

The Surgical Forum of Great Britain and Ireland

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The Surgical Forum of Great Britain and Ireland

“Choosing Wisely”

Foreword

The Surgical Forum of Great Britain and Ireland, formerly known as the Senate of Surgery, is comprised of the Presidents and Vice Presidents of the four Royal Colleges and the Presidents of the ten SAC defined and GMC recognised surgical specialties. The Surgical Forum is therefore a truly representative voice of surgery across the entirety of Great Britain and Ireland.

In recent years the Surgical Forum meetings have all followed a similar format: a topic is selected that is important across both the specialty spectrum as well as having relevance to all geographic parts of the UK and Ireland and, as such, is relevant to all four Colleges. Each meeting is for a full day, is prefaced by invited guest speakers to lay the groundwork to the subject and then all members of the Forum are invited to contribute to the discussions. The proceedings of the meetings are described in a discussion paper, which is agreed by all participants prior to being posted on SSA and College web sites and being made available to the media.

The topic of the most recent Forum meeting was ‘Choosing Wisely’. This meeting was held at the Royal College of Surgeons of England on Monday 25th January 2016. An attendance list and programme showing names of invited speakers and their representative organisations are attached as Appendix 1. In addition to the Presidents, or their representatives, of the four Royal Colleges and ten Specialty Associations, ICBSE, JCIE, BOTA and ASIT were represented.

This document aims to stimulate discussion. It is not a policy statement. The document is based upon discussions that occurred during the meeting as well as afterwards. Preliminary drafts were distributed to all participants as well as to other interested parties in surgery. This document is therefore a representation of the opinion of the surgical profession throughout the UK and Ireland.

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“Choosing Wisely”

Summary

- All of us working in the NHS need to look at and evaluate our working practices to ensure we are providing the best possible outcomes to the public we serve.
- Good health care and positive post-treatment outcomes lead to better rehabilitation and patients are less likely to need costly continuing care or repeated admissions. This demonstrates the economic importance of high-quality, efficient care for all.
- The problem arises in identifying where individual practices can be altered to improve services and making those changes happen at a local level.
- NHS could save up to £500 million a year by carrying out fewer ineffective or inefficient treatments.
- Evaluation of procedures necessitates reliable information on risk benefit analysis as well as cost effectiveness. Despite the numbers of NHS managers, we have remarkably little good information on cost effectiveness to inform decisions about appropriate interventions.
- We urgently need better education for our patients. At present expectations are too high and too unrealistic. This is compounded by a lack of understanding both within the public and the profession of “risk”. This problem is compounded by politicians who frequently raise expectations on flimsy evidence.
- Evaluation of procedures necessitates reliable information on efficacy of the procedure, risk benefit analysis and cost effectiveness.

1. Background to “Choosing Wisely”

In 2012 the American Board of Internal Medicine (ABIM) Foundation launched the Choosing Wisely campaign to promote physician and patient conversations about making wise choices about treatments (www.choosingwisely.org)¹ To date, more than 70 US medical specialty societies have become partners in the campaign and have published lists of tests, treatments or procedures they say are overused or unnecessary.

The campaign has been covered widely by the news media in the United States as well as in academic publications such as JAMA and the New England Journal of Medicine.

As of 2015 *Choosing Wisely* had been adopted by 12 countries, including Canada, Italy and Australia. In the UK, the Academy of Medical Royal Colleges has taken the lead on this initiative formally adopting it as policy in 2015. Working in collaboration with other clinical, patient, and healthcare organisations, the intention is that participating organisations will develop lists of their “top five” tests or interventions of questionable value. The Academy, Royal Colleges, and partners, including *The BMJ*, have agreed to then promote dissemination of this information.

It is hoped that the decision by the Surgical Forum of Great Britain and Ireland to select *Choosing Wisely* as its topic for debate in January 2016 will stimulate debate and interest in this subject across the surgical spectrum and result in a significant contribution to the efforts of the Academy to avoid unnecessary or inappropriate therapeutic interventions.

