

DOES OUR HEALTH CARE LAW PROVIDE FOR DEATH PANELS?

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Reviewing an earlier version of our Health Care Law (HR 3200), Sarah Palin wrote on her Facebook page on August 7, 2009: "The America I know and love is not one in which my parents or my baby with Down Syndrome will have to stand in front of Obama's "death panel" so his bureaucrats can decide, based on a subjective judgment of their "level of productivity in society," whether they are worthy of health care."¹

Then House minority leader John Boehner (R, OH), speaking of the same section of the bill Palin was referring to, said, "This provision may start down a treacherous path toward government-encouraged euthanasia if enacted into law."²

Palin's and Boehner's remarks brought a flurry of criticisms about "misinformation" and "extremist fear-mongering." The term "death panels" was unfortunate, since it allowed those unfamiliar with the Health Care Law to readily dismiss the charge. If Palin had spoken of "health care rationing panels," her charge may have been taken more seriously. Does our current Health Care Law provide for the rationing of health care? Let us consider the evidence.

Background

Currently, about 800,000 doctors treat the 250 million Americans who have health insurance, as well as those without health insurance in their offices, publicly funded clinics, emergency rooms, and hospitals. The final version of our Health Care Law (The Patient Protection and Affordable Care Act), with no planned or funded increase in the number of doctors and nurses, adds 22 to 47 million (depending upon who is doing the counting) to the ranks of the insured. The Obama Administration plans to pay for the expected increased costs incurred by cutting some \$313 billion in Medicare payments over the next ten years.³ This may cause large numbers of doctors to stop seeing Medicare (elderly) patients. The government has noted that our over-65 population is increasing, and that health care costs rise with age. Accurately or not, President Obama repeatedly reminds us that half of all such costs are incurred in the last six months of life. (This is hardly surprising, since individuals are often ill at this stage). Dr. Donald Berwick, the current head of the Centers of Medicare and Medicaid Services (CMS) has said, "The chronically ill and those towards the end of their lives are accounting for potentially 80% of the total health care bill ..."⁴ Thus, the elderly and chronically ill are logical target groups for those seeking to cut costs.

President Obama's Perspectives

In speaking to large groups, President Obama has said that critics of his health care plan accuse it of wanting to "pull the plug on Grandma," which he disavows. However, he has also said the following:

Referring to a woman's observation that, at over a hundred years of age, her mother was very vital with a lot of spirit, which should be taken into account in health care decisions, Obama said, "I don't think that we can make judgments based on people's spirit. That would be a pretty subjective decision to be making. I think we would have to have rules..." [made up by the federal government].⁵

During his campaign, Obama also noted that the elderly who found it difficult to walk because of bad knees or hips might not need surgery, where pain-killers would do.

In 2008, when asked by a reporter if he supported Oregon's assisted suicide and medical marijuana laws, President Obama responded, "I think that the people of Oregon did a service for the country in recognizing that as the population gets older, we've got to think of issues of end-of-life care."⁶ Apparently, when you ask Obama about assisted suicide, he thinks of the elderly.

President Obama's Appointments

President Obama's appointments to key health care positions are quite enthusiastic about health care rationing. They include:

- **Dr. Ezekiel Emanuel** Dr. Ezekiel Emanuel was appointed as health policy advisor at the Office of Management and Budget and as a member of the Federal Council of Comparative Effectiveness Research. Writing in *The Wall Street Journal*, Betsy McCaughey notes that Dr. Emanuel "has written extensively about who should get medical care, who should decide, and whose life is worth living."⁷ Following are brief excerpts from her lengthy article:

"Dr. Emanuel says that health reform will not be pain free, and that the usual recommendations for cutting medical spending ... are mere window dressing. ... True reform, he argues, must include redefining doctor's ethical obligations. ... Dr. Emanuel chastises physicians for thinking only about their own patient's needs. ... Dr. Emanuel believes doctors should serve two masters, the patient and society."

