

I just lost 20 minutes in my EMR to prescribe a grape popsicle for a patient. Yes, I have to prescribe popsicles. Yes, they are in EMR. Yes, I can prescribe different routes for the popsicle (including intraocular).
[Fernando Zampieri @f_g_zampieri | 23.08.2019](#)

“Clinical practice has been and should remain an exercise in judgment driven by the evidence that a doctor and patient have in front of them, rather than by thoughtless adherence to what a manual says”.
[The BMJ @bmj_latest | 9.10.2019](#)

Interesting. Just spoke to a doctor specializing in sleep medicine about sleep tech, and they drew a comparison to the weight loss industry: “people spend billions on gadgets and supplements touting a quick fix, but they don’t listen to the free advice”.
[Christina Farr | @chrissyfarr | 9.10.2019](#)

“The reason progressives often lose the argument is that they focus too much on wealth redistribution and not enough on wealth creation. We need a progressive narrative that’s not only about spending, but investing in smarter ways”. @Maz-zucatoM
[Zahra Al-Harazi | @zahrasays | 9.10.2019](#)

Teaching is, I believe, a branch of the entertainment industry. Nobody learns when bored.
[Richard Smith | @Richard56 | 7.10.2019](#)

Med students shd be taught to be AI bullshit detectors. They need to ask: Is this technology ripe? Is it a barrier or enabler for patients? Does it save time & energy or waste it? What will my role be in 30 years? What are the potential harms?
[Richard Lehman | @richardlehman1 | 6.10.2019](#)

Ho appena ascoltato questo lapsus freudiano di grande attualità: “viviamo in un egosistema”.
[Luca Sofri | @lucasofri | 5.10.2019](#)

A person who speaks 3 languages is tri-lingual. A person who speaks 2 is bi-lingual. A person who speaks 1 language is English.
[Clive Wismayer | @clivewismayer | 4.10.2019](#)

Publishers, reviewers and other members of the scientific community must fight science’s preference for positive results — for the benefit of all.
[Matthew Westmore | matt_westmore | 4.10.2019](#)

“Overdiagnosis is not a purposeful act; it is an unfortunate side effect of our irrational exuberance for early detection”. + “Early detection is great for the business of medicine”.--Gil Welch, the 1st author of @NEJM paper, on the epidemic of overDx
[Eric Topol | @erictopol | 3.10.2019](#)

“Prospective evidence of the potential benefits of using #AI in medicine remains limited”. nature.com/articles/s4157...
[@NatRevClinOncol](#)
 Nearly a year later from @NatureMedicine review, not much has changed.
[Eric Topol | @erictopol | 3.10.2019](#)

What to expect from AI in oncology

An increasing number of studies suggest that artificial intelligence could revolutionize medicine. In oncology, we are only beginning to fully understand the practical implications.

In the past few years, the terms ‘artificial intelligence’ (AI) and ‘machine learning’ (ML) have become common in the news, several important medical advances have been made using these approaches. Some might conclude that we are witnessing a new era in medicine, although others could be concerned. What are AI and ML, and how can they affect the practice of medicine?

One of the challenges for the use of AI in oncology is that of access to data. Essentially, individuals participating in clinical trials with AI systems could have better outcomes than those seen in conventional medicine. The challenge is to ensure that diagnosis and treatment decisions are based on the best available data, not just on the data that is most readily available. Some reports believe that, similarly to other new technologies, the data associated with using AI will only be high during an initial period and will decrease over time. This expectation is not unreasonable, considering that medical centres will not be able to afford the initial investment of resources to introduce these tools in their practice. It is not clear, however, whether this will be the case for all AI-based tools, particularly those that are used for diagnosis and prognosis. These tools, however, should not be interpreted as a replacement for the clinical expertise of the physician, but rather, as an indication that their work could be optimized and, importantly, the waiting time for patients to receive a diagnosis can be reduced. Indeed, it is now often recommended to use AI and ML in a way that complements the expertise of the physician, rather than replacing it.

Following is not the only area in which AI has the potential to improve the outcomes of patients with cancer. Any piece of information that can be translated into patient, population, or practice-level data can be used to create only a few strategies, can be virtually taught to a machine. ML-based approaches are being used in areas such as radiology and clinical trial design. Another promising use of AI would be the integration of multi-omic data from each individual in order to facilitate the administration of tailored treatments.

In this article, I will discuss some of the challenges in implementing approaches using AI in oncology. I will also discuss some of the challenges in implementing approaches using AI in oncology. I will also discuss some of the challenges in implementing approaches using AI in oncology.

Finally, some experts are optimistic and believe that, with access to AI, clinicians will have more time to spend with their patients. Such a shift will only come if the total duration of patient visits remains the same and AI is not used to increase the staff shortage. Importantly, some patients might perceive the adoption of AI by their clinicians as a decrease in the attention of their care.

In summary, the practical implications of using AI in oncology practice are not yet completely understood. In addition to the challenges discussed, prospective evidence of the potential benefits of using AI in oncology remains limited, thus motivating the first research. The introduction of AI into oncology clinical practice is a complex effort that will require multi-stakeholder engagement and, most importantly, the input of patients and their families and the cooperation of regulatory bodies.

1. Bawa A, et al. Nat Rev Clin Oncol. 2019;15(10):591-600. doi:10.1038/s41571-019-0200-1



Everyone: Help us change psychiatry’s misleading narrative: Say depression pills, not antidepressants, as they do not have specific effects for depression; say major tranquillizers, which is what anti-psychotics do - they have no specific effects for psychosis.
[Peter Götzsche | @pgtzsche1 | 1.10.2019](#)

If Medicine wants to maintain trust, it, we, prof societies, must welcome unconflicted critical appraisal of evidence. Cheerleader panels at meetings is a blemish.
[John Mandrola | @drjohnm | 29.9.2019](#)

“Use of language matters, and getting it right (or wrong) can promote (or prevent) an ethos of shared endeavour between clinician and patient”.
[Jordan Canning | @jordancanning | 26.09.2019](#)

‘Multimorbidity’: an acceptable term for patients or time for a rebrand?
 “Writing Through Extreme Grief Helped Me Become Myself Again”. Catalysts for creativity buff.ly/2XWXFic
[Danielle Ofri | @danielleofri | 25.9.2019](#)

There are real ramifications of the oversimplification of medicine. Protocols, guidelines and exams delude us into thinking there is a ‘right’ answer. Honesty about uncertainty is the key.
[Sam Finnikin | @sfinnikin | 2.10.2019](#)