Paediatrics *Evolve* Masterclass 2016

Opened by RACP Paediatrics & Child Health Division President Dr Sarah Dalton and facilitated by Dr Norman Swan, the Masterclass provided an invaluable opportunity for current and future leaders from a variety of paediatric specialties, to discuss Evolve*, share experiences of low-value care, explore the root causes of low-value practices, and put forward practical ways to change.*

The successful Paediatrics Evolve *Masterclass drew clinicians from far and wide to Parliament House in Sydney. Attendees included general and specialist paediatricians – Fellows and Trainees – from across Australasia, as well as representatives from the Royal Australian and New Zealand College of Radiologists (RANZCR), the Australian College of Nursing (ACN), state health departments, hospitals, and Choosing Wisely Australia. RACP President Dr Catherine Yelland, President-Elect Dr Mark Lane, and RACP CEO Linda Smith participated throughout.*

From words to action

Dr Dalton urged us to practise not just cleverly but wisely. That is, to think clearly and critically about the treatments, tests, and interventions prescribed by paediatricians; to reflect on whether or not they are supported by good evidence. Dr Dalton spoke to the significant collaborative effort that had gone into the General Paediatrics list, which was released on the same day. But, she said, 'it's not enough to have a list.' And warned everyone not to be complacent but to take personal responsibility for turning the list into common clinical practice: 'We used to put [lists] on a dusty shelf now we put [them on] a dusty website.' At the end of the day's discussions, Dr Dalton said, everyone should know 'what we need to do next, [having had] input into next steps, and be clinical leaders in making change'.

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Dr Swan followed, saying, 'The easy bit, hard though it was, was to come up with the list. The first list is the start of the journey in moving from low-value paediatric care to high-value paediatric care.' Reflecting the initiative's name, medical evidence is continually evolving. 'What you used to think was the best possible care is no longer the best possible care.'

Getting to the heart of the problem

The day's proceedings pivoted around a discussion on cognitive bias within clinical practice, led by Associate Professor Ian Scott, Director of Medicine and Clinical Epidemiology at Princess Alexandra

Hospital, Brisbane. Widely praised, A/Prof Scott's talk opened up a refreshing and very useful way for attendees to reflect on their own biases and to consider how to cross the divide between today's clinical practice and where we need to be.

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'We need to realise we're humans,' A/Prof Scott said. 'Sometimes we're not always as rational as we think we are or should be. Humans are predictably irrational. It's not because we're obstinate or stupid, it's just that we have a need to think in a certain way that gets us through our daily busy life with a minimum of mistakes.' Cognitive rules of thumb save the time and effort taken up by slower, analytical thinking and decision-making.

The first step, said A/Prof Scott, is making ourselves more aware of our own thought processes and what influences them. 'We need to realise that the way we think is sometimes taking us away from what the science says we should do.' We need to cultivate a tolerance for uncertainty, emphasise analytic reasoning, not allow ourselves to fall into groupthink, acknowledge the possibility of more than one answer, and involve patients in the decision-making, including the inherent risks and uncertainty.

There are things we can do

A/Prof Scott explored a number of countervailing heuristics or 'de-biasing' strategies which can help correct erroneous thinking and habits. These are more likely to be effective than externally imposed financial incentives, regulation, or public reporting. 'None of us like having a practice imposed on us by non-clinicians,' he said. Of course, we can build checklists into electronic ordering, particularly once e-records are commonplace in hospitals. But, if this is all we do, we risk this becoming a passive experience that doesn't teach or promote critical thinking, but simply channels practice down a certain path which may not be ideal in patient care.

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'At the end of the day, you can't substitute for the thinking individual,' A/Prof Scott said. Nor, he said, should the aim be to demoralise clinicians by unduly restricting their decision-making autonomy. But, we can start to nudge behaviour in the right direction: by using a combination of internal audits with personalised feedback from respected peers, understanding patient expectations and including them and carers in the decision-making, and encouraging constructive questioning on our ward rounds and clinics. Moreover, we should be

emphasising role-models – they can challenge the status quo and normalise new and better ways, which may appear at first to deviate from the norm.

'We're not intending to shame anyone, we're not going to get emotional. But, we should be open to exploring, in a collegiate environment, the cognitive missteps in what turned out to be less-than-ideal decisions for patient care..' A/Prof Scott spoke of 'huddles' around real-world cases; harnessing what has been termed the 'teachable moment' to cultivate reflective clinical practice.

'We need to shift the culture: make it OK not to know everything.'

A/Prof Scott stressed that there is no magic bullet to mitigating reasoning error due to cognitive biases. 'This is tough stuff. Awareness is key.' Nevertheless, he is convinced that, in this way, we can reduce inappropriate care and improve patient satisfaction at the same time.

Starting to *Evolve*

A panel discussed the development and implementation of *Evolve* top-5 lists, with Prof Fergus Cameron, Vice-President of the Australasian Paediatric Endocrinology Group (APEG), Dr Melanie Wong, Immediate past-President of the Australasian Society for Clinical Immunology and Allergy (ASCIA), and Mr Mark Nevin of RANZCR.