Quoting Dr. Emanuel, McCaughey notes that he believes that only "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."

McCaughey notes that Dr. Emanuel and co-authors presented a "complete lives system" in an article in a medical journal in 2009. They state, "When implemented, the complete lives system produces a priority curve on which individuals aged roughly 15 and 40 years get the most substantial chance [at health care], whereas the youngest and oldest people get chances that are attenuated." Dr. Emanuel concedes that his plan appears to discriminate against older people, but he explains, "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." [That is, his logic suggests that denying care to a 65-year-old that you would give to a 20-year-old is not age discrimination, because the 65-year-old is older!]

Again quoting Emanuel, McCaughey notes that he also puts the youngest at the back of the health care line because: "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.”

“Dr. Emanuel says the ‘major contributor’ to rapid increases in health spending is the constant introduction of new medical technologies, including new drugs, devices, and procedures.” Therefore, “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.”

- **Cass R. Sunstein** Sunstein was appointed President Obama’s Regulatory Czar, and reports to the Office of Management and Budget. He is noted for his fondness for policies which change behavior by “nudging” people – that is, limiting their choices and making some choices more attractive (e.g. cheaper) than others. Sunstein agrees with Dr. Emanuel’s logic. Writing in the *Columbia Law Review* in 2004, he says, “Other things being equal ... the welfare gain from a program saving (say) one thousand people between forty and sixty-five is unquestionably higher than the welfare gain from a program saving (say) one thousand people who are sixty-five and over. ... After all, the sixty-five-year-olds were themselves forty once.”⁸
- **Dr. Donald M. Berwick** President Obama appointed Dr. Donald M. Berwick to head the Centers for Medicare and Medicaid Services (CMS) in a “recess” appointment, when the U.S. Senate was not in session. Hence, Berwick did not go through the normal hearings, nor was the Senate able to vote to confirm his appointment. Dr. Berwick now has control of the agency that provides health care to 100 million seniors, children, low-income and disabled people, with an annual budget of over \$800 billion.

Dr. Berwick has made his views on managing national health care known through many speeches and publications. He is an admirer of Britain’s National Health Service (NHS), and a critic of America’s free market system. In a 2008 article in the *British Medical Journal*, Dr. Berwick criticized our free enterprise system, saying, “I find little evidence that market forces relying on consumers choosing among an array of products, with competitors fighting it out, leads to the health care system you want and need. In the U.S., competition is a major reason for our duplicative, supply driven, fragmented care system.” Berwick praised the British system for rejecting “the darkness of private enterprise,” and said, “I am a romantic about the National Health Service. I love it.” He noted, “You plan the supply [of health care]; you aim a bit low; you prefer slightly too little of technology or a service to too much; then you search for care bottlenecks and try to relieve them.”⁹ In a 2009 interview in *Biology Healthcare*, Dr. Berwick said regarding rationing, “The decision is not whether or not we will ration care – the decision is whether we will ration with our eyes open.”¹⁰ Elsewhere, he noted, “Rational common interests and rational individual interests are in conflict. ... the Holy Grail of universal coverage in the United States may remain out of reach unless, through rational collective action overriding some individual self-interest, we can

reduce per capita costs.”¹¹ (That is, what is best for the individual patient may be too costly for society).

