REMAPPING DEBATE
Asking "Why" and "Why Not"

# Even best medical reporting infected with "make do" bias

**Press Criticism** | By Craig Gurian | Health care

June 19, 2013 — Elisabeth Rosenthal's front-page story in The New York Times two weeks ago carried quite an ambitious subhead: "Colonoscopies Explain Why U.S. Leads the World in Health Expenditures." In important respects, her article met its ambitions, most particularly in explaining the consequences of this country's failure to regulate pricing for the medical services received by most of the population (a failure that treats health care as though it were a commodity no different from a toaster or a DVD player). Rosenthal also made a convincing case that lobbying (in this case by a professional association of anesthesiologists) has effectively kept medical costs higher than they need to be.

> The reporter turned to a representative of the highly influential organization that is as reflexively against expensive options (independent of utility) as the most self-interested physician lobbying group could support.

But Rosenthal was not immune to the popular phenomenon of overplaying *over*-treatment and underplaying *under*-treatment, a topic that Remapping Debate reported on earlier this year. In a similar vein, she failed to appreciate the importance of searching for the best treatment, as opposed to focusing exclusively on reducing the cost of care at the current level. Finally, her point about price variability could have been made better — if less dramatically — by honing in on what *most* procedures cost, not the procedures at the 5th and 90th percentiles.

## Hear no market evil, see no market evil, speak no market evil

Rosenthal made clear a fundamental point about medical pricing. The United States, she noted, is "unique among industrialized nations" in not regulating or intervening in medical pricing (other than in connection with rates for Medicaid and Medicare).

And this isn't a function of all the other industrialized countries having abandoned fee-for-service systems:

"Many other countries," Rosenthal wrote, "deliver health care on a private fee-for-service basis, as does much of the American health care system, but they set rates as if health care were a public utility or negotiate fees with providers and insurers nationwide, for example."

Rosenthal quoted Dr. David Blumenthal, president of The Commonwealth Fund and a former advisor to President Obama: "In the U.S., we like to consider health care a free market…But it is a very weird market, riddled with market failures."

One manifestation of an unregulated market: gaming the system to maximize profits. Thus, for example, Rosenthal's explanation of the growth of outpatient surgical centers.

"When popularized in the 1980s, outpatient surgical centers were hailed as a cost-saving innovation because they cut down on expensive hospital stays for minor operations like knee arthroscopy," she wrote. "But the cost savings have been offset as procedures once done in a doctor's office [like colonoscopies] have filled up the centers, and bills have multiplied," she concluded.

## Turf wars

As Rosenthal pointed out, a significant part of the cost of many colonoscopies is the cost of the participation of an anesthesiologist, even though colonoscopies require only moderate sedation (provided by a "Valium-like drug or a low dose of propofol," sedation that, in other countries, is "administered in offices and hospitals by a wide range of doctors and nurses for countless minor procedures, including colonoscopies").

Why are anesthesiologists so much a part of the colonoscopy picture here? Because when propofol was first approved as an anesthesia drug by the FDA, the agency issued an advisory that the drug should be "administered only by those who are trained in the administration of general anesthesia" (that is, anesthesiologists), and, despite evidence that lower doses can be safely administered without an anesthesiologist, "the American Society of Anesthesiologists has aggressively lobbied for keeping the advisory, which so far the F.D.A. has done."

## Are we really too casual in prescribing colonoscopies?

Way too casual, to judge from the article. The one-sided information provided on this point represented one of the article's principal sins.

Here's Rosenthal's take, consistent with the overuse mantra that the Obama Administration embraces and that has swept the country more widely: "While several cheaper and less invasive tests to screen for colon cancer are recommended as equally effective by the federal government's expert panel on preventive care — and are commonly used in other countries — colonoscopy has become the go-to procedure in the United States."

And this: "[S]tudies have not clearly shown that a colonoscopy prevents colon cancer or death better than the other screening methods. Indeed, some recent papers suggest that it does not, in part because early lesions may be hard to see in some parts of the colon."

For a facile quote on the supposed absurdity of performing so many colonoscopies, Rosenthal turned to a representative of the highly influential organization that is as reflexively against expensive options (independent of utility) as the most self-interested physician lobbying group could be in favor of them:

"'We've defaulted to by far the most expensive option, without much if any data to support it,' said Dr. H. Gilbert Welch, a professor of medicine at the Dartmouth Institute for Health Policy and Clinical Practice."

Remarkably, however, Rosenthal failed to cite a 2012 study, the lead author of which was Dr. Nancy Baxter, an associate professor of surgery at the University of Toronto and St. Michael's Hospital. That study, a large U.S. population-based case-control study showed that colonoscopy was associated with a material reduction in the odds of colon cancer mortality, "indicating a substantial protective effect."

While the association was stronger for cancers on the left side than on the right, the results "indicate a clinically meaningful reduction in risk of colorectal cancer [CRC] death with colonoscopy throughout the colon and rectum."

