The Shifting Paradigm of Preventive Screening: Physicians Need to Modify Their Approach

by Neil Bell MD SM CCFP

Changing our Approach to Preventive Screening

Family physicians and other health care clinicians need to reconsider how we approach screening in our practices. Over the last 10 years, working in collaboration with other past and present members of the Canadian Task Force on Preventive Health Care, I have been involved in the development and dissemination of guidelines and knowledge on screening. One of the biggest tasks has been conveying to clinicians that screening can cause **both**benefits and harms. In many screening interventions, there is a close trade-off between harms and benefits and individual patient's values and preferences can alter the balance for or against screening decisions. Overdiagnosis and false positive test results are inherent with screening and can cause harm to individuals who were not destined to have any clinical manifestations of the disease under consideration - something which is only now widely recognized. Overdiagnosis is impossible to determine once the diagnosis has been established and, therefore, this potential harm needs to be communicated clearly before a test is done. The other major impetus pushing the need for change is the increasing emphasis on patient-centred and collaborative health care (shared information, shared accountability).

Overdiagnosis is defined as the detection of an asymptomatic "abnormality" or "condition" that if not detected would have caused no symptoms or death.

Transition to Collaborative Care or Shared Decision Making Approach

Adopting this collaborative approach is challenging. First, as health care providers we need to update our knowledge and understanding of the many concepts required to assess the balance between the harms and benefits of screening. Second, we need to further develop skills in shared decision making, understanding patient preferences and values, and effectively communicating the harms and benefits to patients in a manner that they can understand. Part of this process includes developing our ability to effectively use knowledge translation tools to communicate with our patients. Finally, family physicians need to adapt our organizational structure and office-based practices to support this new paradigm of patient-centered/collaborative approach to screening. Automated systems need to change from systems developed to prompt patients without discussion, to systems that support informed discussion between us and our patients on the potential benefits and harms of screening.

Goals of screening need to move from measuring a high uptake in eligible patientpopulations to measuring how much patients engaged in shared decision-making[1] - whatever their decision.

How Can Family Physicians Develop These Skills?

One source of the knowledge to support this process is the "Prevention in Practice" series that began in the July

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2017 edition of *Canadian Family Physician*. This series of papers covers many of the key concepts about screening. Topics covered include the balance of harms and benefits, appropriate measures of outcome and effect size, shared decision making, and practice organization related to screening. High quality guidelines and knowledge translation tools can also be found on the websites of the Canadian Task Force on Preventive Health Care and the United States Preventive Services Task Force. Other sources of information are highlighted in each of the papers in the "Prevention in Practice" series. It is incumbent on all of us to facilitate transition to this new approach and make shared decision making part of our everyday practice.

Neil Bell is Professor in the Department of Family Medicine at the University of Alberta.

Conflict of Interest - None declared.

Reference

1. Gigerenzer G. Towards a paradigm shift in cancer screening: informed citizens instead of greater participation. *BMJ* 2015;350:h2175 doi: 10.1136/bmj.h2175

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