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Mark Masselli: This is Conversations on Health Care. I am Mark Masselli.

Margaret Flinter: And I am Margaret Flinter.

Mark Masselli: It's the dog days of August and Margaret and I are on vacation but we planned ahead and we are bringing you a brand new episode for your listening ears.

Margaret Flinter: Alright. Mark, so let's jump right into today's show and introduce our guest.

Mark Masselli: Today, we will be speaking with Dr. M. Gregg Bloche about his new book titled The Hippocratic Myth: Why Doctors Are Under Pressure to Ration Care, Practice Politics, and Compromise their Promise to Heal, published by Palgrave Macmillan.

Margaret Flinter: No matter what the story you can hear all of our shows on our website www.chcradio.com, subscribe to iTunes and get the show downloaded, or if you want to hang on to our every word and read a transcript of the shows, come visit us at www.chcradio.com and don't forget you can become a fan of Conversations on Health Care on Facebook and follow us on Twitter.

Mark Masselli: As always, if you have feedback, e-mail us at www.chcradio.com; we love to hear from you. Let's check in with our producer Loren Bonner with Headline News.

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Loren Bonner: I am Loren Bonner with this week's Headline News. New figures show that the Department of Health Center for Consumer Information and Insurance Oversight approved additional waivers from part of last year's health reform law. The additional waivers bring the total number up to 1472 according to HHS. Some health care plans, usually offered to low wage workers place caps on how much the policy will pay out in benefits over a year. The health care reform law gradually bans those limits but allows HHS to grant waivers to companies that would be more likely to stop offering coverage altogether than to provide more comprehensive coverage. HHS will stop granting waivers after September.

Have you ever wondered how much you could expect to pay out of pocket if you needed treatment for diabetes or how your insurance plans benefits compare with other companies? Starting as soon as March of 2012 consumers will be presented with this kind of information through a new rule that's part of the health

reform law. Private health insurance plans will be required to provide current and perspective customers with a brief standardized summary of policy costs and benefits. Officials are likening the new summary to the Nutrition Facts Label, required by packaged foods. For insurers, the new form would likely have the biggest sales impact in the individual insurance market, which is expected to grow substantially after 2014 when the bulk of the health reform law goes into effect. Until then the proposed summary will go through a public comment period before being finalized by the Department of Health and Human Services.

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Mark Masselli: Today, Margaret and I are speaking with Dr. M. Gregg Bloche, author of the new book The Hippocratic Myth, Why Doctors Are Under Pressure to Ration Care, Practice Politics, and Compromise their Promise to Heal, published by Palgrave Macmillan. Dr. Bloche is a physician, health policy expert, and legal scholar. Welcome Dr. Bloche. You were a health policy advisor to President Barrack Obama's presidential campaign in 2008 and now you have written a book about why doctors are under pressure to ration care. How does what you are saying in the book relate to the health reform debates? We heard I think probably a couple of summers ago people are up in arms about government death panels and the idea of rationing health care.

Dr. M. Gregg Bloche: Well I am thrilled that health reform has passed and it's on track to being implemented, it's going to provide access to health care to more than 30 million Americans who have not had it. But the next huge step is to get a grip on cost; we just can't afford what we are spending now and we can't afford the rate of increase in health care. Health care spending is the main driver behind long term fiscal deficits that threaten to bring our country down, threaten to undermine not just our national security but our prosperity. So we are going to have to find ways to say no. Let me tell you about Sarah, not her real name. Sarah is a patient who I talk about in The Hippocratic Myth. She was an 80 year old woman who was visiting her daughter and was admitted to the hospital with a massive, she suffered a massive heart attack, was rushed to the hospital obviously by her daughter, was taken to intensive care and put on intravenous medications ____4:55 raise your blood pressure. Almost all of her heart was destroyed; she had what doctors call about 10% ejection fraction. And doctors figured that her case was close to helpless and they told Sarah and they told Sarah's daughter that they didn't think pressing on was going to make sense and meanwhile they were spending tens of thousands of dollars every few days in the intensive care unit to keep her alive. And as soon as the doctors delivered the dire prognosis, Sarah's daughter became upset and the daughter then began paying close attention to clinical details. She questioned the doctors about their intentions, the doctors in turn grew annoyed. One of docs expressed that annoyance to the patient. According to colleagues, he came to Sarah's bedside and told her that she didn't have enough heart muscle to survive and then said have you ever stayed in a really expensive hotel like a Plaza, you know how

expensive a room is, $600 to $800, well how expensive this room is $10,000. Well the daughter threatened to sue, demanded new doctors and insisted that the staff go all out to keep her mom alive and the doctors worried about a lawsuit did so. Then several weeks later Sarah walks out alive and she survives for another year or so.

