SCRIPTDOCTOR: MEDICINE IN THE MEDIA

Why & How Ezekiel Emanuel Came to Write His 'What Cannot Be Said on Television about Health Care' Commentary for *JAMA*

By Andrew Holtz, MPH

The title grabbed me right away: "What Cannot Be Said on Television about Health Care." The commentary by NIH bioethicist Ezekiel J. Emanuel, MD, PhD, which appeared in the May 16th issue of the *Journal of the American Medical Association* (**http://jama.ama-assn.org/cgi/content/full/297/19/2131**), echoed some of the themes of this column—that the words and frames used on TV reveal much about the fundamental beliefs of people that shape their health behaviors, and also the beliefs of legislators and others that shape health care policy.

"Today, the United States is undergoing a significant change in the language of medicine," Dr. Emanuel wrote. "There are three phrases that should and can no longer be said about the US health care system without qualification, embarrassment, criticism, or even denunciation: 'The United States has the best health care system in the world,' 'Health care is special,' and 'New is better.'"

I rang up Dr. Emanuel to ask him why he wrote the piece.

"I wanted people to wake up. I really wanted to challenge people. And I'll tell you, if my e-mail is any indication, I've obviously hit a nerve and I've obviously been tendentious," he told me the day after his commentary appeared. "I thought this was just me letting off steam, but I've obviously hit a nerve, which I have to say I didn't anticipate."

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He said the response has been both much bigger and more supportive than he expected. The responses were still coming in several days later when I checked back. "If anything it's gotten more positive," he said. "A lot of people calling me and e-mailing me and saying how much they liked everything I had to say. People are quibbling about this and that, but even people who quibble appreciate things I said."

There's an important difference between long-held concerns about access to health care or insurance coverage and the three points Dr. Emanuel highlights. Instead of just talking about how to get more health care to more people, the media chatter indicates growing doubt about the essence of how the US organizes and delivers health care.

Letter Provides Evidence of Erosion in Confidence

One e-mail sent to Dr. Emanuel offered evidence of widespread erosion in confidence in the US health care system. The note from Princeton professor Angus Deaton, PhD, referred to international polling he's been doing with the Gallup group. Dr. Deaton provided me with a copy.

"Here is what I wrote to Dr. Emanuel based on numbers I calculated from the Gallup data," he said: "In more than 120 countries in 2006, they asked 1,000 or more people identical questions, including one that asked whether 'In this country, do you have confidence in your health care or medical system?' In the US, only 52 percent of people said yes. There is no other rich country in the world with a number like that, and if you slide down the scale of GDP per capita, the nearest country with as low or lower figure is Puerto Rico. Countries that do better include India, Iran, Malawi, or Sierra Leone. The US is 65th out of 119 countries for which we have data on this,'" Dr. Deaton wrote.

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Medicare

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remedy the steep Medicare cuts, Dr. Wilson said that none had been introduced yet.

This year Congress needs to reauthorize the State Children's Health Insurance Program (SCHIP) for low-income children, and Dr. Wilson said "we would be comfortable with" a piece of legislation that would both reauthorize SCHIP and address the Medicare cuts.

"There's long been bipartisan support for stopping Medicare cuts, and where there's a will, there's a way." He added, "When something is important enough, Congress finds a way to fix the problem."

Asked if any of the presidential candidates have Medicare remedial plans that the AMA supports, Dr. Wilson said, "We look forward to working with all of them."

Ending the subsidy the government now pays to Medicare Advantage plans is one way to find money to prevent Medicare physician pay cuts, Dr. Wilson said. The subsidy, he said, increases reimbursement by 12% for Medicare Advantage plans compared with traditional fee-for-service Medicare plans.

If the Medicare Advantage subsidy were eliminated, it would save about $65 billion over five years, Dr. Wilson added. In April CMS announced the Medicare Advantage capitation rates for 2008, which will increase by about 3.5%—a rate of growth that is less than the 4.3% estimated Medicare growth trend for 2008.

Action to prevent the cuts should be taken sooner rather than later, Dr. Wilson said. "We would really like not to come back next year and tell you, 'We told you so.' We think it makes a lot of sense to do something now."

Curtailing Services in Response to Medicare Cuts

In addition to finding that physicians will curtail the number of Medicare patients they treat unless deep Medicare cuts are averted, the AMA survey also found that physicians will make potential changes to their practices.

If payments are cut by 10% in 2008:

- **72%** of respondents will defer the purchase of new medical equipment.
- **67%** will begin to refer complex cases.
- **58%** will discontinue nursing home visits.
- **65%** will stop providing certain patient services.
- **57%** will discontinue rural outreach.
- **54%** would reduce their staff.

These practice-change percentages rise dramatically given the scenario of payments being cut by about 40% by 2015:

- **84%** will defer the purchase of new medical equipment.
- **80%** will begin referring complex cases.
- **72%** will stop visiting nursing homes.
- **85%** will stop providing certain services.
- **72%** will discontinue rural outreach.
- **77%** will reduce their staff.

NCCN Conference

Seeking New Tools for Advanced Breast Cancer

By Ed Susman

HOLLYWOOD, FL—Despite the advent of targeted therapies for advanced breast cancer, the search continues to find agents that will offer more than just life extension, a topic that was discussed here during a featured lecture at the National Comprehensive Cancer Network's 12th Annual Conference on Clinical Practice Guidelines and Quality Cancer Care.

Present knowledge allows doctors to treat advanced breast cancer on the basis of the biology of the tumor, especially indicating an earlier role for use of trastuzumab if tests indicate that the tumor overexpresses the HER2 gene, noted George Somlo, MD, Director of Breast Oncology and High-Dose Therapeutics at City of Hope Cancer Center.

There remain large gaps in knowledge about how to use trastuzumab.

