# Are we doing too much?

"We need more of this." How many times have we heard that? Doesn’t matter what it is – a new drug, a different psychological therapy, more social care. It’s a bit like the mantra “more research needed” which ends most academic papers. Have you ever read a paper that ended “Less research needed”? Actually, there was one once – a report on aromatherapy. But you know what we mean.

But actually, the truth is that the real problem we face is not having too little, but too much. Too much treatment. Too many tests. Too many diagnoses (as psychiatrists we should plead guilty to that charge). Some of this is obvious. Anything that does good can also do harm, and sometimes considerable harm. Investigations that aren’t needed are wasting money. And so on. But it’s worse than that.

The opportunities to cause harm are many and various. It's not just exposing people to the risk of physical side-effects for no good reason. It can reinforce beliefs and behaviours. It can convince people that they are suffering from serious illness that the doctors have not yet found, but will be uncovered by further and increasingly expensive investigations. It can create disorder where there was none before – look at the evidence that single session psychological debriefing increases, not decreases, the risk of PTSD. In short, as Proust said:

"For each illness that doctors cure with medicine, they provoke ten in healthy people by inoculating them with the virus that is a thousand times more powerful than any microbe: the idea that one is ill."

MARCEL PROUST, "The Guermantes Way,"
Remembrance of Things Past

Now we have an opportunity to play our part in what is a global campaign to do something about this. It's called [***Choosing Wisely***](http://www.aomrc.org.uk/general-news/choosing-wisely.html), and it aims to increase awareness and understanding about where the hotspots of overuse are in today’s clinical practice.

To add to this dilemma, [**patient expectations**](http://www.kingsfund.org.uk/time-to-think-differently/trends/public-attitudes-and-expectations/public-expectations-and-experience-services) are increasing, and there is often an onus on psychiatrists to ‘do something’ at each consultation. This can undermine balanced decision-making, where minor potential patient benefit with a minimal evidence base can outweigh significant potential harm and tremendous financial expense. Alternatively, look at the unintended consequences of NHS 111 - nearly all the algorithms that they use end with advising the caller to see a medical practitioner. Result: 3 million extra GP visits last year.

One of us, SW, qualified at the start of the Evidence-based medicine movement, and indeed was a committed supporter. And it has heralded an era of great advances in clinical care – after all who would want an evidence-free medicine? However, it has tended to provide more information about new things we could be doing, rather than providing evidence about what we should not be doing any more, for many obvious reasons. So how can we ensure that patients are provided with the right tests and treatments and are not over-investigated or over-treated? NICE have created a ‘[Do Not Do](https://www.nice.org.uk/proxy/?sourceurl=http://www.nice.org.uk/usingguidance/donotdorecommendations/index.jsp)’ recommendations database of close to 1000 interventions, but almost no doctors have heard of this. A different approach is needed to address the potential overtreatment of patients. This approach will need to engage individual doctors and patients to change their conversations to discuss risk more clearly and realise that often doing ‘less’ is actually doing ‘more’.

A potential solution to this issue has come from a surprising source, when considering the sheer volume of waste that occurs in their health system – namely the US. The [***‘Choosing Wisely’***](http://www.choosingwisely.org/)campaign aims to reduce overtreatment in health care by attempting to ***stop*** the use of various interventions that are not supported by evidence and ***stop*** tests that are duplicative of other tests or procedures already received.

The ‘Choosing Wisely’ campaign in this country was launched last month by the Academy of Medical Royal Colleges in the UK in a [**BMJ editorial**](http://www.bmj.com/content/350/bmj.h2308). The Academy is requesting that all Medical Royal Colleges in the UK identify a 'top five' list of tests or procedures that are commonly used in their specialty, but whose necessity should be questioned. These tests or treatments should either be stopped altogether, or their routine use should be stopped.

We, as a college, are currently compiling a list of tests, interventions or treatments that should either stop being used routinely, or at all, because of a lack of evidence for clear benefits over harms. We are asking all members to contribute their suggestions for what should be on this list. An expert reference group will be created, chaired by our new Registrar, Adrian James, that will decide what should make our top five list. This list will be submitted to the Academy, which will then be widely publicised.

### What can you do?

We need your input and would really welcome any thoughts or suggestions you may have for this list. Be bold. We might at some stage collect together the suggestions that we cannot use, especially if witty. But please give this some thought – involve your trainees for example or medical students – it would make a great discussion or teaching point.

And then **submit your ideas to Deborah Hart****.**

**Remember – doing less. You know it makes sense.**

Professor Sir Simon Wessely and Dr Daniel Maughan

18th June 2015