References
1. Brody H. Moral values in health care reform: implications for family practice. J Am Board Fam Pract 1994; 7:236-41.
2. Sade RM. Medical care as a right: a refutation. N Engl J Med 1971; 285:1288-92.

The above letter was referred to the author of the article in question, who offers the following reply:

To the Editor: Because Dr. Chop is doing precisely what I recommended in the article to which he refers — seeing the debate about health care reform as involving ethical issues and not merely political and economic issues — I can hardly criticize his conclusions too severely. A few brief reactions might, however, be informative.

The basic moral difference between Dr. Chop's position and my own appears to lie in the relative priority of libertarian or individualistic values and what are increasingly being called "communitarian" values. Those who hold that the American political tradition should adhere solely to libertarian values would, of course, denounce any government-run health care system or indeed any health care system at all that depends upon either taxation or mandates. But these libertarians must then deal with important criticisms of their view of the individual — that they have created an unrealistic portrayal of an isolated, atomistic being whose membership in families, communities, and other social and cultural units is irrelevant to the moral definition of selfhood. In addition, this system of morality is totally inadequate to define what would count as a compassionate or caring society, once we get beyond the procedural stipulation that all members of the society must have freely consented to whatever is done.

This view of the American political tradition was discussed within the ethics working group to the "secret" Health Care Reform Task Force and was rejected in favor of a view which holds that Americans have always adhered to a balance between libertarian and communitarian values, even when our political rhetoric seemed to deny the existence of the latter. (It might be of some interest that it was more the religious, rather than the philosophical ethicists, in the group who took the lead in demanding that we confront the communitarian values as an important component of our political tradition.) On this view, human individuals are fundamentally beings who live in societies, and the societies in which we live and in which we have been raised form an important element of our identities as persons. Not only is a good society one in which we assure a wide range of basic liberties equally to all citizens, but it is also a society in which, when it comes to important personal and social goods, some balancing occurs between individual liberty and other basic values.

My colleagues who practice and teach in such countries as Canada, Australia, and New Zealand would deny heatedly that their nations do not cherish individual liberty. (They might add that what they see in the US is not cherishing of liberty but some form of idolatry.) They certainly believe that nationalized health care in their countries, particularly in the old days when funding was more plentiful, is fully consistent with respect for individual freedom as a core political value.

Returning to the practical level, I see every day in my own practice how my own choices and the choices of my patients are constantly being eroded. Seldom is it government interference, today, that is the culprit; instead it is the operations of the "free" market system as both employers and insurers seek to maximize profits. As new insurance and managed-care contracts are signed, the rules of the game seem to change month by month, and the hassle factor rises exponentially. I can only conclude that if I want to practice the sort of medicine that I was trained to practice and to serve the needs and interests of all of my patients (not just the temporarily well-insured ones), the Clinton plan would offer a much more positive environment than the present fragmented, market-driven nonsystem.

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To the Editor: On reading Brody's article[1] on the virtues behind the Clinton health care plan — the third such article that I have read on this very same subject[2,3] — I was reminded of Mark Twain's observation, "The more he spoke of virtue, the more we checked our wallets."

Why do we need to be told over and over again that Clinton's plan is virtuous? After all, most Americans do support universal access to health care.

Robert Blendon of the Harvard School of Public Health explains that the public has a low level of confidence in the government. "Unfortunately, complex plans require a very high level of trust of political leaders, because you basically have to say — 'Look, I can't understand this, but I trust you.' And Clinton does not have that level of trust."[4]

The public fear is that decisions about medical care will be made by a blind bureaucracy; Americans fear that their personal physicians will be replaced by an impersonal "doc in the box" who worries more about cost containment than treating their illnesses. Another fear of older Americans is that the Clinton health care plan will actually decrease their medical coverage, especially if rationing is instituted in the future.

Brock, who was also on the Clinton ethics panel, admits that "Health plans facing cost containment pressures would make many decisions about what type of treatment is appropriate given the cost, and they would seek guidance from . . . authorities about what limitations they impose."[2]

Civil libertarian Nat Hentoff[5] has observed that Hillary Rodham Clinton's statement that "people will know that they are not being denied treatment for any other reason that it is not appropriate — *will not enhance or save the quality of life*" (italics mine) could mean being denied treatment if you are judged to have

a poor quality of life, i.e., if you are old, retarded, or chronically ill.

