



Transcript of podcast
interview with Shannon
Brownlee, author of
*Overtreated: Why Too Much
Medicine is Making
Americans Sicker and Poorer*

Your main argument in the book, that Americans are receiving too much healthcare, not too little, seems counterintuitive. You claim, however, that many of the treatments and procedures that patients are receiving are unnecessary, and you cite an array of data to prove this. My question is why have so few others been talking about this from this angle?

When I started the book four years ago, or actually, I started thinking about it and talking about it about five years ago, when I said people were being treated unnecessarily, people looked at me like my hair was on fire. I think it has to do with how we frame the problems, how we think about things, and we have been thinking for a long time in this country that the real problem was the uninsured. That has been such a sort of monomaniacal way of thinking about things ... that it's been hard to imagine that you can have people not get enough care, not have access to care because they're not insured, and at the same time, be given too much care.

Are there certain procedures or tests that tend to be overused more than others that people should be particularly aware of?

I think [for] any invasive surgery and any invasive test you need to really ask a lot of questions. The example that comes up pretty regularly is back surgery. A majority of Americans have back pain at some point in their lives, and most back pain goes away by itself. If your back pain has been lasting for weeks and surgery is brought up as an option, that's something you should think very, very hard about. It's very invasive.

Another thing is, for example, bypass surgery. Bypass surgery is extremely serious surgery, and for many patients, especially elderly patients, the potential for benefit from the bypass surgery may not be all that great. They should think about what the side effects are going to be, what the long-term effects are going to be, what the actual risk of the surgery is going to be, what the possible benefit is, and whether or not that's worth it for them. They may need extra time with the doctor, they may need to have things explained in multiple ways to be able to come to a truly informed decision about what they want to do.

What are some of the consequences of this overtreatment?

There are many consequences at many levels. Probably the most important is for the individual patient. One of the consequences can be harm — that you get treatment that does you no good, but in fact at the same time, it puts you at risk. If you think about it for a moment, everything in medicine carries risk. Even the tiniest little procedure like a blood draw. There is some very, very small risk associated with that. The more invasive a treatment is, the more powerful a drug is, the greater the potential for harm. If you're getting

something that has no possibility of actually benefiting you, either by improving the quality of your life or making it longer, it still poses the same risk. That is one of the biggest and most powerful pieces of information that I think American patients need to absorb, that there's no free lunch in medicine. If you're getting something that's not doing you good, it is still posing risk.

The second level up is it's consuming resources if your physicians, doctors, hospitals, and nurses are all busy giving people stuff they don't need. It's leaving them less able to pay attention to giving patients the things that they really need, the kind of care they really do need.

One level up from that is, it costs a lot of money. We are wasting anywhere from \$500 to 700 billion a year on care that is not doing patients any good and is in fact putting them at risk.

How do we overcome consumers' belief in technology and their perception that more medicine is generally better, and that we have a right to all of the tests and procedures that may be available to us?

I think that's another multi-level answer, and a multi-level question. People—Americans—have an inflated view of the power of medical technology compared to their European counterparts. Surveys ask people what do you think about new technology, do you want access to new technology, do you follow new technology in the news, and Americans are very, very high on all of those scores. They are very interested in medical technology and they have this implicit belief that if it's new it's got to be better.

Guess who's been driving that? The press has been very, very important in driving that belief, that if it's new, it's better. So one answer to the question of how do we change that perception is once again the press. Newspapers are beginning to start writing more critically about new technology. The *New York Times* in particular I think is doing a really good job of starting to question the value of medical technologies that we've sort of assumed were wonderful and new and therefore were going to help people, and maybe they'll help some people, but maybe they won't be as great as we might have thought.

The press is going to have to have a very important role, but I think physicians also have to play a really key role. Primary care physicians in particular need to have the time that it takes to talk to their patients, to be able to say, I know you saw that ad for Vioxx on TV, but Vioxx is a new drug and we really don't know its side effects, and it may not be so great, and in fact it turned out that it wasn't so great, so why don't we try an old tried and true drug that we know is really effective in your case and we also know what the side effects are? Physicians have to start being able to talk to their patients a little more honestly about what we know and what we don't know, and take the time that it's really going to take to get patients to understand the limits of medicine.

