

# **Genere e Appropriatelyzza**

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# Appropriateness: the next frontier

1994

## *Appropriateness ratings could revolutionise health care*

The health care systems of developed countries share common problems. Firstly, the explosion of costly medical technologies increasingly jeopardises our ability to give everybody all the care that would benefit them. And, secondly, the explosion in medical services has made it virtually impossible to remember the indications, complications, and costs of procedures and drugs—that is, to practise good medicine without additional help.

Studies of appropriateness underline the seriousness of these problems. By appropriate care I mean that for which the benefits exceed the risks by a wide enough margin to make it worth providing. If we could increase appropriate and decrease inappropriate care, the benefits to patients and society in terms of health and wealth would be enormous. Indeed, without methods to detect inappropriate care, society's ability to maintain universal insurance coverage may disappear.<sup>1</sup>

But how do you measure the appropriateness of care?<sup>2</sup> Although the clinical literature is the place to start, it mostly concerns the efficacy of a procedure performed under ideal

conditions and tells us little about what happens when the procedure is done under less than ideal conditions.<sup>3</sup> Furthermore, research rarely includes outcome measures that are relevant to patients and practitioners—for example, effects on health status or function.<sup>4</sup>

To measure appropriateness, colleagues and I at the RAND Corporation and the University of California, Los Angeles, have developed an explicit method, beginning with a literature analysis that summarises what is known about a procedure's efficacy, effectiveness, indications, cost, and use. The next step is to develop a list of specific clinical indications based on that review. Using the list of indications and the literature review, a panel then rates appropriateness on a scale of 1 to 9. On the basis of these ratings and clinical data collected from medical records we can measure appropriateness in actual practice.

Some of the findings have been worrying. For example, among Americans aged over 65 being treated in the fee for service system, carotid endarterectomy was performed for reasons that were unusual, at best, in true trials of appropriateness.

2000

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## Gender differences of symptom reporting and medical health care utilization in the German population

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**Abstract.** *Aim:* Gender differences in morbidity have been widely confirmed in representative health surveys in North America and Europe. Significantly more women than men suffer from somatic complaints. It is less clear whether differences in symptom reporting provide an impact on health care utilization and to which degree psychosocial factors exhibit confounding influence. *Methods:* We analyzed data from a representative health examination survey in Germany with 7466 participants in the age range of

utilization was associated with higher symptom reporting levels. Nevertheless, females constantly exhibited more medical utilization than males in all symptom reporting groups. Age and marital status had no univariate influence on symptom reporting whereas low social class status ( $p = 0.001$ ), poor perceived/self assessed health ( $p < 0.0001$ ), and high levels of chronic distress ( $p < 0.0001$ ) were associated with more symptom reporting. In multivariate analysis, the female gender lost its significance on



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Child Psychiatry and Human Development  
June 2005, Volume 35, Issue 4, pp 359-381

# Gender Appropriateness of Symptom Criteria for Attention- Deficit/Hyperactivity Disorder, Oppositional-Defiant Disorder, and Conduct Disorder

[Jeneva L. Ohan](#), [Charlotte Johnston](#)

**2005**



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2008

ORIGINAL PAPER

## Racial and Gender Trends in the Use of Implantable Cardioverter-Defibrillators Among Medicare Beneficiaries Between 1997 and 2003

Clinical indications for implantable cardioverter-defibrillators (ICDs) have expanded rapidly in the past decade. Randomized clinical trials have found that ICDs reduce mortality in patients with documented ventricular arrhythmias and in those with left ventricular dysfunction who are at high risk for sudden cardiac death.<sup>1-6</sup> In addition, ICDs have also demonstrated improvements in clinical outcomes in real-world populations,<sup>7,8</sup> suggesting favorable cost-effectiveness ratios when compared with standard medical ther-

