Health Ins Broker Disclosure Ethics I

Mass CE course #C10774, 3 ethics credits

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Table of Contents

Introduction
The Health Insurance Broker's Role and Responsibilities

Health insurance brokers have several legal and ethical disclosure responsibilities when they present a policy.

First, they must honestly explain policy terms. Second, they cannot leave out important information. Third, they must honestly quote the price.

But do they also have a fourth ethical requirement – to disclose policy implications, such as likely medical outcomes and medical risks? Should the broker provide clients about likely impacts of using their health insurance policies? Should they present clients with data about treatment practices and medical outcomes?

In other words, should the broker explain how insurance policies are often misused by poorly informed subscribers and how this may cause subscriber harm? Or how the various incentives in our healthcare system combine often to provide more care than many people need, or indeed that is good for their health?

The knowledgeable broker knows that patients sometimes overuse our medical system, meaning get excessive and unnecessary care. Some insurance programs may actually increase the likelihood of this. High deductible plans, for example, may inhibit overuse until the deductible is met, then disinhibit the same behavior after. Subscribers may think 'care is now free to me – or almost free – so I might as well get as much as possible to save money next year.' Rather than generating benefit, this excessive care can only harm the subscriber / patient in two ways.

First, excessive care increases patient costs both directly or indirectly. The direct cost increases come from copayments and other out-of-pocket spending like parking, transportation, missed work, hiring childcare and the like. The indirect costs come from increasing your company's utilization experience – or your community's – thus impacting premium cost trends over time.

But in many ways, the cost increases are the lesser of the two harms caused by overtreatment.

The second, and potentially greater harm comes from the healthcare system itself. All medical interventions contain an element of patient risk. At the most benign for example, there's the potential skin irritation from a Band Aid; at the most harmful, a treatment side effect that results in serious harm or death.

Consider the sad case of Samantha Reckis, a 7 year old girl living on Cape Cod in 2003. [1] Samantha ran a fever over Thanksgiving and her parents gave her Children's Motrin, about as

[1] Family Awarded $63 Million in Motrin Case, Wallack and Lazar, Boston Globe, Feb 3, 2013

safe and benign a medication as exists. Unknown to anyone at the time, Samantha suffered from an uncommon skin disorder called Stevens-Johnson syndrome that makes your skin feel hot, more or less like a bad sunburn. That's what her parents felt apparently when they touched her skin.

The Stevens-Johnson condition can be exacerbated by exposure to ibuprofen, an ingredient in Motrin. When Samantha's parents gave her Children's Motrin to reduce her 'fever', she had a bad reaction – so bad, in fact that it developed into a condition known as Toxic Epidermal Necrolysis, an extremely rare and painful skin condition. Over the next 9 years, poor Samantha endured multiple hospitalizations and surgeries, lost nearly all of her skin, suffered permanent lung and liver damage and became legally blind.

In February 2013, a Plymouth County jury found that Johnson and Johnson, the makers of Motrin, was at fault for causing Samantha's condition because the company had failed adequately to warn patients of this potential adverse effect. Such a notice, the jury decided, could have alerted Samantha's parents or physicians to stop using the drug and thus reduce the harms caused to Samantha. The jury awarded Samantha $50 million and each of her parents $6.5 million, all to be paid by Johnson and Johnson.

This is an extreme example of harms from a standard and safe medical intervention. If Children's Motrin can cause all these harms to a little girl, imagine the potential downsides and potential harms from more invasive and risky interventions. Vioxx for example, a drug marketed as 'just as safe as aspirin but with fewer stomach bleeds' led to 12,000 deaths according to a court settlement. Menaflex, a bovine based knee cartilage replacement, caused adverse reactions in 42% of patients in pre-approval FDA studies. Estimates of the harms caused by medical devices range from a low of 16,000 Americans to a high of 160,000.[2] (We have only this wide estimate of device harms due to the lousy data on device harms. But even the low estimate seems pretty high to me.)

Should brokers inform their subscribers of these types of risks? Should brokers tell patients how to protect themselves from harms? Or should brokers adopt the 'let the buyer beware' ethical standard and limit their own responsibilities to selling insurance policy packages?

Research has demonstrated that above a certain level of care, generally defined as the Medicare norm in low cost regions, the excess doesn't generate patient benefit. As Jonathan Skinner, a Dartmouth Institute of Healthcare researcher summarizes

> There is just no evidence that doing more helps. At best you do the same and in some cases you actually do worse [due to infections, errors, sides effects, etc.] [3]

[2] Jeanne Lenzer, The Danger Within Us for many more examples and details.

[3] Jonathan Skinner, John E. Wennberg, How Much is Enough", NBER Working Paper 6513, 1998

Other researchers have discovered that patients who receive excessive and unnecessary care actually have slightly higher mortality rates. As Elliott Fisher, Director of the Dartmouth Institute for Health Policy and Clinical Practice learned in his huge early-2000s research study on treatment variation, hospitals that spent the most on patient care and did the most tests and procedures experienced a 2 – 6% higher patient mortality rate. [4] The reason, according to Fisher, is quite simply that

> The additional medicine patients get in the high-cost regions leads to the harm. [5]

Fisher in his studies noted that for every 10% increase in regional medical spending per capita over the Medicare minimum, the risk of death went up.

More care, in other words, is worse for you than less care. Once Fisher and his cohort discovered this, an entire industry of researchers descended on healthcare statistics to determine which interventions generate the best benefits, which the most harms and, perhaps most importantly, how to determine those outcomes.

One result of this years-long effort is that researchers have learned that patients generally have 2 or more treatment options that generate roughly similar outcomes but that may pose very different risks. Not to mention different costs.

Another is that researchers determined that only a relatively small proportion of medical interventions have been tested to see how well they actually work - how effective they are, in other words.

A third is that researchers have definitively learned that more medical care isn't always better than less.

Fisher actually summarized all this research in a brief Letter to the Editor of the Boston Globe on March 2, 2018 entitled 'Check Your Assumptions at the Door.' Patients should, he recommends

> Question widely held assumptions:
>
> That current treatments – including drugs – all have been proven safe and effective (safe, maybe; effective, no) …

[4] Brownlee, Overtreated, page 50

[5] Fischer, et al, The Implications of Regional Variations in Medicare Spending Part 2, Annals of Internal Medicine 2003:138, pages 292 - 293

> That physicians can tell you what's best for you (they can, but only if they know what is important to you);
>
> Or that more medical care is always better (it's not).
>
> The system is ripe for disruption and new thinking. But it will take a fearless commitment to keeping patients at the center.

Should the broker – the 'benefits advisor' – participate in this 'fearless commitment to keeping patients at the center'… in other words, a client educational process? Or should the broker ignore current research and stick with spreadsheeting and compliance?

Should the broker teach clients how best to use their benefits and specifically their health insurance policies? Or does the broker's ethical responsibility end with arranging medical care financing?

Should the broker stick with a narrow definition of professional responsibility and let the policy buyer beware? Or should the broker adopt a more expansive definition of professional ethics?

What ethical disclosure responsibilities does the broker have?

Education, Not Advocacy

This is an education course, not an advocacy exercise. My goal is to stimulate broker's thinking. I hope this course will help you consider your own ethical standards.

I'll outline in this course a very activist ethical position based on an interpretation of Biblical sales ethics - specifically the story of Abraham's first commercial transaction, the purchase of a burial plot for his wife.

I do not advocate any particular religion or any religion at all for that matter. I base this course on the Bible because it has served as the ethical basis of western civilization for thousands of years. Living according to Biblical teachings is generally synonymous in our society with living ethically. That's a good enough starting point.

I absolutely don't advocate for or against any particular medical interventions. Those specific decisions are entirely between the patient and his or her advisors. I hope though, in this course, to introduce some decision making tools that can help patients explore critical issues more effectively with their care givers, much along the lines of Elliott Fisher's observations.

Rather that advocating for or against any particular tests, medications or procedures, I'll introduce an educational platform that brokers can adopt to help their clients identify necessary and beneficial care as distinct from unnecessary and non-beneficial. I'll show how to educate subscribers in a value-neutral way, using lessons from healthcare economics, behavioral economics and medical studies.

This particular course, Broker Disclosure Ethics I, will cover only part of the educational process. I envision a Broker Disclosure Ethics II and possibly Broker Disclosure Ethics III text also. Each will focus on a different part of the necessary client educational process. My hope is that brokers who read all these related texts will emerge with a clearer understanding of the issues and potential solutions…as well as a practical education implementation process.

My contention is that brokers who adopt this approach will help their clients / patients get better outcomes with less risk and at lower cost.

Not all brokers will agree with my analysis. Some will think that my interpretation of Abraham's purchase is flawed. Full disclosure: I'm not a Biblical scholar. Not even close.

Others will argue that the Bible is not relevant to today's health insurance market. They may be right. Again, not a Biblical scholar.

Still others will argue that I set an unrealistically high ethical standard for health insurance brokers. I disagree with that objection.

In fact, I'd argue exactly the opposite: that brokers who adopt the standards outlined in this course will have healthier businesses than brokers who do not. My position, in brief:

- All professional brokers – at least the ones I meet in class, and that's well over 1000 in the past few years - are well trained and competent.
- All have access to the same prices and data from the same health insurance carriers.
- All know the regulations and / or can access regulatory information online equally easily.
- All are committed to excellent customer service and all take their professional responsibilities very seriously.
- But only some – a small but growing number – teach their clients how to navigate our mind numbingly insane and complex medical care system to avoid waste and harms.
- Only a few teach clients how to maximize their chance of medical care benefits and minimize their risks of harm.
- Only a few teach clients that more care may be worse for them than less care, that patients generally have treatment options, that some treatments shown effective in studies may be overused in real life so will likely not generate any benefit to a specific patient, and much more.

I respond to critiques that these ethical standards are unrealistic with this question: if you were a benefits manager for a large company, would you prefer the broker who only spreadsheets and advises on compliance? Or would you prefer the broker who also teaches these critical thinking and navigational skills?

I’d bet on the later.

Nonetheless, regardless of whether you agree with the ethical standards introduced in this course, I hope you will consider them and that you will be a better broker as a result.

Review Questions
Answers on the next page

1. Which disclosure responsibilities does the health insurance broker have according to this text?
    a. Policy costs only
    b. Policy coverages only
    c. Policy coverages and gaps
    d. Policy costs, coverages, gaps and some likely implications of using the policy

2. Is overuse of medical care a problem in the US today?
    a. No
    b. Only for orthopedic care
    c. Primarily for cardiac care
    d. Yes

3. What is one harm from having employees overuse medical care?
    a. It increases company utilization and experience modifier thus leading to higher premiums in the future
    b. Employees will miss too much work on physician visits and the company may lose money
    c. Employees will discuss their medical experiences too often and this may reduce workplace efficiency
    d. Employees will become paranoid about their health and workplace efficiency may suffer

4. What is a second harm from medical overuse?
    a. People will face medical risks without much hope for concomitant benefit
    b. The US economy will tank
    c. Americans will perceive themselves as too sick to work and the economy will tank
    d. Doctors will earn too much money and skew real estate prices

5. Is more care generally better than less care?
    a. Yes
    b. Only for orthopedic care
    c. Never for cardiac care
    d. No

6. What have we learned from research into care over-utilization?
    a. That Americans never overutilize medical care
    b. That overutilization is a national good thing because it stimulates medical research
    c. That overutilization of prescription drugs helps most people avoid addiction

d. That over-utilization increases mortality rates

7. Have all medications been proven safe and effective?
    a. Safe maybe, effective no
    b. Safe no but effective yes
    c. None have been proven safe or effective
    d. All have been proven safe and effective

8. Is this text primarily an educational text, an advocacy exercise or a medical treatise?
    a. Educational text
    b. Advocacy exercise
    c. Medical treatise
    d. None of the above

9. Where does the fundamental ethical standard in this course come from?
    a. The Bible
    b. The Koran
    c. The Buddah
    d. The US Constitution

10. This text makes several claims about health insurance brokers. Which below is not such a claim? In other words, which statement below is **false**?
    a. Today's health insurance brokers are well trained, competent and professional
    b. All health insurance brokers have access to the same data and pricing
    c. All health insurance brokers understand the regulatory environment
    d. No health insurance brokers are interested in their client's well being

11. This text makes several additional claims about health insurance brokers. Which below is not such a claim? In other words, which statement below is **false**?
    a. Only some teach their clients how to navigate our complex medical care system
    b. Only some teach their clients how to maximize their chance of medical care benefits and minimize their risks of harm
    c. Only a few teach clients that more care may be worse than less care
    d. Most have extensive educational programming aimed at expanding medical literacy

12. Which type of health insurance broker does the author prefer: one that only spreadsheets and ensures regulatory compliance or one that also teaches basic medical literacy?
    a. One that only spreadsheets
    b. One that only ensures regulatory compliance
    c. One that spreadsheets and ensures regulatory compliance
    d. One that spreadsheets, ensures compliance and teaches basic medical literacy

Review Questions
Correct answers in bold

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    c. One that spreadsheets and ensures regulatory compliance
    d. One that spreadsheets, ensures compliance and teaches basic medical literacy

Chapter 1
Why Health Insurance Brokers Needs Disclosure Standards

The only effective, sustainable way to control your client's healthcare expenses is to teach them how to avoid unnecessary, ineffective, excessive and low quality medical care. That's my opening position.

Any other attempts to control healthcare expenses - financial engineering, clever insurance plan designs or ancillary programs – fail to reduce healthcare inflation. Here's the depressing historical summary: Over the past 60 years, we've tried

- Cost sharing or 'major medical' in the 1960s. These programs were inflationary so they were replaced by
- First dollar coverage or HMOS in the 1979s through 90s, the opposite of cost sharing. People complained about the restrictions so they were replaced by
- High deductible plans, the opposite of first dollar coverage post 2000. People complained about the deductible size.

We've tried

- wide hospital networks figuring that more competition would lower costs, and
- narrow hospital networks, figuring that more carrier control would lower costs;
- defined benefit plans to allow employers more design latitude and
- defined contribution plans to allow employees wider choice,
- individually underwritten plans to reward healthy people and
- community wide rates to avoid penalizing sick people and
- virtually everything in between.

Some companies have adopted ancillary programs to reduce spending like

- Wellness programs to reduce demand for medical services, but these show disappointing returns on investment if any returns at all, and
- Price transparency programs to help employees spend less for specific medical services, but these have little, if any impact outside of a few commodity services like X-rays and MRIs that are probably way overused anyway. What's the point in getting a less expensive unnecessary scan?

