

Written Testimony

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to the

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House of Representatives**

**Committee on Energy and Commerce
Subcommittee on Health**

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Good morning. I want to thank Chairman Pallone and the rest of the committee.

My name is Eric Novack and I am a medical doctor who has spent the last 13 years training and in the practice of orthopedic surgery. In those years, I have had the incomparable honor of taking care of literally thousands of patients and families whose lives have been disrupted by injury and infirmity. I have spent most of the past six years taking upwards of 14 days of emergency room call each month.

I have taken care of the young and the old, the healthy and the sick, the wealthy and those in need. And I make it my philosophy to try to treat everyone with the same level of dignity and respect.

My health care career spans over 23 years: I have worked as an emergency medical technician answering 911 calls in impoverished and dangerous inner cities, as well as in college towns and rural areas of New England. I have worked as a mental health worker assisting in the care of the acutely and chronically mentally ill in Rhode Island. I have volunteered in homeless clinics in San Francisco during the AIDS epidemic. I worked as a resident taking care of countless trauma patients at one of the nation's premier trauma centers in Seattle. I took care of our nation's true heroes, our veterans, at VA hospitals in San Francisco and Seattle. And I have spent the last 8 years in the practice of orthopedic surgery in Arizona.

Make no mistake—the very ability for everyone in this room and your families to seek out the kind of health care you believe is best is under direct assault. And the risk that you will lose control over your health and health care has never been greater.

My testimony will discuss the fundamental importance of protecting patient's rights first when considering health care reform as well as some areas of reform that have already passed and others that are being considered. Health care reform must be built on a foundation consisting of the protection of the right of individuals to be in control of their own health and health care, not special interests or government bureaucrats. If those rights are not made the top priority, they will be lost.

The first and second amendments of the US Constitution, and the rest of the Bill of Rights, have become the bedrock of our free society. Fundamentally, our Bill of Rights is written in a way that restricts government power and promotes individual liberty. They are the rights that were designed to create the framework where a free people could wake up each day and seek the best for themselves, their families, and future generations.

Unbelievably, nowhere in the US Constitution, or in the constitution of any of the 50 states, do any of us have any right to be in control of our own health. And until our last election, nor has there been any modern attempt to protect or preserve those rights in any Constitution. Arizona's Proposition 101 sought to place two basic rights in our state Constitution. First, preserving the right to always be able to spend your own money for lawful health care services. Second, to prevent the government from coercing you

to join a government-sanctioned health system—because once you are forced into a plan, your health care options will be restricted by the rules of the plan, public or private. This was a true grassroots campaign. It was an uphill battle, but a remarkable one—and an idea went from concept to over 1 million votes in 18 months, and came up less than 0.5% short of winning.

Fortunately, the Arizona legislature has courageously recognized the critical issues raised by the initiative, and is on the verge of referring the Arizona Health Care Freedom Act to the ballot in 2010. The basic rights of Proposition 101 are preserved, but the language is more clearly defined and those who run Arizona's safety net health care system believe that their ability to provide care will be protected.

Obviously, health care reforms are now an enormous issue here in Washington. Unfortunately, the reforms that have recently passed and the bulk of those that are being considered do not appear to have much respect for the basic freedoms that the Arizona initiatives seek to protect.

The stimulus bill passed by this body in February effectively gives the federal government nearly unfettered access to every American's most private information: their personal health records. The stimulus bill forces every American to have an accessible electronic health record by 2014. Government bureaucrats can access that information without either permission or notification of patients as long as it is considered 'research'. Perhaps even more amazingly, the government may share or sell our health information to private entities that are doing research without our permission either.

This is so critical that it bears repeating: my personal health records, and those of my family and my patients, must be in an accessible database, presumably over the internet and can be viewed without consent. It is one thing to have your social security number stolen—while inconvenient and sometimes worse, the damage caused by identity theft is fixable.

Once someone hacks into a database with private health information and puts it out there with the intent to harm, however, will be a different matter entirely. That genie cannot be put back into the bottle.

Think that cannot happen? The state of Virginia is currently trying to negotiate a situation where a hacker is holding the personal health information of 8 million people hostage. The data was stolen from government computers. The perpetrators are demanding \$10 million, or they will release the information to the public at large.

Now imagine a single repository--- even if technically not ‘centralized’ on one set of servers--- where 300 million people have our most personal information. The potential for damage and harm is endless.

At least in the private world, each company only can hold so many records—and they understand that losing data, which is rarely as complete as the planned database will contain, could result in such severe penalties and lawsuits as to put them out of business. No one really thinks the government health IT department would be closed down if such a breach

occurred. To paraphrase Milton Friedman, the result would rather be an *increased* budget for the agency.

Nowhere in the health care reforms discussed since the passage of the stimulus do I find any mention of restoring real privacy to medical records. Given that the majority of committee members are attorneys, I would ask if the members would be comfortable if the federal government were to be a place where all private attorney-client communications were stored, and could be used for research purposes without consent.

