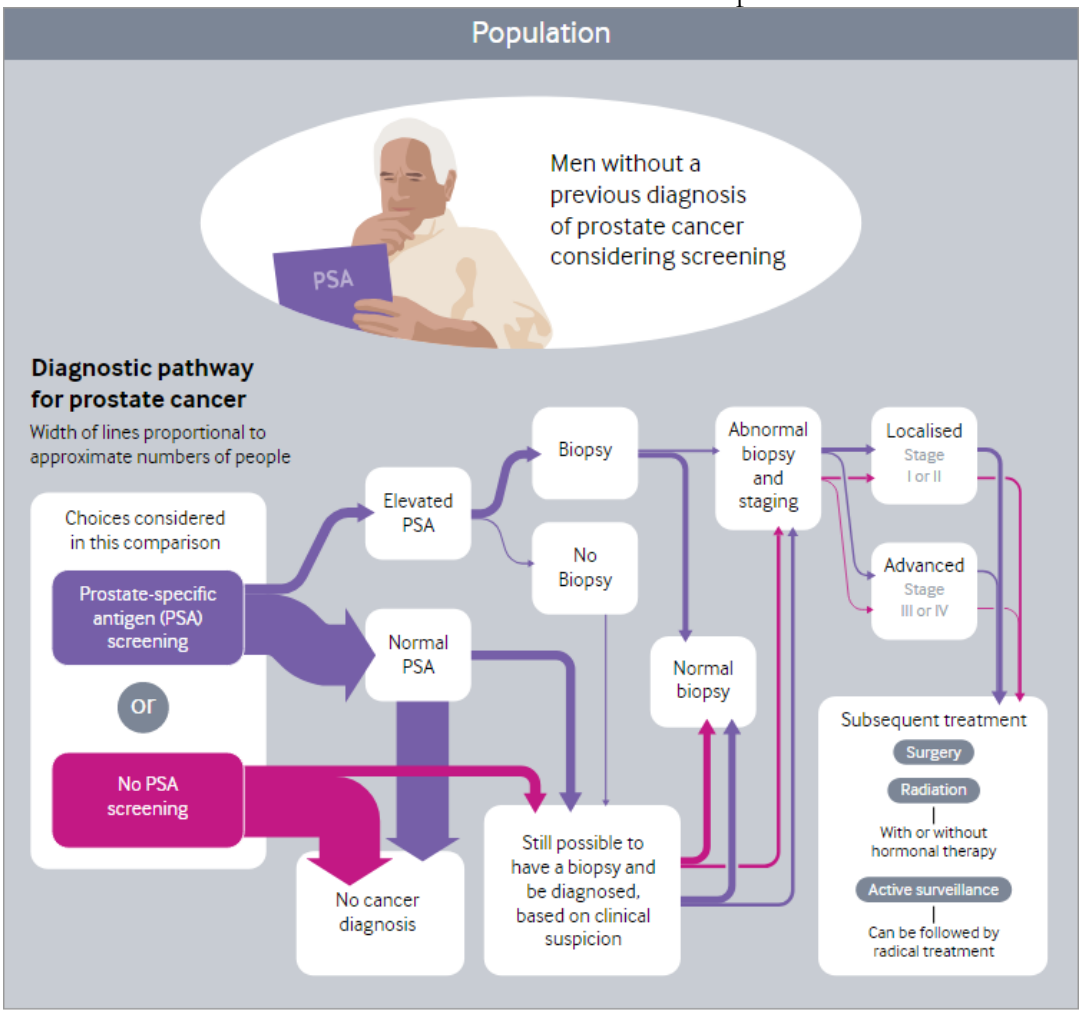
DOI	https://doi.org/10.1136/bmj.k3617
Notes	In this piece Paul Batalden reflects on how healthcare has been viewed – as a product, and as a service. But healthcare is not truly simply either. It is also not analogous to an airline or a nuclear power plant as has been claimed on occasion. It's more of an imperfect, uncertain knowledge-seeking collaboration of patients and clinicians. Batalden focuses on the 'coproduction' which is the "the interdependent work of users and professionals who are creating, designing, producing, delivering, assessing, and evaluating the relationships and actions that contribute to the health of individuals and populations." Some may regard this as the aim of truly patient-centred care. Batalden's closing sentences seek to show the way ahead as "Clinicians need to learn in ways that encompass all of the forms of knowledge described here, including eliciting a patient's immediate and long term aims. On an individual level, this can be described as shared decision making. On a system level, this way of thinking and practising may enable us to transform healthcare to improve health for our patients and populations."