Now what is the story (Inaudible 00:06:21)? Now you could say it shows how we should never give up hope, you could tell a kind of romantic story about that and it's a moving story. But the problem is that we can't afford to spend like that to try to keep every Sarah alive when the chances are so tiny. In the real world, when we do spend like that, we are taking money away from community health programs, from prevention, from a whole bunch of other activities, from education for poor kids, from a whole bunch of other activities that government engages in that achieve a bigger bang for the buck and we have to make those priority decisions and doctors right now are on the frontlines as the pressure mounts to make those decisions.

Margaret Flinter: You know Dr. Bloche, I think you raise about a 100 issues probably with that story which are all fascinating and important ones to follow up but let me bring it down to a few. One, I think we should acknowledge what The Hippocratic Oath is and your reference to it as the Hippocratic Myth certainly about protecting patients, about a relationship with patients where you stand beside them, fight for them and fight for their interest as you point out people trying to do and sometimes having difficulty doing in the current situation. But it also struck me about another discussion we followed out with many people about the issue of shared decision making and the goal and the trend towards trying to have shared decision making process in which patients and the families end people who know them, people who have a relationship with them, hopefully their primary care provider or other people who stand in that place work with patients to come to a decision based on all the information that they have. So, I guess a question is, is shared decision making one way out of this dilemma or, and I think you alluded to this a little bit in your book is it too much to ask people to make decisions when they are well about what will happen down the road when they are not well and all of a sudden it's reality or conversely to engage in sure decision making when they may be too sick to be able to think clearly about what those options are. Maybe you could talk with us a little bit about that.

Dr. M. Gregg Bloche: I think it's a really important part of the story not just when people are well but also when people are in dire straits so long as they are able to be conscious and aware. And what's really a challenge for a doctor, and here's part of the alchemy of medicine, the art of medicine, what's really a challenge for the doctor, is to have an individualized sense, a personalized sense of how much each patient and how much each family member is able and willing to hear, how able emotionally is each patient and each family member to participate in this process. I can remember once lifting off of an airliner from (Inaudible 9:17) and a person I was traveling with got upset when the pilot said

that the plane was extra heavy because of its load and the takeoff run was going to be especially long, and she said well I prefer not to know that. And there are lot of things that patients and family members prefer not to know and the challenge for doctors is to not impose too much. But within those constraints engaging patients in these decisions wins over trust, it's not just a matter of enhancing people's autonomy in clinical situations and with greater trust may well come a willingness to conserve resources that might only be used irresponsibly.

Mark Masselli: Dr. Bloche, a contributing factor to increase in health care spending is technology and it sort of brings us back to the Sarah story. Sure that had a big impact on her turnaround. But as you noted it's becoming more difficult for us to afford to pay for it. I guess 20% of our GDP is being spent on and heading up. But we don't want to halt technology. So talk to us a little bit about how we can make sure that new technology is being tested not only for safety and effectiveness but also for cost effectiveness.

Dr. M. Gregg Bloche: I think the challenge is this. There is basically two kinds of medical technology that we are developing. We are developing technology that's in the realm of bio-engineering and software that is astonishing in its elegance and its sophistication and at the same time quite crude in what it biologically does; it replaces biological functions rather than curing them, and much of what we do in intensive care units is illustrative. We can intervene with Left Ventricular Assist Devices and other kinds of devices to substitute for what the body as it breaks down is less and less able to do. That's really expensive not only because of the Intellectual Property Protections that the developers of these technologies have but because you really need quite highly trained personnel in order to operate the technologies and you are continuing to operate them to replace what the body does. Whereas genuinely decisive technologies and I am looking back to Lewis Thomas's dichotomy be between halfway technologies and decisive technologies, genuinely decisive technologies like in a prior day the antibiotic revolution perhaps in more recent years the statins for control of cholesterol, they intervene in biological processes, their elegance is of a different sort, it's a biological kind of elegance. It's not cure, internal adjustment of a biology, they fix this and they tend to be really cheap to operate, they are not nearly as fancy in terms of the electronics but they make a bigger biological difference and they are cheaper. So the kind of scientific advance that leads to genuinely decisive technologies is what we ought to be encouraging with Intellectual Property Protection and investment in research. The kind of advance that leads to much more expensive ways to achieve tiny marginal benefits is what we should not be encouraging and that's the main thing along with insurance that's driving or assuring health care spending.

