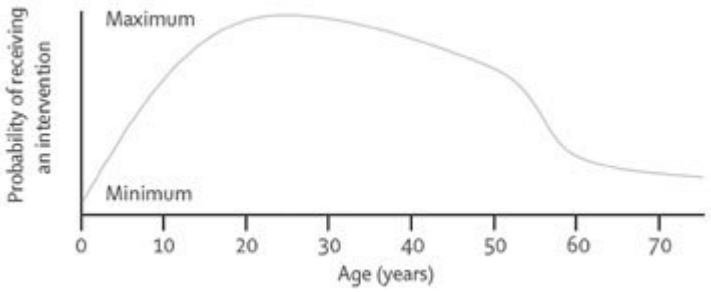
Obama's Health Rationer-in-Chief

White House health-care adviser Ezekiel Emanuel blames the Hippocratic Oath for the 'overuse' of medical care.

August 27, 2009, Wall Street Journal by Betsey McCaughey

Dr. Ezekiel Emanuel, health adviser to President Barack Obama, is under scrutiny. As a bioethicist, he has written extensively about who should get medical care, who should decide, and whose life is worth saving. Dr. Emanuel is part of a school of thought that redefines a physician's duty, insisting that it includes working for the greater good of society instead of focusing only on a patient's needs. Many physicians find that view dangerous, and most Americans are likely to agree.

The health bills being pushed through Congress put important decisions in the hands of presidential appointees like Dr. Emanuel. They will decide what insurance plans cover, how much leeway your doctor will have, and what seniors get under Medicare. Dr. Emanuel, brother of White House Chief of Staff Rahm Emanuel, has already been appointed to two key positions: health-policy adviser at the Office of Management and Budget and a member of the Federal Council on Comparative Effectiveness Research. He clearly will play a role guiding the White House's health initiative.



"Principles for Allocation of Scarce Medical Interventions" The Lancet, January 31, 2009

The Reaper Curve: Ezekiel Emanuel used the above chart in a Lancet article to illustrate the ages on which health spending should be focused.

Dr. Emanuel says that health reform will not be pain free, and that the usual recommendations for cutting medical spending (often urged by the president) are mere window dressing. As he wrote in the Feb. 27, 2008, issue of the Journal of the American Medical Association (JAMA): "Vague promises of savings from cutting waste, enhancing prevention and wellness, installing electronic medical records and improving quality of care are merely 'lipstick' cost control, more for show and public relations than for true change."

True reform, he argues, must include redefining doctors' ethical obligations. In the June 18, 2008, issue of JAMA, Dr. Emanuel blames the Hippocratic Oath for the "overuse" of medical care: "Medical school education and post graduate education emphasize thoroughness," he writes. "This culture is further reinforced by a unique understanding of professional obligations, specifically the Hippocratic Oath's admonition to 'use my power to help the sick to the best of my ability and judgment' as an imperative to do everything for the patient regardless of cost or effect on others."

In numerous writings, Dr. Emanuel chastises physicians for thinking only about their own patient's needs. He describes it as an intractable problem: "Patients were to receive whatever services they needed, regardless of its cost. Reasoning based on cost has been strenuously resisted; it violated the Hippocratic Oath, was associated with rationing, and derided as putting a price on life. . . . Indeed, many physicians

were willing to lie to get patients what they needed from insurance companies that were trying to hold down costs." (JAMA, May 16, 2007).

Of course, patients hope their doctors will have that single-minded devotion. But Dr. Emanuel believes doctors should serve two masters, the patient and society, and that medical students should be trained "to provide socially sustainable, cost-effective care." One sign of progress he sees: "the progression in end-of-life care mentality from 'do everything' to more palliative care shows that change in physician norms and practices is possible." (JAMA, June 18, 2008).

"In the next decade every country will face very hard choices about how to allocate scarce medical resources. There is no consensus about what substantive principles should be used to establish priorities for allocations," he wrote in the New England Journal of Medicine, Sept. 19, 2002. Yet Dr. Emanuel writes at length about who should set the rules, who should get care, and who should be at the back of the line.

"You can't avoid these questions," Dr. Emanuel said in an Aug. 16 Washington Post interview. "We had a big controversy in the United States when there was a limited number of dialysis machines. In Seattle, they appointed what they called a 'God committee' to choose who should get it, and that committee was eventually abandoned. Society ended up paying the whole bill for dialysis instead of having people make those decisions."