Berwick’s views caused quite a stir among U.S. legislators. After being re-nominated by President Obama (recess appointments last only two years, as opposed to regular appointments), Berwick was finally scheduled to appear at a Senate hearing in November 2010, where Senate committee members were given only five minutes each to question him. Here, Berwick apparently had a miraculous change in his long-held views! He told the Senators that he has long opposed rationing health care, and indicated he believed people who are near death still have a right to medical treatment. He said patients “should get all the care they want and need, when and where they want and need it.” Berwick also said that since we are such a large and diverse nation, he didn’t think a one-size-fits-all scheme is appropriate for the United States.¹²

Rationing Structures Within the Health Care Law

Our Health Care Law contains several structures that can facilitate the rationing of health care. These include the following:

- **The Coordinating Council on Comparative Effectiveness Research.** This new federal agency will determine need after conducting comparative effectiveness research. The purpose of the research is to determine which treatments, technologies and medicines work best (or cost least) in which situations. While on the positive side this could share medical information and improve care, on the negative side, it may lead to one-size-fits-all solutions and allow a federal agency to determine how our doctors treat us. Dr. David Janda, a U.S. physician who testified before Congress, indicated how this would work in our instant-communication-internet society. He stated he, or any other physician, would diagnose the patient before him, send that diagnosis with the patient’s information via the internet to **The National Coordinator for Health Information Technology**, which would send back a treatment protocol to be implemented for that patient. This might even occur while the patient was still in the doctor’s office. When he asked what would happen if he decided not to implement the protocol because of his specific knowledge of a particular patient’s circumstances and medical history, Dr. Janda was told, “Doctors and hospitals which are not meaningful users of the system over time will face penalties.” When he asked how much the penalty might be, he was told the first offense would be \$100,000. Asking what the second penalty might be, he was told it would be a jail sentence. (How’s that for a governmental “nudge”?)¹³

We should note that during committee deliberations, three amendments in the Senate and two amendments in the House that were meant to ensure that comparative effectiveness research would not be used for health rationing purposes were voted down by the Democratic majority.

- **The Independent Payment Advisory Board (IPAB).** This agency is a presidentially appointed 15 member board whose purpose is to hold the cost of Medicare within certain limits, starting in 2014, at first pegged to inflation. After 2018, reductions will be pegged to per capita growth of the economy plus one percentage point. In his speech on the budget in April of 2011, however,

President Obama said he wanted even tighter cost controls, by lowering the percentage to one-half percent.

IPAB will make Medicare cost recommendations to Congress, most probably by lowering payments to doctors, hospitals and other providers for specific services. Congress can pass the IPAB recommendations, substitute its own, or waive them by a 60% majority vote in the Senate. If it does none of these things within a certain time, the Secretary of Health and Human Services will automatically implement the IPAB plan. Since doctors and hospitals will be paid less for the services they provide, many will drop out of the system, and seniors will have the amount of care available to them curtailed, and face de facto rationing via long treatment delays.

The effects of IPAB's decisions may well stretch beyond the government Medicare program, since private insurers often use Medicare rates as a benchmark in paying for services.

Commenting on this agency, Stanley Kurtz of *The National Review* stated, "...IPAB is the real death panel, ... a body of unelected bureaucrats with the power to cut off care through arbitrary rules based on one-size-fits-all cost calculations, just as in Britain."¹⁴

- **Advance Care Planning Consultations.** The Health Care structure that Sarah Palin originally referred to as a death panel was Section 1233 of H.R. 3200 entitled, "Advance Care Planning Consultation." It authorized reimbursements to physicians and other providers to engage in consultations with patients about "advance care planning," which would lead to actionable "physician orders for life sustaining treatment (POLST). The physician or practitioner was to explain "the continuum of end-of-life services and supports available, including palliative care and hospice." Among the four levels of treatments specifically mentioned that the individual may consider are these two: "the use of antibiotics; and the use of artificially administered nutrition and hydration." (In other words, the individual was asked to consider whether he or she wishes to employ antibiotics and be given nutrition and hydration, or whether they would prefer to have an infection or starvation and thirst take their lives.)

