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DARING TO TELL THE TRUTH ABOUT HEALTH CARE

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An Essay on Freedom Principles

Joel McCloskey
Merit Scholarship
Winner– 2003

"We hold these truths to be self-evident that all men are created equal that they are endowed by their Creator with certain inalienable rights, that among these are Life, Liberty, and the pursuit of Happiness."[1] At the time of the Declaration of Independence, this was a rather bold statement. The general idea among most people was that the aristocrats and upper-class were so much higher in importance than the lower-class citizens. This statement made by the forefathers of our country was to say, "We do not believe that the upper-class people are worth more than the lower and we will not stand for it." They wanted a country where people were treated fairly and everyone had an equal opportunity to succeed.

The statements of equality in the Declaration of Independence came from the belief in God that many of the writers held. [2] Equality, as they knew, comes directly from God and it was God who invented the idea of all men being equal. Colossians 3:11 says "Here there is no Greek or Jew. circumcised or uncircumcised, barbarian, Scythian, slave

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Dr. Ian Bogle

Speech excerpts from the Chairman of Council of the British Medical Association
Monday 30 June 2003

Chairman, members of the Representative Body. This is my last speech as Chairman of Council...

I have been at the helm of the BMA during one of the most interesting and challenging periods in its history – moves towards greater openness and accountability in assessment of performance and fitness to practise, three major contract negotiations and a government modernisation programme that will have far reaching consequences for the future of the health service and the future of the medical profession.

When I leave this stage for the last time on Thursday, I will be bowing out of medicine and medical politics for good.

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Towards Socialized Medicine A Historic Chronology Part I

Edward R. Annis, MD

Edward Annis, M.D. and Robert Urban M..D.

We are at war --- an unconventional war. I am not referring to our nation's war against the terrorists --- no. I am referring to war as described by Webster as

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being in a state of forceful opposition. It has been carried on for a number of years, slowly, craftily and by surreptitious incrementalism with such success that most doctors fail to realize its true origins or the sources of its present strength.

In the 1920s, England had a group of primarily wealthy heirs, writers and self-styled intellectuals who founded the Fabian Society, its aim to transform Britain into a socialist society.

They were the authors of permeation which purpose was to infiltrate major political parties so that socialistic programs could be implemented no matter which party was in power.

Shortly thereafter the Fabians assisted the formation of a sister society in the United States called the Intercollegiate Socialistic Society. Because it failed to take hold, it wasn't long before they changed the name to The League for Industrial Democracy.

The League continued its efforts through the twenties and thirties without obtaining any substantial support for widespread socialism. Around 1932 they tried to get President Franklin Delano Roosevelt to incorporate medical care along with social security for the elderly, but FDR then said no because "it would lead to socialized medicine," which he opposed. I remember: I was in my pre-med at the University of Detroit and on the debate team.

It was in the late thirties that they revised their efforts toward incrementalism whereby they would first seek to socialize medicine for the elderly and then pursue their overall objective, one by one.

In 1941, because progress was still very slow, they again changed their name --- this time to the Union for Democratic Action.

In 1943, their influence began to gain strength and they played a major role in the introduction of the Wagner-Murray-Dingell Bill to provide medical care for the American people via Social Security.* This quickly gained support from American labor leaders. Though never totally successful, the Wagner-Murray-Dingell Bill was introduced in 1943, 1945, 1947 and 1949.

Just four days after its initial introduction in 1943, a specially called meeting of the American Medical Association's House of Delegates recognized for the first time the importance of political forces and thus authorized the establishment of a Washington, DC, office and the Council for Medical Service and Public Relations. This was the majority decision despite prolonged and at times very heated debate on the part of physicians who maintained that the AMA should stick to medicine, education, research and clinical practice and leave politics to the politicians.

In 1947, for the third time, the Wagner-Murray-Dingell Bill was defeated and the Republicans took over the majorities in both House and Senate. This led admitted socialist, labor leader Walter Reuther to meet with Harvard socialist historian Arthur Schlesinger, Jr., who with only a few leaders of the Union for Democratic Action organized to change the name to the Americans for Democratic Action.

In that same year, 1947, Schlesinger wrote in Partisan Review, "If socialism is to preserve democracy, it must be brought about step by step, in a way which will not disrupt the fabric of custom. The transition must be piecemeal --- it must be parliamentary, it must respect civil liberties and the due process of law." And from a later passage, "Socialism then appears quite practicable within this framework of reference as a long-term proposition."

In 1949, two years later, for the fourth time, the Wagner-Murray-Dingell Bill was introduced, having obtained widespread media attention and increased political strength. This caused the AMA leadership to hire a public relations firm, Whitaker & Baxter, to conduct a national campaign to educate physicians and patients, assisting those who again defeated Wagner-Murray-Dingell.

Following this victory, doctors went back to practicing medicine, while labor leaders, headed by Walter Reuther, continued their efforts towards implementing socialized medicine.

In 1957, resurrected by the Americans for Democratic Action (ADA), the Wagner-Murray-Dingell Bill became the Forand Bill. It was introduced by Aime Forand of Rhode Island at the urging of socialist Nelson Cruikshank of the AFL-CIO and socialist Andrew Biemiller, congressman from Wisconsin. Aime Forand admitted he had never even read the Bill but introduced it following their requests.