*Differences in the use of implantable cardioverter-defibrillators (ICDs) have been reported, but the extent to which they have widened after the publication of major clinical trials supporting their use is unclear. Using data on Medicare beneficiaries, the authors determined annual age-standardized population-based utilization rates of ICDs for white men, black men, white women, and black women from 1997 to 2003. During the study period, overall use of ICDs increased most for white men (81.7–254.7 procedures per 100,000 from 1997 to 2003) and black men (38.0–151.7 procedures per 100,000), with white women (28.9–98.4 procedures per 100,000) and black women (18.2–77.3 procedures per 100,000) showing smaller increases in comparison. After adjustment with multivariable regression models, differences in utilization rates between whites and men widened compared with blacks and women between 1997 and 2003, a period when indications for ICD therapy have expanded. Congest Heart Fail. 2009;15:51–57. ©2009 Wiley Periodicals, Inc.*

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# Racial and Gender Disparities in Implantable Cardioverter-Defibrillator Placement: Are They Due to Overuse or Underuse?

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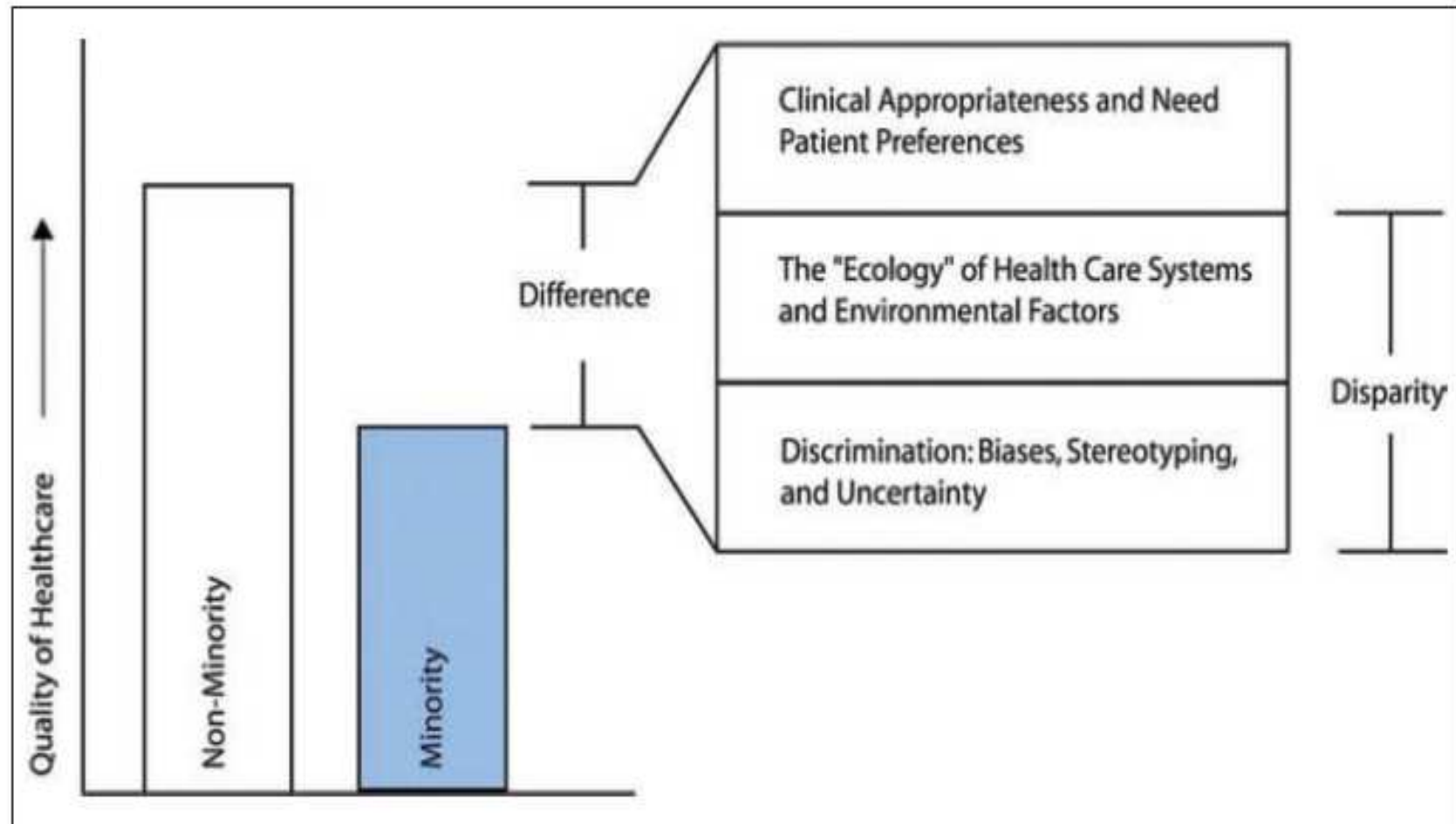


