



PRESCRIPTIONS FOR HEALTH REFORM:

A PODCAST FROM THE BLUE CROSS BLUE SHIELD OF MASSACHUSETTS FOUNDATION

Transcript of podcast interview with
Dr. Nortin Hadler, author of *Worried Sick: A Prescription for Health in an Overtreated America* and *Stabbed in the Back: Confronting Back Pain in an Overtreated Society* 2.12.10

Q. I'd like to talk a little about both of your last two books, *Worried Sick* and *Stabbed in the Back*, because I think the former sets out some of the broader landscape, while the latter drills down into one aspect of it. So would you start by telling us a little about why you wrote the books, and who you wrote them for?

A. Well, I'm a senior faculty member, I'm a medical educator, who has been on the faculty at the University of North Carolina since 1973, which is when I left Boston, having been a Harvard Medical student and done all of my training at Massachusetts General Hospital, and we headed south, having been exposed to what I thought was the finest in bedside clinical scholarship.

Let me define that. The finest in bedside clinical scholarship is where we are able to attempt to recognize the limits of certainty. And in terms of my career as an educator, that has been the banner. We don't do anything to patients without first discussing whether or not we will advantage the patient, and how certain we are we will advantage the patient. So that has been one of the themes of my career.

Another theme has been as a clinical epidemiologist interested in workplace health and safety.

About 10 years ago, I was faced with a personal moment of truth, if you will. I was perfectly content as a clinical educator, and I was perfectly content with the productivity as a clinical investigator, that's a dozen books, and a couple of hundred research papers, and I found it harder and harder to teach medicine in this country. I've taught in many others, but harder and harder in our country because what I saw going on at the American bedside, and what I knew was beyond the limits of certainty, became commonplace. And what I decided to do

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was to figure out how I might be able to educate the people at large, my students and my patients, as to what would make sense to do in the 21st century, the end of the 20th century in terms of clinical care.

And I spent about three or four years meeting and greeting the so-called stakeholders and a lot of legislators. And I realized that we had become ethically bankrupt as a profession and that the institution of medicine was built on a bunch of sophisms that had very little to do with the care of the patient.

We had forgotten what I had learned in Boston all those years ago. What are the limits of certainty, and how do we justify going beyond the limits of certainty when we have information that says we shouldn't?

So, realizing that I wasn't going to make a big difference amongst the stakeholders, I decided that what I could do best was to educate beyond the bedside, and decided to write four books. The first three have been published, the fourth I'm writing currently, and the books you mentioned are the second and third. The first was a book called *The Last Well Person*. I've published all of these with university presses because I wanted to have peer review, and the first I chose to publish with McGill, fearing that I couldn't get peer review in the United States of America. There's a folly to peer review in that we tend to have peers of like mind, who look at the world through the same rose-colored glasses, and some of the things I was going to say in these books would not readily find peers amongst the thought leaders in various disciplines in our country, but I had no fear in Canada, Great Britain, or Europe. And the *Last Well Person* is now translated into French, about to be translated into German, and is out in paperback.

Worried Sick picks up where *Last Well Person* leaves off. What I do is I look at 10 of what we think of as state-of-the-art-of-medicine clinical contracts, things that relate to how do we make it likely that we will live to a ripe old age, what are our risk factors in not getting to a ripe old age, and what do we do about those risk factors, and other issues like how we treat a number of discrete entities. What I do is I examine for the general audience, the literature that speaks to how certain we are that what we're doing actually advantages to them. These books have shadow chapters. The shadow chapters go through the statistics and the data itself. The books have thousands of references. The point was, can I inform the debate as to effectiveness, because I actually think that the biggest issue we face in this country is not so much the quality of care or even the distribution of care. It is the lack of effectiveness of what we do, because I firmly believe that if what we do to any fellow human being doesn't advantage them, well, I don't care how well we do it, and I



don't care how inexpensively we do it, and I don't care how much ready access there is, if it doesn't work, we shouldn't do it. I believe that effectiveness is the horse, and quality and distribution and costliness are the cart.