Andrew Biemiller was defeated in 1950 at the same time that Claude Pepper, who had adopted Reuther's philosophy for government, was defeated. It was also in 1950 Florida physicians organized the Florida Medical Committee for Better Government, which had been helpfuI in Pepper's defeat. That committee later became FLAMPAC. President Harry Truman's previously admitted support was not evidenced and the Forand Bill died in committee.

Reuther and his AFL-CIO people continued their efforts, and the King Anderson Bill was introduced by Representative Cecil King of California and Senator Clinton Anderson of New Mexico. The King Anderson Bill sought to socialize all citizens over age 65, rich and poor alike, to be financed by Social Security.

Meanwhile, with strong support from Democratic leadership, an alternative bill was introduced, the Kerr-Mills Bill. This Kerr-Mills Bill was designed to help the really needy people over 65 years of age. It did not require penury; it did not demand sales of home or property, and it was designed especially for those who were bereft of adequate income.

With strong support from the AMA and the leadership of the two most powerful Democrats, Kerr-Mills was pushed by Democratic leaders like Senator Smathers of Florida, Herlong of Florida, Watts of Kentucky, Long of Louisiana, Russell of Georgia and Curtis of Nebraska.

Sen. Ted Kennedy then introduced an amendment,

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pushed by Reuther, to cover everybody over 65 to be paid for with Social Security taxes, but it was defeated.

With tremendous bilateral support in the House, followed by a Senate vote of 89-2, Kerr-Mills was passed on August 23, 1960. A couple of weeks later it was signed by President Dwight Eisenhower and became law.

The Kerr-Mills Law was then sent to the Department of Health, Education and Welfare (HEW) for implementation, but here Reuther's minions took over. Charged with the responsibility to implement the law, they instead put forth every effort to prevent its operations. As I traveled and spoke around the country to urge implementation of Kerr-Mills, I repeatedly ran into HEW Undersecretary Ivan Nestigan, Assistant Secretary; admitted socialist Wilbur Cohen; plus Zumas and Quigly --- other princlpals, who determined to sabotage Kerr-Mills, kept repeating that Kerr-Mills did not do enough and that we needed King Anderson, which Reuther and Kennedy were still espousing to take care of everybody over 65 - their first step toward their ultimate goal to fully socialize medicine.

Despite this strong opposition, Kerr-Mills continued to expand. Signed into law in September 1960, by August 1961 it was in the process of implementation in 33 states. By November 1964, 39 states and the District of Columbia had established programs providing medical assistance for the aged. All covered hospital services, 30 covered nursing home care, 34 covered doctors' visits, and 25 covered prescription drugs.

Despite its favorable progress the power changed suddenly on November 22, 1963, when President John F. Kennedy was assassinated and Vice-President Lyndon Baines Johnson became president. The continuing power of Walter Reuther was quickly demonstrated. I have in my office a copy of LBJ's appointment schedule the morning after Kennedy's assassination. It was obtained from the LBJ Library in Austin, Texas, and heading the list --- in spot number one --- Walter Reuther.

It is significant to note that President Kennedy seemed to shrug off the entire array of welfare state programs promoted by the Americans for Democratic Action, and was quoted as saying, "I never joined the ADA, I never have felt comfortable with those people."

Just three years before the assassination, the ADA had berated then Senator Lyndon Johnson for bottling up their bills in committee, but having been elected to the presidency by way of Walter Reuther and his labor millions, Johnson kept his promise to Reuther and King Anderson was again introduced, this time as House Bill #1 and Senate Bill #1.

During the week leading up to the debates, I still spoke to preserve Kerr-Mills. But with the ADA, backed by Reuther and reportedly hundreds of millions of AFL-CIO dollars, not only was Johnson elected but also 51 newly handpicked members of Congress. I wish that I had kept copies of the brochure later distributed by the AFL-CIO. It showed a picture of the House and Senate assembly in the House Chambers with the caption: "51 did it --- The Great Society with Medicare its crowning glory!"

During the last week before the final vote for the again King Anderson legislation, I was in Washington. When I arrived, as usual, I went first to the AMA Washington office.

I was then told that two congressmen had asked that, if I was in Washington, I come by their offices. Both related parallel stories. "Dr. Annis, I don't always agree with the AMA but this time you guys are right --- it is bad legislation; however, if I vote with you, you will still lose. I have been called to the White House, and if I vote with you, the people I represent will suffer so I have no choice."

Another congressman told me that during an earlier visit by one of Reuther's men to solicit his vote, "I pointed to a large box filled with letters and told him, 'Look at all those letters, all against you,' only to be told, 'Mr. Congressman, we elected this Congress, not your letter writers.' "

Later that same day I visited four other offices only to be told, "I haven't read the Bill, I don't intend to read the Bill, but I have to vote for it."

A visit to Wilbur Mills received a similar story. He said, "They have packed my committee, they have packed Senator Kerr's committee, and there is nothing that we can do about it. Johnson controls this Congress."

Thus, it was sheer political power and nothing else that introduced the seeds of government invasion into medicine and their growth to provide the mess we are in today.

Shortly after Medicare became law in 1965, Walter Reuther, from his headquarters at Solidarity House in Detroit, organized a Committee of One Hundred for National Health Insurance.

