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VIEWPOINT ARTICLE

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From concept to clinical application: The importance of including trust in low-value care curricula

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Low-value care—medical services that provide little or no benefit to patients compared with their harms, alternatives and costs—is a common and costly global problem.[1–3] Unnecessary medical services not only yield billions of dollars in wasteful spending each year but also cause physical, psychological and financial harm to patients.[4,5] While campaigns, such as *Choosing Wisely*, *Choosing Wisely Canada* and *Choosing Wisely UK* target practicing clinicians internationally,[6] many medical schools have begun to pre-empt this problem in future generations by teaching students about wasteful care. Much of this teaching focuses on clinical guidelines, the costs associated with excess medical services and clinical reasoning around test-ordering.[7] However, teaching students clinical guidelines and methods of reasoning to avoid unnecessary services may be insufficient, as trust plays an important role in uptake of guidelines and avoidance of waste. Emphasising trust-building skills alongside teaching about low-value care in medical education may thus improve the efficacy of existing low-value care curricula. Students should be equipped with skills to develop different aspects of trust, including trust in health systems, interpersonal relationships, and self (Figure 1).[8]

Providing high-value care requires a degree of trust in health systems. For instance, health care providers must be able to trust guideline development processes and the data used in order to trust the corresponding recommendations. Historically, guidelines have represented a unified voice from professional organisations on best practices. However, throughout the uncertainty of the COVID-19 pandemic, we saw that some clinicians express a lack of trust in organisations issuing recommendations due to rampant misinformation.[9,10] Similarly, patient trust in health systems and recommendations has similarly decreased in recent years due to misinformation and inconsistencies in recommendations throughout the pandemic.[11,12] In teaching guideline-based care, it is thus critical to teach students about where guidelines come from, how guidelines are developed and guidelines' quality of evidence so that students themselves can critically appraise the recommendations and make judgements about their clinical use and trustworthiness. This not only fosters their own trust in guidelines but also enables students to explain the basis of recommendations to potentially weary patients who must be able to trust that the health care system will provide care that is both effective and free of avoidable harms, costs and violations of dignity.[13]

Patients must also be able to trust in their provider's ability to ensure safety and consistently provide high quality care. Patients' trust in clinicians is shaped not only by their medical expertise but also by patient perceptions of clinician compassion, competence and care.[11] Interpersonal trust between patients and clinicians is especially important for fostering open dialogue when establishing what outcomes matter most to patients, discussing the value of a test requested by a patient or explaining clinical guidelines that contradict patient expectations. Teaching patient-centred communication strategies, such as PEARLS (Partnership, Empathy, Acknowledgement, Respect, Legitimization, and Support), alongside value-based care principles may help students build trust and rapport with patients when value conversations come up, allowing for patient-centred application of appropriate care.

Clinicians often cite fear of missing something, lack of time and a desire to be responsive to patients as reasons for engaging in wasteful care.[14] In order for classroom teaching to translate to the clinical setting, students and trainees must therefore be equipped with tools that allow them to trust their clinical judgement and their ability to effectively engage in potentially challenging conversations with patients about waste. To address concerns about missing something when choosing not to order potentially unnecessary medical tests, students

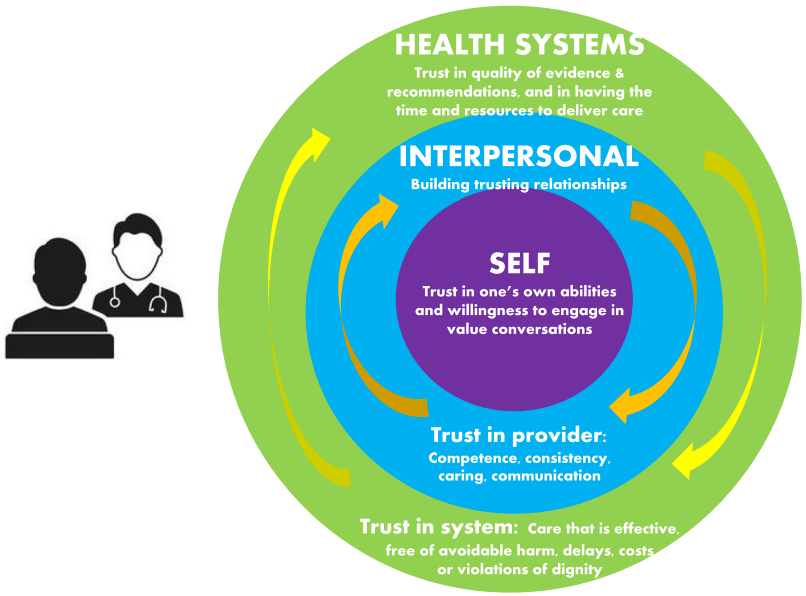

FIGURE 1 A framework for trust in high-value care.

must be shown that clinically significant findings on low-value testing are the exception, not the rule, and that contradicting evidence-based guidelines without a strong clinical reason often does more harm than good. Similarly, teaching a framework for discussing value with patients that includes the anticipated natural history of disease, how medical tests may alter care, the benefits and downsides of tests and treatments and possible alternatives,[14] may allow students to feel more confident in their abilities to effectively and efficiently engage patients in value conversations. Preparing for and anticipating such conversations, combined with a strong foundational framework, can empower students to efficiently facilitate these discussions, even among time constraints.[15] With this knowledge, comfort and confidence, students may be more likely to apply appropriate guidelines to their clinical practice.

Though teaching about low-value care in undergraduate medical education is a critical first step in eliminating waste and improving value, students must also learn to engage with guidelines, to trust themselves to effectively apply them and to build trusting relationships with patients that allow for shared decision making. Without incorporating these aspects of trust into medical school curricula, students may lack the skills necessary to apply their knowledge of low-value care to the clinical setting.

AUTHOR CONTRIBUTIONS

Kathleen L. Mulligan: Conceptualization; writing—original draft; writing—review and editing. **Elina Kurkurina**: Conceptualization; writing—original draft; writing—review and editing. **Rahul Anand**: Conceptualization; writing—original draft; writing—review and editing.

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ETHICS STATEMENT

As this piece is not a research article, no ethical approval was necessary.

CONFLICT OF INTEREST STATEMENT

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DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no datasets were generated or analysed during the current study.

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