

UNNECESSARY CARE

Is profit driven healthcare to blame?

A newly launched movement led by prominent doctors is challenging the basic assumption in US healthcare that more is better. **Jeanne Lenzer** reports

At 8 am on her first day as an intern, Diane Meier attended the resuscitation of an 89 year old man with end stage congestive heart failure. The staff shocked the man's heart repeatedly. They tried four times to place a central line. They injected pressors directly into his heart, stuck his femoral artery for blood gases, and performed chest compressions for over an hour before finally pronouncing him dead. Two decades later, after witnessing similar pre-death rituals countless times, Meier published the story of a 73 year old man with metastatic lung cancer who told his doctors he didn't want invasive testing and treatment. His doctors consulted a psychiatrist, who said the man was "in denial" about his illness. After some pressure from his doctors, the man and his family agreed to further diagnostic testing and treatment, including placement of a gastrostomy tube. He was ultimately subjected to 47 days of painful and invasive treatments before dying.¹

For Meier, who went on to win a MacArthur "genius grant" for her work in palliative care, it was not the patient who was in denial, but his doctors. Physicians are trained to believe that staving off death, even if only for days, is their over-riding mission, and all available technology should be employed to achieve that goal. The cost of this self delusion in Meier's eyes can be measured in the patient's suffering, inadequate pain relief, and in time lost that could have been spent at home with family and loved ones. On a national level, the problem is daunting: annually, 65% of all deaths in the United States now occur in hospitals, multiplying the instances when futile or unnecessary care is given.

The harms of overtreatment are not restricted to dying patients. Overly aggressive treatment is estimated to cause 30 000 deaths among

Medicare recipients alone each year. Overall, unnecessary interventions are estimated to account for 10-30% of spending on healthcare in the US, or \$250bn-\$800bn (£154bn-£490bn; €190bn-€610bn) annually.²

Signs of change

Earlier in the year, Meier, along with more than 130 prominent doctors from the US, Canada, and the UK participated in a two day conference on avoiding avoidable care, the first in the US to focus exclusively on overtreatment. The gathering in Cambridge, Massachusetts, was co-convened by the Lown Cardiovascular Research Foundation in Brookline, Massachusetts, and the New America Foundation, a Washington DC think tank.

The impetus for the meeting arose two years ago, when Vikas Saini, a Harvard cardiologist and president of the Lown foundation, read Shannon Brownlee's book, *Overtreated: How Too Much*

Medicine is Making Us Sicker and Poorer.³ Saini contacted Brownlee, who is acting director of health policy at the New America Foundation, and together, they hatched a plan to convene the conference. Saini says, "We wanted to bring together the many people we knew who felt that the system was out of con-

trol in order to find out if there was enough common purpose and commitment among them to try to do something about unnecessary care."

The pair conceived of the meeting as a "big tent," Saini says. "We wanted to jumpstart a conversation within the clinical community about our ethical obligations to avoid the harm caused to patients by overtreatment."

The meeting attracted a who's who of American medicine, including Bernard Lown, inventor of the cardiac defibrillator and winner of the Nobel Peace prize; Donald Berwick, former administrator of the US Centers for Medicare and

bmj.com News: Experts consider how to tackle overtreatment in US healthcare (*BMJ* 2012;344:e3144)

doc2doc Overdiagnosis: do we know when to stop? Discuss at doc2doc

bmj.com/multimedia Jeanne Lenzer (pictured) investigates the harms of overtreatment



Medicaid Services; and Harvey Fineberg, president of the Institute of Medicine, which co-hosted the meeting.

Participants poured out examples of rampant overtreatment, ranging from the overuse of screening tests and imaging technology to an epidemic of questionable surgery (tonsillectomies alone increased by 74% from 1996 to 2006). Rita Redberg, a cardiologist and editor of the *Archives of Internal Medicine*, told the gathering that many interventions need to be challenged, such as cardiac computed tomography, cancer screening for people over 75, and elective cardiac angioplasties. She cited a study that found nearly half of elective percutaneous coronary interventions (PCI) were either inappropriate or of "uncertain" benefit.⁴ She said, "Most patients who are getting a PCI think that they are getting it to prevent a heart attack and that they are going to live longer."⁵ Yet the only established benefit of angioplasty for stable coronary disease is possible relief of symptoms.

The group identified multiple reasons that clinicians and hospitals overtreat, including malpractice fears, supply driven demand, knowledge gaps, biased research, profit seeking, patient demand, and financial conflicts of guideline writers. Other commonly cited problems included the rapid uptake of unproved technology and the failure to inform patients fully of the potential harms of elective treatments.

Several speakers emphasised the way physicians are paid and trained in the US as central factors. Meier told the *BMJ*, "Medical students are taught to do things, not how to know what not to do. Medicine is a very action based profession, and that's how physicians in the US are paid, perhaps not coincidentally. You don't get paid for telling people that watching and waiting might be best, or that keeping someone comfortable might be better." The result is that overtreatment is woven through American medical culture—as one participant said, "It's in the air we breathe."