It wasn't long before he felt that for more rapid growth a name change was in order, and it became the National Council of Senior Citizens --- which few understood to be a vital associate of the AFL-CIO.

During the forty years of liberal domination in the Congress, the National Council of Senior Citizens received over 90 percent of its funding from federal dollars --- this usually amounted to sixty to eighty million tax dollars each year. During the last five years, recent government reports show that they received 334 million tax dollars.

The National Council of Senior Citizens has always been a major advocacy organization for Social Security-financed medical care. The organization retained that name from its inception until last year when, because it was losing support due to unwanted attention by some in the media and in Congress over a long series of scandals, it too changed its name. As of January 1, 2001, it became the Alliance for Retired Americans. It still retains its cloak to hide the close affiliation with the AFL-CIO.

Walter Reuther was killed in a plane crash not long after Medicare became a reality. **Meanwhile, the ADA laid claim to the accumulating billions of dollars**

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in union war chests derived from steadily-flowing, withheld wages from millions of workers, whether or not they chose to belong to the Union. Few voters realize the socialistic origins of the Americans for Democratic Action as they are persuaded to vote for liberal legislators seeking ever greater government controls.

Though unsuccessful in their earlier years, true to Schlesinger's promise by pursuing both permeation and incrementalism, the socialists have made great progress and today have willing disciples in both Houses of Congress and both political parties, though their greatest power and numbers still dominate in the Democratic Party.

What I have related is not an exaggerated fantasy. It is in fact true history and provides a realistic perspective as to how the Lilliputian-like bands have been steadily applied to harness our profession. In our society, things don't happen --- people make them happen!

We will conclude this article with "Part II: Fighting the Leviathan" in the Spring 2003 issue of the Medical Sentinel.

Footnote:

* It was this bill that inspired conservative physicians to found the Association of American Physicians and Surgeons (AAPS) to preserve the practice of private medicine and oppose socialized medicine.---Ed.

Dr. Annis is past president of the AMA, an AAPS member, and the author of Code Blue: Health Care in Crisis (1993).

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Toward Socialized Medicine

Part II

Fighting the Leviathan

Edward R. Annis, M.D.

The Misnomer of "Insurance"

There are laws against the mislabeling of products to hide their real ingredients or to claim the presence of a component that is lacking. But which is the worse disservice to Americans? The mislabeling of products manufactured for sale, or the misrepresentation of ideas or political actions? Millions have been led to believe that programs such as Social Security and Medicare are insurance simply because they are called "social insurance."

Even though the Medicare Part A card is labeled "Health Insurance," the United States Supreme Court held long ago that Medicare is not insurance, but rather a tax on one segment of the population to pay the bills for another segment. In other words, it is a tax on workers to pay the medical bills of retirees. Similarly, Social Security is a tax on today's wages to pay a pension to those retired at age 65, or even at age 62. No insurance contract exists for either of these programs, and no Social Security or Medicare funds are banked for investment and growth.

In the early 1940s until the government's intrusion into medicine by Medicare in 1965, private medical insurance was expanding rapidly. In 1965, 7.7 million of the 16 million Americans then over the age of 65 were covered by private medical insurance. That insurance, like homeowner's insurance, car insurance, and life insurance, enabled policyholders to share the risks of catastrophic or unexpected needs.

Insurance was not only readily available but also reasonable in cost because it was utilized only by those faced with costly services in cases of serious illness or accident. In order to be insured, the risks had to be unpredictable. Before government interfered, costly medical and surgical needs were rarely experienced by more than 5 to 6 percent of the public in any one year.

Contrast the situation today, when insurance is expected to cover all minor aches and pains and to cover federal or state mandates for coverage that is neither needed nor desired.

Accelerating Cost Increases

Today, the half-life of medical knowledge is estimated to be less than five years. There is a steadily emerging stream of new and better diagnostic and therapeutic tools, along with an expanding pharmaceutical industry. The new medications may be more expensive, but they possibly obviate the need for still more expensive and invasive treatments, hospitalization, or surgery.

As costs increase, we hear or read almost daily that some 39 to 40 million people are without insurance for medical care. While no clamor exists for investigating which costs are excessive, or which costs are unnecessary, there are insistent demands for government to assure universal coverage of these excessive costs.

Often described as one-seventh of the nation's economy, medical services constitute the only segment denied the freedom of the marketplace, as a result of government regulations, mandates, and price controls. Rules and regulations for Medicare alone have now reached 130,000 pages, and a recent government report stated that for Medicare alone, more than $2 billion dollars every month is lost because of mismanagement, waste, and fraud.

While President Clinton in his inaugural address stated that "the era of big government is over," since that date more than 400,000 pages have been added to the Federal Register.

Why should never-elected bureaucrats, protected by tenure and assured of lifetime economic protection because of taxpayer-paid pensions, be empowered to write rules and regulations, print them in the Federal Register, and then implement them with the force of law? Congressional failure of oversight has allowed these unaccountable bureaucrats to impose ever-increasing, unintelligible

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paperwork on citizens, with its attendant costs.

One of our Founding Fathers, James Madison, wrote: "It will be of little avail to the people that laws are made by men of their choice, if the laws be so voluminous that they cannot be read and so incoherent that they cannot be understood..., that no man who knows what the law is today can guess what it will be tomorrow!"

