**Listen to THIS - Episode 6: Why is it so hard to do less in healthcare?**

Tara Lamont: Welcome to Listen to THIS, where we have conversations examining how we can improve the quality and safety of healthcare.

In this series, we'll dive into both current and longstanding healthcare challenges and shine a light on some of the work that's being done to address them. I'm Tara Lamont, Fellowship Advisor at the Healthcare Improvement Studies Institute.

Today we're talking about why can be hard to do less in healthcare. It's now accepted that there are many areas where we need to be more careful and reduce treatments for the general good. From cutting down the use of antibiotics or antipsychotic drugs to unnecessary lab tests and scans. Overmedicalisation is framed as a problem that can be solved by educating patients and staff to accept that less may better.

But in this episode we explore some of the reasons why this can be hard for staff and systems in the NHS today. Joining me today to discuss these interesting issues are three THIS Institute fellows and researchers.

Heather Cassie: Hi there, I'm Heather Cassie. I'm a Senior Lecturer at the School of Dentistry at the University of Dundee and a THIS Institute Postdoctoral Fellow.

Claire Hastings: Hi, I'm Claire Hastings and I'm a postgraduate researcher at the University of Leicester within the Population Health Department. And I'm also a paramedic, for coming up to 20 years now.

Jane O’Hara: And I'm Jane O'Hara. I’m a Professor and one of the Directors of Research based at THIS Institute, which is based at the University of Cambridge. It's great to be here.

Tara: I want to start by finding out what you're exploring on the general theme of doing less in your particular projects or work to date. Perhaps I can start with you, Heather?

Heather: Yes absolutely. So my area of research is around reducing unnecessary tests and treatments in dental primary care and implement an evidence-based practice. So my current work, which is focused in dentistry, is on the reduction of two behaviours which have been carried out routinely in practice.

That's the routine provision of a six-month checkup and the routine provision of a scale and polish. And both of these treatments have been subjects of recent clinical trials which have identified that they're unlikely to improve patient care.

Tara: Great. We'll look forward to hearing more about what you're finding in your research as we go on. But perhaps, Claire, could you tell us a bit about your project?

Claire: My project is based in primary care, primarily in general practice area. So I'm interviewing GPs, advanced nurse practitioners and advanced paramedics about their experiences of making decisions, of not doing.

And so when I say not doing, I mean a care decision that means we're not going to provide an active intervention, as it were. More of a watch-and-wait approach. So I'm interviewing them about their experiences of making those decisions with patients. I’m also I'm really interested in how they're recording those decisions and if a robust way of recording those decisions, of not doing, could help improve the confidence of the healthcare professionals when making those decisions and almost make it easier for them to choose a non-intervention approach.

Tara: Jane, I wonder how this resonates with the work that you've done over the years on patient safety.

Jane: I'm definitely not a de-implementation specialist, so I'm really interested in my colleagues’ experiences here. But a lot of it, as you say, does resonate with wider issues I think in patient safety.

From a patient safety perspective and thinking about systems and how safe care is created within our complex systems, I think adding things into and taking things out of those systems is of equal interest.

And certainly traditionally we've had much more focus on putting things in, getting people to adopt new behaviours, on new treatments. And the whole evidence-based guideline literature and field is focused on supporting people to meet those evidence-based guidelines. But much less has been done about de-implementation.

And I think, particularly from a safety point of view, this is increasingly becoming a problem and we're seeing a lot of what people, including my colleague Rebecca Lawton, are now calling ‘safety clutter’.

So it's the sort of stuff that hangs around in the system that people think is to do with safety or to achieve safety, but actually potentially doesn't, or certainly doesn't in its current configuration or within everything else that's going on in systems.

So I think the focus on de-implementation of both treatments and practices is very much welcomed from a systems perspective.

Tara: That's really interesting. I think we ought to unpick a little bit that…we're talking about lots of different things here, aren't we? And they may have different system and organisational and cultural solutions, as it were.

So I guess one set of things is screening or more sensitive tests, picking up conditions which we wouldn't have known about, may not bother patients, but we then need to treat.

