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## THE WALL STREET JOURNAL

WSJ.com

GENERAL NEWS | JUNE 20, 2009

ESSAY

# The Myth of Prevention

*A doctor explains why it doesn't pay to stay well. Decoding what works, what falls short in Obama's plans to reform health care*

By [ABRAHAM VERGHESE](#)

When President Truman had his shot at universal health care in 1949, the American Medical Association unfortunately made use of Sir Luke Fildes's famous painting, "The Doctor," in a negative campaign. "The Doctor" happens to be my favorite painting, mostly because of the story behind it: Sir Luke Fildes lost his oldest son, Phillip, on Christmas Eve, 1877; despite the tragedy, he was so impressed with the physician who cared for the child, that for his first commission from sugar merchant Henry Tate (who would go on to establish a collection and gallery in London by his name) he chose to depict "the physician in our time."

You've probably seen a print: At the center of the canvas a mortally ill child lies on a makeshift bed in what is clearly a fisherman's cottage. The doctor seated by his patient, leans forward, chin on his hand, intently studying the child. His posture and gaze suggest that nothing less than the child's recovery (or death) would lead him to break his vigil. The anxious parents are in the background waiting for some sign from the doctor.

The AMA used this image on thousands of posters, adding the caption, "Keep Politics Out of this Picture." They hoped to convince the public (and did) that government intervention would mean the end of home visits; government intervention would eliminate what Fildes captures so well: the sacred bond between doctor and patient.

"Sacred bond," alas, is not among the descriptors I hear when patients tell me what they think of us or our health care system. The descriptors fit to publish include "inattentive," "no-one-in-charge" and "money grubbing." In fact, a thoughtful lay friend recently said to me in the context of her medical care, "Face it, Abraham, medicine is corrupt." She stated this casually, as if it were an obvious and well-known fact, not waiting to see if I would agree. At the time I remember that I sputtered. I wanted to protest but the sounds would not come out. That word "corrupt" gnawed at me for days.

I had another such sputtering moment during the course of President Obama's speech to the AMA this week, but I shall come to that presently. The speech was remarkable for many things, but most of all for the way the audience of physician members sat and took their lumps. The fact that they clapped at times, and even gave him a standing ovation, surprised me. The speech was a model of clarity, full of the kinds of truths we in medicine have managed to dodge and distort for years. But keep in mind he was speaking to the AMA, the organization most responsible for conditioning the public to respond to the words "socialized medicine" with the fight-or-flight response one has on seeing a rabid skunk approaching.

President Obama pointed to the problem of "a system of incentives where the more tests and services are provided, the more money we pay." As if to rub it in, he added, "And a lot of people in this room know what I'm talking about."

Oooo, there was that “corrupt” word again, even though he did not say it. This part of the speech drew no applause, just stony silence.

Yes, Mr. President, a lot of people inside and outside that room know exactly what you are talking about. A skewed reimbursement scheme set up by Medicare, a system that pays generously when you do something *to* a patient, but is stingy when you do something *for* a patient, is largely to blame. Cut, poke, sew, burn, insert, inject, dilate, stent, remove and you get very well paid; if you learn how to do this efficiently, maybe set up your own outpatient center so you can do it to more people in a shorter time (which is what happened when this payment system was put in place in 1989) and you are paid even more. If, however, you are a primary care physician, and if, just like the young doctor who saw my parents yesterday, you spend time getting to know your patients, and are willing to play quarterback when your patient enters the hospital, so that you can herd the consultants and guide the family through a bewildering experience that gets surreal if you are in the intensive care unit, then you may have great personal satisfaction but you will make five to tenfold less than your colleagues in the doing-to disciplines.

Our reimbursement system, as the president put it, “is a model that has taken the pursuit of medicine from a profession—a calling—to a business.”

My wife tried to tell me the other day that she had just ‘saved’ us money by buying on sale a couple of things for which we have no earthly use. She then proceeded to tote up all our ‘savings’ from said purchases and gave me a figure that represented the money we had generated, which we could now spend . . . she had me going for a minute.

I mention this because I have similar problems with the way President Obama hopes to pay for the huge and costly health reform package he has in mind that will cover all Americans; he is counting on the “savings” that will come as a result of investing in preventive care and investing in the electronic medical record among other things. It’s a dangerous and probably an incorrect projection.

Prevention of a disease, we all assume, should save us money, right? An ounce of prevention . . . ? Alas, If only such aphorisms were true we’d hand out apples each day and our problems would be over.

It is true that if the prevention strategies we are talking about are behavioral things—eat better, lose weight, exercise more, smoke less, wear a seat belt—then they cost very little and they do save money by keeping people healthy.

But if your preventive strategy is medical, if it involves us, if it consists of screening, finding medical conditions early, shaking the bushes for high cholesterols, or abnormal EKGs, markers for prostate cancer such as PSA, then more often than not you don’t save anything and you might generate more medical costs. Prevention is a good thing to do, but why equate it with saving money when it won’t? Think about this: discovering high cholesterol in a person who is feeling well, is really just discovering a risk factor and not a disease; it predicts that you have a greater chance of having a heart attack than someone with a normal cholesterol. Now you can reduce the probability of a heart attack by swallowing a statin, and it will make good sense for you personally, especially if you have other risk factors (male sex, smoking etc).. But if you are treating a population, keep in mind that you may have to treat several hundred people to prevent one heart attack. Using a statin costs about \$150,000 for every year of life it saves in men, and even more in women (since their heart-attack risk is lower)—I don’t see the savings there.

