LESS IS MORE

Undertreatment Improves, but Overtreatment Does Not

WHEN WE LAUNCHED THE “LESS IS MORE” series, it was with the goal of correcting what we see as a prevalent bias in American medicine: that more care (more diagnostic tests, more treatments, more procedures) is better care. As modern medicine has produced some spectacular interventions, including antibiotics for infections, antiretroviral agents for persons with human immunodeficiency virus infection, detailed imaging through computed tomography, and magnetic resonance imaging to obviate the need for diagnostic surgery, it is not surprising that physicians and our patients think that more diagnostic tests and treatments are always better.

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After all, isn’t it always better to catch a disease earlier? If a person is ill or in pain, shouldn’t we treat them? If they are likely to develop an illness, shouldn’t we try to prevent it? As we have shown in several articles in this series, the answer to these questions is “not necessarily.” Trying to catch disease early in the case of prostate cancer often means subjecting men to unneeded prostate biopsies and treatments that do not extend life but are associated with troubling adverse effects, including incontinence and impotence.1,2 Treating a patient with chronic nonmalignant pain can lead to addiction, with all its sequelae, overdose risk, and increased mortality.3 Attempting to prevent ulcer disease with proton pump inhibitors may lead to increased bone fractures4 and Clostridium difficile infection.5

Our goal in highlighting those instances in which the risks of tests and treatments outweigh the benefits is not to reduce the use of medical tests and treatments per se, but to correct the bias toward overtreatment and to reduce the harm that it causes. An article in this issue illustrates the need for special efforts to overcome such bias.6 Kale and colleagues developed a set of quality indicators of underuse, overuse, and misuse of medical treatment. Underuse was failure to provide an evidence-based treatment (eg, a β-blocker in a person with coronary artery disease). Overuse was performing an intervention that is not recommended (eg, prescribing antibiotics for upper respiratory infections). Misuse was giving the wrong treatment (eg, prescribing a medication that is dangerous for elderly persons to someone 65 years or older).

Using 2 national databases, the authors performed cross-sectional comparisons of outpatient visits in 1999 to visits in 2009. In the absence of bias toward overtreatment, we would expect equal progress to be made on all 3 types of indicators. The true pattern was much more interesting. Six of the 9 underuse indicators improved; 1 of 2 of the misuse indicators improved; but only 2 of the 11 overuse indicators improved and 1 got significantly worse (prostate screening became more common among men older than 74 years).

Clearly, there is much work to be done to overcome the bias toward overtreatment. We are heartened by recent efforts to decrease overuse, including the American Board of Internal Medicine’s “Choosing Wisely” campaign and the National Physicians Alliance’s “Promoting Good Stewardship in Clinical Practice.” Meanwhile, this journal will continue to highlight the opportunity to improve our practice and the health of our patients by doing less, not more.

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REFERENCES