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A USA TODAY study found that tens of thousands of times each year, patients undergo surgery they don't need.

Jonathan Stelly was 22, a semi-pro baseball player aiming for the big leagues, when a fainting spell sent him to his cardiologist for tests. The doctor's office called afterward with shocking news: If Stelly wanted to live to age 30, he was told, he'd need a pacemaker.

Stelly knew it would be the end of his baseball dream, but he made a quick decision. "I did what the doctor said," he recalls. "I trusted him."

Months after the surgery, local news outlets reported that the Louisiana cardiologist, Mehmood Patel, was being investigated for performing unnecessary surgeries. Stelly had another doctor review his case. Then another. And another. They all agreed: He needed blood pressure medication, but he never needed the pacemaker.

Today, Patel is in prison, convicted of billing Medicare for dozens of unnecessary heart procedures. Stelly, now 34, still has the pacemaker – but the doctors shut it off years ago.

"Baseball was my life, and he took that away," Stelly says. "For nothing."

Tens of thousands of times each year, patients are wheeled into the nation's operating rooms for surgery that isn't necessary, a USA TODAY review of government records and medical databases finds. Some, such as Stelly, fall victim to predators who enrich themselves by bilking insurers for operations that are not medically justified. Even more turn to doctors who simply lack the competence or training to recognize when a surgical procedure can be avoided, either because the medical facts don't warrant it or because there are non-surgical treatments that would better serve the patient.

The scope and toll of the problem are enormous, yet it remains largely hidden. Public attention has been limited to a few sensational cases, typically involving doctors who put cardiac stents in patients who didn't need them.

In fact, unnecessary surgeries might account for 10% to 20% of all operations in some specialties, including a wide range of cardiac procedures — not only stents, but also angioplasty and pacemaker implants — as well as many spinal surgeries. Knee replacements, hysterectomies, and cesarean sections are among the other surgical procedures performed more often than needed, according to a review of in-depth studies and data generated by both government and academic sources.

Since 2005, more than 1,000 doctors have made payments to settle or close malpractice claims in surgical cases that involved allegations of unnecessary or inappropriate procedures, according to a USA TODAY analysis of the U.S. government's National Practitioner Data Bank public use file, which tracks the suits. About half the doctors' payments involved allegations of serious permanent injury or death, and many of the cases involved multiple plaintiffs, suggesting many hundreds, if not thousands, of victims.

Those malpractice cases, which can be settled with no admission of wrongdoing, account for no more than a fraction of cases in which people got surgery that wasn't needed, and there's no way to know the total number. In an era when many hospitals are required to report every infection and surgical error, neither the federal government nor the states track unnecessary surgeries or their consequences, which can include surgery-related infections or other complications — a nicked nerve or artery, for example — that can cause severe disability, even death.

"It's a very serious issue, (and) there really hasn't been a movement to address it," says Lucian Leape, a former surgeon and professor at the Harvard School of Public Health. Leape, a renowned patient safety expert who began studying unnecessary surgery after a 1974 congressional report estimated that there were 2.4 million cases a year, killing nearly 12,000 patients.

Leape's take today? "Things haven't changed very much."

EXPENSIVE AND UNSEEN

The costs of unnecessary surgeries touch consumers and taxpayers in ways most never imagine. Medicare, Medicaid and their private insurance counterparts spend billions of dollars on operations that shouldn't be done, draining health care dollars that could go to far better use.

About 10% of all spinal fusions paid for by Medicare in 2011 were not necessary, either because there was no medical basis for them or because doctors did not follow standards of care by exploring non-surgical treatments, according to a USA TODAY analysis of data from Medicare program audits. That translates to $157 million in improper payments, just for spinal surgeries in a single year.

Only the most egregious claims of unnecessary surgery make headlines: The Maryland cardiologist sentenced in 2011 on charges that he put cardiac stents in more than 100 patients who didn't require them; or the lawsuit filed this year by nearly 100 patients alleging that a Cincinnati doctor did needless spinal surgeries to implant bone-grafting devices.

Far more often, cases go unnoticed.

The procedures are notoriously tough to identify, even for the victims. If, for example, someone has an unnecessary knee replacement, that person might never know that the pain could have been relieved just as effectively with physical therapy or a less invasive procedure. The symptoms are gone, so the patient suspects nothing.

"If we ever learn about it at all, it's only after the fact, if something goes wrong and the patient sees another doctor, or if Medicare or someone else comes in retroactively and does an audit," says Rosemary Gibson, an authority on patient safety and author of *The Treatment Trap*, a book on unnecessary care. "The system, in my opinion, doesn't want to know about this problem."

Academic studies have discovered high rates of unnecessary surgery, particularly in spinal and cardiac operations.