And then there’s the blanket use of potentially harmful drugs like antibiotics, the waste of too many tests if they're done as precaution, perhaps when clinicians are feeling less confident or they're less experienced. And then that last one which you were touching on, Jane, about the use of low-value treatments or the de-implementation of things that we know on effectiveness grounds need to be phased out.

And those are all quite different things but somehow come together in this way. And I think you mentioned, Heather, about choosing wisely.

And in the Scottish context, it's realistic medicine, is that right? So there's various initiatives to try and embed some of what we know needs to be done. Do you want to say a little bit more, Heather, around the effectiveness evidence that you're working on, but then what you're finding out about how it plays out in practice?

Heather: So in terms of the clinical trials around the routine provision of a six-month checkup and the routine provision of a scale and polish in particular in relation to the six-month checkup…what the evidence suggests is actually it has no benefit over and above a risk-based recall interval.

So that would be a personalised risk-based recall interval which could be anywhere between 3 and 24 months based on various different risk factors such as smoking, drinking, dental decay, periodontal disease, a factor such as that. So what we're actually looking to do is behaviour substitution. So it's replacing that six-month checkup with a risk-based recall interval.

And so the work I've been doing has been very much looking at what are the barriers and enablers from the patients, but also the dental professional's perspective to moving towards that risk-based recall interval. And as you would expect, there are some similarities across those different stakeholders, but there are some unique differences as well.

Tara: What would you say are some of your headline findings and has there been anything that surprises you?

Heather: Fear is really the headline find in particular in relation to the dental profession, there's a lot of anxiety and worry around changing their practice and part of that's cultural and it's something that people were have been trained to do and they have always done.

But also in terms of primary care dentistry, there's concern around the impact that will have on their business model because…certainly in Scotland we have a different funding model to that in England, but the same principles apply around fees and treatment are intrinsically linked. So in terms of running a business, there are concerns around the impact of changing that particular behaviour.

There's also concern around missing something and one of the areas that dentists are particularly concerned around, as missed as something like an oral cancer and the impact that could have, fear of litigation…obviously in extreme circumstances, but also concern around losing the relationships that they've built up with their patients.

So being able to provide that more holistic healthcare approach and the impact that seeing patients less frequently might have. So that's very much the dental team perspective. Patients are probably less concerned around the move towards a risk-based recall interval. There is a little bit of concern around liking the reassurance of being seen regularly, but actually they just want to understand more about the risk assessment process, what that means, how it's determined and what they can do to influence it. So generally patients are more positive.

They like the idea of a personalised recall interval.

Tara: And Claire in terms of the professionals’ resistance, does that chime with what you're finding with GPs and others?

Claire: I think the general practice perspective…it’s so multifaceted. There's so many different things changing of practice. I think there is an element of that. I think there are no certain blood tests, routine blood tests being sent that probably aren't required because they've always done it. And it's an easy thing to box and order without considering the consequences and changes in some medications as well.

I think you mentioned earlier, Tara, about opiates as well, about the change in that medication. And that's been a big shift, to not prescribe those medications for pain or chronic pain. So there is a little bit of that.

But I think in general practice and the people I'm talking to, what seems to be coming through most of all is that the time it takes to do less.

So actually so many things are in place. If you are making a decision to not intervene or to not do a test or give a prescription, then the conversation you have with the patient takes longer. So you have to have that lengthened conversation which means that you might go late in your list of appointments for the day and everybody else is waiting. The write up of that. Most people will write a lot more in the notes if they're making that decision. So that takes longer.

And then also there's a fear of…I mentioned a fear of litigation and there is that fear as well, I think of getting it wrong. But what people talk about more is the burden of time that complaints cause.

So even if people are really confident in their decision, they know they've done the right thing, they've done a really good assessment...Let's take antibiotics for example. So person's got a cough, they've done a thorough examination, they definitely don't need them. They agree that with the patient goes away, but then decides they're not happy, so fills in an online form of a complaint, which gets bounced around and often will come back to that healthcare professional who's then got to write a statement or write a reflection on why they made that decision when it's the right decision in the first place.

