

You are here: [Home](#) » [Cost of Health Care](#), [Health Care Delivery](#), [Health IT](#), [Perspective](#) » Daring to Practice Low-Cost Medicine in a High-Tech Era

Perspective

Daring to Practice Low-Cost Medicine in a High-Tech Era

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Sean Palfrey, M.D.

A child with chest pain or tics, a toddler who is limping, a 12-year-old girl with abdominal pain or headaches, an infant whose fever does not respond to antibiotics — these are age-old challenges that pediatricians face. I have been teaching pediatrics to residents and medical students for more than three decades, but over the past few years, as I've watched trainees at work, sitting at their computers, and ordering and monitoring tests, I've grown worried that the practice of medicine has tipped out of balance.

Recent advances in scientific knowledge and technology have resulted in the development of a vast array of new tests, new pharmacologic agents, and new diagnostic and therapeutic procedures. These are so accessible to us in the United States that few of us can resist using them at every opportunity. By being impatient, by mistrusting our hard-earned clinical skills and knowledge, and by giving in to the pressures and opportunities to test too much and treat too aggressively, we are bankrupting our health care system. Ironically, by practicing this way, we are perpetuating serious economic and racial disparities and have built a health care system that rates in the bottom tier among all developed countries in many categories of children's health outcomes.

Most doctors are intensely risk-averse. We don't tolerate uncertainty. Not wanting anything bad to happen, we reflexively overtest and overtreat in order to protect our patients — and ourselves. We feel judged by everyone — ourselves, our colleagues, our patients, the health care system, and the lawyers. The meaning of "first do no harm" has changed for us. We feel that "doing everything" is the best practice and the way to prevent harm, and we believe that it will shelter us from blame. We order tests and treatments because they are available to us, well before their importance has been established, their safety has been determined, and their cost-benefit ratio has been calculated.

The evaluation of a child with fever and cough is a good example. There are many possible causes, and we have a huge battery of available tests that might give us potentially relevant information. But why should we no longer trust our physical exam, our knowledge of the possible causes and their usual courses, and our clinical judgment? How much will we gain by seeing an x-ray, now, and how likely is it that the result will necessitate a change in our management? How dangerous would it be if we chose to perform certain tests later or not at all? Might our residents not learn more by thinking, waiting, and watching? Who is actually benefiting when we order a test — the patient, the laboratory, the drug company, the health plan administrators, or their investors? And who is losing health care as we spend these dollars? We need to ask these questions of ourselves and our residents at every step of the clinical process.

I believe that we must rediscover the value of clinical judgment and relearn the importance of the personal, intellectual, scientific, and administrative thought that is central to the best practice of medicine. We need comparative-effectiveness research, as well as cost-benefit and long-term-benefit analyses, to inform us how to integrate traditional clinical skills with the use of new tests and therapies. Our time and attention have been diverted to the task

of sorting out data instead of sorting out what is important to our patients, their families, and the community at large. This new style of test-avid, cover-all-possibilities practice is bankrupting our health care system and depriving many families of access to health care and a medical home. Not having a medical home can be as devastating as not having a physical home. If children have no primary care, we have no way to prevent their asthma attacks, poisonings, obesity, or suicides, and if they are unimmunized, they may spread vaccine-preventable illnesses to their young siblings and aged grandparents. Society as a whole is the loser.

We as clinicians must change our practice patterns, but first the medical community, through standard-of-practice guidelines, must give us permission (or better yet, encourage us) to practice in a less costly way, so we don't feel we are expected and incentivized to order expensive tests or treatments. Similarly, clinician-teachers must develop the confidence (or be given the imperative) to teach students, residents, and fellows how to practice in the most knowledge-based, least invasive, most frugal fashion possible and to seek input from physicians with more clinical experience when they feel the urge to order a test or initiate a treatment.

Education of the public is also critically important. We need to admit to our fellow citizens that the United States, despite its wealth, technology, and research expertise, is 21st in the world in terms of many indicators of health, and we must convince them that population-wide changes designed to improve health outcomes would be in everyone's best interest. We need to teach our patients that more medicine is not better medicine, that it is poor health care for doctors to order too many tests or too many interventions, and that costly efforts do not equal better health care. As we address their personal needs, we need to explain to our patients that we have to use new medical technology with care and wisdom. Indiscriminate health care spending is not fiscally sustainable at a national level and actually hampers the achievement of many universal health benefits.

Every participant in our health care system must focus on ways to optimize health while decreasing cost, at every step of the process. We need to change the financial incentives currently embedded in health care reimbursement systems that reward the use of tests, procedures, consultations, and high-cost therapies. And finally, the legal system needs to be more restrained about pursuing lawsuits when a difficult diagnosis is missed or a treatment fails, to diminish the pressure on health care providers to practice expensive, defensive medicine at every turn.

