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ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Too Much Medicine? Thinking Twice Before Treating

WORRIED SICK: PRESCRIPTION FOR HEALTH IN AN OVERTREATED AMERICA

Are we looking in the wrong place to improve the effectiveness of medical care delivery. Welcome to the Clinician's Roundtable. I am your host, Dr. Maurice Pickard and joining me today is Dr. Nortin Hadler, Professor of Medicine and Microbiology, Immunology at the University of North Carolina at Chapel Hill and Attending Rheumatologist at the University of North Carolina Hospital and the Author of the recently published book "Worried Sick. A Prescription for Health in an Overtreated America."

DR. MAURICE PICKARD:

Thank you Dr. Hadler for joining us today.

DR. NORTIN HADLER:

Thank you Maurice it's a pleasure to be here.

DR. MAURICE PICKARD:

To begin with what are the principle themes that you expound in this new book of yours?

DR. NORTIN HADLER:

The whole set of arguments are based on several principles that we don't talk enough about in clinical medicine. One is the concept of medicalization, that's where we take life's predicaments, label it a disease and design intervention. Medicalization is a scourge in America. The second theme is the difference between disease-specific mortality and all cause mortality. Most of us don't hear about the epidemiology of all-cause mortality. Its called in our country social epidemiology, in Britain its called life course epidemiology and it's a notion that I came up with as a medical student when I wrote the first of my laws of therapeutic dynamics, which is the death rate is 1 per person. Actually published that 25 years ago along with 3 other laws. If the death rate is 1 per person, then I am going to die. I am not so sure I care what kills me as much as I care when, and if I have some handle on human life expectancy and in the book I talk at great length about what we know about species expectancy, lets say 85 years of age. Then I don't really care how many diseases I have on my 85th birthday. I care what the trip was like, I care a little bit about what the passage would be like, but I care less, which shows my diseases turns out to be the grim reaper. The implications of this shift in epidemiologic mindset, there are enormous and very dramatic

for example if you take the 15-year-old birth cohorts today and you remove every single breast, prostate, and colon, you will do nothing for the longevity of that cohorts, you will spare a few outliers death before their time, but you will do nothing because most people die with these diseases not from them. That changes the entire way we look at everything we do in medicine that's designed to save us death from a particular process when we need to look at whether or not the quality of life and its longevity are compromised. I should point out that the major influences on longevity are not directly in our clinical purview. About 80% of your mortal hazard lives with questions like, are you comfortable in your socioeconomic status and do you like your job and things like what's your serum cholesterol, turns out to be relatively trivial. So the second issue is in life cause epidemiology, the first issue was medicalization and third theme is what I call type 2 medical malpractice. Type 2 medical malpractice is doing the unnecessary even if you do it very well. Type 1 is doing the necessary poorly and I will argue in this book with lots of illustrations that a lot of what we do, particularly the high-ticket items have been thoroughly studied and the benefits are either nonexistent or trivial and really shouldn't be done anymore. In fact, remodel the healthcare in this country based on effectiveness and come up with a far more rational discussion that anything we are hearing in the current climate. So those are 3 of the major themes, they have important epidemiologist ramifications, some of which is sort of a rethinking of epidemiology. We have taken epidemiology beyond the reasonable. When we ask of our data sets questions relate to very tiny effects in outcome in a very heterogeneous population. It's the reason why this year if you feed your family margarine you are criminal and last year if you fed them butter, you are criminal. Its because there is no way we can really measure in a population whether or not butter or a margarine in the all the other exposures and in all of the social epidemiology and in all of the other risk factors anything important for butter versus margarine or any other such advice. So those are the 4 principle themes of the book and I use very definite examples and discrete examples and lengthy discussions to illustrate them all throughout the book.

DR. MAURICE PICKARD:

Your book mentions, you want leaving to be gentle and the legacy to be meaningful, and I was struck by that and it doesn't mean that you are against all types of intervention, but certainly you point towards the socioeconomic factors of trying to make jobs more meaningful and rewarding as being something that maybe where we should be putting our money as opposed to high-tech medicine. How do you go about making jobs meaningful and rewarding?

