

# Congress must stay out of the doctors' office

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By Howard Hoffberg  
Guest Columnist

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When a patient walks into my examination room, he or she rightly expects that my diagnosis will be personalized, taking account of his or her symptoms, medical history and lifestyle. Early on, physicians learn that personalizing a patient's medical treatment is essential.

Physician and patient working together to provide personalized care usually results in the best outcome. That's why there's nothing more frustrating than having a third party thrust itself into the physician-patient relationship, whether it's an insurance company or a government agency. This thought has been on my mind as policy makers debate the creation of a government-run institute for comparative-effectiveness research.

In theory, such an institute would be a useful clearinghouse of information for physicians. It could show us the merits of treatments we haven't heard about. Or detail the costs of treatments we employ regularly.

But if a comparative-effectiveness institute dictates how physicians practice medicine, patients will suffer. Policymakers would be wise to keep the government out of the doctor's office.

Research into the effectiveness of various treatments is certainly beneficial. Patients demand that their doctors be up-to-speed on the latest therapeutic options and the government could play a useful role in disseminating the latest research findings.

Medical research, however, will always be somewhat inexact. A scientific study can only evaluate the effects of a given treatment on the individuals in the sample. Thus, conclusions are generally drawn based on how a treatment affects the average participant.

But the patient sitting in my exam room is rarely "average." The success or failure of a treatment is determined by a host of personal factors, such as genetics, diet and age.

Thus far, however, governments have tended to ignore this reality when determining which treatments to cover.

Britain's experience with comparative-effectiveness trials provides an instructive example. The state-run National Institute for Health and Clinical Excellence, which determines which treatments the government will

cover, has recently been moving patients with high cholesterol off name-brand Lipitor and onto generic – and less expensive – simvastatin.

The British government surely saves money on the switch, but the budget cuts don't come without costs. An eight-year study released last September determined that "major cardiovascular events" increased by more

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than a third among patients who were forced onto simvastatin.

It's crucial that such scientific evidence trump government cost concerns. British doctors found their treatment options limited by government price sensitivities and patients paid the price.

Congress shouldn't replicate that mistake here. If our government creates an agency to research new medicines and treatments, it shouldn't use the agency's findings to limit options. It should instead provide physicians with the best information we can use while personalizing the course of treatment for our patients.

Practicing physicians depend on clinical studies when making treatment recommendations. Comparative-effectiveness research can play an important role in informing those recommendations. But it's critical that doctors – not bureaucrats – be in charge of how that research is applied once they enter the exam room.

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