These are major changes, but today we are far from providing good care for all our citizens and far from achieving health care equal to that in many other countries. We need to incorporate more realistic clinical, scientific, and financial information into practice in order to bring our health care practices, and our health care system, back into balance.

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142 Responses »

1. *william killinger M.D.,FACP*

Physician
Jacksonville Florida, USA
Disclosure: None

March 9, 2011 • 1:33 PM

Until tort reform becomes a reality,your laudable approach has little chance of becoming common practice.

2. *Cesar prinzac*

Physician
RIO DE JANEIRO , Brazil
Disclosure: None

March 9, 2011 • 10:22 PM

Couldn't agree more. I have a private practice in Brazil and I spend as much time as is necessary to teach my patients about the illusion of "test-therapy", many doctor make patients believe that over testing has a medical benefit. They wish, and we all gotta pay the bill.

Let's try to educate doctors, students and the public opinion. Good doctor – patient relationship really cuts down on litigations, I promise you!!

3. *John Putt*

Other Health Care Professional
Clinton Township Michigan, USA
Disclosure: None

March 9, 2011 • 10:34 PM

Dear Dr. Palfrey

I applaud the contents of your article. If I had a wish in this area, it would be to have your article prominently displayed across every newspaper, journal, magazine, television, and internet venue available. With your permission I would gladly post copies of it in clinical areas in which I work and also refer to it on different Internet sites (i. e. "reddit")

4. *Sean Palfrey*

Physician
Boston Massachusetts, USA
Disclosure: None

March 10, 2011 • 10:05 AM

My thanks to all of you for your thoughtful comments. I hope that we can develop the current "practice standards" into a more considered, scientific, data-driven form of practice that will improve our medical care, save money, and enable us to serve more people better.

I welcome all your help in doing this.

Sean Palfrey, MD,
sean.palfrey@bmc.org

5. *Yan-Feng Li M.D.*

Physician
Shanghai , China
Disclosure: None

March 13, 2011 • 7:47 AM

As an orthopedist, I strongly agree with Dr.Palfrey. In the emergency room of China, many patients are overtested and overtreated, especially the X-ray and antibiotics. And doctors in China have to overtest for the reason of testification inversion, as well as overtreat for more money. Too many factors are involved, so it is a hard work to practice low-cost medicine, I think.

6. *Robert Mikkelsen MD*

Physician
Fond du Lac Wisconsin, USA
Disclosure: None

March 15, 2011 • 8:07 AM

So very true. My specialty of general surgery is no exception. Does every patient with abdominal pain need a CT scan? Does every surgical approach need to be “minimal” when it really isn’t. We need to maintain the courage to let some time determine the clinical course of investigation.

7. *Mario Baruchello*

Physician
bassano del Grappa , Italy
Disclosure: None

March 16, 2011 • 4:43 PM

Mario Baruchello
General Practitioner
Bassano del Grappa – North Italy
In my opinion task of the general practitioner is talk with patients to help them carry the fate of their health to individual responsibility and social solidarity. This combination may have the strength to change the practice of health care today oriented to the enthusiasm uncritical toward technology, helping to create a practice sustainable, changing the attitude toward progress, scientific innovation, the nature of the person, of society and human suffering.

I invite my colleagues to reflect on the death of the physical semeiotics that has moved away from the patient’s body with the great illusion of objective medical technology.

8. *Henk de Vries*

Other Health Care Professional
Hull , England
Disclosure: None

March 16, 2011 • 7:50 PM

I was trained as a doctor in Leiden in the Netherlands where Boerhaave adhered to these very same principles. Most diagnoses are made clinically on history and examination alone and blood test and radiological investigations are only additive.

I have now practiced as a g.p. in the UK for over 10 years and as we are not incentivised by more testing we are much more restrictive, which cuts down costs but also saves an incredible amount of clinic time. It does require years of dilligently acquiring these clinical skills but it certainly pays off in running clinics better and in actual fact getting more patient statisfaction.

Most patients get fed up of more and more blood tests without any additive value and more radiological investigations which do not tell them a lot more than we already knew from the start anyway.

Your approach discourages patient dependent behaviour which is only a good thing. I think it is well written and indeed the way forward.

9. *Guillermo Elizondo Riojas*

Physician
Monterrey , Mexico
Disclosure: None

March 16, 2011 • 8:10 PM

Dear Dr. Parlfrey:

As a radiologist, I totally agree with all your arguments. It is incredible that now days, imaging studies are asked even before the clinical history and physical examination are performed. Also, asking for a Ct is not enough; now it has to be contrast enhanced, volumetric, with 3D reconstruction, etc.