A 2011 study in the *Journal of the American Medical Association* reviewed records for 112,000 patients who had an implantable cardioverter-defibrillator (ICD), a pacemaker-like device that corrects heartbeat irregularities. In 22.5% of the cases, researchers found no medical evidence to support installing the devices.

Another 2011 study, in the journal *Surgical Neurology International*, evaluated 274 patients with neck and back complaints over a one-year period: More than 17% had been told they needed surgery but had no neurological or radiographic findings that indicated an operation was necessary.

"I am seeing more and more patients who are told to have operations they don't need," says the spinal study's author, Nancy Epstein, a neurosurgeon and chief of Neurosurgical Spine and Education at Winthrop University Hospital in Mineola, N.Y.

"If patients have operations they don't need, they risk having major problems — infections, paralysis, heart attacks, strokes," Epstein says. Yet she notes that virtually no data are collected on complications or patient injuries from unnecessary surgery. "Nobody reports the complications, so finding the real morbidity and mortality of these procedures is extremely difficult."

WALKING WOUNDED

Willie Boudry, a construction worker, was referred to Eric Scheffey by his company's insurer after he slipped and wrenched his back carrying pipe on a muddy job in 2002.

Boudry, now 53, never knew the neurosurgeon had recently come off probation by the state medical board for doing unnecessary surgeries. Nor did he know Scheffey faced scores of malpractice claims and was sanctioned previously in connection with cocaine use. He knew only what Scheffey told him: He needed surgery.

Scheffey fused Boudry's spine in multiple places, installing screws and other hardware, but the pain worsened. By the time Boudry limped in to consult another neurosurgeon, Scheffey had been suspended again, charged with more unnecessary surgeries in a case that later got his license revoked for good.

Boudry's new surgeon removed the screws and hardware — he said they weren't needed. But Boudry is permanently disabled, finished as a construction worker. He's in a subsidized assisted living complex and offsets his rent by driving a resident shuttle a few hours a day.

Boudry's surgery was "unnecessary and quite extensive," and Scheffey "did it poorly," according to an affidavit from another neurosurgeon Boudry hired as an expert for a malpractice suit he filed. Much of his settlement went to paying back the worker's compensation he received.

"I can't make real money; I'm in chronic pain, so I can't even drive for long," Boudry says. "I refuse to be a cripple. … I taught myself to walk without a cane and don't take painkillers. But I struggle with depression, anxiety. It's been hard."

A MATTER OF MONEY, MOSTLY

There are three broad categories of unnecessary surgery: the immoral, the incompetent and the indifferent.

Doctors who perform needless operations to enrich themselves are the public face of the problem. Lured by the millions of dollars that can be made by billing Medicare, Medicaid and private insurers for expensive procedures that aren't necessary, they've become a top target of investigators who consider this type of health care fraud to be particularly insidious.

"There's a health and safety aspect … and we take that very seriously," says Joseph Campbell, the FBI's deputy assistant director for criminal investigations.

Cases are tough to identify, he says. Surgeons might draw attention if they perform certain procedures at especially high rates. But "we have to determine whether the surgery was necessary, and if it was unnecessary, was it incompetence, just mistakes, or was there something nefarious."

The challenge gets even more daunting in court, where questions of medical necessity often boil down to a matter of opinion, with dueling assessments from each side's experts.

"We look for cases where, based on an examination of records and claims data, the (surgery) numbers are so out of whack with a physician's peer group that it counters that presumption that we typically give a doctor" to make judgment calls, says Randy Harwell, civil division chief for the U.S. attorney in central Florida. "It's quite difficult in a medical necessity case to get to a place where all those things come together … to paint a picture where (the doctor) is actually sinister."

In most cases of unnecessary surgery, there is no sinister character — or criminal intent. The driving factors are more complex and more subtle.

"I think there are a very small percent of doctors who are crooked, maybe 1 or 2%," says John Santa, a physician and former health system administrator who became director of the Consumer Reports Health Ratings Center in 2008.

"I think there's a higher percentage who are not well trained or not competent" to determine when surgery is necessary, Santa says. "Then you have a big group who are more businessmen than medical professionals — doctors who look at those gray cases and say, 'Well, I have enough here to justify surgery, so I'm going to do it.'"

The pressures are real. Doctors' income can hinge largely on the number of surgeries they do — and the revenue those procedures generate. Those numbers also can determine whether doctors get privileges at certain hospitals or membership in top practices.

There's no way to know what portion of unnecessary surgeries are related to these more subtle pressures, as opposed to poor training or fraud. Researchers simply know they're happening.

Some of the most widely cited evidence comes from Dartmouth College's Institute for Health Policy and Clinical Practice, which uses data from Medicare and other sources to document large variances in the rates at which surgeries are done in different parts of the country.

Data from 2008-2010, examining common surgeries that carry a risk of being done unnecessarily, show:

• Radical Prostatectomy: Medicare patients in Lansing, Mich., were 10 times more likely to have surgical prostate removals than those 500 miles away, in York, Penn. Lansing's rate for the surgeries was the nation's highest, 2.7 times the average; York's was lowest, less than a third of the average.

