



Executive Summary

How Technocrats are Taking Over the Practice of Medicine

A Wake-up Call to the American People

Twila Brase, R.N., President

Evidence is said to be the new bright star of health care. A growing chorus of voices is thus calling for physicians and other health care practitioners to follow evidence-based medicine (EBM), or so-called “best practices.” To practice EBM, supporters say physicians must follow evidence-based clinical practice guidelines. Despite being painted as scientifically sound, there are more than a few detractors of EBM, including physicians, patients, and researchers. Even those who support evidence-based medicine and practice guidelines worry about how it may play out in real-life patient care.

Clinical practice guidelines are needed, according to EBM proponents, for various reasons including:

- Health care cost containment
- Reducing variation in physician practice patterns
- Keeping physicians up to date with the latest medical research
- Medical malpractice reform

However, the concerns surrounding EBM and practice guidelines are significant. They include:

- Rigid standards of care imposed on patients
- Restrictions on professional freedom and judgment
- Rationing of health care services
- Politicization of medicine

Uwe Reinhardt, Ph.D., a noted economist at Princeton University, warns in a published conversation on EBM:

My fear is that medicine will slide into the same intellectual morass in which economists now wallow, often with politics practiced in the guise of science. In medicine, it might be profit-maximizing in the guise of science.¹

The “Evidence” Problem

Evidence-based medicine is defined as “the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients.”² However, there are problems with the available “evidence,” including researcher bias, disagreement in defining “best evidence,” incomplete reporting of research results, and conflicting studies.

The Institute of Medicine, in *Patient Safety: Achieving a New Standard for Care*, notes that determining what

classifies as authoritative evidence is not clear cut:

There are gaps and inconsistencies in the medical literature supporting one practice versus another, as well as biases based on the perspective of the authors, who may be specialists, general practitioners, payers, marketers, or public health officials (Maviglia et al, 2003).³

Shifting Control Through “Science”

Professor Gary Belkin, M.D., Ph.D., is author of one of the most comprehensive papers on the motivation and philosophy behind the new focus on scientific evidence in medicine, “The Technocratic Wish: Making Sense and Finding Power in the ‘Managed’ Medical Marketplace.” He says EBM is not purely about so-called “good science,” but about the destructive industrialization of medicine by those who want to control it.⁴

Arnold Rosoff, J.D. spoke at a federally-sponsored workshop. In his summary of Belkin’s paper, he spoke of the search for justification that would enable a shift of power away from the medical profession. Data analysis and use of population-wide health statistics are key tools used by government policy makers and health plans. He concludes:

...In Belkin’s view, managed care has embraced the technocratic wish in its desire to find a rationale and a mechanism for standardizing medical practice and reining in physicians’ natural inclination to treat each patient as a special case.⁵

Physician Response

Physicians often decry practice guidelines as “cookbook medicine.” Nevertheless, insurers, government agencies, employer groups and the U.S. Congress have begun implementing “pay-for-performance” strategies—including use of private medical records to monitor physician performance—to gain physician cooperation with standardization and practice guidelines. In the process, practice guidelines have essentially become practice directives. Yet, despite financial consequences, some physicians refuse to follow guidelines—to the benefit of patients. Underscoring the concern of physicians regarding loss of professional autonomy, Eric Wall writes, “Whether guidelines fulfill their promise or merely become a tool for cost-containment, rationed care, specialty self-interest, and privilege may not be the most important question...The real question for family physicians is: who will have such control?”⁶

Validity of Guidelines Questioned

Numerous concerns revolve around practice guidelines. For example, guidelines quickly become outdated, many are of dubious quality, and guideline developers often fail to make explicit how recommendations are devised, leaving practitioners to follow in blind faith. Additional concerns include conflicting guidelines, population-based focus, selective interpretation, insertion of developers’ value systems, and negative impact on medical advances.

Potential for Harm

Patients can be harmed by practice guidelines. David M. Eddy, M.D., Ph.D., at Duke University, warns,

If an individual physician and a patient make a wrong decision, that patient will be harmed, but the damage will stop there. In contrast, practice policies are intended to influence thousands, even millions, of decisions. If a policy is wrong, the harm can be huge.⁷

Guidelines may also prove useful to those who want to ration care. In England, in 1999, the National Institute for Clinical Excellence was created to, among other things, provide guidance on “best practice.” In a substantial article on the issue, Keith Syrett called this “technocratic approach” a “means for scientifically depoliticizing the rationing debate.”⁸

Guidelines - History

Proposals to require use of practice guidelines are not new. After health care spending rose sharply following the 1965 enactment of Medicare and Medicaid, third-party payers began to develop practice guidelines. Since the 1990s,

state legislatures have begun introducing them for cost control and medical malpractice reform, the Clinton Health Security Act included guideline requirements, and the Medicare Modernization Act of 2003 enacted a demonstration project including “evidence-based guidelines.”

