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EDITOR'S PAGE

What Is Appropriate: *uh*-proh-pree-it [*adj.*] or *uh*-proh-pree-yet [*v.*]?

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Webster's Dictionary gives us 2 ways to pronounce the word spelled "appropriate" and more than 2 definitions (1). One definition for the verb is "to take exclusive possession of to the exclusion of others." For the adjective it is "suitable for a particular person, condition or occasion . . ." As it is currently being applied in the selection for cardiovascular procedures, the word "appropriate" is taking center stage. Not the verb, although some of our critics would like to believe that device and procedure selection is for personal gain "to take possession of" and therefore to receive the benefit from. Another definition of the verb should be of interest to us, that is, the appropriation of our collective resources to health care research, and so on. That could be the subject of another epistle. But, it is not the verb that is creating so much interest. It is the adjective, "appropriate," that sounds so benign. Even Aunt Lucy from Peoria would find this term perfectly reasonable. The only problem is that the opposite of appropriate is inappropriate. This is far less nuanced, so that the American College of Cardiology (ACC)/American Heart Association guidelines, which espouse 4 levels of advice, are always accompanied by the disclaimer that they are not to be used to judge whether a procedure should be allowed. However, if you ask a third party payer what "appropriate" means, it is pretty clear that they prefer to think about "approved" or "disapproved."

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Do not get me wrong. I am a strong supporter of quality assurance and improvement, and I believe that the evidence generated by clinical trials and careful observation should be compiled to refine our judgment. This process is best applied by those in the profession in order to achieve better outcomes for our patients. The concern is that others who are not charged with delivering care will find the dichotomous separation of "appropriate or not" to be an easy and attractive tool to constrain the performance of helpful therapies. Indeed, our appropriateness document does state, "Appropriateness criteria are intended to assist patients and clinicians but are not intended to diminish the acknowledged difficulty or uncertainty of clinical decision-making and cannot act as substitutes for sound clinical judgment and practice experience" (2). This is a beautiful statement that I am sure was crafted with the same care that Thomas Jefferson applied to our Declaration of Independence. On the other hand, the number of scenarios that can be classified for appropriateness, by necessity, are limited. Nonetheless, the attempt to define appropriate selection for interventions, as has been done for imaging procedures, is important, and it is critical that it be done by the profession.

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How can we utilize the existing evidence and the documents created by our College to improve our informed judgment in a way that will satisfy not only Aunt Lucy in Peoria, but also those who may be incentivized to find fault with our selection (i.e., payers)? A survey of all the catheterization laboratories in New York State by the New York Cardiac Services Program revealed that although all have careful outcomes assessment processes, selection for revascularization is monitored incompletely. It ranges from no formal system for reviewing selection, to systematic selection of up to 25% of cases for internal review, and in some laboratories, mandatory external review.

The ACC has joined with the Society for Cardiac Angiography and Interventions to sponsor an accreditation process organization, ACE (Accreditation for Cardiovascular Excellence), which will provide external review to assess facilities, personnel, quality assurance, safety protocols, and indications and outcomes (3). A certificate will be awarded to laboratories that achieve predetermined benchmarks. This process has been applied to some laboratories performing carotid stenting and is planned to include laboratories performing other procedures, including coronary

JACC: CARDIOVASCULAR INTERVENTIONS, VOL. 4, NO. 3, 2011
MARCH 2011:363–4

interventions. This effort could help stimulate facilities to develop systematic processes to ensure the appropriate selection for therapeutic revascularization.

Some of the suggested models for improving selection have been put in place. George Dangas shared with me the idea of placing the figures from the appropriateness document in plain sight in each catheterization laboratory (Fig. 1). We have followed that advice in my hospital. Dr. Samin Sharma has taken the step of having noninvasive cardiologists review his cases prospectively to see if they fit appropriateness criteria. The European Society of Cardiology guidelines state that for multivessel disease patients, a recommendation for revascularization should include input from "the heart team" composed of a noninvasive cardiologist, an invasive cardiologist, and a cardiac surgeon. Although the intent of this recommendation is laudable, the practicality of assembling all of these individuals to discuss each case is daunting. Another approach we have used is to have a proportion of randomly selected cases presented at a monthly conference on revascularization. Since no one knows whose cases will be presented, this process acts as a type of audit that everyone is subject to and must think about when selecting patients for a procedure. We have previously discussed the value of taking questionable patients off the catheterization table so that a full discussion of their options can be made and well understood informed consent can be provided (4). This practice could ensure that no cases judged inappropriate would be performed without further consideration. It is unlikely that one process will fit all laboratories, but the development of a process is essential. The ACC has been the leader in developing standards, guidelines, and appropriate indications, and most laboratories now participate in the National Cardiovascular Data Registry. No one enjoys responding to allegations such as those that have occurred in recent months. It is much better to establish a proactive way to assure ourselves of appropriate selection. If we do that, the explanation to others, including Aunt Lucy in Peoria, will be easier. As opposed to the verb, the adjective "appropriate" is not an easy word to define. My favorite definition is Webster's first, "... is suitable for a particular person" (1). If we think of that person as ourselves, we should not be too far off base. The challenge is to prove that is what we are doing.

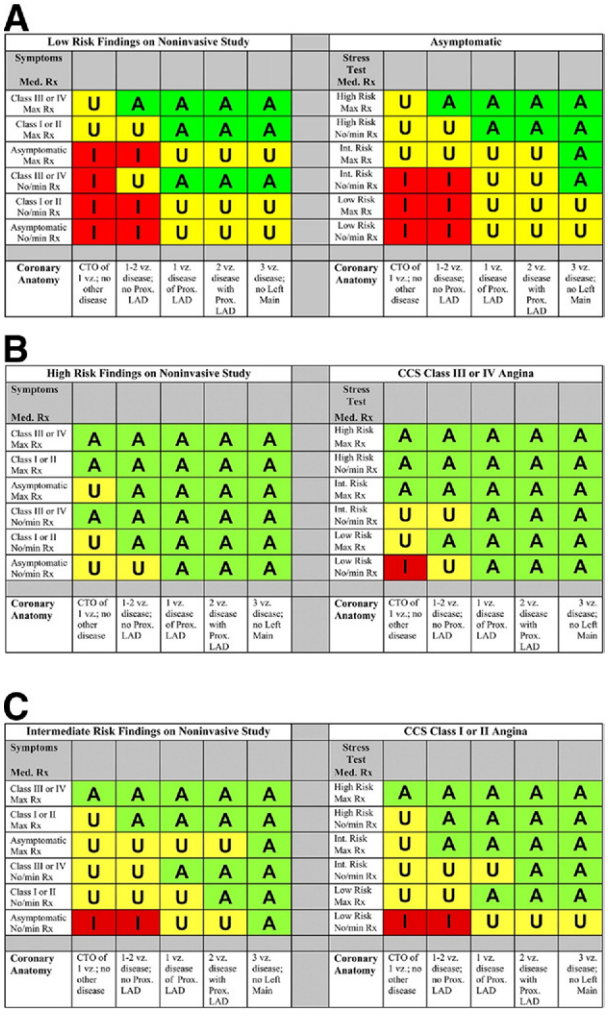

Figure 1. Appropriateness Criteria for Coronary Revascularization

Reprinted, with permission, from Patel et al. (2). A = appropriate; CCS = Canadian Cardiovascular Society; CTO = chronic total occlusion; I = inappropriate; Int. = intervention; Med. = medical; Prox. LAD = proximal left anterior descending artery; Rx = treatment; U = uncertain; vz. = vessel.

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