Contributing to the cost increases are the overhead of agencies like Blue Cross/Blue Shield that are assigned by the government to handle economic transactions. Managed care, a euphemism for the entrepreneurial interference between patients and physicians for profit-making ventures, takes another chunk out of the medical dollar, including lavish compensation of chief executive officers. In August, 2002, it was reported that Anthem paid its CEO $13,000,000 in200l.

Government regulation and managed-care overhead, both extraneous to medical care, are major contributors to costs, yet they make no direct contribution to the actual care of the sick and the injured.

The Growth of Litigation

A third contributor to cost is the predatory section of the trial bar. Plaintiffs lawyers even advertise on television to incite litigation for stress, worry, and concern over what might happen, disregarding the absence of any known impairment.

The last 20 years have seen a steady growth of class-action suits, making multimillionaires and sometimes billionaires of lawyers, especially those milking the cash cows of asbestos and tobacco. Newly attained wealth has been used to gain political power at both state and federal levels. For example, in the year 2000, the Democratic Party committees received $11.6 million in contributions from wealthy trial lawyers and their lobbyists, even exceeding the $11.3 million that the Democrats received directly from labor unions.

Physicians, no matter how talented or experienced, are limited by price controls that deny even the very wealthy the ability to reward their doctors more generously than the government allows. Meanwhile, young attorneys start at $100 to $150 per hour. Some older attorneys receive $500 to $800 per hour, and some attorneys have even received in excess of $30,000 per hour

California Medicine reported in August, 2002, that in recent years 25 percent of California physicians had been sued, with only 10 percent of the cases getting to court with a legitimate cause. The other 90 percent includes those that settled rather than incurring the expense of defending a nonmeritorious suit.

What Can Physicians Do?

Our best weapon is truth. We must make our case to our patients. Unless our freedom and economic rights are restored, we will continue to be overwhelmed by more government intrusion. Patients need to hear that the most direct, the most economical, and the best medical care is a result of direct contract between patients and their physicians, with no middleman.

Americans need to be reminded that the Constitution grants only limited and defined powers to the federal government. The government does not have a legitimate authority to deny physicians the right to receive a market price for their services: a right enjoyed by mechanics, plumbers, carpenters, architects, engineers, athletes, film stars, government employees, and lawyers.

Shortly after his inauguration, President Ronald Reagan, speaking before a crowd of 5,000 at the Jefferson Memorial, presented his Economic Bill of Rights, based on fundamental constitutional principles: 1. Freedom to work; 2.Freedom to enjoy the fruits of that work; 3. Freedom to own and control property (that includes intellectual property); 4. Freedom to participate in a free market.

Physicians today are denied every one of these freedoms. It is time to say "Enough!" Only strong, sustained political activism will regain these rights. To win the battle, we must fight it, and as Winston Churchill told the graduating class of his old prep school, "Never, never, never give up!"

Edward R. Annis, M.D. *is a Past President of the American Medical Association. This article is derived from remarks made to an annual meeting of the Florida Medical Association.*

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or free, but Christ is all, and is in all." [3]

In Genesis 1:27 it says that God created Adam on the sixth day of creation. Eve was created sometime soon thereafter.[4] Later in the book of Genesis, in chapters 6 and 7, a description of the worldwide flood that destroyed the earth is given.[5] This flood left only Noah and his family alive. If Adam and Eve were the first two people living, that means that everyone who lived after them is one of their descendants. That includes white and black people, rich and poor, Christian and Muslim. Everyone who lived after the flood is a descendant of Noah and the same is true for them. We were all made with exactly the same rights, regardless of the characteristics that people say make us different today.

If people would look at each other with that in mind, there would be no racism or bigotry. But secular culture has clouded our vision. There has always been some form of prejudice in the world. In early times it was based mostly on class. That changed in the last couple of hundred years when people began to judge based on race and nationality. The introduction of evolution into our society tells us to believe that some creatures, and people, are not as evolved as others. Evolution is a primary source of racism in our society. There are many examples of this. One took place in the early 1900's when an African Pygmy named Ota Benga was brought to America and put in a zoo with some primates as an illustration of an evolutionary link between monkey and men. He was looked at as less evolved than other men. After several years he was freed, but later killed himself because of the treatment he had endured.[6] This was brought on by the tainted view of God's creation held by modern man.

Some of the founders of this country believed that God was the Creator of every person and every good thing on this earth. At the time the Declaration of Independence was written the writers were really only speaking of freedom for white men, mainly the property owners. Women of that time were not allowed to vote and neither were black people, most of whom were slaves. Though most of them must have realized that God had created people equal, they must have struggled with that fact because black men were not allowed to vote until much later and women even longer.

Today however, most people have an advantage that they may not have had then- freedom: freedom to vote, freedom to practice their religion, freedom to be who they want to be. That is the way God intended it to be. Every man and woman has been created equal and is entitled to pursue what they wish within reason and the law.

