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Choosing Wisely and the Perceived Drivers of Endoscopy Use

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Choosing Wisely is a campaign led by the American Board of Internal Medicine (ABIM) Foundation in collaboration with specialty medical societies including the American Gastroenterological Association (AGA)¹. *Choosing Wisely* seeks to reduce several categories of overutilization of health care services (e.g., overtreatment, and failures in care coordination and execution of care processes)². *Choosing Wisely* is based on principles of *Parsimonious Medicine*: an appeal to professionalism and physicians' "good, sound judgment" to identify and apply clinical evidence³. Parsimonious medicine suggests that appropriate utilization occurs when physician judgment and best evidence are applied within the context of individual patient's needs³. *Choosing Wisely* addresses both physicians and patients through the publication of lists of "Five Things Physicians and Patients Should Question" for each specialty. The *Choosing Wisely* items identified by the AGA highlight potential overutilization of 1) pharmacologic treatments for gastroesophageal reflux disease, 2) screening colonoscopy in average risk individuals, 3) surveillance colonoscopy in individuals with low-risk polyps, 4) surveillance esophagogastroduodenoscopy (EGD) in individuals with Barrett's Esophagus (BE), and 5) computed tomography (CT) in individuals with functional abdominal pain.¹

The success of *Choosing Wisely* will depend on how patients and physicians weight the importance of best evidence against other factors that shape decisions at the clinical encounter. As part of a patient-centered, comparative effectiveness study of screening and surveillance esophagogastroduodenoscopy (EGD), we conducted qualitative interviews to explore patient and physician perceptions of one of the AGA Choosing Wisely items.⁴ Analysis of these interviews identified factors perceived to influence under and over utilization of surveillance EGD for Barrett's Esophagus in the context of AGA clinical practice guidelines.

We conducted in-depth qualitative interviews with 20 patients with BE who use the Veterans Administration (VA) system and 14 gastroenterologists from three practice settings: tax-supported public, private academic, and VA settings. We concluded sampling

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for each subgroup at the point of thematic saturation⁵. Interview content was informed by models of decision-making⁶. Interviews with patients elicited information about their experiences, perceptions, and attitudes regarding BE and surveillance EGD. Interviews with physicians elicited perceptions of practice guidelines and decision making regarding surveillance EGD in patients with BE. All interviews were recorded, transcribed, and analyzed for content.⁵ Of our sample of 20 patients with BE, the mean age of participants was 62.9±7.3 years; all male; and 10 had BE without dysplasia and 9 had BE with low-grade dysplasia. All of the 14 gastroenterologists interviewed were experienced endoscopists, 36% were female, 50% practiced in private settings full or part time; and had a median of 14 (range 1–36) years post-fellowship experience. Table 1 describes quotes from patients and gastroenterologists that frame the drivers of utilization of EGD for patients with BE as part of guideline-based cancer surveillance. Figure 1 depicts these 9 themes as drivers of utilization for surveillance EGD.

Our interviews identified drivers of over and under utilization of EGD within the context of BE surveillance. Patients and physicians endorsed many factors (Figure 1) that drive utilization of EGD, other than the quality of evidence, that may not be influenced by appeals for professionalism or quality of evidence. These factors include, access and payments for healthcare (for patients), financial incentives and medical-legal considerations (for physicians). The results of our study specifically explore one of the Choosing Wisely items co-sponsored by AGA: follow-up surveillance examination should not be performed in less than three years as per published guidelines for BE patients without dysplasia¹. However, current practice is not indicative of adherence to this item; for example, a recent three-site study (including one VA facility) found EGD overutilization was common among BE patients and insurance-related incentives were the primary driver of utilization⁶.

The emphasis that *Choosing Wisely* places on Parsimonious Medicine is unlikely to mitigate the many drivers of overtreatment given some of the current evidence and structural issues related to healthcare delivery in a largely fee-for-service system. High quality evidence is critical because it anchors definitions of appropriate utilization (as illustrated in Figure 1). However, three of the five Choosing Wisely items from the AGA directly address overutilization of endoscopy (colonoscopy and EGD) where evidence guiding the optimal time interval between repeat studies is modest at best, yet there are multiple perceived factors driving overutilization. Moreover, systematic changes affecting incentive structures and medico-legal concerns are needed to encourage and enable the types of shared decisions that are consistent with best evidence. Without incentives to counteract the factors favoring overutilization, *Choosing Wisely* will struggle to meaningfully impact clinical decision making.

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Figure 1.

Table 1**Drivers of Utilization Among Patients and Gastroenterologists**

Promoters of utilization
<i>Patient expectation</i>
<p>"In fact there's some patients that would like to be endoscoped more frequently and they're like, are you, it's, they're sayin' you know, '3 years. That sounds like a long time.'" (MD #4)</p> <p>"Well now I take them now probably every couple of years so...when I can the VA's real picky; they won't let you do them all the time you know." (Pt #105)</p>
<i>Practice guidelines</i>
<p>"I need guidelines and I need them because that's the reason, you know, it's just like, it makes you be more efficient. Otherwise you are practicing voodoo medicine..." (MD #3)</p> <p>"...it's getting more and more difficult to justify this [EGD] which is why the AGA guidelines came out saying 'Look, there's not enough data to support for or against.' They just threw up their hands in the end, said 'We don't know.'" (MD #4)</p>
<i>Fear of cancer</i>
<p>"I think it's always the fear of cancer. Cancer is still - that big C is still one of those words." (MD #1)</p> <p>"...but when I heard that I said 'Hey whoa I gotta watch this OK and make sure it doesn't turn into cancer...I got really worried.'" (Pt #95)</p>
<i>Financial incentives</i>
<p>"You get money for every time you scope somebody as opposed to here where you're on a salary." (MD #9)</p> <p>"And if you don't work with people then they tend to go to the next doctor and repeat the same message, you know?" (MD #7)</p>
<i>Medical-legal fears</i>
<p>"...you're always aware about litigation and missing a cancer and something like that, and so you probably do them more often." (MD #13)</p>
Barriers to utilization
<i>Patient access to care</i>
<p>"... the patient has to take a day off of work, patient has to get a ride and needs another person here" (MD #10)</p> <p>"Well sometimes at the end of the month, uh your gas problems. You don't have the money to buy gas to get up there...that's \$40 a round trip." (Pt #68)</p>
<i>Patient fear of discomfort</i>
<p>"Now they may run away after the first one because they find it uncomfortable and that sort of thing, but you have some patients that will say 'no.'" (MD #2)</p> <p>"Yes I just, I don't, don't like hurt... I'm worried about, I know if I go back I'll get hurt and I don't want that. Or not hurt but discomfort then if I, no that just, no ain't no reason in that." (Pt #69)</p> <p>"But also I will see that they administer a sedative to me that will put me deep under ...because nobody wants to experience the pain that I have" (Pt #96)</p>
<i>Patient co-pay</i>
<p>It doesn't happen in the VA so much, but in the private setting we actually have a significant co-pay, deductible. (MD #10)</p>