

## Diagnostic and therapeutic procedures among Australian hospital patients identified as Indigenous

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TO THE EDITOR: Cunningham has shown that in Australian public hospitals patients identified as Indigenous are significantly less likely than other patients to have a principal procedure recorded.<sup>1</sup>

This finding is based on data collected by the Australian Institute of Health and Welfare using the coding scheme of the *International classification of diseases*, 9th revision, clinical modification (ICD-9-CM). No information was available about the clinical indications for conducting a principal procedure. Despite this crucial omission, Cunningham speculates about the reasons for the disparity in the rate of procedures between Indigenous and non-Indigenous patients. These speculations include alarming suggestions such as the possibility of systematic discrimination against Indigenous patients of both an institutional and personal nature. She then concludes that "Work is urgently needed to characterise more fully the nature, level, sources and consequences of institutional and interpersonal discrimination so that we can reduce unfair treatment, ensure equitable care and improve outcomes for the most disadvantaged Australians".

These speculations and conclusions are simply unjustified by the data. In addition, such comments may cause more harm than good — Indigenous people have become extremely sensitive about medical and social research and may reject future investigations that are essential to their welfare.

There are reasons other than adverse discrimination which may explain the data. These include the common rejection by

Indigenous patients of medical advice to have a procedure (they may well be adopting the wisest action), and their more frequent admission to hospital (rather than outpatient care), as they may have travelled from remote communities (ie, there are social criteria for admission without the need for medical procedures). Furthermore, the quality of the data must be questioned, as many Indigenous patients are admitted to hospitals where the data forms are completed by unskilled personnel who do not understand the meaning of a "principal procedure".

1. Cunningham J. Diagnostic and therapeutic procedures among Australian hospital patients identified as Indigenous. *Med J Aust* 2002; 176: 58-62. □

### Joan Cunningham

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IN REPLY: Lawson suggests that my conclusions<sup>1</sup> are not justified, and that they may "cause more harm than good". I strongly disagree.

He suggests a number of alternative explanations, including "social" admissions for remote patients, and poor coding, but these do not account for the differences observed. Over half of the separations identified as Indigenous were of urban (19%) or rural (33%), rather than remote, area residents. Disparities in procedures for Indigenous and other patients were evident for each area. Almost half (46%) the separations identified as Indigenous were in principal referral or major hospitals, where coding should be of a high standard. Indigenous-non-Indigenous disparities existed within each hospital category. The results presented in my report<sup>1</sup> were adjusted for area of residence, hospital category, as well as several other factors, and large differences in procedures remained.

Lawson also suggests that rejection of medical advice by Indigenous patients may play an important role. Rejection of advice certainly occurs on occasion, by both Indigenous and non-Indigenous patients. I question whether it is "common", as Lawson suggests, but that is not really the point. It would be far more productive to ask why and how this occurs, and how interactions between healthcare providers and Indigenous patients can be improved.

Lawson takes exception to my raising the possibility of systematic discrimination in the Australian healthcare system, referring to it as "alarming". In that we are in complete agreement. I, too, find it alarming. However, unlike Lawson, I choose not to deny it, but to accept it as an important challenge. My aim is not to make medical practitioners defensive, but to invite them to participate in finding ways to reduce disparities. Systematic discrimination can occur even when well-meaning people are trying to do the right thing. The systems in which we work can defeat our best intentions, even when we don't realise it. The reasons why a procedure was not performed on a particular patient may be perfectly sound given the circumstances. What we must ask ourselves is how those circumstances came to be, and what we can do to change them.

I agree with Lawson that some Indigenous people are sensitive about research, but I do not accept that they will "reject future investigations that are essential to their welfare". On the contrary, I expect that many Indigenous people would be happy to participate with healthcare providers in the development and implementation of creative solutions to improve the healthcare system.

1. Cunningham J. Diagnostic and therapeutic procedures among Australian hospital patients identified as Indigenous. *Med J Aust* 2002; 176: 58-62. □

## Hindsight bias in medicolegal expert reports

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TO THE EDITOR: It is possible to diminish bias, especially in litigation concerning general practitioners.<sup>1</sup> First, request all the defendant's clinical notes about the patient, not merely the records of the incident. Then, before reading the allegations or the history following the incident, read the entire history of the patient's contacts with the doctor or the practice: frequency of

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