Follow the money…

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Our hospital CEO mentioned at an administrative meeting the other day that an anesthesiologist who owns a pain clinic on the mainland is aggressively pursuing an appointment with her. He wants to talk, she thinks, about providing some service on our island. She says that he has an impressive website and 20 employees. We Googled the website at the meeting. It is impressive.

She’s been resisting the meeting on the grounds that he wouldn’t find enough work here, but he’s insistent. She’ll meet with him soon, I imagine.

What can he offer? Treatment for pain, certainly. How? Simple things are already available here, so he will probably want to offer complex and expensive options – injections (the website lists more than 15 general types), implanted drug delivery systems, and implanted spinal cord stimulators.

Though he’ll probably want to do procedures, he will probably not propose a complete coordinated multidisciplinary service. Still, wouldn’t that be great? Somebody could come help us stamp out pain through technology and drugs.

But there’s a question. Do interventional pain procedures really stamp out pain? I had dinner last week with an old friend from the University of Washington, an anesthesiologist who has been involved in chronic pain work for more than 40 years. In his view, there’s very little objective evidence that any of the expensive, high-tech new therapies work well in treating or eliminating chronic pain. In particular, few double-blind studies justify the procedural approach to pain relief, despite its popularity and despite the fact that pain docs bill bushels of money for performing these procedures.

Our CEO is one of the smartest and most dedicated administrative people I’ve ever known. But she’s in no position to say, “Yeah, well prove that all this expensive stuff works, Bub.” Instead, she may feel obliged to make space for a doc who wants to do procedures that produce substantial revenue for the hospital. She’s obliged to serve the hospital’s financial viability, not make judgments about the efficacy of expensive treatments.

So she may need to support procedure-based medicine that sounds good and is reimbursed without question by all insurance companies, whether or not it’s really of lasting value to patients. She can’t question the value of pain procedures, any more than she can question the value of invasive cardiac procedures or cancer therapies.

But there’s certainly room to question. Who should be doing that?

Jeffrey Parks questions. Dr. Parks is a general surgeon who blogs courageously as Buckeyesurgeon. His most recent entry (<http://ohiosurgery.blogspot.com/2013/03/cardiac-outcomes.html>) refers to a review of *Broken Hearts: The Tangled History of Cardiac Care*, a new book by Harvard medical historian David S. Jones. Jones’ book, he observes, “explores the rise of interventional cardiology and cardiac surgery since the 60's and how much of the rationale for such a procedure-dominated treatment strategy is undergirded by some surprisingly shoddy data.”

Parks says that Jones’ book cites the troubling lack of evidence from controlled trials that either coronary artery bypass grafting or less-invasive coronary stenting has any demonstrable effect on survival when compared to medical management of coronary artery disease. Parks recalls no time during his surgical training when he heard cardiac surgeons question whether CABG procedures were effective, though they lamented the decline in such procedures, as it restricted new jobs available for fellows. Cardiologists, too, he says, have persisted in inserting coronary stents in spite of lack of evidence clearly showing improved long-term survival.

“We may be too far gone to change anything,” Parks says.  “The coronary intervention/surgery sector is a $100 billion industrial complex.” The idea that the medical/pharmaceutical/industrial complex might be as troubling as the military/industrial complex against which Dwight Eisenhower warned us is increasingly part of conversation now. See Steven Brill’s lengthy Time Magazine piece entitled “Bitter Pill: Why Medical Bills are Killing Us” (<http://www.time.com/time/magazine/article/0,9171,2136864,00.html>). Brill covers a lot of ground, but he’s pretty clear that medical billing is out of control. Hospitals charge whatever they want, according to seldom shared price lists that he calls “chargemasters.” People pay whatever their insurance companies have negotiated – except for the uninsured, who are expected to pay the hugely inflated prices of the chargemaster. It’s been that way all the time I’ve been in medicine, but the gap between what’s charged and what’s paid is much greater now.