For all the reasons you explained (medical legal, academic, etc.) we are more and more dependent of technology and each time less dependent of reasoning and clinical and common sense judgment.

As other of the readers commented, I can not publish this article in every newspaper or TV add, but at least I will contribute posting it in my Facebook page and sending it to all my residents and colleagues.

Thank you very much for the opportunity to think about this matter.

10. *PERRY HOOKMAN MD*

Physician
Boca Raton Florida, USA
Disclosure: None

March 16, 2011 • 8:16 PM

“Why are we testing for all causes for anemia all at once? I asked an intern. Shouldn’t we have a working diagnosis, and if we can’t confirm it with one test, then go to the next one?”

He said to me “There isn’t enough time to use testing the old fashioned way. Once you miss something because you held back on testing you’ll be in big trouble, and an old fashioned doctor won’t be there to hold your hand!”

Histories and physicals [H & P] also have a sensitivity and specificity – just like any other diagnostic testing. And the sens/spec of H&P is further confounded by the doctors’ and patient’s communication skills.

The problem is that we have absolutely NO PREDETERMINED ACCEPTABLE MISS RATE. There is no such thing as standard of care until something is missed. Before

we can agree that a test is unnecessary, we also have to agree that some conditions are undiagnosable.

Who in America would be willing to accept that?

11. *Leo Leer*

Physician
Eureka California, USA
Disclosure: None

March 16, 2011 • 8:16 PM

Dr. Palfrey,

Thank you for your wonderful essay. It can be very tiring to explain to patients why I don't recommend a particular expensive test – most of them, I think, initially assume that I'm somehow in cahoots with their insurance company or am too lazy. Indeed. True laziness is to follow the path of some of my colleagues and simply order every MRI or make every referral that is requested of me. As a family physician, I think that it can be particularly difficult to work to limit my patients' exposure to unnecessary care – as much as it's important to make sure they get the care they need when they need it.

Your piece should be required reading for everyone in this country who cares about health care. Thank you again.

12. *David Thompson*

Physician
Portland Oregon, USA
Disclosure: None

March 16, 2011 • 8:23 PM

This method of practice requires a setting in which followup is easy to achieve. I was director of a student health service at an academic medical center. The students had their own insurance plan but premiums were rising unaffordably. We had enough staff but not enough money for the kind of care we were practicing. We made a conscious decision to consider postponing tests in favor of closer follow up when feasible, which was most of the time. (We also reduced waiting times from two days to same day.) The phone call and/or scheduled follow-up visit became part of our diagnostic armamentarium and as we predicted, patients improved, didn't need the tests after all. We had more time with our patients, and they were happy about that particularly because there were out-of-pocket copays for tests but no copay for the primary care visit. We were too small to "do a study" but our professional staff and support staff agreed we were having more fun and patient satisfaction measures rose. Our contract with the insurance company included a clause that allowed us the second year to get a substantial check for overpayment of premium. We used this to reduce the premiums for all students the following year. Emergency room doctors in community hospitals can't do this because they can't count on good followup. So they over-test and over-prescribe.

13. *Bernie O'Malley*

Physician
Princeton New Jersey, USA
Disclosure: None

March 16, 2011 • 8:49 PM

Dear Dr Palfrey,

You hit the nail on the head with your comments. I was so inpoired by the simplicity of your comments that I sent a message to Mr B Obama at Whitehouse.gov with a short clip starting with the impatience issue. Thank You and keep the pressure on early and often.

BBO'Malley,
Princeton, N.J.

14. *Jack Resnick MD*

Physician
new york New York, USA
Disclosure: None

March 16, 2011 • 8:54 PM

Hear, Hear,

What's true in pediatrics is an order of magnitude or more truer in adult medicine.

The best way to avoid the fear of litigation that drives our distorted behavior is to establish long-term relationships with our patients. I've only been sued once in my 40 years — by someone whom I'd only seen once. (And that suit was dismissed once, and rejected by a jury the second time.) I have to be forced to order a PSA. I talk people out of CT and MRI scans all of the time. They appreciate being set free from the lunacy that has overtaken the practice of medicine.

Jack Resnick, MD

15. *Chris Foley*

Physician
St Paul Minnesota, USA
Disclosure: None

March 16, 2011 • 8:57 PM

Aptly stated position but with precious few details. The new “functional” medicine as per Sidney Baker MD should be taught, observed, and embraced. Understanding the “why” of illness has been ignored for far too long. Baby Smith and Baby Jones are indeed different, and understanding these uniquenesses leads down the path of prevention. Algorithms and practice guidelines are required for very acute conditions, but they are antithetical to managing prevention and the emergence of chronic conditions. Without the functional model and principles, costs will likely go down only from rationing and penalties.

