

CONVERSATIONS ON LOW-VALUE CARE

Language Matters: Talking About Low-Value Healthcare With Patients

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Let's say you're a physician and you are trying to explain to your patient why a particular procedure or treatment option does not represent a good value. You can talk about value in a variety of ways. You don't want to waste the time that it will take the patient, and the providers, to deliver that treatment. You can explain that all medical treatment costs money, and this option is expensive compared with other approaches. Or you can point out that all medical interventions carry some level of risk, and the benefits of this one are quite low relative to those potential risks. Whatever the reason, the treatment is considered low value.

Treatment choices should always provide the highest possible value to every patient within the parameters of evidence-based medicine. No one wants to waste resources or engage in practices that don't work very well, significantly impair quality of life, or incur costs equal to or higher than those of other effective treatments.

But for many patients, what makes sense to the physician and reflects evidence-based practice can seem abstract, impersonal, or even threatening. The problems can arise because although providers and patients often share the same goals for their care and treatment, they use different language or understand language differently when it comes to having discussions about what constitutes high- versus low-value treatment. The success or failure of conversations about value in healthcare frequently hinges on the words that are used in these discussions and the way that the options are explained to individual patients.

This cognitive and semantic dissonance begins with the word "value," a word that can mean many things depending on who says it and in what context. For healthcare providers, value generally connotes an algorithm that measures benefits versus costs. In most cases, value includes an assessment of the resources required to produce the desired outcomes. Resources almost always involve money, the cost to the system or the patient, but can also

encompass time or opportunity costs. At one end of the spectrum, treating advanced cancer that has failed to respond to other therapies with a fourth or fifth line of chemotherapy, which is expensive and causes significant adverse events, is very likely to be low value. At the other, an emergency department visit, x-ray, and specialist consultation for a simple ankle sprain may be less dramatic, but also clearly low value. Both interventions allocate resources for interventions that have very low probabilities of achieving good outcomes for the patient. Nonetheless, patients may push for these and other low-value approaches because they perceive a potential individual benefit.

When patients talk about value, however, resource allocations, direct costs, time, and the other factors that go into developing the algorithms are far from their minds. Patients generally aren't interested in or knowledgeable of mathematical formulas when they think about their healthcare decisions. They want to know if you can cure their cancer or, if you can't, how long and how well they can live. They want to be reassured that their swollen ankle isn't really broken. Value for patients means getting what matters most to that patient at that specific time in their lives. Value is most often an individual, personal assessment rather than an evidence-based, systemic one.

This can mean that when the doctor talks about a treatment being low value, the patient may hear that they are not worth the time, effort, or costs involved in delivering that treatment. That physician may be trying to save the patient from something that is unnecessary or ineffective, whereas patients perceive that something is being taken away from them. Doctors may frame their recommendations in terms of what is wasteful to the system. Patients think less about the system and far more about their individual needs and wants, and they tend not to want to hear that their treatment is "wasteful" or "low value."

Issues related to language and perception are often more prevalent and more serious with traditionally underserved populations. Medicaid patients and those who face severe financial toxicity can be highly sensitive to the idea that they, not the treatment options, are low value. They may fear that they are being offered lower-level care because they lack the resources to pay for the higher-end treatments available to others. For these vulnerable patients, words like "wasteful" or "high cost" can sound like code that means "I'm getting a lower tier of treatment."

Physicians and other healthcare providers who engage in treatment decision making with patients can avoid both these misunderstandings and their consequences by becoming more aware of the language they use when they talk to every patient about high- and low-value care. It is critical and in everyone's best interest

to identify and reduce the low-value care that we deliver in our healthcare system. We do not have unlimited resources, and we do have to make rational, systemic decisions about how best to use what we have. In addition, we are currently in the midst of a remarkable era in which new, highly effective, individualized treatments are emerging. Removing the waste and low-benefit interventions from our medical care system is one path to freeing the resources needed to ensure that everyone has access to these advances. We can, for example, see real, documented high value in genomic sequencing for patients with lung cancer who can then benefit from targeted therapies rather than more scattershot, less effective treatments.

Patients need to understand the meaning of low- versus high-value treatments in terms that they understand and that address their values. Physicians can help this happen by talking specifically about benefits and risks for the individual patient, not the system. What we will learn from this procedure that will make a difference in how we treat your condition? What does this drug cost compared with one we think can be just as effective? Can we have a treatment plan that doesn't require you to come to the clinic as often? What can you realistically expect in terms of a longer life, or quality of life, if we do another round of chemotherapy instead of palliative care?

In the end, it is all about effective communications between providers and their patients, and effective communications depend on trust. Trust is never a one-way street. Patients, of course, need to trust their providers, but providers need to trust their patients to know what matters to them. Conversations that take place about what is high or low value have to keep the individual patient's care, safety, and best outcomes at their heart, and they must be true dialogues, shared and understood by everyone involved. That is, in itself, a very high value.

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