These programs all fail for the same reason: Patients will always find a way to access a medical service that they believe will improve their health. In other words, if patients – i.e. your subscribers – believe they need it, they'll get it.

Even if that belief is false. And there's nothing you can do about it.

The only thing we've never tried: teaching employees how to avoid unnecessary and poor quality care. That's a really promising approach.

And that's what ethical brokers should introduce.

Disclosing data on medical care quality: some ethical issues

This text will introduce medical care quality metrics. It's designed to give brokers and patients – ordinary people not trained in medicine, statistics or econometrics, not professional researchers and not nerds - the tools necessary to choose high quality, beneficial medical care and avoid low quality, ineffective or harmful care.

Once you, as a broker, understand these metrics, you'll be in a position to decide whether or not to teach them to your clients. Anecdotal evidence suggests that the better brokers understand these topics, the more likely they are to teach them to clients.

And the more ethical it makes them.

The wise patient today knows that more care doesn't mean better care. But do most of your subscribers and patients have the skills to differentiate high from low quality care, and better from poorer outcomes? I suspect not. That can put you in an uncomfortable ethical position.

Consider this evidence from the US Department of Health and Human Services. 88% of Americans, they find, are medically illiterate, meaning lack the skills necessary to assess likely treatment benefits and harms [6] though I suspect the real number – the percentage of people who understand and use the tools described later in this text – is actually much lower.

Interestingly, however, virtually everyone I meet either professionally in classes or socially claims to be medically literate and generally sees themselves not only as medically literate but also very well informed about medical care. I think that underscores the problem!

Health and Human Services also claims that medically illiterate patients have higher hospitalization rates and medical costs, and poorer health outcomes, the exact opposite of broker's goals.

Knowing this, can you, as a broker, simply develop plans that raise deductibles without including a complementary education program that helps your subscribers spend their deductibles wisely? Is that really ethical? Would you want someone to do that to you?

'Do unto others as you would have them do unto you.'

How a medically literate consumer thinks

[6] https://health.gov/communication/literacy/quickguide/factsbasic.htm

Here's a simple overview of how a medically literate person makes a medical care decision. Ask yourself as you go through this list – how many of your clients follow this protocol? And, if you don't teach it to your clients, who will?

- **First determine how well the medical intervention works** and decide if it works well enough for you. You'll need to understand what a comparative study is, and to understand how to interpret the study results. I'll show you how. Different patients can make different decisions based on the same set of facts.

- **Second consider your treatment options.** You have them about 85% of the time. Learn to explore them. Again, I'll show you how.

- **Third determine which providers – practitioners and hospitals – generate the best outcomes for your preferred intervention**. I'll show you a simple and useful way to choose. It's better than looking up lots of outdated statistical indicators on lots of hard-to-navigate-and-understand websites.

- **Fourth, evaluate your insurance policy** to see which providers are in-network, which treatments are covered, what your copayments are and how to access the care you want.

I submit that an ethical broker will teach subscribers to follow this process, with the likely result that they'll tend to generate better outcomes with less risk and at lower costs.

But deviate and watch spending and risk increase and benefits potentially decline.

The Goldilocks principle

Good, proper and appropriate medical care fits the Goldilocks principle: not too little, not too much, but just right.

- Too little medical care leads to *undertreated* patients and poorer-than-optimal outcomes. Undertreated patients are harmed by their diseases.
- Too much medical care leads to *overtreated* patients and higher-than-necessary costs and medical risks. Overtreated patients are harmed by their care, not their diseases.
- Inappropriate medical care leads to suboptimal outcomes, excessive costs, patient dissatisfaction and sometimes lawsuits.

Overtreatment, and inappropriate care represent about 40% of medical interventions. I'll explain in the 'Slippage' chapter below. Attacking slippage, in other words, becomes a prime focus of ethical broker activities.

The best medical decisions

The best medical decisions come from wise, well informed patients working together with thoughtful, caring clinicians.

- **Patients** know their own hopes and fears and the benefit / risk tradeoffs they are prepared to make. Different patients, when faced with the same set of facts, can reasonably make different care decisions and all be right.

- **Clinicians** have extensive knowledge and experience that can aid a patient.

    - Wise patients avail themselves of this knowledge, experience and counsel.
    - Unwise patients ignore it or delegate decision making to their clinician.

    Ignoring clinician counsel deprives patients of potentially valuable insights. That's the 'art' of medical care.

    Delegating decision making forces your treaters to assume or guess the benefit / risk tradeoffs you're willing to make. Studies suggest that clinicians often get this wrong.[7]

The Slippage Problem in US Healthcare

I got this term from David Cordiani, CEO of Cigna, a huge national health insurer, who introduced it in his keynote talk at Yale's annual Healthcare Conference in April, 2015. 'Slippage' is to healthcare what 'breakage' is to shipping and 'spoilage' is to food service – stuff that goes wrong, the inevitable problems at afflict any industry.

We can estimate the amount of slippage in our healthcare system from expenditure data since we so often assign dollar values to medical interventions. Read the expenditure data below as indicators of slippage volume: when I suggest that 40% of *expenditures* are ineffective or inappropriate, I imply that about 40% of *interventions* are ineffective or inappropriate. Not an exact equality but good enough for government work.

Cordani somewhat conservatively pegged slippage at 'at least 25%' of all US healthcare spending but added that the real figure is probably much higher. Consider 25% a low estimate.

Aetna, another huge national health insurer, less conservatively says on its website that

[7] Mulley et al, Patient Preferences Matter

> Wasteful spending likely accounts for between one-third and one-half of all US healthcare spending. [8]

Aetna claims that the biggest area of excess is defensive medicine including redundant, inappropriate or unnecessary tests and procedures. I'd add redundant, inappropriate, unnecessary or ineffective medications to Aetna's list.

And the Dartmouth Atlas, generally considered the bible of healthcare utilization analytics, uses a widely quoted estimate of 'up to about 1/3' of all US healthcare spending but added 'we view this as an underestimate given the potential savings even in low cost regions'.[9]

I think they're right, especially about the 'underestimate' bit.

Interestingly a 2018 study in Washington State puts some meat on the slippage bone. The Washington Health Alliance analyzed utilization and billing data from 2.4 million commercially insured patients using 47 oft-overused services, and found that 45% of services delivered were wasteful accounting for 36% of medical spending.

The Washington study is noteworthy for a couple of reasons. First the Washington Health Alliance, the group responsible for this study, consists of virtually all the hospitals, insurance carriers and large benefits agencies in the state. This report was cowritten by the Washington State Medical Association and the Washington State Hospital Association, essentially the medical establishment in Washington.

Second, the group identified overuse from the ChoosingWisely list. ChoosingWisely is a creative and very useful medical decision making tool that far too few patients know or use.

ChoosingWisely is funded by the American Board of Internal Medicine Foundation that basically asked lots of specialty medical associations to submit a list of service that their members do but that don't generally benefit patients. Among the 70+ organizations that submitted a list: the American Academy of Allergy, Asthma and Immunology, the American Academy of Family Physicians, the American Academy of Dermatology, the American College of Cardiology and many more.

Each partner organization submitted at least 5 services that 'physicians and patients should question' because of the low level of benefit provided (if any benefit at all) and / or high level of patient risk.

ChoosingWisely is a useful, albeit low bar for poor quality care.

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[8] http://www.aetna.com/health-reform-connection/aetnas-vision/facts-about-costs.html

[9] http://www.dartmouthatlas.org/keyissues/issue.aspx?con=1338

The Washington State folks identified 'appropriate' care as care that it

- Supported by evidence
- Truly necessary
- Not duplicative of other tests or procedures already received and
- As free from harm as possible.

They used ChoosingWisely's list as the basis for determining low quality care and waste, defining low quality care as

- Likely wasteful, meaning there are serious questions about the appropriateness of the service, or
- Wasteful, meaning the service was very likely unnecessary and should not have occurred.

Remember that 'likely wasteful' and 'wasteful' care is, while clearly subjective, defined both by ChoosingWisely – i.e. the various medical specialty organizations - and the state hospital and medical establishment. Again, a pretty conservative bar.

Third, the Washington State report focused on 47 commonly overused services of which just 11 common tests, procedures and treatments represented 93% of the overuse. That list includes preoperative tests and lab studies prior to low-risk surgery, too frequent cancer screenings, eye imaging tests for people without significant eye disease, annual EKG tests or cardiac screening for people with low risk of heart disease, and imaging for uncomplicated conditions such as low back pain.

In other words, the Cordani, Aetna and Dartmouth systemic slippage estimates are supported by the Washington State details indicating that (a) slippage is a huge financial problem and (b) it comes from a relatively limited number of services.

Brokers thus can focus their educational efforts fairly narrowly and have a potentially great impact on their client's health and finances. Our question: is it ethical to do so? And should they?

Five kinds of slippage

Let's expand on the Washington State definition of low quality care to identify 5 types of medical interventions that can generate patient harm and financial waste:

- **Care that doesn't work** or works so badly that you don't want it

- **Care that works on some people** but likely not on you for reasons like age, sex, overall health and, surprisingly, socio-economic status

- **Care that works in tests but is overused in real life** so quite possibly won't benefit *you*
- **Care that you don't want** when you learn of your treatment alternatives
- **Care from low quality providers** (clinicians and hospitals) when higher quality providers are available

I'll discuss all these in more detail below.

How to avoid slippage

Identifying slippage is Step 1. Avoiding it is Step 2.

My suggested slippage avoidance process: teach your clients *to ask the right questions of their doctors*. I developed this process for two main reasons:

First, extensive research shows that most patients trust their doctors and value the patient doctor relationship. Attempts to undermine or go around it seemed doomed to failure.

Patashnik, Gerber and Dowling argue in their excellent book Unhealthy Politics that physicians are the most credible source of patient information, far more than 'studies' or 'guidelines'. [10] Any attempt to undermine physician credibility, in their and my opinion, will simply fail.

My questions therefor enhance the doctor-patient discussion process. Remember that doctors are all highly trained, have access to all the relevant literature, are experienced you and generally welcome patients sharing their hopes, fears and concerns. At least, that's what physicians report.

Second, very few patients are 'medically literate' and able to understand, evaluate and critic medical studies and reports.

This doesn't mean people are stupid!

Rather, it means they haven't had the necessary training. Medically illiterate folks – even if they're otherwise very well educated – need guidance when googling to understand complex information about medical technology and science.

I don't see the utility of showering medically illiterate folks with data and study conclusions. You end up with 'This study shows surgery benefits but that study shows medication benefits. I'm confused so I'll ask my doctor' and you go to my first reason above.

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My questions and the discussions they prompt can overcome those problems. These questions allow your subscriber's physician – their most trusted medical advisor - to interpret complex information and apply it to them.

[10] Patashnik, Unhealthy Politics, chapter 3

But who in our complex healthcare system, teaches your subscribers how to talk with their doctors? There's clearly a need as demonstrated by the waste data presented above. Seems to me we as a healthcare system, and brokers as a profession, have dropped the ball on this.

Why Brokers?
The problem of advice bias

Who advises people NOT to receive medical care or to question routine medical advice and care? In our healthcare financing system, physicians are paid to treat. They have a financial incentive to intervene for they generally do not get paid unless they do something to the patient. Many studies have shown that surgeons tend to recommend surgery far more than non-surgeons do, and sometimes more than patients need.

But physicians, as Patashnik, Gerber and Dowling argued above, are patient's most trusted advisors.

Thus we see a biased medical advice system. Practitioners generally only make money by providing medical care. No one in our healthcare system is paid to advise patients against medical care. No one, in other words, balances the economic intervention interests of clinicians.

'But my doctor suggested that I not have this procedure' goes the superficial but true counter argument. Put this into a tri-partied context.

- Some care is clearly necessary, meaning that virtually all physicians evaluating the same patient would recommend it.
- Some care is clearly unnecessary, meaning that virtually no physicians evaluating the same patient would recommend it.
- And some care is in the gray area, meaning that some physicians might recommend it while others might not.

The 'my doctor recommended against this procedure' statement probably falls into category 2 above, though possibly category 3 too.

The advice bias problem arises only in category 3, the gray area. Research suggests that this is perhaps the largest of the 3 categories.

How large is each category? In other words, what percentage of medical care falls into each? John Wennberg, founder of the Dartmouth Institute, answers this in his book Tracking Medicine. [11] He calls our category 1 'effective care' defined as services that, on the basis of

[11] Wennberg, Tracking Medicine, pages 8 – 10, then Parts II and III

reasonably sound medical evidence, are known to work better than any alternative. This group of treatments accounts, based on his research, for only about 15% of all medical care.

Wennberg calls our category 3 above, the gray area, 'preference sensitive' care meaning care for which there is more than one option and in which different people can make difference decisions and all be correct. Preference sensitive care requires judgment and individuality to evaluate the risk-benefit tradeoffs.

Consider torn or injured rotator cuffs, for example. A surgeon will likely examine the patient, identify a rotator cuff tear and recommend surgery. But a physical therapist, reviewing the same data on the same patient, might well suggest physical therapy, at least to start. Is one right and another wrong?

That situation arose for a student of mine, a licensed health insurance broker in his 60s who managed to tear his right rotator cuff. 'It was so weak and sore' he told me, 'that I couldn't shift the gears on my pick up.' It apparently had a gear shift next to the steering wheel.

He went on to tell me that he visited an orthopedic surgeon who took an MRI, identified the cuff tear, and recommended surgery. 'I would have agreed to surgery' he went on to say, 'prior to hearing your lectures and reading your books.' (See – there actually is some value to education!)

'But I asked the surgeon if all physicians would agree with that analysis and recommendation. He answered with a snort that some might suggest physical therapy but that would be a waste of time and that I'd be back in his office shortly thereafter.'

My former student decided to try PT and reported when next I saw him that his shoulder was pain free and that he had regained 99%+ range of motion – it might have been 100% but he wanted to be conservative - in the same time as surgical recovery but without the costs and risks of surgery. 'Thanks' he smiled as he relayed the story.

Wennberg estimates that preference sensitive care represents about 25% of medical spending, making our category 3 larger than category 1, the clearly beneficial group of treatments.

Wennberg goes on to describe supply sensitive care, or the 60% of medical spending that is about the frequency with which patients get treatments. Physician decisions, he claims, are strongly influenced by the capacity of the local medical market. Areas that have more surgeons experience more surgery; areas with more Neo Natal Intensive Care Units have more babies admitted to NICUs; areas with more cardiac catheterization beds have more cardiac catheterizations, etc.

