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NEWS

Experts consider how to tackle overtreatment in US healthcare

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The first randomised study of coronary artery bypass surgery was not carried out until 16 years after the procedure was first developed, a conference on overtreatment in US healthcare was told last week. When the results were published, they "provided no comfort for those doing the surgery," as it showed no mortality benefit from surgery for stable coronary patients.

This example of surgeons embracing an expensive and invasive technique before it had been properly evaluated was given by Bernard Lown, professor emeritus of cardiology at the Harvard School of Public Health. He was speaking at the Avoiding Avoidable Care conference in Cambridge, Massachusetts, on 25 and 26 April, at which experts met to explore what drives overtreatment and how to reduce it.

Lown, who is now in his 90s, told the audience, "I've been waiting 60 years for this conference." He said that the problem of unnecessary, invasive, and potentially harmful treatments in cardiology was particularly acute and that overtreatment grew "exponentially" after René Favaloro started performing coronary artery bypass surgery at the Cleveland Clinic in the late 1960s.

The number of revascularisations soon exceeded a million each year, said Lown, yet the first randomised study of the technique wasn't done until 16 years after it was developed.

Other participants at the conference pointed out ways in which overtreatment and avoidable care cost lives, harmed patients, and consumed up to 30% of the $2.5 trillion healthcare budget in the United States.

Vikas Saini, a Harvard cardiologist and president of Lown's Cardiovascular Research Foundation in Brookline, Massachusetts, which organised the event with the non-profit public policy think tank the New America Foundation, told the *BMJ*, "It's clear that not just one thing needs to be changed to fix the problem. We have to have a culture change in medicine that will include changing payment schemes, how medical journals report studies, how patients receive their information, how professional guidelines are devised, and how we perceive good care. At the core, we need to transform the nature of the doctor-patient relationship from a series of transactions to a genuine alliance."

Harvey Fineberg, president of the US Institute of Medicine, told participants that the "costs of healthcare have strained the federal budget and negatively affected state governments, the private sector, and individuals." At the same time, he added, the number of people without health insurance rose to 46.3 million in 2008.

Donald Berwick, former head of the federal Centers for Medicare and Medicaid Services, said that failures of reliability, failures of coordination, administrative complexities, fraud, pricing anomalies, and overtreatment—all forms of unhelpful, wasteful expenditure—account for as much as a third of healthcare costs in the US.

Participants cited obstacles to reducing unnecessary care. They said that when doctors tried to raise the issue of overtreatment of people at the end of life, opponents claimed that efforts to reduce such treatment would result in "death panels."

During a panel discussion on the ethics of avoiding unnecessary care, Diane Meier, professor of geriatrics and palliative medicine at Mount Sinai School of Medicine and director of the Center to Advance Palliative Care in New York, told the story of a patient whose oncologist suggested intrathecal chemotherapy for brain metastases even though the treatment was clearly futile.

Meier asked the oncologist, who had kept the patient alive for years, whether the treatment could actually help the patient. He acknowledged that the treatment was futile but told Meier that he offered it because "otherwise she'll think I'm abandoning her."

Jerome Hoffman, professor emeritus of medicine and emergency medicine at the University of California, Los Angeles, also a presenter on the ethics panel, responded to claims that any attempt to deal with overtreatment is a form of rationing that infringes on personal freedoms.

He told the *BMJ*, "While avoiding unnecessary and often harmful care is not the same as rationing, we do have to make rational decisions about how to apportion limited resources. And we already have widespread rationing; unfortunately our current version is based on profitability rather than on effectiveness or social justice."

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