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ZUR DISKUSSION

When Choosing Wisely meets clinical practice guidelines

Wenn "Choosing Wisely" auf Leitlinien trifft

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Summary The American Board of Internal Medicine (ABIM) Foundation launched the Choosing Wisely campaign in 2012 and until today convinced more than 50 US specialist societies to develop lists of interventions that may not improve people's health but are potentially harmful. We suggest combining these new efforts with the already existing efforts in clinical practice guideline development. Existing clinical practice guidelines facilitate a more participatory and evidence-based approach to the development of top 5 lists. In return, adding top 5 lists (for overuse and underuse) to existing clinical practice guidelines nicely addresses a neglected dimension to clinical practice guideline development, namely explicit information on which Do or Don't do recommendations are frequently disregarded in practice.

SCHLÜSSELWÖRTER
Choosing Wisely;
Leitlinien;
Überversorgung;
Unterversorgung

Zusammenfassung Die *American Board of Internal Medicine* (ABIM) *Foundation* hat im Jahr 2012 die sogenannte Choosing-Wisely-Kampagne gestartet. Diese Kampagne überzeugte bis heute über 50 US-amerikanische Fachgesellschaften davon, sogenannte Top-5-Listen zu erstellen. Top-5-Listen präsentieren medizinische Maßnahmen, die dem Patienten nicht nützen, sondern sogar schädlich für die Gesundheit sein können. In diesem Beitrag wird vorgestellt, wie die Entwicklung von Top-5-Listen evidenzbasierter und partizipatorischer werden kann, indem sie in ein bestehendes Leitlinienprogramm integriert wird. Im Gegenzug bieten entsprechende

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Top-5-Listen eine Möglichkeit, die bislang in der Leitlinienentwicklung vernachlässigten Aspekte von Über- und Unterversorgung explizit zu adressieren. So könnten Top-5-Listen aufzeigen, welche „Tun"- oder „Lassen"-Leitlinienempfehlungen in der Praxis häufig nicht berücksichtigt werden.

Background

For the last 16 months a working group of the German Network for Evidence-Based Medicine (DNEbM), together with other experts in clinical care and health services research, as well as patient representatives, has discussed how to facilitate the uptake of a "Choosing Wisely" (CW) initiative in Germany [1]. In this paper we present two major results of this discussion that can inform current initiatives in North America [2,3] as well as emerging initiatives in other countries [4]. First, we describe methodological challenges of the North American CW model. Second, we suggest how to overcome at least some of these challenges.

Methodological challenges of the current Choosing Wisely initiatives

A multi-stakeholder workshop conducted by the DNEbM in March 2013 identified the following three methodological and two political challenges of the CW initiative as initially begun in the United States:

1) *Lack of methodological requirements or even recommendations on how to develop top 5 lists*. The current CW initiative does not require patient participation, transparency, evidence-based decision making, management of conflict of interest, nor structured consensus finding. Thus CW fails to meet methodological standards for sound medical decision-making that have been implemented during the last two decades. Though pragmatism seems to be the guiding principle in CW - certainly for good reasons - it has been questioned whether this principle should exclude explicit requirements for top 5 list development. The workshop recommended that an alternative be sought that upholds the pragmatic nature of CW while improving the methodological minimum requirements for top 5 list development.
2) *Neglect of the topic of underuse of medical interventions with proven benefit as an equally important challenge in health care*. Physician and patient representatives argued that a CW initiative should aim to raise public as well as physicians' awareness of both overuse of (ineffective, harmful) and underuse of (effective, beneficial) medical interventions.
3) *Need for transparency about applied prioritization criteria*. CW needs more explicit prioritisation criteria if it implies a narrow understanding of "top 5". A narrow understanding of "top 5" means that these five medical interventions are given most attention, and efforts to battle their specific overuse are preferable to alternative efforts to battle overuse of other interventions. Prioritisation criteria such as disease severity, urgency, extent of harm, costs etc. would probably play a role in such a scenario.
4) *Need to highlight the limited claim of CW*. Several contributions in the workshop highlighted that the respective top 5 lists should not promote the incorrect public impression that they are a solution for overuse. On the contrary, a CW initiative should raise awareness of overuse itself and of the context that gives rise to it.
5) *Desire that health insurances are prevented from "freeloading"*. Top 5 lists for overuse developed by physicians themselves might be an attractive opportunity for insurance companies to stop coverage for these interventions. Such a form of "freeloading" on the CW initiative could prevent or strongly limit providers' engagement in this type of overuse discussion.

