Please Do No Harm

A Doctor's Battle with Medicare Price Controllers

Lois J. Copeland M.D.

I am a physician, an internist in a solo practice, and I am in mourning for the dignity and nobility of the medical profession.

I started in my current practice in Bergen County, New Jersey, 18 years ago when I took over the practice of a retiring physician. I was seven months pregnant with my first child at the time, and I went into labor while making rounds on a Friday night. I was back at work full-time three days later. I returned to work as promptly after the births of my three other children. It was not unusual in the early years of my practice to find me arriving at the emergency room, a baby under each arm, to see a patient.

I consider myself an old-fashioned doctor. I try to get to know my patients, and their families, in an effort to provide quality care to them. Because I have a large practice, and work 12 hours a day, I have been well compensated financially, but I do not charge outrageous fees, nor do I require my patients to come to see me more than is strictly necessary. I make house calls, and my practice includes a number of patients I care for at no charge. Over the years I have become close to my patients, many of whom are senior citizens; I regard a great number of them as my friends.

These close relationships, the opportunities to comfort and heal, and the intellectual challenges of medicine have been gratifying—so much so that despite the great difficulties of raising a young family and having so little time to spend with them, despite the long hours and intense effort my practice demanded, I have felt, until lately, richly rewarded by my work.

Patient Against Doctor Against Government

Most physicians know that this level of devotion to our profession is disappearing in America. Government intervention in medicine has taken away the dignity of the physician and the privacy of the patient-physician relationship, and it threatens the financial viability of private practice. Government price controls have restricted many physicians' freedom to care for government-insured patients adequately, reduced the number of physicians willing to care for these patients, and still has not reduced overall medical costs. Mountains of paperwork and continual wrangling with health-system bureaucrats are distracting physicians from the more important work of treating the sick, while shrinking profit margins and hassles caused by mandatory regulatory compliance are forcing many doctors out of private practice. We are seeing more and more forced rationing of care, especially for senior citizens.

And finally, the government has denied older Americans freedom of choice in health-care purchasing. The Medicare bureaucracy has attempted to prohibit doctors from making private contracts with their Medicare patients, even when no Medicare reimbursement is being sought, effectively turning the large majority of senior citizens in this country into disenfranchised, second-class citizens, with little voice in the intimate decisions of their own health care. Together, these federal interventions have degraded the medical profession, pitting patient against doctor against the government.

I decided to act against this degradation, and in 1991, along with five of my patients, I fought one part of the federal health system, Medicare Part B, as administered by the Health Care Financing Administration and the Medicare carriers. Our goal was to regain freedom of choice for those senior citizens who want full access to high-quality health care, as well as privacy and dignity in their relationship with their physician. Our story is a warning to those who, like the members of Hillary Clinton's task force, believe that the solution to America's health-care problems is government or third-party management.

The Distress of Medicare

My greatest distress as a physician in private practice has come from Medicare, specifically Medicare Part B, and the agencies that administer the Medicare program. Medicare is the government-sponsored health plan for Americans over 65 who are not actively employed, and the disabled. Every American over the age of 65 who collects Social Security is eligible for Medicare coverage.

Lois J. Copeland *is a physician in private practice in Hillsdale, New Jersey.*

Photos: Margaret Bonilla

James Stewart and Trudy Drucker, two of the five patients who joined Dr. Copeland in suing the Medicare system.

Medicare is divided into two parts: Part A, which pays for most hospital care for the elderly, as well as some non-physician nursing-home and home health-care services; and Part B, which covers physician services and related expenses. Those eligible enroll in Part B by paying a premium that is deducted from their Social Security benefits. It is Medicare Part B that has caused some of my most disheartening and degrading experiences as a physician.

Medicare was conceived during the era of the Great Society programs of the 1960s. Then-President Lyndon Johnson envisioned Medicare as a low-cost, universal form of health insurance for the retired and elderly. Although its goals were noble, one of Medicare's unfortunate side effects was that private insurance companies eventually stopped offering health-insurance policies to retirees and senior citizens, since the market for such policies faded as Medicare participation grew. It has been said that President Johnson coerced insurers into dropping such coverage in order to guarantee Medicare participation by all seniors.

Today there are virtually no insurance companies offering primary, first-dollar health coverage to these groups. The great majority of elderly Americans are enrolled in Part B out of necessity; those who might choose another form of health coverage really have no available options. Enrollment is automatic unless specifically declined in writing. A 10-percent annual penalty prevails in the premium if enrollment is delayed.

