



## FEATURE

## TOO MUCH MEDICINE

## Choosing Wisely: how the UK intends to reduce harmful medical overuse

The Choosing Wisely campaign has laudable aims to reduce harmful and costly medical overuse, writes **Jacqui Wise**, but will it make a difference in the UK?

Jacqui Wise *freelance journalist, London, UK*

The Choosing Wisely campaign in the UK, launched by the Academy of Medical Royal Colleges in October last year, lists 40 tests and treatments that are unlikely to benefit patients.<sup>1,2</sup> For example, the campaign advises that uncomplicated back pain does not usually require imaging; screening for prostate specific antigen does not lead to longer life; and chemotherapy for patients with terminal cancer may cause harm and should be minimised.

The campaign aims to encourage doctors and patients to have a conversation about the risks and benefits of interventions. Joan Reid, policy manager for the Choosing Wisely campaign, told the *BMJ*: “Medicine has developed to such an extent that we now have an armoury of tests, treatments, and procedures for any given disease whereas a couple of decades ago we didn’t have that same choice. So the doctor needs to have a detailed discussion with the patient about their experience, their lifestyle, their attitude to risk, and their social circumstances.”

Choosing Wisely was developed in the United States in 2012 by the American Board of Internal Medicine Foundation ([www.choosingwisely.org](http://www.choosingwisely.org)). The US list has 450 tests and treatments that are unlikely to be of benefit, supported by many resources, including education modules for doctors and materials for patients. Canada, Australia, Germany, Italy, Japan, Netherlands, and Switzerland have similar campaigns.

### Five interventions

For the UK list, the academy asked all of the 24 medical royal colleges and faculties to propose “five tests, treatments, or procedures which have questionable benefits and should prompt a careful discussion with patients rather than being carried out without question.” Each college or faculty appointed a Choosing Wisely lead, and it was up to them to interpret this in any way they chose.

Five interventions were suggested because it seemed a manageable number, but if the college contributed two or six that was fine. A committee of senior clinicians and representatives from the National Institute for Health and Care Excellence (NICE) examined the initial list of 55 items and

reduced it to 40 because some were duplicates or incompatible with NICE guidance. A spokesperson for Choosing Wisely added: “We also wanted to avoid one specialty telling another what to do. For example, telling primary care doctors not to order tests.”

Not all the colleges contributed in the first round. The Royal College of Surgeons and the Royal College of Anaesthetists got together for their suggestions, and some of the smaller faculties didn’t have the resources to join in. One obvious omission was the Royal College of Physicians. This was because the college represents 30 subspecialties and found it too difficult to produce a list of just five interventions. However, for the next list each subspecialty will be asked individually to suggest five tests or treatments for inclusion.

### End-of-life care

The UK version is still in its infancy and the aim is to add to it annually. Reid said that the next tranche of recommendations will have a focus on end-of-life care and will consider underuse as well as overuse of treatments. The plan is also to be more focused on conditions rather than on individual tests, treatments, and procedures. The next list will include those colleges that have not already contributed and those that have but want to add more items.

NICE already has a lengthy list of “do not do” recommendations,<sup>3</sup> so why is the Choosing Wisely campaign even needed? David Warriner, clinical fellow at the Academy of Medical Royal Colleges, argues: “The NICE list has its merits but it is more aimed at clinicians. Our Choosing Wisely list is more patient focused.”

When the Choosing Wisely campaign was first announced it was criticised in the *Guardian* newspaper as a way of rationing treatments and saving money.<sup>4</sup> But Reid disputes this: “In the US the focus is particularly about reducing spending. For us the emphasis is much more on shared decision making.”

Some items on the list may seem a little obvious to most clinicians. For example, one states that day surgery should be considered the default for most surgical procedures; another that when patients are frail or in their last year of life doctors should discuss stopping drugs that aren't needed to control symptoms. Many items focus on shared decision making and link to shared decision aids. For example, one says if drug treatment is being considered to prevent heart disease, stroke, or osteoporosis in previously well people doctors should ensure that the decision is shared with the individual concerned.

## Better conversations

Carl Heneghan, professor of evidence based medicine and director of the Centre for Evidence-Based Medicine at Oxford University, says the aim to improve conversations between patients and their doctors and nurses is good. "However, for general practitioners communication is ingrained in training and central to the consultation. As a consequence we have known about many of these recommendations for some time. For example, recommendations that radiography is of little benefit for lower back pain if there are no other concerning features has been known for over 20 years." However, he points out that imaging for lower back pain remains common practice in countries such as the United States.

Heneghan is critical of the idea that shared decision making should be based on untried and untested decision aids, saying it is at odds with an evidence based service. He questions, for example, how many doctors and patients have tried to use the decision aid on taking a statin to reduce the risk of coronary heart disease and stroke, which is 23 pages long with a 15 page guide. "Before decision aids are recommended it is imperative that they are set in an evidence based context," he says.