One of the things that you spoke about in your book was the erosion of primary care. You were just saying that primary care doctors have to take the lead in this. Is that made difficult by this erosion of primary care?

Oh, man, is it ever. I mean, you look at your average primary care doctor, and the way they work, they kind of look like gerbils on a wheel, they're running as fast as they can to stay in the same place. What I mean by that is that they're seeing as many patients as they can in a day in order to stay afloat financially. So they're really struggling, and the idea that your primary care doctor is going to take the time that is necessary to really explain your condition and really explain what we know about it and really explain what we know about the possible treatments, I mean that's laughable in today's system.

In addition, we've got this erosion of primary care in the sense that young medical students are not going into primary care. They're coming out with huge debt and they look at what a primary care doctor makes versus what an interventional radiologist makes, and it's a no-brainer. They're going to pay their debt off a whole lot faster if they go into interventional

radiology. So we're having trouble keeping the numbers of primary care doctors up and we simply have to pay them very, very differently and we have to change the responsibilities that they have.

There are a number of things to explore there. Let me ask first what can patients do to help realize there's this risk of being overtreated and to be aware of that as they go in to see a doctor, whether it's a primary care physician or a specialist?

What can patients do? Well, they can start asking lots of questions. I know that can be really hard to do because it sort of seems to be questioning the authority of your physician and your physician's ability to care for you. But it isn't. Getting cared for ought to be a two-way street, a real shared process. What patients need to do is start asking key questions, like: If you do this test, will it change the way you treat me? What will this test tell you that will change your mind about how to treat me? Are there side effects to this drug? Is there an alternative to this surgery? What if we just wait and watch rather than doing the surgery right away? Is there an old drug that will work as well as this new drug? What do you know about the side effects of this test or drug?

Those are the kinds of questions that patients ought to be asking. Once again we kind of get back to the problem of time, because so often, your primary care physician whizzes into the room with clip board in hand, or maybe now a little computer, and asks you a few questions and then starts writing a prescription and then is halfway out the door before you pull it together to say "Ahh, can you clarify something for me?" Patients actually need to say "I need more of your time," and if you need to come back for another appointment, so be it. But you need to be able to ask those questions about how you're being treated, what everything means, what you need to do to take care of yourself.

Let's pull back to the policy level again after having drilled down into the patient view. How do your findings influence your opinion of a consumer-driven healthcare solution that provides coverage through high-deductible insurance and individual health savings accounts?

This is not going to solve the problem. This is going to nibble around the edges. It's basically going to shift costs to the patient. Is the patient going to do a better job of deciding what's valuable care and what isn't? I just don't think so. I don't think they have access to the information, despite the enormous amount of stuff on the Web, it's not very good, and many patients can't grasp the stuff on the Web or they can't get access to the Web. There's not a lot of evidence that patients make better decisions when they have more skin in the game, as it's called.

I think that the high-deductible, high-copay solution is not a very big solution. It's a pretty puny solution. What we really have to do is redesign how healthcare is delivered. . . . Patients are not acting in their own best interest necessarily, and they're not necessarily going to act in a way that's going to help doctors and hospitals redesign how they deliver care.

I think it's going to be up to the big payers to start paying in a different way, to start getting hospitals and doctors to reorganize. We have this incredibly diverse healthcare "system," and a lot of it is really lousy. If we look around the country there's this huge geographic variation in the kind of care and how much care similar patients get in different parts of the country.

The other thing we know is that there are these little islands of excellence in this huge sea of high-priced mediocrity. These islands of excellence are called organized group practices. We know that these organized group practices deliver higher quality care and they do it for lower costs. We all know the names of a lot of these places—they're the Mayo Clinic, the Billings Clinic, the Geisinger Clinic, Group Health of Puget Sound. We know that these group practices do a better job. What payers need to be doing, I think, is thinking

about how they can get the rest of the disorganized system to start to organize itself. What incentives can they give hospitals chains to turn themselves into organized group practices?

