New Technologies: A Call for Restraint

Despite the increasing use of clinical practice guidelines to aid clinical decision-making, obstacles to the potential full use of guidelines still exist. Interestingly, 2 major barriers in the clinical context balance at opposite ends of the implementation spectrum.

The first obstacle is clinical inertia—the failure to intensify treatment to achieve optimal targets. An oft-cited example in oncology is the finding that a substantial number (30%) of patients across a broad spectrum of clinical practices receive therapy with a relative dose intensity less than 85%. Perhaps even more puzzling, more than half of the under-treated patients are started at doses below those established in clinical trials. Hopefully the judicious use of quality improvement methods, including system and computerized checks, can overcome some of this inertia.

At the other end of the spectrum is what might be called the “My Big Fat Greek Wedding Windex phenomenon,” after the belief of one of the characters in that film that the cleaning product Windex could be used for almost everything. In oncology, the phenomenon suggests that once a modality is found useful in one situation, its use is indiscriminately disseminated to many other applications. Certainly, some of these applications are based on science, but others rest on more tenuous theoretic rationales.

In light of this obstacle, I found it refreshing that Mayer et al., in their paper on use of the new agent lapatinib in breast cancer, strike a cautionary note. They propose that lapatinib be used in patient groups for whom its efficacy has been determined and that expanded use should await further testing.

The mandate for restraint is especially highlighted by Anderson and Carlson in their paper, Guidelines for Improving Healthcare in Limited Resource Countries: The Breast Health Global Initiative. Based on deliberations from representatives from 33 countries at a Global Summit in 2005, the group identified 4 levels of resource availability—basic, limited, enhanced, and maximal—that determine the essential elements for breast cancer care at that level. The authors strongly emphasize, and I agree, that this is not to be construed as institutionalizing substandard care. Rather, the system attempts to define which public health and medical interventions are the most efficacious and will maximize patient outcomes given a certain level of resources.

A mistake in using this tiered schema is the assumption that “maximal level” resources and care provision implies license to use any modality without regard to total resource consumption or cost. The economic problems facing the U.S. healthcare system are well documented at this point. A new emphasis on balancing benefits and cost is emerging and serves as an important construct in determining how “optimal care” is defined. Physicians and facilities that deliver care of the highest quality with the most prudent use of resources will provide the value that patients, payers, and employers are seeking.

And so, back to Mayer et al.: new technology should always be welcomed in our fight against a relentless enemy. However, we must also exercise restraint in using these new tools. Even America, the land of plenty, has limits. We must use our new resources wisely, so that all can benefit.

References