There was general agreement on some solutions: use guideline writers free of conflicts of interest, implement shared decision making, reduce excess hospital capacity, and reform tort law. There was some disagreement about whether the provisions in the recent Affordable Care Act would reduce overtreatment. The majority endorsed global payment schemes in a primary care driven system.

Inevitable opposition

While many of the Cambridge conference participants have been warning for decades about the harms of overtreatment, it is only now, with global financial downturns and growing awareness of the unsustainability of healthcare spending, that the issue is receiving significant attention from the American media and politicians. With some 30 million Americans expected to be newly

insured under the Affordable Care Act, interest in cutting costs has become a central topic in US politics, and overtreatment is increasingly a focus in the clinical community.

A flurry of books, articles, international initiatives, and conferences focused on various aspects of overtreatment has appeared in the past few years. The American Board of Internal Medicine announced its Choosing Wisely campaign in

Is the USA's problem ours too?

The United Kingdom is fortunate that it is insulated against some of the needless overtesting, overtreating, and overdiagnosing that doctors in the United States are rising up against. Instead, we have the National Institute for Health and Clinical Excellence (NICE), which offers evidence based appraisals of healthcare interventions and screening and which protects against treatments of little or no efficacy being offered on the NHS. We also have the UK National Screening Committee, which provides critical reviews and recommendations of what screening is effective and useful.

Does this mean that we can relax? Unfortunately not. The general practice contract has improved the quantification of what we do, but the price of this is that more patients are exposed to guidelines rich in pharmaceutical recommendations. Some may be beneficial. However, most lack guidance about when prescribing should end or is no longer likely to be useful; we lack data about the risks of the polypharmacy that the contract generates. It is common for patients to be taking 10 or more medications; yet such patients are rarely seen

in randomised controlled trials. Faced with the contract, GPs are made to ask themselves why a patient is not taking a drug, rather than why they should be.

A long campaign for fairer, better information on NHS screening—which was supported by one of the instigators of breast screening in the UK, Professor Michael Baum—looks like it may have, at least in part, succeeded. The current review of information given about screening tests in the UK is likely to recommend balanced information on the pros and cons of screening and promote informed choice.¹ There is no doubt that screening causes overdiagnosis and overtreatment. However, private screening clinics, of which there are many, thrive.

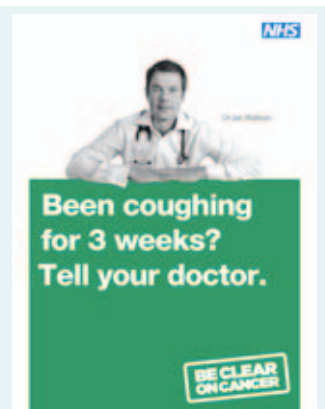
Similar problems are created by non-evidenced awareness campaigns. For example, the UK government's recent "Three week cough campaign" to promote awareness of lung cancer increased the number of chest x rays performed but did not significantly increase diagnoses of lung cancer.² Charities also use awareness campaigns, but the benefits of earlier diagnosis are rarely proved and they risk

investigating people who are unlikely to benefit.

These campaigns are often pivotal to publicity by patient groups and charities. However, financial relations between these groups and the drug industry—with its agendas for the uptake of new interventions and its PR expertise—are often unclear. And despite the continuing problems of opaque data from clinical trials,³ earlier this year doctors were told not to "accept the negative myths about cooperating with industry" in guidance supported by numerous colleges, medical journals, the BMA, and the Association of the British Pharmaceutical Industry.⁴

Shopping last month, I was handed leaflets from a stall demanding "awareness" about restless legs, suggesting I could get treatment from my GP. The same week a drug representative tried to gain access to my practice to "educate" me on treatments. We can hardly avoid harm when we allow this to perpetuate.

But politics threatens most. The coalition government intends to begin "value based pricing" in 2014; this will mean that government rather than NICE will



Did this UK campaign (above) lead to unnecessary chest x rays?

decide which treatments to fund.⁵ Will this result in political whim, rather than evidence based, decision making? The Health and Social Care Act has given permission for the dissolution of the NHS into a mere brand, and with competition companies who are likely to fragment care despite evidence that continuity results in less intervention and better satisfaction.^{6,7} Our iatrogenic harms may be slightly less obvious than those in the US, but they are politically engrained.