The authors of Section 1233 included Rep. Earl Blumenauer (D, OR) who submitted an amicus brief to the Supreme Court in support of assisted suicide in the case of Gonzalez vs. Oregon. Assisted suicide was legalized in Oregon in 2005. Furthermore, Compassion & Choices, a pro-assisted suicide group also claimed credit for this section, stating:

"We are working hard to reach our goal to make end-of-life choice a centerpiece of national health insurance reform. The technical term for our goal is "Physician Order for Life Sustaining Treatment" (POLST). In practical terms, it's a new requirement for Medicare to provide coverage for the 'conversation' – the dialog between doctor and patient about a patient's wishes and options for end-of-life treatment. ... Winning Medicare coverage to fund the discussion will be transformational."

The conversation between doctor and patient was to take place every five years, or more often if the patient's health condition changed, and was to lead to an "actionable" end-of-life plan which was portable and could be executed if the patient wished or was incapacitated. Those medical providers wishing to participate in this program were subject to the approval of the

Secretary of Health and Human Services, and were to be trained in the use of “patient decision aids and shared decision making.” The government was to develop these “decision aids.”

What type of decision aids might the government develop, and which physicians, if any, might not be “eligible” to participate in the program? We might get some idea by looking at a pamphlet meant to be a “decision aid” for military veterans who were having health problems.

In 1997, the Veteran Administration’s National Center for Ethics in Health Care published a 52-page end-of-life planning document entitled, “Your Life, Your Choices.” After reviewing this document, the Bush Administration suspended its use. The Obama Administration brought it back, however. Page 21 of this document, which presents the veteran (who may have put his or her life on the line and lost limbs in the service of their country) with a checklist entitled “What makes your life worth living?” The respondent is asked to “express how you would feel if this factor by itself described you.” Among the 19 items in the checklist are these:

- I can no longer walk but get around in a wheelchair.
- I rely on a feeding tube to keep me alive.
- I can no longer control my bowels.
- My situation causes severe emotional burden for my family.
- I am a severe financial burden on my family.

The respondent is given four columns to check, headed by these words: “Life like this would be:” The first and most optimistic of the choices is “difficult, but acceptable.” The next three choices are: “worth living, but just barely,” “not worth living,” and “can’t answer now.” To make sure the respondent does not miss the point, he or she is then asked, “If you checked ‘worth living, but just barely’ for more than one factor, would a combination of these factors make your life ‘not worth living.’ If so, which factors?” This is followed by: “If you checked ‘not worth living,’ does this mean that you would rather die than be kept alive?”

Those who raised concerns about the government-sponsored advance care consultations, whether or not they referred to them as “death panels,” were accused by others of telling “absurd lies,” fabricating myths, and of being “hypocritical, dishonest, perverted and mendacious.” In any event, the government-funded advance care consultations were temporarily dropped from the health care bill. However, they reappeared in December 2010, having been issued as a regulation by Dr. Donald M. Berwick. The regulation again calls for government funded consultations between patients and health care providers, which may include verbal or written information. Included in the topics to be discussed are “Whether or not the physician is willing to follow the individual’s wishes as expressed in an advance directive.”¹⁵ Under this regulation, however, such consultations are to take place annually, (rather than only every five years), and more often if the patient’s health condition changes. Upon hearing that the regulation was to take effect on January 1, 2011, Rep. Earl Blumenauer’s office “celebrated ‘a quiet victory,’ and issued an e-mail to its supporters stating: “We would ask that you not broadcast this accomplishment out to any of your lists, even if they are ‘supporters’—e-mails can too easily be forwarded. ... The longer this goes unnoticed the better our chances of keeping it.”¹⁶ (So much for transparency).