"The patients getting trastuzumab are doing better," he said, pointing out that treatment with biological agents can be effective in treating patients with HER2-overexpressing tumors. "However, when it comes to second-line and third-line treatment we haven't the tools to create a cure."

For about half the women with advanced breast cancer an anti-estrogen approach is reasonable, since about 50% of women have estrogen-positive tumors, Dr. Somlo said. For the women with non-estrogen positive breast cancer, chemotherapy is the main treatment modality. For about 25% to 30% of women who overexpress HER2, trastuzumab and other newer agents such as lapatinib are possible treatments.

There have been a variety of combination trials with drug such as doxorubicin and paclitaxel, and while those studies have produced increased responses, they have not extended overall survival. In some cases— specifically the use of combination docetaxel and capecitabine, and paclitaxel with capecitabine—survival time has increased by about three months.

None of the combinations, however, have been attempted sequentially. "If there was a mandatory crossover design in these studies, it is possible the results might have been similar," he said.

"There remain large gaps in knowledge about how to use trastuzumab. For example, there are no randomized studies about when it is appropriate to stop treatment. "

He suggested an arbitrary stop after six cycles of chemotherapy after a complete response and 12 months more of trastuzumab.

"There are no established tools to trigger either stopping or reinstating therapy," he said. "Hence, one needs to be pragmatic and assess the impact of side effects on quality of life and the risk of inducing resistance with continuing therapy versus fear of relapse. In women with HER2-overexpressing tumors, we tend to keep treating with trastuzumab unless there is a problem with cardiac toxicity."

"The length of time to treat with trastuzumab is a difficult problem,"

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Evaporating 'US Is Best' Attitude

Dr. Emanuel says the reactions to his commentary reinforce his sense that the smug "US is best" attitude is evaporating.

"I think it's dead. Are there going to be holdouts? Absolutely. But I think in general people don't buy it anymore," he said.

He also wrote that the sense that spending on health care is somehow special and different from spending on other goods or services has taken a hit as costs continue to rise. "The tipping point came when the media began reporting that the high cost of pharmaceuticals forced some elderly to choose between drugs and food."

To me, the key phrase here is "when the media began reporting." Some people have always had trouble paying for health care, but news stories about people choosing between health care and other necessities weren't as commonplace as they are now.

That's important, because it reflects changes in commonly held attitudes. It's always easier to report a story that matches the general beliefs and assumptions of news editors. For example, a decade ago public health researchers were seeing and talking about rising obesity and diabetes rates, but I didn't see many reporters or editors covering that news. Ironically, the phenomenon was too new to be news.

Then as the number of reports on obesity piled up, "obesity epidemic" became an accepted and understood term. Now it's easy to pitch a story on some aspect of obesity, because it fits a recognized pigeonhole.

Most major news outlets are conservative—in the sense that their coverage meshes well with the predominant worldview of people in the news business—that is, college-educated employees of medium-to-large corporations who live in or near major cities. (The oft-heard charges that the media are "liberal" have more to do with differences between segments of US society than with anything peculiar about news organizations.)

AP Pick-up

So the decision by the Associated Press to highlight Dr. Emanuel's commentary as one of two articles based on that week's *JAMA* confirms his argument that criticism of the US health care system has become mainstream.

The AP lead was "The US health care system is 'a dysfunctional mess,' and politicians who insist otherwise look ignorant, according to a medical journal essay by a prominent ethicist at the National Institutes of Health."

Even more telling was the balancing comment from a policy analyst who said "a strong case can be made that the US health care system is the best." A few years ago, no such defense would have been needed.

In his *JAMA* commentary, Dr. Emanuel wrote, "The evolution in what can and cannot be said on TV regarding the U.S. health care system confirms and reinforces that there is an important change occurring in how many Americans view the health care system. The change in language suggests Americans now recognize that the system has deep structural problems."

Ezekiel J. Emanuel, MD, PhD, wrote in his *JAMA* piece: "The evolution in what can and cannot be said on TV regarding the US health care system confirms and reinforces that there is an important change occurring in how many Americans view the health care system. The change in language suggests Americans now recognize that the system has deep structural problems....Reform cannot occur without acknowledging that there is a problem."

Outside of Health-Care-Wonk-World

Yet critiques of the US health care system, in everyday conversations and in the media are still in the primal scream stage. Outside of health-care-wonk-world, most people lack the background and vocabulary to articulate the specifics of their dissatisfaction beyond financial pain and overwhelming confusion about how to navigate the system.

Dr. Emanuel agrees: "The first is, the system is so damn complex it's hard for people to figure it out. They understand they don't like it, but it's hard for them to figure out what needs to be changed....And the second thing that I think is true is that the alternatives—there are too many of them, they are too cacophonous—it's very hard for people to figure out what the key points are."

It will take time, and some skilled reporting, to move the public discussion (as seen on TV) from a general plaint to a nuanced conversation about solutions. It's still hard to find much beyond the false dichotomy of status quo vs single-payer or "exposés" of various alleged bad guys (greedy docs or greedy lawyers or greedy CEOs, etc.).

Dr. Emanuel said he looks forward to reporters and editors taking the next step.

"The media need to begin challenging—and I think they have gotten a little more aggressive about this— the pabulum that comes out, and they need to be more skeptical of what is passed out about the health care system," he said. "I want the media to be skeptical and to challenge anyone who uses one of these common tropes."

Fifteen years ago, when the Clinton administration proposed a mammoth new health care financing system, it didn't take much beyond the "Harry & Louise" ads for supporters of the status quo to gain control of the media discussion and ultimately the political process. Dr. Emanuel's observation that you can no longer blithely assert on TV that "the US system is best" or that "health care is special" or that "new is better" indicates that the ground rules for the health care reform debate are fundamentally different now.