TEXTO & CONTEXTO ENFERMAGEM
TEXT & CONTEXT NURSING TEXTO & CONTEXTO ENFERMERÍA

DE-IMPLEMENTING LOW-VALUE CARE: THE IMPACT OF WHAT WE CHOOSE NOT TO DO

Ruy de Almeida Barcellos[1,2]
Patricia Treviso[1,2]
Mara Ambrosina de Oliveira Vargas[3]

[1]Universidade Federal do Rio Grande do Sul, Escola de Enfermagem e Saúde Coletiva, Departamento de Enfermagem Médico-Cirúrgica. Porto Alegre, RS, Brasil.
[2]Hospital de Clínicas de Porto Alegre. Porto Alegre, RS, Brasil.
[3]Universidade Federal de Santa Catarina. Florianópolis, SC, Brasil.

Healthcare systems face the challenge of balancing rising costs with outcomes that truly matter to patients. The Value-Based Health Care (VBHC) movement proposes a profound transformation in the way care is understood, in which value is measured not by the number of procedures performed, but by the outcomes that are meaningful to patients in relation to the resources used[1]. This approach challenges practices that persist more out of tradition than effectiveness and calls on professionals to reorient care toward what is relevant, safe, and humane.

The international debate on low-value care emerged in high-income countries, driven by initiatives such as Choosing Wisely and the sustainability agenda of universal health systems. However, translating this concept to contexts of scarcity and inequality, such as those in Latin America, requires recognizing that the problem is not only the overuse of interventions but also the absence of what is essential to care.

In these contexts, especially in Brazil, this reflection encompasses ethical and clinical aspects that are not always adequately articulated. Nursing, due to the breadth of its practice and its closeness to patients, plays a decisive role in adapting practices and promoting efficient, equitable, and person-centered care[2]. Commitment to value implies recognizing that practices carried out in the name of safety or routine must be aligned with evidence and clinical necessity. Providing value-based care means discerning what truly contributes to patient safety and well-being and, when appropriate, reviewing or replacing what does not add real benefit.

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Low-value care can be defined as any practice that uses resources and professional time without offering relevant clinical benefits, being disproportionate to risk, cost, or patient needs, and potentially causing harm or diverting attention from what truly matters in care[3,4]. In Nursing, it manifests both in unnecessary administrative tasks and in standardized clinical interventions performed by tradition that neglect individualized care and attention to each person's specificities. Examples include procedures carried out at rigid, standardized intervals without reassessment or individualization of need, and preventive interventions applied indiscriminately regardless of risk classification established by care scores. Collectively, these practices drain time, energy, and institutional resources, reduce space for clinical reasoning, and weaken the therapeutic bond that constitutes the essence of caring. Figure 1 conceptually synthesizes this pathway, linking low-value care and value-oriented de-implementation in Nursing practice.

The figure synthesizes the pathway between low-value care and conscious de-implementation, in light of Value-Based Health Care, highlighting practices that consume time and resources without relevant clinical benefit, as well as the role of de-implementation as an active, ethical, and contextual process guided by clinical judgment, scientific evidence, and patient-centeredness.

Although advances in protocols and processes have brought significant gains in safety and quality of care, the accumulation of controls and secondary tasks has generated a new paradox: the more care is structured into routines and documentation, the greater the risk of distancing nurses from patients. Time of presence—the essence of care—has been replaced by time devoted to documentation and control. When standardization exceeds the limits of clinical relevance and ignores the singularity of care, there is a tendency to do everything for everyone, diluting what is essential and emptying the meaning of Nursing work.

Identifying what constitutes low-value care, however, is not simple. One of the main challenges lies in distinguishing practices proven ineffective from those whose evidence remains uncertain. Labeling uncertainty as uselessness stifles innovation, while maintaining routines without evidence perpetuates waste. The way forward is to classify practices according to strength of evidence and risk, test gradual withdrawal with exception criteria, and monitor clinical and experiential outcomes.

