

Choosing Wisely in primary care

Moving from recommendations to implementation

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At the core of the Choosing Wisely Canada (CWC) campaign is the commitment to engaging clinicians and patients in conversations about unnecessary tests and treatments. As of April 2018, the campaign is 4 years old, and important milestones have been achieved. Recommendations have been developed and physicians are aware of the campaign, yet many of us still struggle to choose wisely in practice. There are many challenges around implementation, but with our continued efforts, we can help to advance this cause.

Drs Lynn Wilson and Kimberly Wintemute lead the primary care strategy of the campaign, working to help chart the course and ensure the campaign continues to address the needs of family physicians.

We are grateful to have had a regular interview feature in *Canadian Family Physician*, sharing the stories of how family physicians from across Canada are implementing the campaign and what drives their commitment to do so. We are excited to now embark on a new series (page 368)¹ with a change in focus that offers tools to make it easier for Canadian family physicians to choose wisely in practice and engage in shared decision making with patients.

Awareness of the campaign

In the 4 years since the campaign launched in 2014, broad physician awareness has been achieved. Nearly 90% of all Canadian physicians have heard of Choosing Wisely, and 42% say that they use the recommendations in daily practice.²

Anecdotally, we hear from clinician colleagues that the campaign has “changed the conversation” in Canada. Before CWC, we accepted overuse as an inevitable part of our practice. Choosing Wisely has given us a language and tools to address this with confidence and to make changes.

Implementation and measurement of CWC recommendations is occurring within primary care. At Family Medicine Forum 2016, there were 2 academic sessions describing practice activities related to implementation, and at Family Medicine Forum 2017, there were 8.

Relationship with Practicing Wisely, the Ontario College of Family Physicians, and the College of Family Physicians of Canada

The College of Family Physicians of Canada has highlighted the core concepts of CWC—resource stewardship and “do no harm”—more specifically in the revised 2017 CanMEDS–Family Medicine framework.³ This requires

related competencies to be built into both family medicine training and continuing professional development.

These ideas are not new to family medicine. In fact, before the launch of CWC or Choosing Wisely in the United States, a group of insightful and motivated Canadian family physicians started to tackle this problem. In 2011, Drs Frank Martino, Anne DuVall, Danielle Martin, and Jennifer Young founded a professional development program entitled “Best Practices: Don’t Just Do Something, Stand There.” This in-depth offering of the Ontario College of Family Physicians (OCFP) addressed how to go about shared decision making with patients around screening and chronic disease management “without medicalizing a healthy person.”⁴ When CWC was launched, “Don’t Just Do Something” was the only rigorous and relevant continuing professional development program offering the then Mainpro-C credits.

“Don’t Just Do Something” and CWC quickly became siblings. The OCFP and Dr Jennifer Young evolved the accredited course and changed its name to Practising Wisely.

With the endorsement and assistance of the College of Family Physicians of Canada, the OCFP has trained facilitators across the country. The Practising Wisely course and CWC maintain a close working relationship, with a group of family physician leaders committed to the advancement of both.

The Practising Wisely course,⁵ now offered in 6 of the provinces and territories, is the exemplar for high-quality continuing professional development in which participants learn both the *what* and the *how* of addressing the problem of overuse.

Our team, your medical society recommendations

Choosing Wisely Canada has a small central office, based at the University of Toronto in Ontario. The team manages the central operations of the campaign, including fielding 40 to 60 inquiries from clinicians per week. These include requests for posters and tent cards for clinical offices, queries about how to implement recommendations, and feedback about the campaign.

A common misperception among clinicians is that the 6 CWC physician leads and 6 full-time-equivalent employees develop campaign lists of recommendations. This is incorrect. A core feature of the campaign is that lists are generated by and “belong to” medical professional societies, which work with their members to identify tests, treatments, and procedures commonly used in their specialty that are not supported by evidence and that could expose

patients to harm. Each recommendation references relevant scientific literature; the societies review their lists yearly for changes in evidence. The recommendations are generally noncontroversial; many clinicians express that they are “obvious”—and this is exactly the point.

Within Canada, measurement has demonstrated probable overuse in various clinical areas.⁶ Despite the fact that some recommendations might seem obvious, CWC research has shown considerable variability among family physicians with respect to practices such as ordering electrocardiograms for low-risk patients⁷ and imaging for low back pain, timing of Papanicolaou tests, and ordering of dual-energy x-ray absorptiometry scans.⁸

Because of the breadth of primary care, family physicians have recognized that many recommendations⁹ put forward by other specialty societies are often implemented by us. For example, the Canadian Association of Gastroenterology recommends giving some patients a trial off their regular proton pump inhibitors.¹⁰ The person most likely to initiate this is the family doctor, not the consultant.

Improving shared decision making

In a recent internal evaluation of CWC, a key theme emerged from surveys of physicians and patients: We need more tools to help with shared decision making.

Barriers commonly cited by physicians regarding shared decision making include competing initiatives and priorities, practice culture, physician resistance to change, and the time required for patient education (Dale McMurchy Consulting, *Review of the Choosing Wisely Canada Campaign: Summary Report*, November 2017, unpublished data).

The Canadian Medical Association conducts regular online surveys of physicians from across Canada, and on the topic of CWC, 48% of respondents endorsed that they need more support and tools to help make decisions about which services might be appropriate for their patients.² Most physicians surveyed (77%) agreed or strongly agreed that the primary responsibility for decreasing inappropriate use of services rests with care providers. However, 64% expressed that patient demands are more often responsible for unnecessary use of health services than are decisions made by doctors. More than 90% of respondents agreed that patients need more support to make decisions in this realm.²

Work on multiple levels is needed

Breaks in continuity of care can lead to overuse.¹¹ That is, patients are more likely to receive an unnecessary prescription, investigation, or procedure when they receive care from a clinician other than their usual primary care provider. We know that breaks in continuity can stem from poor access, a measure in which Canada scores below many other comparable countries.¹² It seems clear that both *system changes* at the macro level and *practice changes* at the micro level are needed to address overuse.


Looking forward

We are listening to Canadian physicians and are trying to increase the number of tools available to implement the campaign. This includes updating the CWC website with point-of-care tools that can guide clinical conversations to be more robust in both evidence and patient-centredness. And in our new series in *Canadian Family Physician*, we will highlight family physicians who are choosing wisely in practice, specifically through shared decision making with patients. Where possible, we will highlight point-of-care tools used to enhance this process.

Looking inward

The ability to self-reflect is an essential element of medical professionalism³ and can drive positive practice change to move the dial on overuse. The drivers of overuse are complex and many; one single solution will not be effective in reducing unnecessary tests, treatments, and procedures. We might need to admit that we are not sufficiently aware of risks and benefits of common treatments¹³; that we have been under a “therapeutic illusion” that a treatment effect is greater than it actually is¹⁴; that we can improve our skills around data interpretation¹⁴; or that we can do better in risk-communication strategies.¹⁵

An important part of primary care practice is counseling patients on behaviour change. There is a parallel here to the process of professional advancement, which can be deeply satisfying and personally transformative. Like our patients, we find ourselves at differing stages of change when it comes to practice improvements. Understanding our position within the stages of change and how to potentially move oneself along is humbling and important.

We are grateful to the countless Canadian family physicians who champion this campaign in their daily practices, teaching, research, and leadership. Here’s to shared decision making, to richer conversations, and to choosing wisely in practice. 

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Competing interests
None declared

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