I recommend that all physicians learn more about the Institute for Functional Medicine — it is the future of patient care and cost reduction.

16. *Bill Cayley Jr*

Physician
Eau Claire Wisconsin, USA
Disclosure: None

March 16, 2011 • 10:41 PM

Thanks for the thoughtful comments. A book that does a great job of touching on some of these issues is Ray Downing's **Suffering and healing in America**. (<http://www.amazon.com/Suffering-Healing-America-American->

[Doctors/dp/1846191300/ref=sr_1_5?ie=UTF8&s=books&qid=1300328813&sr=8-5\)](https://doctors.dp/1846191300/ref=sr_1_5?ie=UTF8&s=books&qid=1300328813&sr=8-5)

17. *Paul Kaplowitz MD*

Physician
Washington Washington DC, USA
Disclosure: None

March 16, 2011 • 11:02 PM

I heartily agree with Dr Palfrey. While the effects of excessive diagnostic testing as drivers of increased health care costs are quite obvious in the inpatient setting, this is also a major problem in the outpatient setting. In my area, pediatric endocrinology, I see examples every week of needless testing by both primary care physicians and specialists to rule out disorders which are very unlikely given the patient's history and physical findings (or lack thereof). The "test of time" will usually separate those with real disease from the normal variations and self-limited problems if we have the patience to limit tests and see the patient back. Too often there is either impatience to try to get an answer right away or there is too much worry about the possible consequences of missing diagnoses which are rarely the answer to the problem the patient is being seen for.

18. *Anton Broms*

Physician
Tualatin Oregon, USA
Disclosure: None

March 17, 2011 • 1:14 AM

Thanks for such a succinct assessment of how we practice medicine in the USA. I do not think dollars or liability changes how we make medical decisions. Physicians today have little appreciation for critical and skeptical thinking. Doctors seem to busy to stop and questions new technologies or treatments. This is a systemic issue for our entire education system. Why do not patients ask about effectiveness or marginal benefits for exponential increases in costs? Small investments in basic education focused on medical decision making could reap huge benefits.

19. *Rakesh Sudan Dr.*

Physician
Amritsar , India
Disclosure: None

March 17, 2011 • 2:14 AM

I applaud the thoughts of Dr. Palfrey. I am a Cardio-Thoracic surgeon in India. The malady of over testing and over treating has assumed malignant proportions in this country and it is minimally for risk of legal actions or for completion of diagnosis, It is primarily so here for monetary reasons. I belong to the old school and many a times over-testing physician colleagues turn to me to help them in diagnosis due to my well honed clinical acumen.

20. *Ganesh Pai Dr*

Physician
Manipal , India
Disclosure: None

March 17, 2011 • 3:03 AM

Clearly, Dr Palfrey's concerns echo across different specialities, and different regions of the world. India is no exception. The slowly emerging spending power of the middle class can be a bane too, in the sense that it contributes no small measure to the over-eager medical fraternity who can go overboard with therapies and tests that can easily be avoided.

21. *Jose Stoute*

Physician
Hershey Pennsylvania, USA
Disclosure: None

March 17, 2011 • 5:58 AM

No where in medicine is the pressure to overtreat more evident than in the area of infectious diseases. The development of practice guidelines which have been developed in the spirit of zero tolerance for failure is forcing us to leave no stone unturned and overtreat. There is no room for "watch and see". Sometimes this pressure leads many clinicians to overinterpretation of the guidelines when I see that every fever in the hospital automatically elicits a "knee jerk" response to start vancomycin and piperacillin/tazobactam even in patients who are clinically stable and not immunocompromised or that every pulmonary infiltrate in immunocompromised patients leads to the use of antifungal therapy without room for thought. This "zero tolerance" for failure is what ultimately will bankrupt our system and within the practice of infectious diseases is driving selection of resistant microorganisms.

22. *Caroline Theunissen MD*

Physician
Brussels , Belgium
Disclosure: None

March 17, 2011 • 6:45 AM

Working as an infectious diseases specialist in a European country, I also totally agree with Dr Palfrey. Tests and (antibiotic) treatments are too often prescribed because of fear to miss a diagnosis instead of finding the disease. This has indeed high consequences (and not only in the US) on costs and quality of medicine and it keeps young doctors from becoming good and reasonable physicians. Thank you Dr Palfrey!