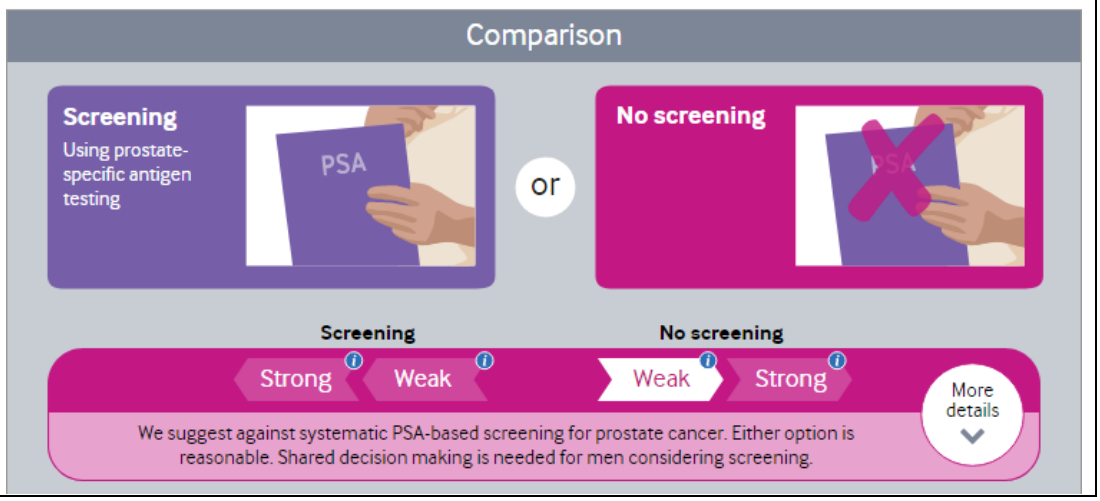
For information about the Commission's work on patient and consumer centred care, see https://www.safetyandquality.gov.au/our-work/patient-and-consumer-centred-care/

Prostate cancer screening with prostate-specific antigen (PSA) test: a clinical practice guideline
Tikkinen KAO, Dahm P, Lytvyn L, Heen AF, Vernooij RWM, Siemieniuk RAC, et al
BMJ. 2018;362:k3581.

DOI	https://doi.org/10.1136/bmj.k3581
Notes	The diagnosis and then treatment of prostate cancer has been a hotly contested area for some time. The *BMJ* has published this guideline that seeks to provide some clarity, with a bottom line that routine testing is not recommended for most men as the benefit is small and uncertain and there are clear potential harms. The 'What you need to know' points are: • PSA testing has increased the number of men diagnosed with and treated for prostate cancer, but many of these men would never have experienced any symptoms or death from prostate cancer

- This guideline makes a weak recommendation against offering systematic PSA screening based on an updated systematic review.
- Men who place more value on avoiding complications from biopsies and cancer treatment are likely to decline screening. In contrast, men who put more value in even a small reduction of prostate cancer mortality (such as men at high baseline risk because of family history or African descent, or those concerned to rule out the diagnosis) may opt for screening
- Shared decision making is needed for men considering screening to make a decision consistent with their individual values and preferences.