2. Why do we over diagnose and over treat?²

Why is it these days that we seem less able to do nothing? To watch and observe, to get to know our patients, to understand their preferences, priorities, fears and anxieties? Why this mad rush to investigate? *“Current medical protocols have a non-negotiation policy with patients’ symptoms. We blast off the doors with investigations releasing clouds of clinically irrelevant biological variations and then indiscriminately empty a magazine of interventions which are all in the name of best practice for the patient”*³.

There are many reasons for the medical professions’ propensity to over-investigate and often to over-treat. These include the following:

- **To provide reassurance:** there is a widely held belief that investigations reassure the patient. Diagnostic testing is often undertaken simply to reassure patients that their symptoms are benign. Yet this well-intentioned act can have unintended negative consequences. A repeated request for diagnostic testing validates and reinforces convictions that symptoms are serious and potentially pathogenic. It is now well recognised that the potential for iatrogenesis is increased when test findings are inconclusive and is especially high if further testing is necessary to investigate a false positive result.⁴ Who would doubt this when one looks at the morbidity in terms of stress and anxiety caused for thousands of women who undergo screening mammography and who are then recalled with a so-called positive result only to subsequently learn that they have no significant pathology. Or what of the consequences of serial PSA measurement, the propensity of repeated surveillance for benign colonic polyps or our obsession with serum cholesterol?
- **A need to exercise trained skills:** doctors practice that which they are trained to do. Psychiatrists talk, physicians prescribe and surgeons operate. Refer a patient to a surgeon and his default position is to operate. Refer a patient to an oncologist and his default position is chemotherapy and so on. In this era of specialist care, we, as doctors, have sometimes lost the ability to look beyond our narrow field of interest. Modern medicine needs to embrace the concepts of holistic care. Nowhere is this more true than in the cancer MDT.
- **Fear of litigation:** few would disagree that fear of litigation accounts for much over-investigation and over-treatment. It is tempting to blame the compensation culture and the legal profession for this and there would seem little doubt that they have made a major contribution to fuelling patient dissatisfaction. Additionally, doctors are frightened of being reported to the GMC, and unquestionably this influences the way they practice. Like it or not much medical practice these days is based on protecting the doctor not treating the patient. Unfortunately, doctors and surgeons now work in a climate of fear; fear that not to do the test will be seen at a later date as negligent when in fact it might have been a deliberate act of care and compassion. This fear is fed by a media that delights in medical misdemeanour and the public who remain convinced that failure to do a test can alter the natural history of disease. No test ever altered the natural history of disease!
- **The illusion of communication:** we frequently hear the clarion cry from the colleges and the educationalists of the importance of communication skills but the reality is that the essence of communication has been undermined by an obsession with investigation and the fear of

missing a diagnosis. Until the profession is prepared to unite and protect and support the doctor who deliberately makes a policy of saying we will 'wait and see' such that this can be a plausible defence to the aggressive expert witness or lawyer who argues that such and such an investigation should have been done earlier then the roller coaster of mass investigation will continue. This unquestionably will be to the detriment of the patient's welfare and care.

3. Patient involvement

3.1 NHS Survey 2014⁵

From April 2013 to March 2014, 15.3 million people were treated as an inpatient within the NHS. Understanding people's experiences of care and treatment while they are an inpatient provides key information about the quality of services, and this can be used to drive improvement both nationally and locally.

- One in 10 (10%) respondents said that they were not involved as much as they wanted to be in decisions about their care and treatment and 20% said that 'not enough' information about their condition or treatment was given to them.
- 14% of respondents (down from 15% in 2013) who had an operation or procedure stated that they were not told how they could expect to feel after the operation or procedure. One in 10 respondents (10%) said that they didn't receive an explanation from a member of staff about how the operation or procedure had gone in a way they could understand.
- Nearly one in four (24%, up from 23% in 2013) could not find a member of the hospital staff to talk to about their worries and fears, and 13% (down from 14% in 2013) did not get enough emotional support from hospital staff.

3.2 All are familiar with the mantra "no decision about me without me" widely used in the introduction of *The White Paper, Equity and Excellence: Liberating the NHS; which set out the Government's vision of an NHS that puts patients and the public first. Sadly, most would agree, there is little evidence to demonstrate that this aspiration has been achieved*

In summary, a significant minority of patients treated within the NHS feel they receive inadequate information about their care.