1.The Unanimous Declaration of the Thirteen United States of America (Philadelphia, 1776).
2. Michael Farris. Constitutional Law for Christian Students (Purcellviue: Home School Legal Defense Association, 1998)12.
3. New International Version (Grand Rapids: Zondervan, 1993)
4. New International Version (Grand Rapids: Zondervan, 1993).
5. New International Version (Grand Rapids: Zondervan, 1993)
6. Kat Ham, Carl Wieland, and Don Batten. One Blood: The Biblical Answer to Racism (Green Forest, AR Master Books. Inc., 1999)131

Comparison of States with Caps to States without Meaningful Non-Economic Caps (Average Malpractice Premium Increase)			
States with Caps < $250,000		**States without Caps**	
California	**20%**	**Arkansas**	**18%**
Indiana	**15%**	**Connecticut**	**50%**
Montana	**21%**	**Georgia**	**32%**
Utah	**5%**	**Nevada**	**35%**
		New Jersey	**24%**
		Oregon	**56%**
		Pennsylvania	**77%**
		Washington	**55%**
		Ohio	**60%**
		West Virginia	**30%**
AVERAGE	**15%**	**AVERAGE**	**44%**

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The one memory that will linger long after the sweet taste of negotiating successes and the sour taste of acid encounters with self-serving secretaries of state have left my palate is the creeping, morale-sapping erosion of doctors' clinical autonomy brought about by micro-management from Whitehall which has turned the NHS I hold so dear into the most centralised public service in the free world.

The stifling of innovation by excessive, intrusive audit and the imposition of Department of Health diktats.

The shackling of doctors by prescribing guidelines, referral guidelines and protocols.

The suffocation of professional responsibility by target-setting and production-line values that leave little room for the professional judgement of individual doctors or the needs of individual patients

No doctor has any trouble signing up to genuine, evidence-based efforts to drive up standards and improve the quality of services to patients.

But the paranoid centralism which has characterised this and previous governments' handling of the NHS will not lead to improvements in patient care. It will turn professionals into bean counters answerable not to their patients but to politicians, auditors, commissioners and managers under pressure to deliver on edicts, priorities and targets emanating from Richmond House.

I'm nearing the end of a 40-year career in medicine – a career that I have loved and from which I have drawn enormous personal and professional satisfaction.

Nothing comes close to the unspoken but absolute trust that exists between patient and doctor, to the privilege of being let into people's lives and people's thoughts, to the patient who says 'Thank you doctor, that helped'.

But when I look back over my career and how the practice of medicine has changed in that time, there is one thought I cannot shake from my mind. The challenge, the responsibility, the risk that I relished, and that I regarded as being fundamental to my professional status, have all but disappeared.

When I first went into practice against the wishes of my father, who was a doctor himself but wanted me to be a dentist because the pay was better, I wasn't interested in financial rewards. I wasn't interested in adulation from awe-struck patients or being hero-worshipped by nubile young nurses. I wasn't interested in achieving immortality as the discoverer of some rare and exotic disease.

I became a doctor because I wanted to help people who were ill or in distress. I earned £9 a week and I was on duty for four nights out of seven.

My motivation and my satisfaction came from knowing that I was able to apply my knowledge and exercise my judgement free from control or interference from outside the consulting room.

I felt free, and safe, to do what I thought was best for those in my care.

I was only in my early 20s when I faced my first life or death test - a seven-year-old boy with a congenital heart condition, in heart failure, and sent home from hospital to die because the surgeons didn't think he would survive an operation. I discussed the options with his mother – let him die or take a chance with radical treatment that might save him. With her consent, I administered four times the recommended adult dose of a powerful diuretic new on the market in an effort to get him fit for surgery. I wasn't even sure whether the drug was licensed for use in children, but I was sure that if I did nothing he would be dead within a week. His condition improved dramatically, and after I'd fought tooth and nail to get the surgeons to see him again, he was operated on and survived. That seven-year-old is now a strapping 48-year-old with children of his own.

I took a risk in the hope that it might save a boy's life. I wouldn't take that risk now. I am in no doubt that my career would be on the line if I acted outside accepted protocols for the treatment of certain conditions.

I accept, like all of us do, that national standards, quality markers and assessment of individual and team performance are essential in a modern, patient-centred NHS. Transparency and accountability are the counterweights to clinical freedom.

But remove the responsibility, remove the risk, remove the challenge in practising medicine and you remove a large part of what being a doctor is all about.

We spend a lot of time at the BMA talking about low morale in the medical profession and what needs to be done to address it. We have rightly identified workload, work intensity, patient demand and increasing bureaucracy as factors contributing to its continued downward spiral.

For me, and I suspect for many of my colleagues who are contemplating early retirement, leaving medicine in mid-career or asking themselves early on in their careers whether medicine was the right choice for them, the biggest demotivator has been the deprofessionalisation of medicine brought about by protocols, guidelines and government targets.

Ministers and managers have muscled in on the doctor-patient relationship, and we now have a healthcare system driven not by the needs of individual patients but by spreadsheets and tick boxes.

Clinical decisions have been taken out of clinicians' hands and the fundamental NHS principle of care based on need and need alone has been superseded by the principle of care based on numbers.

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Targets are set nationally without any appreciation of what they might mean for individual doctors sitting in consulting rooms with individual patients. If you set targets for the treatment of one group, you automatically disadvantage others whose clinical need may in fact be greater. If you set targets for access to services, you encourage those providing the services to give more thought to throughput of patients than to what is actually wrong with those patients and what their individual treatment needs are.

