that "It would surely . . . be a strange constitutional doctrine which would concede to the legislature the authority to totally ban a product or activity [such as gambling] but deny to the legislature the authority to forbid the stimulation of demand for the product or activity."[4]

During the past decade, however, the Supreme Court has all but repudiated its *Posadas* holding and begun a robust defense of commercial speech. Most pertinently, in a 2001 decision in *Lorillard Tobacco Company v. Reilly*, it rejected a set of Massachusetts antitobacco measures designed to protect young people from advertising, concluding that the state had demonstrated neither that the proposed restrictions would have an effect on smoking by minors nor that they were tailored narrowly enough to preclude unnecessary intrusions on expressive freedom.[5]

How the Court will decide the case that is now bound to come before it is unclear. Whether it will distinguish between the current legislation and the *Lorillard* ruling regarding point-of-sale advertising and outdoor billboards, whether it will tolerate the dampening effect of tombstone advertising on companies' ability to reach consumers, and whether the limits on packaging will be viewed as narrowly tailored or as crippling firms' ability to promote the consumption of a legal product will all depend on how the justices read and apply the Court's precedents. The Court will also need to address the January 2010 decision by the U.S. District Court in Kentucky holding that limiting advertisement to a black-and-white tombstone format would represent a violation of commercial free-speech rights. Inevitably, the political context surrounding the current regulatory move will have an effect. This move was not simply the determination of a state health official or a regulatory body but a bill passed overwhelmingly by both houses of Congress and signed into law by the President on the basis of massive, if contested, evidence about how advertising limits might advance the public health and the protection of children.

But it would be a mistake for us to limit consideration of this issue to constitutional doctrine alone. The encounter over tobacco advertising raises profound questions. Why does the United States alone among advanced liberal democracies extend to advertising exacting protections more commonly afforded to political, social, and cultural expression? How did we come to believe that the exchange of commercial appeals in the marketplace of goods and services should be equated with free exchange in the marketplace of ideas? Are our freedoms really secured by a constitutional doctrine that would limit our capacity to inhibit the promotion of toxic goods? This is an opportune moment to reflect on these questions and their implications for the relationship between public health goals and the rules that should be foundational in a democracy.

Financial and other disclosures provided by the authors are available with the full text of this article at NEJM.org.

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This article (10.1056/NEJMp0909626) was published on January 13, 2010, at NEJM.org.

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Medicine's Ethical Responsibility for Health Care Reform — The Top Five List

Howard Brody, M.D., Ph.D.

Early in 2009, members of major health care–related industries such as insurance companies, pharmaceutical manufacturers, medical device makers, and hospitals all agreed to forgo some future profits to show support for the Obama administration's health care reform efforts. Skeptics have questioned the value of these promises, regarding at least some of them as more cosmetic than substantive. Nonetheless, these industries made a gesture and scored some public-relations points.

The medical profession's reaction has been quite different. Although major professional organizations have endorsed various reform measures, no promises have been made in terms of cutting any future medical costs. Indeed, in some cases, physician support has been made contingent on promises that physicians' income would not be negatively affected by reform.

It is appropriate to question the ethics of organized medicine's public stance. Physicians have, in effect, sworn an oath to place the interests of the patient ahead of their own interests — including their financial interests. None of the for-profit health care industries that have promised cost savings have taken such an oath. How can physicians, alone among the "special interests" affected by health care reform, justify demanding protection from revenue losses?

Physicians might insist that they should be immune from income loss if the causes of excessive health care costs are beyond their control. The American Medical Association (AMA), for example, addresses cost containment almost solely by calling for malpractice reform, suggesting that high costs are the fault of the legal and not the medical system.[1]

Unfortunately, the myth that physicians are innocent bystanders merely watching health care costs zoom out of control cannot be sustained. What we now know about regional variation in costs within the United States suggests that nearly one third of health care costs could be saved without depriving any patient of beneficial care, if physicians in higher-cost regions ordered tests and treatments in a pattern similar to that followed by physicians in lower-cost regions.[2] We also have good reason to believe that physicians in lower-cost regions order and provide evidence-based tests and treatments just as often as their higher-cost colleagues do, but they tend to avoid providing care whose usefulness is not well supported by existing evidence.[3] In short, U.S. physicians could do a great deal to control costs if they were willing to practice more in accordance with evidence-based guidelines and to study more seriously the data on regional practice variations.