3.2 Paternalism

3.2.1 Paternalism, the dictum that “the doctor knows best”, is no longer the pre-eminent theme in the doctor patient relationship. Increasingly patients demand information and can independently access information from numerous sources. The ethical principle of autonomy prevails whereby the patients’ right to choose, the right to decide and the right to refuse prevail. Acceptance of the principle of autonomy in the doctor patient relationship has important implications in the decisions as to appropriate treatment and investigation.

3.2.1 Autonomy may itself result in over diagnosis and over treatment as a consequence of inappropriate patient demand.

3.2.3 The principle that patients are entitled to full and comprehensive information prior to undertaking surgery has recently been emphasised by the Montgomery ruling. This emphasises that patients must be told of any “material risks” and marks a significant change in practice from long established Bolam principle⁶.

3.3 Evidence based medicine

3.3.1 Until recently the Randomised Controlled trial and the meta analysis were regarded as the gold standards upon which medical treatments should be based. There is now increasing recognition of the value and importance of qualitative data in the assessment of diagnostic and therapeutic modalities.

3.3.2 A major problem with RCTs is the difficulty in ensuring equivalent groups are compared and then extrapolating results to general populations.

3.3.3 Considering the difficulties obtaining reliable data based upon prospective studies there is much to recommend the use of information obtained from national registries. Their adoption for all new technologies is to be recommended.

3.3.4 There needs to be increased support for surgeons to ensure participation in audit collection and publication of surgeon identifiable results. The trials and tribulations of publishing such data are well recognised.

3.4 Patient Choice

- 3.4.1 We need to strongly articulate what we think is right as a profession and speak with one voice. Otherwise the consequence is mixed messages for the patient, which inevitably results in variations in care.
- 3.4.2 We have to understand the consequence of change – and this mandates strong leadership from the profession.
- 3.4.3 Decisions about care have to involve the patient. If the patient is not provided with options then dissatisfaction is more likely to occur.
- 3.4.5 More effort needs to be made in determining what patients want; outcomes data are essential. Information from PROMs may assist decision making.
- 3.4.6 However, it needs to be recognised by the wider public that what the NHS can provide and what the patients wants are often very different. Patient autonomy and patient choice cannot be pre eminent themes in the provision of health care.

4. “Top five lists”

- 4.1.1 Both the American Board of Internal Medicine (ABIM) and the Academy have requested that Associations, specialities and medical interest groups define what they consider to be their “top five” interventions that they consider most unnecessary. No College or Association President considered this a worthwhile exercise.
- 4.1.2 This reticence to produce lists was not a reflection of a lack of enthusiasm for the Choosing Wisely initiative but more a consequence of the fact that lists produced by Associations and others elsewhere invariable came out with interventions already deemed inappropriate in this country.
- 4.1.3 Whilst there are clearly variations in surgical practice around the country it was agreed that there few if any surgical procedures for which there would be general agreement that they were uniformly inappropriate.

4.1.4 There needs to be more work done on trying to set thresholds for some of the commoner operations e.g. a level of visual acuity for a cataract operation or a level of symptoms for a TURP of a TKR perhaps. This is an area for future research.

5. Regulation

5.1 Appropriate regulation of healthcare provision is essential for initiatives such as *Choosing Wisely* to work. Regulation necessitates good leadership.

5.2 Regulation involves whole system improvement: shifting the curve of performance. It necessitates identification and eradication of rogue outliers.

6. Standardising care

6.1 There is much evidence to demonstrate that there are wide variations in the standards of care throughout the UK and Ireland. For example, mortality rates following emergency laparotomy vary from 10-25% (NELA audit, 2015)⁷. Further, the "Atlas of Variation" illustrates marked differences between geographical areas in the provision of certain surgical treatments⁸. The GIRFT (Getting it Right First Time) initiative has shown marked variations in outcomes following a variety of elective orthopaedic procedures⁹.