How often should a physician see patient in pain, suffering from a chronic condition or desiring to feel better? Once a month? Once a quarter? Semi-annually? The answer, according to Wennberg:

> The doctor will sort it out based on how sick an individual patient is and how many opening he has in his schedule. Specialists tend to fill their appointment books to capacity. [12]

Thus a physician might say to a patient 'I'd like to see you again in 3 weeks', but the office booking clerk, seeing that the doctor is booked for the next 6 weeks, asks the doctor if waiting 6 weeks is OK. 'Fine' the doctor replies, raising the question of why he or she originally wanted to see the patient in 3 weeks.

This is sometimes called Roemer's Law, named after a healthcare economist named Milton Roemer who discovered that if more hospital beds exist in a region, there are more hospitalizations.

And it's sometimes called 'supply induced demand.' A hospital buys a new MRI machine and suddenly lots of patients need MRIs. Or when a new dermatology practice opened near my house, I tried to get an appointment only to learn that they were fully booked for the next 3 months. How was that possible for a new practice? According to Wennberg, they simply saw patients more frequently to fill up their calendars. (I don't know if that was the reason but it certainly seemed likely.)

Wennberg's estimate that 25% of medical spending goes to preference sensitive care and 60% falls into the supply sensitive category highlights the problem of advisor bias. And our current fee-for-service physician payment system exacerbates it. Your physician might consciously think 'I'd like to see this patient again in 3 weeks' and subconsciously 'and I'll get paid to see her.'

Or 'this procedure will probably help the patient' and subconsciously 'and I'll get paid to perform it.'

Does this actually happen? Let me quote conclusions from 3 recent studies on the impact of fee for service payments on physician recommendations:

- On average a 2 percent increase in payment rates leads to a 3 percent increase in care provision, with elective procedures responding most strongly to pricing incentives.[13] In other words, when physicians get paid more to do something, they do it more frequently.

[12] This discussion comes from Maggie Mahar, Money Driven Medicine, page 172, including Wennberg's quote.

[13] Do Physician's Financial Incentives Affect Medical Treatments? Clemens et al, https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2101251

- When specialists are paid through a fee-for-service scheme rather than on a capitation basis, surgery rates increase 78%. [14] Again, the more specialists are paid, the more they tend to do.

- Patients seeing fee-for-service ophthalmologists were twice as likely to have cataract surgery as patients seeing doctors in capitated systems. Interestingly the number of cataract surgeries dropped by 45% within 6 months after a studied ophthalmology group of physicians switched to a capitated payment contract. [15] Or, in the vernacular, physicians respond to financial incentives.

Thus we see a systemic bias in favor or patients receiving more medical care based on the advice – potentially biased - that they're likely to get. This makes medical service different from, for example, legal services.

In court the prosecution and defense attorneys argue different interpretations of the same facts, more or less, in John Wennberg's terms, different preference sensitive interpretations. The judge or jury then decides who is right.

But in medical care, patients only have one interpretation, that of their own physician. Patients generally rely on one interpretation and rarely have the skills to question it. (Yes, patients sometimes get second opinions and these can be incredibly useful. But only if they're used in specific ways. I'll get to that.)

We lack in medicine the 'alternative interpretation' feature that opposing attorneys offer in legal services. Where do patients learn how and when to question tests and procedures, especially common ones – things like the eye imaging tests, cancer screenings and annual EKGs that the Washington State report highlighted as waste?

Carriers might play that role – but the managed care experience of the 1990s has turned popular opinion against trusting carriers too much.

Second opinions are too cumbersome. Who wants to get a second opinion when the doctor says 'let's run this test to rule out' something or other? Or when your doctor says 'it's time for your annual mammogram'? Or even 'your cholesterol level is getting high. The guidelines recommend that I put you on medication to lower it.' 'High' to your doctor may be 'moderate'

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[14] Shafrin, Operating on Commission: analyzing how physician financial incentives affect surgery rates, Health Economics http://onlinelibrary.wiley.com/doi/10.1002/hec.1495/abstract

[15] Effect of Physician Reimbursement Methodology on the Rate and Cost of Cataract Surgery, Shrank, 2005 https://www.ncbi.nlm.nih.gov/pubmed/16344447

for the patient, assuming, of course, that the patient is medically literate, an assumption that is incorrect 88% of the time according to HHS.

Even if patients get a second opinion, it may be from another doctor in the same practice who may have an informal – perhaps even unconscious – motivation to support his/her colleague.

That leaves the broker. Should the broker advise clients of potential risks of easy availability of medical care? How much should the broker inform clients about systemic abuses? In sum…

What ethical disclosure responsibilities does the broker have to protect his/her client from unnecessary / excess treatments and the related potential medical harm?

Review Questions
Answers on next page

1. What is the only effective, sustainable way to control your client's healthcare expenses?
    a. Promote medical literacy
    b. Raise deductibles
    c. Introduce a wellness program
    d. Ration employee access to medical care

2. Roughly what percent of Americans is medically literate?
    a. 12%
    b. 50%
    c. 75%
    d. 100%

3. Roughly what percent of Americans consider themselves medically literate and well informed about medical care according to this text?
    a. 12%
    b. 50%
    c. 75%
    d. 100%

4. Which statement is true about medically literate patients?
    a. Medically literate patients have lower hospitalization rates and medical costs
    b. Medically literate patients have higher hospitalization costs
    c. Medically literate patients have higher medical costs
    d. Medically literate patients have poorer medical outcomes

5. This text outlined a 4 step medical decision making process. Which below is not one of those steps?
    a. Determine how well a medical intervention works for your ailment
    b. Explore your treatment options
    c. Learn which provider – doctor and hospital – does that treatment the best
    d. Pray

6. How does this text differentiate undertreatment from overtreatment?
    a. Undertreatment increases the risk of being harmed by the disease; overtreatment increases the risk of being harmed by the care
    b. Undertreatment is like rationing
    c. Overtreatment means you are harmed by a different disease
    d. Undertreatment costs the healthcare system much more

7. About how much slippage exists in US healthcare?
    a. Less than 5%

b. About a third
c. More than 80%
d. More than 90%

8. What is ChoosingWisely?
    a. A list of treatments that patients and clinicians should question and likely avoid
    b. A list of really good treatment
    c. A list of the best medications
    d. A list of the best hospitals

9. What is one lesson from the Washington State study?
    a. That wasteful and low quality care represent over a third of all medical spending
    b. That environmental factors drive most healthcare spending
    c. That environmental factors do not drive most healthcare spending
    d. That commercial insurance policies control spending very well

10. John Wennberg of Dartmouth identified 3 categories of medical care. Which below is not one of them?
    a. Necessary and effective care
    b. Preference sensitive care
    c. Supply sensitive care
    d. Alternative, low cost care like herbs and potions

11. Which below is most credible to most patients?
    a. Double blind controlled studies
    b. Guidelines published by medical specialty associations
    c. Research studies from famous medical schools
    d. Recommendations from the patient's own doctors

12. What approach does this author recommend for helping patients avoid wasteful care?
    a. Learn the key questions to ask their doctors so they focus discussions on likely outcomes
    b. Read lots of medical studies from high quality research institutions
    c. Learn the guidelines that relate to your medical problems
    d. Get opinions from others who have had your medical condition treated successfully

Review Questions
Correct answers in bold

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Chapter 2:
Overview of Disclosure Ethics

The Biblical View of Business Ethics: 'Do not do unto others as you would not like done to yourself' and 'Love thy neighbor as yourself' are two fundamental ethical dictates of Judeo-Christian religions. We – Americans coming from Judeo-Christian traditions and teaching – believe that we have responsibilities to treat others as we would want them to treat us.

The Business Ethics Center of Jerusalem defines business ethics as 'the value structure that guides individuals in the decision making process when they are faced with a dilemma of how to behave within their business or professional lives.'[16]

Ethical business considerations fall into two separate categories.[17] **First,** business ethics regulates conduct in direct contact situations, such as with employees, clients or suppliers. These commonly fall into standard categories including employee relations, honest representation and truth in advertising.

These types of ethical issues have an immediacy or personal effect: lying to a customer may induce that person to buy the wrong product. Shading the truth may persuade a client to purchase a policy that benefits the broker inappropriately. In both cases, the only party harmed is the party in direct contact with the unethical broker.

Second, business ethics involves social responsibility. These ethical issues consider how much all of us must take responsibility for society as a whole. Ethical social behavior, for example, includes protecting our natural resources, caring for the poor and providing equal educational opportunities to all.

This course will deal primarily with the first type of ethical business considerations – the direct contact situations – though we will make some social responsibility types of ethical observations also.

Unequal Knowledge about our Healthcare System

What does 'unequal knowledge about the healthcare system' mean?

Brokers typically know a great deal more about our healthcare system than do their clients. Among the areas of broker expertise:

- Underwriting guidelines
- Regulations

[16] See www.besr.org/DCPage.aspx?PageID=198

[17] This discussion comes from www.besr.org/DCPage.aspx?PageID=199

- Provider cost data (at least rough and crude measures)
- Outcome data (again, rough and crude measures)
- Treatment complication data (assuming a well informed broker)
- And several similar categories.

We will explore the broker's ethical responsibilities to share all available information with their clients.

In developing our overall position on the ethics of disclosure, we will rely primarily on the Torah. Why?

The Torah also known as the beginning of the Old Testament or Five Books of Moses, has served as the moral and ethical foundation of our Judeo-Christian western civilization for thousands of years.

Virtually all the great historical ethicists and philosophers had a deep understanding of the Torah's teachings. These permeate our shared views of right and wrong, morals and ethics, and have done so for a very long time.

Some Judeo – Christian Business Ethical Positions on Disclosure:
Abraham's first purchase

In the first commercial transaction in the Torah or Old Testament, Abraham laid down the 'full disclosure' commercial principle.[18]

The story of Abraham purchasing a burial plot for his wife Sarah is instructive from our ethical viewpoint. The haggling over land takes five steps in Genesis 23: 3 - 20:

> **Step 1:** Abraham explains what he needs in vague terms – a burial plot for his wife. He does not stipulate where or exactly what kind of burial plot;
> **Step 2:** The sellers offer 'the choicest of our burial places';
> **Step 3:** Abraham considers this (perhaps even goes on a guided tour of choice burial places) then asks for 'the cave of Machpelah…which is at the end of [the sellers] field', and offers to pay 'full price';
> **Step 4:** The sellers confirm that they have exactly what Abraham wants 'the field and cave that is in it';
> **Step 5:** The buyer and seller ultimately agree on the land and price and transact the purchase in public 'in the presence of the sons of Heth, before all who went in at the gate of his city'.

Note the similarity with health insurance policy sales:

[18] This genesis of this discussion comes from www.torah.org Business Ethics: The Challenge of Wealth, *Parchas Chayei Sarah, Parchas Metzora, Parshas Shoftim* and *Responsa-Vayigash*

Step 1: the Buyer explains what he/she needs in vague terms – a policy to cover my employee's medical needs, perhaps with some specific issues in mind;
Step 2: the Broker says 'we have many quality plans available' and explains them;
Step 3: the Buyer considers several options, then stipulates what he/she wants;
Step 4: the Broker confirms that a specified policy contains the desired benefits;
Step 5: the Buyer enrolls by signing a contract.

It was clear from Abraham's negotiations that he had the opportunity to view the land and cave prior to purchasing. The seller had helped him learn about the land, pointing out the choicest burial place. Indeed, the seller may even have warranted the land: 'none of us will withhold from you his burial place', thereby confirming that this was, in fact, burial property.

The seller apparently understood that Abraham – 'a foreigner and a visitor' – did not know all details about local burial plots. The seller therefore helped Abraham learn everything that he needed to know so he could make a wise, informed purchase.

There was no ambiguity about the land, the location or the use. No confusion about exactly what Abraham bought…because the seller provided such a thorough and detailed education.

'Let the Buyer Beware' is Unethical

The lesson about this transaction? That in the Torah there is no concept of 'let the buyer beware'. The seller taught Abraham everything he needed to know about local burial plots, made very clear to Abraham exactly what he was buying and made his declarations publicly.

'Let the buyer beware' assumes that all parties to a commercial transaction have the same information regarding price, quality, use, location, comparative markets, etc. This was clearly not true for Abraham, the 'foreigner and visitor'. The seller could have taken advantage of his lack of knowledge to swindle him – but did not. The seller educated the buyer. This is the ethical business lesson of Genesis 23: 3 – 20.

'Let the buyer beware' also assumes that all parties have not only equal information and equal access to information but also equal abilities to understand the information available. In the Biblical case, Abraham was only able to understand the intricacies of burial plots after being educated by the seller. Is this concept still valid today? Can 'let the buyer beware' serve as a valid basis for commercial transactions?

The answer is no. Traditional Torah ethics remain valid today for two main reasons.

First, sellers and buyers rarely have exactly the same information. The seller generally knows his / her products far better than the buyer. The simple reason is that the seller deals in this market – for this product – far more frequently than does the typical buyer.

Today's health insurance broker, for example, spends his or her entire professional life dealing with health insurance policies. The broker constantly hears customer and market feedback – 'I thought the policy covered this but my claim was rejected' or 'The specialist my doctor recommended wasn't in network' or 'This carrier answered all my questions completely and handled my claim quickly' for example.

The buyer, on the other hand, probably only deals with health insurance issues once or a very few times per year. This puts the buyer at an information disadvantage. He or she simply can't know as much about the products, carriers, markets and nuances as the pro who deals with these issues daily.

This was clearly the case for Abraham, whose expertise did not include detailed knowledge of local burial plots. That's why he relied on the seller's representations and information – he had no other option.

Second, in the real world, sellers can understand their product information far better than the buyer can. This is primarily because the health insurance broker has studied healthcare issues in far greater depth than the typical buyer. Even if the buyer has access to information, he / she often lacks the background and context in which to place that information.

Again, this is similar to Abraham's situation. He was a merchant, with expertise in his own arena – not in burial plots. He was not in a strong position to understand burial plot issues without additional education.

Our clients are similar to Abraham. They are accountants, schoolteachers, fishermen or others, with expertise in their own fields, not healthcare. Lacking the broker's healthcare education and background, they are less able to understand healthcare details and issues than the broker.

How many of your clients know and understand the systemic information presented earlier in this text?

Thus for these two reasons – that the broker has both better access to product information and a better ability to understand that information – today's health insurance salesperson has an ethical responsibility to educate the client. Just like Abraham's burial plot seller.