23. *Andrea Araujo*

Physician
Brasília , Brazil
Disclosure: None

March 17, 2011 • 8:27 AM

In field of Pediatrics we've seen not only a tendency to overtest and overtreat sick children, but a clear tendency to medicalisation normal aspects of children's lives: accessories for breastfeeding, medicines for colics and cough, etc. As Dr Palfrey alerts, "Who is actually benefiting when we order a test — the patient, the laboratory, the drug company, the health plan administrators, or their investors?". And how deep has actually been the influence of medical products providers on medical education and training?

24. *Richard Farrow*

Other Health Care Professional
Sun City Center Florida, USA
Disclosure: None

March 17, 2011 • 9:21 AM

Lets take this a step further. Lets take a second look at the pharmaceutical promotion on TV. Who should make the prescribing decision, the patient or the physician. We are too quick to abandon many less expensive drugs in favor of the one as seen on TV. Just because the insurance will pay for the more expensive drugs is no reason to consider it better.

25. *Ken Dandurand*

Other Health Care Professional
Westfield Massachusetts, USA
Disclosure: None

March 17, 2011 • 10:30 AM

Kudos, Dr. Palfry, I was once told by a wise physician “treat the patient not the test” and as you so eloquently state we have gotten away from this. In addition to the rush to do more tests and use the latest technology mentality, your point of waiting and watching is well taken. In this medical environment of everything now I find myself asking practitioners, is it better to give the wrong drug quicker? This is a defensive practice that can have more unintended consequences for the patient than waiting and getting it correct. Another point is the over-reliance on health information technology. This is perpetuated by the government’s initiative to increase spending on this area over the next 10 years as part of The Health Care Reform Act. Unfortunately, as pointed out in numerous studies the clinical impact of Healthcare IT as currently constructed is modest at best. Finally, we as Americans are infatuated by the latest greatest as the therapy we want and push our practitioners to use the more expensive new drugs without acknowledging these agents create their own set of problems. Again thanks for your needed insight.

26. *James Wilkin*

Physician
Cincinnati Ohio, USA
Disclosure: None

March 17, 2011 • 10:36 AM

I would definitely agree with Dr. Palfrey. My specialty is cardiology and I have an academic practice in which I am assigned the task of helping a wide range of physicians in training develop an approach to medical care as outlined in your article. In cardiology we have large numbers of carefully crafted guidelines. The problem is that we do not follow our own knowledge base. It is so hard to sell the concept of patient clinical assessment with verification of the clinical findings as opposed to “skipping” to the ultimate imaging modality that is available at a high cost. The same is true in therapy. Not all coronary disease needs revascularization.

27. *William Klykylo, M.D.*

Physician
Dayton Ohio, USA
Disclosure: None

March 17, 2011 • 11:28 AM

It is extremely revealing that not a single response to this important article has disagreed with its central premise – not a one! We ALL know what is going on, but we seem helpless in the face of financial incentives and pressures, political currents, legal threats, and our increasingly impersonal and technophilic culture.

Regrettably, many of us are also hobbled by rigid political and economic dogma rooted in the narrow POV of too many clinicians. We have to look at the big picture, we have to be willing to give up a 19th-century worldview, and we must speak truth to power. In doing so, we will be standing in opposition to many of the most cherished – and now maladaptive – aspects of American culture: greed, selfish individualism, irrational optimism, and an illusory concept of “freedom.”

I wonder if we have it in us.

28. *Sarah Towne DO*

Physician
San Francisco California, USA
Disclosure: None

March 17, 2011 • 5:44 PM

I asked a student why he wanted a CBC and Chem-7, and he said “because we haven’t checked in 3 days”. I pointed out that we hadn’t checked his either, and perhaps we should? Don’t order things unless you already have an idea what you’ll find. Still good advice; came from one of my preceptors.

I couldn’t agree more with this post. Hear, hear!

29. *Fred Schwartz MD, FACP*

Physician
Worcester Massachusetts, USA
Disclosure: None

March 17, 2011 • 6:47 PM

Thank you for having the fortitude to express your support for what in many hospitals is looked down upon, i.e. cost effective medical care. Unfortunately, most of our teaching hospitals do not agree with your perspective. Medical students, interns, residents and fellows are inculcated with praise for ordering more, and higher tech, diagnostic studies and procedures. This practice is construed as thorough and conscientious, not wasteful and irresponsible.

Even if tort reform is achieved, I fear that until the ethos of teaching institutions changes, the practice (and rewards for) ordering more consults, more studies, more labs, and more procedures will only increase. Perhaps this is because the hospital setting, where the majority of medical education occurs, is dominated by sub-specialists and procedure oriented specialties who profit by ordering diagnostic studies and procedures. It is important to understand what drives this culture and what can (and must) be done to change it.

