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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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-

ments must provide care for anyone seeking it regardless of income or insurance status. For the elderly and persons with heart disease, kidney disease, cancer, spina bifida, prematurity, etc., survival rates are best in the United States.[6] Could it be that we get what we pay for? Most health care dollars are spent in the last year of life. Could it be that health care costs are so high precisely because of such existent government insurance programs as Medicare?

I am not saying that no problems exist, but the problems are wrongly defined by socialized medicine proponents such as the Clintons.

I also believe that health care problems are best dealt with by the people and not the government. Government is not the cure, it is a major part of the problem. As Dr. Brody states, the Resource-based Relative Value System plan (a much simpler concept than the present massive national health plans) had an effect exactly opposite what was intended. The saga of the Clinical Laboratory Improvement Amendment (CLIA), a minor health care laboratory regulation, is illustrative of what government can do for health care. From the *Federal Register* of 28 February 1992, we read the following. "The final rule will significantly increase expenses." "Facilities and individuals in underserved areas will be *most* affected." (In other words, government placed a disproportionate burden on those least able to support it.) "The CLIA program could thwart larger public health objectives by hindering screening services to the poorest Americans." "There exists no irrefutable evidence demonstrating that performance will improve under regulation." The cost of this one bill is equal to a full one-third of all physicians' income. Total government control of health care would be even more disastrous.

I offer a few other criticisms:

- The plan offers no solution to lawyer-generated problems — a considerable cost in health care. This is not surprising, given the plan's authors. I challenge the ethics committee to debate the question, "Is the failure to address legal-generated costs in the present proposal unethical?"
- Although two-thirds of Americans are displeased with our system, 90 percent are pleased with their own health care.[7] This high level of personal satisfaction and paradoxically high public dissatisfaction is explained by the constant barrage of doom-mongers trying to socialize medicine. I have grave reservations that a system with a 90 percent approval rating is really that bad. Health professionals responsible for this incredibly high level of satisfaction should be proud of our system rather than guiltily hoping that the government grants a few more relatively unencumbered years prior to the deluge of socialized medicine.
- A poll showed that when asked to pay $50 a year more for health reform, support dropped to less than 30 percent.[1]
- There would be long lines at McDonald's if hamburgers were free. Quebec found that 60 percent of the increase in health care consumption that followed their socialization of medicine was due to higher use and not to treating previously untreated individuals. At the US airbase I just left, our populations used the more expensive emergency facilities at more than five times the rate of a similar population without free care.
- Canada's health costs are rising faster than our own.
- Under the Clinton plan, political appointees, not patients or health care workers, would decide how much to spend and what (and what not) to treat.
- It would be a felony punishable by 15 years in prison to accept money from a patient under the Clinton health plan.
- Forty percent of the 1 million Canadians awaiting surgery for up to a year or more are suffering great (and needless) pain.
- No more than 45 percent of physicians could be specialists, and racial and ethnic quotas would be imposed to fill available spots.
- The drug industry would be completely controlled, effectively halting new product development. For example, Canada has not developed a new drug in 20 years as a result of its version of socialized medicine.
- Behavior is the cause of much morbidity and mortality. The national health plan will weaken even more the link between actions and consequences.
- Remember the short-lived catastrophic health care plan? Even though equitably funded and inexpensive, pressure groups like the AARP forced its repeal because the elderly would have to pay some of the costs. And the elderly are the demographic group with the highest income.

I greatly appreciate that Dr. Brody did not resort to calling anyone who opposes this plan stupid, greedy, or worse. I think the behavior of the Clintons and others who respond to opposition by insulting name-calling is disgraceful. The loss of freedom, increased costs, and decreased quality of care that I believe would result from any national health plan concern me as a patient and a physician. Surely we can do better than this?

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

To the Editor: Dr. Baxter's thoughtful letter raises many points, which space will not permit me to answer in detail. Responding to only two of them: first, to the extent that I can extract a principle that underlies Dr. Baxter's objections to the Clinton approach, it is that the government should not be involved in administering health care in the United States. Although this principle could be elevated to some sort of moral absolute, it seems to function in Dr. Baxter's arguments instead as an empirical assumption — if the government becomes involved in something, it is sure to fail or at least to become more expensive. Certain facts currently belie this conclusion. Advocates of a single-payer plan have pointed out that while the administrative overhead costs of government-run health care systems, both in the US and abroad, run below 5 percent, the current administrative overhead in the private United States insurance industry tends to run between 15 and 20 percent. (Incidentally, by so far refusing to advocate a single-payer plan and insisting that he intends to guarantee *private* insurance to all Americans, Clinton has clearly positioned himself *against* what would most correctly be defined as "socialized medicine" to the extent that his plan is estimated to save much less money in the long run than would a single-payer plan.)

The Health Reform Task Force process in spring 1993 brought more than 500 persons into the Executive Office Building during a 6-week period and in the opinion of at least some Washington health insiders, was the most *open* effort made within anyone's memory to obtain massive expert and public input into the design of a national health care program. Why, then, were medical organizations (as opposed to individual physicians, who were much in evidence) excluded? I cannot imagine that, had this effort occurred in 1960 or 1970, the American Medical Association (for instance) would not have had a front-row seat throughout the planning process. I think the reasons for the exclusion of our medical organizations are obvious. First, our history during the past 50 years is not helping to shape meaningful reform but is steadfastly opposing virtually any reform, no matter how necessary. Second, and even more important, the pronouncements from organized medicine give very little evidence of a *principled* stance on what would truly be in the best interests of our patients; instead they are a rather tired recitation of what best serves physicians' pocketbooks (with the stance of the American Academy of Family Physicians and some other groups, such as the American College of Physicians, something of a refreshing exception). My purpose in writing my article on ethical principles was to encourage all of us in medicine to get back in touch with our core value commitments so that in the future we can provide the leadership which has been lacking up till now.

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