

A CHOOSING WISELY LITERATURE SYNOPSIS ARRANGED BY YEAR & ALPHABETICALLY BY AUTHOR

2014

Academy of Medical Royal Colleges. Protecting resources, promoting value: a doctor's guide to cutting waste in clinical care .London: Academy of Medical Royal Colleges; 2014.
www.aomrc.org.uk/wp-content/uploads/2016/05/Protecting_Resources_Promoting_Value_1114.pdf

This report by the Academy of Medical Royal Colleges makes a number of recommendations about reducing wasted clinical resources, including that colleges identify areas of waste and give leadership in tackling them through use of tools such as the National Institute for Health and Care Excellence 'do not do' database and a Choosing Wisely list for their specialty. A cultural shift is needed – “don't do something because it can be done; do it if it is necessary.” The report includes a waste reduction toolkit and gives examples of how health professionals can ensure that resources are used in the most effective way to provide the best possible quality and quantity of care for patients.

Colla CH. Swimming against the current — what might work to reduce low-value care? N Engl J Med 2014; 371: 1280—3.

The article discusses the pros and cons of policy tools aimed at patients (e.g. patient education) and healthcare providers (e.g. evidence-based guidelines) to reduce low-value care. Whilst the discussion focuses on the United States which has a fee-for-service system, the article includes a table summarising the various financial incentive and information policy tools that exist. More evidence of the effectiveness of these tools in reducing low-value care is needed.

Hurley R. Can doctors reduce harmful medical overuse worldwide? BMJ 2014; 349:g4289. doi: 10.1136/bmj.g4289

The article reports some of the views from an international Choosing Wisely meeting and what other countries are doing. It outlines the Choosing Wisely approach of engaging doctors to identify and reduce low-value care and communicating to patients that more care is not always better. Patients need to be encouraged to ask their doctor a series of questions about a proposed intervention. The key point is shared decision-making.

Levinson W, Kallewaard M, Bhatia RS, Wolfson D, Shortt S, Kerr EA. 'Choosing Wisely': a growing international campaign. BMJ Qual Saf 2014; 0: 1—9. doi: 10.1136/bmjqs-2014-003821

The article presents the experiences from 12 countries in planning or implementing Choosing Wisely. It identifies key elements of a Choosing Wisely campaign and five principles (physician led, patient focused, evidence based, multi-professional, transparent) essential to its success that should be incorporated in a Choosing Wisely campaign in any country. The goal of a Choosing Wisely campaign is to change the culture of medical care that has historically supported overuse of unnecessary interventions to provide high-quality care, prevent harm and decrease the use of unnecessary care.



Morden NE, Colla CH, Sequist TD, Rosenthal MB. Choosing Wisely — The politics and economics of labelling low-value services. N Engl J Med 2014; 370: 589—92. doi: 10.1056/NEJMp1314965

The article highlights the wide variation in the low-value interventions included on the US specialty societies' lists in terms of their potential impact on health, and discusses possible mechanisms to accelerate translating the lists into practice change. Good communication, public education, and more high-impact recommendations are critical for success. The Choosing Wisely campaign invites doctors to own their role as stewards of limited health care resources.

Wolfson D, Santa J, Slass L. Engaging physicians and consumers in conversations about treatment overuse and waste: a short history of the Choosing Wisely campaign. Acad Med 2014; 89: 990–995. doi: 10.1097/ACM.0000000000000270

The leaders of the Choosing Wisely campaign, the American Board of Internal Medicine Foundation and Consumer Reports, outline the history and purpose of the campaign, its structure and approach, lessons learned and future plans. Professional values and doctor-patient conversations to reduce unnecessary care underpin the campaign. Medical specialty societies have developed more than 250 evidence-based recommendations, some of which have consumer-friendly resources produced by Consumer Reports. Evaluation of the campaign's impact is needed.

2015

Bhatia S, Levinson W, Shortt S, Pendrith C, Fric-Shamji E, Kallewaard M, et al. Measuring the effect of Choosing Wisely: an integrated framework to assess campaign impact on low-value care. BMJ Qual Saf 2015; 0: 1–9. doi: 10.1136/bmjqs-2015-004070

The article proposes an integrated measurement framework, using the example of low back pain imaging, which may be used to assess the effectiveness of a Choosing Wisely campaign. Unintended consequences (e.g. underuse of high-value care) as well as intended consequences are included. Measurement tools, including their pros and cons, are identified for assessing doctors' awareness, attitudes and behaviour, and patient engagement and acceptance.