Several years ago, publisher Frances Lear[6] predicted that the economic pressure of caring for the elderly will lead to an increased use of living wills, nontreatment decisions, and the legalization of physician-aided dying. One indeed wonders whether the recent propaganda deluge promoting "voluntary" physician-assisted suicide has a connection with the need for cost containment. When the Administration turns to proponents of euthanasia, such as Brock[7] and Brody,[8] to write the ethics behind their plan, when our beloved Surgeon General supports assisted suicide for the seriously ill,[9] and when the White House director of disability outreach thinks this "right" should be granted to the disabled,[10] it makes one wonder.

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Nanty Glo, PA

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6. Lear F. Lunch with Fanella Rouse. Lear's 1991 (Oct):17-9.
7. Brock D. Voluntary active euthanasia. Hast Cent Register 1992; 22:10-22.
8. Brody H. Assisted suicide: a challenge for family physicians. J Fam Pract 1993; 37:123-4.
9. Surgeon general backs assisted suicide. Nat Catholic Register 1994 (June 12):7.
10. Gianelli DM. Michigan ponders the particulars of assisted suicide. Am Med News 1994 (Apr 11):2,12.

To the Editor: Dr. Brody's insightful article "Moral Values in Health Care Reform" (May-June 1994) was greatly appreciated. His insider view was most interesting. Perhaps pseudoinsider would be more appropriate, as he was a consultant and not a member of the ethics subgroup.

His status raises a question about the merits or ethics of the entire process. Medical professionals were not initially included in the working groups, and only a relatively few were added as consultants when the outcry became bothersome to the Clinton administration. This purposeful exclusion of those best qualified to address health concerns is problematic. Further, these lawyer-bureaucrat groups were chaired by a person who has no pertinent qualifications whatsoever other than being married to the President. President Clinton governed Arkansas for a decade, and that state never ranked above 49th for health care. I would be hard-pressed to come up with a group less qualified to make health recommendations.

Perhaps these lawyers and bureaucrats would let a group of practicing physicians draw up a plan for controlling escalating legal and bureaucratic costs. Such a plan would limit their numbers to a percentage of the population equal to other countries, which would greatly decrease their numbers. A global budget rate fixing, requiring that 55 percent not work in specialty areas, such as malpractice and product liability, and requiring them to work for one of three government-controlled companies would also be a part of such a plan. Of course, accepting money from a client would be a felony just as accepting money from a patient under the Clinton plan would make me a felon.

I think regulation without representation is fully as immoral as was taxation without representation.

Indeed, my major opposition to this health plan is not based on any particular aspect of the plan (although it is filled with ill-advised ideas). It is based on the immoral way in which the plan was drawn up and the immoral underpinnings of centralized control upon which it is constructed.

Dr. Brody asserts that a driving force for health care change is the "widely agreed" upon idea that health is taking money that could be used to make "our nation more competitive." First, "widely agreed" is not the same as true. Second, the use of warm and fuzzy phrases like making "our nation more competitive" means precisely nothing unless there are specific ways to accomplish this. Even supposing this plan could save money (which it cannot and will not), there is no reason to expect that these imaginary savings would make our nation more competitive — whatever that phrase means.

The rationale behind this competitiveness idea that business will spend less on health care is obviously false. Most of our present economic and job growth comes from small businesses that often do not offer cradle-to-grave benefits. Forcing these businesses to buy health insurance will make them *less* competitive. Because many physicians fit this group, then physicians' expenses and health care costs will also rise. Second, the added cost of insuring marginally productive workers will increase unemployment by making these workers unemployable.[1-3] As unemployment increases, tax revenues fall. To make up for this, remaining workers and businesses must pay more taxes, further lessening our competitiveness, not to mention that the unemployed worker loses esteem, income, and training that would have qualified him for a better paying job. The net result is a *less* competitive nation.

Further, the health care "problem" was never defined by the Administration; therefore, any "solution" is fatally flawed. Eighty-seven percent of Americans are insured.[4] Of the remaining 13 percent, nearly one-half earned more than twice the poverty level (> $23,000 for a family of four) and could be expected to pay for their health care or insurance.[1] A full two-thirds of the uninsured are *not* poor.[5] Most of the uninsured were uninsured for only a short time. The chronically uninsured number only 3 percent of the population. All the elderly have insurance (Medicare). The poor have Medicaid. All pregnant women and women and their families with young children who cannot afford insurance are already eligible for insurance. All emergency depart-