Do Your Fellow A Favor

The Torah builds on this concept and goes even further. Halakha or Jewish law forbids the seller from hiding product flaws, and even from creating a false impression. This is covered in the Jewish legal concept of 'mekach taut' or faulty sale. According to this doctrine, the seller is obligated to make full disclosure of any defect in the goods or services sold.

To quote Rabbi Dr. Meir Tamari, an expert on business ethics, 'even where the seller was ignorant of the flaw, the sale may be cancelled' as the buyer cannot be forced to accept a

discount as compensation for the defect. [19] Thus, the broker who claims 'I didn't know that the policy contained that' has no ethical defense: Jewish law makes the seller responsible to understand fully all the implications of each health insurance policy.

Rabbi Tamari goes even further in a discussion of Parshas Shoftim when he quotes the Rabbis that 'he who does not *do his fellow a favor*, is not of the sons of Abraham' for 'we force one to act contrary to the selfishness of Sodom'.

Now the seller has an even greater ethical burden. Not only must he / she educate the buyer and make full disclosure, but the seller must *do his fellow a favor* and highlight problems with the health insurance policy that *may* occur.

Why would Jewish law --- which later became Judeo-Christian ethics – place such a burden on sellers?

There appears some thinking that these burdens ultimately work to the advantage of the seller. If all sellers act ethically as described above, then it becomes very easy to sell products to buyers. The reason: buyers would have a very high degree of confidence in the seller's representations.

Business Ethics = Business Efficiency

In doing this, the Torah advises us to *put business long term financial interests ahead of short term profit goals.*

If everyone followed the Torah's teachings, in other words, we would have a very well functioning business economy. The Torah can be seen as a manual for how to prosper in business. We'll read its various ethical teachings in this light.

Ethical sellers – i.e. those who follow the Torah's teachings - would not have to prove their honesty or credibility. They could concentrate, instead, on selling products. This is very efficient: sellers could focus on their income generating activities (i.e. sales) rather than spending time explaining or justifying their personal ethical standards, or establishing personal credibility. They would thus generate higher incomes.

Abraham's burial plot sellers, apparently, had this credibility, as there is no mention of Abe searching for other plot sellers. He did not shop around for a 'better deal'. He was – apparently – satisfied with his seller's ethical positions and chose to do business with him.

The religious laws outlined above ultimately work to the seller's advantage.

[19] ibid. Responsa-Vayigash

Efficiency and Health Insurance Sales

Let's apply this standard to health insurance brokers. If we all *do our clients a favor* and warn them about risks of healthcare systemic abuse and excess, then we may help control healthcare inflation. By *doing our clients a favor*, we may serve the interests of our entire economy by reducing healthcare costs.

In short, we do well for our clients and do well for our country by doing our clients a favor. We also, according to the Torah, do well for ourselves as brokers by adhering to this ethical standard.

Whose Interests Should the Broker Protect?

This ethical disclosure standard seems to require brokers to act against physician and hospital financial interests by educating clients about medical risks, waste and low quality care – teaching them, in other words, how to make wise medical care decisions. Providers, under our fee-for-service financing arrangements, have an economic incentive to treat, and often to overtreat, up to about 40% of the time according to the data presented earlier. Brokers, under this standard, have the burden of countering these physician economic incentives.

Seen in this light, the Torah's teachings may set up a conflict in our healthcare economy. Let's look at the gray area, in which a subscriber may or may not need treatment, and discuss the economic incentives facing each party. (Ethical discussions always focus on gray areas, as these are the difficult cases. There's no ethical dilemma in an easy or obvious case.)

Providers – physicians and hospitals – have an economic interest in treating and make the most money by providing the most treatment. The lens through which they view the patient may – consciously or unconsciously – include their own financial self interest. 'Patients of this type', they may think, 'often improve with treatment.'

Upton Sinclair, and American writer in the early 1900s, summarized this problem succinctly while campaigning for governor of Illinois:

> It is difficult to get a man to understand something when his salary depends on him not understanding it.

When in doubt, our economic system tends to motivate providers to treat.

Patients with health insurance generally have little or no *economic* incentive to avoid treatment. They purchased insurance exactly for this situation. They generally have minimal out of pocket costs, depending on their policy type and deductible situation. Even a $1000 or $3000 out of pocket payment pales in comparison to a potentially life saving treatment or to treatment that eliminates a chronic pain.

In addition, patients who are sick or in pain are often scared and want to trust someone who offers relief. The reassuring physician who counsels 'I have treated many patients like you successfully' provides exactly the advice that the patient wants to hear.

Thus, our systematic incentives may induce unnecessary treatment for patients in the gray area. The providers gain, but the patient doesn't pay.

Who Wins and Who Loses in the Gray Area?

This seems, at first cut, a win-win situation. The provider wins – gets paid. The patient wins – gets better. Even if the patient doesn't improve much, he/she didn't pay much. No harm, no foul.

Except for two problems. **First**, in the US, a great deal of care generates little to no patient benefit, as discussed earlier. But the provider always gets paid. Our 'win-win' becomes 'providers win, patients get nothing' around 40% of the time, according to the Washington State study.

Those odds might be attractive to patients if medical treatments were risk-free; if we never had treatment complications, then reasonable and rational patients might decide that a 60% chance of improvement is good enough. They might discount the 'no benefit' risk and agree with their physician's advice to receive treatment.

Unfortunately, however, medical treatments are never risk-free. This is the **second** problem. There are always significant complication risks. I discussed Samantha Reckis earlier – remember her? The little girl on Cape Cod who went blind from taking children's Motrin. Expanding on this, consider these two data points:

- Medical errors occur, on average, twice per day for every person in Intensive Care; [20]
- Up to 40% of hospital deaths occur in patients who are not hospitalized for end-of-life issues. [21]

This is not the business efficiency envisioned in the Torah's ethical discussions. This is very inefficient and unethical: one group in our society (providers) wins with every transaction while another (patients) loses around 40% of the time. And sometimes, loses big.

The Broker's Education Responsibility

[20] Atul Gawande, The Checklist, The New Yorker, December 10, 2007

[21] Data from Dr. David Pryor, Medical Director of Ascension Health, lecture given 4/7/08 to the Massachusetts Healthcare Council in Waltham, Massachusetts

What group in our society can counter the providers? Who can give warnings to patients about risk? Who can give unbiased advice to patients about when to trust providers and when not to? Who can act – in Biblical terms – like Abraham's burial plot seller?

I suggest that the broker has these responsibilities. This is a wider definition of broker duties than is currently common in our industry. But it is the definition that follows from the ethical standards discussed in the Torah.

Is it enough simply to describe the health insurance policy in detail?

Such a description would include a discussion of copayments and deductibles, pre-existing condition exclusions if any, available providers, prescription drug coverage, price etc and then show alternative products and describe them.

Though this may satisfy some customers, it does not satisfy the Torah's ethical requirement.

The broker also has an ethical responsibility to describe policy implications – the likelihood of benefit and harm from using the health insurance policy.

And the broker has an ethical responsibility under the 'do your fellow a favor' principle to teach clients how to identify and avoid wasteful and / or harmful medical care.

How Much Should Brokers Disclose?

The question posed by Rabbi Tamari in Parchas Shoftim above, in the discussion of *do the fellow a favor* remains: How much should a seller disclose about a product to a customer?

Tamari starts with the religious doctrine of Mekach Taut or faulty sale, discussed above. That's the doctrine requiring full disclosure of any defect in the goods or services sold, and a cancellation of the sale due to product defects *even if the seller was ignorant of the flaw at the time of sale*.

It is unclear from Genesis 23 exactly how much information Abraham's burial plot seller provided. He apparently provided a great deal and probably all that was necessary in that circumstance. But we get into a gray area when applying the lessons of Genesis to more complicated transactions, like health insurance policy sales.

Is it a 'product defect', for example, if someone goes to a less expensive and also lower quality in-network hospital and picks up an infection? Or if someone opts for surgery and has a complication, only to learn later that physical therapy might have been a wiser choice? Or if someone takes a heart attack prevention medication, later has a heart attack and subsequently learns that the medication was proven ineffective in comparative studies?

That's why the Rabbis expanded their discussion to include *do the fellow a favor.* Now we have the ethical tools to address this question.

Review Questions
Answers on next page

1. What does 'let the buyer beware' mean?
    a. That the buyer should beware that the seller is probably lying when he/she represents something
    b. That the buyer should beware that the seller is probably taping the transaction to protect him/her self in the event of a fraud accusation
    c. That the buyer should beware that the product probably contains hidden defects that the seller is not under any legal or ethical obligation to disclose
    d. That they buyer must do his/her own product research because the seller feels him/her self under no ethical obligation to disclose product details

2. What does 'let the buyer beware' assume?
    a. That the buyer understands that the seller is probably lying when he/she represents something
    b. That all parties to the transaction have equal abilities to understand the product information available
    c. That buyers have a certain minimum level of intelligence
    d. That sellers have less than a certain minimum level of intelligence

3. Is 'let the buyer beware' an ethical or unethical standard?
    a. This is an ethical standard
    b. This is not an ethical standard. In fact, it is unethical
    c. It is only an ethical standard for service type products like health insurance
    d. It is generally an ethical standard but is inappropriate for service type products like health insurance

4. What does 'do your fellow a favor' mean?
    a. That buyers should help sellers whenever possible
    b. That sellers should try to put themselves in the buyer's position, and should educate buyers as they would like to be educated themselves if they were the buyer
    c. That sellers should embrace 'the selfishness of Sodom' thus creating a more competitive market
    d. That buyers should embrace 'the selfishness of Sodom' thus putting more demands on the seller

5. Is 'do your fellow a favor' an ethical standard?
    a. No
    b. Yes
    c. Only when the buyer figures that the 'favor' is worth less than the product in question
    d. Only when the buyer figures that the 'favor' is worth more than the product in question

Review Questions
Correct answers in bold

1. What does ‘let the buyer beware’ mean?
    a. That the buyer should beware that the seller is probably lying when he/she represents something
    b. That the buyer should beware that the seller is probably taping the transaction to protect him/her self in the event of a fraud accusation
    c. That the buyer should beware that the product probably contains hidden defects that the seller is not under any legal or ethical obligation to disclose
    d. **That they buyer must do his/her own product research because the seller feels him/her self under no ethical obligation to disclose product details**

2. What does ‘let the buyer beware’ assume?
    a. That the buyer understands that the seller is probably lying when he/she represents something
    b. **That all parties to the transaction have equal abilities to understand the product information available**
    c. That buyers have a certain minimum level of intelligence
    d. That sellers have less than a certain minimum level of intelligence

3. Is ‘let the buyer beware’ an ethical or unethical standard?
    a. This is an ethical standard
    b. **This is not an ethical standard. In fact, it is unethical**
    c. It is only an ethical standard for service type products like health insurance
    d. It is generally an ethical standard but is inappropriate for service type products like health insurance

4. What does ‘do your fellow a favor’ mean?
    a. That buyers should help sellers whenever possible
    b. **That sellers should try to put themselves in the buyer’s position, and should educate buyers as they would like to be educated themselves if they were the buyer**
    c. That sellers should embrace ‘the selfishness of Sodom’ thus creating a more competitive market
    d. That buyers should embrace ‘the selfishness of Sodom’ thus putting more demands on the seller

5. Is ‘do your fellow a favor’ an ethical standard?
    a. No
    b. **Yes**
    c. Only when the buyer figures that the ‘favor’ is worth less than the product in question
    d. Only when the buyer figures that the ‘favor’ is worth more than the product in question

Chapter 3: Some Concrete Ways for Health Insurance Brokers to 'Do Your Fellow a Favor' and to Avoid 'Letting the Buyer Beware'

We discussed the low quality and wasteful care problems earlier in this text. Let's drill down on the issue here as a brief summary.

Our fee-for-service healthcare financing system is weak at generating outcome data - we have fewer follow-up studies than we should. Many argue that this is due to our billing system: providers get paid based on inputs – procedures performed – rather than on outcomes. This can create a disincentive to study care effectiveness. Studies showing that treatments generate poor outcomes may hurt them economically.

Ditto for drug manufacturers, device manufacturers, hospital and other participants in the healthcare system. All exhibit a reluctance to engage in outcome studies.

As a result, medicine today is less scientific than we would like to believe. Here's Shannon Brownlee, author of *Overtreated*, articulating the treatment outcome problem over the past few decades and continuing until today:

> Much of what doctors were doing was based more on hunches than good research. There were gaping holes in medical knowledge even when it came to something as seemingly mundane as a tonsillectomy. [22]

And here's Harvard Business School Professor Michael Porter on the issue of choosing the 'best' physician or hospital:

> Physicians generally lack information on results, or their efficiency in achieving results, that is essential for knowing if they are doing their job well…most physicians lack any objective evidence of whether their results are average, above average or below average. [23]

As a result, medical practitioners rely on guidelines or norms. Not always a good idea. Yale Medical School Professor Dr. Sherwin Nuland explains the problems using routine standards or current 'care norms' as decision making justification:

> Better watch out or the pendulum swing of medical dogma will bash your head in. It swings back and forth far more often than most people realize and with greater velocity.
>
> Thirty years ago patients with inflammation of … the colon were routinely treated with a diet low in roughage. There was no uncertainty about this course of action…and yet, a

[22] Brownlee, op cit, page 27

[23] Porter and Teisberg, Redefining Health Care, page 54

few years later, medical opinion reversed: decreased roughage was found not to be a panacea but a cause of the disease.

This new medical discovery was announced in the same assuredness and supported by just as much evidence as had been used for precisely the opposite viewpoint. [24]

This is sometimes called Medical Reversal, today's in-vogue term to describe how we embrace a treatment for a while only to reject it years later when it's shown to be non-beneficial or harmful. Nuland summarizes one such incidence above. Vinay Prasad in his brilliant book Ending Medical Reversal lists dozens more including

- Estrogen replacement therapy for postmenopausal women to reduce heart attacks, a treatment he claims 'was of no benefit to the heart….Doctors stopped recommending it not because we discovered something better, but because we never should have used it in the first place.' [25]
- Coronary stent insertion to prevent heart attacks in asymptomatic patients until the COURAGE study showed that stents did not help patients live longer. [26]
- Vertebroplasty or insertion of medical grade cement into brittle vertebra to strengthen the bones and take pressure off the nerves. This became a billion dollar a year business in 2012 even though two 2009 studies showed that patient pain reduction was the same in the placebo and treatment groups. Patients, companies – your clients – spend a billion dollar a year on a treatment works no better than a sham!
- And over 140 more in his book's Appendix.