## Modest success

As yet little hard evidence indicates that campaigns such as this reduce unnecessary tests, treatments, or procedures. A study in *JAMA Internal Medicine* in 2015 found that the US campaign has had only modest success.<sup>5,6</sup> The researchers looked at seven interventions in the first Choosing Wisely list, published in 2012, and found that use fell significantly for only two—imaging for headache and cardiac imaging in patients without a history of cardiac conditions.

Wendy Levinson, professor of medicine at the University of Toronto and chair of Choosing Wisely Canada, told *The BMJ* that the focus of its campaign was not to save costs but to avoid harm and reduce waste. She said that the campaign is working with the Canadian Institute for Health Information to get provincial and national measures to evaluate Choosing Wisely but this takes time. However, she said that some hospitals have seen impressive results. "For example, North York General, a hospital in Toronto, changed its order sets in the emergency department and reduced laboratory tests by 31%, with no impact on quality of care or patient outcomes."

Warriner agrees that it is important to audit the effect of the UK's Choosing Wisely campaign. The academy is about to start work with a small group of pathfinder trusts and clinical commissioning groups to carry out a baseline audit over six months for around a dozen tests, treatments, and procedures. The Choosing Wisely regime will then be implemented and the effect monitored over 12 months. The plan is to publish the results once there are sufficient data.

## Engaging patients

Part of the challenge is getting the message out to both doctors and patients. In the United States, Choosing Wisely partners with the consumer advocate organisation Consumer Reports and is well funded. However, a random survey of 600 US doctors found that only a fifth (21%) had heard of the campaign.<sup>7</sup> The level of public awareness has not been assessed. By contrast, the UK campaign is run on a relative shoestring funded entirely by the academy. The academy is talking to NHS England but it is not clear whether it will get any support. Choosing Wisely UK has no plans at the moment to measure the success of the campaign in terms of awareness.

In Canada Choosing Wisely was supported by the Ontario Ministry of Health and Long Term Care when it first launched, and it now has support from Health Canada. Levinson said, "We have surveyed Canadian doctors and the majority are aware of the campaign and over 40% say they use campaign materials every day in practice."

Whether the UK campaign will have much impact when the health system has no financial incentive to restrict doctors' activity remains to be seen. As Malhotra and colleagues pointed out in *The BMJ* when the Choosing Wisely initiative was first proposed in the UK: "General practice is increasingly pressured to focus less on open dialogue with patients about treatment options and more on fulfilling the demands of the Quality and Outcomes Framework and adhering to local commissioning decisions."<sup>8</sup>

Margaret McCartney, chair of the Royal College of General Practice's overdiagnosis group, said she was pleased to see wider recognition of the problems of overdiagnosis and overtreatment. "However, it would be naive to think that a list of things not to do can possibly tackle the systemic problems we are now dealing with—for example, unsuitable guidelines being applied to groups of people with a low likelihood of benefit from the recommendations they contain, or the underfunding of general practice, which disrupts continuity of care."

Competing interests: I have read and understood BMJ policy on declaration of interests and have no relevant interests to declare.

Provenance and peer review: Commissioned; not externally peer reviewed.

- 1 Choosing Wisely. Clinicians recommendations. <http://www.choosingwisely.co.uk/>
- 2 Torjesen I. Royal colleges issue list of 40 unnecessary interventions. *BMJ* 2016;356:i5732. doi:10.1136/bmj.i5732 pmid:27784663.
- 3 NICE. NICE guidelines: savings and productivity. <https://www.nice.org.uk/savingsAndProductivity/collection?page=1&pageSize=2000&type=Do%20not%20do&published=&impact=Unclassified&filter=>
- 4 Campbell D. Doctors to withhold treatments in campaign against too much medicine. *Guardian* 2015 May 12. <https://www.theguardian.com/society/2015/may/12/doctors-to-withhold-treatments-in-campaign-against-too-much-medicine>
- 5 McCarthy M. US Choosing Wisely campaign has had only modest success, study finds. *BMJ* 2015;356:h5437. doi:10.1136/bmj.h5437 pmid:26463464.
- 6 Rosenberg A, Agiro A, Gottlieb M, et al. Early trends among seven recommendations from the Choosing Wisely campaign. *JAMA Intern Med* 2015;356:1913-20. doi:10.1001/jamainternmed.2015.5441 pmid:26457643.
- 7 PerryUndem Research/Communication. Unnecessary tests and procedures in the health care system: what physicians say about the problem, the causes, and the solutions: results from a national survey of physicians. 2014. [www.choosingwisely.org/wp-content/uploads/2015/04/Final-Choosing-Wisely-Survey-Report.pdf](http://www.choosingwisely.org/wp-content/uploads/2015/04/Final-Choosing-Wisely-Survey-Report.pdf)
- 8 Malhotra A, Maughan D, Ansell J, et al. Choosing Wisely in the UK: the Academy of Medical Royal Colleges' initiative to reduce the harms of too much medicine. *BMJ* 2015;356:h2308. doi:10.1136/bmj.h2308 pmid:25985331.

Published by the BMJ Publishing Group Limited. For permission to use (where not already granted under a licence) please go to <http://group.bmj.com/group/rights-licensing/permissions>