Or take the coronary calcium scans or heart scan, which most authorities suggest is not a test to be done on people who have no symptoms, and which I think of as the equivalent of the miracle glow-in-the-dark minnow lure advertised on late night infomercials. It’s a money maker, without any doubt, and some institutions actually advertise on billboards or in newspapers, luring you in for this ‘cheap’ and ‘painless’ way to get a look at your coronary arteries. If you take the test and find you have no calcium on your coronaries, you have learned that . . . you have no calcium on your coronaries. If they do find calcium on your coronaries, then my friend, you have just bought yourself some major worry. You will want to know, What does this mean? Are my coronary arteries narrowed to a trickle? Am I about to die? Is it nothing? Asking such questions almost inevitably leads to

more tests: a stress test, an echocardiogram, a stress echo, a cardiac catheterization, stents and even cardiac bypass operations—all because you opted for a ‘cheap’ and ‘painless’ test—if only you’d never seen that billboard.

Poor McAllen, Texas. It happens to be the focus of a recent “New Yorker” piece by Atul Gawande, a piece that President Obama referred to in his speech to the AMA, because health care costs in McAllen are twice that of comparable cities while health outcomes are no different. The reasons are complex but probably because good physicians are ordering lots of tests, calling in lots of consultants, making good use of the equipment they own and the imaging centers they might have a stake in (and yes, they think they can be objective in ordering an MRI or CAT scan that sends the patient to their own facility); it has to do with hospitals competing with each other for the kinds of patients with conditions that are reimbursed well, and wooing patients, wooing high-volume physicians (some of whom are invited to invest in the hospital) to make full use of their PET scan, their gamma knife, their robotic-surgery facility, their cancer center, their birthing center. That was Atul Gawande’s conclusion, and I would concur.

But I’d like to officially let McAllen off the hook and say that having practiced in five states, including 15 years in the great state of Texas, we are all complicit in practicing just that kind of medicine if you look hard enough and if you looked at us individually. Conflicts of interest are rife; they are almost the rule. So is the ability to wear blinders so we are (mostly) oblivious to our conflict.

Which brings me to my problem with the president’s plan: despite being an admirer, I just don’t see how the president can pull off the reform he has in mind without cost cutting. I recently came on a phrase in an article in the journal “Annals of Internal Medicine” about an axiom of medical economics: a dollar spent on medical care is a dollar of income for someone. I have been reciting this as a mantra ever since. It may be the single most important fact about health care in America that you or I need to know. It means that all of us—doctors, hospitals, pharmacists, drug companies, nurses, home health agencies, and so many others—are drinking at the same trough which happens to hold \$2.1 trillion, or 16% of our GDP. Every group who feeds at this trough has its lobbyists and has made contributions to Congressional campaigns to try to keep their spot and their share of the grub. Why not?—it’s hog heaven. But reform cannot happen without cutting costs, without turning people away from the trough and having them eat less. If you do that, you have to be prepared for the buzz saw of protest that dissuaded Roosevelt, defeated Truman’s plan and scuttled Hillary Clinton’s proposal. The good news is that the AMA, representing perhaps 15% of active practicing physicians, is not as powerful as it was in Truman’s time, and in the eyes of the public and many in medicine, its identity in the reform debate, is that of a protectionist, self-serving, organization; as a result, even their most progressive statements are viewed with suspicion. I’ve found the views of the American Medical Student Association particularly exciting—the next generation of physicians I sense has a deeper commitment to affordable health care for all than ours; they are, simply put, better people.

We may not like it, but the only way a government can control costs is by wielding great purchasing power to get concessions on the price of drugs, physician fees, and hospital services; the only way they can control administrative costs is by providing a simplified service, yes, the Medicare model (with a 3% overhead), and not allowing private insurance to cherry-pick patients (some of them operating with 30% overheads, the cost passed on to you).

Contrary to what we might think, comparative studies show us that the US when compared to other advanced countries, does not have a sicker population: we actually use fewer prescription drugs and we have shorter hospital stays (though we manage to do a lot more imaging in those short stays—got to feed the MRI machines). The bottom line is that our health care is costly because it is costly, not because we deliver more care, better care or special care. Alas, a solution that does not address the cost of care, and negotiate new prices for the services offered will not work; a solution that does not put caps on spending and that instead projects cost-savings here and there also won’t cut it. Leaders have to make tough and unpopular decisions, and if he is to be the first President to successfully accomplish reform there does not seem to be much choice: cut costs.

To come back to my favorite painting: a computer cannot take the place of the doctor in Fildes’s painting; an electronic medical record (EMR) may or may not save money (it won’t be anywhere as much as is projected) but what it will do is ensure that we doctors, nurses, therapists, particularly in hospitals will be spending more and more time focused on the computer, communicating with each other, ordering and getting tests, buffing and

caring for our virtual patient—the iPatient is my term for this phenomenon—while the patient in the bed wonders where everybody is. Having worked exclusively for the last seven years or so in hospitals that have electronic medical records (EMR), I have felt for some time that the patient in the bed has become an icon for the real focus of our attention, the iPatient. Yes, electronic medical records help prevent medication errors and are a blessing in so many ways, but they won't hold the patient's hand for you, they won't explain to the family what is going on.

I have a print of the Fildes painting close at hand, a reminder that all the marvels of science, all the advances of medicine don't replace what patients want of their doctors and what most of us wanted to offer when we felt the calling to medicine: the opportunity to be fully present at the bedside, to bring the human comfort that only the presence of an attentive physician can bring, to convey to patient and family the unspoken promise, "I will stay with you through thick and thin." That's a privilege I won't trade for anything you can offer me. The line in the president's speech to the AMA, a line that got great applause, was this and it says it all: "You entered this profession to be healers—and that's what our health-care system should let you be."

—Abraham Verghese is Professor and Senior Associate Chair for the Theory and Practice of Medicine at Stanford University. He is the author of the novel "Cutting For Stone."

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