**Nakela L. Cook<sup>1</sup>, E. John Orav<sup>2</sup>, Catherine L. Liang<sup>2</sup>,  
Edward Guadagnoli<sup>3</sup>, and LeRoi S. Hicks<sup>2, 3</sup>**

**2011**

## **Abstract**

Previous studies documented racial and gender disparities in implantable cardioverter-defibrillator (ICD) placement. The authors examined whether racial and gender disparities in ICD placement are due to underutilization or overutilization. Among 1,054 adults hospitalized from 2001 to 2004 with ventricular arrhythmias in a large academic hospital, the study found that 17% of patients had clinical indicators concordant with ICD placement. Among patients with clinical indicators concordant with ICD placement, Black patients had a 1.5-fold higher risk of ICD placement compared with White patients.



**Figure 1.** Differences, disparities, and discrimination: Populations with equal access to health care

Source: Gomes and McGuire (2001) from IOM. *Unequal treatment: Confronting racial and ethnic disparities in health care*, 2002.

# Research

Anthony J Avery, Grant M Dex, Caroline Mulvaney, Brian Serumaga, Rachel Spencer, Helen E Lester and Stephen M Campbell

## Development of prescribing-safety indicators for GPs using the RAND Appropriateness Method

2011

### Abstract

#### Background

In the UK, a process of revalidation is being introduced to allow doctors to demonstrate that they meet current professional standards, are up-to-date, and fit to practise. Given the serious risks to patients from hazardous use of medicines it will be appropriate, as part of the revalidation process, to assess the safety of prescribing by GPs.

#### Aim

To identify a set of potential prescribing-safety indicators for the purposes of revalidation of individual GPs in the UK.

### INTRODUCTION

Medication prescription is one of the most powerful tools for GPs in the prevention and treatment of disease and the alleviation of symptoms. Nearly 800 million prescriptions are dispensed annually in the community in England.<sup>1</sup> However, medication-related adverse events are an important source of patient morbidity, many cases of which could be prevented by the highest-quality prescribing and medicines management.<sup>2-5</sup>

Revalidation is a single, integrated process that allows doctors working in the UK to demonstrate that they meet current professional standards, are up-to-date, and fit to practise, by providing supporting information in a revalidation portfolio.<sup>6</sup>

Although potentially useful for analysing prescribing patterns, these data are rarely linked to diagnoses and patient characteristics, and so have limitations when assessing quality and safety. Other indicators have required very detailed analysis and assessment of clinical records (for example, the medication appropriateness index<sup>7</sup>), which would not be feasible for the large-scale assessment of all GPs in the UK.