Some of the methods of these organized group practices echo the practices of traditional HMO's, for example, doctors paid by salary instead of on a fee-for-service basis. But at the same time, you talk about how managed care didn't provide the expected cost savings, and in fact helped lead to the erosion of primary care. So where did managed care go wrong?

Managed care was mostly managed money. Managed care was "HMO's lite." That was part of the problem. One way I think about it was managed care companies, which were basically payers, insurers, were treating the components of what make a great organized group practice kind of like a Chinese menu, and they were taking a little from column A and a little from column B, they were doing a little capitation, they were doing a little utilization review, they were doing a little of this and in not getting buy-in from the physicians, they failed. In doing it in this sort of piecemeal fashion, they failed. I don't think that they really understood how medicine really works and how physicians and hospitals really work, or if they did, they just kind of ignored it and decided that the way they could do it was by squeezing money out of them.

The other thing that they did, and I finally got an answer to why they did this, was that the people they squeezed the most were primary care doctors. If you talk to primary care doctors who went through the managed care era, their per-patient, the capitation payment went from something like \$21 a month per patient down to about \$7 per patient.

I asked a group of insurers why they did this, because in the end they shot themselves in the foot. They turned primary care doctors into traffic cops instead of the person who was truly coordinating the care of the patient, managing the patients who have chronic illnesses, making sure that they weren't referring them too often to specialists, and instead, by squeezing them so much, they turned primary care doctors into traffic cops who basically handed out prescriptions and referrals. The reason was that specialists gathered into groups that ended up being able to negotiate very well on price. The only people left to squeeze were the primary care doctors in a lot of markets. This ended up being I think very, very destructive. It has helped speed the erosion of primary care.

One group you say is actually getting it right is the Veteran's Administration, and you propose using the Veteran's Health Administration as a model for reform. What is it that they are doing right, and why has it succeeded where others have failed?

I think the VA is one model for reform. My colleague Phil Longman at the New America Foundation has this really interesting idea where you basically take people—for instance, in Massachusetts. The state of Massachusetts is now having to insure a lot of people in its efforts to offer universal coverage. What it could do is take a number of VA hospitals that are being underutilized and basically say OK, you now are going to be within the VA system, and it would then put that hospital back to work. A number of doctors might want to go and work for the VA, because it's a pretty great place to work in a lot of ways. That's one model.

But one of the reasons the VA worked was that it was a top-down system. The doctors were already salaried. Ken Kizer, the reformer who came in the 1990's, and really revamped the VA, could decree what could happen, which was one of the reasons it worked. I don't see that working all that well in the rest of the system.

I think a more promising method for getting this kind of organization and integration is for hospitals and physicians that are already working together to start to organize themselves. They can still accept fee-for-service, for example, the way the Mayo Clinic does, but pay their physicians a salary.

I have this little dream for the hospital in my town. I live in Annapolis, Maryland, which is a town of I think 40,000, not including the greater county area, and there's one main hospital. There's a limited number of doctors, maybe 100, 150 doctors in town, and they all

have privileges at that hospital. I can imagine the doctors and the physicians in my town saying we're going to become a truly organized practice. But they'd have to be willing to do it. It's sort of like the old joke about light bulbs and psychiatrists. The light bulb has to really want to change.

How do we begin then, to make these reforms? How do we motivate them to want to change?

I think that there's a greater acceptance that something has to change out there in the provider community than there ever has been before. I think the message that we're on a course for fiscal disaster, not just for Medicare, but for the entire country, that we simply cannot continue paying more and more of our GDP into health care, has started to really penetrate and make a difference. There are a number of things that need to be tried. It's not going to be a silver bullet, it's going to be silver buckshot.

One possibility is called bundled payments, that's an idea that's being talked about where you pay for an episode of care. You possibly pay the physicians and the hospital jointly, forcing them to have to work together.