Prasad argues that much of what doctors do is unfounded in science and is, simply, wrong. This can help us focus on the broker's ethical disclosure issue. Should the broker, armed with a company's claims experience and recognizing that some employees have preventive stents or vertebroplasty, inform the client of these issues?

Clearly brokers cannot give medical advice. They're not qualified or licensed to do so and should avoid doing it, despite the fact that I regularly hear about brokers giving medical advice. One, for example, told me in class that clients often ask her how to choose a primary care physician. Her shocking answer, shocking to me at least: look for a PCP with specific training in your issues of concern.

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[24] Sherwin B. Nuland, 'Medical Fad: Brain, Midwives and Leeches' New York Times, June 25, 1995, section 4, page 16.

[25] Prasad, Ending Medical Reversal, pages 2 – 3

[26] Ibid, page 27

> 'If you have gastro-intestinal problems, for example, look for a PCP who is trained in internal medicine. If you have orthopedic problems, ask your potential PCPs if they have any advanced training in orthopedics.'

I say 'shocking' because I know of no studies showing that those kinds of PCPs generate better patient outcomes than a control group and neither did this broker. (See why a basic knowledge of comparative studies is useful?)

But I see a potential lawsuit on the horizon. (I'm not a lawyer.) What happens to a client who follows this broker's advice, chooses a PCP and has a bad medical outcome? Might the client sue the broker for poor advice? (I'm still not a lawyer and have no idea is this is realistic or not. But why would a broker open herself to such potential problems?)

I will argue instead that brokers should teach clients how to identify and avoid unnecessary, ineffective and wasteful medical care. Two reasons for this. First, the company hires the broker to help control healthcare costs, to save money on healthcare in other words. Part of this professional responsibility includes helping the company avoid wasting money on ineffective care.

That seems to me part of the broker's fiduciary responsibility, and a core part at that.

Second, under the 'do your fellow a favor' ethical standard, the ethical broker should preemptively educate clients before they waste money on ineffective care. What would Abraham have said if he bought a cemetery plot for his wife and only later learned that the seller knew Abe was purchasing non-cemetery land but didn't say anything in advance? The Rabbis would label that unethical and so, I suspect, would most reasonable people today.

Today's broker knows about healthcare waste, low quality care and care harms based on their own studies and professional education if not only from the data presented in this text. You have the knowledge. Is it ethical to withhold it from your clients? We've clearly seen, under the 'do your fellow a favor' standard, that it is not.

The ethical question has, thus, shifted from '*should* the broker disclose information about healthcare system waste to the buyer?' to '*how* should the broker disclose this information?'

The Process of Disclosure in today's healthcare system

Dr. Prasad echoes many researchers in claiming that clinicians rely on hunches rather than facts far too often. Science gives us facts; hunches give us guesses.

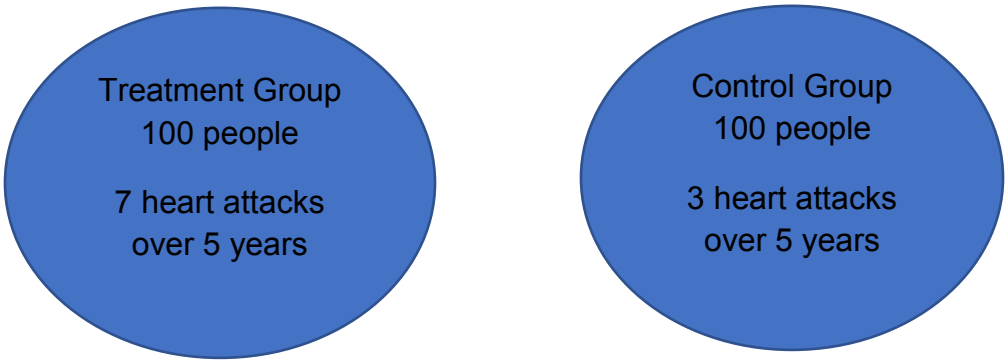
I propose that Step 1 in client disclosure and education starts with explaining how medical science arrives at facts and how to differential facts from hunches. That process – science in other words – relies on comparative testing.

Comparative tests tell us if and how well a medical intervention works in real life, on real people.

When testing, medical researchers typically divide a large group of people in half to make 2 identical smaller groups. They give one group the treatment but not the other. [27]

Then researchers watch both groups for a time period, say 5 years, and note medical differences like the number of heart attacks, deaths or strokes. They attribute any differences to the intervention.

Here's a simple visual representation of a comparative study for a hypothetical heart attack preventive medicine. The Treatment Group gets the medicine while the Control (or Placebo) Group does not. In this case, for simplicity purposes, I've assigned 100 people to each group. Note that this example is not based on any actual medication and is presented only to show what a comparative study looks like.



Can you determine how well the medicine worked to prevent heart attacks? In this example, the medicine prevented 4 heart attacks per 100 people over 5 years.

Simple! Actually not simple at all. Medical research methodology is very complicated and worthy of many texts, each much longer than this. But this example shows the essence of what a comparative study is. In effect, this example shows how the science tells us how well medical care works.

[27] Research methodology is extremely complicated. If you're interested in learning more, check out Know Your Chances by Woloshin et al. It's an easy to read introduction to medical statistics and research methodology.

Scientifically determined outcomes, 'facts' in other words, rely on comparative study data. That's how researchers determined that vertebroplasty worked no better than a placebo to reduce back pain, that estrogen didn't protect postmenopausal women from having heart attacks and that stents in stable patients did not prevent heart attacks….among lots of other things.

But what happens if you don't have 5 years available? Say that a new heart attack prevention medicine just came on the market, looks promising and you, a person with some elevated heart attack risk, have a doctor's appointment the next day.

Your doctor may say 'this is the newest generation of heart attack preventive medicine and has been configured to reduce the side effects of the old drug. I suggest you try it and see how you tolerate it.'

In theory the new drug works well. But it hasn't been tested yet in real life, on real people, for years. So how well does it work?

Dr. Prasad studies that issue. He asks in his research 'how well do medical interventions work if they haven't been subjected to comparative tests?'

How well, in other words, does medical theory hold up to subsequent testing?

Prasad and his team conducted a fascinating study summarized in his book Ending Medical Reversal. They reviewed every article in the New England Journal of Medicine between 2001 and 2010 and pulled out those that tested an established medical practice, i.e. subjected an established medical practice to a comparative study. Established medical practices are those commonly used on patients like inserting stents into stable patients and, at least for a time historically, prescribing estrogen to postmenopausal women to prevent heart attacks … interventions that made medical sense and that the medical community embraced.

363 studies qualified.

Prasad then asked 'Of those 363 studies, how many *affirmed* the practice?' i.e. found that it benefited patients.

38% affirmed the practice, 40% negated the practice, (found it ineffective or harmful) and 22% were ambiguous.

Dr. Prasad's research shows that if you base your medical decisions on biology, physiology, anatomy and logic – *but not on test results* – you are wrong about as often as you are right.

We'll call this Prasad's Law at restate it clearly here: Medical interventions that haven't been subjected to comparative testing are ineffective or harmful about half the time. How do we

know that they're ineffective or harmful? We learn this when they're subsequently tested, potentially many years in the future.

But that's after patients have used it!

According to Dr. Prasad, rather than focusing on outcomes, patients often

> gravitate toward the nuts and bolts — what does it do, how does it work?
>
> But the real question is: Does it work? What evidence is there that it does what you say it does? What trials show that it actually works?
>
> You shouldn't ask *how* does it work, but *whether it works at all*. [28]

He goes on to claim that 'of all those things we're doing currently that lack good evidence, probably about half of them are incorrect.' [29]

Why is this the case?

Our bodies are enormously complicated and our understanding of medical risks, causality and treatment impacts is surprisingly limited. Sometimes (often?) rather than using the most *important* biological or anatomical factors in our medical theories, we use the most *easily accessible and measurable*.

Here's an analogy to illustrate: [30]

> Assume that our bodies are controlled by a wizard located in our brain, more or less like the fellow behind the curtain in the Wizard of Oz.
>
> The wizard in our brain has a wall of knobs that control body parts and functions - one controls cholesterol levels, another blood pressure, a third bone density, a fourth eye ball pressure, etc.
>
> If each knob is 1 inch in diameter and 1 inch apart (so the wizard can get his fingers around it) the wall is six and a half feet high and half a mile long!

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[28] Quotes from Nicholas Bakalar, Medical Procedures May Be Useless, or Worse, New York Times July 26. 2013, italics added

[29] These are quotes from Dr. Prasad's video http://www.mayoclinicproceedings.org/cms/attachment/2007391767/2029532458/mmc3.mp4 . Some minor edits for grammar and syntax

[30] I've adapted this example from David Newman, Hippocrates's Shadow, page 202

We simply can't account for all the initial effects, rebound effects, interactions and modifications from turning a knob or two. We don't always know, for example, how turning a knob 2 feet high 100 yards from here affects a level controlled by a knob 3 feet high 300 yards away. And how either of these affects a knob 4 foot high 400 yards away. Or the impact of the last knob change on the first. And so on.

Medicine rarely works in the simplified 'if A causes B, and B causes C, then A causes C' scenario.

Now, as an ethical broker, don't you think this is something your clients should know? A meaningful way to 'do your fellow a favor' is to explain what a comparative test is and why using test data as the basis of medical decision making is so important.

Or do you prefer to 'let the buyer beware' and endure the same client decision making mistakes next year as last. And as the year before that.

And then, when your client complains that premiums increases are too high, simply raise deductibles and say 'wellness program' more loudly…just like last year, the year before and the year before that.

Medically well informed patients always ask 'has it been tested for the outcomes that concern me?'

If it *has been* tested, then your doctor can tell you how well it works. All physicians today can access extensive databases of medical studies…in their offices… in real time so they can answer this question.

If answers exist.

Asking this question may motivate your doctor to refresh his or her memory and look for new studies that have been published since the last time he or she checked.

You and your doctor can then decide if the intervention works well enough for you. I'll show you how in the next section.

But you may learn that the intervention *has not been* appropriately tested. In that case, you know your chance of benefit is only 50/50. Prasad's Law tells us that.

And even if it benefits you, it might not benefit you very much.

Examples of medical care that *should* work, but doesn't
Case studies that illustrate the power of ethical disclosure education

I'll present 6 case studies to show the power of asking 'has it been tested for the outcomes that concern me?' and why you need to ask this question about every medical intervention: [31]

- Niaspin, an HDL 'good cholesterol' boosting drug
- Atenolol, a blood pressure lowering drug
- Zetia, a cholesterol lowering drug
- Vertebroplasty, a back surgery technique
- Arthroscopic knee surgery, a knee osteoarthritis remedy
- Rest after heart surgery, an historical example to tie everything together

Niaspin, an extended release niacin drug. Niacin, a B vitamin, has been shown in tests to raise good (HDL) cholesterol. More good cholesterol is associated with a lower heart attack risk, so artificially raising it benefits patients, at least in theory.

Niacin doesn't lower total cholesterol like commonly prescribed statin drugs.

Cardiologists have prescribed various niacin products for years. One, Niaspin manufactured by Abbott Labs, generated about $900 million in 2009 sales from about 8 million prescriptions. [i]

In 2011, the AIM-High trial of niacin effectiveness showed that, while extended release niacin *is* associated with higher HDL levels and lower triglyceride levels, this *does not* translate to a reduction in cardiovascular events like heart attacks and strokes. [ii]

In 2013, a second study, this time of Merck's niacin drug Tredaptive found the same thing: no difference in coronary event rates between people taking Tredaptive with a statin, and those just taking the statin. [iii]

Dr. Steven Nissen, Chief of Cardiology at the Cleveland Clinic, summarized the Tredaptive study findings: It raised good cholesterol. It lowered bad cholesterol. It didn't improve clinical outcomes. That is a stunning finding. [iv]

Two studies on two different niacin based drugs arrived at the same conclusion: niacin doesn't reduce rates of heart attacks or strokes.

This is an example of Prasad's Law: interventions that appear to make biological sense and that are adopted before publication of comparative tests are proven ineffective or harmful about half the time when they finally are tested.

[31] All reference notes for this section appear at the end of this text

Patients who bought and took Niaspin received no heart attack or stroke reduction benefit from it.

They only exposed themselves to side effects like burning, tingling, itching, headaches, stomach upset, intestinal gas, dizziness, and redness of the face, arms, and chest. [v]

Plus the price of Niaspin pills.

Atenolol, a blood pressure lowering drug

High blood pressure is a common condition in which the long-term force of the blood against your artery walls is high enough that it may eventually cause health problems such as heart disease. High blood pressure can damage the heart and coronary arteries and lead to heart attacks, strokes and death, among other events.[vi]

Lowering blood pressure, therefore, *should* reduce the number of heart attacks, strokes and deaths. So strongly do physicians subscribe to this theory that they write millions of blood pressure lowering medication prescriptions annually, worth billions of dollars, including 36 million prescriptions for atenolol in 2010.

Atenolol recorded $161 million in 2014 sales.[vii]

Unfortunately comparative study hard outcomes do not support the theory.

Start in 2003 with publication of the LIFE study on two of the most commonly prescribed blood pressure lowering medications - also called beta blockers - losartan and atenolol. [viii] Neither outperformed the placebo.

In an accompanying European Heart Journal editorial, Dr. Franz Messerli, writing for the European Society of Cardiology concluded

the LIFE study should be considered as the final straw that will break the camel's back and hopefully motivate physicians to no longer expose their elderly hypertensive patients to the cost, inconvenience, adverse effects, and most importantly, to the inefficacy of beta-blockers.

That was followed up by a 2004 meta review (a compilation that integrates results from several different studies to develop a single conclusion) in the Lancet entitled 'Atenolol in hypertension: is it a wise choice?' [ix] Those reviewers found that

there were no outcome differences between atenolol and placebo in the four studies, comprising 6825 patients, who were followed up for a mean of 4.6 years on all-cause mortality, cardiovascular mortality, or myocardial infarction [heart attacks].

The theme was then picked up in the March 15, 2005 issue of The American Family Physician, a publication of the American Association of Family Physicians. Dr. Henry Barry's article 'Should Atenolol Be Used for Hypertension?' concluded that, though atenolol *did* lower blood pressure,

It does not appear to reduce the rates of cardiovascular mortality or morbidity.

Let's summarize:

- One major, high quality comparative study in **2003** concluded atenolol generates 'no benefit'
- A large meta study in **2004** concluded 'no benefit'
- Physicians writing in various highly regarded journals – who reviewed the underlying study data – between **2003 and 2005** recommended *against* prescribing these drugs
- **Six years later**, docs wrote 36 million Atenolol prescriptions and **ten years later** Atenolol achieved $161 million in annual sales.