Dr. Emanuel argues that to make such decisions, the focus cannot be only on the worth of the individual. He proposes adding the communitarian perspective to ensure that medical resources will be allocated in a way that keeps society going: "Substantively, it suggests services that promote the continuation of the polity—those that ensure healthy future generations, ensure development of practical reasoning skills, and ensure full and active participation by citizens in public deliberations—are to be socially guaranteed as basic. Covering services provided to individuals who are irreversibly prevented from being or becoming participating citizens are not basic, and should not be guaranteed. An obvious example is not guaranteeing health services to patients with dementia." (Hastings Center Report, November-December, 1996)

In the Lancet, Jan. 31, 2009, Dr. Emanuel and co-authors presented a "complete lives system" for the allocation of very scarce resources, such as kidneys, vaccines, dialysis machines, intensive care beds, and others. "One maximizing strategy involves saving the most individual lives, and it has motivated policies on allocation of influenza vaccines and responses to bioterrorism. . . . Other things being equal, we should always save five lives rather than one.

"However, other things are rarely equal—whether to save one 20-year-old, who might live another 60 years, if saved, or three 70-year-olds, who could only live for another 10 years each—is unclear." In fact, Dr. Emanuel makes a clear choice: "When implemented, the complete lives system produces a priority curve on which individuals aged roughly 15 and 40 years get the most substantial chance, whereas the youngest and oldest people get changes that are attenuated (see Dr. Emanuel's chart nearby).

Dr. Emanuel concedes that his plan appears to discriminate against older people, but he explains: "Unlike allocation by sex or race, allocation by age is not invidious discrimination. . . . Treating 65 year olds differently because of stereotypes or falsehoods would be ageist; treating them differently because they have already had more life-years is not."

The youngest are also put at the back of the line: "Adolescents have received substantial education and parental care, investments that will be wasted without a complete life. Infants, by contrast, have not yet received these investments. . . . As the legal philosopher Ronald Dworkin argues, 'It is terrible when an infant dies, but worse, most people think, when a three-year-old dies and worse still when an adolescent does,' this argument is supported by empirical surveys." (thelancet.com, Jan. 31, 2009).

To reduce health-insurance costs, Dr. Emanuel argues that insurance companies should pay for new treatments only when the evidence demonstrates that the drug will work for most patients. He says the

"major contributor" to rapid increases in health spending is "the constant introduction of new medical technologies, including new drugs, devices, and procedures. . . . With very few exceptions, both public and private insurers in the United States cover and pay for any beneficial new technology without considering its cost. . . ." He writes that one drug "used to treat metastatic colon cancer, extends medial survival for an additional two to five months, at a cost of approximately $50,000 for an average course of therapy." (JAMA, June 13, 2007).

Medians, of course, obscure the individual cases where the drug significantly extended or saved a life. Dr. Emanuel says the United States should erect a decision-making body similar to the United Kingdom's rationing body—the National Institute for Health and Clinical Excellence (NICE)—to slow the adoption of new medications and set limits on how much will be paid to lengthen a life.

Dr. Emanuel's assessment of American medical care is summed up in a Nov. 23, 2008, Washington Post op-ed he co-authored: "The United States is No. 1 in only one sense: the amount we shell out for health care. We have the most expensive system in the world per capita, but we lag behind many developed nations on virtually every health statistic you can name."

This is untrue, though sadly it's parroted at town-hall meetings across the country. Moreover, it's an odd factual error coming from an oncologist. According to an August 2009 report from the National Bureau of Economic Research, patients diagnosed with cancer in the U.S. have a better chance of surviving the disease than anywhere else. The World Health Organization also rates the U.S. No. 1 out of 191 countries for responsiveness to the needs and choices of the individual patient. That attention to the individual is imperiled by Dr. Emanuel's views.

Dr. Emanuel has fought for a government takeover of health care for over a decade. In 1993, he urged that President Bill Clinton impose a wage and price freeze on health care to force parties to the table. "The desire to be rid of the freeze will do much to concentrate the mind," he wrote with another author in a Feb. 8, 1993, Washington Post op-ed. Now he recommends arm-twisting Chicago style. "Every favor to a constituency should be linked to support for the health-care reform agenda," he wrote last Nov. 16 in the Health Care Watch Blog. "If the automakers want a bailout, then they and their suppliers have to agree to support and lobby for the administration's health-reform effort."

Is this what Americans want?

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