



## **ENGAGING PATIENTS IN REDUCING LOW VALUE CARE MORE EFFECTIVE THAN DOCTOR-TARGETED CAMPAIGNS**

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TO protect themselves from the potential harms of low value care, patients must take an active role in clinical decision making, according to the authors of a Perspective published today by the *Medical Journal of Australia*.

Professor Ian Scott, Director of Internal Medicine and Clinical Epidemiology at the Princess Alexandra Hospital in Brisbane, and Professor of Medicine at the University of Queensland, and colleagues defined low value care as “care that is ineffective, harmful or confers marginal benefit at disproportionately high cost”.

While professionally-led campaigns such as Choosing Wisely Australia and the Royal Australasian College of Physicians’ EVOLVE program, aim to reduce the prevalence of low value care by alerting doctors to commonly overused interventions, “evidence appears stronger and impact seems greater for strategies directed to, or mediated by, patients”, wrote Scott and colleagues.

“Reframing low value care as having negative consequences, not just ‘worth a go’ or ‘better safe than sorry’, may incentivise patients, clinicians and policymakers to engage more in mitigation efforts,” they wrote.

“Negative consequences can arise directly from an episode of low value care, or indirectly from subsequent downstream care cascades, such as invasively investigating incidental but benign findings from a previous unnecessary investigation.

“Harms can be physical, psychological, social, financial and relational (mistrust).

“Even providing potentially beneficial care to patients who do not want it can cause harm, at least psychologically.

“Moreover, giving low value care to one individual may result in delayed delivery of high value care to another individual, who may then suffer preventable harm.”

Scott and colleagues argued that research evidence suggests “many patients perceive the negative consequences of overuse, and interventions that empower patients to challenge such overuse are effective in decreasing it by 25-40%”.

Successful engagement, they wrote, depended on several factors:

- motivation and ability of clinicians to engage patients in decision making;
- clinician knowledge of, and agreement with, what constitutes low value care;
- the clinical context; and,
- availability of decision support resources for both parties within clinical workflows.

“Such engagement is time-consuming for clinicians and inadequately remunerated, impractical in emergency situations or for patients unable or unwilling to engage, and may incite patient anxiety or dissuade them from further consultations,” wrote Scott and colleagues.



“However, evidence-based strategies can overcome these barriers and reinforce patient perceptions of receiving optimal care and their desire to reconsult.”

The authors recommended that patients be encouraged to ask the following questions:

- **Is there a decision we need to make?** In urgent situations, clinicians may need to reach out and not wait for patients to ask.
- **What are my options?** All clinically viable options should be presented, including doing nothing.
- **What are potential benefits and harms of each option?** Where possible, these should be expressed using natural numbers (eg, four out of 100 people like you will experience a stroke every year; this treatment will reduce that to two out of 100, although one person of 100 will have a significant bleeding event).
- **How will each option affect me in terms of what I consider important?** Patients may want to know costs involved, duration of inability to work or perform social activities, skill and place of those performing a procedure.

“Efforts to increase patient empowerment in decision making should be seen as foundational for reducing low value care, and should underpin all other strategies targeting clinicians, payers and policymakers,” Scott and colleagues concluded.

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