

with legally viable options available to support public health.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

From the Department of Public Health and the Center for Obesity Research and Education, Temple University, Philadelphia (J.L.P.); and the Sanford School of Public Policy, Duke University, Durham, NC (K.D.B.).

1. Cohen DA, Story M. Mitigating the health risks of dining out: the need for standardized portion sizes in restaurants. *Am J Public Health* 2014;104:586-90.

2. U.S. Department of Agriculture, Economic Research Service. Food consumption and demand: food away from home (<http://www.ers.usda.gov/topics/food-choices-health/food-consumption-demand/food-away-from-home.aspx#.VBcdRaP4ei0>).

3. In the matter of New York Statewide Coalition of Hispanic Chambers of Commerce v. the New York City Department of Health and

Mental Hygiene, No. 134 New York Court of Appeals (2014).

4. New York City Department of Health and Mental Hygiene, Board of Health Notice of Adoption of an Amendment (§§81.53) to Article 81 of the New York City Health Code.

5. New York Statewide Coalition of Hispanic Chambers of Commerce v. New York City Dept. of Health & Mental Hygiene, 110 A.D.3d 1 (NY App. 1st Dept 2013).

DOI: 10.1056/NEJMp1410076

Copyright © 2014 Massachusetts Medical Society.

Civil Disobedience and Physicians — Protesting the Blockade of Medicaid

Charles van der Horst, M.D.

On May 6, 2013, I was arrested by the North Carolina Capitol Police in front of the doors of the state Senate chamber, protesting our legislature's decision to forgo Medicaid expansion under the Affordable Care Act (ACA). For a practicing physician and professor of medicine, this was an unusual turn of events in an academic career. But given that 23 states have decided not to expand Medicaid, I find it less surprising that I was arrested than that more health care professionals have not taken to the streets to protest the harm being wreaked on our patients by decisions driven by partisan politics.

In North Carolina, many physicians, nurses, and other health professionals advocated for passage of the ACA, writing editorials and letters to legislators and holding a rally with patients in front of the University of North Carolina Hospitals. When the ACA was signed into law in March 2010, and again when the U.S. Supreme Court upheld it in June 2012, we breathed a sigh of relief. No longer would we have to

worry that our patients could not afford the medications they needed. Preventive care provided without copayments could reduce expensive admissions and alleviate chronic shortages of hospital beds. Providing contraceptives free of charge would decrease the number of unwanted pregnancies that shackle teen mothers to unrelenting poverty. We believed that these and many other benefits meant the dawn of a new era in U.S. health care.

Since passage of the ACA, 23 million to 28 million Americans have gained access to health insurance through insurance exchanges, Medicaid expansions, and the mandate that children be allowed to remain on their parents' policies until the age of 26.¹ Several studies have shown a very concrete benefit of expanding insurance: reduced mortality.² If a Medicaid expansion in North Carolina achieved similar results, hundreds of deaths per year could be prevented. Less tangibly, millions of citizens have had a weight lifted from their shoulders and can now feel free to change jobs or pursue less lucra-

tive careers as entrepreneurs or artists, assured that they won't have to go without health insurance.

Yet many states have decided not to expand Medicaid, even though the federal government is bearing 100% of the costs for the first 3 years and never less than 90% thereafter. Those decisions have left 5 million Americans — most of them the working poor, with incomes below the federal poverty level — in the "Medicaid gap."³ I see many such patients in my practice.

In February 2013, before a law was passed in North Carolina blocking Medicaid expansion, health care workers and nongovernmental patient organizations held a press conference at the North Carolina General Assembly building. Then we published an editorial arguing that expanding Medicaid would be financially beneficial to North Carolina in the long run. Our legislature plowed on. So on April 29, 2013, the "Moral Monday" protests began, in an attempt to change the minds of Governor Pat McCrory, House Speaker Thom Tillis, and

North Carolina legislators. To academics, such a quest might sound quixotic, but protests (along with common sense) have helped to lead several conservative Republican governors to change their views on Medicaid expansion. Jan Brewer (R-AZ), John Kasich (R-OH), and Rick Scott (R-FL) had all campaigned against the ACA but eventually supported its implementation. We hoped that protests in North Carolina would have a similar effect.

On that April day, a few hundred peaceful protestors sang songs and carried placards; 17 of them were arrested in front of the General Assembly chamber doors, including leader Reverend William Barber II of the North Carolina NAACP, the historian Tim Tyson, and Duke faculty member and physician assistant Perri Morgan. The following Monday, I was arrested along with 32 others, including lawyers, professors, and activists. By the end of the legislative session in July, more than 900 people had been arrested, and thousands were traveling to Raleigh from all over the state on Monday afternoons. With the protests and arrests receiving constant publicity, our governor, who had been elected with 54.6% of the vote, saw his approval rate drop to 39%, while the legislature's fell to 24%.⁴ The Moral Monday protests, by contrast, remain popular and are known statewide. Our political leaders have not budged, but the protests have educated and informed independent voters about the impact of legislative decisions and fueled a voter-registration drive with enthusiastic supporters.

Although my personal decision to protest was somewhat spontaneous, the rally was not. The

event was carefully planned by a broad coalition of North Carolinians, including environmentalists, voting-rights advocates, leaders in reproductive health, educators, workers, and immigrants, all led by the North Carolina NAACP. The protest was organized in the tradition of civil disobedience, whose history reaches back through Martin Luther King, Jr., and Mahatma Gandhi to Henry David Thoreau. Physicians and other health care workers chose to participate out of frustration at our inability to protect our poorest patients. We could make difficult diagnoses on the inpatient service and express empathy for patients and their families, but when it came to seeing them as outpatients or ensuring that their prescriptions were filled, we were helpless. These problems are not unique to North Carolina.