Association Between Physician Burnout and Patient Safety, Professionalism, and Patient Satisfaction
A Systematic Review and Meta-analysis
Panagioti M, Geraghty K, Johnson J, Zhou A, Panagopoulou E, Chew-Graham C, et al
JAMA Internal Medicine. 2018 [epub].

DOI	https://doi.org/10.1001/jamainternmed.2018.3713
Notes	It feels as if I have included quite a few items on burnout in recent months. This most recent addition to the literature is a systematic review and meta-analysis that examined 47 studies covering 42,473 physicians in order to examine whether physician burnout is associated with an increased risk of patient safety incidents, suboptimal care outcomes due to low professionalism, and lower patient satisfaction. The authors report finding that "**burnout** is associated with **2-fold increased odds** for **unsafe care**, **unprofessional behaviors**, and **low patient satisfaction**." They also report that **depersonalization** associated with burnout "had the strongest links with these outcomes" and that "the association between unprofessionalism and burnout was particularly high across studies of **early-career physicians**."

Margaret McCartney: A summary of four and a half years of columns in one column
McCartney M
BMJ. 2018;362:k3745.

DOI	https://www.bmj.com/content/362/bmj.k3745
Notes	Margaret McCartney has been a columnist for the *British Medical Journal* for some years. For her final column she has provided a pithy list of 36 observations. Twitter has seen many congratulations for her work, and this column, and quite a few additional suggestions. Among her observations: • Screening is only for people with no symptoms. If you have symptoms it's not screening. • Screening is often counterintuitive. False positives proportionately rise when prevalence falls. • Inadequately tested tech can do as much harm as inadequately tested medicine. • Apparent problems are fixed more effectively when they're first understood. • A system that uses blame to attempt improvement is likely to make good professionals miserable and leave. • Earlier isn't necessarily better. Lead time bias and overdiagnosis create mirages and do harm. • If it's not evidence based it might as well be homeopathy. • Poverty kills. Statins do not effectively treat poverty. • Cycling is fantastic. Cities that make cycling easy and safer are healthier cities. • Food should be pleasurable, and there are various ways to lose weight. Studies of diets are often flawed. Beware of people touting "simple" solutions and diet books. • Many people seek to make money from those who don't understand science. Doctors should call out bollocksology when they see it. • Humans make mistakes. Honesty breeds forgiveness and better practice. • However, repeating policy errors is unforgivable if predictable. Health policy needs an "evidence desk" to critically review and stop avoidable errors. I make an ongoing offer to any government to staff that desk. • Keep your "thank you" cards. They will sustain you through your darkest days. • We need to know the absolute risk. What's the all cause mortality? There's no use not dying from a disease if the treatment kills you. • We should aim not to "raise awareness" but to improve knowledge.

	• Political in-fighting over the NHS wastes time, money, and morale. We should seek cross party cooperation, use evidence, and acknowledge uncertainty in decision making. • People should be offered interventions and be given help to make decisions. Doctors should be judged on how helpful they are, not the decision made. • Systematic reviews usually shed more light than heat. • False promise increases with the opportunity for profit. • We're all going to die: CPR isn't good treatment for many. Citizens should know that, unless they opt out, they've been opted in. • Less medicine may be better treatment. It can often feel risky to deprescribe, even though it shouldn't. • We need #alltrials reported. • Appalling workloads that are neither appealing or safe will not be cured with more "resilience." • Medicine is a tough, unglamorous, difficult job which, with understaffing and austerity, often feels impossible to do well. • Medicine is an absolutely brilliant job, and having long term relationships with patients and families is one of the most joyous and fulfilling aspects of work.