Our own survey of A&E consultants carried out in March this year after a pre-announced seven-day Health Department audit of waiting times in casualty departments in England uncovered the extraordinary lengths to which some hospitals will go to pull the wool over the auditors' eyes. More than half bussed in temporary staff, and bussed them back out again as soon as the audit was over. A quarter made staff work double or extended shifts. Sixteen per cent cancelled routine surgery so beds would be available for patients admitted through A&E. There are countless other examples of the trickery and ruses used by managers to please their political masters. Keeping patients in ambulances because the A&E waiting time clock doesn't start ticking until they arrive in the department. 'Warehousing' patients in A&E departments because of a lack of available inpatient beds. Classifying patients on trolleys as 'admitted' to hospital even though they have no access to food or hygiene facilities. Putting patients on reserve waiting lists so they don't appear on the waiting list proper. Admitting patients who are near the waiting time target limit to hospital at the expense of patients whose need is greater but who haven't been waiting as long. Pushing through small, swift, non-essential operations at the expense of those that require a theatre or bed space.

And if all else fails, cheat – or as the National Audit Office more politely puts it, make 'inappropriate adjustments'.

'Inappropriate adjustments' identified by the NAO in its investigation into waiting list manipulation included excluding patients from lists until the month of their appointment and telephoning patients to find out when they were going on holiday then offering them admission dates during that period.

You would think wouldn't you that the government would be distancing itself from these corrupt and immoral practices. Instead, it has turned a blind eye, been triumphalist about its 'achievements' and colluded in the deception and doublespeak. Did you know that the official definition of a bed according to this government is, and I quote, 'a device that may be used to permit a patient to lie down'? This rather conveniently means trolleys and examination couches can be counted as beds for statistical purposes. But why stop there? Why not put up hammocks in hospital car parks? Why not ask patients to bring sun loungers and sleeping bags from home?

When the BMA criticises the target culture and warns that the billions of pounds of extra investment in the NHS aren't affecting the frontline delivery of services on a large enough scale to make a real impact on the public or on the professionals providing those services, we are accused by government of scaremongering and of wanting to veto reform.

"It called for fewer targets and for ministers to allow NHS managers and medical staff to be left to decide how best to achieve them. In its own press release on the launch of foundation hospitals, the Department of Health promised that 'the best hospitals will be freed from excessive Whitehall control' – a seemingly remarkable admission by the government about the misguidedness of its own approach.

If Whitehall control is excessive, then why not remove it from all hospitals?

Good targets, like those for a reduction in death rates from heart disease and cancers, are drawn up by clinicians for clinicians, not by politicians looking for a quick fix to appease an expectant and impatient public. Politically-motivated national performance targets based on quantity not quality offer no room for local flexibility and encourage short-term gain at the expense of long-term improvement. Politically-motivated national performance targets based on quantity not quality offer no incentives for managers or clinicians to improve the standard of the services and care they provide. Politically-motivated national performance targets which come with a threat of penalties and punishment for those who fail to achieve them make honest people dishonest. Politically-motivated national performance targets have driven a wedge between doctors and managers.

The consultant contract ballot went down in England and Wales not because there wasn't enough money attached, not because doctors are resistant to reform. It went down because consultants were not prepared to submit to a level of ministerial and managerial interference in clinical decision making that would have been intolerable, and would have made a mockery of their professional responsibility and their duty of care to their patients. Consultants who voted against the contract voted against a proposed extension of their NHS hours into evenings and weekends not because they wanted more time on the golf course or more time to do private practice, but because they suspected most managers would want to use those extra sessions to hit politically-motivated productivity targets with no clinical evidence base.

The father of the NHS, Aneurin Bevan, once famously remarked that the sound of a bedpan falling in Tredegar Hospital would

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resound in the Palace of Westminster.

More than 50 years, and countless restructurings, later, Nye Bevan's words resonate loud and clear with those of us who have watched successive governments pay lip service to the ideal of decentralisation while at the same time trying to retain their iron grip on the NHS from Whitehall. Given this government's obsession with issuing diktats on the minutiae of NHS activity, I'm surprised there isn't a target for the passing of motions. The auditing of every bowel movement on every ward in every NHS hospital would be a fitting memorial to Alan Milburn now that he has decided to spend more time with his family. Mr Milburn may not have noticed, but consultants have families too. It is a pity he was not able to appreciate their predicament when he was trying to force them to work evenings and weekends.

There are major challenges ahead for my successor, and for the BMA. We must persuade government that if it is prepared to engage the medical profession in a debate about the future of the NHS, it can restore the medical profession's confidence in its handling of the NHS. We must persuade government to re-open a constructive dialogue with parts of the profession where relationships have broken down.

We must look at our own organisation – at how we work, at how we represent our members, at how we communicate with our members, at how we negotiate on behalf of our members...

Above all, we must fight to restore our professional status, and to convince government that the way to deliver sensitive, patient-centred healthcare is to allow doctors to exercise autonomous clinical judgement, and to accept the risk, the responsibility and the accountability that go with it.

At the risk of sounding pompous, medicine is an honourable profession, a noble profession.

I am proud to be a doctor.

The right to practise medicine as a professional and not a government bean counter is worth fighting for.

Please don't give up that fight.