HealthPACT. Caring Wisely: Optimising patient care in Australia and New Zealand. Workshop report. 2015. www.health.qld.gov.au/healthpact/docs/report-caring-wisely.pdf

This report summarises a workshop to discuss what the Australian and New Zealand governments should do next in formulating effective policy around disinvestment in the public hospital system. Workshop sessions focused on identifying and prioritising interventions for disinvestment and the barriers in translating disinvestment policy into clinical practice. Key points of agreement included that identification of low-value care is important, information about current practice is a prerequisite, disinvestment information needs to be provided at a local level, and incentives for disinvestment may result in better adoption.

A pre-workshop discussion paper is attached to the report. The paper gives background information about past and current disinvestment activities, including the Choosing Wisely Australia campaign, and the challenges of disinvestment for doctors, funders and policy makers.

Malhotra A, Maughan D, Ansell J, Lehman R, Henderson A, Gray M, et al. Choosing Wisely in the UK: the Academy of Medical Royal Colleges' initiative to reduce the harms of too much medicine. BMJ 2015; 350:h2308. doi: 10.1136/bmj.h2308

The article outlines the Academy of Medical Royal Colleges' approach to introducing Choosing Wisely in the United Kingdom in collaboration with other clinical, patient and healthcare organisations. The authors suggest that guideline committees should produce decision-making tools that assist informed discussion with patients. Decisions should be made on the best match between evidence about the benefits and harms of each intervention and the goals and preferences of the patient.



Rosenberg A, Agiro A, Gottlieb M, Barron J, Brady P, Liu Y, et al. Early trends among seven recommendations from the Choosing Wisely campaign. *JAMA Intern Med* 2015; 175: 1913—1920. doi:10.1001/jamainternmed.2015.5441

This United States study, using an insurance company's national claims data, looked at changes in frequency of seven Choosing Wisely services over the first two to three years. There was a significant decrease in use of two services (imaging for uncomplicated headache and cardiac imaging without history of cardiac conditions). Use of two services increased significantly (human papillomavirus testing in women under 30 and non-steroidal anti-inflammatory drugs for patients with chronic conditions that can be worsened by these drugs). Use of three services was unchanged (preoperative chest X-ray without indication, antibiotics for acute sinusitis, imaging for uncomplicated low back pain). Additional interventions rather than just the provision of information may be required to affect change.

Colla CH, Kinsella EA, Morden NE, Meyers DJ, Rosenthal MB, Sequist TD. Physician perceptions of Choosing Wisely and drivers of overuse. *Am J Manag Care* 2016; 22:337—343.

This survey of doctors practising at a large United States ambulatory care provider assessed awareness of Choosing Wisely almost two years after its introduction and views on possible drivers of overuse. The response rate was 72%. Awareness of Choosing Wisely was significantly higher among primary care physicians (47%) than medical specialists or surgeons. Primary care physicians reported feeling significantly more pressure from patients for interventions than other doctors. Support for doctors in dealing with uncertainty associated with conservative management and that addresses drivers of overuse may be beneficial in reducing overuse.

O'Donnell JL. Editorial. Evolve osteoporosis and other guidelines avoiding cognitive bias. *Intern Med J* 2016; 1129—1132. doi: 10.1111/imj.13212

The editorial suggests that standardised critical appraisal of clinical guidelines is more likely to have an impact on low-value care than some of the Royal Australasian College of Physicians' current Evolve (Choosing Wisely) recommendations, which are directed to other specialties rather than the speciality that derived it. Cognitive bias in clinical guidelines is illustrated using the example of bone mineral density scans for monitoring the effectiveness of treatment for osteoporosis.

Silverstein W, Lass E, Born K, Morinville A, Levinson W, Tannenbaum C. A survey of primary care patients' readiness to engage in the de-adoption practices recommended by Choosing Wisely Canada. *BMC Res Notes* 2016; 9: 301. doi: 10.1186/s13104-016-2103-6

This Canadian study of primary care patients aged 50 or more years suggests provision of patient educational materials in waiting rooms can improve knowledge around the use of unnecessary care. The response rate was 53% -- participants were highly educated, mostly female (59%) and had a mean age of 63 years. Participants chose one topic from five common unnecessary interventions (annual electrocardiogram (ECG) testing, use of antipsychotic drugs for dementia, use of antibiotics for sinusitis, imaging for low back pain, and hypnotic use for insomnia) and rated their agreement to knowledge and behaviour statements in relation to the topic before and after reading a Choosing Wisely brochure on the topic.

