Realistic Medicine, The National Clinical Strategy & Preventing Cancer

SCPN

EDINBURGH

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The National Clinical Strategy

- **Recognises demographics, prevalence of chronic illnesses, complexity, persistent inequalities, social needs, low value care.**

  and financial and workforce constraints.

- **Increased investment in Primary Care** **(cf "The Cost Conundrum")**
- **Provision of social care**
- **Addressing discharge delay**
- **Regional planning of secondary care services**
- **Improved processes in secondary care**
- **Realistic Medicine**

Realistic Medicine

Problems:

- **Complexity, loss of continuity, variation,**
- **over-reliance on guidelines,**
- **poor handling of risk**
- **patients don't feel in control**
- **failure demand**
- **health literacy,**
- **unrecognised regrets**
- **over-reliance on medical solutions**

<u>Solutions include:</u>

Informed patients: Individual decisions

Minimal interventions where possible

Reducing unwarranted variation

Recognise harm and regret

Explanation/tolerance of (some) risks

Social Care essential for complex problems

Realistic expectations – especially at end of life

Relevance to SCPN??

Prevention:

Not discussed in NCS, but of critical importance

Discussion of healthy life expectancy & unhealthy life expectancy

Impact on cancer co-morbidities - as well as incidence & survival

Personal thoughts:

- **Scotland's progress impressive**
- **Professional vs individual vs community responsibility**
- **North Karelia experience – communities demanding action**
- **"Constituency Reports"**
- **Primary Care not fully engaged with primary prevention**

Relevance to SCPN??

Screening:

- **Must continue to develop (e.g. HPV testing)**
- **Continue to emphasise benefits (less treatment)**
- **Must acknowledge potential harms (Montgomerie)**
- **Ability to separate out indolent cancers**
- **Contribution of genetics?**

Relevance to SCPN??

Early Detection:

- **Thoughtful awareness raising of symptoms - targeted**
- **Increase continuity in primary care**
- **Excellent GP referral guidelines**
- **Greater diagnostic access for primary care**
- **Investment in diagnostics and staffing**
- **Transforming out-patients**

Conclusion:

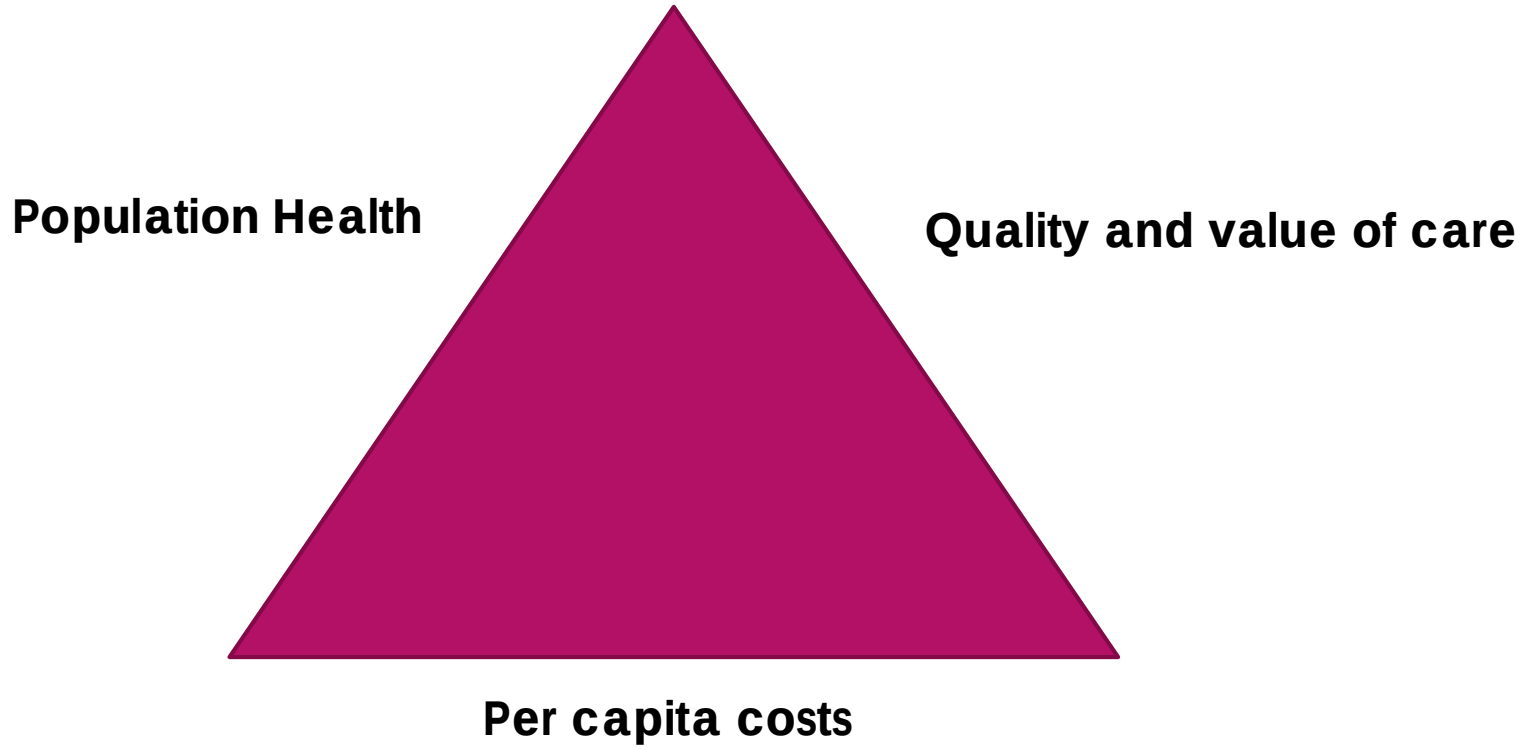
- **Healthcare becoming unaffordable?**
- **Staffing presenting increasing challenges**
- **Considerable waste**
- **Has distorted priorities ?**
- **Severe health inequalities persist**

The longer-term future must include a preventative approach

Thank you for listening

Any Questions?

The Triple Aims*



* From I.H.I.

Doctors as potential patients:

2 scenarios: both for patients with colon cancer.

Operation A : 80% cured

16% die within 2 years

1% risk colostomy,diarrhoea

Operation B: 80% cured

no risk of complications

20% die within 2 years

Ubel et Al: Archives of Internal Medicine: vol 171 no 7 630-44

Doctors as potential patients:

- 250 physicians questioned (2 groups)
- 38% chose option B for themselves
- 25% chose option B for patients

Conclusion is that doctors tend to under-estimate side effects in patients – or are driven by resisting mortality in patients

Ubel et Al: " Physicians recommend different treatments for themselves": Archives of Internal Medicine: Vol 171: p1760; 2011.