

De-implementation of Low Value Care and the role of behavioural science in Healthcare Quality Improvement

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Dear Editor,

Implementing change to clinical practice is challenging as it requires addressing the needs and existing beliefs of clinicians both as individuals and as a group. It is our observation that interventions aimed at bringing about behavioural change in healthcare frequently default toward attempting to improve motivation through education or persuasion, despite it being clear that clinicians are often already motivated to deliver high-value care.

The COM-B model proposes that behaviour is dependent not only on motivation, but also on capability and opportunity, and that sustainable change is unlikely if any of these domains remain unsupported.¹ While much work has been carried out in recent years with regard to implementing change at shop-floor level in healthcare, including the publication of the HSE Health Services Change Guide in 2023², it is our opinion that addressing the behavioural change aspect of such work is vital to ensure sustainable outcomes.³

De-implementing low value care requires clinicians to alter embedded individual and collective behaviours within complex social and organisational systems. As part of a larger project aimed at de-implementing low value care by reducing the number of unnecessary coagulation tests ordered in a Paediatric Emergency Department, doctors of all grades working in our Paediatric Emergency Department were invited to complete a structured survey examining their capability, opportunity and motivation to undertake such a change in their clinical practice. Clinicians across all grades demonstrated clear motivation to reduce unnecessary coagulation testing and recognised the potential environmental, financial and clinical benefits of doing so. Strikingly, our survey revealed that barriers to de-implementing change differed according to clinicians' capability and opportunity to enact the desired behaviour.

Among more junior clinicians, the dominant theme related to capability. Junior clinicians described habitual defensive investigation practices, uncertainty regarding indications for testing, and perceived pressure from inpatient teams and families. Although motivated to reduce unnecessary testing, they identified a need for explicit written guidance, decision

supports and repeated reinforcement at the point of care in order to confidently change practice. In contrast, senior clinicians generally reported already possessing the knowledge and confidence required to order fewer tests but instead focused on opportunity-based interventions such as restricting access to coagulation bottles or requiring clinical indications before laboratory processing. This divergence demonstrates how clinicians occupying different roles within the same department may require fundamentally different implementation strategies despite sharing the same overall goal.

Our survey suggests that meaningful clinical change requires meaningful engagement with the clinicians expected to enact that change. While motivation appeared strong across all grades, the mechanisms required to translate that motivation into behavioural change differed substantially between groups. Interventions focused solely on “convincing” clinicians to change risk overlooking the more practical barriers that determine whether change is achievable in day-to-day practice. Supporting junior clinicians through capability-enhancing measures such as clear guidance and decision supports, while addressing opportunity through environmental restructuring for senior staff, may therefore represent a more effective and sustainable approach to de-implementing low value care within the Paediatric Emergency Department.

Declaration of Conflicts of Interest:

None declared.

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