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INSIDE

Career: Hospitalist Update: For Hospital Medicine Physicians, Emerging Opportunities Plentiful in Clinical and Operational Realms. Pg. 1

Career: When Is It Time to Change Jobs? Pg. 9

Clinical: Screening for Prostate Cancer, as published in the New England Journal of Medicine. Pg. 11

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Hospitalist Update: For Hospital Medicine Physicians, Emerging Opportunities Plentiful in Clinical and Operational Realms

By Bonnie Darves

Hospital medicine has made a lot of headway for a relatively new physician specialty. In just over 25 years, hospitalists have integrated themselves into virtually every aspect of care delivery in hospitals and health systems. From their beginnings as in-hospital internists and family medicine physicians managing the inpatient care of community primary care physicians’ patients, a vital role that persists today, hospitalists are now serving in top leadership positions, commandeering quality improvement initiatives, and developing facility-wide protocols. They’re also comanaging specialists’ patients and delving deep into hospital operations and IT infrastructures to help facilitate systems improvements.

For young physicians contemplating where they’ll hang their stethoscopes, that broad swath of practice possibilities is a large part of the specialty’s appeal. According to Rohit Uppal, MD, MBA, chief clinical officer for TeamHealth Hospitalist Services in Orlando, Florida, “The lure of hospitalist practice is that physicians are exposed to aspects of medicine that they might not encounter elsewhere and also have the opportunity to learn...
leadership skills on the job,” Dr. Rohal said. “There’s really no other specialty that exposes you to the breadth of medicine.”

For example, hospitalists may work with colleagues in the ER and critical care, cardiology, neurology, orthopedics, and, in limited cases, trauma specialists, Dr. Rohal said. In a newer role, serve as physician advisers assessing the status of and optimal care setting for an even broader range of patients.

Increasingly, Dr. Rohal said, hospitalists are also integrally involved in managing transitions of care and the systems issues that challenge hospitals. Hospitalists are moving into informatics, quality improvement (QI), care management, telehealth, and services utilization. “The possibilities, in terms of career paths for hospitalists, are robust — and growing. Hospitalists were already being viewed as leaders in the hospital before the pandemic hit. Their impressive performance during COVID-19 cemented that,” said Dr. Rohal, whose company employs approximately 3,000 hospitalists at 200 U.S. sites.

Jerome C. Siy, MD, a past president of the Society of Hospital Medicine and division medical director of hospital-based specialties for HealthPartners in Minneapolis, Minnesota, agrees that hospitalists’ role in helping hospitals navigate the pandemic has revealed even more ways, particularly in telehealth, that hospital medicine physicians’ expertise might bring value.

Today, Dr. Siy said, hospitalists are being tapped for key roles in operations — improving electronic health records (EHRs) and consulting on informatics innovations. “We’re even seeing hospitalists getting involved in emerging areas such as predictive analytics, patient risk scoring, population health, and nascent hospital-at-home programs,” he said.

“As an early-career hospitalist, you have to invest in growing your knowledge base and carving out time to do committee work if you want to pursue a leadership role. There are new skill sets to learn, and that takes time.”
— Jerome C. Siy, MD, HealthPartners

Per Danielsson, MD, a hospitalist who has helped hospitals pilot hospital-at-home (HAH) programs, which seek to provide hospital-level care for older patients who may be at risk for functional decline or other problems associated with long inpatient stays if they remain in the hospital. He views the model as a win-win for hospitals and the hospitalists who clinically manage such patients. Hospitalists bring valuable experience to HAH programs because of their extensive expertise in triaging acutely ill patients, working in multidisciplinary teams, and, recently, delivering telemedicine.

In a June 2019 article in the Journal of Hospital Medicine, Dr. Danielsson predicted that HAH hospitalists might one day become a subspecialty of their own.

In a field that continues to grow steadily, and at a time when hospitals are amenable to placing talented hospitalists in just about any administrative role they’re interested in, there’s no shortage of both traditional practice opportunities and jobs that combine clinical and administrative work. Today, an estimated 50,000 hospitalists practice in the United States, and the specialty experienced a 50 percent growth rate between 2012 and 2019, according to a study published in Journal of Hospital Medicine in August 2022.

**What early-career hospitalists are seeking**

Even if the sky is the limit in terms of the myriad ways that hospitalists might configure their clinical careers or combine clinical and administrative work, young physicians considering — or newly entering — the field choose the specialty for its schedule flexibility and its perceived ability to deliver acceptable work/life balance. Ijeoma Carol Nwelue, MD, hospitalist medical director for Baylor Scott & White Health in Fort Worth, Texas, said that even early-career hospitalists aren’t shy about articulating their wish lists.