30. *Fareed Khaja M.D, FACC*

Physician
West Bloomfield Michigan, USA
Disclosure: None

March 17, 2011 • 8:57 PM

I agree completely with Dr.Palfrey and congratulate him for writing such a succinct article on current practice of medicine. I am an adult cardiologist working in an academic center. As an attending in the Chest Pain center I see Stress Tests ordered over and over again when a good history and Physical exam would clearly rule out myocardial ischemia as the cause of chest pain. Unfortunately Angina is now diagnosed after a stress test or a coronary angiogram rather than by history as originally proposed by Heberdeen.

My teaching to students, residents and fellows for the last 40 years has been to treat the patient and not the TEST. I also propose that every resident and attending should get a copy of hospital bill of their patients who are discharged.

I think this article should be published with permission of NEJM in every medical journal as well as in lay press and on NPR.

31. *Chuah SK Dr*

Physician
Kuala Lumpur , Malaysia
Disclosure: None

March 17, 2011 • 9:41 PM

I cannot agree more. I have been nagging some of my colleagues and junior physicians about too much unnecessary investigations especially imaging studies and also my radiological colleagues for giving in to requests for such investigations too readily. On course they are not happy but I need to express what will be detrimental to society. Hope medical schools will incorporate this into the curriculum and clinical teaching.

32. *Aninda Das*

Physician
Los Angeles California, USA
Disclosure: None

March 17, 2011 • 10:22 PM

Dear Dr. Palfrey,

Thank you for that very timely and insightful article. I am a pediatrician with a large medical group in Los Angeles practicing mainly ambulatory pediatrics for the last 9 years. But I am also a pediatric infectious disease consultant at 2 local community hospitals. I am an international medical graduate from India, having completed my residency and fellowship at Children's Hospital Los Angeles. My training in India in the mid to late 80s was quite low-tech in its scope. In a recent survey from my U.S. alma mater, requesting feedback about ways to improve the residency training program, I had suggested improving the clinical skills of residents by emphasizing bedside rounds rather than their computer and PDA skills in making a diagnosis and formulating a treatment plan. This is premised on my experience with the clinical skills of the relatively new graduates that I have worked with both in the community hospitals and the ambulatory setting. It is indeed very disconcerting to often see the lack of a logical plan for diagnostic testing and indiscriminate choice of antibiotics (according to the physician's preference), particularly in the community hospital settings. I sincerely hope that residency training programs around this country would subscribe to your contrarian perspective.

33. *Richard Levitt M.D.*

Physician
Roswell Georgia, USA
Disclosure: None

March 18, 2011 • 9:54 AM

At last, someone has had the courage to voice the obvious. “The emperor has no clothes!” I have felt like an “outlier” in not wanting to do every test on every patient, especially if it has no effect on the outcome, that is, if the treatment is unchanged. Generally, the test only confirms what you already suspect. When my asthmatic patients show up in the ER because they have no copay and are still “coughing”, and the atelectasis is read as “pneumonia” by the ER doc, only to be confirmed as atelectasis by the radiologist in the a.m., the patients feel the technology and antibiotic is the way to go for the “correct” diagnosis. They push for more testing in the future, rather than to improve their treatment by adding, for example, and ICS.

But our reliance on third party payers is also responsible. If the patient had to bear the burden of the cost then they might also want to “watch and wait” for the natural history of the disease to evolve. But if someone else is paying, then the true value of paying premiums requires an investment in technology to get a return on the dollar, not merely a visit to the doctor, often leaving without a prescription.

Congratulations on voicing the obvious.

34. *Richard Goldsmith MD*

Physician
Jersey City New Jersey, USA
Disclosure: None

March 18, 2011 • 11:35 AM

There is nothing new under the sun. When I was an intern and resident at Mt Sinai Hospital (before the days of “centers”) almost 60 years ago, all lab test results came back on 8 1/2 by 4 inch slips. It was the interns job to enter the results on a large flow sheet, which showed all the various tests along the left margin and the dates along the top, with a “thousand” little boxed in which to write the numbers. I was a standard of house-staff excellence to fill in as many boxes as possible, which meant ordering every test and repeating them very often. There was a short interval of reaction to this absurdity and an effort to be more circumspect and to use more clinical acumen. BUT then came the age of high tech, and the age of big jury awards. The flow sheets gave way to other paper forms and these gave way to computers, but we are back to filling in all the boxes again. A young patient of mine recently suffered a ruptured appendix, while the surgeon waited eight hours to obtain a CT scan, even though the clinical history and physical findings were absolutely typical. I have yet to go a physician myself who does an adequate, much less thorough physical examination. One goes so far as to put a stethoscope on my multi-layered, fully clothed abdomen while talking to me non-stop. He tells me he needs to document that an examination was done. BUT, with the next breath come the recommendations for a new high-tech, expensive and time consuming imaging or functional test. I have gone to the extent on several occasions of questioning the need and refusing to comply with these recommendations that I thought would not add any useful information or result in any change in management. Perhaps we, when we are patients, should start to reject the over-use of tests on ourselves, and point out the lack of necessity from our vantage point as an informed consumer of medical care. We should also speak up about the failure of physicians to use their eyes, ears and hands as trustworthy diagnostic tools.