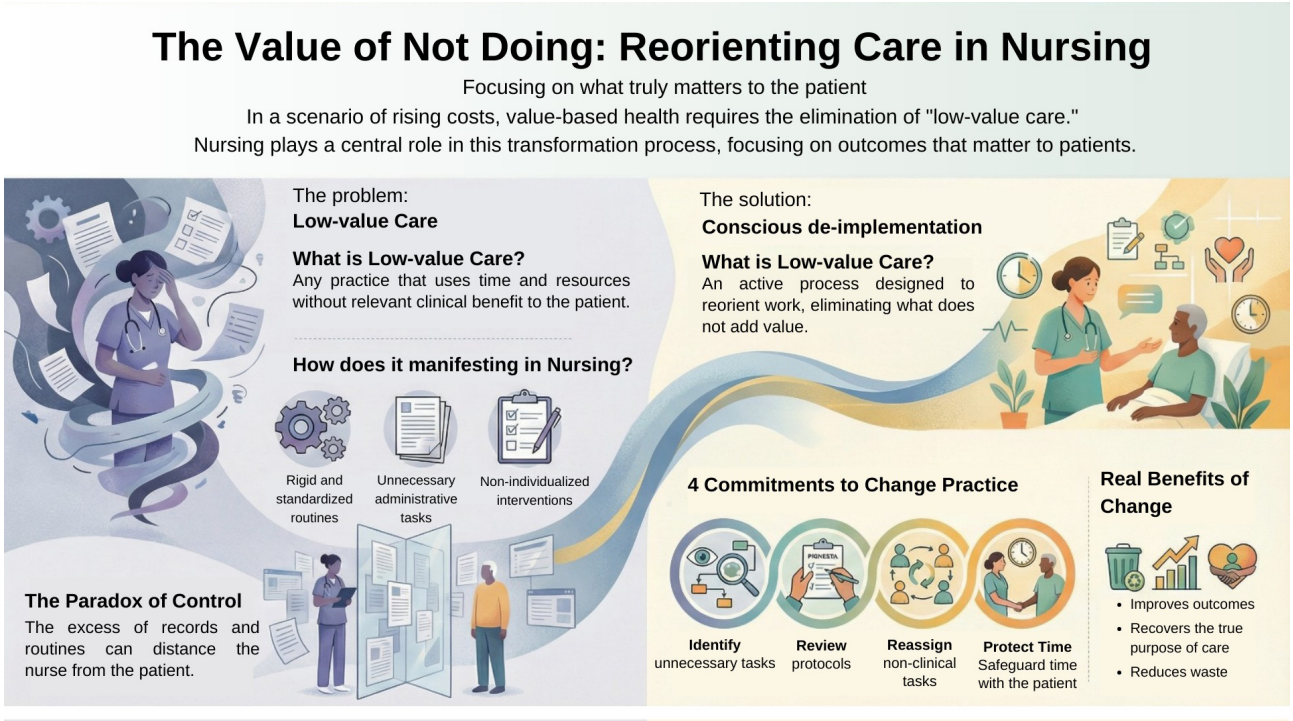

Figure 1 – Conceptual representation of the value of not doing in Nursing.

Practices with consolidated evidence of ineffectiveness should be prioritized for removal, whereas those marked by uncertainty require robust research and cautious use guided by clinical judgment and patient preferences[4,5,6].

Despite conceptual advances, important gaps remain in measuring and de-implementing low-value Nursing care. The literature shows that interventions aimed at reducing overuse are rarely tested with methodological rigor and often lack indicators sensitive to Nursing practice. Implementation science offers promising pathways by articulating multifaceted strategies of education, audit, and organizational management to promote sustainable change in clinical practice[4,6].

