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TRAINEE FOCUS - OPINION

Deliberate clinical inertia: A paradoxical strategy to improve patient flow?

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Demand for ED services in Australasia over the last two decades has increased disproportionately to population growth.[1] When demand is high and timely assessments are challenging, it can lead to unnecessary tests and treatments: an issue compounded by the phenomenon of intervention bias. This article will discuss how adopting a philosophy of '*doing nothing*' when appropriate can alleviate pressure on emergency services while providing safe and effective care.

What is deliberate clinical inertia?

The concept of deliberate clinical inertia has been discussed in a previous series in this journal.[2–4] It refers to the conscious process of '*doing nothing*' as a positive response to clinician and system intervention bias. This is particularly relevant in busy ED settings with multiple competing interests and non-linear processes, where decisions are often made rapidly with incomplete information. '*Doing nothing*' requires clinicians to consistently and consciously incorporate pre-test probability (PTP), in combination with clinical assessment, to inform when tests and treatments are of such low yield that the threshold for ordering or intervening has not been reached.[5] If this threshold is not met, further tests and treatments are unhelpful at best, and may be even harmful for the patient or healthcare system.

The cost of unnecessary tests

Almost one-third of all health service-based diagnostic testing is ordered in the ED.[6] Test ordering in a busy ED is often conducted prior to complete assessment. However, 'front-loaded' or 'just-in-case' tests are often unhelpful and confer little additional benefit over history and clinical examination.[7] Such 'timely' test ordering is often conducted with the purview of improving wait times and time-based metrics. However, the consequences include over-ordering of tests, increased costs, over-diagnosis, and patient harm.[8] This suggests that indiscriminately focusing on speed can compromise the accuracy of assessments, working diagnoses, and the appropriateness of treatment plans. Moreover, making swift decisions may paradoxically exacerbate ED overcrowding: when patients undergo unnecessary tests, the time required for results to return can delay care for other patients.

An insightful experiment would be to randomise patients to 'assessment by senior clinician before any tests can be ordered' *versus* 'usual care'. It could be expected the former would be associated with more rational decision making, higher accuracy in working diagnosis, and a reduction in unnecessary tests and treatments. Additionally, the former would be expected to deliver more beneficial patient-centred outcomes in terms of reduced adverse events, greater patient satisfaction, and lower representation rates. On the other hand, metrics such as time to be seen would likely be longer, because senior clinicians are not always readily available.

Establishing the right balance between quality of care, wait times, and cost, could be informed by a discrete choice experiment (DCE), where ED consumers are asked to rank the importance of these domains for different scenarios. Prior research suggests patients prefer lower cost, shorter wait times and high quality of care, but were consistently willing to wait longer before making trade-offs (such as being seen by a different provider than an emergency physician or get less comprehensive care) for certain conditions.[9] A future study could review patient and consumer choice by a similar DCE, including further organisational, patient safety and process factors to inform where the optimal balance lies between speed and quality of care.

Evidence supporting 'Less is More'

Numerous studies within emergency medicine have shown conservative approaches or less invasive treatments can lead to similar or better patient-centred outcomes, while being more time efficient for patients and healthcare providers, and cheaper for the system (see Table 1). Pellatt et al.[10] found that patients

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TABLE 1. *Example where deliberate clinical inertia could save time and/or resources, with similar or better patient outcomes*

Author and topic	Patient	Staff	Cost
Pellat et al.[10] Buddy taping Boxers fractures	Same hand function as plaster	Easier and quicker	Fewer orthopaedic outpatient appointments
Brown et al.[11] Conservative management for mod/large pneumothorax	Fewer adverse events, fewer surgical interventions	Easier and quicker	Fewer days in hospital, less need for surgery
Lim et al.[12] Multi-model intervention to reduce peripheral intravenous cannula insertion (PIVC)	Fewer adverse events	Opportunity to spend time on other tasks	Lower costs due reduction in unused PIVC and complications
Kalsi et al.[16] Reduction of coagulation ordering using a nudge strategy	No change in adverse events	Nil effect	20% reduction in ordering of coagulation studies
Perez et al.[17] Observation for uncomplicated alcohol intoxication	Same intoxication scores, same length of stay	Easier, no risk of needle stick	No need for PIVC, blood tests and fluids
Lousick et al.[18] CT head in overdose only if clinical findings dictate (seizures, signs of injury, focal neurology)	Less radiation	No need to transfer to CT	Shorter time in ED and avoiding CT scan cost
Brindle et al.[19] Oral antibiotics for patients with uncomplicated cellulitis	Same clinical outcomes as intravenous antibiotics	Easier and quicker for staff	Shorter length of stay

with uncomplicated fifth metacarpal neck (Boxer's) fractures do not require plaster immobilisation; buddy taping was associated with shorter ED length of stay, while having the same or better patient-centred outcomes. Brown et al.[11] showed that in patients with a primary moderate to large spontaneous pneumothorax, a non-interventional approach was non-inferior in terms of lung re-expansion, while adverse events were three times lower, and hospital length of stay 5 days shorter. A final example established that a multi-modal intervention led to a 10% reduction in insertion of unused peripheral intravenous cannulaes.[12] This was associated with reduced national cost in the order of tens of millions of dollars from reduced insertion (equipment and staff), and reduced complications. These examples demonstrate that not every patient requires an intervention, and that doing less when appropriate can be associated with similar or better patient outcomes, shorter ED and hospital length of stay, and lower cost.

Enhancing patient engagement and satisfaction

Deliberate clinical inertia is not merely an exercise in restraint or avoiding testing and interventions; it is an opportunity to enhance patient engagement and satisfaction. By gathering comprehensive clinical histories and physical examinations, clinicians are more likely to have an accurate assessment and estimate of the PTP, and patients are more likely to trust the outcome of a consultation and be engaged in shared decision-making.[13] Engaging patients in discussions about their care, explaining the rationale for a conservative approach, and providing signposts for what can be expected may be more useful than a battery of tests.

Flow and overcrowding

Deliberate clinical inertia presents a tool to address systemic challenges of overcrowding and access block in Australasian EDs. By prioritising thorough assessment and judicious intervention, EDs can improve patient flow. This shift in practice

requires a cultural change within the emergency medicine community: one that values thoughtful decision-making over knee-jerk reactions, and accuracy over speed. In addition, education and training on the principles of deliberate clinical inertia and metacognition around type I (fast) and II (slow) thinking[14] should be integrated into medical curricula and ongoing professional development programmes.[15] This will equip emergency medicine practitioners with the tools to recognise when to act and when to withhold intervention, thereby fostering a more sustainable approach to emergency care.

Conclusion

As demand for care increases, it is imperative that we rethink our approach to care, recognising that sometimes, doing less can be better, cheaper, easier and faster.

Competing interests

GK is an Editorial Board member of EMA. To minimise bias, he was excluded from all editorial decision-making related to the acceptance of this article for publication.

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