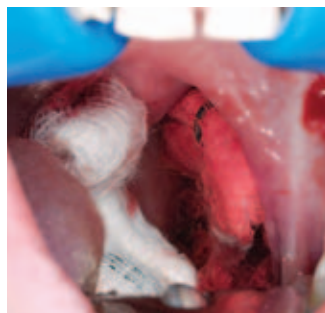
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Left from opposite page: Diane Meier, Shannon Brownlee, David Himmelstein, Vikas Saini, and Bernard Lown, all part of a movement committed to tackling overtreatment, such as overuse of tonsillectomies, cardiac computed tomography, and elective cardiac angioplasties

December 2011, enlisting nine specialty societies to each identify five tests, treatments, or services “that should be re-evaluated.” The *Archives of Internal Medicine* launched its section, “Less is More,” in April 2010, to examine “unnecessary harms of treatment and testing, with no expected benefit.” Other initiatives include PharmeOut, a Georgetown University Medical Center project that “advances evidence-based prescribing”; the international “selling sickness” conferences; a 2013 conference on preventing overdiagnosis⁶; and the international Healthy Skepticism project.

Participants in the Cambridge conference hope to forge a coalition of groups from these initiatives. But as these initiatives begin to move forward and join forces, they will face formidable challenges from the healthcare industry and the general public. Certainly this has been the case in the past. In 2000, Citizens for Better Medicare spent over \$65m on a television advertisement opposing President Clinton’s proposed Medicare prescription drug benefit plan. The ad featured “Flo,” an arthritic bowler who claimed she wanted “big government out of my medicine cabinet.” Citizens for Better Medicare turned out to be a front group for the drug industry, which opposed price controls.⁷ More recently, patient groups, many of which are heavily funded by industry, have denounced independent evidence based screening guidelines, suggesting that they constitute “rationing” and the work of government “death panels.”⁸

Some specialty professional societies and doctors’ groups also claim that rationing is just around the corner. AmericanDoctors4Truth sponsored a television advertisement in which President Obama pushes an elderly grandmother in a wheelchair off a cliff rather than allow her to have a pacemaker.

The overtreatment movement will have to respond to inevitable charges of rationing, but Meier vigorously opposes the use of the word. “Rationing means that you are limiting necessary care. What we are proposing is limiting unnecessary care—harmful care.” Jerome R Hoffman, emeritus professor of medicine and emergency medicine at the University of

California, Los Angeles, suggests no amount of denying will prevent the message from being distorted by those whose interests it threatens. He told the *BMJ*, “Advocates shouldn’t be afraid when opponents try to demonise making wise choices by labelling it ‘the R-word.’ Of course we should budget resources—as we do everywhere in our lives. In addition, there’s already lots of rationing in healthcare; wouldn’t it be better for us to decide what should be available, based on what’s best for our health, rather than having insurance companies decide, based on what’s most profitable for them?”

Is there an elephant in the room?

Proponents of reducing overtreatment will also have to contend with disparate views on who should pay for healthcare: government, private insurers, or a mix of the two. David Himmelstein, professor at the City University of New York School of Public Health, cofounder of Physicians for a National Health Program, and a proponent of a “single payer,” or government funded system, says that as a young physician he saw “murderous undertreatment” at a public hospital where he worked, while patients at a nearby private hospital were subjected to the dangers of overtreatment. “We have a problem of malapportionment,” says Himmelstein. By adopting a single payer health system, he says, the US could save 45 000 lives lost because of undertreatment each year and save enough money to cover the 50 million currently underinsured or uninsured.

Himmelstein says that tackling undertreatment could go a long way toward reassuring a sceptical public that the overtreatment movement is not a dressed-up scheme to ration care with a real goal of boosting profits. In Lown’s view “undertreatment is the Siamese twin” of overtreatment, and both are bound together by the drive for money. “When it’s more profitable not to treat because someone is uninsured, they are left untreated, and when it’s profitable to treat the insured, they are overtreated,” he says.

Saini says, “We can take care of our patients in the way we all want to be treated—humanely,

with just the right amount of technology that improves health and wellbeing, but not an ounce more. If we do that, cost containment follows as a result, not as the deliberate goal.” Hoffman comments, “At some point, the movement will have to address the elephant in the room. Physicians and nurses have a fiduciary responsibility to put the needs of patients first. But the fiduciary responsibility of companies selling healthcare services is very different; it’s to the bottom line of shareholders. Whenever there is tension between what’s best for the public health and what’s most profitable, these companies must choose the latter. Ultimately, after we agree on which interventions are useless and wasteful, we’re still going to have to tackle the more difficult question, as Bernard Lown so eloquently put it, of whether or not profit driven healthcare is an oxymoron.”

Brownlee and Saini contend that the only way to move forward is by growing a movement, and they hope to develop the resources for a national, coordinated effort. They report strong interest from the Cambridge participants in another meeting next year, and would like to see it be more international in scope. They say that engaging clinicians will be a central focus of their efforts, a strategy that Lown supports. He says that doctors are accorded special credibility by the public because “we speak from within the belly of the beast” of the healthcare system.

“The intense debate about how to move forward is a sign that overtreatment matters,” Brownlee says. “We want everyone involved and sharing their expertise on potential solutions. There is room for many political ideologies and beliefs about how to pay for healthcare. The crucial step right now is to get the medical community mobilized around the idea that overtreatment harms patients.”

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