I hope you're beginning to understand why you need to ask if it has been subjected to comparative testing about *every* medication.

And find out what those test results are.

Even for medications that have been around for a long time.

Zetia, a cholesterol lowering drug. Zetia (ezetimibe) lowers cholesterol by blocking its absorption in the intestines, unlike statins that block cholesterol absorption in the liver.

Some patients can't tolerate statins.

Others might not achieve their desired cholesterol reduction goals with statins alone.

Zetia offers benefits to both types of patients: those who can't tolerate statins and those who don't achieve their cholesterol goals from lifestyle changes and statins alone. As Zetia's website, zetia.com, said from about 2011 - 2016 [x]

> *Adding Zetia to a statin is proven to help reduce cholesterol more than a statin alone.*

Zetia's annual sales ranged between about $1 and $4 billion since 2008.

Unfortunately for Zetia users and the people who pay for it, we should also point out the next sentence on zetia.com, the one following 'Adding Zetia to a statin is proven to help reduce cholesterol more than a statin alone', this one written in bold

> **Unlike some statins, Zetia has not been shown to prevent heart disease or heart attacks.**

The New York Times review of Zetia's 2008 clinical trial, concluded it [xi]

> … failed to show that the drug had any benefits…[and]
>
> … no trial has ever shown that it can reduce heart attacks and strokes

Our old friend Steve Nissen from the Cleveland Clinic (of Atenolol fame above) called these results 'shocking'. [xii]

Harlan Krumholz, cardiologist at Yale Medical School went even further, asking 'How can a drug have $4 billion in sales without any evidence of benefit?' [xiii]

Vertebroplasty to relieve back pain Let's switch focus now from medications to procedures. Consider vertebroplasty, a procedure to inject medical grade cement into fractured vertebra (back bones) to reduce back pain. It's a minimally invasive procedure with a low complication rate, about 1 – 3%.[xiv] Complications include soft tissue damage, nerve root pain and compression, pulmonary embolism, respiratory and cardiac failure and death.

In 2008, the US market for vertebroplasty was $245 million.

Then in 2009 the New England Journal of Medicine published two studies comparing vertebroplasty to a control or placebo group that received lidocaine (a topical skin numbing agent), massage and aromatherapy to reproduce operating room smells.

- The Australian study found 'no beneficial effect' of vertebroplasty compared to the control group.
- The Mayo study concluded that patient improvements were similar in the placebo and experimental groups.[xv]

Vertebroplasty, in other words, worked as well as, but no better than, the safer and far cheaper placebo.

Dr. Rachelle Buchbinder, lead author of the Australian study, recommended that vertebroplasty not be performed outside of research settings. There are some risks, she reasoned, without any demonstrated patient benefits.

The market for vertebroplasty then grew to about $1 billion in 2012.[xvi]

Read that last sentence again. Even though 2 high quality studies showed in 2009 that vertebroplasty works no better than a placebo, patients spent hundreds of millions of dollars *more* for it 3 years later!

And that market continues to grow.

Surgery for Knee Osteoarthritis Knee osteoarthritis is a degenerative disease that causes pain, stiffness and decreased knee function.

Arthroscopic surgery, including lavage (removal of particulate material such as cartilage fragments and calcium crystals) and debridement (surgical smoothing of articular surfaces and osteophytes) was the widely used treatment in the early 2000s despite the fact that, according to the New England Journal of Medicine in 2008 'scientific evidence to support its efficacy is lacking'. [xvii]

Estimates of the number of knee arthroscopies performed annually in the US vary, and not all address osteoarthritis so we'll have to estimate the size of this problem:

- A 2002 New England Journal of Medicine study estimated 650,000 procedures at $5,000 each, creating a $3.25 billion market. [xviii]
- A 2014 NEJM study estimated the market at 500,000 knee arthroscopies at about $20,000, generating a $10 billion market. [xix]
- Vinay Prasad in his 2015 book Ending Medical Reversal estimated the market at 700,000 patients spending $4 billion.[xx]

How poorly does the scientific evidence support the efficacy of arthroscopic surgery to treat knee osteoarthritis?

- A 2008 New England Journal of Medicine published study concluded that they 'failed to show a benefit of arthroscopic surgery for the treatment of osteoarthritis of the knee' [xxi]
- This followed a 2002 comparative study which concluded 'At no point did [the] arthroscopic-intervention group have greater pain relief than the placebo group'
- In addition, 'objectively measured walking and stair climbing were poorer in the débridement group than in the placebo group at two weeks' (Treatment side effects really matter!)
- The 2002 study concluded 'This study provides strong evidence that arthroscopic lavage with or without debridement is not better than and appears equal to a placebo procedure in improving knee pain and self-reported function.' [xxii]

Those disagreeing with these study conclusions present the usual 'weak study methodology' case, primarily, I would suggest, to protect their incomes. Even at our lowest market estimate - $3 billion – that's certainly a big incentive for lots of people to protect their turfs.

These studies raise some uncomfortable questions:

- Why, after the 2002 paper, did doctors continue to prescribe this procedure and patients have it?

- Why after the 2008 study did both parties continue to use it?

This is an extension of Prasad's Law that says treatments adopted absent testing are proven ineffective or harmful about half the time. Here we have treatments used *even after* studies showed no patient benefit, underscoring the need for you to ask this question and insist on a clear answer about *every* medication and procedure.

Asking encourages your doctor to check (again?).

Never hurts but may help.

A lot!

Rest after heart surgery, an historical example to tie all this together. We'll start in the early 1900s with Dr. James Herrick's advice then fast forward to today's protocols.

Herrick was an extraordinarily influential coronary care researcher who received impressive accolades from both the Association of American Physicians and the American Medical Association.

In his major 1912 paper, Herrick wrote that, after having a heart attack or heart surgery 'the importance of absolute rest in bed for several days is clear'. [xxiii]

Herrick's recommendations were adopted by most hospitals according to cardiologist Eugene Braunwald. Over time hospitals extended Herrick's advice of absolute bedrest from several days to a few weeks.

That remained the treatment norm for decades. Indeed, thirty four years after Herrick's paper, Dr. Thomas Lewis published his own coronary care textbook *Diseases of the Heart* and elaborated on Herrick's prescription:

> Rest in bed should continue for 4 – 6 weeks to ensure firm cicatrisation of the ventricular wall … Patients have lost their lives … by neglect of these precautions. [xxiv]

Lewis' justification came from pathological studies showing that it can take 6 to 8 weeks for firm scarring of the lesion to occur. Rest for that amount of time was considered necessary to minimize ventricular rupture risks. [xxv]

Dr. Paul Woods, another coronary care authority, reinforced that message in his textbook *Diseases of the Heart and Circulation* in 1959, 13 years later, recommending 3 – 6 weeks of bedrest or more depending on the severity of the heart attack.[xxvi]

Thus three medical textbooks written between 1912 and 1959 agreed: post heart attack and heart surgery, patients should rest, pretty much for as long as possible.

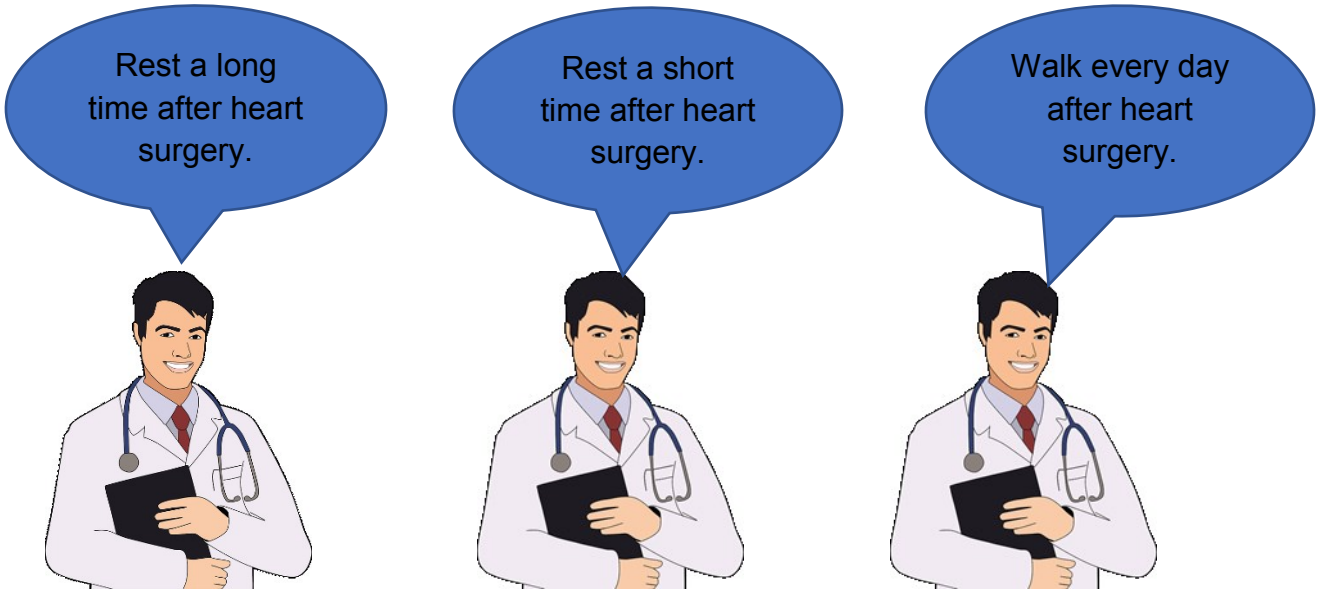
But by the 1960s medical opinion reversed. Braunwald in an overview of cardiac practices, claims doctors began to realize that

> Prolonged bed rest, which had been routine since Herrick's day, could actually be harmful in some patients by leading to venous thrombosis and fatal pulmonary thromboembolism. In uncomplicated cases, the duration of absolute bed rest was shortened to about five days. [xxvii]

Patients who asked 'what do you recommend doc?' in the ***1940s and 50s*** would have received the long bedrest recommendation.

But patients who asked the same questions in the ***1960s and 70s*** would have received the short bedrest advice.

And today, patients are advised to walk every day during the first 6 – 8 weeks post heart surgery, the exact opposite of Herrick's, Lewis's and Woods' recommendations. [xxviii]



How can 'rest' and 'don't rest' both be right? They obviously can't. At least one is wrong. Drs. Herrick, Thomas and Woods offered their *best guesses* backed up with biological justifications. In effect, they said 'our best guess is that the risk of ventricular rupture exceeds the risk of

venous thrombosis and fatal pulmonary thromboembolism' (if they even knew those risks existed).

Their guesses were really testable propositions which, apparently, weren't actually tested until relatively recently. When tested, we learned that thrombosis risks exceed ventricular rupture risks. Thrombosis and embolism risks are so high in fact that today's patients are advised not even to stand in one place for more than 15 minutes! [xxix] The exact opposite of Herrick's, Thomas's and Woods' advice.

That's why wise patients don't research *why* a specific medical recommendation makes sense. Doctors and scientists can justify a wide range of (often conflicting) recommendations, just as we've seen here. Prasad's Law tells us that absent testing for specific outcomes of concern, those recommendations are wrong about half the time.

Instead of relying on theory, wise patients rely on test data, the facts.

The tragedy of this story is that some heart attack recovery patients presumably died in the last century *from following the established protocols and textbook advice*.

They didn't ask if the recommendations had been tested.

The ethical broker's next step:
Help clients interpret test results

Let's return to our simple comparative study example in which 7 people in the placebo group had heart attacks and 3 did in the treatment group. How does a medically literate patient discuss these results?

This presents a golden opportunity for brokers to teach clients how to interpret and discuss treatment benefits with their doctors.

The standard, correct **and useless** way to summarize the tests results is 'this medicine cut the heart attack risk by 57%.' (The math is quite simple: 7 people in the placebo group had a heart attack. 4 people avoided a heart attack by taking the medicine. 4/7 is 57%.)

Though correct, this is not useful for medical decision making.

57% of what?

- In this case, 57% of 7 per 100. (I'm getting confused by all these numbers and I'm writing this stuff!)
- But here's another example of a 57% risk reduction. From 3 in 10,000 to 1.29 in 10,000 over 10 years. That's a 57% reduction.

- Or from 5 in a million to 2.15 in a million over 15 years. That reduction of 2.85 events per million people over 15 years is, again, a 57% reduction.

Preventing 4 heart attacks in 100 people over 5 years may seem like a pretty good benefit.

- But preventing 2.85 heart attacks in a million people over 15 years seems like a pretty small benefit. (If you're not totally confused by now you should consider yourself brilliant.)

Here's a general rule of thumb for reporting test results: whenever you hear expressions like '57% better than', or 'reduces your risk by 57%', ask '57% *of what*?'

- If it's 5 in a million, then a 57% reduction is a pretty insignificant number.
- But if it's 7 in 100, then you probably want to pay attention.

Percentage reductions like 57% better than sound more impressive than they really are. I'd even say that whenever someone quotes study results in this way they're trying to sell you something. That's why retail vendors – refrigerators, clothes, appliances - tend to quote prices in percentage off. It sounds bigger than it is.

- 'Prices slashed by 57%' sounds big.
- 'Prices slashed by $4.38' sounds small.

It's the same in medicine.

A better way

I propose that brokers teach clients to ask these two simple questions to learn the results of comparative tests:

- Out of 100 people like me, how many benefit? and
- Out of 100 people like me, how many are harmed?

Ask '**out of 100**' to get a number for your answer. '4' for example, conveys more information than 'some', 'many', 'a few' or 'quite a few'.

Some patients may decide that 4 people benefiting is good enough to have the treatment while others say 'only 4? That's not very many'. Different people can reasonably interpret the answers differently. That's the essence of a doctor-patient discussion: apply information to the particular desires of a specific patient.

Ask about '**people like me**' because treatments can have different impacts on different demographic groups. Consider these examples.

Age: The American Academy of Pediatrics recommends against prescribing cough and cold medications for respiratory illnesses in children under 4 saying 'these products offer little benefit to young children and can have potentially serious side effects'. [xxx] They're apparently fine for 6 or 8 year olds - or 30 or 40 year olds – but not for very young children.

… out of 100 people … these medications work, but

… *like me* … not if you're under 4 years old

Gender: In 2014, the Food and Drug Administration cut the recommended dose of Ambien, a sleep aid, in half for women after determining that men and women metabolize it differently. Women, it turns out, have more of the drug in their bodies the next morning, putting them at higher risk of impaired driving.[xxxi]

… out of 100 people … the medication works, but

… *like me* … not so well for women

Other patient differences exist but we don't always know how frequently. You and your doctor may have to estimate the impact on people like you.