The Milbank Quarterly
September 2018 (Volume 96)

URL	https://www.milbank.org/quarterly/issues/september-2018/
Notes	A new issue of *The Milbank Quarterly* has been published. Articles in this issue of *The Milbank Quarterly* include: • Surprising Statistics on the **Uninsured** (Gail R Wilensky) • How Do You Solve **a Problem Like Juul**? (Joshua M Sharfstein) • **Guns, Obesity, and Opioids**: A Population Health Science Perspective on 3 Contemporary Epidemics (Sandro Galea) • **Health Reform Realism** (John E McDonough) • **Climate Denial** and a (Hopeful) Lesson From History (David Rosner) • The Impact of **Parental and Medical Leave** Policies on Socioeconomic and **Health Outcomes** in OECD Countries: A Systematic Review of the Empirical Literature (Arijit Nandi, Deepa Jahagirdar, Michelle C Dimitris, Jeremy A Labrecque, Erin Strumpf, Jay S Kaufman, Ilona Vincent, Efe Atabay, Sam Harper, Alison Earle, S Jody Heymann) • Systems Thinking as a Framework for Analyzing **Commercial Determinants of Health** (Cécile Knai, Mark Petticrew, Nicholas Mays, Simon Capewell, Rebecca Cassidy, Steven Cummins, Elizabeth Eastmure, Patrick Fafard, Benjamin Hawkins, Jørgen Dejgård Jensen, Srinivasa Vittal Katikireddi, Modi Mwatsama, Jim Orford, Heide Weishaar) • **Diversity in Medical Device Clinical Trials**: Do We Know What Works for Which Patients? (Stephanie R Fox-Rawlings, Laura B Gottschalk, Laurén A Doamekpor, Diana M Zuckerman) • **Patient-Centered Insights**: Using **Health Care Complaints** to Reveal Hot Spots and Blind Spots in **Quality and Safety** (Alex Gillespie, Tom W. Reader) • Impact of Pharmacists on **Access to Vaccine Providers**: A Geospatial Analysis (Parth D Shah, Justin G Trogdon, Shelley D Golden, Carol E Golin, Macary Weck Marciniak, Noel T Brewer)

Journal of Patient Experience
Volume: 5, Number: 3 (September 2018)

URL	http://journals.sagepub.com/toc/jpxa/5/3
Notes	A new issue of the *Journal of Patient Experience* has been published. Articles in this issue of the *Journal of Patient Experience* include: • **Ascribed Meaning of Disease Control**: Perspectives of Patients With Type 2 Diabetes (Laura M Girling, Sarah E Chard, and J Kevin Eckert) • Use of **Visual Decision Aids in Physician–Patient Communication**: A Pilot Investigation (Mary Beth Mercer, Susannah L Rose, Cassandra Talerico, Brian J Wells, Mahesh Manne, Nirav Vakharia, Stacey Jolly, Alex Milinovich, Janine Bauman, and Michael W Kattan) • Deserve's Got Nothin' to Do With It: A Philosopher Visits the **NICU** (David I Waddington) • Creating Naptime: An **Overnight, Nonpharmacologic Intensive Care Unit Sleep Promotion** Protocol (Melissa P Knauert, Nancy S Redeker, Henry K Yaggi, Michael Bennick, and Margaret A Pisani) • **Just for Today** (Mahima Thomas) • Patient Experience and Satisfaction With **Acceptance and Commitment Therapy** Delivered in a Complimentary Open Group Format for Adults With **Eating Disorders** (Brad A Mac Neil and Chloe C Hudson) • Challenges to **Care and Medication Adherence** of Patients With **Chronic Myeloid Leukemia** in a Resource Limited Setting: A Qualitative Study (R A Bolarinwa, S A Olowookere, T O Owojuyigbe, E C Origbo, and M A Durosinmi) • Codesigning a **Measure of Person-Centred Coordinated Care** to Capture the Experience of the Patient: The Development of the **P3CEQ** (Thavapriya Sugavanam, Ben Fosh, James Close, Richard Byng, Jane Horrell, and H Lloyd) • Willingness to Pay for **Teledermoscopy Services** at a University Health Center (T S Raghu, James Yiannias, Nita Sharma, and Allan L Markus) • **Naive Expectations to Resignation**: A Comparison of Life Descriptions of Newly Diagnosed Versus Chronic Persons Living With Stage D HF (Michael M Evans, Judith E Hupcey, Lisa Kitko, and Windy Alonso) • **Satisfaction** With Health Care Among Patients Navigated for **Preventive Cancer Screening** (Emilia A Hermann, Jeffrey M Ashburner, Steven J Atlas, Yuchiao Chang, and Sanja Percac-Lima) • **Patient-Centered Communication** Behaviors That Correlate With Higher **Patient Satisfaction** Scores (Doug Finefrock, Sridhar Patel, David Zodda, Themba Nyirenda, Richard Nierenberg, Joseph Feldman, and C Ogedegbe) • Patients and Providers Are Amenable to **Fecal Immunochemical Testing** by Digital Rectal Exam (Harini Naidu and Brian C Jacobson)