In this context, de-implementation does not simply mean ceasing to perform certain practices; rather, it involves reorienting practice itself. It is an active process, grounded in implementation science and guided by the ethical principles of care. Four commitments make de-implementation operational: identifying activities that consume time without contributing to decision-making; revising protocols according to risk; reallocating non-clinical tasks to non-care support personnel; and protecting nurses' time at the bedside. International evidence indicates that, when conducted systematically, de-implementation reduces waste, improves outcomes, and has become an effective strategy for enhancing quality and sustainability[4]. In alignment with initiatives such as the Choosing Wisely campaign, this approach encourages Nursing to critically reflect on the rational use of resources and the value of its own practices, reaffirming its commitment to value, safety, and the very purpose of caring[6].

Nevertheless, this process entails ethical, cultural, and institutional challenges, as de-implementation is simultaneously a technical and an ethical act. It requires nurses to exercise professional autonomy in determining the appropriateness of bedside interventions, supported by governance structures that provide institutional backing, performance indicators, and the capacity to review clinical protocols. Resistance rooted in tradition, legal uncertainty, and the difficulty of changing deeply embedded clinical behaviors remain among the most widely recognized barriers. Overcoming these obstacles requires shared leadership, effective communication, and the engagement of interprofessional teams. Ultimately, the success of de-implementation depends on organizational environments that recognize nurses' clinical judgment and create the conditions necessary for the responsible exercise of professional autonomy.

Another aspect deserving careful consideration concerns the expansion of Nursing's scope of practice, which has historically encompassed clinical, managerial, and educational responsibilities. Administrative, logistical, and operational activities legitimately form part of this role, particularly in Latin American settings, where the coordination of patient care and healthcare teams is often concentrated in a single professional. However, when institutional demands come to dominate daily practice without directly contributing to the quality of care or addressing patients' needs, a subtle yet profound shift occurs away from the essence of caring. This overlap of responsibilities may transform nurses into managers of tasks rather than managers of care. Recognizing and balancing this boundary is an essential component of the de-implementation process and of rebuilding value-oriented practices. Rather than diminishing Nursing's managerial role, this movement redefines it as a mechanism for promoting quality, efficiency, and patient-centered care.

Low-value care threatens not only the sustainability of healthcare systems but also the meaning of professional practice itself. By eliminating practices that are unnecessary, inappropriate, or unsupported by evidence, Nursing reclaims the fundamental purpose of care and restores coherence among knowledge, practice, and ethical values. In healthcare settings where access and quality depend on the rational allocation of resources, a commitment to value is also a commitment to equity. Delivering value to patients requires critical reflection on everyday practice, a willingness to question established routines, and the courage to embrace change. The true value of care is not measured by the number of tasks completed, but by the quality of the decisions that preserve human time and

meaningful presence at the bedside. In an era marked by scarcity of attention and an excess of routine activities, the greatest waste is becoming disconnected from patient care.

The Brazilian experience reflects both the challenges and the potential of the Latin American context and makes a substantial contribution to the global discussion on de-implementation. Shaped by the tension between resource constraints and a commitment to universal public healthcare, this perspective broadens the international debate and demonstrates that the Global South is not merely a recipient of models but also a producer of knowledge and an ethics of care. In Brazil, where the universality of the Unified Health System (SUS) coexists with persistent resource limitations, Nursing acts as a mediator between what is possible and what is necessary, transforming de-implementation into a daily exercise in distributive justice and practical rationality, while reaffirming the value of bedside presence and evidence-informed clinical decision-making.

By choosing not to perform practices that do not add value, Nursing reaffirms the essential meaning of caring: transforming knowledge into wisdom, routine into reflection, and presence into value.

CONCLUSION

Reflecting on what truly matters in patient care requires shifting the focus from automatic task execution to the quality of clinical decision-making. By treating de-implementation as a conscious professional decision, this editorial reaffirms Nursing as a field of practice that integrates clinical judgment, responsibility, and commitment to people-centered care. In contexts of limited resources and growing complexity, de-implementation helps align evidence, context, and professional values, strengthening an equitable, clinically relevant, and meaningful Nursing practice.

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CORRESPONDING AUTHOR
Ruy de Almeida Barcellos.
rbarcellos@hcpa.edu.br