“Young physicians really want that work/life balance, so schedules are a big issue for them,” she said. “Hospitalists really want their work planned around their life, and they’re expecting not to have to grind it out every day. They want specific fixed hours, but they also want some schedule flexibility when they need it.”

Most hospitalist organizations are attempting to deliver on both fronts. Still, the predominate schedule in the specialty is seven on/seven off (often called a “7/7”) — hospitalists work seven days or nights in a row, followed by seven off — can be a bit of a grind when hospitalists are in the “on” mode, several sources acknowledged. As such, some groups are exploring ways to shorten shifts or otherwise reconfigure schedules. So far, no new standard has emerged.
Young physicians are also looking for ways to serve the community at large. They’re increasingly articulating that desire when they interview for positions, observed Dr. Nwelue, now a veteran of the field. “That’s something we’ve been seeing a lot in recent years — young physicians wanting dedicated time for community outreach, for opportunities to care for or teach patients outside of the hospital setting,” she said. “It’s a common request of this new generation.”

Hospitalists want to teach, too

Also high on the wish list for many young hospitalists are formal or informal teaching opportunities. Although hospitalists in academic medicine have such opportunities as a matter of course, many of those practicing in other settings such as community hospitals also want to spend some time teaching students, residents, or even other colleagues, several sources mentioned. Fortunately, some of the hybrid community hospital/academic institution partnerships that have emerged in the past decade are giving hospitalists a chance to do some teaching and research work in addition to their clinical duties.

In the academic realm, some programs are seeking more expedient pathways for early-career hospitalists move into medical education more quickly — with the objective of providing that career satisfaction sooner that it might occur traditionally in competitive academic environments. The University of Chicago, for instance, has pioneered an innovative Passport to Clinical Teaching program, which offers early-career hospitalists access to medical-education opportunities that they can pursue on their own time and can coordinate with their clinical responsibilities.

“A lot of young hospitalists really want to teach and to learn how to become mentors, but it’s challenging because their schedules are heavy clinically. And there is substantial competition for available teaching time in academic environments,” said Elizabeth A. Murphy, MD, assistant professor and director of clinical service development in the University of Chicago’s Section of Hospital Medicine. “What we’ve done is create structured content on becoming a better teacher that hospitalists can access on their own time.”

More limited teaching opportunities are available as a series of Passport rotations in various domains, that cohort members complete within about a year, Dr. Murphy noted. Participants typically spend time at external community hospitals that operate smaller residency programs or host medical students and can use extra hands. Cohort members also learn how to develop continuing medical education (CME) offerings, work in community health clinics, and engage in scholarly activities, among other offerings.

J.P. “John” Murray, MD, a young University of Chicago hospitalist who now directs the hospitalist consult service, maintains that his Passport program participation effectively jumpstarted his career. “I really appreciated the fact that the Passport program is geared toward young hospitalists. It provides lots of opportunities to get involved with residents and medical students, that you might not have otherwise,” Dr. Murray said. “It provides a framework and exposure. It keeps you sharp, and it provides a way to show leadership that you’re very interested in teaching.”

The program started in 2020 and has been well received, Dr. Murphy said. Some of the learners in the initial cohort have received teaching awards or moved into formal teaching roles. “Many hospitalists come into academic medicine because of their favorable training experiences and because they want to be part of what academic medicine does,” Dr. Murphy said. “This offers early-career hospitalists a way to do that, and it gives us a way to harness the mentoring talent we have.”

Telehealth and other practice options

Not surprisingly, because of their varied exposure to many aspects of care delivery and the skills they gained navigating the pandemic, hospitalists have been pivotal in helping hospitals develop and expand telehealth services, to reach both home-bound patients and those in underserved areas. Dr. Siy noted that hospitalists at his organization provide telehealth services at night to outlying hospitals and some reserve a portion of their clinical time to work in rural hospitals.

Dr. Nwelue reported that her organization is piloting a hospitalist-managed telehealth service aimed at managing lower-acuity patients — such as those with infections that require IV antibiotics — who can be safely cared for at home with nursing intervention and hospitalist management. Likewise, in pediatrics, a field that has struggled with capacity as dedicated pediatrics units have shrunk or disappeared, pediatric hospitalists are using telemedicine to expand their reach into rural and smaller hospitals. In particular, pediatric hospitalists are helping such facilities care for lower-acuity young patients that present to their emergency departments.
In recent years, another brand of hospitalist has emerged — transitionalists. These hospitalists focus on the intersection of inpatient care and so-called step-down units. Transitionalists practice either part-time or full-time in post-acute settings such as inpatient rehabilitation facilities, long-term acute-care hospitals, or skilled nursing facilities. In such roles, hospitalists often serve as medical directors.

