

# **The Dilemma of Overtreatment**

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We stand in awe of the advancements of modern medicine. We would not want to live in a world without antibiotics, anesthesia, joint replacements, cardiac stents, and other medical miracles.

However, according to a 2017 survey of physicians, with more than 2,000 respondents, doctors believe that 20.6 percent of all medical care is unnecessary. In their introduction, the authors state: "Waste in health care is increasingly being recognized as a cause for patient harm and excess costs."<sup>1</sup>

The intentions are good, but the financial costs of modern technological medicine are devastating. Any cardiac intervention may top \$100,000. The co-pay might be \$15,000 to \$20,000. The cost of treating malignant melanoma may reach \$10,000,000, due to the costs of the new monoclonal antibody drugs and bone marrow transplantation.

Treatment protocols may be aggressive and are even described as an assault on the patient. Patients often do not understand the complicated information and just have to go along with what is presented to them.

Teaching hospitals must take some of the blame for unrestrained interventions. Medical education stresses state-of-the-art equipment, new protocols, and the latest research. Academicians who are the role models for the students promote their latest findings with little thought about the harmful effects that they may cause. Medical residents are under pressure to do tests to prove a diagnosis in order to avoid harsh criticism from the attendings and embarrassment in front of their peers.

There is an obsession with numbers and scores that serve to make the physician feel more secure. We may recognize that we are treating numbers rather than a patient, but there does not seem to be much that we can do to change that. Bedside clinical skills become dull as we rely more on an imaging study than on history and physical examination. Patients suffer not only from their illness but also from the onslaught of tests and procedures.

Over-testing and overtreatment are part of defensive medicine. Fear of lawyers and lawsuits is real and prompts more testing than would otherwise be done. Fear of criticism by other doctors does not get much attention but should not be underestimated. Peer review is important, but it is done by doctors who were not at the bedside and never evaluated the patient. A negative peer review is often based on not having done enough tests in the opinion of the Monday-morning-quarterback reviewers. If there is an incentive to do so, then good care is portrayed as inadequate or bad. Physician reviewers may have motivations other than quality of care or furtherance of patient safety, as described by the AAPS Committee to Combat Sham Peer Review.<sup>2</sup>

Cookbook medicine can result in over-testing and overtreatment. In complying with protocols and evidence-based medicine we often forget that the numbers and images may have no bearing on the person in front of the doctor. The

new hypertension guidelines (JNC 8) call for medication for a blood pressure of 130/80 or greater, if lifestyle changes are not effective.<sup>3</sup> According to the American Heart Association, these guidelines would lead to 46 percent of the U.S. adult population being categorized as having hypertension. Even the American Academy of Family Physicians has decided not to endorse these new guidelines, noting that they do not take into account the potential harm of driving blood pressure ever lower.<sup>4</sup> The implications of these guidelines will be discussed at the annual AAPS meeting in October. (Mark your calendar now for Oct 3-6, in Indianapolis.)

The emergency department is an everyday location for over-testing. An intoxicated patient who is somnolent but has no signs of head injury or focal neurological findings will often have a head CT (computed tomography). A patient with syncope is likely to have a head CT, even though this is not part of the basic workup of syncope. Patients with a urinary infection may be tested for sepsis under the Surviving Sepsis Campaign.

Our past president, Dr. Melinda Woolfer, spoke at the 2014 annual meeting about created illnesses. Conditions have been re-named for marketing reasons. An example is "overactive bladder." Urology did not have such a diagnosis until it was made up by a drug company and given an official ICD code. Conditions are redefined and get new attention. Osteoporosis is arbitrarily defined based on deviation from the normal bone density of a 30-year-old. A drug company provided bone density machines and sent speakers out to promote their product. As more testing is done, more prescriptions are written, resulting in billions of dollars in sales. Direct-to-consumer advertising results in patient requests for prescriptions. Ordinary life experiences are medicalized and treated with psychoactive drugs.

The hospitalist movement contributes to over-testing. Patients are now cared for by hospital-employed physicians who have no previous knowledge of the patient, except what might be found in old records. Typically, this results in repeat testing and overtreatment. The patient's own physician is not part of the new paradigm that denies the patient a trusted resource.

There are good reasons to allow for some degree of over-testing and overtreatment. Doing more than might be deemed absolutely necessary helps ensure that those patients who truly need the test or procedure are more likely to be taken care of. When these issues of over-testing and overtreatment are raised, it is usually by detractors of the medical profession. They go on to demand more government control of medical practice.

At AAPS, we believe that the doctor and the patient are the ones who should make the medical decisions. This may sound simplistic at a time when insurance companies and hospitals think they know better than the doctor. It is assumed that such a novel idea will never work: the patient wants everything done, and the doctor can profit handsomely by fee for service. That is why managed care is needed, according to conventional wisdom.

At AAPS we believe that doctors and patients can make sensible decisions. Shared decision-making (SDM) is a way to negotiate with patients in order to prevent overdiagnosis and overtreatment. SDM is a process whereby the doctor and patient jointly make a medical decision. It involves explaining a range of options and inquiring as to what is most important to the patient. Risks and benefits are explained. The option of watchful waiting is identified as a positive action to counter the public's bias for active tests and treatment. SDM may be particularly helpful in the context of cancer.<sup>5</sup>

Doctors and patients are encouraged to make prudent decisions about medical care with the use of a health savings account and a high-deductible plan. Direct Primary Care (DPC) is an innovative alternative payment model to improve access to high-functioning medical care. Patients are able to sidestep the massive insurance bureaucracy by use of health savings accounts and DPC.