• Gall bladder removal: Medicare patients in McAllen, Texas, were three times more likely to have a surgical gall bladder removal than those in Mason City, Iowa. McAllen's rate for the surgeries was the nation's highest, 1.6 times the average; Mason City's was lowest, closer to half the average.

• Knee replacement: Medicare patients in Lincoln, Neb., were nearly four times more likely to have knee replacement surgery than those in Honolulu. Lincoln's rate for the surgeries was the nation's highest, nearly 55% above the national average; Honolulu's was lowest, less than half the average.

Absent any hard data on what drives the different surgery rates, researchers have adopted a generic explanation: physician preference.

CUT FOR NOTHING

Michael Rosin had a busy dermatology practice treating hundreds of mostly elderly skin cancer patients in Southwest Florida. But the cancers were a fiction.

Rosin, now 62, was sentenced to 22 years in prison in 2006 and ordered to pay more than $7 million for intentionally misdiagnosing patients with cancer, then doing skin surgeries — often multiple times on a single patient — to remove lesions he knew were benign.

"He would look us over, take a sample for a biopsy, then come back and say you have some kind of cancer," recalls Robert Avrutik, 89. "He'd keep finding more, and you never know yourself whether it's cancerous, so you figure, 'Oh, I've got all these cancerous things. Eventually, he'll get rid of them all.'"

Avrutik and his wife, Marie, visited Rosin again and again. Each time he would tell them both that he needed to remove more lesions.

"He'd always have to put in six, seven stitches; it would be sore, you had to attend to it, so it was really a pain," Avrutik says. "My wife still has a couple of scars on her face, and she yells about him from time to time."

When federal agents caught up with Rosin, he'd worked the scam for nearly a decade, prosecutors said. In all, they counted more than 800 victims.

MORE KNOWLEDGE, FEWER SURGERIES

The fee-for-service nature of U.S. health care, where the hospitals and doctors get more money for every operation they perform, essentially rewards those that put more patients under the knife.

"There's no financial reason not to do it, so there's no pressure," says Leape, the Harvard physician. "There are no regulators breathing down their backs; Medicare and the insurance companies continue to pay for it."

The 2010 health care law, still being implemented, promises changes in the payment system that may pressure health care providers to cut unnecessary surgeries, Leape says. But the key, he says, is to redefine the doctor-patient relationship.

Informed or shared decision-making, in which doctors help patients play active roles in choosing their treatment, is the mantra of many patient advocates and a number of surgeons themselves. The idea is that doctors lay out all the information about a surgery — potential benefits, evidence for doing it, options for non-surgical treatment — so patients can decide whether it's right for them.

"We see dramatic variations in rates of (surgery) for … conditions where multiple treatment options are possible," the Dartmouth researchers concluded. "Such extreme variation arises because patients commonly delegate decision-making to physicians. … When patients are fully informed about their options, they often choose very differently."

Having surgeons talk with patients might not be enough. Safety advocates say patients themselves must take an active role.

"Don't just take a doctor's word," says Patty Skolnik, who founded Citizens for Patient Safety after her son, Michael, died at 22 from complications in what she says was unnecessary brain surgery. "Research your doctor, research the procedure, ask questions, including the most important one: 'What will happen if I don't get this done?'"

People often feel pressed to make immediate decisions on surgery when there's no rush, Skolnik says. "I say, 'Slow it down. Stabilize and get another opinion.'"

A 1982 study in the journal *Medical Care* found that a mandatory second opinion program for Massachusetts Medicaid patients led to a 20% drop in certain surgeries, such as hysterectomies, that were considered more likely to be done unnecessarily. A 1997 study in the *Journal of the American College of Surgeons* looked at 5,601 patients recommended for surgery and found that second opinions found no need for the operation in 9% of the cases. Among those who got the countervailing second opinion, 62% opted not to have the operation.

But many patients simply aren't inclined to question their doctors.

"We expect the physician to know what's best for a patient," says William Root, chief compliance officer at Louisiana's Department of Health and Hospitals. "We put so much faith and confidence in our physicians, (and) most of them deserve it. But when one of them is wrong or goes astray, it can do a lot of damage."

Root worked previously for the Inspector General at the U.S. Department of Health and Human Services, where he helped build the case against Mehmood Patel, the Louisiana cardiologist who put in the pacemaker that ended Jonathan Stelly's baseball dreams. That case was "one of the worst," Root says, because Patel was so trusted in the community that no one questioned him.

Stelly wishes he had.

"I'd known him since I was a kid," says Stelly, who moved to Denver and started a business that markets water ionizing and antioxidant equipment. "(But) when someone's doing something that can change your life forever, you have to get a second opinion. You have to ask questions."

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