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Remapping Debate interviewed Dr. Baxter, who confirmed that, "if your definition of 'gold standard' is highest accuracy, then it's going to be colonoscopy" as compared to other procedures.

We also spoke with Dr. Alfred Neugut, a professor of medicine and epidemiology at Columbia University Medical Center. Neugut confirmed that his position had been, as of two or three years ago, that it was uncertain the extent to which colonoscopy is better than sigmoidoscopy. The latter procedure, as explained to Remapping Debate by Dr. David Johnson, a former president of the American College of Gastroenterology, "cover[s] only about a third of the colon, 40 percent, and we know that…nearly 40 to 45 percent of polyps in cancers are above the reach of [that] short scope."

Neugut, however, has written more recently that the Baxter study was "game-changing" and demonstrated that the colonoscopy is associated in a reduction in CRC mortality "clearly superior to that of sigmoidoscopy."

In short, those Americans who heeded advice to have colonoscopies were, in the main, doing the best thing for their health. It's hard to imagine that this wouldn't have been reported on if the atmosphere were not suffused with the "Cadillac care" narrative.

(I should point aout that it may be the case that some patients without suspicious symptoms or a family history of colon cancer are being prescribed follow-up colonoscopies too frequently. A study cited by Rosenthal did find almost 25 percent of this subset of the study cohort had a follow-up colonoscopy in fewer than seven years, as opposed to the generally recognized recommendation of a 10-year follow-up after a negative result with no intervening symptoms. But the article in The Times failed to mention that the study was limited to patients at least 66 years of age. Individuals aged 50 to 65, widely believed to be under-screened for colon cancer, were not, as the cited paper itself made clear, part of the study.)

## Apples and oranges

Rosenthal was not wrong to indicate that there are those (including the U.S. Preventive Services Task Force) that describe screening methods other than colonoscopy as acceptable. That position should not, however, been accepted at face value.

Take, for example, the "fecal occult blood test" (FOBT). Performed annually, it is included as one of those acceptable screening methods. (If an FOBT is positive, of course, the next step is a colonoscopy.)

Dr. Jason A. Dominitz is the National Program Director for Gastroenterology at the Department of Veterans Affairs. In an interview with Remapping Debate, he said that FOBT could "potentially detect the important polyps before it's too late," noting that "many polyps never become cancer."

Doesn't this leave out an important fact about what an FOBT can do?

> "If your definition of 'gold standard' is highest accuracy, then it's going to be colonoscopy" as compared to other procedures, said Dr. Baxter.

Dr. Brian Jacobson, an associate professor of medicine at Boston University School of Medicine and chair of the Health and Public Policy Committee of the American Society for Gastrointestinal Endoscopy, provided an answer, pointing out to Remapping Debate that polyps "tend not to bleed unless they're very large," meaning that FOBT is "not great as a polyp detection test." FOBT, in other words, is "really looking to detect cancer when it's still in an early and, therefore, hopefully curable form. So it's not so much of a preventive test as [it is] an early detection test," Jacobson said.

Now Dominitz was not himself arguing that FOBT is a cancer prevention procedure, and, in fact, emphasized to us that he was not "anti-colonoscopy" and that he agreed completely with the proposition that an important advantage of colonoscopy is that a colonoscopy can remove polyps before they become a problem.

Nevertheless, in casual discourse, the nuance of what tasks different screening methods can perform is lost in the fog of purported "equivalence," even though most people, if asked, would not see cancer prevention and cancer detection as the same thing. They're not, and the difference deserved more than Rosenthal's characterization of colonoscopy as merely "intuitively" appealing. Likewise, her discussion of the "anointment" of colonoscopy in 2000 by the American College of Gastroenterology as a "the preferred strategy" for prevention falsely pictured Americans as foolishly acting like sheep in following what appears to have been a sound recommendation.

## Missing the importance of who performs the procedure

The article in the Times failed to apprise readers that some of the studies that had questioned the relative superiority of colonoscopy had looked at patient populations where a high proportion of colonoscopies were not performed by gastroenterologists, something that may have caused the potential of colonoscopy to be understated.

Multiple experts we spoke to agreed that there is great variation in the skill level of those who perform colonoscopy, both between specialties and within a specialty.

Baxter said that "colonoscopy is really quite a complex skill and [there is] quite a variation in providers." Her study found that the association with reduction in cancer was "significantly stronger" for colonoscopies performed by a gastroenterologist as compared with a surgeon, primary care physician, or other doctor.

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And Neugut said "even among gastroenterologists there's variability in quality," likely accounted for in part by the fact that those who have the opportunity to perform the highest volume of procedures tend to have their skills honed more.

Dr. Durado Brooks, the director of Prostate and Colorectal Cancers at the American Cancer Society, concurred, telling Remapping Debate that, "A lot of this has to do with…practice and technique and developing good skills." He added that some practitioners simply start out and remain more proficient than others.