So *Worried Sick* and *Last Well Person* are hard-to-ignore books simply because they're not books of opinion. They're books that display what we know about some of the things we do most commonly to Americans. We will discover that when you do such an exercise, that it is hard to justify anyone having coronary artery bypass grafts or stents of any kind. It's hard to justify most elective orthopedics from surgery for regional backache to almost everything that's done through an arthroscope, and on and on. There are a number of these things that represent a tremendous percentage of the effort and expense of the so-called health care delivery system that is being done to Americans despite the data that suggests strongly that we're not helping them.

Q. But you came back to a U.S. publisher for *Worried Sick*. Do you sense that there's a greater acceptance here now for some of the ideas that you set forth in your first book?

A. Well, there always was a greater acceptance than most people would imagine. I don't think—I never feel very much antipathy from the physicians. I've been educating physicians for a long time and do a tremendous amount of lecturing. There is antipathy on the part of the people who have a tremendous investment in particular procedures, and there is antipathy on the part of the American people, because whenever you say something like I just said, that I would never let anybody check my cholesterol. I'm a well man, and there's nothing in it for me to check my cholesterol or to treat me. If you say that without fully educating the reader or the audience, it sounds like I want to ration health care. Well, I don't want to ration health care at all. I would like us to even do away with co-pays. I've never felt comfortable with the Rand study that formulated co-pays. I want to make rational health care.

The antipathy comes from people who are invested in what is irrational about our health care. The antipathy comes from people who are not at all evil but are very much invested in what they do to folks. So that if you're a cardiologist—I'm not suggesting that there's any malfeasance—if you're a cardiologist who's used to putting in stents, that's a technically demanding exercise, and you take great pride in the prowess which you bring to the cath lab. So that cardiologists tend to sit around and talk about what they did to the patient, not whether they should

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have done it in the first place. And they're very inventive, because there are now several randomized controlled trials that can't show any benefit from stenting, and suggest that there actually may be harm, and instead of saying "Well, maybe we ought to rethink what we're doing in its entirety," the usual response is they didn't do it the right way, they didn't do it to the right artery, they didn't do it soon enough, even though we have data that [shows it] doesn't matter how soon you do it in Canada. It doesn't advantage the patient. The peer review amongst the people who put in stents is much more related to technical accomplishment than to patient outcome. So yeah, the reason I came to American publishers, university publishers was it was much more convenient and clearly at this point, there is a large audience that is capable of stepping back and asking the question I want them to ask, which is, "Will this really advantage me?"

Q. You give examples not only of cardiovascular disease, but also breast and prostate cancer screening, aging, back pain. What kind of cost savings are we talking about in aggregate if we were able to focus on the most effective treatments and eliminate everything else?

A. In terms of direct costs, now there's a tremendous issue with overhead and inefficiencies and the like, which by the way, no other country has, but if we're talking about the direct costs and what's done to people, with the current American pricing system, which is also outrageous, we would cut the direct cost down by over 50 percent. When we model this, and actually in *Worried Sick*, and even more in the new book, we present some of the data on modeling what would happen if you based your health insurance, I actually call it health assurance, disease insurance, system, on effectiveness, and it will take direct costs down by 50 percent, but that's for me a secondary issue. It may be important for the policy people, but what we will be doing is sparing Americans a tremendous amount of things and procedures and pills for which there is data that says there is no important benefit derived from having the things, the procedures, and the pills. That's got to be the moral high ground. This is not a debate for me in health care finance, it's a debate in health care. If it doesn't work, if there's no meaningful benefit, I don't care if you're giving it away. Don't do it to anybody.

Q. You talk a little bit about regional lower back pain in *Worried Sick*, but then you chose to expand that into a standalone book. Why did you choose that particular ailment for your next book?

A. Well, there are a couple of answers to that, but one of the simplest is I've been a

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student of that topic for 35 years. I've published multiple books for a professional audience and literally hundreds of papers, so it's an area that I have contributed to, to a great extent throughout my career.

And it is an object lesson on the principal issues that I think we face in our country more than any other. The lessons that relate to medicalization, that means we're taking things that really are maybe difficult personal problems and predicaments and calling them diseases and treating them as diseases despite the fact that we have plenty of data that suggests doing that doesn't advantage the patient. In fact, in the case of backache, there are plenty of examples of where it disadvantages the patient.