An interesting *<u>like me</u>* category that most people don't consider but that an ethical broker should discuss: social status

I'll define social status ambiguously as a combination of wealth, income and sense of control over your life, analogous to the way former US Supreme Court Justice Potter Stewart defined pornography: you know it when you see it.

The notion that social status impact disease rates and treatment effectiveness was first introduced in the Whitehall studies during the last 1900s. These studies tracked disease and death rates by job and rank in the British civil service and their conclusions have been reproduced in other studies, in other countries.[xxxii]

Whitehall found that low social status folks had higher disease and death rates than high status folks. Surprisingly – and this is the big deal - this was not *only* due to measureable factors like cholesterol, blood pressure, blood sugar, smoking, obesity or exercise rates.

After correcting for those factors, *the lowest status folks were about twice as likely to have heart attacks, develop other diseases and die as the highest status ones*.

Whitehall also found a gradient: the higher you are on the social status scale, the lower your disease and death rates and the reverse, the lower you are on the social scale, the higher your disease and death rates.

Over and above specific disease risk factors, Whitehall concluded, there is something about social status *independently* that impacts people's health. Harvard School of Public Health Professor Nancy Kreiger, whose own work affirms Whitehall's conclusions, put it this way:

> An individual's health can't be torn from context and history. We are both social and biological beings—and the social is every bit as "real" as the biological. [xxxiii]

A major 2016 study in JAMA, the Journal of the American Medical Association found that the life expectancy gap between the richest 1% of Americans and the poorest was about 12 years on a gradient similar to Whitehall's. In an accompanying editorial, Nobel laureate Angus Deaton emphasized the impact of income and social status on health and castigated traditional medical thinking:

> The finding that income predicts mortality has a long history… the mortality gradient by income is found wherever and whenever it is sought…**but the medical mainstream emphasizes biology, genetic factors, specific diseases, individual behavior, health care, and health insurance.** [xxxiv]

Consider the medical impacts of your own social status. Let's say that after examining you, your doctor says 'your cholesterol level is slightly higher than I'd like. The guidelines suggest lowering it. I'll prescribe a medication.'

- If you're a *low* status person (facing higher than average heart attack risks according to Whitehall) you may be undermedicated, leaving you exposed to *disease* harms.
- But if you're a *high* status person (facing lower than average heart attack risks according to Whitehall) you may be overmedicated, exposing you unnecessarily to *medication* harms.

Try to include social status factors in your 'like me' discussions with your doctor along with age, gender, general health status, family history etc. One good information source is the 2004 report 'Work, Stress and Health: The Whitehall II Study'. Share it with your doctor. It's surprisingly easy to read and it may change the way you think about medical care.

It did for me.

Define the benefits that matter

Identify the **benefits** of interest to you. If you are taking a heart attack prevention medication ask 'out of 100 people like me, how many avoid a heart attack by taking this medication?'

If you want to reduce your back pain, ask 'out of 100 people like me, how many enjoy less back pain as a result of this procedure?'

Beware of listing 'lower my cholesterol' or 'lower my blood pressure' as the benefit you hope to achieve. These 'test benefits' may or may not correlate closely to 'patient' or 'event' benefits. Focus on the specific benefits you hope to achieve.

And be as specific as possible.

ONE PATIENT'S EXPERIENCE ASKING THE 'OUT OF 100 PEOPLE LIKE ME' QUESTIONS

Sean, a middle aged insurance professional told his story in class one day. He had previously attended several of my lectures and apparently they had an impact.

Sean had been brought up in conservative Ireland and learned that there are two people you never question: your priest and your doctor.

Fast forward several decades. He moved to Massachusetts, built a successful business and had his own family. One day he took his daughter to the doctor for a minor issue. I don't know what it was.

The doctor prescribed treatment and Sean remembered the lectures and plucked up the courage to ask 'Doc, out of 100 kids like her, how many benefit from this treatment?'

The doctor's answer was apparently satisfactory.

But more importantly for our story is what happened next. The doctor, as Sean recounted the story, shook his hand and introduced him to the other physicians in the practice saying (and here's the direct quote)

I have 1700 patients in my practice. Sean is 1 of only 4 who have ever asked me how well medicine works

I asked Sean for permission to use his story. His email response:

Please feel free to quote me. If it helps 1 person then it worked

Some case studies to indicate the power of asking this question
Real life situations that develop from ethical disclosure actions:

Consider antibiotics to treat pediatric ear infections, a quite common childhood problem. Ear infections can be painful for the child and frightening for the parents who, not unreasonably, want to do something to help their child.

Ear aches are sometimes viral and sometimes bacterial. Doctors often prescribe antibiotics.

This intervention – antibiotics to treat pediatric ear aches - has been studied so Prasad's Law doesn't apply.

A meta review – that's a compendium of several individual studies – of 15 studies on 4100 kids concluded that 6 in 100 who took antibiotics reported less ear pain after 2 – 7 days; 94 in 100 did not enjoy less ear pain as a result of the antibiotics. [xxxv] Most had a complete recovery within 2 – 7 days without the medication.

But 11 in 100 who took antibiotics suffered uncomfortable side effects like diarrhea.

- Out of 100 kids who take antibiotics to treat ear infections, how many benefit by enjoying less ear pain in 2 – 7 days? **6**
- Out of 100 kids who take antibiotics to treat ear infections, how many are harmed by diarrhea or other uncomfortable side effects? **11**

Now you have sufficient information to discuss this intervention with your pediatrician. Does it work well enough for your child? Some parents may decide yes, others no.

But in both cases, it's an informed decision made by a parent in light of the facts.

Dozens of similar cases exist. One website www.TheNNT.com lists about a hundred. ChoosingWisely www.ChoosingWisely.org takes a slightly different approach and lists hundred more. Both sites will provide good information for you to discuss with your doctor.

Comparing 'out of 100 people like me…' to 'the guidelines say…'
Case study of hypertension

The American Heart Association recommends that people over 60 years old begin treatment for high blood pressure when their readings exceed 150/90. [xxxvi]

But out of 100 people like that, how many benefit by following those guidelines?

Some answers come from a 2009 Cochrane report that summarized 15 trials totaling 25,000 subjects over age 60 with moderate to acute hypertension followed for average 4.5 years. [xxxvii]

> Out of 100 people over 60 years old with moderate to acute hypertension, how many avoid cardiovascular disease or death over 4.5 years?
>
> Answer: About 4

Here are Cochran's numbers:

- Risk of cardiovascular death or disease without taking hypertensive medication: 14.9/hundred. This is the control group.
- Risk of cardiovascular death or disease among patients taking hypertensive medications: 10.6/hundred. This is the test group.

- Medication benefit: 4.3 fewer deaths or diseased patients/hundred (4.3%)

I don't know how many, if any, were harmed by the medication.

This case study shows why the ethical broker doesn't simply 'let the buyer beware' and rely on some set of guidelines but instead 'does his fellow a favor' and teaches a better question to ask.

What if your doctor can't answer these questions?

Prasad's Law! If your doctor can't answer these questions, the medical intervention hasn't been studied thoroughly.

It's ineffective or harmful about half the time. [xxxviii]

Period.

That's why asking these questions is so important!

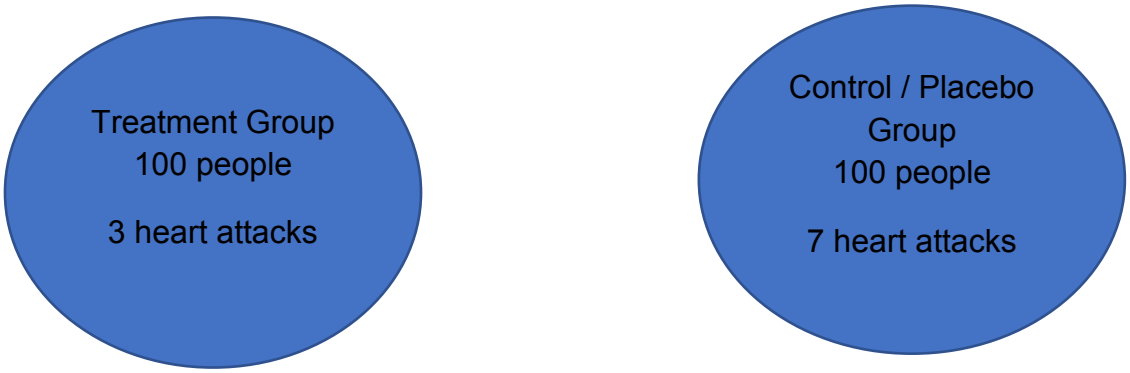
An alternative metric that some ethical brokers have introduced

A different version of 'out of 100 people like me, how many benefit and are harmed' has been developed by researchers over the past couple of decades. It's called the Number Needed to Treat (NNT) and Number Needed for Harm (NNH).

The Number Needed to Treat tells us how many people need to take a particular medication, or have a test, for one person to benefit. An NNT of 1 means that if 1 person takes this medication, then 1 person will benefit from it.

But an NNT of 50 means that 50 people need to take a medication for 1 person to benefit. We get NNT data from comparative studies (remember them?)

Consider this comparative study of the same heart attack prevention medicine we introduced earlier. Can you estimate the number of people who need to take the medicine to prevent 1 heart attack?



In this hypothetical example, the medication prevented 4 heart attacks per 100 people who took it. Therefore 25 people had to take the medicine to prevent 1 heart attack. The Number Needed to Treat or NNT is 25.

Once you know this, you can compare treatment effectiveness. In fact one group of clever researchers has developed an entire website based on NNT calculations called, not surprisingly, TheNNT.com. This site lists the Number Needed to Treat and to Harm for lots of different interventions.

Here's a sample to show the power of using NNT calculations to choose a heart attack prevention treatment for people without heart disease and who have not had a heart attack.[32]

- The NNT for statins to prevent a non-fatal heart attack is 104.
- The NNT for statins to prevent a stroke is 154.

Now consider the Number Needed for Harm from statins:

- The NNH for developing diabetes is 50.
- The NNH for muscle damage is 10.

This means that 104 people need to take statins for 5 years to prevent 1 non-fatal heart attack. But 2 of those 104 people will develop diabetes and 10 will experience muscle damage.

This example shows how you can compare benefits and harms from a medical intervention.

Let's now look at how to compare benefit from different medical interventions. This time we'll compare statins to adopting a Mediterranean Diet.

- The NNT of statins to prevent 1 heart attack among people with no heart disease and who have not previously had a heart attack is 104.
- The NNT of people who adopt the Mediterranean Diet is 61.

In addition, some people were harmed by the statins – we discussed that above – while none were harmed by the Diet. (Remember that I don't give medical advice. These are just some research summaries.)

---

[32] The statin calculation comes from http://www.thennt.com/nnt/statins-for-heart-disease-prevention-without-prior-heart-disease-2/. The Mediterranean Diet calculation comes from http://www.thennt.com/nnt/mediterranean-diet-for-heart-disease-prevention-without-known-heart-disease/

These metrics, the NNT and NNH, give patients a clear way to compare treatments and to decide which works best, just like the ‘out of 100 people like me, how many benefit’ question discussed above. Both metrics get to the same answers but some people prefer one to the other. I thought it useful to introduce both in this section.

Review Questions

Answers on next page

1. What, according to this text, is the basis for many / most medical recommendations?
    a. Scientifically determined facts
    b. Physician hunches
    c. Medical research
    d. Physiology and anatomy

2. How do we determine facts in medicine?
    a. Through comparative studies
    b. By analyzing biology and physiology
    c. By hunches
    d. By algorithms

3. What is a comparative study?
    a. Divide a large group of subjects in two, then give one of the two groups the treatment and the other a placebo
    b. Compare different people who take the same medicine to get a good overview
    c. Compare the effects of medical care on lots of different people
    d. Study how well a medical intervention works in the real world

4. What is Medical Reversal?
    a. Stop doing something that doesn't work
    b. Take different drugs to reverse the impact of the initial drug
    c. Redo or undo a surgery
    d. Go to a second doctor when you are not satisfied with the first

5. How often do subsequent comparative studies lead to Medical Reversal?
    a. About half the time
    b. Less than 5% of the time
    c. More than 95% of the time
    d. Always

6. What is a good follow up question when you learn that 'this medication cuts your chance of having a heart attack by 57%'?
    a. 57% of what?
    b. Really?
    c. So you recommend it?

d. Would you take it yourself?

7. Which is a better metric: Asking 'Out of 100 people like me, how many benefit?' or asking 'What is the NNT of that treatment?'
    a. Asking 'out of 100 people like me, how many benefit?'
    b. Asking 'what is the NNT of that treatment?'
    c. Neither is a good question for your doctor
    d. Both questions mean essentially the same thing

8. If you have a medical treatment that has not been subjected to comparative testing, what is the likelihood that your will receive no benefit from the care?
    a. 50%
    b. 4%
    c. 85%
    d. 99%

9. What is Prasad's Law?
    a. A penny saved is a penny earned
    b. Medical interventions that have not been subjected to comparative studies are shown to be ineffective or harmful about half the time when they finally are tested
    c. The most hospital beds in a region, the more hospitalizations
    d. Never start a land war in Asia

10. Which factor below was shown in the Whitehall studies to impact disease rates and life expectancy?
    a. Social status
    b. Childhood exercise rates
    c. Prenatal care
    d. Driving distance to your primary care doctor

11. If the Guidelines recommend treatment, does this always mean a large number of people will benefit?
    a. Yes
    b. No
    c. Yes for preventive care but no for chronic
    d. Yes for chronic care but no for preventive

Review Questions

Correct answers in bold

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Chapter 4: Integrating These Ethical Standards Into a Discussion with a Benefits Administrator

Consider this situation: A Benefits Administrator for a large company puts the company's benefits out to bid. Two brokers respond. Both offer similar plans at similar prices. Both are experienced. Both are professional. Both offer all the standard services – 401(k) administration, FSA administration, wellness programs, etc. Both are impressive.

The Benefits Administrator tries to find some reason to choose one broker over the other. Since they appear to be mirror images of each other, he has little to choose. So he asks both brokers 'why should I choose you?'

Broker A talks about experience: 20 years in the business, a good customer service reputation, intimate knowledge of carriers and plenty of references. Broker A talks about his commitment to clients and interest in helping clients. He even offers to meet with the Benefits Administrator quarterly to provide policy and regulatory updates.

Certainly, thinks the Benefits Administrator, Broker A is fine. There's nothing wrong with him. A solid choice.

