

COMMENTARY

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De-adoption and its 43 related terms: harmonizing low-value care terminology

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Abstract

Research into the prevalence and impact of low-value medical practices has evolved substantially over the past two decades. However, despite international efforts, many challenges still remain with regards to progress in this field, including limits in the capacity to identify and prioritize low-value care practices and to systematically appraise clinical and policy attempts at redressing low-value care. A recent article by Niven et al. in *BMC Medicine* consolidates the current literature and terminology on the de-adoption of clinical practices, advocating the use of de-adoption as an appropriate term to label low-value care and proposes a new synthesis model to facilitate efforts to reverse ineffective and harmful medical practices. We hope that this work will facilitate advances in low-value care research and policy, and shift focus towards establishing evidence for de-adopting low-value interventions, which is crucial since attempts to reduce low-value care interventions have shown mixed results.

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Keywords: De-adoption, Harmful, Ineffective, Low-value care, Medical interventions

Background

In the 1990s, England's National Institute for Health and Care Excellence co-opted the term 'disinvestment' from industry parlance, heralding its transition to the health sector [1]. Within industrial settings, disinvestment primarily refers to the removal of resources from obsolete items such as machinery. In healthcare settings, there is less scope for such binary verdicts and, as such, more attention is given to the complex issues associated with the ethics of waste reduction. The most common definition places it as "*processes of withdrawing (partially or completely) health resources from any existing health care practices, procedures, technologies or pharmaceuticals that are deemed to deliver little or no health gain for their cost, and are thus not efficient health resource allocations*" [2], allowing for resource re-allocation. As Niven et al. [3] so aptly indicate, many related concepts are subsumed within misuse, overtreatment, overdiagnosis, overmedicalization, waste, opportunity cost, allocative and/or technical efficiency, resource re-allocation, and de-adoption. Terminological proliferation has ensued

for several years, as visualized in the word cloud presented herein (Fig. 1) and derived from the most common terms identified by Niven et al. [3].

The article by Niven et al. [3] represents an important contribution to the field, representing, along with the manuscripts referenced within it, a valuable repository cataloguing the current state-of-the-science from around the world with regards to efforts at reducing the use of low-value healthcare. Throughout article we are reminded that contemporary de-adoption initiatives can be likened to 'old wine in a new bottle', for related programs have emerged and re-emerged since the 1970s [4, 5]. While the desire to minimize waste and deliver safe, effective, and efficient healthcare is old wine, the new bottle is represented by ever-evolving research, analysis, health technology assessment methods, and dovetailed policy processes. It is clear that the clinical, research, and policy communities have attended to the successes and failures of the past and are evolving to develop more robust methods moving forward. Further, many of the challenges faced are universal (e.g. sources of resistance to a potential loss function, burden of evidence requirements, levers to encourage optimal use), yet initiatives tend to be context specific: there is no

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one model to drive this step given that the circumstances of individual healthcare environments are widely varied and context specific [13]. For example, as the recent OECD report reveals [14], individual countries have tackled the problem of cesarean delivery over-use differently, all with varying degrees of success. Niven et al. [3] further emphasize this point in their synthesis. So too, rather than re-inventing the wheel, the 'adaptation of a knowledge step' in the Niven model is well founded, with growing examples of existing policy processes that can be merged with promising initiatives, thus adding value to the overall process. The next step in their model involves the evaluation of de-adoption processes and outcomes [15]. Without doubt, there is a dearth of information in this domain due to the lack of a publication imperative by policy stakeholders performing this work and/or due to evidence lying in grey literature that is difficult to obtain. Sustaining de-adoption initiatives is particularly challenging and it is well regarded in the field that de-adoption is far from merely reversing the implementation process [6]. The last step of this framework, namely the assessment of barriers and facilitators to the de-adoption of interventions, is perhaps the most important. While this framework step has received a great deal of attention from both the clinical and policy analysis perspectives [2, 16, 17], it remains under-represented in terms on quantitative evaluation.

Conclusions

We commend the authors for summarizing the current literature on low-value clinical practices, the terminology used thus far, and the impact of de-adoption interventions. This scoping review substantially contributes to the continuing maturation of low-value clinical practice literature. This is an important step in consolidating the research to date, particularly regarding what constitutes low-value care, and is essential to generate the evidence base for de-adoption approaches of clinical practice.

Competing interests

Associate Professor Adam Elshaug receives consulting/sitting fees from Cancer Australia, the Capital Markets Cooperative Research Centre – Health Quality Program, NPS MedicineWise (facilitator of Choosing Wisely Australia), and the Australian Commission on Safety and Quality in Health Care, and is a Ministerial appointee to the (Australian) Medicare Benefits Schedule Reviews Task Force.

Authors' contributions

DG and AE contributed to conception of the article. Both authors were involved in drafting, editing, and revising the manuscript and both agreed to its publication. Both authors read and approved the final manuscript.

Acknowledgements

Danijela Gnjidic is supported by a National Health and Medical Research Council Early Career Fellowship. Adam Elshaug receives salary support as the HCF Research Foundation Principal Research Fellow.

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Received: 2 October 2015 Accepted: 8 October 2015

Published online: 20 October 2015

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