But if they know that if that happens, it's going to be longer…often it's a harder thing to do. The right thing is the harder thing to do. It's actually sometimes just easier to give the prescription for the antibiotics and it's going to cause them less work and they're really busy in general practice. So anything that can make life easier.

Tara: That's a really powerful point, actually, about the time for proper shared decision making and the incentives that militate against that. Jane, do you have any thoughts about that?

Jane: I think part of the issue here is that sometimes we don't know what is going on when people do or don't do things. And I think that's what you're describing there, Claire. And also, Heather, you were talking about how what's lost when you don't have these routine checkups, you wouldn't know that from a NICE guideline or from an RCT because often you wouldn't get to that level of detail about what's actually going on in those healthcare presentations or in those interactions between staff and patients. And so I suppose often these things are difficult and multifactorial because we don't actually know in the fullness of the activity what it is actually achieving.

And I think about other things, like a colleague of mine, Rebecca, she's doing a big programme of work on de-implementing double checking of medications, because actually, the evidence is not terribly strong for it and it takes up an awful lot of time.

And there's some suggestion that it actually increases patient safety problems if people are coming in to do a check and they're the more senior person on the ward. So I think in all of these things, whether it's practice or treatment or a drug or service even, I think it's too simple to think that you could maybe embed something, you can then just flip those and take it out, you know, the same frameworks will work for implementations as they will work for the implementation and particularly with respect to anything that has patient safety implications.

I think what you say, Heather, particularly around the fear, is so strong and it might not even be a conscious fear, it might be just something that sits in the background humming and guide you in your decision making and your practice, even with you not really understanding that's what it's doing.

And it just becomes…we think of this as culture, don't we? The way that people work and people don't really question that, it just eats. And so whether you're consciously or consciously is acting on those things.

I think culture, particularly when it comes to patient safety, that internalised concept of culture and then the group level facets, I think hugely interact hugely to create whether somebody does or doesn't think something.

Tara: Absolutely. And both the explicit, the sort of system incentives working in one direction and then what people, as you say, Jane, are internalising and very much from all the work on and so on, the last, worst case will influence professionals much more than the odds of something happening again.

Jane: Just to pick up on what Claire said around time, I wonder whether in the de-implementation thing, actually that seems almost a perverse kind of finding, really, doesn't it?

You would think that doing less takes time, gives you back time, but it doesn't with what you're saying, actually to do these things and have these deliberative conversations with people who work in a shared decision making kind of way and give them all of that information and to hold that risk together, I think, and to sit in that uncertainty seems to take more time rather than just filling out a prescription and off you go with your antibiotics. So I think that's a super insight.

Claire: I just wanted to just add on to that really, because I think what I'm finding is there seems to be this. It's almost like a transactional relationship between the patient and the healthcare provider. So what seems to happen is, if you've booked an appointment or you've phoned for an ambulance or you go into a clinic and you've waited for that appointment and you might wait a long time for it, then you go into that appointment, the patients almost expect to leave something within return.

They've invested their time in getting to that point and they want to leave with something. And as a healthcare professional, you want to have happy and satisfied patients who feel they've had good care.

So it is always much easier to just take them to hospital if that's where they want to go, or to give them the prescription. But what we're not good at as healthcare professionals is really thinking about the harms that decision is making.

Because we might be in the short term validating the patient. They feel they've been listened to, they've got something to take away, but we don't always consider…if I take this patient, she's in her 80s, up to hospital, even though I don't think she needs to go because she wants a checkup, well, she might fall in the corridor when she's waiting to be seen, she might get an infection. And we don't automatically have those harms that our decisions to actively do something might cause.

And I think that's a problem and I think that's something we maybe need to tackle and to improve that, to really understand how giving something can also be harmful. Because we worry about missing things if we don't do an intervention. We don't worry about causing a problem by doing an intervention.

Tara: Absolutely. And I think that do something impetus is very strong.

Jane: So you've talked about time in two different ways there, haven't you?

I's time in terms of a transactional thing between the patient and healthcare professional and then it's the time where the impact of your decision becomes obvious or becomes important.