Prof Cameron spoke about the challenges involved with change: 'Whatever you look at you're going to be upsetting somebody, so it's difficult to talk about.' The trick, he said, was not to be threatening and to encourage open and honest discussion. Prof Cameron suggested targeting trainees, as well as paediatricians and physicians, and working with the public. Dr Wong agreed, saying that we need to be more realistic about what tests might achieve, and work with patients and parents to set expectations more appropriately. Both Dr Wong and Mr Nevin stressed the importance of tailoring the wording of recommendations, recognising that language can profoundly influence adoption. Mr Nevin said RANZCR was tracking Medicare data to gauge impact, reaching out to general practitioners on imaging guidelines, and working to ensure policy supports best practice. Ultimately, he said, 'we need to shift the culture: make it OK for referrers not to know everything.'

From evidence and practice to evidence-based practice

In her presentation on how best to translate evidence into practice, A/Prof Harriet Hiscock from the Murdoch Children's Research Institute spoke of working with patients and parents to reshape expectations, and also emphasised the need to pay careful attention to language. She highlighted that one of the more powerful ways to effect change is via audits of clinical practice of unnecessary

care, coupled with non-punitive, anonymous feedback: individuals are not shamed but are made aware of where they sit in relation to their peers. And not to forget the simple stuff, such as signage at the point of care, providing clinicians with useful, simple reminders of what not to do. A/Prof Hiscock said we need not only to tell clinicians what they should not do, but also ask, 'What should you do? What are the do do's!'

Ms Angela Melder, Manager of the Centre for Clinical Effectiveness at Monash Health, explained the importance of 'accountable leadership at all levels'. With far too much evidence for individuals to manage, Ms Melder said that *Evolve* and Choosing Wisely had been 'hugely helpful' in enabling efficient dissemination of clear and practical recommendations for practice for health services and busy clinicians. *Evolve* recommendations are incorporated into handovers on the paediatric wards and also reflected on in weekly grand rounds.

Evolving forward

Table discussions saw attendees reflect on the presentations and knuckle down to focus on what works, what gets in the way, and what they can do to take *Evolve* off the paper and into the clinics and wards. There were thoughtful and lively conversations about what individual Fellows and Trainees could do, and where departments, hospitals, and the College could drive practice change. Many good, practical suggestions were made – summarised below.

For individual Fellows and Trainees**:* Take ownership of *Evolve*. Allow for uncertainty. Be open to questioning yourself and others. ***For senior doctors: Become a role model, spend more time talking and teaching, create a culture of 'mindful medicine' that encourages reflection and self-awareness, encourage trainees and new doctors to ask questions, and incorporate communications skills into your training. Engage parents in the clinical decision-making. Encourage respect for other professionals, e.g. nurses, GPs, and allied health workers.

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***For departments and hospitals**:* Use the legitimacy and leadership of tertiary hospitals to make change (which will require a multifaceted approach). Generate discussion, creating fora to facilitate presentations and other structures for reflective practice. Benchmark the use of *Evolve* recommendations, encourage senior staff to become role models and enlist clinical leaders as *Evolve* champions. Identify the drivers of inappropriate tests and treatments, build *Evolve*

recommendations into your IT systems and implement clinical audits, make them a routine part of handover conversations.

***For the College**:* Attendees highlighted that the College has a powerful role to play, especially in advocacy, inter-college cooperation, incorporating *Evolve* into education and training (including trainee projects), and setting standards and articulating values. It should ensure lists include not only what not to do, but on what to do instead. The College could develop guides to implementing *Evolve*, template materials that can be easily tailored and adapted, suggest indicators of success. It should use its authority and legitimacy, engage organisational leaders, and provide paediatricians with the support they need to engage other professionals.

The openness to new ideas, the enthusiasm for self-relfection, the passion of the discussions, and the willingness to find practical solutions and become advocates – these are good indicators of a successful Masterclass. The College's Policy & Advocacy Unit will now tap this wealth of ideas as *Evolve* shifts from an emphasis on list development to practice and cultural change. As Dr Dalton said, 'We have to "future proof" training so doctors know that their practice will be always changing.' What is best practice today will be different in the future, and Evolve will help paediatricians, physicians and other health professionals continue to provide contemporary high-quality, high-value care to all their patients.

Dr Dalton and A/Prof Hiscock, together with Dr Hamish McCay from Waikato Hospital, feature on the College's *Pomegranate* podcast: https://www.racp.edu.au/pomegranate/View/episode-17-better-practice-in-paeds.

Feedback on the 2016 Paediatrics *EVOLVE* Masterclass

100%

Everyone found the Masterclass worthwhile, helping them to get a good handle on *Evolve*.

87%

Most people came away from table discussions with ideas they might take forward.

100%

All attendees found the session on cognitive bias helped them to reflect on their own practice.