What high quality clinical practice guidelines add to Choosing Wisely

Core requirements for high quality Clinical Practice Guidelines (CPGs) demand that the development of recommendations be based on the best available evidence, and on consensus among relevant stakeholders, including patient representatives. Moreover, CPG development increasingly includes conflict of interest management [5]. In Germany, guidelines are produced by the scientific medical societies and coordinated by the Association of the Scientific Medical Societies (AWMF). Guidelines of the highest quality are required to

- be produced by a representative multidisciplinary expert group including patients,
- be based on a systematic review of the evidence
- develop recommendations using a structured consensus process with independent moderation [6].

Furthermore, the German register for CPGs requires the publication of all guideline authors' conflicts of interest, and of the process used to discuss, assess and manage conflicts of interest within each guideline group.

Almost all participatory, evidence and consensus-based guidelines include both positive ("Do") and negative ("Don't do") recommendations. According to the level of evidence, the balance of benefits and harms, and further explicit grading factors, these recommendations are qualified as "strong" or "weak". The German National Disease Management guideline "Low Back Pain" includes 30 strong "Do"-recommendations and 28 strong "Don't Do" recommendations [7].

Some guideline groups form an interdisciplinary panel in order to develop a set of quality indicators (QI) based on the original set of all CPG recommendations after finalization of the guideline. This process is obligatory for National Disease Management Guidelines [8] and oncological guidelines, which are embedded in the German Guideline Programme

in Oncology [9]. The respective criteria for choosing quality indicators according to the German manuals are

- the quality characteristic captured with the quality indicator is important for patients and the health care system,
- the definition is clear and unambiguous,
- the indicator expression can be influenced by providers,
- there is a strong evidence and/or consensus base, and
- the risk of potential false incentives is not considered relevant.

Both the set of all Do and Don't do recommendations and the already preselected set of QIs could serve as starting points for developing top 5 lists. The above mentioned "Low Back Pain" guideline recommends 10 performance measures, four "Don't Do" and six "Do" [6].

Provided that CPGs developed according to rigorous methodological standards are used as the starting points for top 5 lists, this would increase transparency, patient participation and rationality (evidence-based) in the development process. We concede that this would make the resulting top 5 lists disease-specific rather than "profession specific".

What Choosing Wisely adds to clinical practice guidelines

The identification of top 5 lists for overuse and underuse adds an important aspect to CPG development that is currently neglected internationally: at present, CPGs recommendations do not inform the public explicitly about which "Do" and which "Don't Do" recommendations are often not followed in real life health care. Top 5 lists make this information explicit.

Priority setting in the development of top 5 lists

The development of top 5 lists necessarily involves prioritization. However, the primary goal of top 5 lists is not to identify the five issues that are the most harmful *or* the least cost-effective. The primary goal of the CW initiative is to raise awareness and improve understanding of the counter-intuitive phenomenon that medical interventions can cause more harm than benefit. To fulfil this goal, besides criteria like relevance to patients and the health care system, the following three, non-traditional, prioritisation criteria might be useful for the development of top 5 lists based on existing CGP recommendations: comprehensibility, communicability and feasibility. Comprehensibility means that lay-people can easily understand what the listed interventions are and that those interventions may be used on them. Communicability means that the listed interventions may easily be argued against via public media, requiring, for example, that available evidence sufficiently demonstrates the lack of (average) net-benefit. Feasibility means that providers are in a good position to reduce overuse of listed interventions.

Conclusions

Countries that already possess a well-developed system for CPGs might have a very attractive fast track option for implementing a CW initiative. Existing CPGs facilitate a more participatory and evidence-based development of top 5 lists. In return, adding top 5 lists (for overuse and underuse) to existing CPGs nicely addresses a neglected dimension to CPG development, namely explicit information on which Do or Don't do recommendations are often not followed in practice.

While overuse and underuse are considered to be a worldwide challenge we recommend that existing CPG groups consider the implementation of a pragmatic CW initiative by using strong Do and Don't do recommendations from high quality CPGs.

Competing interests

We declare the following interests: MF and MN work full time in a program for clinical practice guideline development. ML works full time for the medical advisory service that consults the social health insurance in Germany.

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