References

1. Brody H. The AAFP access plan: getting it almost right. J Am Board Fam Pract 1992; 5:655-6.
2. Ginzberg E. Health care reform — where are we and where should we be going? N Engl J Med 1992; 327:1310-2.
3. Woolhandler S, Himmelstein DU. The deteriorating administrative efficiency of the US health care system. N Engl J Med 1991; 324:1253-8.
4. Letters. N Engl J Med 1991; 325:1316-9.
5. Gauthier AK, Rogal DL, Barrand NL, Cohen AB. Administrative costs in the US health care system: the problem or the solution? Inquiry 1992; 29:308-20.
6. Wennberg JE. Outcomes research, cost containment, and the fear of health care rationing. N Engl J Med 1990; 323:1202-4.

To the Editor: I would like to comment in reference to the editorial in the November–December 1992 issue entitled "The AAFP Access Plan: Getting It Almost Right" by Howard Brody. Dr. Brody contends that health care in the United States is a "nonsystem." He relates that it is administratively inefficient and drives up costs two ways: "First, more employees are needed to process all the different payers. Second, more employees are needed to track each item of care and supplies dispensed . . . ."

Certainly, few physicians in private practice would argue that a more simplified system is needed. However, Dr. Brody's solution to this administrative waste is a single-payer system. A single-payer system, I assume, would be the government, or more specifically the federal government. He further contends that the only reason not to take that last step (of creating a single-payer system) is to maintain "the ideological veneer of private enterprise."

I am left to conclude, therefore, that Dr. Brody's answer to reducing administrative waste and a burgeoning bureaucracy in our current health care system is to turn the whole thing over to the federal government, the same government that has created a $4 trillion deficit and increases it daily by $1 billion. If this is Dr. Brody's contention, then I will take "the ideological veneer of free enterprise" over federal peckerwood any day.

Neal D. Jacobson, DO
Baker City, OR

The preceding letters were referred to the author of the article in question, who offers the following reply:

To the Editor: Dr. Gillette notes a number of obstacles to the implementation of substantial health care reform in the United States. What are physicians to do when truly basic reform seems "politically nonviable" and the status quo is both ethically and economically nonviable? I argue that we ought to see what can be done to marshall political support behind a single-payer system. Whatever we do will have serious drawbacks in its implementation phase. A single-payer system seems to me to provide the sort of framework that will allow the drawbacks to be sorted out quickly and to allow physicians who care about patients' concerns to champion quality of care most effectively.

A brief form of Dr. Jacobson's comment might be, "If you like the Post Office, you'll love national health insurance." We should first recall, however, that a single-payer system need not necessarily be a government-administered system; there are numerous alternative models. Second, the facts about government waste and inefficiency might not square with our natural prejudices — for instance, why does the US Social Security System pay 5 percent for administrative overhead while the average private health insurance company pays 15 percent?

Howard Brody, MD
Michigan State University
East Lansing

Newsletters in Family Practice

To the Editor: I wish to compliment Dr. Shaughnessy and colleagues on their important original contribution to the continuing education of family physicians, "Survey and Evaluation of Newsletters Marketed to Family Physicians,"[1] which was objective, balanced, and fair.

The authors evaluated eight newsletters and summarized their data in helpful graphs. What was missing, however, was any elaboration of the subjective differences in these newsletters, which are large and important.

Questions that readers will have include the following: is the content directly relevant to office practice? Is the style readable and engaging? Is the point of view that of a generalist or a specialist? The most important question is whether there is a consistent philosophy of medical care and practice presented or are the chosen abstracts supposed to represent a value-neutral smorgasbord of noteworthy recent literature. The studies that are left out of these newsletters are as important as what is included. These choices are not random and are worth considering; they should be made explicit. For the record, I would like to state mine.

My goal in presenting *The Family Practice Newsletter* is to identify, synthesize, and persuade. I present my data from the perspective of an individual, practicing, generalist physician who is looking at a large amount of expert information both from peers and from specialists in other fields. I convey the personal dilemmas that I have faced in trying to scan a too voluminous literature, in trying to extract the small amount that can and should become familiar to practicing physicians, and in trying to incorporate these individual pieces of data into a coherent, systematic, and value-laden framework.

Two central biases permeate all of my work — that the practice of medicine should make sense to the practitioner and that the appropriate response to modern information overload is strategic learning (as through newsletters) and strategic practice. Strategic

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