In the event that patients and family are unrealistic, then the doctor must have final authority to make decisions. Just as when a surgeon determines that a patient is not a candidate for surgery, the medical doctor must be allowed to determine whether to proceed or set limits on diagnostic studies and treatment. Physicians are not ethically obligated to deliver care that, in their best professional judgment, will not have a reasonable chance of benefit for the patient. Patients have no right to demand improper care.<sup>6</sup>

Physicians are in the unenviable position of being attacked for doing too much or too little. However, physicians must retain the authority to make decisions according to their own knowledge and judgment. Private-practice doctors are often called dinosaurs, but what is obsolete about having a doctor who knows you and will take care of you? As our past president

Dr. Lois Copeland said: "When they call in the middle of the night, I already know the patient and the past history." At AAPS we believe that the best chance of getting it right—that is, not too much or too little medical care—may well come from an independent doctor. The patient should be able to consult with an independent doctor who is not beholden to "the system," the hospital, the accountable care organization, or the government. As we focus on numbers, maybe it is the compassion quotient that needs to be raised.

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## REFERENCE

1. Lyu H, Xu T, Brotman D, et al. Overtreatment in the United States. *PLoS ONE* 2017; 12(9): e0181970. Available at: <https://doi.org/10.1371/journal.pone.0181970>. Accessed May 21, 2018.
2. Huntoon LR. Sham peer review: disaster preparedness and defense. *J Am Phys Surg* 2011;16:2-6.
3. James PA, Oparil S, Carter BL, et al. 2014 Evidence-based guidelines for the management of high blood pressure in adults: report from the panel members appointed to the Eighth Joint National Committee (JNC 8). *JAMA* 2014;311:507-520. doi:10.1001/jama.2013.284427. Available at: <https://jamanetwork.com/journals/jama/fullarticle/1791497>. Accessed May 21, 2018.
4. American Academy of Family Physicians. Guidelines Developed by External Organizations Not Endorsed by the AAFP. AAFP; 2018. Available at: <https://www.aafp.org/patient-care/clinical-recommendations/non-endorsed.html>. Accessed May 21, 2018.
5. McCafferey KJ, Jansen J, Scherer LD, et al. Walking the tightrope: communicating overdiagnosis in modern healthcare. *BMJ* 2016;352:i348. Available at: <https://doi.org/10.1136/bmj.i348>. Accessed May 21, 2018.
6. Cotton V. End of life issues and futile medical care. *Current Management in Critical Care*. Kansas City Southwest Clinical Society; May 1, 2014.

# AAPS PRINCIPLES OF MEDICAL POLICY

**Medical care is a professional service, not a right.** Rights (as to life, liberty, and property) may be defended by force, if necessary. Professional services are subject to economic laws, such as supply and demand, and are not properly procured by force.

**Physicians are professionals.** Professionals are agents of their patients or clients, not of corporations, government, insurers, or other entities. Professionals act according to their own best judgment, not government "guidelines," which soon become mandates. Physicians' decisions and procedures cannot be dictated by overseers without destroying their professionalism.

**Third-party payment introduces conflicts of interest.** Physicians are best paid directly by the recipients of their services. The insurer's contract should be only with subscribers, not with physicians. Patients should pay their physician a mutually agreed-upon fee; the insurer should reimburse the subscriber according to the terms of the contract.

**Government regulations reduce access to care.** Barriers to market entry, and regulations that impose costs and burdens on the provision of care need to be greatly reduced. Examples include insurance mandates, certificate of need, translation requirements, CLIA regulation of physician office laboratories, HIPAA requirements, FDA restrictions on freedom of speech and physicians' judgment, etc.

**Honest, publicly accessible pricing and accounting ("transparency") is essential to controlling costs and optimizing access.** Government and other third-party payment or price-

fixing obscures the true value of a service, which can only be determined by a buyer's willingness to pay. The resulting misallocation of resources creates both waste and unavailability of services.

**Confidentiality is essential to good medical care.** Trust is the foundation of the patient-physician relationship. Patient confidences should be preserved; information should be released only upon patient informed consent, with rare exceptions determined by law and related to credible immediate threats to the safety or health of others.

**Physicians should be treated fairly in licensure, peer review, and other proceedings.** Physicians should not fear loss of their livelihood or burdensome legal expenses because of baseless accusations, competitors' malice, hospitals' attempts to silence dissent, or refusal to violate their consciences. They should be accorded both procedural and substantive due process. They do not lose the basic rights enjoyed by Americans simply because of their vocation.

**Medical insurance should be voluntary.** While everyone has the responsibility to pay for goods and services he uses, insurance is not the only or best way to finance medical care. It greatly increases costs and expenditures. The right to decline to buy a product is the ultimate and necessary protection against low quality, overpriced offerings by monopolistic providers.

**Coverage is not care.** Health plans deny payment and ration care. Their promises are often broken. The only reliable protection against serious shortages and deterioration of quality is the right of patients to use their own money to buy the care of their choice.