The evidence base for developing quality indicators for safe prescribing is limited; however, systematically combining available evidence with expert professional opinion using a consensus methodology can create quality indicators in areas where

## Box 1. Inclusion and exclusion criteria

### Inclusion criterion

1. The indicator describes a pattern of prescribing that is potentially hazardous and may put patients at risk of harm.

### Exclusion criteria

1. The indicator describes a pattern of prescribing that could not easily be attributed to a single doctor.
2. The indicator describes optimal prescribing for long-term conditions where prescribing decisions are likely to be made over time (potentially by more than one prescriber), rather than at a single consultation.
3. The indicator describes a pattern of prescribing that is so unusual in UK general practice that the yield is likely to be too low to justify inclusion in the indicators set.
4. Extraction of data required for the indicator (from general practice electronic health records) is unlikely to be feasible.

Multiple sources of information were used to identify potential indicators;<sup>11-24</sup> these are outlined in Table 1. These sources were identified by one of the researchers with the help of a reference group between August 2008 and March 2009. The indicators developed in this project were derived mostly from existing sources because of the considerable amount of work that has been done on prescribing-safety indicators in other countries and other settings.<sup>11-24</sup> Over 400 prescribing indicators were reviewed against the inclusion and exclusion criteria and against attributes of good indicators, including importance, validity, and feasibility of data collection using electronic health records.<sup>10,25</sup>

After removing duplicates, 50 indicators were considered suitable for inclusion in round one of the subsequent consensus technique. Of these, 44 came from a least one of the sources highlighted in Table 1; four came only from the *British National Formulary (BNF)*<sup>14</sup> and two only from the draft design specification for NHS IT systems.<sup>15</sup>

### Defining the indicators and evidence base

In most cases, indicators were defined according to the wording used in previously published studies and reports but, in some instances, this was altered either to make

indicators from the sources included are shown in Table 1. For example, many Assessing Care of Vulnerable Elders<sup>11</sup> indicators developed in the US, relate to process measures rather than prescribing decisions that can be attributed to one GP; likewise, some of the Beers criteria<sup>13</sup> and indicators of the Screening Tool of Older Persons' potentially inappropriate Prescriptions (STOPP)<sup>24</sup> relate more to the appropriateness of prescribing than safety.

The indicators were presented in the following categories:

- A: cardiovascular and respiratory disease;
- B: central nervous system (including analgesics);
- C: anti-infective agents;
- D: women's health and urinary disorders;
- E: musculoskeletal;
- F: hazardous co-prescriptions, interactions, and allergy; and
- G: laboratory-test monitoring.

### Consensus process

The RAND Appropriateness Method was used to select the most appropriate indicators. This method seeks to combine scientific evidence with the collective



# Validation of prescribing appropriateness criteria for older Australians using the RAND/UCLA appropriateness method

2012

Benjamin Joseph Basger, Timothy Frank Chen, Rebekah Jane Moles

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## ABSTRACT

**Objective:** To further develop and validate previously published national prescribing appropriateness criteria to assist in identifying drug-related problems (DRPs) for commonly occurring medications and medical conditions in older ( $\geq 65$  years old) Australians.

**Design:** RAND/UCLA appropriateness method.

**Participants:** A panel of medication management experts were identified consisting of geriatricians/pharmacologists, clinical pharmacists and disease management advisors to organisations that produce Australian evidence-based therapeutic publications. This resulted in a round-one panel of 15 members, and a round-two panel of 12 members.

**Main outcome measure:** Agreement on all criteria.

**Results:** Forty-eight prescribing criteria were rated. In the first rating round via email, there was disagreement

## ARTICLE SUMMARY

### Article focus

- Drug-related problems (DRPs) are common in older people. They may result in drug treatment goals not being achieved and/or the occurrence of adverse drug events.
- The aim of this study was to further develop and validate a previously published list of prescribing appropriateness criteria for use in older people which may be used to improve the quality of the Australian medication review process, and for quality assessment and education in medicine use.

### Key messages

- The use of medication assessment criteria is one method to assist in identifying DRPs. Criteria developed elsewhere may have little or no applicability to

Fulvia Signani

# LA SALUTE SU MISURA

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