

MEDICAL TREATMENT EXCESSES EXAMINED

Local symposium focuses on wasteful tests, procedures

By [Paul Sisson](#) ([/staff/paul-sisson/](#)) 5:06 a.m. March 16, 2015

More testing.

More surgeries.

More technology.

For decades, the measuring stick for medical progress has been doing more.

But while modern medicine has regularly delivered amazing new treatments, there is growing concern that some procedures are overused.

Simmering since the late 1970s, the push for reform became very real in 2010 with passage of the Affordable Care Act. The law includes provisions aimed squarely at medical overuse, which studies have shown can harm patients and drive up health care costs.

Last week, hundreds of medical experts gathered at the Omni Hotel in downtown San Diego to discuss ways to make sure patients are getting the right amount of care when they need it — without having to undergo unnecessary procedures or missing out on early interventions that could head off bigger problems later on.

Organized by the Boston-based Lown Institute, the symposium brought together doctors, patients and their advocates from across the nation.

“The core problem, I think, is that what people want is health, not necessarily health care, but what the system incentivizes is more health care,” said Dr. Vikas Saini, the institute’s president.

The medical establishment has paid increasing attention to the topic. In 2010, the Institute of Medicine estimated that about \$210 billion is wasted each year through overuse of medical services. Other estimates have put the figure as high as \$800 billion.

Those numbers come from a range of studies that have documented use of some procedures that are unlikely to deliver much medical benefit, are no more effective than cheaper treatments or are not desired by patients once they have been informed of potential side effects and complications.

Examples include yearly pap smears for women, despite scientific evidence showing that a three- or five-year interval is just as effective. Or the prescribing of antibiotics for viral illness like the common cold. Or the use of stenting for patients with stable heart disease who are not suffering a heart attack.

Dr. Elliott Fisher, director of The Dartmouth Institute at Dartmouth College in New Hampshire and an internationally known expert on medical overuse, said stents are a good example of how a valid therapy for certain patients has been expanded too much.

“Most patients will believe that having an elective stent done when they have stable chest pain is going to prevent a heart attack, but randomized clinical trials do now show that to be true,” Fisher said.

Another common overuse category is spinal surgery for nonspecific back pain that’s not connected to an infection or a disease, he said.

“Even with something like a slipped disk, studies show that most people will get better if they try six weeks of physical therapy,” Fisher said.

Dartmouth has been a leader in analyzing how levels of health care usage can vary greatly among different regions of the country. California ranks fifth in the nation in terms of “treatment intensity,” behind New Jersey, New York, Florida and Nevada.

Studies from Dartmouth and elsewhere have indicated that patients tend to receive more treatment in parts of the country with greater numbers of doctors and hospitals. This means it’s more likely for patients in these resource-rich areas to be admitted into a hospital and receive aggressive treatment, particularly in their final few years of life.

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While a greater likelihood of treatment might seem like a good thing, it can be detrimental if certain therapies aren’t needed in the first place. Every surgery comes with risks of infection and medical error, not to mention the financial expense for the patient, 3/17/15, 7:52 AM

Even within a city, there can be high variability in the cost of medical procedures among health providers.

And disconnects between physicians and insurance companies can often result in patients paying for services that end up not being categorized as essential or coverable.

Financial issues were front and center at the Lown conference as New York resident Peter Drier took the stage. Drier received a \$117,000 out-of-network bill from a neurologist who consulted with Drier's orthopedic surgeon during a three-hour surgery to repair a herniated disc in his neck.

Having selected his surgeon carefully, Drier was outraged to learn that the consultant was brought in without his knowledge, without confirming a genuine need for the additional care and without first checking to make sure his insurance policy would pay for that neurologist. Although Drier's insurance company eventually paid the bill, the experience left him with a new understanding of the risks involved in receiving medical care.

For people who are uncomfortable questioning medical authority, Drier had a simple prescription: fear.

"To get the courage or get the gumption to ask the questions that you need to ask, you need to be afraid of getting a bill that is larger than what you make in a year," he said.

The conference included information for doctors and hospital administrators on how to reduce overtreatment. In the audience was Dr. Daniel Hoefler, chief medical officer for Sharp HealthCare's palliative care program.

Many of the conference participants were interested in a program that Hoefler helped to implement for people with congestive heart failure. Sharp regularly contacts these patients to make sure they're adhering to specified treatment regimens — rather than waiting for them to show up in an emergency room.

Hoefler said over eight years, the program has reduced primary hospital admissions for congestive heart failure by 94 percent.

He is embarking on a new program that uses sophisticated algorithms to predict potential outcomes of surgeries for older patients. Current disclosures made before a surgery usually focus on the immediate risks — such as bleeding and infection — but leave out additional risks that would affect the most frail patients. Those longer-term risks include a serious chance of cognitive impairment or loss of mobility.

If the potential complications were better noted during surgery consultations, elderly patients would be less likely to approve many procedures, Hoefler said.

"We need to be able to say, 'No, it's OK that mom doesn't have her second knee replacement because this is not the same as it was for her 10 or 15 years ago. Who she is, and her physiology, has changed, and her risk is tremendously higher. Yes, it's OK for her to have four Vicodin or four Percocet (pills) a day because that's safer than going for surgery,'" he added.

In the end, many who gathered at the Omni said the public should not wait for doctors and hospitals to fix the overuse problem.

Shannon Brownlee, senior vice president of the Lown Institute, said there is a reason why several breakout sessions at the conference focused on community organizing.

"It's going to take a social movement," Brownlee said. "We're talking about a \$3 trillion industry, and it doesn't really want to change."

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