In another recent development, hospitalists are being tapped as in-house consultants. They’re helping hospitals reduce unnecessary services utilization, assess medical-necessity issues, and streamline post-discharge care continuity. Because hospitalists develop in-depth familiarity with specialists’ practice patterns, test ordering, and patient lengths of stay, hospitals are discovering that hospitalist input pays dividends in both reducing costs and improving care.

Inside hospitals and health systems, organizations are realizing that young tech-savvy hospitalists can also be instrumental in helping them vexing issues. Hospitalists are being tapped to help resolve workflow, IT, and EHR issues that cause inefficiencies — or clinician frustration. “This is an ideal role for early-career hospitalists who have an interest and some expertise in healthcare technology,” said Dr. Siy. “There’s a real demand for such skills.”

One of the big draws in the early years of hospital medicine was that hospitalists working “7/7” schedules could use some of the off-week time to moonlight at local hospitals, perhaps to pay off education debt more rapidly. Although moonlighting isn’t as common as it once was in the field, some hospitalists recognize that they can use their off time to learn new clinical or business skills or even start new ventures.

Mitchell Durante, DO, and Anthony King, DO, hospitalists at BJC Healthcare Christian Hospital in St. Louis, Missouri, recently decided to take advantage of their “7/7” schedule flexibility to start a manipulative medicine clinic that’s open during their off weeks. “It took us a few years to get this up and running, but we’re excited about starting our own business,” Dr. Durante said. “That’s one of the good things about hospital medicine — it gives you the flexibility to do something like this.”

Some hospitalists are also utilizing their newly developed telemedicine skills with their flexibility to carve out opportunities to provide remote care and consultations from home. Others are developing new products or apps, launching podcasts, or serving an independent medical reviewers.

The other ‘ists’—growth of specialty hospitalists is slow, but steady

In the past 15 years, several specialties have made strides in developing inpatient-only services based on the hospitalist model as specialists wrestle with the growing challenges of simultaneously managing a combined outpatient/inpatient practice.

The mainstays of the specialty hospitalist movement remain orthopedics, trauma, anesthesiology, OB/GYN, general surgery, and gastroenterology. But psychiatry and neurology are both increasingly embracing the hospitalist model. In a pioneering venture, the University of California San Francisco has started a Neurohospitalist Division that utilizes a structure similar to the traditional medicine hospitalist model.

Leadership roles

Although it’s not uncommon now to see hospitalists as medical directors, chief medical officers, and health-system committee chairs, young hospitalists should understand that both a learning curve and a willingness to devote extra time to small-scale initiatives are prerequisites for obtaining leadership roles, Dr. Siy noted. “As an early-career hospitalist, you have to invest in growing your knowledge base and carving out time to do committee work if you want to pursue a leadership role. There are new skill sets to learn, and that takes time,” he said.

Organizations are trying to accommodate hospitalists’ desires to move into leadership roles without waiting a decade or longer. TeamHealth, for example, operates a designated leadership track for interested hospitalists. And it’s a popular option, according to Dr. Uppal. In addition, the Society of Hospital Medicine’s Leadership Academy offers a wide range of courses that enable hospitalists to obtain leadership and management skills.

“The possibilities, in terms of career paths for hospitalists, are robust — and growing. Hospitalists were already being viewed as leaders in the hospital before the pandemic hit. Their impressive performance during COVID-19 cemented that.”

— Rohit Uppal, MD, TeamHealth Hospital Medicine

For Jessica Porter, MD, a TeamHealth hospitalist medical director at Memorial Hospital Miramar in Hollywood, Florida, the opportunity to
When Is It Time to Change Jobs?

By Nisha Mehta, MD, a physician leader whose work focuses on physician empowerment, community building, and career longevity in medicine

Statistically, the majority of physicians will change jobs within their first five years out of training. Additionally — even at later stages of physician careers — an increasing percentage of the physician population consider changes in their career. Physician turnover is an often talked about issue amongst hospital administrators and practice owners.

Why is this? Well, part of it has to do with the challenges associated with being a physician in the current health care landscape. My father, a cardiologist, spent four decades of his career with the same group. Many of his friends can say the same. On the other hand, I know a far lower percentage of colleagues who could say with confidence that they see themselves with the same group for the remainder of their careers. Aside from practical drivers of physician turnover, such as a desire to be closer to family or a change in the job of a significant other, many are finding their workplaces increasingly challenging. As consolidation within the health care space increases, physician demographics change, and the pressure to do more with less increases, more physicians find themselves asking if their situation is sustainable.