Guidelines are plentiful, and derived from many sources. In fact, guideline production has become its own industry, with the U.S. government providing funds to 13 designated Evidence-based Practice Centers. Production, review, and updating take significant time. The cost of the process depends on whether they are developed and updated by the public or the private sector. Yet no studies have measured the cost of guideline implementation and some say it is not clear that guidelines save money.

Medical Malpractice

Policy makers often push standardized practice guidelines as protection for physicians against medical malpractice litigation. But others say the promise of malpractice relief is simply a political maneuver to obtain physician support for practice guidelines. Regardless, legal experts say that guidelines will not likely protect physicians in the court of law. Daniel W. Shuman, J.D., from Southern Methodist University School of Law in Dallas, explains, “Almost always, the health care people talk about population-based evidence, and almost always, the legal people talk about evidence based at the level of the individual.”⁹ There are also Constitutional issues with laws that have allowed physicians, but not patients, to use guidelines as evidence in court. And judges and juries have additional significant issues to consider when guidelines are brought as evidence, including bias, appropriateness, and actual harm.

Conclusion

Looming on the visible horizon of American health care is a new attempt to control the practice of medicine and limit—indeed, ration—patient access to health care services. The evidence-based medicine initiative involves a technocratic takeover of the practice of medicine through data collection, guideline creation, clinical surveillance, pay-for-performance strategies, and centralized decision-making. In short, EBM is aimed at stopping the heart of health care—the compassionate, first-do-no-harm, to-my-own-patient-be-true ethics of medicine.

Fully implemented, EBM will lead to a limited list of approved health care services—“best practices”—as determined by the agendas and values of a small cadre of politically-motivated, personally-biased individuals sitting around a table somewhere making treatment decisions far from the patient’s bedside.

Americans must become involved and engaged. Without immediate and focused intervention, vulnerable patients will be left to depend on the personal whims, financial agendas, and political biases of people who do not even know their name.

Twila Brase, R.N., is president of Citizens’ Council on Health Care. She provides presentations to industry and policy leaders, testifies before state legislatures and national committees, and has appeared in numerous news reports, including on CNN, NBC Nightly News, and NPR. Ms. Brase was the featured guest on a 2004 healthcare series: “Patients’ Perspective” (WCCO-AM). Her comments have appeared in diverse publications including The Associated Press, Bureau of National Affairs (BNA), Business Week, MSNBC, Star Tribune, Time, and United Press International. She is a certified Public Health Nurse, and resides in St. Paul, Minnesota.

ENDNOTES

¹ Carlson Robert P. “The Promise and Perils of Evidence-Based Medicine.” *The Physician Executive*. May/June 1999; p 43-52.

² EVIDENCE-BASED MEDICINE (Churchill Livingstone, 2000) by David L. Sackett, Director, Trout Research and Conference Centre, Irish Lake, Ontario, Canada. p. 246.

³ Patient Safety: Achieving a New Standard for Care. Institute of Medicine. 2004; p. 158.

⁴ Belkin, Gary S [M.D., M.P.H., Ph.D.]. Telephone conversation with author. July 30, 2004.

⁵ Rosoff Arnold J. “Evidence-Based Medicine and the Law: The Courts Confront Clinical Practice Guidelines.” *Journal of Health Politics, Policy and Law*. April 2001; v 26(2). (referencing: Belkin G. “The Technocratic Wish: Making Sense and Finding Power in the ‘Managed’ Medical Marketplace.” *Journal of Health Politics, Policy and Law*. 1997; v22: 509-532.

⁶ Wall, Eric M. “Practice Guidelines: Promise or Panacea?” *The Journal of Family Practice*. 1993; 37(1): 17-19.

⁷ Eddy David M. “Designing a Practice Policy: Standards, Guidelines, and Options.” *JAMA*. June 13, 1990; 263(22): 3077, 3081, 3084.

⁸ Syrett Keith [University of Bristol]. “A Technocratic Fix to the ‘Legitimacy Problem’? The Blair Government and Health Care Rationing in the United Kingdom.” *Journal of Health Politics, Policy and Law*. August 2003; 28(4).

⁹ Marwick Charles. “Will Evidence-Based Practice Help Span Gulf Between Medicine and Law?” *JAMA*, June 7, 2000. 283(21): 2775 – 2776.