

# Letters

## RESEARCH LETTER

### LESS IS MORE

#### Creating a List of Low-Value Health Care Activities in Swiss Primary Care

In 2010, the idea emerged of creating lists of low-value health care activities as a way to confront rising medical costs and encourage cost-conscious care. The Good Stewardship Working Group<sup>1</sup> and Brody<sup>2</sup> pioneered the idea of “top 5” lists, leading to the Choosing Wisely campaign.<sup>3</sup> Building on this momentum, there has been widespread interest in proposing additional lists.<sup>4</sup> In 2012, the Swiss Society of General Internal Medicine committed to creating a list for Swiss ambulatory internal medicine.

**Methods** | Institutional review board approval or waiver was not obtained for this study. A review of publications was performed using the search terms *low value*, *disinvestment*, *less is more*, and *avoidable care*. Three sets of lists were identified (1103 recommendations)<sup>3,5,6</sup> as of March 5, 2013. Two physicians excluded recommendations that were not relevant to ambulatory internal medicine (eg, specialized medicine, pediatrics), leading to an initial list of 38 international recommendations.

An online Delphi process was then applied, using successive electronic survey instruments placed on the Survey Monkey website ([www.surveymonkey.com](http://www.surveymonkey.com)). All committee members of the Swiss Society of General Internal Medicine and the Swiss Society of Family Medicine, along with professors from the divisions of General Internal Medicine and Family Medicine at the 5 Swiss university medical schools, were invited to participate as experts. A 7-member advisory committee was formed based on Swiss Society of General Internal Medicine members who expressed a specific interest in this subject.

In round 1, experts gave their level of agreement with the international recommendations using a 10-point Likert scale. Experts could also propose additional recommendations. After a review of publications to ensure their validity based on available evidence, 12 of 21 novel recommendations were retained.

In round 2, recommendations with intermediate scores in round 1 (average scores, 7-9) were reranked based on experts' level of agreement, along with the 12 novel recommendations.

For round 3, recommendations with scores greater than 9 were graded based on a 3-point Likert scale in 3 areas: frequency, costs, and patient harm. *Frequency* was defined as how often the average general practitioner is faced with the decision to perform the test or prescribe the treatment. *Costs* were direct costs and not those of unanticipated adverse effects or

complications. *Harms* were defined as potential harms from the test or treatment, including those that could be expected from the recommendation. For reasons of implementation, the final list was limited to 5 of the 10 most frequent recommendations.

**Results** | Of the 59 experts contacted, 35 agreed to participate (59%; mean [SD] age, 51 [6.3] years; 27 men [77%]). A flowchart of the recommendations is shown in the **Figure**. Through rounds 1 and 2, a total of 50 items were ranked based on an agreement scale of 1 to 10, including the 12 novel recommendations. The mean (SD) agreement score was 8.52 (0.80) of 10. Of the 18 recommendations reviewed in round 3, the top 10, ranked by perceived frequency, are seen in the **Table**. The final top 5 list was made by consensus of the advisory committee, who believed there would be too much overlap if there were 2 recommendations for respiratory tract infections.

**Discussion** | Our study illustrates a method to allow medical societies to create their own national lists based on existing international work.<sup>3,5,6</sup> Our high agreement scores suggest that there is enough consensus to allow for the adaptation of such lists in other countries.

The Good Stewardship Working Group<sup>1</sup> used a small committee for the generation and initial selection of recommendations and a larger group of 255 health care professionals for validation; we started from an initial list of international recommendations and used a panel of 35 experts for selection. We are currently conducting an implementation study among Swiss general practitioners.