We all have aspects of our jobs that are pain points, and the expectation that any job will be perfect is unrealistic. How do you know you’re not lead came early — soon after she completed residency in 2016. She jumped at the chance. “I’d always been interested in leadership, and in contributing, because, well, someone did the same for me. It was a steep learning curve, but I managed it and found I really enjoyed the administrative work,” said Dr. Porter.

Today, although Dr. Porter maintains a full clinical schedule, she manages to fit in most of her administrative duties during her “on” weeks, and receives a stipend for her leadership work. Those duties include managing operations and coaching physicians, representing hospitalists’ interests at hospital management meetings and, as needed, boosting morale. “It’s very gratifying work, and I think it’s important to have a seat at the table when [organizational] decisions are being made,” she said.

Dr. Porter advises young hospitalists who are interested in leadership to look for committee and task force openings, engage in quality improvement initiatives and, above all, express their interest in leadership roles. “If you don’t ask, you don’t get it — whether it’s a raise or a leadership opportunity,” she said.

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just trading one set of pain points for another — which in a worst case scenario, is potentially worse elsewhere?

When considering a job change, I always recommend writing down the pain points at your current job, delineating which ones are dealbreakers, and which ones could potentially be changed if discussed openly with the employer. If you are planning on leaving anyways, it’s advisable to first see if the current situation can be fixed. Although these conversations can be uncomfortable, ultimately if you’re planning on leaving regardless, it may be that there’s little to lose in trying. Similarly, ensuring that these same pain points are not present at the new job is prudent.

Factors such as salary, flexibility in work hours, opportunities for growth or promotion, dissatisfaction with the current job environment and the direction a company is going in, burnout, or other non-salary aspects of the compensation package are all examples of things that lead to job turnover that could potentially be negotiated with the current employer.

There are other factors which many see as writing on the wall that a change is inevitable. Sometimes these can be related to changes in ownership or management structure of a group, a confirmed trend toward cutting physician compensation or hiring patterns that suggest the physician’s time at the job is limited, or administrative mandates that have been challenged and upheld, which leave the physician with the conclusion that they can’t practice medicine in a way that they enjoy or feel is best for the patient.

Many people stay with jobs out of comfort or fear of change. Unfortunately, this leads to burnout, and ultimately is a threat to career longevity. If you’re feeling unhappy with your job, it’s time to either advocate for change within your current position, or consider other options.

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**Clinical Practice**

Caren G. Solomon, M.D., M.P.H., Editor

**Screening for Prostate Cancer**

Paul F. Pinsky, Ph.D., and Howard Parnes, M.D.

This Journal feature begins with a case vignette highlighting a common clinical problem. Evidence supporting various strategies is then presented, followed by a review of formal guidelines, when they exist. The article ends with the authors’ clinical recommendations.

A 60-year-old patient asks whether he should undergo screening for prostate cancer and, if he undergoes screening and the results are positive, what his options would be with respect to further diagnostic testing and treatments. How would you respond?

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**The Clinical Problem**

Prostate cancer is currently the most diagnosed cancer (excluding nonmelanoma skin cancer) and the second leading cause of cancer death among U.S. men. Prostate cancer was diagnosed in an estimated 268,500 men in 2022, and approximately 34,500 died of it.¹ The disease occurs primarily in older persons, with the incidence greatest among men in their 70s and mortality highest among men in their 80s. The incidence among non-Hispanic Black men is 1.7 times as high as that among non-Hispanic White men, and mortality is 2.1 times as high; incidence and mortality are lower among Hispanic men and Asian men than among White men and non-Hispanic Black men.²

Measurement of prostate-specific antigen (PSA), a protein secreted by both normal and malignant prostate epithelial cells, was approved by the Food and Drug Administration (FDA) in 1986 for use in monitoring patients with known prostate cancer and later (in 1994) as an aid in the detection of prostate cancer in conjunction with digital rectal examination in patients 50 years of age or older.³⁴ Notably, this approval occurred in the absence of evidence that early detection of prostate cancer leads to improved patient outcomes. The onset of widespread PSA screening in the late 1980s is widely acknowledged to be the primary cause of the sharp increase in prostate cancer incidence that was observed in the next decade; rates later fell, beginning in approximately 2009 (Fig. S1A in the Supplementary Appendix, available with the full text of this article at NEJM.org).⁵ From a peak in the early 1990s, prostate cancer mortality steadily decreased during the next two decades by approximately 50% and has subsequently remained essentially constant (Fig. S1B).¹