35. *John Clarke*

Physician
Limerick , Ireland
Disclosure: None

March 19, 2011 • 8:34 AM

When new practitioners join our private practice, having left the state systems where allegedly 'no-one pays', invariably they order maybe 10-15 thousand euro of laboratory tests in their first month or so and are shocked when they are confronted with the costs of their actions and the realization that the patients will actually have to pay for these tests. Their behaviour does modify as a result and they will invariably order quarter of the cost in tests in the subsequent months.

It would be an interesting research project to cost doctors practice versus clinical outcomes. There might not be much difference in outcomes between 'expensive' doctors and 'cheap' doctors!

36. *Charles Bagley M.D.*

Physician
Manhattan New York, USA
Disclosure: None

March 19, 2011 • 3:01 PM

Unnecessary testing is routine and driven by the fee schedule; I (a practicing Neurologist) could not make a living if I didn't routinely perform EMG testing in my office for example. Only 10% of EMGs are necessary. Pay someone who is fellowship trained in EMG \$200/hour to do EMG testing (technician can do the NCV) and disallow self referral. The quality of the EMGs would be better and most of the current EMGs would be eliminated because of the self referral factor.

The best way to eliminate unnecessary tests is to treat the patient and resolve the signs and symptoms of their condition. The fee schedule is structured to favor proprietary forces (patentable drugs, specialist procedures that utilize proprietary tools etc.) There are so many examples of treatments that are not proprietary that the medical profession has refused to recognize that I have concluded that: for most patients seeking treatment from a physician in the US, there is someone somewhere doing some kind of therapy (often "alternative" medicine but also treatments that are established in the conventional literature such as providing a heel lift for a back pain patient with a short leg—a diagnosis that is routinely missed by MDs, chiropractors, physical therapists who see these patients. Curing disease is not profitable in a fee for service system and the track record of curing disease by medical profession is not very good. I personally am reluctant to go to a conventional MD because of what I see in the medical profession and the understanding I have from my own experience in finding better and cheaper solutions for many different conditions.

We would be better off if our expensive technology were more appropriately used. We would be far better off if our health care research dollars were used to produce the best clinical science (instead of the best proprietary medicine)

I propose that an HMO be created in the following format: Primary care doctors would be given a panel of 2000 patients paying perhaps \$500/month (the income of the panel would be therefore \$1 million/month). All of the drugs, hospitalization, ER costs, tests and procedures would be paid out this pool. Risk sharing methods would be employed to ensure that individual physicians are not at risk. PCPs would be selected who have skills that are likely to resolve patients problems in the primary care setting and eliminate the excesses that specialists and hospitals typically add to the insurance costs. These doctors would have skills in osteopathy, prolotherapy, oxidative medicine, nutrition science and other disciplines.

As the excesses are eliminated, money accumulates in the account and can be distributed to the doctor as a reward when actuarial analysis determines that a statistically valid excess has occurred.

The relative value scale of the fee schedule has to compete with the relative value of inexpensive sophisticated nonproprietary medical practices that have decades of favorable clinical experience backing them up.

37. *Michael Eliastam*

Physician
Marlborough Massachusetts, USA
Disclosure: None

March 19, 2011 • 7:05 PM

It is gratifying to see that almost all the comments are positive, I am a little surprised not to see the mention of Abraham Verghese, Professor of Medicine and Senior Associate Chair for the Theory & Practice of Medicine at Stanford. I believe we need to bring together these emerging 'wise' people who are finding a way to articulate; what so many of us feel. I assume his appointment is intended to signal an effort by Stanford to restore physical diagnosis as an important and useful part of clinical medicine. His heartwarming writing advocates for a return to a more personal and clinically based model including the use of ritual to achieve patient comfort with what has been offered by the physician.

(<http://www.nytimes.com/2011/02/27/opinion/27verghese.html?pagewanted=2&r=1&sq=Verghese&st=cse&scp=1>)

His novel, *Cutting For Stone*, and his memoirs show clearly that he is a devotee of the learning of clinical skills by apprenticeship, and the systematic application of these including careful history taking and performance of the physical examination. The development of the Stanford 25 under his leadership

(<http://stanford25.wordpress.com/>) is a useful response to the almost universal bemoaning by so many academic clinicians of the inexorable disappearance of real clinical medicine.

