



When Less Is More: Issues Of Overuse In Health Care

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April 25, 2014



Editor's Note: This post is part of an ongoing Health Affairs Blog series on palliative care, health policy, and health reform. The series features essays adapted from and drawing on an upcoming volume, [Meeting the Needs of Older Adults with Serious Illness: Challenges and Opportunities in the Age of Health Care Reform](#), in which clinicians, researchers and policy leaders address 16 key areas where real-world policy options to improve access to quality palliative care could have a substantial role in improving value.

About 18 months ago, Daniel Wolfson, executive vice president of the American Board of Internal Medicine (ABIM) Foundation began asking audiences of clinicians if any of them had ever seen a patient subjected to unnecessary medical care. As one of the architects of the Choosing Wisely campaign, an initiative of the ABIM Foundation intended to reduce overuse of medical services, Wolfson had a particular interest in the answer to this question. He was surprised to find that in some of his audiences, a majority of clinicians have personal experience with overuse.

Clinicians' newfound willingness to concede that overuse is a problem comes as good news for people who have long labored to increase awareness of this aspect of medicine in America, including the authors of this

post and many of the readers of [Health Affairs](#).

Overuse is costly, pervasive, and causes harm to patients, yet it has been remarkably difficult to get the medical profession, health care industry, and general public to take note of it, much less take steps to reduce it. Today, however, there are multiple efforts underway that offer hope for real change, including [Choosing Wisely](#), the growth of palliative care, and the [Lown Institute's Right Care Alliance](#); but until now, the most difficult step has been the first: for patients, payers, physicians and policymakers to acknowledge the scope of the problem.

Current Estimates

Current estimates for unnecessary expenditures on overuse range from 10 to 30 percent of total health care spending. Even the lower estimate, [from the Institute of Medicine](#), amounts to nearly \$300 billion a year. No specialty is immune from practices that lead to overuse, as a recent spate of papers in medical journals can attest. In cardiology, even using criteria that are relatively permissive, an estimated 11 percent of stents are delivered to ["inappropriate patients."](#) At some hospitals, that rate is closer to 20 percent.

In primary care, antibiotics are still prescribed for upper respiratory infections caused by viruses, and patients with uncomplicated acute low back pain are still referred for MRI imaging tests. [The Dartmouth Atlas](#) reports that many patients in the terminal stages of cancer undergo chemotherapy that is likely to do nothing to lengthen life, but all too often makes their last days more miserable.

Then there's [renal denervation](#), a surgical treatment for millions of patients with resistant hypertension initially touted as a potential "cure" by the American Heart Association, which has now been shown to be no better than sham surgery. At least it only took three years for the well-controlled study to be conducted.

And this is just the tip of the iceberg. The problem of overuse is so widespread, so deeply embedded in American health care, that even the popular press has begun to notice. A [series](#) that began last year in [Bloomberg News](#) details the overuse of stenting and other cardiac procedures in hospital after hospital, including a major academic medical center. [The New York Times](#) has published stories and op-eds on the overuse of everything from CT scans to Mohs surgery.

Clinical Evidence

And yet, for such a significant issue, there's an astonishing amount we still don't know. The U.S. has no research agenda on overuse, and thus we do not know with any precision how often it occurs. We can name its myriad causes, such as fee-for-service payment, defensive medicine, supply-induced, patient demand, and a poor base of clinical evidence, but we do not know how much each factor affects clinician behavior. There is remarkably little information about the rate and nature of the harm overuse causes to patients, families, and clinicians.

To date, most research on overuse has focused on overtreatment, or rates of inappropriate delivery of such treatments and tests as cardiac stenting, antibiotics, ear tubes, elective induction of labor, and tonsillectomy, discreet medical services for which appropriateness criteria have been established.

This leaves a lot of uncharted territory. Only a minority of the decisions that clinicians make are based on valid science, leaving a vast swath of procedures and tests that are performed in the face of incomplete knowledge, if not an absolute dearth of clinical evidence. Even when developed by specialty societies, [clinical practice guidelines](#) are often little more than expert opinion. They are generally not subject to unconflicted external professional review, nor are

they reviewed by unbiased patient or other public bodies.

There is also increasing attention being paid to rates of misdiagnosis and overdiagnosis from such screening tests as the PSA test and calcium imaging, which pick up lesions or conditions that would not have caused symptoms had they been left undetected, or detect lesions that are not necessarily abnormal but lead to further tests and complications.

The [Dartmouth Atlas](#) has documented wide geographic variation in rates of "preference-sensitive" treatments and tests, such as cardiac bypass surgery and elective cholecystectomy, as well as [hospital-based rates of "rescue care" for patients at the end of life](#).

Understanding Harm

While it's not clear what the appropriate rate for such treatments might actually be for any given population, there's [ample evidence that a significant percentage](#) of elective care is given to patients who would have chosen to avoid it, had they better understood their choices and the tradeoffs involved.

Of the three aspects of overuse that bear greater and more systematic scrutiny, harm is probably the least understood and the most important, especially for older patients with serious conditions. Although hard data are scarce, anecdotal evidence of widespread and egregious harm to chronically ill, frail, elderly patients can be found in any hospital in the country.