The association between PSA screening and mortality is less clear than the association between screening and incidence, with various analyses undertaken to assess the relative contribution of screening (as compared with other factors, including treatment improvements) to the reduction in mortality.⁶ An estimate with the use of a quantitative model showed that slightly less than half the reduction in mortality was as a result of screening.⁷

In the majority of prostate cancer cases currently diagnosed in the United States, the disease is localized, with only approximately 7% of patients presenting...
Randomized, controlled trials of prostate cancer screening. The European Randomized Study of Screening for Prostate Cancer (ERSPC) was a multicenter, randomized, controlled trial that was initiated in the early 1990s to assess the effect of PSA screening on prostate cancer mortality among 162,388 men 55 to 69 years of age.1,23 Handed screening involved assessment of PSA every 4 years with a biopsy-recommendation threshold of 3.0 ng per milliliter, although there was some variation among the study centers; the control group was not offered screening as part of the trial (and in which PSA screening rates were believed to be low, although rates were not rigorously assessed across the trial sites). Among men in the intervention group, the median number of screenings, positive results, and biopsies per participant was 1.9, 0.33, and 0.27, respectively. The positive predictive value of biopsy was 24.8%. Prostate cancer diagnoses were more common in the screening group than in the control group (rate ratio, 1.90 at 9 years and 1.41 at 16 years). At the 16-year follow-up, the rate ratio of prostate cancer mortality in the screening group was 0.80 (95% confidence interval [CI], 0.72 to 0.90); rate ratios were similar at 11 and 13 years. The risk differences per 1000 U.S. men 55 to 69 years of age were 1.04 (95% CI, 0.87 to 1.24) and 0.93 (95% CI, 0.81 to 1.08), respectively;23-25 the rate ratio for disease of grade groups 4 or higher at 17 years was 0.89 (95% CI, 0.80 to 0.99). The U.K. Cluster Randomized Trial of PSA Testing for Prostate Cancer (CAP) trial was a primary care–based, randomized, controlled trial of 23,233 men 55 to 69 years of age who were assigned to receive an invitation to one-time PSA screening (with prostate biopsy recommended in persons with PSA levels >3.0 ng per milliliter) or to not be offered screening.26 PSA screening was performed in 36% of participants in the intervention group, within the 35-to-50% range on which the power calculations were based. At the median 10-year follow-up, the rate ratio for prostate cancer diagnosis was 1.19 (95% CI, 1.14 to 1.25). Prostate cancer mortality did not differ significantly between the groups (0.30 in the intervention group vs. 0.31 in the control group per 1000 person years; rate ratio, 0.96; 95% CI, 0.85 to 1.08). An analysis that accounted for adherence to screening showed similar results (rate ratio, 0.93; 95% CI, 0.67 to 1.29). Systematic reviews of PSA screening trials have noted a high risk of bias in the PLCO trial owing to contamination of the control group and in the CAP trial owing to low adherence to screening.27-29 A review by the U.S. Preventive Services Task Force (USPSTF) also noted that there was uncertain applicability of results from the ERSPC trial in the United States owing to a higher proportion of men with baseline PSA levels that were below the median of 4.0 ng per milliliter (the randomized group threshold of 4.0 ng per milliliter) and a higher incidence of biopsies than is customary in U.S. practice, and noted a greater use of radical prostatectomy in the intervention group than in the control group.29 The USPSTF review resulted in an estimate, based on data from randomized, controlled trials, that screening 1000 U.S. men 55 to 69 years of age may prevent deaths from prostate cancer in 1.3 men in the 13 years after initial screening.

Randomized, controlled trials of conservative management or curative treatment

The Scandinavian Prostate Study Group (SPCG)–4 trial and the U.S. Prostate Interventions versus Observation Trial (PIVOT) randomly assigned men to undergo prostatectomy or to receive ob-

Key clinical points

Screening for prostate cancer
- Prostate cancer is the most diagnosed cancer (excluding nonmelanoma skin cancer) and is the cancer with the second highest mortality among men in the United States. Prostate cancer–specific survival at 10 years is 95% among men with localized disease.
- Prostate-specific antigen (PSA) screening should involve shared decision-making with consideration of the risks and benefits of screening and patient preferences.
- Findings from randomized trials suggest a modest reduction in prostate cancer mortality with PSA screening; screening 1000 men may prevent deaths from prostate cancer in 13 men in the 13 years after initial screening.
- Persons with elevated PSA levels on screening may choose to undergo further tests to inform the need for biopsy, multiparametric magnetic resonance imaging (MRI) to identify biopsy targets, or both.
- Persons with low-risk or favorable intermediate-risk prostate cancer may choose to undergo active surveillance (periodic PSA tests and biopsies) under immediate curative treatment (surgery or radiation therapy).
- Surgery and radiation therapy generally provide excellent outcomes in prostate cancer but may result in harms, including urinary incontinence and erectile dysfunction with surgery, and bowel dysfunction and erectile dysfunction with radiation therapy.

