Choosing Wisely: Five Ideas that Physicians and Patients Can Discuss

David W. Parke II, MD - San Francisco, California
Anne L. Coleman, MD, PhD - Los Angeles, California
William L. Rich, III, MD - Washington, D.C.
Flora Lum, MD - San Francisco, California

In 2012, the American Academy of Ophthalmology joined 16 medical specialty societies in the second wave of the Choosing Wisely campaign, initiated by the American Board of Internal Medicine (ABIM) Foundation. Participating societies each created a list, “Five Things Physicians and Patients Should Question,” consisting of specialty-specific, evidence-based recommendations to help patients and physicians make wise decisions about tests and procedures, based on a patient’s individual situation. In some settings, the specified tests and procedures are clearly appropriate and beneficial. However, in other cases the benefits may not be readily evident, prompting further dialogue between the physician and the patient to clarify the patient’s expectations and understanding.

The initial Choosing Wisely campaign was launched with national media attention in April 2012, involving 9 national medical societies. Prominent partners include consumer and business organizations such as the American Association of Retired Persons, Consumers Union (publisher of Consumer Reports), the Leapfrog Group, National Business Coalition on Health, Midwest Business Group on Health, and the Pacific Group on Health. Consumer Reports plans to publish materials (as they did in the first release of the campaign) to facilitate discussions between patients and their physicians and to encourage patients to ask questions about which tests and procedures may be appropriate for them.

The genesis of this campaign can be found in a 2002 initiative, “Medical Professionalism in the New Millennium: A Physician Charter,” developed by the ABIM Foundation, the American College of Physicians Foundation, and the European Federation of Internal Medicine. Placing the primacy of the welfare of the patient in a broader societal framework, this charter describes a responsibility of physicians to advocate for the cost-effective and just distribution of finite health care resources. In 2010, Dr. Howard Brody proposed a specific strategy for advancing this goal by creating a list of commonly used but often unnecessary tests or procedures, “A top 5 list also has the advantage that if we restrict ourselves to the most egregious causes of waste, we can demonstrate to a skeptical public that we are genuinely protecting patients’ interests and not simply ‘rationing’ healthcare, regardless of the benefit, for cost-cutting purposes.” Building upon this idea, the National Physicians Alliance created the Promoting Good Stewardship in Clinical Practice Project, which promulgated top 5 lists in internal medicine, family medicine, and pediatrics.

In a recent editorial in the New England Journal of Medicine, Brody iterated his call for physician leadership in this area of reducing nonbeneficial interventions. While acknowledging that the boundary between appropriate and wasteful use of health care resources may be fuzzy, Brody asserted that eliminating interventions for which there is evidence of a lack of benefit can help to control costs and may delay or ameliorate onerous decisions about health care allocation. He issued a challenge to the profession, “Will U.S. physicians rise to the occasion, committing ourselves to protecting our patients from harm while ensuring affordable care for the near future?”

Estimates of the impact of unnecessary tests and procedures range as high as 30% of all health care spending. The Institute of Medicine Committee on Better Care at Lower Costs also estimated that about 30% of health spending in 2009—roughly $750 billion—was wasted on unnecessary services, excessive administrative costs, fraud, and other problems. Quantifying the potential impact of eliminating unnecessary clinical activities outlined by the Good Stewardship Working Group, Kale et al concluded that if the most overused items in primary care were eliminated, cumulative annual savings to the health care system could exceed $6.7 billion. The authors conservatively estimated that these activities would be considered unnecessary. The activity associated with the bulk of the expenditures was the prescribing of brand statins instead of generic statins unless indicated, resulting in costs of $5.8 billion per year (95% CI, $4.3–$7.3 billion). Unnecessary testing of bone density in women younger than 65 years of age accounted for $527 million per year (95% CI, $474–$1054 million). Although many of the identified activities contributed a small fraction to the total, these still represent resources that could be spent elsewhere more productively, e.g., ordering of complete blood counts when unneeded accounted for $32.7 million in direct costs (95% CI, $23.9–$40.8 million).

To develop a top 5 list for ophthalmology, the Academy started with its Health Policy Committee, which identified several candidate interventions based on available evidence in the literature. The Academy’s Secretariat of Quality of Care helped to evaluate the evidence for each of these ideas. Input was sought from the membership and from subspecialty societies for tests and procedures that potentially are superfluous. These data were collated and the finalized top 5 list was approved by the Academy’s Board of Trustees in August 2012. Ophthalmology’s list, along with lists from other medical societies, can be found at www.choosingwisely.org.

The list of 5 ideas is:

1. Don’t perform preoperative medical tests for eye surgery unless there are specific medical indications.
2. Don’t routinely order imaging tests for patients without symptoms or signs of significant eye disease.
3. Don’t order antibiotics for adenoviral conjunctivitis.
4. Don’t routinely provide antibiotics before or after intravitreal injections.
5. Don’t place punctal plugs for mild dry eye before trying other medical treatments.

Understanding that it is impossible to reduce ophthalmology or any other medical specialty to a checklist of steps, it is important to view top 5 lists as sources of guidance for the physician’s ultimate clinical judgment. For example, such a list might imply limiting optic nerve imaging only to patients who have been diagnosed with glaucoma. However, the physician may believe imaging is justifiable in a patient with a suspicious optic disc to rule out glaucoma. In summary, although we believe that gains in efficiency are possible through the use of top 5 lists, we also believe that gains in health outcomes can best be achieved by physicians exercising optimal clinical judgment. It will be important going forward for the Academy and other professional societies to ensure that guidelines in Preferred Practice Patterns and other materials are appropriately aligned with top 5 lists to make sure that patients who need diagnostic tests or other procedures actually receive them.

The economic impact of some of ophthalmology’s top 5 interventions is not trivial. As an example, if a commonly used antibiotic were prescribed for every intravitreal injection, the annual cost could exceed $300 million annually. Scientific evidence does not support this routine clinical practice.

In demonstrating good stewardship of health care resources, ophthalmology is joining other physician societies to take a leadership role in working with patients, consumer organizations, and business groups to strengthen the physician-patient relationship. We hope to contribute to the broader effort to contain health care costs by addressing inefficiencies in the health care system and reducing costs where appropriate without sacrificing quality of care. We invite you to join colleagues in ophthalmology and other medical disciplines by having these types of discussions with patients to make wise decisions, based on the best available evidence.

References

Erratum
With apologies from the publishers, the final authorship in the article entitled, “Prevalence of Glaucoma in a Rural Northern China Adult Population: A Population- based Survey in Kailu County, Inner Mongolia” by Wuilian Song, MD, Li Shan, MD, Fang Cheng, Pan Fan, MD, Lijuan Zhang, Wei Qu, MD, Qiju Zhang, MPH, and Huiping Yuan, MD, PhD (Ophthalmology 2011;118:1982-88) was missing the notation that the first two authors contributed equally to the work.