And then backache, regional backache, low back pain in otherwise well people who have no systemic illness and have no trauma, that's the topic we're talking about, regional backache is not a surgical disease, even though it has an enormous surgical industry. It also has spawned several other professions, and several other disciplines, all of which represent a tremendous part of the fabric of health and life in our country, despite a tremendous amount of information that says, wait a minute, are you sure you really want to think of yourselves in this context of a diseased person with a bad back who might have had some euphemism like a ruptured disk or something like that, all of which are normal. If you can go a year without a backache, that's distinctly abnormal. So the issue is not "do you get backache?" Of course you get backache. The issue is how do you handle it, what does it mean to you, what does it do to your level of function and comfort and for how long?

Q. You mentioned the role that specialists play in driving this medicalization, for example, cardiovascular surgeons who want to put in stents. Are the specialists the only ones to blame for this medicalization, or are there other factors as well?

A. Well, medicalization is a societal construct rather than a medical-surgical construct. Americans think this way. We've learned to think this way. The book, by the way, starts with some of the history of the way we think about backache across time. I can take it back to Sumerian tablets. I actually start with one of the more interesting case reports which is Jacob in Genesis, and how we've come to conceptualize backache and what it means and when it became a medical condition, and how the physicians and surgeons responded to the notion that it was a medical condition, and how we became desperate about our backaches so that we put ourselves at great risk because we had a bad back. These are all a continuum of social construction over time, which has peaked in our time

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in society. It is a segment of life in America despite an enormous amount of information that says that we've got it wrong. We're thinking about it wrong, we're doing ourselves harm, we're learning languages that describe an experience where the language doesn't help us feel better. It actually makes us think of ourselves as flawed. It allows us to go to desperate measures because of the structure of the construct rather than the structure of our back.

Q. Many are now talking about the benefits of so-called “evidence-based” medicine. One thing that you remind us of in your books is that it can be hard to determine what treatments are effective and therefore what constitutes valid evidence. Why is this so hard and how can we do a better job of it?

A. I don't even think it's so hard. I mean, we literally have hundreds and hundreds of randomized controlled trials that speak to issues of backache. We have an enormous amount of information. It's not private information, it actually is available, so available that there are international bodies of scientists who review it and try to come to some sense of whether or not there is evidence for particular interventions. All I do is look at some of these consensus groups, none of which are perfect. No study is perfect, no way of looking at the data is perfect, but I just apply a couple of common sense razors to the analysis and ask what could they be missing that's really important. And if the answer is they can't be missing very much here at all, why are we putting people at risk if I have to treat 100 people and maybe do something good for one? I don't believe that can happen. And besides, I'm not so sure that if patients understood that there was one chance in a hundred of something good happening to you, almost comparable to the odds of having something good without the intervention, would they choose the intervention? I just finished an essay called “The Health Care Lottery.” We have a problem in our country with our lottery mentality. It is true that somebody is going to win your state's lottery. Does Massachusetts have a lottery?

Q. Yes.

A. We do, too. Someone wins, and everybody says, gee whiz, if there's a chance I could win, and you're telling me you're going to pay for this intervention, and you're telling me that the short-term risks, because we usually only know the short-term risks, are tolerable, well, I want to go for the win. That's the lottery mentality. But that has nothing to do with health care. When we do randomized controlled trials and come up with a small difference between the outcomes for the treated group and the outcomes for the untreated group, that means you're almost as likely to win the lottery if you didn't buy the ticket as if you did.



That's the lottery mentality we've got to teach America, so that when I say to you, "You know, it's perfectly reasonable that we don't go down this path, because the chance of your doing well is not very high if we go down this path, and it's almost as high if we don't, and I don't believe there's a real difference between the likelihoods going down the path of treatment or going down the path of not having a particular treatment," most people would step back and say, "Gee whiz. Why am I putting myself through this procedure or these extra risks when I'm not going to do very well either way, or I am going to do very well either way? I'd rather take my chances without the intervention." Once you start talking like that, you can start talking about well, is there a fiduciary role that we're missing here? Should society be able to say, "You know, if it isn't really important, whatever we decide in our community, important event, we shouldn't pay for it."