Strategies and evidence

Interpretation of PSA levels
In the United States, a PSA level of 4.0 ng per milliliter has been the generally accepted threshold at which providers recommend prostate biopsy; in Europe, a cutoff of 3.0 ng per milliliter has more commonly been used. However, there is no PSA level below which prostate cancer can be definitively ruled out. In the Prostate Cancer Prevention Trial, prostate cancer was detected in 15.2% of men whose PSA levels remained below 4.0 ng per milliliter throughout the 7-year trial and in 6.6% of men with a PSA level of 0.5 ng per milliliter or lower at the end of the trial.21 However, only 2.3% of men with a PSA level of 4.0 ng per milliliter or lower had disease with a grade group score of 2 or higher as shown on the end-of-study biopsy. Data from the Physicians Health Study showed a cumulative risk of lethal prostate cancer of only 0.3% through 15 years among men 55 to 59 years of age with baseline PSA levels that were below the median of 1.0 ng per milliliter.22
Positive PSA test (>4)

Confirmatory PSA test

Positive

Multiparametric MRI

Monitoring

MRI-guided biopsy with or without standard biopsy

Negative

Standard biopsy

Blood and urine imaging tests

Score indicating low risk

Score indicating high risk

Return to screening

Figure 1. Follow-up after PSA Screening. Blood and urine imaging tests include the Stockholm-3 model, the Prostate Health Index, the 45CScore Test, and the PCA1 test. Depending on the triage test score and other factors, next steps may include standard biopsy, multiparametric magnetic resonance imaging (MRI), or monitoring. PSA denotes prostate-specific antigen.

The standard method of tissue diagnosis of prostate cancer is the 12-core, ultrasonography-guided, systematic biopsy procedure. However, ultrasound-guided biopsies have been shown to reduce the incidence of misclassification and to increase the incidence of detection of clinically significant disease. A score of 3 or higher on the Prostate Imaging Reporting and Data System (PI-RADS) scale (scores range from 1 to 5, with higher scores indicating higher cancer risk) for any lesion prompts an MRI-guided biopsy of the lesion. Systematic biopsy is also typically performed, although the additional yield appears to be very small.
low in persons with lesions with a score of 5 on the PI-RADS scale. Questions remain regarding the safety of forgoing standard biopsies in persons who have not previously undergone biopsies and have an elevated PSA level and nonsuspicious results on MRL.10

A potential downside of the greater sensitiv-
ity of MRI in identification of small, higher-grade lesions is the risk of overdiagnosis.26 For example, a study showed that among 999 men with negative standard biopsies, the addition of MRI-targeted biopsies led to the detection of grade group 1 and grade group 2 disease in 7.4% and 7.5% of the men, respectively, the vast ma-