One way to approach the question of potential relative benefit would have been to ask, "How good can this procedure be in the hands of a true expert?" and then follow that up by asking, "How can we *increase* the skill level of more practitioners so that more people are getting the highest quality colonoscopy possible?"

That wasn't the approach the Rosenthal article took, and that approach is anathema to the health care cost-cutters. If citizens are given a moment to think about potential benefits, there is a risk that they may say, "Perhaps we want to *raise* the standard of care that our society provides."

## Conflation, conflation, conflation

A particularly interesting argument regarding the relative merits of screening procedures has to do with "adherence." As Baxter put it to us: "Screening is only effective if you actually will get it. And although when you talk to gastroenterologists, and surgeons, and people who've had colon cancer, they all promote colonoscopy, *in fact many people don't want it*."

But simply accepting what people currently "don't want" is not the only way to go; here, again, there is a choice to be made. Instead of assessing the effectiveness of colonoscopy based on *where people are now*, one could imagine *potential* effectiveness if there were *greater* adherence, and public health policy could be shaped to help people overcome inhibitions about undergoing the procedure that are unrelated to actual risk.

As Dominitz pointed out, there is a need for "programmatic screening," where it's not just the good fortune of your doctor remembering to suggest a procedure. We have the ability to "build systems" to ensure those reminders, but we have to resolve to do so.

On another point, Dominitz suggested a circumstance where annual FOBT could detect a fast-growing cancer, whereas reliance on a colonoscopy not scheduled for another couple of years might mean that the cancer wouldn't be detected in time.

Leaving aside the question of the relative infrequency of that scenario, his presentation was an important illustration of the tendency to set things up in an either-or fashion. Perhaps, instead, it would be useful to think about taking advantage — both on the individual level and the population level — of *both* FOBT and colonoscopy. But the health care world — ruled as it seems to be by health care economists — won't do so, and this certainly wasn't a type of approach or strategy considered by the Rosenthal article. Why? I think anything that suggests the prospect of greater cost makes that thing a possibility that dare not speak its name.

Indeed, the god before whom almost all health care policy currently bows is the god of cost-effectiveness. Baxter herself said that the question is the extent to which colonoscopy will be more effective and "does that make it worth the extra cost and the invasiveness of the procedure." (Johnson said that, presuming a qualified expert performs the procedure, the relative risks associated with colonoscopy are small, in particular in relation to complications like perforation. Other experts we spoke to agreed that colonoscopy risks are relatively low.)

Cost-benefit can be an appropriate question, it's just not the first question, and it shouldn't be the case that a society can't choose to assign a very high value to each life saved.

**COST VARIABILITY**

| Percentile | Atlanta | New York | Seattle |
|---|---|---|---|
| 25th | $1,150 | $1,290 | $1,371 |
| 50th (median) | $1,864 | $2,083 | $1,542 |
| 75th | $3,080 | $5,397 | $2,151 |
| Ratio of 75th to 25th | 2.68 to 1 | 4.18 to 1 | 1.57 to 1 |
| High quoted in NYT chart on web | $4,506 | $8,577 | $4,156 |

## Bringing some nuance to the cost data

The interactive graphic used in the online version of the article, with the tag "The Cost of a Colonoscopy Varies Across the Country," is startling: $8,577 in New York, for example.

(The fine print shows that the amounts displayed represent the *highest* amount paid in a metropolitan area, based on an analysis by Healthcare Blue Book. The print version of the article had the high price in big print and the low price in small print, with an explanation that outliers — those below the 5th percentile and those above the 90th percentile — were excluded.)

But Remapping Debate contacted Dr. Jeffrey J. Rice, chief executive officer of Healthcare Blue Book, to explore these data further. As requested, Rice forwarded what he said was a representative sample of data from three areas — Atlanta, New York, and Seattle — that were included in the Rosenthal story, explaining that the data reflected costs for commercially-insured patients (not those on Medicaid or Medicare).

We derived median prices (the 50th percentile), and the numbers don't shout so loudly: New York came in at $2,083; Atlanta at $1,864; and Seattle at $1,542. As the chart to the right of the previous page shows, there is certainly significant price variation, but the spread between the 25th and 75th percentiles — that middle 50 percent of procedures — is less than the article would lead one to believe.

None of this negates the concerns that Rosenthal identified about the market failure (and concomitant failure to regulate) that makes health care unnecessarily expensive, but the data should have been used in a way that represents better the mainstream of the cost of care.

## Another set of questions to be asked

Rosenthal's article stated that, "In coming months, The New York Times will look at common procedures, drugs and medical encounters to examine how the economic incentives underlying the fragmented health care market in the United States have driven up costs, putting deep economic strains on consumers and the country."

That's a worthwhile project. But there's a phrase in the recent story that is crying out for further attention: "top-notch patient care." No one appears to be prepared to examine (independent of cost) what is, in fact, the best-of-the-best — or how cost-cutting mania squelches our appetite for that aspiration.

*Samantha Cook did the principal research and reporting for this story.*

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