It is not appropriate to dismiss inappropriate care

Personalised care does not justify use of therapies that have been shown to lack benefit

"The question we should be asking is: how is it possible for inappropriate care to occur?"

Will you be disbelieving, dismissive, disheartened or alert to the dangers after reading the study in this issue of the *MJA* that identified potentially inappropriate care in Australian hospitals?[1] Using routine hospital admissions data, Duckett and colleagues found that five procedures not supported by clinical evidence happen more than 100 times a week and there is great variation in hospital-specific rates of procedures that should not be done routinely.

Disbelieving

Confirmation that inappropriate care continues to occur challenges to the core the optimal, ethical and patient-centred medical care that medical professionals strive to provide.[2] To disbelieve the findings would be human,[3] as "evidence contrary to our personal beliefs tends to be dismissed as unreliable, erroneous or unrepresentative".[4]

To counter the discomfort these findings provoke, we may rationalise, arguing that the appropriateness of care is quintessentially where the art and science of medicine merge, where balancing the logic of evidence with the personal values of each individual patient leads to variation in care. However, personalised care does not justify inappropriate care.

Or we may argue that this is to be expected when there is a vacuum of evidence about what is appropriate (eg, the established and widespread practice of off-label use of medications[5]), or that today's radical ideas may become standard practice in another era.[6,7] However, neither of these are valid counterarguments to Duckett et al's findings.[1]

Instead of disbelieving, we should consider how we respond to consumers who will react to the results of the study with incredulity — and perhaps even outrage — that a contemporary health care system continues to deliver therapies with clinical research evidence showing they are of no benefit to patients. Patients should be receiving care that is appropriate and, ideally, based on evidence of benefit. Robust research evidence from testing the merits of a therapy and demonstrating a lack of benefit identifies inappropriate care. This is different to a lack of research evidence of benefit.

Dismissive

Those who would be dismissive will point to the inherent limitations in the study; for example, reaching conclusions about health care interventions with the use of a secondary analysis of hospital discharge data instead of clinical registries.[8] The use of cross-sectional data, describing clinical practice from 5 years ago, provides no insight into temporal trends and whether these inappropriate procedures have tapered and are now eradicated. Further, a very small number of interventions were examined; and the highest volume of inappropriate care, also referred to as "do not do" treatments, involved hyperbaric oxygen therapy. This highly specialised therapy is only available in a small proportion of health services in Australia and accounted for 79% (4659/5888) of all procedures included. The remaining do-not-do interventions affected a very small but important number of patients.

Disheartened

The true believers who sought a revolution to improve patient safety and quality of health care will be disheartened. Unexplained variation in care was first reported over 5 decades ago[9,10] and there was a flurry of activity throughout the world[11] to improve the quality of health care, which generated considerable momentum from the evidence of patient harm.[12]

Duckett and colleagues' study reminds us that we still do not have answers about how to ensure a high quality of care, that the impacts of most interventions to improve care remain incompletely understood, and the potential for inadvertent adverse consequences is ever present.

Alert to the dangers ahead

Inappropriate care is a "wicked problem"[13] — difficult to resolve and requiring a fundamental change across the health care system. The danger ahead is we become mired in negative emotions. Now is the time to be interested, somewhat trusting and encouraged. Be interested in understanding and contributing to solving a complex

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doi: 10.5694/mja15.00742

problem, and put to use the natural inquisitiveness and skills of inquiry required in any consultation to make a diagnosis. Be somewhat trusting of the data, given there is substantial other robust empirical evidence showing inappropriate use of common procedures (coronary angiography, carotid endarterectomy, caesarean section) in health care.[14] Be encouraged that this important aspect of quality health care continues to receive attention.

These findings call for action and we should all be interested in the outcome. However, we need to be only somewhat trusting of the recommendations for addressing inappropriate care through pay for performance, the use of rewards or sanctions as these may be premature, are conventional and provide at best a partial solution.

What should happen next?

Instead of dismissing, we should consider that for any inappropriate care to occur, complicit action on a large scale is required. To deliver a do-not-do procedure a medical practitioner must first be credentialled, have a defined scope of practice and operate within their clinical team alongside support services and the governance structures of an organisation. Start counting how many people are involved. Therefore, the question we should be asking is: how is it possible for inappropriate care to occur? And what systems-level agreements perpetuate this situation?

Instead of feeling disheartened we should embrace this opportunity to address appropriateness of care, which is integral to all six domains of quality.[15] Our approach to this situation will be far more sophisticated because of the collective experiences and lessons on how to improve practice from the past 25 years.

Instead of merely feeling alert to the dangers ahead, we must be engaged and encouraging in our efforts to seek out the underlying factors and new solutions. This requires a change in thinking[16] and incorporating the science of performance measurement with the science of human factors (a branch of applied science that draws on psychology, engineering, computing science, education, ergonomics and anthropology to improve patient care).

Prudent policy makers, medical practitioners and patients expect community resources to focus on efficacious and effective provision of health care. The ideas and concepts presented by Duckett et al[1] are worthy of heated debate and concerted action to explore what we must do to eradicate inappropriate care.

Competing interests: No relevant disclosures.

Provenance: Commissioned; externally peer reviewed. ■

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