Supporters of advance care consultations rightly point out that we all ought to think about end-of-life questions, and discuss them with our physician(s). However, Ione Whitlock of *Life Tree* notes that the physician's orders for life sustaining treatment paradigm (POLST) was developed by several pro-assisted suicide groups. She notes that the annual consultation may not be as much an event, as it is a "values-clarification process." This process "is repetitive and often conducted when the patient [or their proxy] are under duress, as the patient's condition changes." While advocates see it as fostering autonomy and clarifying for the patient what they really want, the danger is that "It creates the illusion of 'self-determination' while fostering consensus ethics. ... the iterative, goal-oriented process is designed to reduce the use of what some ethicists call 'inappropriate' treatments, but what others may call ordinary and life-enhancing."¹⁷ Bioethicist Wesley J. Smith notes that the consultations may involve "a constant drip, drip, drip of conversation after conversation after conversation, which only end when the patient agrees to what the doctor or his ethics committee want."¹⁸

Betsy McCaughey, a health policy expert, says: *"Doctors should always be paid for the time they spend counseling patients, including about the tough choices they are making toward the end of their lives. But the government shouldn't be scripting what doctors should say to patients. The government isn't a trusted [or disinterested] educator, it has a stake in reducing the care provided to elderly patients."*¹⁹ *"Medicare officials call the counseling 'voluntary.' Medicare grades and pays doctors based on compliance with protocols. Getting patients to sign advanced directives is one of the measures that affect doctors' compensation. Measure 47 of the **Physician Quality Reporting Index (PQRI)** is 'percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record, or documentation ... that an advanced care plan was discussed.' Until 2015, doctors will earn a bonus for high scores on the PQRI, and under the Obama health law beginning in 2015 they will be penalized for low scores. In other words, if patients don't take the end of the life consultation and follow through by making living wills, it could lower the doctor's pay for the entire year."*²⁰ (Another gentle governmental nudge.)

Conclusion

To keep things in perspective, we should realize that the rationing of health care is already with us. It occurs in a number of ways. The first is the refusal of private insurers to pay for certain procedures, for whatever reason. The second is the operation of hospital ethics committees. Thirty-four states have provided the legal framework for these committees to make decisions about care protocols for their patients. Some 22 of the states do not protect patients or families from denial of treatment based on "quality of life" opinions of the professional personnel involved.²¹ Third, individual states employ rationing in the administration of their health care programs. For example:

In the summer of 2005, Missouri lawmakers cut 90,000 people from their Medicaid program, citing budget deficits. The cuts included funds for "durable medical equipment" which includes feeding tubes and the nutritional formula that flows through them. While patients can apply for exceptions to the law, most were not informed about this option. There is an appeals process, but as of August 24, 2005, 396 out of 427 were denied.²²

In June, 2008, lung cancer patient Barbara Wagner was notified that her oncologist-prescribed medication that would slow the growth of cancer would not be covered by the Oregon Health Plan; the

plan, however, she was informed, would cover doctor-assisted suicide should she wish to kill herself. Similarly, in July, 2008, Randy Stroup, a 53-year-old resident with prostate cancer, but no medical insurance, was initially denied chemotherapy by the state because it was too expensive. However, they offered to pay for his assisted suicide drugs.²³ (Both individuals subsequently received the assistance they needed.)

In 2010, Arizona's Medicaid agency announced it could no longer cover liver transplants for Hepatitis C patients. Medicaid patients will be allowed to stay on an organ waiting list, but when a match is found, they must come up with the money (some \$200,000). Those who can't afford the surgery immediately are placed on a hold list until they can afford it.²⁴

Realizing that these are the facts of life, we must still point out that end-of-life and other treatment decisions are best made at the local level, involving patients, their families, and their doctors, who are most familiar with the medical, psychological, social, religious and familial circumstances involved. They should not be made by remote bureaucratic panels which are not aware of these circumstances, and whose main concerns may be financial. Our health care law does provide for "death panels," or more accurately, rationing panels. This is reflected in the President's attitudes, in those he has appointed to administer our health care system, and in the structures set up therein. As one official noted, "The message is clear: government can save money by encouraging old people [and others] to die a little sooner than they otherwise would.

Instead of being regarded with reverence and cherished, human life is subject ... to a utilitarian cost-benefit calculus and can be sacrificed to serve fiscal policy and the sacred imperative of trimming a budget."²⁵

Endnotes

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