International Journal for Quality in Health Care online first articles

URL	https://academic.oup.com/intqhc/advance-access
Notes	*International Journal for Quality in Health Care* has published a number of 'online first' articles, including: • Patient–clinician relationship seems to affect adherence to **analgesic use in cancer patients**: a cross sectional study in a Taiwanese population (Pi-Ling Chou Kun-Ming Rau Ta-Wei Yu Tai-Lin Huang Jia-Ling Sun Shu-Yi Wang Chia-Chin Lin)

	• Effectiveness of adherence to recommended clinical examinations of diabetic patients in **preventing diabetes-related hospitalizations** (Giovanni Corrao Federico Rea; Mirko Di Martino; Adele Lallo; Marina Davoli; Rossana De Palma; Laura Belotti; Luca Merlino; Paola Pisanti; Lucia Lispi; Edlira Skrami; Flavia Carle, on behalf of the working group 'Monitoring and assessing diagnostic-therapeutic paths' of the Italian Heath Ministry

Online resources

[UK] NICE Guidelines and Quality Standards
https://www.nice.org.uk
The UK's National Institute for Health and Care Excellence (NICE) has published new (or updated) guidelines and quality standards. The latest reviews or updates are:

- NICE Guideline NG105 *Preventing **suicide** in community and custodial settings*
  https://www.nice.org.uk/guidance/ng105
- NICE Guideline NG106 ***Chronic heart failure** in adults: diagnosis and management*
  https://www.nice.org.uk/guidance/ng106
- Quality Standard QS9 ***Chronic heart failure** in adults* https://www.nice.org.uk/guidance/qs9

[UK] Artificial intelligence (AI) in health
https://www.rcplondon.ac.uk/projects/outputs/artificial-intelligence-ai-health
The (UK) Royal College of Physicians has released this position statement on the use of artificial intelligence (AI) in health. The College calls on the medical profession to **embrace the technology**, but to **make sure that it works for patients**. The position paper stem from a July 2018 roundtable event that had a clear message that AI is already a reality for doctors and that while AI presents many opportunities for health, it also presents challenges which should be carefully considered. The consideration **first and foremost** must always be **patient safety**.

[USA] The Most Undervalued Employee in Your Business
https://www.inc.com/laura-montini/the-most-undervalued-employee-at-any-organization.html
The item in the last issue of *On the Radar* on the value of whinging reminded me of this piece that I saw a few years. The piece reviews a book on personalities in the workplace that identifies four character types: agreeable takers, disagreeable takers, agreeable givers, and disagreeable givers.
I suspect we all know 'agreeable takers' in our lives. These are the charismatic, narcissists that use their charm to ingratiate themselves with the powerful as they build their careers while being, as the piece puts it diplomatically, "less motivated to be as cordial and caring with their peers and subordinates."
The author argues that it is actually the 'disagreeable givers' who can be the most useful in improving organisations and their performance as they take a critical view, challenge the status quo and have the organisation's purpose and performance at heart. As the piece observes "Disagreeable givers are the people who, on the surface, are rough and tough, but ultimately have others' best interests at heart …They are the people who are willing to give you the critical feedback that you don't want to hear--but you need to hear."