Choosing wisely

Sir,

Your editorial (vol 76(12), 2015, p. 678) misunderstands what the Choosing Wisely initiative is – and what it is not; it is important that we set the record straight – albeit briefly. The facts, as published by the *BMJ* and the Academy of Medical Royal Colleges and widely reported across the mainstream media, speak for themselves. Choosing Wisely is designed to: 'promote conversations between doctors and patients by helping patients to choose care that is:

- Supported by evidence
- Not duplicative of other tests or procedures already received
- Free from harm
- Truly necessary.'

It is not about:

- Cutting costs to the NHS (this may be an effect, but equally it may not, as other, more effective and/or costly treatments may be offered as an alternative)
- Doctors refusing or withdrawing treatment
- Offering financial incentives to doctors to reduce or replace treatments and/or procedures
- Creating a false time limit on any audit or implementation programme.

This last point bears further explanation. The audit, or review of tests, procedures and treatments, to be more accurate, is currently being conducted by the Academy's 22 Medical Royal Colleges and faculties. Early results show some specialities are coming up with more than five treatments or procedures of questionable value – X-rays for lower back pain for example, while other specialities are coming up with fewer than five. Once these results are properly assessed and analysed they will be publicized to patients and disseminated to doctors through their own professional bodies. This, we expect, will enable both doctors and patients to have a meaningful conversation about which type of treatment or procedure is best for them in their circumstances. The initiative is ongoing and should be permanently so if clinicians and patients are to be good stewards of the resources at hand and standards of care are to be improved for the benefit of all.

At its heart Choosing Wisely seeks to create an environment where shared decision making is the norm. That is where patients are sufficiently enfranchised to question treatments and procedures that are proposed and doctors are sufficiently enfranchised to explain the pros and cons of what is on offer. A good example from my own branch of medicine is encouraging patients with mild depression to consider exercise as an alternative to antidepressants. The evidence for the success of this strategy is overwhelming and well-documented, but not perhaps widely understood by patients or clinicians. Thus, it is about moving to a culture that provides care that is right for the patient, not simply the care that is available. As with all cultural change, we know that this will not happen overnight, but that is not a reason not to start this process.

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Sir,

I am writing in my personal capacity only, not as representative of any body.

The Choosing Wisely campaign has good intentions. It is impossible, though, for a list of five 'do not do' things produced by colleges to solve the problems of overdiagnosis or overtreatment in medicine, and to be fair I do not think the campaign has ever suggested that it would.

Many problems in medicine are systemic, however, and it is these systems that need to be addressed to ensure that we are getting as close to good medicine as we can; representing evidence fairly, so that we can make shared choices that are as close to what the patient wishes as possible, ensuring that we are cognisant of the gaps in the evidence base, making sure that we are taking account of the real-life problems of multimorbidity and polypharmacy.

Furthermore, organizations that give guidelines to doctors can miss out essential data such as numbers needed to treat or harm, and usually exist for single conditions when patients often have multiple conditions. Incentive payments to doctors under the Quality and Outcomes Framework demand 'exception reporting' for non-compliance rather than coding as 'patient choice'. It is only by improving on the systems that doctors work in that we can get close to doing better for patients.

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Sir,

I read with interest the editorial concerning the Choosing Wisely campaign from the Academy of Medical Royal Colleges. This is part of a wider movement, including Preventing Overdiagnosis, Prudent Practice, Too Much Medicine and Selling Sickness, seeking to minimize labelling patients with diagnoses that will not subsequently cause harm or premature death during their lifetime.

I feel Dr Hobson misunderstands the purposes of both the wider movement and the specific Choosing Wisely campaign. Reducing overdiagnosis is not dependent on financial incentives and in fact perverse incentivization, such as the Quality and Outcomes Framework, is widely recognized as promoting overdiagnosis. Thus, a review of such funding programmes is welcomed and timely. But this is not the sole cause of overdiagnosis or indeed the sole solution.

One would agree that the problem is complex and a cultural change is needed, from government, guideline panels, journalists, patients, charities, device and drug manufacturers, lawyers, medical schools, doctors and so on. This will undoubtedly take time, but the movement in its various guises has been ongoing for several years now and so an audit is needed, even as a baseline. Indeed, recent shop floor displays of dissent, such as GPs rejecting National Institute for Health and Care Excellence (NICE) guidelines over the recommendation of statins in those with a 10% 10-year risk of cardiovascular disease, have demonstrated just how much will there is in the medical fraternity to do the right thing for the patient despite what the 'experts' advocate. Other groups must now follow suit.

Rightly, Dr Hobson questions the very definition of overdiagnosis, which clearly depends on the context of the decision being made, as is the case with any clinical reasoning problem. But in a publicly funded system such as the NHS, financial concerns will never take precedent over clinical decisions, unlike in private health care. Whether the NHS remains publicly funded is yet to be seen. I think Dr Hobson's concerns are misplaced and welcome the involvement of the Academy of Medical Royal Colleges, which will only add credibility and impetus to this much-needed grass-roots movement.

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Sir,

I am grateful for the responses to the editorial, which all challenge and clarify in important ways the portrayal of Choosing Wisely. Although I cannot do justice to every point, this selection does not reflect any opinion about the relative importance of each response.

I agree with all the correspondents regarding the need for both creating a shared decision-making environment, and for a cultural change. Indeed, much like Dr Warriner, I do welcome the involvement of the Academy of Medical Royal Colleges, and agree with Professor Bailey that this process does need to be started, specifically commending Choosing Wisely for its aims in the editorial.

However, I do not think the editorial argued, pace Dr McCartney, that Choosing Wisely would by itself solve overdiagnosis and overtreatment. The editorial states that Choosing Wisely aims to tackle these problems, and specifically quotes from the initiative that it is a long-term programme.

I thank Professor Bailey for clarifying my understanding of the remit of the audit, and welcome the further characteristics expanded upon, that the audit is ongoing in nature, and is being undertaken by the respective Medical Royal Colleges and faculties.

Finally, I would question Dr Warriner's assertion that the editorial argues that reducing overdiagnosis is dependent on financial incentives. Indeed, I argue that this might be the biggest impediment, although this is tempered by Professor Bailey's response regarding what Choosing Wisely is not about.

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