A subset also later had a semi-structured interview. Knowledge improved significantly for all topics after reading the brochure, irrespective of age, sex or educational status. Forty-eight percent said that they would discuss the material with a health care provider and 45% intended to incorporate the brochure's recommendations into their future health behaviour. The majority of the (small subset of) interviewed patients already espoused or were ready to adopt the principles of Choosing Wisely.

Stinnett-Donnelly JM, Stevens PG, Hood VL. Developing a high value care programme from the bottom up: a programme of faculty-resident improvement projects targeting harmful or unnecessary care. BMJ Qual Saf 2016; 25: 901–8. doi: 10.1136/bmjqs-2015-004546.

The article reports the first two years' experience of reducing low-value care in a United States university medical department. Clinicians proposed projects to reduce low-value tests and procedures in their subspecialty, some of which were from Choosing Wisely lists. Opportunity for improvement was assessed from baseline data. Selected projects were implemented through education of the ordering clinicians and system-based change (e.g. electronic best practice alerts when ordering a test). Examples of success included a 90% reduction by two years in bone density scans of women under 65 years without risk factors for osteoporosis. The authors identified factors that affected project success and have developed a framework to assist future project selection based on complexity, value and controversy.

2016

Boyes B. Medical Groupthink: is that surgery, procedure or medication really necessary? Real KM Evidence based. Practical results. 2016. <http://realkm.com/2016/03/17/medical-groupthink-is-that-surgery-procedure-or-medicine-really-necessary/>

This article gives a patient's voice to the experience of potentially undergoing unnecessary and potentially harm-causing investigations and treatments. Bruce Boyes is an Australian man in his fifties, who came close to undergoing a coronary angiogram to investigate Q wave inversion on his ECG. Dr Boyes was concerned enough at the prospect of developing complications from having this procedure, that he found and reviewed some of his earlier ECGs done some 25 years prior. These ECGs showed exactly the same Q wave inversion pattern, hence discounting the cardiologist's opinion that Dr Boyes had experienced "a silent myocardial infarction". Dr Boyes relates previous health encounters that have coloured his approach to medical consultations and advice. These include his chance-reading about the use of imiquimod for treatment for basal cell carcinomas (B.C.Cs). Bruce's facial B.C.C was successfully treated with imiquimod, despite being told by a surgeon there was no alternative to surgical excision and skin graft of his BCC. Dr Boyes's insights provide good examples of the importance of patients being comfortable questioning the advice they are given by their doctor.

Willmott L, White B. Stopping Futile Treatment- the Challenge for Doctors Health Services Research Association Australia NZ. Australian Centre for Health Law Research: 2016

A team of interdisciplinary researchers from the Australian Centre for Health Law Research, have undertaken a study, in which 96 doctors, at 3 Queensland hospitals were interviewed regarding their perceptions of provision of futile treatment to adult patients who are dying. These doctors were taken from a wide range of specialties including internal medicine, cardiology, geriatrics, surgery and emergency departments. The doctors reported their reasons for providing futile treatment fell into one of three categories; doctor related, patient related and relating to the institutional nature of hospitals. Of these, it was found that doctor-related reasons were just as, if not more important in the provision of futile end of life care. These include a medical cultural "aversion to death" and view of it as a failure to provide adequate care, wanting to satisfy patients, avoidance of difficult conversations with the dying patient and their family, and fear of legal consequences.

The authors of this study stress the critical role of, and opportunity for individual doctors and the medical profession as a whole, to bring about change. They do not see that change will occur unless doctors are prepared to lead and act. The authors recommend doctors prioritize good communication with patients and family members, and undertake those difficult conversations, including patients' and families' values and goals of treatment. The importance of institutional support for doctors to do this was also acknowledged.



