

Negotiating “unnecessary”

Microclinical, macropolitical, and coproduction approaches to defining necessity in care

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In April 2017, the Canadian Institute for Health Information, together with Choosing Wisely Canada, released a report entitled “Unnecessary Care in Canada.”¹ This first ever national report echoes findings in other jurisdictions^{2,3} as it tracks a key element in the global drive to reduce per capita costs while improving quality.⁴ The Canadian numbers suggest that up to 30% of selected tests, procedures, and treatments are unnecessary, if not outright harmful. The report’s authors add specific details—for example, 1 in 10 Canadian seniors takes a sedative-hypnotic sleep aid regularly¹—and argue that unnecessary care is contributing to losses at both economic and outcome levels. As we have seen elsewhere, there is money to be saved and quality to be improved in riding the system of unnecessary care. The devil, as always, is in the details. Specifically, in the microclinical and macropolitical interactions where “unnecessary” is determined.

Mismatches between opinions and data in daily clinical practice

At the micro level, in daily clinical practice, we routinely encounter patients whose value-for-money expectations, self-diagnoses, or attention seeking lead to compromise requisitions or prescriptions for magnetic resonance imaging, antibiotics, or even opioid analgesics. Do some colleagues stickhandle a demand for magnetic resonance imaging down to less-expensive computed tomography? Yes. Do some colleagues summon up exactly the right argument at exactly the right time to counter an expected antibiotic prescription? Certainly. But there are just as certainly some of us who are unsure or who choose discretion as the better part of valour in these ongoing microbattles to define what is, and what is not, necessary.⁵ In the absence of high-quality evidence, applicable evidence, or any evidence at all, many of these struggles to define necessity in care are resolved using a “common sense” that emerges from the expertise and experiences of physicians and patients engaged in conversation.

These observations are intended neither to blame patients for what they bring to the clinical encounter, nor to exhort physicians to be more rigid. Rather, our point is that there can often be a mismatch in the opinions and data that patients and physicians bring to determining necessity. On the one hand there are patients’ individual personalities and culturally informed expectations of care and on the other, physicians’ personalities, work flows, and a scientific evidence base. As the realities of everyday clinical work suggest, that evidence base is but one of many opinions and data sources brought to bear as we negotiate necessity. The authority of the evidence base—its power to persuade—hinges on the status of science and facts at a broader political level.

Public debate in a time of polarized engagement

Perversely, here at the macro level, we find ourselves with a familiar mismatch of opinions and data. With public trust in expertise⁶ and government⁷ at an all-time low,⁸ and “alternative facts” apparently playing as important a role in public debate and decision making as any other facts, how does the broader politics of necessity proceed? As at the clinical level, sometimes we wait to make what we think is the right argument at what we think is the right time. In this light, consider Schein and Pronovost’s recent assessment of the evidence for preoperative tests for cataract patients. Their study clearly shows no outcome benefits for patients and a potential yearly savings of \$500 million (US) if the tests are abandoned.² However, this is not the first time this evidence has been used in an attempt to define necessity and influence practice. Schein and colleagues’ original study⁹ appeared nearly 2 decades ago. And so, in the emerging consensus of the macro-level scientific process, we see the same dodges, feints, parries, and thrusts of everyday clinical encounters. Where Schein and Pronovost have taken on—we hope with success—a particular set of tests, there are similar stories of waste to be avoided and outcomes to be improved in treatments and procedures.

But how, in a world of contested evidence and emerging science, do we improve our ability to make convincing arguments? Defining necessity by adding to the peer-reviewed evidence base might still be necessary, but it is no longer sufficient. Where the instinct here might be to double down on these familiar methods—as journalists have, fact checking ever more closely and deeply—there is a complementary approach that operates independently of the assumption that more scientific evidence will succeed where less has not.

Engaging the community

In the early 1990s, the Dunning Commission submitted its final report to the Dutch government, and in it came the recommendation that a “community-oriented approach” be taken to determining which processes, procedures, and service lines were necessary and unnecessary.¹⁰ Less than a decade later the World Health Organization rebooted its medical education and clinical practice newsletter to deal with the challenges of health system reform, and in doing so refined the community-oriented approach. The partnership pentagon introduced in that issue shows “the community” to be 1 of 5 key actors that must convene if unity of purpose and action toward high quality, equity, relevance, and cost effectiveness are to be achieved.¹¹

Seventeen years later, at the end of the evidence-based era of public policy,¹² this sort of radical democratization of the health care system seems not only promising, but also a necessary complement to producing further scientific evidence.

Here we are firmly in support of Born and colleagues, who call for not just patient engagement but public engagement in the Choosing Wisely program.¹³ This, along with Légaré and colleagues' vision of "increasing involvement of patients and the public in co-designing the Choosing Wisely recommendations,"¹⁴ is central. The model for this engagement—this shared decision making at not just the clinical level, but the policy level—needs, however, to go beyond a few select patients contributing to lists of recommendations of things clinicians and patients should question. Rather, it must be conducted as a 5-way conversation born out of alliances and synergies "among key interest groups with specific strengths and expectations."¹¹

Engaging patients and citizens has been shown to be more than an ethical imperative.¹⁵ There is hard evidence showing the efficacy of inclusivity and shared decision making at the policy level.¹⁶ As we take up the challenge of defining necessity in care in collaboration with patients and the public, we need to follow home-grown examples that have successfully combined evidence with the opinions and perspectives of clinicians and patients to create policy change.^{17,18} Canada has built substantial capacity in the field with institutions like the Centre of Excellence on Partnership with Patients and the Public at the University of Montreal in Quebec, the Public and Patient Engagement Research-Practice Collaborative at McMaster University in Hamilton, Ont, and the Patient and Community Engagement Research group at the University of Calgary in Alberta. What remains is for us to leverage these resources and the experience of their staff and patient partners as we take on the challenge of defining necessity in care.

Fostering common understanding

The engagement forums, techniques, and community-based research programs that these centres specialize in represent the best channels both for hard-won scientific evidence to be heard and for even-harder-to-find consensus to emerge. While the data are important, the key point here is that they are coproduced and engaged with by a range of parties. Engaging patients and citizens in the decision-making and consensus-building processes is critical, not just so they can better understand the scientific evidence, but also so scientists and politicians can better understand and accommodate how the public defines necessity. Leveraging the capacities of Canadian institutions that specialize in public engagement in health policy is, we suggest, the best way to escape the impasse of current approaches to defining necessity. Rather than perpetuating the polarized shouting matches that can characterize "engagement" on topics like vaccination or fluoridation, these institutions have the methods and experience to draw out truly engaged conversations. Their talents lie in re-creating, at the macro level, the microclinical moment where common sense emerges from a common understanding of a problem.

In the present era of contested facts and polarized engagement, it is only out of coproduced opinions and data that an authoritative and reliable evidence base will emerge. To achieve common definitions of necessity—definitions that hold under the strain of clinical interactions—we need to commit to these coproduction efforts. As "working with patients to reach common ground on the definition of problems"¹⁹ is a core skill of Canada's family practitioners, we are in a position to lead. Given that patient-engaged policy making enhances a sense of ownership, improves accountability, and encourages the uptake of decisions,²⁰ all that remains is for us to commit resources to, and participate in, the codefinition of what is necessary in care.

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Competing interests

None declared

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