Q. You mentioned the fiduciary role. Whose job should it be to ensure effective medicine?

A. In both *Worried Sick* and *Stabbed in the Back*, I lay out a model for that. It is not the only model. In fact, it is not the best model. The best model we missed by several decades in this country. There are better models abroad. But in our country, we have a mindset and a tradition that needs to be changed in good time, and not cataclysmically, so what I'm actually calling for is not a federal program. We already have an estimated six lobbyists for every congressman. If we had a federal program, we'd probably have many more lobbyists per congressman.

I'm looking for regional programs, maybe state based, there's a tradition for that, with a fixed pot of money and people who are trained, some of whom are going to be trained with MD's, some will be trained without MD's, to consider issues in evidence for effectiveness. Based on the pot of money and the need to distribute the money between funds that would be available for medical interventions and funds that remain available for individuals to do for other things that are important for their health, such as English as a Second Language or job retraining or things that are licensed in your state that actually are extremely important for health. We are loaded with data that those things represent about 80 percent of your mortal hazard. So we're partitioning a fund of money between disease insurance and health assurance using rotating groups of people comfortable doing this.

This is not a skill set that this country lacks. We have a tremendous number of people who are capable of looking at evidence and saying there just isn't enough here to spend the common dollar, and therefore we're not going to save money,



we're going to save your money, it'll go into your other fund so that you could purchase things that are important for your health and the health of your family over time. It's very hard to answer that question in three minutes, and I don't try to in the books, but there are ways to make this a fiduciary role so there isn't a "health czar," a concept I don't like, and so that it isn't something that is lobbyable, based on who I know, but it is transparent, it is competitive between different groups, so if the state of North Carolina thinks there's a little joy in a particular new drug and the state of Massachusetts says there's not enough joy in it, we will find out pretty quickly which state was right.

Q. Is this just a thought exercise at this point, given where we are in our health care debate, or do you think there are components that could still be adopted, either at a state or a nationally level?

A. I am totally convinced that our country in terms of health care finance reform is hell-bent on disaster. That as bad as it is now, and it really is tragically bad, what we call health care in this country, it will get worse. The reason it will get worse is that we have only a piece of the moral high ground. We're about to make sure that everybody has access to health care without saying what health care is. Wouldn't it be tragic if half of the 40 million uninsured happen to have cardiac stents within the next six months? That would be tragic for them because it wouldn't advantage them. It would be tragic for the country because it would be an enormous transfer of wealth, and there's very few places to get that except to increase your deductible, your co-pay.

Q. What would you advise Congress and the President that they would need to do right now to start moving towards a more effective system, as you see it?

A. It's interesting. I have had the occasion to have input, and the response to this conversation is in the stimulus bill. The response was, on the part of people I respect, who actually are health economists and methodologists who are very, very competent. The response went something like this: "We do not have enough information today to base health care on effectiveness. In fact, we need more information." So in the stimulus bill is a tremendous amount of money in terms of academic medicine—it's not a tremendous amount of money in terms of Wall Street Bailout, but it's close to two billion dollars, in doing cost-effectiveness research going forward, so that five years from now, we will have another data set upon which to base effectiveness decisions.



To which I said that we already have an enormous data set. It is not perfect, nor will it be in five years, that this is a holding effort, it's a way to avoid what needs to be done. That doesn't mean that bad people are going to do these studies. People are going to do these studies, very competent scientists, but it essentially is obscuring the most important issues, and on top of that, this comparative effectiveness agenda initially included a comparative cost-effectiveness agenda.

Now that wouldn't have been what I would have applauded, but it would have been interesting, because a tremendous number of the things that we do, that don't work, come in several flavors. They come in inexpensive, more expensive, and much more expensive flavors. So comparative cost effectiveness wouldn't speak to what I want to speak to, which is it doesn't work enough to even fund. It would speak to the fact that many of the things we're doing could be done cheaply, even though I'm saying some of them shouldn't be done at all.