Physicians should recognize that the high cost of future medical care is one of the main stumbling blocks to the passage of health care reform legislation that would extend insurance coverage to most Americans who now lack it. Physicians know from experience how people's health is placed at risk when they lack insurance and access to basic, timely care. A profession that has sworn to put the patient's interest first — to conduct itself as a profession and not merely as a business — cannot justifiably stand idly by and allow legislation that would extend basic access to care to go down to defeat while refusing to contemplate any meaningful measures it might take to reduce health care costs.

In my view, organized medicine must reverse its current approach to the political negotiations over health care reform. I would propose that each specialty society commit itself immediately to appointing a blue-ribbon study panel to report, as soon as possible, that specialty's "Top Five" list. The panels should include members with special expertise in clinical epidemiology, biostatistics, health policy, and evidence-based appraisal. The Top Five list would consist of five diagnostic tests or treatments that are very commonly ordered by members of that specialty, that are among the most expensive services provided, and that have been shown by the currently available evidence not to provide any meaningful benefit to at least some major categories of patients for whom they are commonly ordered. In short, the Top Five list would be a prescription for how, within that specialty, the most money could be saved most quickly without depriving any patient of meaningful medical benefit. Examples of items that could easily end up on such lists include arthroscopic surgery for knee osteoarthritis and many common uses of computed tomographic scans, which not only add to costs but also expose patients to the risks of radiation.[4,5]

Having once agreed on the Top Five list, each specialty society should come up with an implementation plan for educating its members as quickly as possible to discourage the use of the listed tests or treatments for specified categories of patients. Umbrella organizations such as the AMA might push hard on specialty societies and pressure the laggards to step up.

Some societies will be tempted to bluff their way through the Top Five exercise, deliberately omitting cost-cutting measures that would particularly affect members' revenue streams. Societies could display their professional seriousness by submitting their lists for review and comment to several societies in other specialties.

Some would object that considerably more comparative-effectiveness research is needed before such lists can be compiled and

implementation strategies developed. And indeed, today we have no idea how to implement a practical plan that would recapture the roughly 30% of health care expenditures estimated to be wasted on nonbeneficial measures.[2] I would guess, however, that if we were trying to save that entire sum of money, we would be proposing "Top Twenty" or "Top Fifty" lists for many specialties, not just the Top Five. I suggest that no matter how desirable more research is, we know enough today to make at least a down payment on medicine's cost-cutting effort. As good citizens and patients' advocates, we should begin where we can.

A Top Five list also has the advantage that if we restrict ourselves to the most egregious causes of waste, we can demonstrate to a skeptical public that we are genuinely protecting patients' interests and not simply "rationing" health care, regardless of the benefit, for cost-cutting purposes. As we inched closer to the entire 30% savings, we would inevitably face increasingly controversial treatment cutbacks — cases in which a substantial minority of experts believed a treatment provided real benefits for many populations. Such controversies should be postponed until the evidence is clearer and a more acceptable national structure for adjudicating such debates is in place.

Another objection might come from primary care specialties. Given the serious shortage of primary care physicians in the United States, due partly to the income gap between that field and others, shouldn't societies of primary care physicians get a pass on the Top Five list? Although I'm sensitive to the urgent need for increasing the primary care workforce, I would argue that all physicians have ethical responsibilities. Showing that we are ready to stand alongside all other specialties in examining our own practices in light of the best scientific evidence is an important aspect of professional integrity and should not be avoided by any specialty.

Finally, the best rebuttal to the antireform argument that all efforts to control medical costs amount to the "government getting between you and your doctor" is to have physicians, not "government," take the lead in identifying the waste to be eliminated. Mark Twain said, "Always do right. This will gratify some people and astonish the rest." Today, meaningful health care reform seems to be in danger of taking a back seat to special-interest pleading and partisan squabbling. If physicians seized the moral high ground, we just might astonish enough other people to change the entire reform debate for the better.

Financial and other disclosures provided by the author are available with the full text of this article at NEJM.org.

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This article (10.1056/NEJMp0911423) was published on December 23, 2009, at NEJM.org.

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American Values and Health Care Reform

Thomas H. Murray, Ph.D.

With the national debate over health care reform careening between tired, well-rehearsed talking points, on the one hand, and deep-in-the-weeds debates over technical details, initiatives, and financing mechanisms, on the other, many people find themselves feeling frustrated and left out of the conversation. Yet most thoughtful Americans would have something meaningful to say about the values we should choose for the foundation of our system of health care.[1] And by focusing on these fundamental considerations, perhaps we can deepen and broaden the discussion of values and public policy.

Our discussion about health care reform is enriched, for instance, when we recognize that a value such as "liberty," though it surely includes the freedom to