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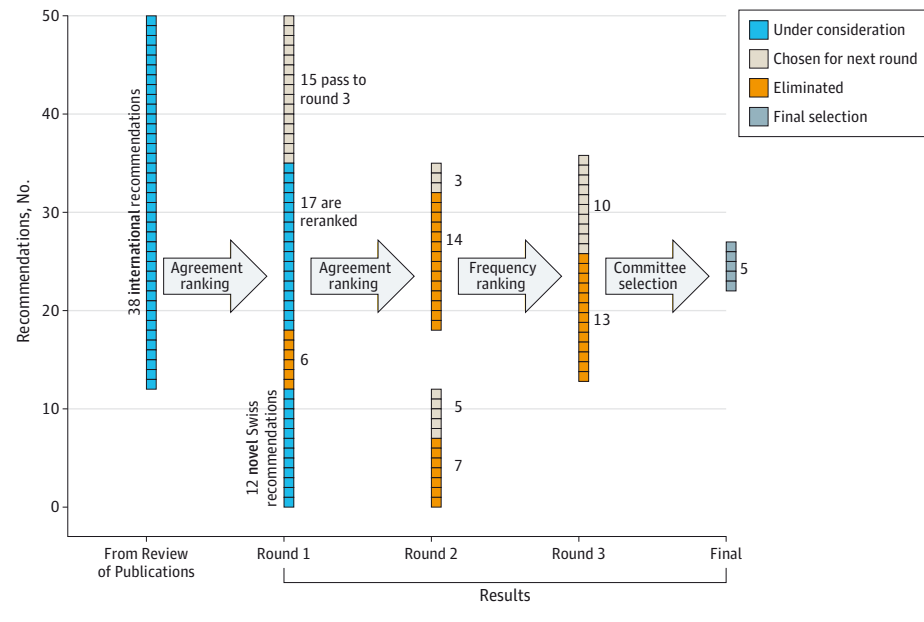
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Figure. Flowchart of Recommendations Through the Delphi Process



A total of 50 recommendations were ranked during the Delphi process, including 38 existing international recommendations and 12 novel recommendations from the experts. From the top 10 recommendations of the Delphi process, an expert panel chose the final top 5 list.

**Author Contributions:** Drs Selby and Cornuz had full access to all the data in the study and take responsibility for the integrity of the data and the accuracy of the data analysis.

**Study concept and design:** Selby, Gaspoz, Rodondi, Neuner-Jehle, Perrier, Cornuz.

**Acquisition, analysis, or interpretation of data:** Selby, Rodondi, Neuner-Jehle, Perrier, Zeller, Cornuz.

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Table. Top 10 Recommendations Based on Frequency Score<sup>a</sup>

Rank	Recommendation	Frequency Score (32-96) <sup>b</sup>	Agreement Score (0-10) <sup>c</sup>
1	<b>Do not obtain imaging studies in patients with nonspecific low back pain</b>	94	9.56
2	<b>Do not prescribe antibiotics for uncomplicated URTIs</b>	92	9.40
3	<b>Do not perform the PSA test to screen for prostate cancer without a discussion of the risks and benefits</b>	90	9.59
4	Do not perform laboratory testing in patients with a clinical diagnosis of an uncomplicated URTI	87	9.03
5	<b>Do not continue pharmacological treatment of GERD with long-term acid suppression therapy without titrating to the lowest effective dose</b>	82	9.50
6	Do not routinely prescribe antibiotics for acute mild-to-moderate sinusitis	81	9.50
7	Do not use antimicrobials to treat bacteriuria in immunocompetent older adults	80	9.16
8	Do not routinely obtain radiographic imaging for patients who meet diagnostic criteria for uncomplicated acute rhinosinusitis	78	9.91
9	<b>Do not obtain preoperative chest radiography in the absence of a clinical suspicion</b>	77	9.26
10	Do not use DEXA screening for osteoporosis in women younger than 65 or men younger than 70	72	9.16

Abbreviations: DEXA, dual-energy x-ray absorptiometry; GERD, gastroesophageal reflux disease; PSA, prostate-specific antigen; URTI, upper respiratory tract infection.

<sup>a</sup> Boldface indicates items retained for top 5.

<sup>b</sup> Frequency scores are from round 3.

<sup>c</sup> Agreement scores are from rounds 1 and 2.

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