### Table 1. Elements of Shared Decision Making in Screening for Prostate Cancer

<table>
<thead>
<tr>
<th>Category and Components</th>
<th>Details</th>
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<tbody>
<tr>
<td>Screening test: PSA test positivity</td>
<td>Approximately 8% (with 4 ng per milliliter as the cutoff for positivity)</td>
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<td>Cancer-risk probability of prostate cancer diagnosis after positive screen</td>
<td>18% at baseline, 11% at postbaseline screen (diagnosis within 1 yr of screening; cutoff of 4 ng per milliliter)</td>
</tr>
<tr>
<td>Potential benefits</td>
<td>Prevention of death from prostate cancer</td>
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</table>
| Among 1000 men invited to undergo screening, approximately 5 will die from prostate cancer and 1.3 will avoid death from pro-
| tate cancer owing to screening in the 15-year period after initial screening |
| Reassurance regarding low risk | In men 55 to 59 years of age, a PSA level of ≤1 ng per milliliter is associated with an approximate 0.3% cumulative risk of lethal prostate cancer (death or metastatic disease) in the 15 years after screening |
| Potential harms | Overdiagnosis |
| In an 11-year period, prostate cancer will be diagnosed in approxi-
| mately 96 of 1000 men, among whom overdiagnosis will occur in 23 to 42% |
| Overtreatment and resulting complications | Of men in whom prostate cancer is diagnosed, approximately two thirds will initially receive active treatment (i.e., radical prostatectom-
| y or radiation therapy) and approximately one third will receive active surveillance; of the latter, approximately half will progress to active treatment |
| Radotherapy is associated with an elevated risk of erectile dysfunction and urinary inconti-
| nence17,20 |
| Likelihood of false positive test, further diagnostic testing (e.g., biopsy), and risk of biopsy complications | 10–15% false positive rate after 3–4 screening rounds, including 5% rate of false positive screening results that lead to subsequent negative biopsy |
| Risk of bleeding and infection with biopsy and 1–3% risk of hospital-
| ization17 |
| Personal risk | Age |
| 50–64 yr: incidence, 253 per 100,000 person-yr; mortality, 9 per 100,000 person-yr |
| 65–74 yr: incidence, 715 per 100,000 person-yr; mortality, 54 per 100,000 person-yr |
| ≥75 yr: incidence, 3351 per 100,000 person-yr; mortality, 224 per 100,000 person-yr |
| Race | Incidence among Black men is 1.7 times as high as that among non-
| Black men, and mortality among Black men is 2.1 times as high as that among non-Black men |
| Family history of prostate cancer | Incidence among persons with a family history of prostate cancer is 2.5 times as high as that among those with no family history of the disease |
| Attitudes and preferences: personal assessment of the relative importance of potential benefits and harms | Benefits: prostate cancer ruled out, risk of dying from prostate cancer reduced |
| Harms: treatment or periodic surveillance testing for a cancer that may never have caused any symptoms, with possible associated complications; an unnecessary prostate biopsy in men without cancer, with possible associated complications |
| Next-step options after confirmed positive PSA test: decisions on biopsy and treatment | Triage tests may allow the patient to avoid or defer the need for biopsy, with a small risk of missed clinically significant disease |
| The use of MRI-guided biopsy can increase detection of clinically significant disease but with some risk of overdiagnosis |
| In low-risk disease, active surveillance, involving periodic PSA tests and biopsies, may provide for avoidance of or delay in the need for curative treatment, with a possible small increased risk of metastatic progression or death from prostate cancer |

### Table 2. Guidelines for the Use of Decision Aids

- PSAs denote prostate-specific antigen.

**A R E A S O F U N C E R T A I N T Y**

Although numerous series have shown the safety of active surveillance with regard to prostate cancer mortality, uncertainties remain about appropriate patient selection criteria (e.g., which patients with grade group 2 disease can safely defer definitive therapy and the appropriate use of monitoring strategies (e.g., the frequency of surveillance biopsy and the need for PSA monitoring), and triggers for intervention (e.g., what extent of tumor-grade progression is acceptable). Whether the tailoring of screening according to race, polygenic risk scores, or other factors results in improved outcomes is unknown.

### CONCLUSIONS AND RECOMMENDATIONS

For the 60-year-old man in the vignette, shared decision making regarding prostate cancer screening should be pursued. Discussion is war-

