

Choosing Wisely? Not as the Academy of Medical Royal Colleges envisages

In mid-2015, the Academy of Medical Royal Colleges launched Choosing Wisely. This initiative aims to reverse the trend towards the ‘overmedicalization’ of illness (Academy of Medical Royal Colleges, 2015). This can lead to both overdiagnosis and overtreatment. The former concerns an (over)enthusiastic diagnosis of individuals with symptoms that will never cause illness or death. The latter relates to treating these overdiagnoses, and providing treatment with little or no evidence to support its clinical value, (Malhotra et al, 2015).

These types of treatment have been referred to as either low- or no-value care (Gawande, 2015). It has even been argued that the concept of overdiagnosis gives rise to so many competing conceptions of the term that the idea by itself does not articulate the problems faced by research and health care in an insightful way as is needed (Carter et al, 2015). The Choosing Wisely initiative aims to tackle overmedicalization by asking medical organizations to compile ‘top five’ lists of clinically low-value interventions to then be disseminated to health-care professionals.

Rather than outline the values promoted by Choosing Wisely, this editorial raises questions relating to the initiative’s aim of developing ‘a Choosing Wisely culture in clinical practice’ (Malhotra et al, 2015). That culture is one whereby discussions between practitioner and patient will be rebalanced to confront more forthrightly the clinical value of treatments, in light of greater public awareness of overmedicalization. The editorial questions whether the purported timelines and proposed actions of the Choosing Wisely initiative are realistic to facilitate this cultural change.

The speed of cultural change

As noted above, the aims of the initiative are bold. Choosing Wisely is in principle to be commended for these aims, particularly at a time when more and more con-

cerns are being raised about the overtly-commercial direction the NHS is heading in (Limb, 2015). But given the size of the aims, both the timescale for the initiative and the suggestions from the Academy of Medical Royal Colleges regarding how to go about facilitating these aims are worrying. Consider what is meant by ‘cultural change’; roughly put, a change in the values, virtues, attitudes, actions, responsibilities and principles that constitute and guide the system in which professionals operate, to make decisions having profound social and economic effects (Beauchamp and Childress, 2013). By way of illustration, the Francis inquiry report (The Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013) into the failings of the Mid Staffordshire NHS Foundation Trust aims to tackle large-scale cultural change, while purporting to work within the existing NHS system. That report proposed a total of 290 recommendations, the executive summary alone stretching to 115 pages.

While Choosing Wisely is perhaps not on the same scale as the systemic reorganization the Francis Inquiry Report recommends, equally the timescales of Choosing Wisely appear to be overambitious. The briefing from the Academy of Medical Royal Colleges (2015) does state that the ‘initiative should be seen as a long term programme and campaign with multiple players rather than a single simple project’. Yet if the initiative really wishes to achieve its purported aims of embedding a culture where regular discussions between professional and patient take place regarding the clinical value of treatments, this immediately raises a tension with the proposed audit of the impact and reduction in unnecessary interventions as a result of the scheme in 2016. This appears to be far too soon to establish, let alone audit, the type of cultural change in health-care professionals’ attitudes that Choosing Wisely seeks to implement.

Quick fixes and external incentive schemes

Likewise, one potential limitation identified by Malhotra et al (2015) is that in choosing which interventions to list as those that should not be used for each specialty, individual societies might choose quick fixes; those interventions that are minor in nature and can easily be stopped, rather than taking time to consider more major procedures that might be clinically of low value. Yet the making of wise choices for Choosing Wisely already appears to be compromised in three significant ways.

First is the time limit placed on the audit, as mentioned above. Second is the resource-allocation system the project has to work within. As is noted ‘[t]he system has no incentive to restrain doctor’s activity; the NHS in England has a system of payment by results’ (Malhotra et al, 2015). General practice, clinical commissioning groups and hospital incomes are now under increasing pressure to focus on those goals of the Quality and Outcomes Framework in primary care and the National Commissioning for Quality and Innovation scheme, which accounts for still 2.5% of a health-care provider’s contract value (NHS England, 2015). This latter scheme, in its most recent guidance, explicitly notes that ‘the national goals seek to incentivise quality and efficiency’.

Internal incentive schemes: an impediment to cultural change

But perhaps the biggest impediment to thorough, considered choices being made for the initiative is the Academy of Medical Royal Colleges explicitly recommending that ‘[c]ommissioners should consider a different payment incentive for doctors and hospitals’ (Malhotra et al, 2015). Given the timescales in which the audit will operate, this appears to incentivize in the short term those superficial quick fixes that render the scheme less effective than it should be.

Second, Malhotra et al (2015) note that Choosing Wisely 'will require commitment from both doctors and patients', to come to a health-care solution based on best evidence. Yet this sort of commitment appears a bad fit with the emphasis on payment incentives. If incentives are given to not use certain treatments, then the quickest and most effective way to do this is simply for practitioners not to offer them. Yet then it appears that if practitioners follow the scheme, they have two (potentially) undesirable alternatives. They can either invest time and resources (that they might not always have) into discussing with a patient a health-care solution based on best practice, while the patient might still want the clinically low-value option for a number of reasons. Alternatively, the practitioner can simply not offer the low-value treatment, but compromise what one of the driving aims of Choosing Wisely is about. That practitioners are placed in the situation does not even consider whether the Choosing Wisely public education campaign will be effective (Hodgson, 2015).

Conclusions

Providing payment incentives for implementing Choosing Wisely does not appear the best way to achieve the attempted cultural change of the initiative. That this is recommended when there is a 'dearth of good research into interventions that might constrain medical excess' is even more puzzling (Macdonald and Loder, 2015). Many health-care practitioners will already endeavour to be undertaking best practice by using what limited resources there are within the existing incentivized systems to inculcate an understanding within patients as to the importance of clinical efficacy, and health-care plans based on this.

Yet, if changing practice is contingent upon financial incentives, what happens when this incentive either alters or is removed? The reward does not truly encourage the change to or formation of character traits that lead to discerning, conscientious decisions with patients about the treatment they receive in light of limited resources. That this is one of the main aims of Choosing Wisely should encourage the Academy of Medical Royal Colleges to rethink how to best implement this initiative with medical professionals. **BJHM**

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KEY POINTS

- The Academy of Medical Royal Colleges has launched a new initiative, Choosing Wisely. One aim is to effect a cultural change within medical professionals to discuss the clinical value of treatments (or lack of) on a more regular basis with patients, and reduce the use of clinically low-value health-care treatments.
- Despite that such a significant change may take time, an audit of the efficacy of the initiative is scheduled for 2016. There appears to be little reason for scheduling an audit of the initiative so soon.
- While mention is made of the existing incentive systems the project has to work within, little sustained focus is given to the implications for the initiative in working in these systems.
- Most worryingly, Choosing Wisely suggests its own incentive system. This threatens to undermine the cultural change at the heart of the initiative. The incentive system means treatment decisions are based not on clinical value as it relates to the patient, but clinical value that is contingent on financial benefits.

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