The cost-effectiveness component of the stimulus package, stimulus bill, was expunged in committee, under tremendous pressure from lobbying groups. So we are not doing cost-effectiveness comparisons, we are doing comparative effectiveness research, and five years from now, we will be exactly where we are today. We will have even more information with or without the stimulus bill, none of it will be absolutely perfect, all of it will be lobbyable, if there is such a word, and we will be back where we started today in our conversation, which is, why are we doing so many things to Americans that don't work?

Q. Let me just ask something on a different level. I know you have connections here in the Commonwealth, as you've said, and Massachusetts has made a number of major health care reforms recently. Do you think the state has done enough to address effectiveness with these reforms, and what more can be done on the state level by Massachusetts or by any state?

A. I can't speak to Massachusetts because I don't know it well enough to comment. I can tell you that North Carolina was not willing to look at the effectiveness agenda. No one will be. It's a third rail. You will get tremendous pushback from the people that don't want this done. Tremendous pushback. In fact, I gave an address at the National Press Club not that long ago, attended by a number of people from Congress and policy positions, and one of the Congressmen, this was actually written up recently, one of the Congressmen said that we would love to have effectiveness, we talk about it all the time, but we are surrounded by people who have vested interest in not letting that happen.

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So until we make this a visible issue, until the country comes to understand that this really needs to be done, that it's not rationing, that this is a rational approach to health care, we have to stop doing to people what doesn't work. And unlike prior generations, we can. In the past, when I was a medical student, an awful lot of what we did to people was based on what we called eminence. Eminence-based medicine. It was the Harvard professor saying, "This is what should be done," and everybody in the country did it. Now we actually ask the question. I consider this the most important advance that medicine has offered society in my lifetime, is not all of the wonderful things we always hear about and read about, and not the miracle of the weak. It's for the first time, we can ask whether or not the advance really works. We've been doing that, and now we have to learn as a country to take advantage of that information.

Q. Would you put the burden on consumers, or doctors, or a combination of them to take the lead in driving for these changes?

A. This gets back to the notion we were talking about in backache and the social construction. There are two ways. Either our president had to be able to take the incredible heat of standing up and saying this, and I don't quite understand how he could do that because it's not his bailiwick. I mean, what does he know about evidence-based medicine and effectiveness and what's going on except what he is told? So he would need to have surrounded himself with people willing to take a tremendous amount of heat for saying this.

Therefore the burden that I'm putting on is on our society. We need a shift in social construction. There's no doubt that there will be impetus for it. There already is, and there will be much more when you discover that you can't afford your deductible, co-pay, and employee contribution much longer, either. That's when people are going to wonder, cast about, and ask why is health care so many times more expensive here than in any other resource-advantaged country? Why are we doing so much more to Americans than any other country is doing, and our health outcomes are not shining lights. To the contrary.

Q. You mentioned that we missed our chance to take up the best model for care, and indicated that that was to be found abroad. Was there a particular country or model that you had in mind when you said that?

A. In my career, I've spent two years in Britain and nearly a year in France and Israel. I set up a teaching program in Japan. I've done worker's compensation studies,

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formerly for the World Health Organization in 12 countries, so I know a little bit more than most American physicians about health care transnationally. There are others who have written about it.

Let's get back to this notion of what health care is. It's a very interesting social construction, what people think of as health, what they expect from their health care providers did not come down on Mount Sinai on the tablet. It actually evolves nation to nation, so that the Japanese system where I taught for a long time would not translate here. The Japanese internist sees 100 to 150 patients a day. Most Americans would not consider that going to the doctor. By the way, the Japanese health care data—we have no recent data, but as recent as we have, outstrips us by far in all outcomes you could measure. There is no other system that I could imagine planting on our soil. But there are ways to make our system rational. The way I'm advocating starts with a very simple little premise. If we have good data that says we're not doing well by you, why are you letting us do it to you, and why are we as a country sharing the cost of doing things that don't work?

Q. Well, last question, then, turning back to consumers. What are the key questions we should be asking our health care professionals before undergoing any kind of treatment?

A. Very simple. How certain are you that this will really advantage me? If we all start asking that, we will change the entire complexion of health care delivery in this country.

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