The stimulus bill contained more than simply a codification of the end of patient privacy. It created the Federal Coordinating Council for Comparative Effectiveness Research. The FCCCER sounds benign. Even more than that, it sounds like something that makes no sense to most anyone who hears it.

The stated goal of supporters is to expand the amount of research being conducted to determine which treatment works better for a given condition. But that is not how it was created. Health and Human Services Secretary Kathleen Sebelius said during her confirmation testimony “When authorizing comparative effectiveness research in both the Medicare Modernization Act and the American Recovery and Reinvestment Act, Congress did not impose any limits on it.”

The reality, and the fear of those of us who have grave concerns about a group of unelected bureaucrats with unlimited power over our health, is that a primary goal will be to determine which treatments and which conditions

the coordinating council members *think* are cost effective. Those cost effectiveness recommendations will then find their way—one way or another—to become a government-controlled health care rationing body.

This would mimic the National Institutes for Clinical Effectiveness (NICE) in England, the same people who delayed and denied herceptin to breast cancer patients because it was too expensive, and who believe that individuals should be viewed as statistics with arbitrarily determined quality life years remaining. It would also, incidentally, mirror the recommendations of former Senator Tom Daschle, who has been very influential in shaping the health care policies of the current administration.

Senator Kyl has made attempts to protect patients' rights by blocking comparative effectiveness research from becoming the basis of a government health care body dedicated to delaying and denying care. He proposed an amendment to the budget bill that would have added those protections. During the debate over the amendment to the budget bill, Senator Baucus stated, "I'm not going to get into all the details and all the various provisions that we must enact to get meaningful health care reform. By meaningful health care reform, I mean controlling costs." The amendment was defeated with only 3 Democrat votes and all Republicans voting in favor.

Using cost control as the driving force behind health reform will turn every American from being a patient into an expense. Without question, those without political power or access, or who perhaps have a rare disease without good lobbyists, will find themselves "cut" from the budget.

In the New England Journal of Medicine (NEJM) in March 2001, Health Technology Czar David Blumenthal, MD, “[g]overnment controls are a proven strategy for controlling health care expenditures”.

This picture should put fear into every senior. Because when FCCCER board member Ezekiel Emanuel, MD, brother of President Obama’s chief of staff, writes that medical student training should move away from the Hippocratic Oath and toward “toward more socially sustainable, cost-effective care”, senior citizen health care is likely to be the first to be sacrificed for the ‘public good’.

The current reform legislation being considered goes even further. It would remove even further the ability for patients to protect themselves from arbitrary bureaucratic power that would determine who gets health care. White House Chief of Staff said of health care reform, “[t]he only nonnegotiable principle is success. Everything else is negotiable.” Apparently, even our right to petition our elected officials is negotiable.

MedPAC, the Medicare Payment Advisory Commission, has for years been in an advisory role to CMS on coverage and payment decisions. Citizens can give input to the Commission and contact their legislators to emphasize the importance of a particular issue of concern. Final determinations are currently made by the Center for Medicare and Medicaid Services after weighing all of these factors.

What is being considered will strip the democratic process out completely. MedPAC will be empowered to make the full slate of recommendations for *every condition and treatment*. Congress will only be able to make an up or down vote on the entire package. So, if the treatment you need to function does not make the cut, you are out of luck.

As a physician, as a patient, and as a family member with loved ones who have health problems, I am very interested in what treatments work, and, just as important, what treatments simply do not work. Health care reforms that put patients first must withstand the same scrutiny.

President Obama recently spoke to the American Medical Association touting the importance of using ‘evidence based medicine’ to figure out what works and what does not.

When it comes to the best treatment for our ailing health care situation, we should do exactly that: “figure out what works,” and what does not. And we have some compelling evidence.

Some of the proposed reforms have been tried already, and in most cases the results have been very disappointing.

Leaders in Congress regularly cite Massachusetts as the model for reform. But what really is going on in Massachusetts, and do we want to repeat it on a grand scale?

Since enacting “universal health insurance” in 2006, Massachusetts’ health care spending has increased at a much higher rate than the country as a whole. And average health insurance for a family of four is now 33% higher than the national average.

Costs are so out of control that legislators and the president’s good friend and supporter, Governor Deval Patrick, are considering a massive increase in the penalties businesses must pay if they do not contribute their “fair share”. The burden on business will be much higher than what the business community and legislators agreed to just three years ago.

To achieve cost controls, the Massachusetts state government is considering forcing people into stringent HMO-style plans, bringing us back to the days of “capitation” of the 1990s, where patients rebelled at the notion that doctors and hospitals were significantly incentivized to *not* give care. Under a capitated system, providers and hospitals get a lump sum based upon the number of people they treat, and only make money if it is not ‘used up’ actually providing care.