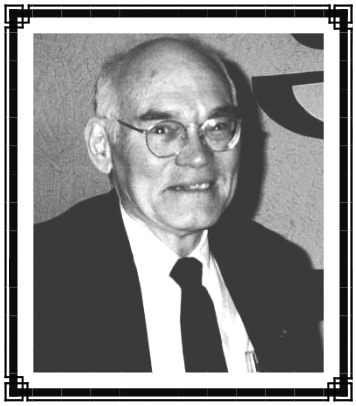
Chairman, I move.

Dr.Ian Bogle

Do you still want a government run socialized system? - **SEPP editors**

SEPP Mourns Passing of Lawrence Dunegan, M.D.

Died—January 9, 2004



Lawrence Dunegan, M.D. has left us and left a great void that cannot be filled. For those of us who knew him, he is remembered as a tireless hero who valued freedom and spent his life promoting the values that need to be maintained and restored not only to reinvigorate our healthcare but our country.

Dr. Dunegan, a pediatrician, more than any politician, defined by his actions the phrase "for the children". He recognized that individual freedoms in healthcare must be preserved or generations to come will be burdened with the cost of too much government and bureaucracy. Dr. Dunegan directed and energized the Student Scholarship program for SEPP. This program involves a rigorous selection process including an essay on topics related to America's freedom principles. Dr. Dunegan promoted trips to the Freedom Foundation for educational sessions on the Founding Principles and was regularly published in our *SEPPIAN* and the *Journal of the Association of American Physicians & Surgeons.*

Dr. Dunegan's inspiring presence among us , his insight, and energies, will serve us well in the ongoing battles against big government, social engineers, and the erosion of freedom . His last gesture to SEPP in his obituary was a request for contributions to SEPP's Student Scholarship Fund.

The TRUTH about Thanksgiving

Geoff Metcalf

And so, as beefy gladiators chase a pigskin down the field in Miami or Detroit, we settle into our living rooms, loosen our belts, wave off a second helping of pie, and remind the little ones this is the day we echo the thanks of the Pilgrims, who gathered in the autumn of 1621 to celebrate the first bountiful harvest in a land of plenty. That first winter in the New World had been a harsh one, of course. Half the colonists had died. But the survivors were hard-working and tenacious, and - with the aid of a little agricultural expertise graciously on loan from the Wampanoag, the Narragansett, and the Mohegan - were able to thank the Creator for an abundant harvest, that second autumn in a new land. The only problem with the tale, unfortunately, is that it's not true. Oh, the part about the Indians graciously showing the new settlers how to raise beans and corn is right enough. But in a November, 1985 article in "The Free Market," monthly publication of the Ludwig von Mises Institute, author and historian Richard J. Marbury pointed out: "This official story is ... a fairy tale, a whitewashed and sanitized collection of half-truths which divert attention away from Thanksgiving's real meaning." The problem with the official story, Mr. Marbury points out, is that "The harvest of 1621 was not bountiful, nor were the colonists hardworking or tenacious. 1621 was a famine year and many of the colonists were lazy thieves."

In his "History of Plymouth Plantation," the governor of the colony, William Bradford, reported that the colonists went hungry for years because they refused to work in the fields, preferring instead to steal. Bradford recalled for posterity that the colony was riddled with "corruption and discontent." The crops were small because "much was stolen both by night and day, before it became scarce eatable." Although in the harvest feasts of 1621 and 1622 "all had their hungry bellies filled," that relief was short-lived, and deaths from illness due to malnutrition continued.

Then, Mr. Marbury points out, "something changed." By harvest time, 1623, Gov. Bradford was reporting that "Instead of famine now God gave them plenty, and the face of things was changed, to the rejoicing of the hearts of many, for which they blessed God." Thereafter, the first governor wrote, "Any general want or famine hath not been amongst them since to this day." Why, by 1624, so much food was produced that the colonists actually began *exporting* corn. What on earth had happened?

After the poor harvest of 1622, writes Bradford, "they began to think how they might raise as much corn as they could, and obtain a better crop." And what solution was decided upon? It turned out to be simple enough. In 1623 Gov. Bradford simply "gave each household a parcel of land and told them they could keep what they produced, or trade it away as they saw fit."

What? Wasn't that the American way from the start? Not at all. The Mayflower Compact had required that "all profits & benefits that are got by trade, working, fishing, or any other means" were to be placed in the common stock of the colony, and that, "all such persons as are of this colony, are to have their meat, drink, apparel, and all provisions out of the common stock."

A person was to put into the common stock all he could, and take out only what he needed - a concept so attractive on its surface that it would be adopted as the equally disastrous ruling philosophy for all of Eastern Europe, some 300 years later.

"This 'from each according to his ability, to each according to his need' was an early form of socialism, and it is why the Pilgrims were starving," Marbury explains.

Gov. Bradford writes that during those terrible first three years "Young men that are most able and fit for labor and service" complained about being forced to "spend their time and strength to work for other men's wives and children." Since "the strong, or man of parts, had no more in division of victuals and clothes, than he that was weak," the strong men simply refused to work, and the amount of food produced was never adequate.

In historian Marbury's words, Gov. Bradford "abolished socialism" in the colony, "replacing it with a free market, and that was the end of famines."

In fact, this lesson had to be learned over and over again in early America. "Many early groups of colonists set up socialist states, all with the same terrible results," Marbury notes. "At Jamestown, established in 1607, out of every shipload of settlers that arrived, less than half would survive their first 12 months in America. Most of the work was being done by only one-fifth of the men, the other four-fifths choosing to be parasites. In the winter of 1609-10, called 'The Starving Time,' the population fell from 500 to 60.