So the impact of that over time isn't always obvious to people. The other thing I wanted to raise there, just thinking about what you were saying was often a problem with taking things away, is because we actually get to this position where to do two policies next to each other can't actually happen. So you have to make a decision about you are taking things out because you're having to do this one and not that one.

I've got an emergent interest with you in this idea of interacting or healthcare policies which don't stack up against each other can't be achieved within the same system. And I think, we talked about antibiotics in particular and if you think about the link between the Sepsis 6 bundle, for example, and the timeliness of antibiotics to be given to people who have query sepsis, and the time poor nature of people to have those detailed conversations with patients about, well, it could be, it also couldn't be, should we do a watchful waiting process or wait for the lab results to come back or whatever it is…you actually can't do a antimicrobial resistance policy initiative, reducing antibiotic prescribing alongside delivery of a Sepsis 6 bundle as it is.

So always you're trading off these two things together. So actually if you're trying to get people to do less whilst at the same time telling them to do things in a really timely way, which of course is right in retrospect, if we look at a population level, prophylactic giving of antibiotics is always going to help deal with sepsis. But what it's not going to do is either with antimicrobial resistance or indeed it might obscure other diagnostic processes. So I think there are some real complexities about how evidence that guides whether you do or don't do something stacks up against each other. And I think again, it comes back to this idea of actually doing.

Having an understanding of all of this stuff within a systems perspective is really important because otherwise you can't know how it's actually going to be enacted.

Tara: I wonder. I know that we've talked previously, the time issue is a really wonderful new insight from your work, Claire.

Another issue that seems to have come from your work, Heather, and perhaps your work, Claire, is the issue of trust. So when we're seeing, particularly with more conservative management and the not doing something, there's sometimes issues with patients feeling that it may be around cost cutting and some sort of scepticism about what's behind that. Did you want to say something about that, Heather?

Heather: I was actually going to mention something about time as well. And just actually something that's come out of the work I've done is that patients are acutely aware of the time pressures that the medical profession, the dental profession are under. So they're very conscious of access issues and length of appointments and perhaps lots of people waiting to be seen behind them.

So they are reluctant to ask too many questions or engage in these shared decision-making conversations because they're really mindful of the pressures that healthcare professionals are under now. So I think that's another factor in terms of time.

And I also think there is that perception that professionals are trained to do something, so they find it very hard not to do something, even if not doing something is still perhaps providing oral hygiene advice or preventive care advice. So it's almost contrary to their training. So culturally they find it quite difficult.

Tara: Those are interesting additional, and I think you've said before, in some places dentists and other professionals might have to actually explicitly say to patients, “it's okay to ask” or to enable that discussion and that time.

Heather: Absolutely.  But in relation to trust, actually there was huge trust around the profession, certainly from, you know, the patients I've spoken to, they're really keen to find out more around the evidence that supports the decision makings around their care. So I think the time and the trust, they go hand in order to create that opportunity for those conversations.

Tara: I think there's another issue around that you've raised before, around the health literacy, too, how possible is it always to have that conversation? And when you're dealing with very complex issues of levels of evidence and levels of certainty about evidence and treatment options. Claire, if you wanted to come in on that or something else.

Claire: Health literacy, I think we definitely need to consider it. I think shared decision-making and good shared decision-making is really important when we're trying to reduce overuse and get the right care for the patients. But it's not...it's not as easy as it sounds, otherwise we would have fixed it by now. Because we've been teaching shared decision making in higher education for…well, since I started training 20 years ago.

Even from personal experience, I know as a paramedic when I've been there and with a patient, this is what I found...We have this option that we could do as a second option. “And what do you think about that? What would your preference be?” Very often those people who have less health literacy or who are perceived to have less health literacy, will just say, “you're the expert, what would you want me to do? You tell me what to do, I'll do whatever you say.”

And then that's difficult, isn't it? Because you can't force somebody into that discussion if they're not willing or able to have that discussion. And often they do feel that they haven't got any training and maybe one meeting with that patient isn't enough for them to really process that. So it doesn't always work. But I think with just going back to trust as well, trust is a really interesting one in general practice, because I've been hearing really mixed things about that and people talk a lot about continuity of care.