Another very important part of this group is Atul Gawande with his many insightful articles in erudite publications including *The New Yorker*, while he continues to practice as a clinically active surgeon. He often writes about the complexity of care for populations of patients. His most recent article in the *New Yorker* reported on an analysis of data from Camden NJ by a practicing physician, Jeffery Brenner. His analysis discovered that about 5% of the 100,000 patient sample of local businesses employees consume over 50% of the dollars spent on their care. The pilot programs there and elsewhere suggest that focused care management can help patients whose medical care requirements are a mixture of social and medical factors, and can reduce the cost of this care. This has significant implications for cost reduction across the country.

It is time to bring these wise people together to begin a conversation!

38. *Tony Cohen M.D.*

Physician
Winchester California, USA
Disclosure: None

March 20, 2011 • 2:18 AM

Back in the 80's, in addition to running my medical practice, I worked several months part time for the New Jersey Peer Review Association reviewing hospital charts; more specifically, diagnostic tests ordered during the first week of admission. What immediately stood out was about 90% of excess testing was ordered by 5% of the physician staff. Obviously, this hasn't been corrected and will continue till offenders are truly dealt with, which at that time was almost impossible and potentially dangerous.

39. *Bruce Barnett MD*

Physician
Sacramento California, USA
Disclosure: None

March 20, 2011 • 2:01 PM

NEJM should be congratulated for publishing Dr. Palfrey's observations about the value of common sense and the wisdom that comes from decades of professional practice. Our duty to our profession as well as our patients requires us to practice medicine that is sensible, ie. scientifically defensible, and not merely defensive. Thus when modern technology threatens to overwhelm my left brain with testing options I check in with my right brain as well to consider what I would expect a trusted colleague to do for my own family

40. *Anthony Glaser MD, PhD*

Physician
Summerville South Carolina, USA
Disclosure: None

March 20, 2011 • 7:45 PM

As with everyone else, I agree wholeheartedly. But the US health care "system" is designed perfectly to do what it does: to incentivize testing, imaging, and treating, at the expense of thinking, communicating, and watching. Most patients believe that "more is better" . . . so they call me, their family doctor, asking for an X-ray or an MRI even before they have been seen . . . and if they go to the local ER or (even worse) urgent-care center, they will get multiple tests and imaging modalities for even the most trivial complaints. As one ER doc said to me when ordering an MRI on a 97 year old with a sore neck: "she's going to die soon, and if we don't check everything we may get blamed for it"

Until the financial and legal incentives are aligned with good care, bad care will continue

41. *Dronacharya Lamichhane MD*

Resident or Trainee
New York New York, USA
Disclosure: None

March 20, 2011 • 11:32 PM

Thank you Dr Palfrey for raising these so obvious but not so often spoken issues in the practice of medicine now a days in the US. I ,as an International Medical Graduate (IMG), have had almost nine months exposure to this health system (in the US). Without any doubt, charm of practicing medicine is on the verge of extinction if not " resuscitated" timely. I think what is degrading the health care system here is injudicious (over)use of readily available tests. Physicians are so much afraid of being penalized in case they miss something or something unexpected happens.Because the patients are very much informed about their condition, we fear they will sue us. Why can we not practise medicine with some faith on what we as a trainee learned in the medical school and during the residency? I need to get a spiral CT scan in a patient coming with shortness of breath because rarely a patient even with no risk factors can have a pulmonary embolism and I have to diagnose it even before I rule out pneumonia or heart failure. I become little impatient and run all possible tests at once. I don't think we need any extra budget to again start practising medicine using our clinical skill, common sense and knowledge. We are just misusing the new expensive tests because we want to experiment with them. We need to carefully see the mortality differences for any

morbidity in a place where there are tests of any kind of available and some other countries where these test are prohibitive due to cost. I personally don't think (although I may not have objective evidence for it) the practice of medicine in the hospital like we do here in the US is certainly not what makes the mortality difference.

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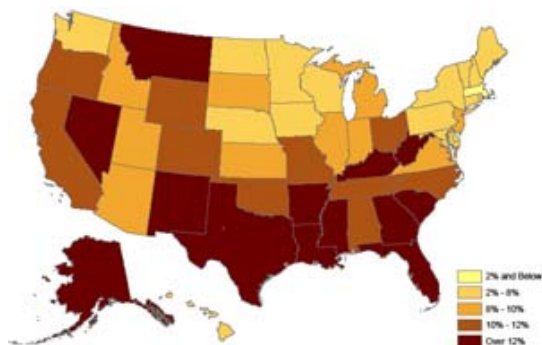
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