"Then the Jamestown colony was converted to a free market, and the results were every bit as dramatic as those at Plymouth. In 1614, Colony Secretary Ralph Hamor wrote that after the switch there was 'plenty of food, which every man by his own industry may easily and doth procure.' He said that when the socialist system had prevailed, 'we reaped not so much corn from the labors of 30 men as three men have done for themselves now.' " They say those who ignore history are doomed to repeat it. Sadly this was a lesson the people of Russia had to learn all over again - at the pain of equally devastating starvation and penury - in our own century. By the 1980s, when the discredited and bloodstained rulers of Russia finally threw up their hands and allowed farmers to raise private crops and sell them for profit on a mere 10 percent of their lands, once again more crops were produced on that 10 percent of the land than on the 90 percent devoted to "collective agriculture," the system under which - as the bitter Russian joke would have it - "We pretend to work, and they pretend to pay us."

Yes, America is a bounteous land. But the source of that bounty - and the good fortune for which we annually gather to give thanks - lies not merely in the fertility of the soil or the frequency of the rains - for there is hardly a more fertile breadbasket on the face of the earth than the Soviet Ukraine.

No, the source of our bounty was the discovery made by the Pilgrims in 1623, that when men are allowed to hold their own land as private property, to eat what they raise and keep the profits from any surplus they sell, the entire community becomes one of prosperity and plenty. Whereas, an economic system which grants the lazy and the shiftless some "right" to prosper off the looted fruits of another man's labor, under the guise of enforced "compassion," will inevita-

(Thanksgiving—Continued on page 11)

Dennis Gabos, M.D.
President of SEPP

Can *YOU* Tell The Difference?

Who made the following quotes?
Regarding the potential benefit of
Health Savings Accounts-

1.— "*They won't work.*" Question: `Why not?' ...`*Well, for two reasons. People are greedy. They'll want to take that money and won't get the services for their family -- the screenings, preventive care.*' " ...*government will tell them when to get the screenings, when to get the preventive care. That's how we're going to do it in my health care plan*." …(and)question: the second reason for doubts about MSAs ?, ... she responded, "*All that money goes to the private sector and the federal government will spend that money better than the private sector will."*

2.—"*Under this reform, senior citizens will be able to keep their Medicare just as it is, or they can choose a Medicare plan that fits them best -- just as you, as members of Congress, can choose an insurance plan that meets your needs. And starting this year, millions of Americans will be able to save money tax-free for their medical expenses in a* ***health savings account****...*
On the critical issue of health care, our goal is to ensure that Americans can choose and afford private health care coverage that best fits their individual needs."

1. Hillary Clinton
2. President George W. Bush

National Health Care Expenditures

Year	Percent Private	Percent Public
1929	86.4%	13.6%
1940	79.7	20.3
1950	72.8	27.2
1960	75.4	24.6
1970	62.2	37.8
1980	57.6	42.4
1990	59.5	40.5
1998	54.5	45.5

Well now that Health Savings Accounts are expanded and available who do you want dictating your healthcare? A single payer government run healthcare system controlled by disinterested self serving arrogant politicians who want to manage your life? Or do you want to be back in charge? See www.sepp.net for more info on Health Savings Accounts. It may save your life or your child's life or your grandchild's life.

Dennis Gabos MD

(Thanksgiving—Continued from page 10)

bly descend into envy, theft, squalor, and starvation.

Though many would still incrementally impose on us some new variant of the "noble socialist experiment," this is still at heart a free country with a bedrock respect for the sanctity of private property - and a land bounteous precisely because it's free. It's for that we give thanks - the corn and beans and turkey serving as mere symbols of that true and underlying blessing - on the fourth Thursday of each November. God bless America - land of the free.

Geoff Metcalf. *His American roots go deep. His ancestors settled in New England in the 1600s, and he is a ninth generation commissioned officer in the U.S. Armed Services and a former Green Beret. He is a retired USAR LTC and has commanded a Special Forces Operational Detachment, and a Military Police Company in addition to various staff positions. Metcalf brings his passionate connection to hundreds of years of American evolution to his own revolutionary radio program.*

SEPP—Schedule for Meetings –2004
All meetings at Tambellini's Restaurant
Route 51 South
Time—6PM for Board of Trustees
7PM General Meeting—Open to all
Dinner Meeting

Quarterly Meetings

Monday May 17, 2004
Monday August 16, 2004
Monday November 15, 2004

Watch for the Health Savings Account Meeting !
Check www.sepp.net

www.sepp.net

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A Health Care Professional and Patient
Advocacy Organization
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SEPP—P.O. Box 101117 , Pittsburgh PA 15237-8117
Web Site —— *www.sepp.net*

SOCIETY FOR THE EDUCATION OF PHYSICIANS AND PATIENTS

The mission of The Society For The Education of Physicians and Patients is to promote the education of patients and health care professionals in order to facilitate unencumbered participation in a healthcare system that respects and nurtures patients' and physicians' freedoms, rights, and responsibilities. The Society focuses on the responsibility of the physician as patient advocate and promotes quality medical care by supporting policies that encourage freedom, choice, enhancement of the patient-physician relationship, and fiscal responsibility.