So if you're someone who is seeing the same GP for a period of years, then there is a lot of trust there in those decisions and people are more comfortable to have those decisions. But on the flipside of that, what some people are saying is that they're finding more and more that patients are coming to a GP and seeing them as a gateway and actually they want to get to the specialist because they think the specialist knows more than the GP, so they almost want to leapfrog the GP to get to where they think they're going to get the better care.

And people talk…GPs talk a lot about that. Not all GPs, but some of the GPs have talked about that in their interviews as feeling as if they're almost…there isn't as much trust as there used to be and the profession's not as respected as it used to be. And it seems to be moving towards like an American-based system where people go to see different specialists for different problems.

Tara: And I'm afraid we're coming near the end of our time with this episode, but I wondered if you each had some reflections on…I imagine with Claire it might be 30-minute consultations with GPs, but in terms of positive steps that we can take to make more appropriate use of healthcare, doing less, more acceptable.

Heather: I think for me it is around patient education and patient-facing resources and how we can provide information about scientific evidence and how that obviously influences changes to care in a way that's accessible to patients.

I think it's really interesting that actually the routine provision of a six month checkup stems back to the 1930s and it was from a radio jingle in America where they say, “brush your teeth twice a day, see your dentist twice a year”. So actually I do just wonder if we need to consider, you know, large public health campaigns and, you know, consider the power of advertising in terms of getting some of these health messages out there first.

Claire: I completely agree with Heather there. I think that's a really good point because I think as a society we have this more is more attitude to our health care. So I think we need to try and start to change that through education. And I don't know if I've got a step, but I think where we could look, there was an area of medicine where we are very good at having these decisions and that's in end-of-life palliative care.

So in that area of practice, when it gets those last few weeks or months of life, we're very good at seeing the value of quality of life and really having those thoughtful decisions with patients and families about what this treatment might do, what the benefits would be, but what it might do to quality of life and the time we've got left.

I think it's really important that you know, at that time, at the end we do start to value quality of life. But I think we need to look at that and think about how people are having those discussions and how we can make people value the quality of their life all throughout their lives and maybe be more aware of the decisions that we're making about their treatment and how that affects their general day to day life.

Jane: Listening to those great answers and just thinking what snappy non-academic thoughts can I give you? I suppose from a patient safety and systems perspective, I'm not sure whether these are positive or whether these are even really doable, but I think that in a sense what I'd like to see more of are multi-level examinations of this problem.

So there's been a lot of work, you know, educating patients, sometimes educating the public, but much less then looking at the interaction between healthcare staff and patients and that's the level of examination. But actually as we know and as we've talked about, even in this short time we've had together, there's so many factors that influence why people do or don't do things.

So to really situate the practice of taking stuff out into its wider system, I think sometimes science can pocket things into little, you know, separate silos of examination and I don't think that's what's needed here. I think we definitely need a multi-level thing.

But then secondly, and it's something, it's picking up on what you said Heather, around public education. But to me I feel it's almost one step further back from that because some of this is about what risks are we happy to take as a society? Where's our level of risk that we're okay with? So are we okay with saying that no child or adult is going to die from the misapplication of a reducing antimicrobial and campaign, for example, versus the impending tsunami of resistance to antibiotics.

Jane: So it's…what's the safety issue today versus the safety issue tomorrow? What are we prepared to do and how are we prepared to do that? Because I think without that more public, citizens-based approach, it's really hard for us then when something does happen to look back and say we did the right thing. Because actually we haven't asked people what we think the right thing is to do. So I think yes, public education, but also public discourse around it would be welcomed.

Tara: That's great. And I think we've touched on some really fundamental issues about risk and acceptability and some really great insights from the work that you're doing at this institute.

So a big thank you to all the guests who joined us today: Heather Cassie, Claire Hastings and Jane O'Hara. I've been your host, Tara Lamont, and I hope you've enjoyed Listen to THIS.

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