DR. NORTIN HADLER:

My research career is mainly focussed on workplace health and safety issues, so we have been very active in understanding and dissecting the influence of words like job security and meritocracy, and when I list the defined health hazards and the resource advantage where one of the most dramatic health hazards we don't even talk about. Its up there with HIV exposure and the war on Iraq and then some place later on comes this terrible health event called downsizing. It may do wonders for the stock, but it does horrors to the workforce and there are a number of natural experiments where large workforces have been followed through a downsizing event and their health goes to hell in a hand basket and they start dying. This is not a trivial event. So what we need to do, its not like we need to guarantee incomes, I am not sure that would work, although if we had time I'd take you through some of the experiments that were done in the 70s along those lines, but what we have to do is have a national discussion so that we have something called human capital, that we are actually valued members of our community and any community that disavows and disenfranchises people not only makes their lives miserable, but stratifies and increases health care expenses. This is the debate we need to have and not whether or not we want to screen for hemoglobin A1c in all of our workforce and in all of schools because I can tell you that treating hemoglobin A1c does nothing for people and I am sure identifying it does anything for people either, except to label them.

DR. MAURICE PICKARD:

If you are just joining us, you are listening to the Clinician's Roundtable on ReachMD XM, The Channel for Medical Professionals. I am your host, Dr. Maurice Pickard and with me today is Dr. Nortin Hadler, Professor of Medicine at the University of North Carolina Chapel Hill and we are discussing his new book, Worried Sick: A Prescription for Health in an Overtreated America.

How does the patient enter into this discourse? Should he be a partner? Certainly my experience is that my patients are on the internet around-the-clock and come in with reams of material about what they should have done. How can we turn the patient into a partner in their healthcare?

DR. NORTIN HADLER:

Not just the patient, but the person who is choosing to be a patient and the answer is, yes, absolutely, the person and the patient needs to be asked, to be proactive about their questioning and our job as physicians is to offer them a port in a storm that has unbiased, unfettered, notions of wisdom and certainty. That takes time and trust and part of the reason we need to change the national debate is no one is willing to say that time and trust are valuable parts of healthcare. What we are willing to say is that everybody needs arthroscopy and a stent both of which are useless. They are ineffective.

DR. MAURICE PICKARD:

We have all experienced this rush to see more and more patients being on the treadmill just because of the payment system that is driving healthcare now and no one seems to be aware of the value of cognitive skills that we bring to it which of course take time and I think also part of this is and I'd like your opinion, do you think patients are losing trust in their caregivers? They see in the media that doctors are looking for ways to augment their revenue stream and are they therefore taking things in their own hands by demanding a certain kind of care.

DR. NORTIN HADLER:

People who are ill have reflexive need to trust, that's very hard for them not to do. I think what's happening in our country for good reason is that the people have less and less confidence in our profession, which is really sad because our profession is populated by an extraordinarily fine group of practitioners, who are constrained in their ethical behavior by an institution of medicine that is ethically bankrupt and that's our issue. Our issue is that this quality agenda that we are all being fed daily is missing the point. Quality of course makes sense, but if what we are doing, being forced to do, rewarded to do, and paid to do doesn't work, I don't care how well you do it, you don't need to do it. So we need to have a sea change in the institution of medicine. I actually in Worried Sick lead up to chapter 14, which is relatively easy to read, model of reform that I have spent a decade on, that I have modeled mathematically that is so extraordinarily simple and rational. We almost had 1 state willing to enact it for their uninsured workforce, but it is running smack into the stake holders, 17% of the GDP is committed to the status quo, and I can assure you that the so-called providers are not part of the stake holder core.

DR. MAURICE PICKARD:

So you talk about in the book, taking on bureaucracy, having a discourse, and you mention that as like teaching a pig to sing is a waste of time and the pig doesn't like it. So where do we go for an answer now?

DR. NORTIN HADLER:

Because of my research and a number of other reasons, I have access to legislatures and corporate leaders and insurance executives and nothing is going to happen there. Nothing will happen until we start having an out-loud national debate where people start to say my problem is not that I can't afford to spend, my problem is that nobody told me I didn't need it. Once you start doing that, I can in a rational sense bring what I call disease insurance down well under $750 per person per year. Disease insurance, things that we need to do to

people because it really benefits them is not that expensive. It's this tremendous waste of money for things that don't benefit people.

DR. MAURICE PICKARD:

As we talk today we begin to realize that all of us in the office who can write a prescription for an MRI and it takes us 2 minutes and then it may also take us 30 minutes with that patient to tell them why they don't need it, we have to begin to open this discourse so that our patients understand when we tell them, they don't need a particular test. That there is evidence-based research to substantiate it.

I want to thank Dr. Nortin Hadler who has been our guest today. He is Professor of Medicine at the University of North Carolina in Chapel Hill and he is the recent author of Worried Sick: A Prescription for Health in an Overtreated America. This audience should look at this book, it is filled with marvelous material and reference to help us practice, I think, a better brand of medicine and certainly probably as a side effect less expensive brand of medicine.

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