6.2 There is now good evidence to show that "standardising care" is associated with improved outcomes both in terms of quality and cost. In the UK there are two very good examples of such standardisation of care; these are the perioperative management of patients after abdominal surgery (so called enhanced recovery) and the "getting it right first time" (GIRFT) initiative in orthopaedic patients.

6.3 *Enhanced recovery*¹⁰

Traditionally, patients following major intestinal resection have remained in hospital for up to two weeks during which time their oral intake was restricted, mobility impaired and analgesia was very reliant on parenteral opioids. In the late 1990s a number of investigators, most notably Kehlet's group from Denmark, developed the concept of 'fast track' surgery. Their philosophy was to employ a combination of epidural or spinal anaesthesia with early mobilisation and oral feeding on the basis that these and other interventions would reduce the stress response to surgery and enhance recovery after surgery. The results of many observational studies seemed to confirm the benefits of such

a 'fast track' approach. These principles were developed in Scarborough and elsewhere by adopting the concept of 'multimodal optimisation' of perioperative care the benefits of which were confirmed in the first prospective randomised trials on this subject. In the last decade a number of studies have been reported all confirming the benefits of such a multimodal approach to perioperative care. The term 'enhanced recovery after surgery' (ERAS) is now most commonly used to describe this modern multimodal approach to surgical management. The principles have now been successfully applied to orthopaedic surgery, urology, and breast surgery. The term, enhanced recovery, has become largely obsolete as multimodal optimisation now represents standard perioperative care.

This work has recently been confirmed in the United States. Here a retrospective review of best practice in colorectal surgery showed that failure of adherence to best practice is associated with a significant increase in complications¹¹.

6.4 *GIRFT*

The 'Getting it right first time' (GIRFT) report published by Professor Briggs in late 2012, considered the current state of England's orthopaedic surgery provision and suggested that changes can be made to improve pathways of care, patient experience, and outcomes with significant cost savings. The report takes the view that this approach has the potential to deliver a timely and cost effective improvement in the standard of orthopaedic care across England:

- identify and administer the correct treatment at the appropriate time, to a high standard with minimal complications
- Improving patient outcomes and satisfaction and reducing complications which will deliver significant annual savings

6.5 *"Solution shop model of hospital care to focussed factory: an American view"*¹²

The full-service US hospital has been described organizationally as a "solution shop," in which medical problems are assumed to be unstructured and to require expert physicians to determine each course of care. If universally applied, this model contributes to unwarranted variation in care, which leads to lower quality and higher costs.

In contrast a "focused factory" model is characterized by a uniform approach to delivering a limited set of high-quality products. Important elements of the focussed factory model

include using information technology to communicate clearly defined expectations, and empowering non-physician providers at the bedside.

Evidence suggests that the focussed factory model is appropriate for most patients and is associated with reduced resource use, length-of-stay, and cost.

Creating a focused-factory model within a solution shop, by applying industrial engineering principles and health information technology tools and changing the model of work, is very effective in both improving quality and reducing costs. It may, however, be less effective in the elderly with multiple co-morbidities

7. Overtreatment

7.1 Many factors lead to over treatment. These include (with particular reference to surgery):

- New technologies
- Hobby surgery
- Societal expectations
- Commercial pressures
- Private practice
- Specialisation

7.2 There are many, well known examples; laparoscopic cholecystectomy was introduced in the late 1980s. Very soon it became the “standard” operation. This occurred despite the absence of reliable trial data, a recognised increased incidence of serious bile duct injury and no analysis of cost effectiveness. Similarly, laparoscopic colorectal surgery is advocated by many as preferable to modern open surgery despite any reliable objective data and good evidence that it is less cost effective. Robotic surgery has many potential benefits but whether these translate into patient benefit is unclear.