Another possibility is to expand what are now being tried in Medicare. There are pilot projects or demonstration projects where Medicare is actually sharing some of the savings with organized practices, so if an organized practice does a better job of caring for its diabetics, and it does it with less utilization but very high quality, Medicare saves some money, and it gives back some of the money to that demonstration project. We could expand that into not just these small group practice projects but into a much larger demonstration.

What are the benefits then to the physicians under this system?

How about having a profession in 10 years?

This is the thing that doctors have to understand. We can't go on as business as usual. Something is going to happen, and it can either happen in a somewhat orderly way, or it can be complete chaos. If we continue to wait, with more and more people uninsured, a catastrophe is waiting out there, a fiscal train wreck. That's one benefit to physicians.

Another benefit to physicians is—surveys suggest that physicians are some of the most dissatisfied professionals in the country. They all feel like they're on gerbil wheels. I'm sure there are some super-specialists who are happy with what they're doing, but primary care doctors are exhausted. They don't feel like they're giving their patients the kind of care they were trained to give them, they don't feel like they're maintaining the kinds of personal relationships with patients that they would like to. I bet a heck of a lot of primary care doctors would really welcome a real change that would restore some of that doctor-patient relationship to them, and ease some of the burden of having to see so many patients every single day.

Massachusetts, as you mentioned, has recently enacted some major healthcare reforms. Are they moving us in the right direction, and what more still needs to be done?

They're moving us in the right direction in the sense that it's absolutely outrageous that the richest country in the world can't seem to cover 15 percent of its citizens. . . . The question I have is: Is Massachusetts now going to take the next step, which is start to reorganize the way care is delivered and start demanding that physicians and hospitals start to act in an organized way and to get it together?

I think one of the things that has to happen is we have to have open recognition that these organized group practices really are models. It's not to say that every physician is going to be in a salaried group practice. But it is to say that they have the answers to many of the problems that we're facing, and that hospitals and physicians need to make themselves look a whole lot more like these organized practices.

Moving from the state to the federal level, what do you think the biggest challenges will be for the Obama administration in tackling the healthcare crisis?

Everything. Congress. Congress and the special interests that don't want to make any changes. Here's the reality of healthcare reform: Somebody's going to lose. There's going to be winners and losers, but it's the losers; nobody wants to be the losers, and if we bend down the cost curve, the rate at which healthcare costs are increasing, it means aspects of industries, branches of industries, entire industries within healthcare may see a major cut in their incomes. And nobody wants to be the one who takes a cut.

I think that they're going to be fighting battles in two fronts. One in Congress and one in the special interests, who are going to fight via Congress and via appealing directly to the American public, saying you're going to get worse care. One of my missions I think is to—and I think a number of people who are writing about healthcare for a general audience, are increasingly trying to do—is to get Americans to understand that it is not so great out there, that what they have is not so great, and it could be a whole lot better.

Do you think we're in a better position now to make change than we were, say, in the early 1990's when President Clinton attempted it?

Yes, and for a number of reasons. Number one, things are ever so much worse than they were. Things seemed bad then; things are really, really bad now.

Number two, we are in this moment of opportunity. The terrible reality of the fiscal crisis we're facing now, and the recession if not depression, is that that is a moment when you can start to make changes. I think we have this extraordinary opportunity where a whole series of forces are coming together. We have economic instability that suggests that we have a chance to really do something about healthcare because we can. We need to.

I think we understand a lot more about what is wrong with our system. I think that back then, in the 1990's, it wasn't quite so clear to everybody that a) the disorganization of the system was a large part of the problem, b) that overtreatment was an enormous part of the problem, and c) that there were these examples called group practices, organized group practices, that could shine a light towards a path towards getting out of the problem. I think that, for example, managed care in some ways knew that HMO's were really good models, but back they didn't really understand what aspects of the group practice model made them so good. Now we understand that a lot better.

I think on that somber, but perhaps hopeful note, that's a good note to close on.

I'm very hopeful. Maybe it's the naiveté of, I don't know what it is, but I am very hopeful that we're going to see some change.