[Multiple surveys show](#) that most Americans would prefer to die at home, yet the majority still die in the hospital, many in the intensive care unit. Indeed, in private, some clinicians say the American way of death is a form of slow torture. Addressing this vast and devastating problem will not be easy, but the hard work has begun.

The Choosing Wisely campaign has elicited lists of ["top five" procedures and tests that are overused](#) from more than 30 different specialty societies. While many observers note that these lists consist of low-hanging fruit – the most obvious or least remunerative examples of overused procedures – they have triggered a wide variety of quality improvement efforts in clinics and hospitals around the country.

However, overuse is more than a technical problem – "it's part of the air we breathe," as physician and bioethicist Howard Brody put it at the Avoiding Avoidable Care Conference, sponsored by the Lown Institute in 2012. Patients often believe implicitly that there's always one more test, one more treatment to try, and that their doctor would never recommend a procedure or a stay in the ICU that was not in their best interest.

For clinicians, overuse is reinforced through the hidden curriculum of medical education, lack of training on how to communicate with patients and families about advance directives while assuring continuing support and care, and by other factors such as financial rewards, discomfort with uncertainty, and fear of liability.

Thus quality improvement efforts aimed at reducing the inappropriate use of discrete tests and treatments must be amplified by efforts to address the embedded culture of overuse. It is not

enough to promote clinical guidelines for appropriate use when we often have so little information on what works and what doesn't, for which patient, and what the patient prefers. Moreover, changing that culture of overuse will require shifts in the infrastructure of health care, the manner in which we train young clinicians, and public views of the power of medicine to prevent death.

We must also implement shared decision making, a formal process for informing patients of their treatment options and eliciting their preferences, through incentives such as quality guidelines and payment, and young clinicians must be explicitly trained to practice it. We need better systems for ensuring that advance directives and person-determined goals for care are respected.

Rates of completion of and compliance with advance directives should be a reportable quality measure. Another reportable measure: the percentage of elective surgery patients who have access to shared decision making and high-quality patient decision aids. And as many health policy experts have already pointed out, we need payment models that value effective care directed at patient goals over simply putting "heads in beds" and performing more procedures.

Palliative care has a central role to play. Patients and their families are quite capable of understanding that there are tradeoffs involved in virtually every medical choice. But there is often a wide gulf between what patients want, how they express it, and what clinicians may subsequently feel compelled to deliver; between patient-centered care and tests and treatments applied by harried and risk-averse clinicians who work in hospitals, nursing homes or other sites of care that are not organized around the needs of patients.

Palliative care practitioners recognize, whether explicitly or not, that patients and families often need help in forming concrete and achievable goals for care, and they need to understand both the potential benefits and the harms of alternative paths, and the limits to what medicine can do to improve the quality of life and lengthen it.

This is especially true for the frail elderly, where [personalized home care can improve quality of life, even length of life](#), while dramatically reducing hospitalizations and the use of expensive but potentially harmful and futile technology.

If we want to break the cycle of overuse, certainly we must give clinicians the evidence and other tools they need to know what the right care is, and a legal system that ensures they won't be sued if that's what they deliver. And we must train them to be better appraisers of evidence. We need a research agenda for the problem of overuse, and ways of measuring compliance practices.

But more than all of these, we need to change the culture of medicine, towards an ethic of "doing more for the patient, and less to the patient," in the words of cardiologist and humanitarian Bernard Lown. It's time to challenge the implicit belief, on the part of both clinicians and patients, that more is better.

TAGS: AGING, CHRONIC CARE, EFFECTIVENESS, END-OF-LIFE CARE, H
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Diane Coleman, JD says:

While this article makes a number of valid points, it demonstrates the one-sidedness about overtreatment that is prevalent among healthcare providers who write

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May 24th, 2014 at 1:41 pm

Sara Buscher says:

Regarding people not dying at home, the article sees this as indicative of overuse. Having worked with many elderly people, what I see is that when a scary complication occurs people want to know what is happening and if it can be fixed. They head to the hospital emergency department. They feel safe at the hospital. This is far better than being alone at home and afraid.

May 23rd, 2014 at 4:17 pm

jim jaffe says:

interesting to see echos of the pervasive belief that the reimbursement system is at fault despite data indicating that there are low- and high-intensity markets and that

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May 8th, 2014 at 1:26 pm

Michael Fleming says:

Thank you for a well written post on these issues. To go a bit further with your points, we must all agree that quality and value are a "participatory sport." That is, much of

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April 30th, 2014 at 9:44 am

McMike says:

Now that we've cracked open the question of excessive, counterproductive, marginal, and unnecessary medicine, perhaps we can wonder whether this tendency and

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April 28th, 2014 at 11:26 am

Carole Chryala says:

Thank you for a cogent, well-written article on the imperative to switch our mindset to recognizing that less truly is more in the treatment of many health conditions.

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April 28th, 2014 at 10:50 am

Ron Hammerle says:

Nearly a quarter century ago, two Robert Wood Johnson foundation ["SUPPORT"] studies showed that despite two decades of litigation and legislation, advanced

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April 25th, 2014 at 1:50 pm

Mark Kellen says:

You have ignored the primary cause of excessive and wasteful medical care: our third party payment model. As long as bills are not directly paid by the patient, the cost benefit calculation will always be skewed toward wasteful care.

April 25th, 2014 at 11:14 am

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