New York Times continues cost-cutting campaign with “doctors thoughts”

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In keeping with its campaign in support of Obama’s recently passed health care legislation and its agenda of cost cutting, the *New York Times* carried an article Saturday by Lesley Alderman headlined, “Doctors Offer Thoughts on Cutting Health Care Costs.”

The article takes as a given that the health care overhaul is a genuine social reform, whose effect will be to provide “substantial” benefits to the general population. It bemoans the fact, however, that the new legislation “does not tackle head-on the staggering cost of health care in the United States.”

In fact, the Obama-promoted legislation is aimed first and foremost at cutting costs for corporations and the government. It will slash hundreds of billions from the Medicare program for the elderly, and contains numerous cost-cutting mechanisms to ration and reduce care for ordinary Americans. This is well known by the *Times* editors. However, these cuts are seen as only a first step in a campaign to limit testing and treatments for the majority of Americans.

The entire framework of the health care “reform” is not to be challenged. Nor is the fact that insurance company and health care industry profits will by all accounts be boosted by the plan. But the ultimate question for patients, the author argues, is “How can the country reduce health care costs while not compromising quality?”

Alderman is not speaking here about reducing premiums, co-pays and deductibles for working families. There are no restrictions in Obama’s plan on what insurers can charge for coverage—and numerous studies have shown that these payments will actually *increase*.

No, the *Times*’ aim here is to promote the cost-reducing features of the health care bill for big business and the government and offer advice on how they might be strengthened. The author cynically attempts to palm off the suggestions of a select group of “doctors on the medical front lines” as a balanced cross-section of medical professionals.

It is notable that in the (“edited and condensed”) comments quoted, none of these doctors openly oppose the health care legislation; none openly promote nationalized health care, a single-payer system or even a government-run “public option.” Where appropriate, Alderman also helpfully notes how the Obama plan will advance the generally regressive proposals presented by this selection of physicians.

Jacques Moritz, M.D., director of gynecology at St. Luke’s-Roosevelt Hospital Center in New York, offers the first suggestion: insuring for catastrophes only. Dr. Moritz states, “When you buy auto insurance, you don’t insure yourself for every dent and nick—you insure yourself for serious accidents. This is the way the health system should work.”

He says that the current insurance model “doesn’t reward patients for being healthy, it rewards them for being sick”—as if patients now are getting sick on purpose just so they can take advantage of insurance payouts. Likening the health of a human being to dings on an auto body is a poor analogy, but one that serves a definite purpose. Patients should be discouraged from seeking treatments for supposedly non-catastrophic medical conditions, and the insurers would be rewarded by not paying out for them.

In health care, however, it is generally impossible to determine beforehand what is “catastrophic” and what is not. Is a chest pain an early signal of heart problems or is it simply a muscle ache? Is a persistent headache the result of stress or a brain tumor? The impact of the doctor’s suggestion, enthusiastically promoted by the *Times*, would be to prevent those who cannot afford to pay from getting tests and consultations aimed at answering these and many similar questions.

Next, James A. Reiffel, M.D., professor of clinical medicine and director, electrocardiography laboratory,

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Columbia University Medical Center, New York, argues for tort reform, something long campaigned for by Congressional Republicans and supported by Obama. Dr. Reiffel says, “Some doctors often order tests to confirm a suspected diagnosis—even when the suspected diagnosis is likely correct with a high degree of certainty—out of concerns regarding the potential for malpractice suits in our current litigious climate.”

The effect would be to prevent patients and their families from seeking legal and financial redress for injuries and deaths caused by medical errors. Alderman notes that the Obama plan already makes a step in that direction, including a provision awarding “five-year grants to selected states to develop alternatives to current tort litigation.” Again, the impact is to encourage doctors to stop giving supposedly “unnecessary” tests.

Dr. Lisa Bernstein, internist and associate professor in the department of medicine at Emory University School of Medicine in Atlanta, Georgia, advocates “spending adequate time gathering information and using actual research data to guide judicious ordering of tests and prescribing of treatments.” This is known in the medical community as utilization of “comparative effectiveness research.”

The *Times* notes that the new legislation calls for the creation of the Patient Centered Outcomes Research Institute. The goal of this panel is to identify treatments that have not been shown to provide adequate levels of positive patient outcome—i.e., they may have benefited what they consider an insignificant number of patients.

While the function of this body is clearly aimed at targeting treatments and services for rationing, the *Times* laments the fact the “institute’s findings could not be construed as mandates though, or used to deny coverage.”

Under the subheading “Stop Overtreating,” the article quotes Dr. H. Gilbert Welch, who says, “There are some people who would benefit from more medical care, but there are many more who are getting too much.” Dr. Welsh is a professor of medicine at the Dartmouth Institute of Health Policy and Clinical Practice in Lebanon, New Hampshire, publisher of the Dartmouth Atlas of Health Care.

The WSWS has analyzed the Dartmouth Atlas study in depth. (See “The Dartmouth Atlas of Health Care study: Shoddy science in support of health care cuts”) Its methodology has been promoted by the Obama administration as a justification for reducing and rationing care.

Among those who are “overtreated,” according to Welch, are those who are dying (“for whom our aggressive care can be inhuman”) and the healthy, “in whom we feel increasingly compelled to look hard for things to be wrong.” Welch bemoans the fact that “screening scans, for instance, find more small cancers and early heart disease.” Presumably, it would be better if cancer and heart disease were only discovered in its late stages.

Welch also worries that “contracted definitions of what’s normal label more people as having disease, such as hypertension and diabetes.” These people should be denied treatment, Welch implies, even if doing so can improve their living conditions and potentially save their lives.

In a September 2008 speech, Obama budget director Peter Orszag, then director of the Congressional Budget Office, hailed Dartmouth Atlas, asserted there is “little evidence that extra spending gets us anything in terms of reduced mortality rates or higher quality.” There is nothing accidental in the *Times* dropping in this quote from Dr. Welch, and it also gives the lie to the suggestion that this is an ordinary cross section of doctors.

Finally, Ms. Alderman quotes Edward Hallowell, a psychiatrist practicing in New York City and Massachusetts, who states, “What’s in jeopardy in medicine—for a host of reasons—is the human connection between doctor and patient.”

Dr. Hallowell’s sentiments undoubtedly reflect a widespread concern among health professionals who experience firsthand strains between doctors and their patients. He says, “Doctors, patients and insurers alike should work together to recreate the familiarity, the warmth, the trust and the friendly alliances that used to define patient-caregiver relationships.”

Under the for-profit system of medical care in the United States, however, which is upheld and enshrined by the Obama health care legislation, these relationships are assured to erode even further, as patient costs rise and services are limited on the basis that life-saving treatments are “unnecessary” or have not been proven “cost-effective.”

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