### Guidelines

- The use of decision aids, tools that help pa-

### Shared Decision Making and Decision Aids

Decision making that involves sharing of infor-

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<td>Reassurance regarding low risk</td>
<td>In men 55 to 59 years of age, a PSA level of ≤1 ng per milliliter is associated with an approximate 0.3% cumulative risk of lethal prostate cancer (death or metastatic disease) in the 15 years after screening</td>
</tr>
<tr>
<td>Potential harms</td>
<td>Overdiagnosis</td>
</tr>
<tr>
<td>In an 11-year period, prostate cancer will be diagnosed in approximately 96 of 1000 men, among whom overdiagnosis will occur in 23 to 42%</td>
<td></td>
</tr>
<tr>
<td>Overtreatment and resulting complications</td>
<td>Of men in whom prostate cancer is diagnosed, approximately two thirds will initially receive active treatment (i.e., radical prostatectomy or radiation therapy) and approximately one third will receive active surveillance; of the latter, approximately half will progress to active treatment</td>
</tr>
<tr>
<td>Radical prostatectomy is associated with an elevated risk of erectile dysfunction and urinary incontinence</td>
<td></td>
</tr>
<tr>
<td>Radotherapy is associated with an elevated risk of erectile dysfunction and impaired bowel function</td>
<td></td>
</tr>
<tr>
<td>Likelihood of false positive test, further diagnostic testing (e.g., biopsy), and risk of biopsy complications</td>
<td>10–15% false positive rate after 3–4 screening rounds, including 5% rate of false positive screening results that lead to subsequent negative biopsy</td>
</tr>
<tr>
<td>Risk of bleeding and infection with biopsy and 1–3% risk of hospitalization</td>
<td></td>
</tr>
<tr>
<td>Personal risk</td>
<td>Age</td>
</tr>
<tr>
<td>50–64 yr: incidence, 253 per 100,000 person-yr; mortality, 9 per 100,000 person-yr</td>
<td></td>
</tr>
<tr>
<td>65–74 yr: incidence, 715 per 100,000 person-yr; mortality, 54 per 100,000 person-yr</td>
<td></td>
</tr>
<tr>
<td>≥75 yr: incidence, 3351 per 100,000 person-yr; mortality, 224 per 100,000 person-yr</td>
<td></td>
</tr>
<tr>
<td>Race</td>
<td>Incidence among Black men is 1.7 times as high as that among non-Black men, and mortality among Black men is 2.1 times as high as that among non-Black men</td>
</tr>
<tr>
<td>Family history of prostate cancer</td>
<td>Incidence among persons with a family history of prostate cancer is 2.5 times as high as that among those with no family history of the disease</td>
</tr>
<tr>
<td>Attitudes and preferences: personal assessment of the relative importance of potential benefits and harms</td>
<td>Benefits: prostate cancer ruled out, risk of dying from prostate cancer reduced</td>
</tr>
<tr>
<td>Harms: treatment or periodic surveillance testing for a cancer that may never have caused any symptoms, with possible associated complications; an unnecessary prostate biopsy in men without cancer, with possible associated complications</td>
<td></td>
</tr>
<tr>
<td>Next-step options after confirmed positive PSA test: decisions on biopsy and treatment</td>
<td>Triage tests may allow the patient to avoid or defer the need for biopsy, with a small risk of missed clinically significant disease</td>
</tr>
<tr>
<td>The use of MRI-guided biopsy can increase detection of clinically significant disease but with some risk of overdiagnosis</td>
<td></td>
</tr>
<tr>
<td>In low-risk disease, active surveillance, involving periodic PSA tests and biopsies, may provide for avoidance of or delay in the need for curative treatment, with a possible small increased risk of metastatic progression or death from prostate cancer</td>
<td></td>
</tr>
</tbody>
</table>

**PSA denotes prostate-specific antigen.**
should be performed periodically (but generally not more frequently than every 2 years).

The opinions expressed by the authors in this article are their own, and this material should not be interpreted as representing the official viewpoints of the Department of Health and Human Services, the National Institutes of Health, or the National Cancer Institute.

Disclosures forms provided by the authors are available with the full text of this article at NEJM.org.

We thank Dr. Peter Greenberg for helpful comments on an earlier version of the manuscript.

Table 2. U.S. and Selected Other Guidelines on Screening for Prostate Cancer.*

<table>
<thead>
<tr>
<th>Organization and Clinical Practice</th>
<th>Recommendation</th>
<th>Screening Interval</th>
<th>Screening Formulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S. Preventive Services Task Force†</td>
<td>Age 55–69 yr</td>
<td>Not addressed</td>
<td>Moderate recommendation (at least moderate certainty that the net benefit is small)</td>
</tr>
<tr>
<td>National Comprehensive Cancer Network‡</td>
<td>Age ≥70 yr</td>
<td>NA</td>
<td>Grade D recommendation</td>
</tr>
<tr>
<td>American Urological Association§</td>
<td>Age ≥70 yr</td>
<td>2 yr</td>
<td>Strong recommendation (high-certainty evidence)</td>
</tr>
<tr>
<td>American Academy of Family Physicians∥</td>
<td>Age ≥70 yr</td>
<td>2 yr</td>
<td>Strong recommendation (high-certainty evidence)</td>
</tr>
</tbody>
</table>

- *EANM denotes European Association of Nuclear Medicine, EAU European Association of Urology, ESTRO European Society for Therapeutic Radiology and Oncology, ESUR European Society of Urogenital Radiology, NA not applicable, and SIOMS International Society of Genitourinary Oncology.
- †The high-risk population includes non-Hispanic Black men and men with either a family history suggestive of prostate cancer or with certain germline mutations.
- ‡Recommendation applies to men with a life expectancy of at least 10 years.

References

1. National Cancer Institute. Cancer statistics: common cancer sites. Surveillance, Epidemiology, and End Results Program. 2022 (7th v1000 cancer profile generated for each major cancer.).
34. Aldred M, Wilker AR, Reese SJ, et al. Clinically relevant, high-risk population includes non-Hispanic Black men and men with either a family history suggestive of prostate cancer or with certain germline mutations. Recommendation applies to men with a life expectancy of at least 10 years.
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