When I was diagnosed with prostate cancer in 2000, I didn’t care how much it cost to cure it, if somebody else was paying. And I definitely didn’t want to wait for double-blind studies to validate the treatments that sounded best to me. I found it difficult at that time to compare one treatment with another, and very difficult to get an idea of the side effect and survival profile of any particular treatment. At some point I realized that it was virtually impossible to get any information on the difference between being treated and not being treated. I had some idea what might happen with different treatments, but almost no information on what would happen if I took no treatment at all. I could clearly see that some people were dying of prostate cancer, but I couldn’t see clearly that any of the treatments I was looking at would have “saved” those people. Controlled trials were completely unknown.

I asked the physician who ultimately became my treating physician in Georgia why it was so hard to get good comparative data, and why people seemed so reluctant to be objective about the treatment they offered. “It’s big money,” he said. Each of the docs offered only a single treatment modality – external beam radiation, seeds, prostatectomy, cryotherapy, and so on. And everybody was so desperate to hang onto the big money in cancer treatment that docs simply could not afford to have their business fall off substantially if patients moved to a more appealing treatment, one which would be provided by somebody else. Objectivity was an expensive luxury for docs maintaining a state-of-the-art treatment center.

Treatment was expensive even then, thirteen years ago -- $25,000 to $50,000 – and it was paid for because the treating docs believed in it and convinced insurers of their beliefs, not because they’d clearly shown effectiveness. They knew that they could make prostates disappear, but they didn’t know whether that would make a long-term difference in who survived the disease. And not one of us wanted to wait ten or fifteen years for results, imagining all the time that the disease was crawling through our innards and destroying our precious generative organs. We patients were never, ever, going to argue for restraint in medical spending, especially if somebody else was going to pony up the money for us.

On another note, I’ve been interested in end-of-life care for a number of years. I’ll practice palliative medicine when I leave the OR, and I’m training in the meantime to be a hospice volunteer. In addition, Jan and I have just been through the process of filling out extensive end-of-life directives with each other.

I’m reminded especially, now, that medicine at the end of life is more of the same. We fear death, and we do whatever we can to avoid it – we commit ourselves to operations, to chemotherapy, to intensive care, to CPR, to intubation and artificial ventilation, to tube-feeding. When we lose the ability to choose, those who love us may commit us to these same options.

As a society, we support that. Medicare will pay for any care a doctor orders, including all futile efforts at preserving fleeting life at the end. On the other hand, Medicare pays a severely limited amount of money for six months for a patient who elects hospice care. How much of this limited care do people on Kauai actually use? We learned that on Kauai people who come to hospice get an average of three weeks of care. We’re that afraid of giving up.

Here’s where palliative care has a role, the search for what Ira Byock calls “the best possible care,” not simply the most interventions. Right now if we simply insist on the next possible treatment, Medicare will pay for it all, no matter how futile. On the other hand, if we actively make a selection in favor of pain relief, comfort, support, and gentle death we swim against the tide of technology, and we find that money available for our care is limited and carefully doled out.

We have plenty of money to provide good medical care. Powerful forces distort the distribution of this money. Our medical/industrial/pharmaceutical complex has effective ways of attracting money preferentially to the new and glamorous – not necessarily the effective. Not all that money improves patient health.

On a final note, a group of Canadian docs who were teaching in the Difficult Airway Course pointed out an interesting difference between their practice and mine. In Canada, they said, the money is all on the table at the start of the game. Surgeons and proceduralists do procedures that use up the money, and are regarded as cost centers. In the US, on the other hand, hospital income comes from reimbursement for medical procedures. Surgeons and proceduralists do procedures that generate revenue for themselves and for hospitals. They’re revenue generators. Cost center versus revenue center. Which has the most power? How can we expect hospital systems to resist the temptation to support procedures that increase revenue, no matter how poorly-studied they may be? Whose job is it to put a flag on the play when a medical procedure is unstudied? Or worse, studied and shown of little value? If we stop paying for unproven procedures, will we have anything left we can offer?