A study of the Massachusetts reforms just published in May 2009 in the journal *Health Affairs* noted that 1 in 5 adults was told in the last year that a desired physician was not taking new patients. Despite the state’s “reform,” the number of emergency department visits had not declined.

At a time when the president is focusing so much attention on “what works and what doesn’t,” why would this data be ignored?

In Chicago, President Obama began his remarks with the statement that “one essential step on our journey [to prosperity] is to control the spiraling cost of health care in America.” A piece of that, he claims, is “is to invest more in preventive care so that we can avoid illness and disease in the first place.” That sounds good, so let’s examine the evidence.

Medicare has tried several disease management projects. The idea is that spending money up front to prevent Medicare patients from needing expensive hospitalizations and disease complications will save the government money in the long run. Among the conclusions in the June 2007 report to Congress on the trials: “fees paid to date far exceed any savings produced.” In other words, the costs of administering the plan made the prevention plan *more expensive*—and did not save any money.

The president also touted the impact on health care costs of reducing smoking and obesity. Surprisingly, the evidence shows that reducing our vices – and even improving our fitness – doesn’t reduce overall health care costs. That’s because healthier people live longer, continuing to use the health care system, and still develop end-of-life health problems.

Health researcher Pieter H. M. van Baal and his colleagues from the Netherlands concluded that, “[o]besity prevention, just like smoking prevention, will not stem the tide of increasing health-care expenditures. The underlying mechanism is that there is a substitution of inexpensive, lethal diseases toward less lethal, and therefore more costly, diseases.”

Also critical to the president's prevention plan is the expansion of electronic medical records for every American, which could be accessed anytime, anywhere. This would, according to President Obama, "mean less paper-pushing and lower administrative costs, saving taxpayers billions of dollars."

Once again, real-life data do not bear this out. In analyzing various reports and studies on the effectiveness of electronic medical records, Drs. Jerome Groopman and Pamela Hartzband, Harvard researchers and self-professed Obama supporters, concluded, "[w]e need the president to apply real scientific rigor to fix our health-care system rather than rely on elegant exercises in wishful thinking."

President Obama made clear in his speech, "one thing we need to do is to figure out what works." In medicine, that takes time, patience and intellectual rigor. Policymaking is no different in that respect. Since the health of 300 million Americans is on the line, health care reform should not be rushed for political expediency. We cannot afford to make mistakes that will mean our grandchildren will, in the words of the president, suffer "from spiraling costs that we did not stem, or sicknesses that we did not cure."

Dr. Benjamin Rush, signer of the Declaration of Independence and namesake of Rush Medical College and Rush University Medical Center in Chicago, is purported to have made the case for putting health care liberties alongside our cherished freedoms of speech and the press. If we do not do so, he warned, "the time will come when medicine will organize into an undercover dictatorship and force people who wish doctors and treatment of their own choice to submit to only what the dictating outfit offers."

I have grave concerns about the ability of any federal dictating outfit to keep the best interests of individual patients as the priority.

Recently, I had the honor—and it is most humbling to be a part of taking care of people in need—of taking care of a 94 year old woman who fell and broke her hip. She fit the picture above, and then some. Looking at her and talking with her family, it was hard to believe she functioned as well before her fall as they claimed.

On paper and in person, her chances of dying around surgery or in the few weeks after were great. The anesthesiologist explained to the family that he was very afraid she would not survive the surgery. But the family felt strongly that the benefits outweighed the risks and we proceeded.

This was right around Thanksgiving.

I received a call after Easter thanking me, because their Grandma came in using her walker to Easter dinner and the whole family was there.

I have no doubt that this woman would have failed to ‘make the cut’ in a system where bureaucrats far removed from the bedside and family are put in control of who can and cannot get care.

Orthopedists are often accused of not using straightforward language—broken bones are not sore and they do not sting, they HURT. No matter what name the bureaucrats and politicians want to use, the plan being put

forth by this committee will mean Washington bureaucrats will have the power to DENY YOU CARE.

Health care reforms are critically needed. Our path is unsustainable.

But instead of jamming through a piece of legislation that few will have read and the American public will not have had time to fully review, we should be following the example of the Arizona legislature with the Health Care Freedom Act.

If we are truly in favor of, as the President has said, not being beholden to the “same entrenched interests”, then protecting those rights first should be the number one priority.

Congress should first pass language mirroring the Health Care Freedom Act—and then embark on further health reforms, knowing with confidence that individual liberty will not be sacrificed on the altar of health care reform.

The cynics who shout that we cannot have health care reform without government intruding into our most personal decisions are false prophets offering a false choice.

I urge the members of this committee to consider health care reform legislation that protects individual liberty, preserves privacy, prevents government bureaucrats from having limitless power over our health, is

based upon genuine evidence that proposed reforms could work: in other words, reforms that protect patients first.

Thank you very much for the opportunity to present my views to you today.