Then Broker B comes along. This broker also has years of experience, a good customer service reputation, good relations with the various local insurance carriers and plenty of references. This broker also offers to meet quarterly to discuss policy and regulatory updates. (Both brokers, it seems, value face time with the Benefits Administrator.)

But in addition to all these services, Broker B makes a surprising statement:

> *My company has a clear business standard that defines our relationship with clients. The ethical standard that we embrace is called 'Do Your Fellow A Favor'. I've studied business ethics and decided that I want my company and my employees to live up to this standard.*
>
> *Many of my competitors use a different ethical standard. They 'let the buyer beware.'*

Intrigued, the Benefits Administrator asks Broker B to continue.

> *I won't save you any premium money in the short term as compared to Broker A. He's a fine broker who is perfectly capable of running rates and showing alternative policies.*
>
> *I won't show you any plans that he doesn't. And I offer all the same services as he does.*
>
> *But in addition to offering everything that he offers, under my 'do your fellow a favor' standard, I'll also educate your employees about how to use our healthcare system.*

I'll tell them things about the healthcare system that they probably won't learn from their doctors but that may help them interact with their doctors. I'll help them become wiser consumers of medical care.

The Benefits Administrator starts to yawn as Broker B continues:

Better educated consumers, who shop more wisely, use medical resources more efficiently. In the long run, this may save you money….maybe quite a bit.

The Benefits Administrator suddenly perks up:

You'll save us money? Explain. Give me an example.

Broker B then summarizes:

I noticed that in the past few years, several of your employees had vertebroposty procedures for their back pain. A few others had arthroscopic knee surgery for knee osteoarthritis. (Broker B apparently really did his homework.)

I also noticed that several take Atenolol and quite a few took Niaspin over the years.

All these treatments have been shown in comparative studies to work no better than a placebo.

That means you may have wasted your company's money on ineffective treatments, and your employees exposed themselves to medical risks without receiving any benefit.

'What?' the Benefits Administrator bursts out, shocked. 'How can you say that?' Broker B continues:

As part of our 'Do Your Fellow a Favor' educational campaign, we teach people how to identify and avoid unnecessary and low quality medical care.

A key part of that educational process involves teaching employees what a comparative study is and how to understand the results.

I'm happy to include you in our seminars, but for now I'll just summarize some studies. Both of those procedures – vertebroplasty and arthroscopic surgery to treat knee osteoarthritis – have been shown to be ineffective in comparative studies. Neither benefited patients more than a sham procedure.

Ditto for Niaspin and Atenolol.

While we don't tell your employees what specific care to get or to avoid – we're not licensed or trained for that - we teach them the skills to evaluate care quality and to discuss this with their doctor. Studies show that employees who have these skills get better medical care, with less risk and at significantly lower costs.

And they tend to avoid ineffective treatments, like the ones I mentioned.

I, of course, don't know which of your employees had these procedures or which took those medications. I only know that it's highly unlikely that they received any benefit from them.

'So,' says the Benefits Administrator, somewhat stunned 'having this information available may reduce my employee's rate of ineffective care. That could affect our Experience Modifier and save us some premium money in the future. Interesting.'

Broker B continues:

The US wastes about a trillion dollars annually on ineffective and unnecessary medical care. Your company alone probably wastes tens of thousands.

Our 'Do Your Fellow a Favor' program aims to reduce that, not by restricting access but by helping your employees make wiser medical care decisions and talk more effectively with their doctors.

It's a new approach in the benefits arena but one that shows great potential.

And it's risk free: people only participate if they want to. But we're finding that lots of employees really want access to this information and pay attention when we present.

'Interesting,' comments the Benefits Administrator. 'I've never heard of that approach but it seems to make sense to me. We would probably need a custom approach to our employees since we work 2 shifts and have several people off-site.'

Broker B responds:

Each company is different and we always try to fashion the educational process around the company's needs. The information content is similar but our approach varies by client.

In the end, the Benefits Administrator considers the two brokers. One who takes the 'let the buyer beware' approach about dealing with our healthcare system. The other who 'does his fellow a favor'.

Which will help my employees the most, he wonders.

In the end, the Benefits Administrator chooses…..*Well, who would you choose?*

Chapter 5

How Should an Ethical Broker Proceed?

The British think death is inevitable; Canadians think death is preventable; and Americans think death is optional.[33]

Shannon Brownlee summarizes an underpinning of our overuse of medicine in *Overtreated*: [34]

> Our relentless search for wellness through medicine has created a kind of therapeutic imperative, the urge to treat every complaint, every deviation from the norm, as a medical condition.

If we test or intervene with every new development along our normal aging process, we'll abuse our medical system --- and likely generate more unnecessary and counterproductive care, and perhaps higher mortality rates.

> We've come to believe that if a test can be performed, it should be performed… [almost] regardless of whether the intervention will improve the patient's sense of wellbeing.

Maybe an old French proverb got it right: the physician's job is 'to cure sometimes; to relieve often; to comfort, always.'

The ethical, sensitive broker understands this and helps clients accordingly.

Clearly no broker can keep current on all healthcare literature and advise clients on all healthcare decisions. That's beyond any human's capabilities.

But, as we have argued in this course, the ethical broker has a responsibility to advise clients not only on policy details but also on likely treatment outcomes, and to help clients chose policies that improve chances of treatment successes.

We have outlined some issues in this course. Many, many more exist.

Hopefully, we have pointed brokers in the right direction, both for ethical advising and for their own future research.

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[33] I don't know the origin of this expression. I first heard it from John Kingsdale, Director of the Massachusetts Healthcare Connector, at a speech at the Boston Harvard Club sponsored by the Pioneer Institute of 1/15/09.

[34] Brownlee, op cit, page 206. Same source for the next quote and the French proverb.

But in this concluding chapter I'd like to offer some general advice for how best to ***do your fellow a favor***: [35]

1. Educate yourself about our healthcare system.

   The more you know about our healthcare system, the better you can help your clients.

   Today's bookstores are full of insightful and useful books about healthcare. Some that I have found particularly useful include

   Overtreated by Shannon Brownlee;
   Ending Medical Reversal by Vinay Prasad
   Overdiagnosed by by H. Gilbert Welch
   An American Sickness by Elisabeth Rosenthal
   Know Your Chances, by Steven Woloshin
   Doctored by Sandeep Jauhar
   How We Do Harm by Otis Brawley
   The Quality Cure by David Cutler
   Mistreated by Richard Pearl

   Typical feedback from my students who have read these books is that they contain fascinating and very useful information. Ethical brokers use that information their normal professional work.

2. Help your clients understand the importance and utility of their primary care doctor. Help them find primary care doctors with whom they can communicate easily.

   The PCP is your client's link to our entire healthcare system. A good PCP will advise your clients in ways appropriate to them: perhaps treating illnesses aggressively for aggressive patients, and conservatively for more conservative folks.

   Too many of us consider specialists the 'really important doctors' who we use for major medical issues, and relegate PCPs to the less important, more minor medical activities like prescription refills and annual physicals.

   Remind your clients to rely on their PCP's advice. The PCP is the medical professional responsible for your 'whole' client, not just for his or her kidneys, heart or blood system. The various Dartmouth Medical School studies showed that the more people rely on their PCP's advice, the better their mortality outcomes.

[35] Some of this advice comes from the Afterward of Overtreated. See Brownlee, op cit pages 308 - 310

3. Help your clients ask questions. Help them remember that doctors are guides to medicine, not gods to be believed unquestioningly.

   Here are 5 questions I regularly teach people to ask.

   - Has the proposed treatment been subjected to comparative tests?
   - Out of 100 people like me, how many benefit and are harmed by it in tests?
   - Is it overused in real life?
   - Would most doctors make the same treatment recommendation or might some suggest something different?
   - How many patients like me do you treat annually?

   This particular text only addressed the first two of these questions. Part II, a different course, will discuss the last 3 of these questions

4. Help your clients use the web appropriately, not excessively. I often encourage people to focus their internet research on 3 sites:

   - ChoosingWisely
   - The US Preventive Services Task Force and
   - Cochrane

   These 3 are financially non-conflicted and present good analyses of likely medical intervention outcomes.

   I tend to stay away from other sites.

Help your clients to have the courage to advocate for themselves and to protect their own interests, for in the end, all healthcare decisions are ultimately their own.

****

We have, in the Judeo-Christian ethical tradition, thousands of years of business experience. Hopefully some of the ideas in this course will help today's health insurance brokers continue that ethical tradition.

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[i] Armstrong, Abbott Doubled Niaspin US Sales Before Trials Cut Use, Bloomberg, June 10, 2013 https://www.bloomberg.com/news/articles/2013-06-10/abbott-doubled-niaspan-u-s-sales-before-trials-cut-use

[ii] This sentence paraphrases the New England Journal of Medicine discussion of the AIM High study http://www.nejm.org/doi/full/10.1056/NEJMoa1107579#t=article .

[iii] http://www.reuters.com/article/merck-cholesterol-idUSL1N0BREGB20130227 and For a good summary see CBS News estimate, Study: Heart Drug Tredaptive is Ineffective, Jonathan Lapook, July 29, 2013

[iv] CBS News, op cit

[v] This list comes from WebMD http://www.webmd.com/vitamins-supplements/ingredientmono-924-niacin%20and%20niacinamide%20vitamin%20b3.aspx?activeingredientid=924&

[vi] http://www.heart.org/HEARTORG/Conditions/HighBloodPressure/WhyBloodPressureMatters/Why-Blood-Pressure-Matters_UCM_002051_Article.jsp

[vii] http://www.pharmacompass.com/sales-forecast/atenolol

[viii] See 'The LIFE Study: The straw that should break the camel's back' by Franz Messerli for a brief summary in the European Heart Journal, March 2, 2003.

[ix] A meta review is a comparison of several tests. Meta reviewers study, for example, the methodology of each individual test to ensure that researchers didn't goof somewhere along the line. http://www.ncbi.nlm.nih.gov/pubmed/15530629

[x] I had used this example in lectures for several years. When I visited the site in late December 2016, I discovered that it had been replaced with a 'prescribing highlights' pdf in small print.

[xi] Drug Has No Benefit In Trial, Makers Say, Berenson, NY Times, January 14, 2008

[xii] Ibid.

[xiii] Another Vytorin Mess for Merck, Herper, Forbes, Nov 15, 2009

[xiv] Estimate from Johns Hopkins Health Library

[xv] For a good summary of those studies, with expanded comments, see Sham-Wow by Walter Eisner in Orthopedics This Week, August 11, 2009, https://ryortho.com/2009/08/sham-wow/

[xvi] http://www.slideshare.net/AnnaGrahm1/minimally-invasive-vertebral-compression-fracture-repair-market-in-2013-2019-transparency-market-research. I was unable to determine how much of this market is vertebroplasty to guessed at $1 billion. For our purposes, it doesn't matter much if the market is $800 million or $1.2 billion: THE PROCEDURE DOESN'T WORK ANY BETTER THAN A PLACEBO!

[xvii] Kirkley et al, A Randomized Trial of Arthroscopic Surgery for Osteoarthritis of the Knee, NEJM, September 11, 2008

[xviii] Moseley et al, A Controlled Trial of Arthroscopic Surgery for Osteoarthritis of the Knee, NEJM, July 11, 2002

[xix] These estimates from Cram, et al, Total Knee Arthroscopy Volume, New England Journal of Medicine, Sept 19, 2014. I was unable to develop a specific number of procedures by year, nor estimate the annual growth rate of knee arthroscopies.

[xx] Prasad, Ending Medical Reversal, page 22

[xxi] Kirkley, op cit

[xxii] Moseley, op cit

[xxiii] Braunwald, The treatment of acute myocardial infarction, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3760555/

[xxiv] Silverman et al, British Cardiology in the Twentieth Century, Chapter 27

[xxv] Julian, Ischemic Heart Disease in Dialogues in Cardiovascular Medicine, 2006 http://www.dialogues-cvm.com/document/DCVM40.pdf

[xxvi] Silverman, op cit.

[xxvii] Braunwald, op cit.

[xxviii] WebMD, Recovering after heart surgery, http://www.webmd.com/heart-disease/guide/heart-disease-recovering-after-heart-surgery#1

[xxix] WebMD, op cit.

[xxx] ChoosingWisely, American Academy of Pediatrics, http://www.choosingwisely.org/societies/american-academy-of-pediatrics/

[xxxi] CBS News 60 Minutes, Feb 9, 2014 http://www.cbsnews.com/news/sex-matters-drugs-can-affect-sexes-differently/

[xxxii] See, for example, Isaacs and Schroeder, Class – The Ignored Determinant of the Nation's Health, New England Journal of Medicine, September 9, 2004 http://www.nejm.org/doi/full/10.1056/NEJMsb040329, Drexler, The People's Epidemologists, Harvard Magazine, March-April 2006 http://harvardmagazine.com/2006/03/the-peoples-epidemiologi.html, The Panel Study of Income Dynamics at the University of Michigan https://psidonline.isr.umich.edu/, and Bradley and Taylor, The American Healthcare Paradox

[xxxiii] Drexler, The People's Epidemiologists, Harvard Magazine, March-April, 2006

[xxxiv] Chetty, The Association Between Income and Life Expectancy in the United States, JAMA, April 26, 2016. See also Deaton's editorial, On Death and Money: History, Facts and Explanations, same issue, slightly paraphrased with emphasis added.

[xxxv] This information comes from Antibiotics for Acute Otitis Media on theNNT.com http://www.thennt.com/nnt/antibiotics-for-otitis-media/. The underlying studies Sanders S, Glasziou PP, DelMar C, Rover sMM. Antibiotics for acute otitis media in children. Cochrane Database of Systematic Reviews 2004, Issue 1. Art. No.: CD000219. DOI: 10.1002/14651858.CD000219.pub2.

Turck D, Bernet JP, Marx J, et al. Incidence and risk factors of oral antibiotic-associated diarrhea in an outpatient pediatric population. J Pediatr Gastroenterol Nutr 2003;37:22-26.

[xxxvi]

http://www.heart.org/HEARTORG/Conditions/HighBloodPressure/PreventionTreatmentofHighBloodPressure/American-Heart-Association-backs-current-BP-treatments_UCM_459129_Article.jsp

[xxxvii] Musini, 2009, Pharmacotherapy for hypertension in the elderly

[xxxviii] I assume your doctor has internet access and can look up any relevant comparative studies. Though I don't normally give specific advice, I'll make an exception here: if your doctor doesn't use the internet … get another doctor!