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OFFICIAL JOURNAL OF THE AMERICAN ACADEMY OF PEDIATRICS

Safely Doing Less: A Missing Component of the Patient Safety Dialogue

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Pediatrics 2011;128;e1596; originally published online November 28, 2011;
DOI: 10.1542/peds.2011-2726

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The American Academy of Pediatrics Steering Committee on Quality Improvement and Management and the Committee on Hospital Care recently published an updated policy statement on pediatric patient safety in *Pediatrics*.[1] The statement is thorough, and it accurately summarizes salient principles. However, like many discussions surrounding patient safety, a key component of the dialogue is missing from the statement. In addition to asking "What more can we do to reduce harm?" we should also be asking "How can we safely do less?" Despite impressive national efforts to improve patient safety over the last decade, rates of harm do not seem to have changed.[2] Further increases in awareness and knowledge, as suggested by the policy statement, are unobjectionable, but often the best way to prevent avoidable harm from medical interventions is to avoid the interventions in the first place.

The risks of overtesting and overtreatment have been well described in the adult literature, to the extent that entire issues of the *Archives of Internal Medicine* have been devoted to the "less is more" theme.[3] Examples of health care overuse from adult medicine abound: proton-pump inhibitors are grossly overprescribed[4] and have led to many unanticipated adverse effects[5,6]; the near-universal use of hormone-replacement therapy for postmenopausal women likely led to increased rates of heart disease, stroke, pulmonary embolus, and breast cancer[7,8]; and widespread prostate-specific antigen testing for healthy men has led to many unnecessary treatments for prostate cancer.[9,10] In short, even well-intended and safely delivered health care can cause harm.

Although safely doing less might make sense to some physicians, there are many factors that impel us, instead, to do more. Doing more feels safer, because it alleviates uncertainty, particularly when the stakes are high. Families might pressure physicians to prescribe drugs or perform tests that might not be indicated. Physicians may also feel pressure from colleagues or the peer-review process, both of which tend to be more critical of missing something than overtreatment. We fear missing something and, worse yet, having someone else discover that we have done so.[11] Medicolegal fears often have a similar effect and have contributed to the common practice of "defensive medicine." In addition, ordering fewer tests is not always easier; in fact, it often requires more vigilance and effort. For example, an untested or untreated child might seem to warrant closer follow-up on the outpatient side, repeated examinations on the inpatient side, or a more lengthy discussion of options with the family. Publication bias is also a barrier to doing less, because the biomedical literature is heavy with positive studies (many of which are subsequently proven wrong[12]) that lead us to do more. Finally, economic incentives created by fee-for-service re-

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Opinions expressed in these commentaries are those of the author and not necessarily those of the American Academy of Pediatrics or its Committees.

www.pediatrics.org/cgi/doi/10.1542/peds.2011-2726

doi:10.1542/peds.2011-2726

Accepted for publication Sep 20, 2011

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PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275).

FINANCIAL DISCLOSURE: *The authors have indicated they have no financial relationships relevant to this article to disclose.*

imbursement and an increasing emphasis on physician productivity also drive physicians to do more. As George Annas commented nearly 20 years ago, "we live in a wasteful, technologically driven, individualistic, and death-denying culture."[13] Physicians are as much a product of this culture as their patients; together we are co-conspirators in a behavioral system that often sacrifices safety for action.

To redress this imbalance, we propose including the minimization of overtesting and overtreatment as a core initiative of the patient safety movement. Any review of an adverse event related to an intervention should include a discussion of whether the intervention was warranted in the first place. Errors of commission (eg, unnecessarily giving an antibiotic that leads to anaphylaxis) should be viewed with as much scrutiny as errors of omission (eg, failing to give an antibiotic for a probable bacterial infection). Research endeavors should continue to critically evaluate accepted practices that might be causing harm. Recent examples of such practices in pediatrics include treatment of a persistent patent ductus arteriosus in neonates,[14] long courses of intravenous antibiotics for osteomyelitis,[15] and routine voiding cystourethrography after a febrile urinary tract infection.[16–18]

"Just to be safe" is often used as a reason to test and treat our vulnerable children. Paradoxically, this maxim might be undermining the patient safety movement. The time has come to repurpose this powerful phrase as justification for safely doing less.

REFERENCES

1. American Academy of Pediatrics, Steering Committee on Quality Improvement and Management and Committee on Hospital Care. Principles of pediatric patient safety: reducing harm due to medical care. *Pediatrics*. 2011;127(6):1199–1210
2. Landrigan CP, Parry GJ, Bones CB, Hackbarth AD, Goldmann DA, Sharek PJ. Temporal trends in rates of patient harm resulting from medical care. *N Engl J Med*. 2010;363(22):2124–2134
3. Grady D, Redberg RF. Less is more: how less health care can result in better health. *Arch Intern Med*. 2010;170(9):749–750
4. Katz MH. Failing the acid test: benefits of proton pump inhibitors may not justify the risks for many users. *Arch Intern Med*. 2010;170(9):747–748
5. Gray SL, LaCroix AZ, Larson J, et al. Proton pump inhibitor use, hip fracture, and change in bone mineral density in postmenopausal women: results from the Women's Health Initiative. *Arch Intern Med*. 2010;170(9):765–771
6. Howell MD, Novack V, Grgurich P, et al. Iatrogenic gastric acid suppression and the risk of nosocomial *Clostridium difficile* infection. *Arch Intern Med*. 2010;170(9):784–790
7. Hulley S, Grady D. Postmenopausal hormone treatment. *JAMA*. 2009;301(23):2493–2495
8. Rossouw JE, Anderson GL, Prentice RL, et al. Risks and benefits of estrogen plus progestin in healthy postmenopausal women: principal results from the Women's Health Initiative randomized controlled trial. *JAMA*. 2002;288(3):321–333
9. Andriole GL, Crawford ED, Grubb RL 3rd, et al. Mortality results from a randomized prostate-cancer screening trial. *N Engl J Med*. 2009;360(13):1310–1319
10. Djulbegovic M, Beyth RJ, Neuberger MM, et al. Screening for prostate cancer: systematic review and meta-analysis of randomised controlled trials. *BMJ*. 2010;341:c4543
11. Welch HG. *Should I Be Tested for Cancer? Maybe Not and Here's Why*. Berkeley, CA: University of California Press; 2006
12. Ioannidis JP. Why most published research findings are false. *PLoS Med*. 2005;2(8):e124
13. Annas GJ. Reframing the debate on health care reform by replacing our metaphors. *N Engl J Med*. 1995;332(11):744–747
14. Benitz WE. Treatment of persistent patent ductus arteriosus in preterm infants: time to accept the null hypothesis? *J Perinatol*. 2010;30(4):241–252
15. Zaoutis T, Localio AR, Leckerman K, Saddlemire S, Bertoch D, Keren R. Prolonged intravenous therapy versus early transition to oral antimicrobial therapy for acute osteomyelitis in children. *Pediatrics*. 2009;123(2):636–642
16. Schroeder AR, Abidari JM, Kirpekar R, et al. The impact of a more restrictive approach to urinary imaging after urinary tract infections. *Arch Pediatr Adolesc Med*. 2011;165(11):1027–1032
17. American Academy of Pediatrics, Subcommittee on Urinary Tract Infection, Steering Committee on Quality Improvement and Management. Urinary tract infection: clinical practice guideline for the diagnosis and management of the initial UTI in febrile infants and children 2 to 24 months. *Pediatrics*. 2011;128(3):595–610
18. Newman TB. The new American Academy of Pediatrics urinary tract infection guideline. *Pediatrics*. 2011;128(3):572–575

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