Margaret Flinter: Well I think you make a great point there and we all hope for the decisive advances whether in technology or in treatments. But there seems to be more of the maybe halfway technologies as you describe them than the decisive ones that come forward and certainly one of the hopes of health reform

in reducing cost is trying to identify which medical procedures are the most effective and selectively eliminating care or procedures that don't have demonstrated clinical effectiveness and to this end, the Patient-Centered Outcomes Research Institute that's part of the health reform law sets out to do this with its 9 member board and that board includes patients, doctors, hospitals, drug makers, device makers, insurance payers, health experts so we have got everybody in there. Is this a meaningful step forward? Will this kind of group have the ability to really make those determinations, and going back to the central premise of your book around physicians' roles in fulfilling the Hippocratic Oath would you support those decisions because as you make the point kind of compellingly it really will help find out what doesn't work most of the time for most of the people but it may miss those people who would have been helped.

Dr. M. Gregg Bloche: Well I think that the Outcomes Research Initiative in Health Reform Bill is a huge step forward. We need the data; the vast majority of clinical decisions that docs make today aren't based on science. We are probably not going to be able to swing this around to the point that most decisions are based on science simply because patients vary so much and there is trade-off between doing effective science and having your scientific results being broadly applicable. But it's a huge step forward, we need to do this kind of research I worry that the oversight board for this body is composed of industry stakeholders rather than independent researchers and scientists following the kind of NIH or intuitive-medicine model but it is a big step forward. We are going to have to take the next step though and that next step is saying no to new tests and treatments that this kind of research shows achieve only tiny benefits at great cost. Germany, England and a number of other countries have begun to incorporate this concern into their decisions about treatment but we so far haven't, it's become unspeakable and in Washington both parties are ready to shout the "R" word rationing the other side.

Mark Masselli: This is Conversations on Health Care. Today we are speaking with Dr. M. Gregg Bloche, author of the new book The Hippocratic Myth: Why Doctors are Under Pressure to Ration Care, Practice Politics, and Compromise Their Promise to Heal. Dr. Bloche, the Independent Payment Advisory Board, IPAB, not to be confused with iPad is another hot button issue on Capitol Hill right now. And Republicans and now some Democrats strongly oppose the advisory board which was part of health reform and set up to recommend to Congress ways to control Medicare's growth. I wonder what your thoughts are on this board and could it help us get more financially stable and how does it also tie back to different treatment modalities looking at the evidence-based or comparative research effectiveness that's going out in the arena right now.

Dr. M. Gregg Bloche: Well the IPAB, the Independent Payment Advisory Board a really good example of exactly the cultural politics that we have been talking about, the unspeakability, the possibility of saying no to some beneficial care, the use of the "R" word, rationing. How can the Independent Payment Board

achieve Medicare cost control? Well through a variety of mechanisms dramatically reducing doctors' and hospitals' fees, new policies when it comes to what treatments are and are not paid for, a variety of mechanisms that have in common the creation of incentives to hold back on potentially beneficial care in other words to do this sort of thing that the doctors at Sarah's bedside felt should be done. And of course once we go down that path there will be aplenty stakeholders who represent different special interest groups and folks in politics, there will be aplenty who will point out exactly this that we are denying beneficial care and so IPAB is of questionable political liability. But the Republicans are proposing something that seems quite different but poses the same dilemma, the Ryan Plan for controlling Medicare and Medicaid costs. Well the Ryan Plan would put Americans below age 55 at least into private plans giving them a voucher once they become eligible for Medicare and then it would hike that voucher by an amount that's much lower every year than the extent to which health care costs rise and so would shift cost to individuals so they could do their own rationers or incentivize health plans to offer really low cost plans so that the voucher would cover the cost and then those health plans would do the rationing. So basically any serious proposal for controlling Medicare spending has to involve saying notice on beneficial care and that means that the "R" can be pointed at it.