Zikmund-Fisher BJ, Kullgren JT, Fagerlin A, Klamerus ML, Bernstein SJ, Kerr EA. Perceived barriers to implementing individual Choosing Wisely recommendations in two national surveys of primary care providers. J Gen Int Med 2016 doi: 10.1007/s11606-016-3853-5

This United States study examined primary care providers' perceptions regarding which Choosing Wisely adult primary care recommendations were difficult for them to follow, difficult for patients to accept, or both, and particular barriers to reducing overuse. National surveys of private sector primary care physicians and federally funded primary care providers were carried out with response rates of 34% and 48%, respectively. There was variation in reported difficulty to follow and a high level (36 to 87 %) of reported difficulty for most patients to accept for recommendations related to medication use (sinusitis, insomnia/agitation/delirium) and imaging (syncope, low back pain). for symptomatic conditions. Malpractice concerns, patient requests, the number of interventions recommended by specialists, and lack of time for shared decision-making with patients were most frequently rated as major barriers to reducing overuse. Findings were largely consistent between the two groups which suggest that such concerns are not predominantly driven by reimbursement issues. Variations in attitudes across recommendations suggest implementation efforts will need to be adapted to the specific barriers in implementing each Choosing Wisely recommendation.

2017

Matulis J, Liu S, Mecchella J, North F, Holmes A. Choosing Wisely: A Quality Improvement Initiative to Decrease Unnecessary Preoperative Testing. BMJ Qual Improv Report 2017 6 doi:10.1136/bmjquality.u21681.w6691

This article from the United States details a quality improvement study, which aimed to reduce rates of unnecessary pre-operative testing and reduce the average time taken for pre-operative appointments. It was undertaken within the pre-operative service of a General Internal Medicine (GIM) Clinic at a rural, academic medical center over a 9-month period. Only patients undergoing low and intermediate cardiac risk surgeries were included. Of note, seven specialties participating in the American Choosing Wisely initiative recommend against performing routine pre-operative testing prior to low-risk surgery.

Baseline data was extracted from the files of patients undergoing pre-operative evaluation identified that 36% of all patients received unnecessary testing. Prior to the intervention, researchers found no standardized process for either performing the pre-operative evaluation nor for the ordering of pre-operative tests. Important contributory factors leading to unnecessary testing were identifiable.

These included; practice tradition, lack of familiarity with current guidelines, institutional pre-operative requirements and time constraints.

The researchers developed a templated Electronic Health Record (EHR) Tool to guide clinicians through recommended documentation format, orders, patient instructions and billing. It was hoped this tool would also be adopted by physicians outside of the pre-operative clinic, and drive wider improved rates of appropriate testing. The researchers employed Nurse Practitioners and Physician Assistants to run the pre-operative clinics, and used standardized processes. Clinical access and scheduling flexibility for these clinics was noted to be improved compared to primary care physician (PCP) run pre-operative clinics.

Results: a statistically significant reduction in unnecessary pre-operative testing was found between the group of patients seen in the intervention group (4%), and the patients receiving usual care (23%). Mean scheduled appointment duration was also significantly lower (40minutes versus 48minutes).



Referring Wisely. The Royal College of Physicians. 2017

The Royal College of Physicians (RCP) noted a great deal of variability in the pattern of referrals between generalist and specialist physicians, and so it invited all Medical Specialties to contribute to their work on “Referring Wisely”.

The aim was to gain a better understanding of the referral processes between General Medical Services (GMS) and Subspecialty areas, and identify areas of less appropriate referrals. It was hoped this could reduce unnecessary referrals, reduce fragmentation of care, reduce duplication of tests, and lead to more appropriate use of services and better use of limited resources. In doing this work, RCP expected that disagreements of opinion may occur, but hoped this could fuel further discussion.

Subspecialty committees were asked to provide two lists. Firstly; a list of the 5 most common referrals from other medical specialty physicians. Secondly; a list of 5 commonly referred conditions from other physicians, where it was expected that the management required was within the knowledge domain of any physician, hence the referral was not needed.

Twenty-three medical subspecialties responded with providing these two lists, and they are available for review in the full article. The lists show that many of the referrals made to subspecialties are for issues, which subspecialist consider, should be able to be managed by any physician. Why does this discrepancy in opinion occur? Suggestions include; lack of clear referral guidelines, lack of appropriate generalist resource, inadequate training for general physicians on specific conditions, patients’ expectations of medical health care provision i.e. generalist versus subspecialist. Of interest for Geriatricians, the greater problem is other specialties do not always recognize the potential benefits of geriatric assessment and don’t refer, rather than over-refer.

It is hoped that formation of these lists may help streamline services and improve the appropriateness and quality of referrals, address areas needed for further education and target knowledge gaps for general physicians, and promote conversations regarding conditions requiring generalist versus subspecialist care. The RCP takes care to note that these lists are not to be used didactically, nor to discourage discussion between generalist and subspecialty physicians.

Updated in August 2017