7.3 There is increasing concern that the cancer multidisciplinary meeting (MDT) now an integral part of all cancer treatments in this country may have the unintended consequence of over treating patients. In particular, there is anecdotal evidence to suggest that many oncological treatments recommended as part of palliative care are inappropriate:

- Treatments should not be recommended by MDTs if there is no clinician or specialist nurse present who is familiar with the patient’s preferences and goals
- Surgeons must be honest in their assessment of potential benefit from non curative surgery

7.4 It is interesting that there is no evidence that over treatment occurs in the management of surgical emergencies. The possible reasons for this include:

- Transparency/scrutiny of emergency theatre usage
- Peer pressure not to be wasting the precious resource
- Surgeons want the simplest quickest procedure to get the job done and go home

7.5 There is increasing concern that some oncological interventions may be less effective than is commonly assumed. For example, the promises made for adjuvant chemotherapy for patients with colorectal cancer far exceed the delivery. Adjuvant chemotherapy does not significantly improve long-term survival rates: any survival advantage at 5 years has virtually disappeared by 10 years. Treatment simply delays recurrence in the 50% of patients who are destined to relapse. Conversely, 50% of adjuvantly treated patients are given chemotherapy they do not need, having been cured by their initial surgery:

- There are 10,000 new patients in the UK per year with colorectal cancer for whom current guidelines would recommend adjuvant chemotherapy
- Only 50% will have some benefit (45% nevertheless relapse and die, fewer than 5% are cured)
- 50% do not need it
- Cost of chemotherapy £16,000 per patient
- Total cost per annum £160 million
- Total cost of unnecessary Rx £80 million
- Total cost of non-curative Rx £72 million
- Total cost of curative therapy £8 million
- Only 5% of our money is well-spent
- It would be well worth investing in tests for minimal residual disease following surgery – such tests could be used to identify the 5,000 patients who currently receive treatment they do not need.
- A policy of deferring chemotherapy until relapse may, when long-term survival is the endpoint, be as effective as routinely prescribing adjuvant chemotherapy for all eligible patients – it would certainly be far less expensive (for the NHS) and disruptive (for patients).

8. Low Priority Treatments

8.1 Low priority treatments are medical treatments where the evidence of clinical and/or cost effectiveness is limited. The term also applies to where funding such treatment is unlikely to have a significantly adverse effect on the patient's physical or mental health or ability to undertake everyday living activities with reasonable independence.

8.2 In 2006, Croydon PCT identified a list of 34 procedures of 'limited clinical value', for which strict access criteria were introduced in order to ensure that only patients likely to benefit from these procedures could access them. The exercise also had an economic component as it focussed on cost benefit and cost effectiveness.

Some examples include: carpal tunnel surgery, cataract surgery, hip and knee revisions, hernia repair, varicose veins, grommets and tonsillectomy.

8.3 The King's Fund published a paper in 2012 entitled variations in healthcare¹³.

They observed:

- 'the existence of persistent unwarranted variations in health care directly impacts on equity of access to services, the health outcomes of populations and efficient use of resources'
- 'when there is strong evidence and a professional consensus that an intervention is effective, there tends to be little or no variation in clinical practice, but for interventions with a weak evidence base and professional uncertainty there is wide variation'
- 'this does not mean that individual practitioners are uncertain, it's just that each makes different decision based on their experience, knowledge and interpretation of the evidence for effectiveness'

8.4 In 2013 the "right care elective surgery project was formed under the aegis of QIPP and the NHS. Following upon this initiative the RCS England developed commissioning guides based upon an evaluation of what defined high value care, how this could be measured and what levers could be used to encourage implementation (CQUINS, audit and peer review).

Commissioning guides are available on line from the College web site for about 30 common surgical procedures.

References

1. www.choosingwisely.org
2. MacFie J. Opening Pandora's Box: the combined evils of over-investigation and over-treatment. JASGBI 2008
3. Spence D. Itchy fingers BMJ 2007; 335:1048
4. McDonald IG, Daly J, Jeelinek VM et al. Opening Pandora's box: the unpredictability of reassurance by a normal test result. BMJ 1996; 313:329-32
5. NHS survey 2014 web link
6. Macfie J. Expert witnesses; a review. Annals Royal College Surgeons England, 2016
7. NELA
8. Atlas of Variation
9. GIRFT
10. Enhanced Recovery Guidelines. ASGBI
11. Better Colectomy project; association of evidence based best practice adherence rates to outcomes in colorectal surgery. Annals of Surgery, 2009; 250; 5-07-513
12. From 'Solution Shop' Model To 'Focused Factory' In Hospital Surgery: Increasing Care Value and Predictability. Health Affairs 2014; 33 ;746-755
13. King's Fund 2012; variations in healthcare
14. [https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216980/Liberating-the-NHS-No-decision-about-me-without-me-Government-response.pdf]