Margaret Flinter: And Dr. Bloche, you served on the Institute of Medicine's Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care. And as we think about this issue of rationing health care we of course have to be very concerned that we don't lose any of the gains that we have made which are imperfect even as they are to try and address some of the historic disparities in delivering health care or making health care available to racial and ethnic minorities. As you look at this issue, how are you thinking about that and how do we protect those gains in an evolving picture where we have limited resources?

Dr. M. Gregg Bloche: I fear that we are going to go in the opposite direction that we are going to fail to protect those gains. And the reason for my fear is this, that health care continues to soar in cost relative to what everything else costs and what Americans are earning. Government's already setting limits and will be setting more severe limits whether they do so in Democratic or Republican ways more severe limits on what they will pay. And so my fear here is that we are going to have more tiering of health care access by wealth than ever before and I should point out it's not just a matter of income it's also a matter of members of minorities groups especially African-Americans who have the same income have dramatically different levels of wealth. The African-American family that's earning say $80,000 a year on average has much less wealth than the white family that's bringing in $80,000 a year. So if the co-pays are rising, if the employee contributions towards health insurance premiums are rising, if Medicare beneficiaries have to pay more and more of the cost of both their care and their insurance then inevitably you are going to have less number of people going into

different health plans with lower tiers of care. And at this point I think it's going to be very difficult to avoid this and I wish there were a whole lot more talk about this issue when cost control plans are discussed.

Mark Masselli: Dr. Bloche, we like to ask all of our guests this final question. When you look around the country and the world what do you see in terms of innovation and who should our listeners at Conversations be keeping an eye on?

Dr. M Gregg Bloche: Well it's a grand question and I think that those who are making difference and I think that some of the work being supported by the Gates Foundation and others, those who are making a difference overseas in terms of public health measures can achieve much more bang to the buck creating infrastructure in the form of clinics that provide basic care to people, addressing some of the worldwide public health scourges things such as malaria which is killing hundreds of thousands of people and more every year. We have it pretty good in this country despite our debates about health care, making a difference when it comes to the issue of obesity which is not just a matter of individual responsibility and people's lifestyle choices it's also a matter of the kind of social choices we make when it comes to, or the development or whether there are parks, the kinds of choices that businesses make about providing access to exercise and recreational facilities. There are whole lot of policy decisions, I guess I boil it down to this, there are lots of policy decision that we make that are not mainly about health care but they really have a much bigger impact on health than what we do in intensive care units and in other high technology medical places.

Margaret Flinter: Today, we have been speaking with Dr. M. Gregg Bloche, author of The Hippocratic Myth: Why Doctors are Under Pressure to Ration Care, Practice Politics and Compromise their promise to Heal. Dr. Bloche, thank you so much for joining us on Conversations today.

Dr. M. Gregg Bloche: Thanks a lot for having me.

Mark Masselli: Each week, Conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives.

Margaret Flinter: This week's bright idea comes from an organization called CYCLE Kids that's been using bicycles to help kids stay active and healthy for over six years. The CYCLE Kids program centers on a unique curriculum whose lessons in bicycle skills and safety engage children in the broader discussions about exercise and healthy eating. The curriculum specifically include teaching children not just how to ride a bike but bike safety skills, basic bike mechanics, the importance of an active lifestyle and a healthy diet, and the environmental science behind pollution-free transportation. CYCLE Kids founder Julianne Idlet says she was inspired to create what she calls a kids fitness oriented organization after hearing too many stories about the public health epidemic of

childhood obesity. Participating schools and community centers receive bikes and helmets, in-person training for teachers and workbooks to support classroom activities. In the past six years, CYCLE Kids has helped the intercity neighborhoods of Boston and New York begin to address the staggering problem of obesity. So far, CYCLE Kids has reached 2300 students who leave their class energized to talk with family and friends about what they have learned and experienced, and the program continues to grow. CYCLE Kids not only makes kids' bodies healthier it strengthens their minds. The curriculum now meets New York and Massachusetts state learning standards for physical education, reading comprehension, and math. By promoting good nutritional habits, practical and recreational exercise and pollution-free transportation, CYCLE Kids is helping both individuals and communities live more sustainable and healthy lives. Now that's a bright idea.

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Margaret Flinter: This is Conversations on Healthcare. I am Margaret Flinter.

Mark Masselli: And I am Mark Masselli, peace and health.

Conversations on Health Care, broadcast from the Campus of Wesleyan University at WESU, streaming live at www.wesufm.org and brought to you by the Community Health Center.