When I graduated from medical school in 1979, we did not take an oath, but I have since striven to adopt the words of Moses Maimonides as my guiding philosophy: "The eternal providence has appointed me to watch over the life and health of Thy creatures" and "Preserve the strength of my body and of my soul that they ever be ready to cheerfully help and support rich and poor, good and bad, enemy as well as friend." My interpretation of this prayer is that I need not only be a good clinician in the hospital or clinic but also attend to the effects on my patients' lives of the wider world, whether my own hospital or the state government. To be good internists, I believe, even subspecialists are obligated not to ignore our knowledge of internal medicine in order to focus exclusively on lungs or livers; we must pay attention to the

whole patient. Similarly, I now believe that our concern for our patients should encompass the effects of public policies that result in direct harm.

By willfully rejecting a Medicaid expansion to thousands of hardworking North Carolina families, our state government was consigning these citizens to the same fate as many patients I've cared for during research and service projects in Africa — dying needlessly for the lack of appropriate preventive care. North Carolina has high infant mortality (a measure on which we rank 46th in the country), a high rate of low birth weight (40th in the country), and a high prevalence of diabetes (36th). We rank among the bottom 20 states in terms of premature deaths (36th), cancer-related deaths (35th), and deaths from cardiovascular causes (31st).⁵ We are not a healthy state. With so many poor medical outcomes that can be prevented through access to good care, how can we not protest the decision to deny several hundred thousand North Carolinians access to health insurance? And how can my colleagues in the 22 other states blocking Medicaid expansion not speak out as well?

More than a year has passed, and we health care workers are still protesting, joined with a coalition of teachers, union workers, immigrants, environmentalists, and people of all races and religions — all staying on message until we reverse these policies. As health care providers, we know we have an obligation to protect our patients not only from harmful diseases but from the harmful policies and toxic politics of the current leadership in our state. In the face of great

danger to our patients and our state, we believe that remaining silent is not an option.

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

From the Division of Infectious Diseases, School of Medicine, University of North Carolina, Chapel Hill.

1. ACASignups.net. Tracking enrollments for the Affordable Care Act (aka Obamacare) (<http://acassignups.net/graph>).
2. Sommers BD, Long SK, Baicker K. Changes in mortality after Massachusetts health care reform: a quasi-experimental study. *Ann Intern Med* 2014;160:585-93.
3. The coverage gap: uninsured poor adults in states that do not expand Medicaid. Menlo Park, CA: Henry J. Kaiser Family Foundation, April 2, 2014 (<http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured>

-poor-adults-in-states-that-do-not-expand-medicaid).

4. Edwards-Levy A. Gov. Pat McCrory approval rating tanks: poll. *Huffington Post*. August 14, 2013 (http://www.huffingtonpost.com/2013/08/14/pat-mccroy-poll_n_3755335.html).
5. United Health Foundation. America's health rankings (<http://statehealthstats.americashealthrankings.org/#/country/US/2011>).

DOI: 10.1056/NEJMp1410288

Copyright © 2014 Massachusetts Medical Society.

The Affordable Care Act, 1 Year Later

Michael D. Stillman, M.D.

This past year in Kentucky has been extraordinary. Our freshman-heavy men's basketball team nearly won a national championship, our attorney general refused to defend a decade-old ban on same-sex marriage, and our commonwealth's citizens — among the poorest and most underserved in the country — finally gained broad access to health insurance. While the first two events ignited segments of our populace, the third fundamentally altered our medical practice, allowing us to provide data-driven and thorough care without first considering our patients' ability to pay.

Last year, I encountered a patient with widely metastatic colon cancer whose diagnosis had been delayed because of lack of health insurance.¹ He had clearly become ill at the wrong moment in our commonwealth's history. Before Kentucky Governor Steve Beshear decided to implement the Affordable Care Act (ACA) and accept federal funding for Medicaid expansion, the 60% of my clinic patients and 650,000 Kentuckians who lacked health insurance received disjointed and disastrous care. They could be seen

in subsidized facilities and be charged for their visits on a sliding scale, but they were asked to pay in advance for most diagnostic tests and consultations. Many of them avoided routine and preventive care — and worried that a medical emergency would leave them bankrupt.

But during the past year, many of my lowest-income patients have, for the first time as adults, been able to seek nonurgent medical attention. I recently evaluated a 54-year-old man with hyperlipidemia and a systolic blood pressure of 190 mm Hg whose last physician visit had been with a pediatrician. Before he enrolled in Medicaid, he would have been unable to pay for his appointment and laboratory work, and I wouldn't have considered offering him a screening colonoscopy since he would surely have been billed for it. Newly insured, however, he was able to afford the tests and medications that most Americans would expect to receive, and he told me he felt proud to have witnessed a sea change in health care delivery in Kentucky and that recent reforms seemed "just."

Expanded health care cover-

age has also improved residency education in Kentucky — a benefit that few of us anticipated. Before the ACA, many of our poorer patients declined preventive measures, had limited access to first-line medications, and avoided hospitalization for fear of financial ruin. The residents I taught were hamstrung in their efforts to care for the uninsured and were forced, against their better judgment, to offer and become accustomed to offering substandard and incomplete care. A graduating resident recently reminded me of two patients we had seen during her intern year who ought to have been admitted to our cardiac service for monitoring of unstable arrhythmias yet who, dreading the onslaught of medical debt, had opted for riskier but less expensive outpatient treatment.

One year after the law's implementation, residents at my hospital can finally provide guideline- and evidence-based care. Since 92% of our clinic patients are now insured, we no longer receive fretful looks when we recommend laboratory tests, we screen for colorectal cancer with colonoscopies rather than with less