The Surgical Forum of Great Britain and Ireland

Monday 25th January 2016, 10.30am, Royal College of Surgeons of England
Choosing Wisely (in Surgery)

<u>Time</u>		<u>Chair</u>
1030	Welcome to the Royal College of Surgeons of England Opening remarks: setting the scene	Miss Clare Marx , President, RCSEng Professor John MacFie, Chair, Surgical Forum
<u>Session 1</u>	<u>Background</u>	Mr Stephen Cannon, Vice President RCSEng Mr Ian Winson, Vice President, BOA
1045 - 1100	'Introducing Choosing Wisely – Why it matters' - <i>Professor Dame Sue Bailey, Chair, Academy of Medical Royal Colleges</i>	
1100 - 1115	Choosing Wisely – A Provider Perspective - <i>Dr Ian Abbs, Medical Director, Guys & St Thomas' NHS Foundation Trust</i>	
1115 - 1130	Should this initiative influence NICE recommendations? - <i>Dr Tom Clutton-Brock, Chair, Interventional Procedures Advisory Committee, NICE</i>	
1130 – 1145	The place of regulation in health care - <i>Dr Hugo Mascie-Taylor, Medical Director, Monitor</i>	
1145 – 1230	Discussion	
1230 – 1315	Lunch	
<u>Session 2</u>	<u>Choosing wisely: examples from clinical practice?</u>	Professor Derek Alderson, Vice President, RCSEng Mr Mark Speakman, President BAUS
1315 – 1330	The Surgeon: do we over treat? - <i>Mr James Hill, Consultant General and Colorectal Surgeon</i>	
1330 - 1345	The Oncologist: do we over treat? - <i>Professor Alastair Munro, Professor of Radiation Oncology, Tayside Cancer Centre, Ninewells Hospital & Medical School</i>	
1345 – 1400	Standardising surgical referral and intervention thresholds: lessons from the 'Right Care' initiative' - <i>Mr Nigel Beasley, Chair East Midlands Clinical Senate, formerly Clinical Lead 'Right Care'</i>	
1400 - 1415	Standardising peri-operative care: enhanced recovery programmes - <i>Professor Alan Horgan, Associate Professor of Education, RCSEng</i>	
1415 – 1445	Coffee/tea	
<u>Session 3</u>	<u>Forum Discussion</u> (to which all College and Specialty Association Presidents will be invited to speak)	Miss Clare Marx, President, RCSEngland Professor John MacFie, Chair, Surgical Forum
1630 – 1700	Summing up	Professor John MacFie, Chair, Surgical Forum

Ian	Abbs	Medical Director
David	Alderson	Vice President
Bill	Allum	Chair
Sue	Bailey	Chair of AoMRC
Kevin	Baird	Vice President
Andrew	Beamish	Past President
Nigel	Beasley	Deputy Medical Director
Peter	Brennan	Chair
David	Burge	President
Stephen	Cannon	Vice President
Carolyn	Capps	Secretary
Tom	Clutton-Brock	Chair of IPAC
Graham	Cooper	President Elect
John	Cooper	COO
Michael	Davidson	Vice-President
John	Duncan	Vice President
Frank	Dunn	Past President
Ian	Eardley	Vice President
Eunan	Friel	Director of Surgical Affairs
David	Galloway	President
Tim	Graham	President
Richard	Hardwick	President-elect
Rhiannon	Harries	President
James	Hill	Speaker
Alan	Horgan	Consultant Colorectal Surgeon
John	Hyland	Vice President
Cathal	Kelly	CEO
Richard	Kerr	President
Paul	May	President-elect
Mike	Lavelle-Jones	President
Graham	Layer	Vice President
John	MacFie	Chair, President, FSSA
Declan	Magee	President
Derek	Manas	President
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Alison	Rooney	CE
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Ian	Winson	President
Mike	Wyatt	President