Generally, physicians who see Medicare patients fall into one of two Medicare categories: participating or non-participating. Participating physicians are in direct contract with the government to provide services to Medicare patients; they bill their local Medicare carrier. The patient pays the doctor the co-insurance fee for the service, but the doctor collects the rest directly from Medicare. Non-participating physicians who are in contract with their patients are paid by their patient, and send a form to the Medicare carrier so that the patient can be reimbursed for the amount he paid to the physician, minus co-insurance. I always have been a non-participating physician. I have taken on Medicare patients gladly, but I want the minimum amount of government intrusion possible in the patient–physician relationship. I want to deal directly with my patients, not through a third party. I do not wish to work for the government; I work for my patients. I believe there is a great danger for my patients in my doing otherwise.

Price Controls and Sanctions

From the time I took over my practice in the early 1970s until approximately the mid-1980s, my experiences with Medicare were quite positive. The program was generously funded, and equal to the best of the private insurance programs. The bureaucratic problems were minimal; essentially, getting reimbursement from Medicare for a patient visit or service was no different than from any other insurance carrier. I and my patients were satisfied with the program, and I was happy to accept new Medicare patients.

The situation began to disintegrate during the mid-1980s when, faced with spiraling Medicare outlays and a mandate to cut costs, Congress enacted a number of initiatives designed to regulate doctors' fees for Medicare-covered services. While refusing to raise Medicare premiums for participants—a politically dangerous move, considering the number of elderly voters in America—Congress in 1985 imposed a temporary price freeze on Medicare physician services. Congress eventually lifted the freeze, but replaced it with a sweeping new Medicare pricing system, the Resource-Based Relative Value Scale (RBRVS), which was enacted in 1989 and phased in during 1992. The RBRVS system, which is still in place, has strict price caps for services

Federal price controls have taken from older Americans their freedom of choice in health care.

and fines and sanctions for doctors not in compliance, and is coupled with controls over the volume of services a physician can provide through the Medicare system.

The RBRVS price limits fell far short of many doctors' actual costs of services, including mine, but the regulations prohibited physicians from charging more than the limiting charges on the RBRVS schedule. And as so often happens when price controls are in effect, many doctors immediately looked for ways around the limits. Some started limiting the number of Medicare patients they would see, or stopped seeing them altogether.

Many physicians solve the reimbursement dilemma by refusing to see new Medicare patients, and referring their old ones to another doctor.

In addition to the price controls, the Health Care Financing Agency (HCFA)—the division of the Department of Health and Human Services (HHS) that administers Medicare—and my state Medicare carrier set new reporting procedures under the RBRVS system for those seeking Medicare reimbursement. The new method required that my office file a complicated claims form, coded with specific Medicare designations, for each and every patient service I provided to a Medicare-enrolled patient, whether that patient was seeking reimbursement from Medicare or not. Filing an incorrect or improper claim could result in a $2,000 fine; overcharging or establishing a private agreement with a patient to pay more than the limiting charge for a service risked a similar fine, and potentially even a loss of license.

The effect of all these regulations was a staggering amount of paperwork for me and my office staff, and continually shrinking income from my Medicare patients. While the price I could charge my Medicare patients was frozen, or in some cases actually declining, my other expenses were going up. I continued to give my office staff their well-earned annual raises, and to pay increased prices for everything from office and medical supplies to garbage removal. Malpractice-insurance costs continued to climb, although they are more stable now than a few years ago. Medicare was paying only about 50 percent of the costs for services I provided to Medicare patients, a situation that continues today.

The Medicare Gap

A few examples of the current gap between my regular fees and Medicare reimbursement illustrates the problem. I generally charge one flat fee for return visits, other than comprehensive physicals, no matter how long the duration of the visit. This fee for non-Medicare patients is $60; the allowed Medicare charge for an intermediate visit is $36.81. My fee for an initial hospitalization of a non-Medicare patient, which includes initiation of a treatment plan, history, physical examination, and hospital chart documentation, is $275, but I am allowed to charge a Medicare patient only $122.71 for this same care. An electrocardiogram (EKG) is another common procedure performed by internists. I charge my non-Medicare patients $50 for an EKG, but the maximum charge allowed for my Medicare patients is only $32.33. Surgeons suffer even greater disparities. In my region, surgeons typically charge $1,200 to $2,000 for a carpal tunnel release, a common procedure performed on the wrist. Medicare allows a maximum charge of $300 for this surgery. With most surgeons paying more than $40,000 annually in malpractice insurance fees alone, it is no wonder that fewer of them are willing to accept new Medicare patients.

I found myself in the same bind as so many other doctors—raising fees for my younger patients to make up for the Medicare shortfall. My younger patients were often far less wealthy than my Medicare patients, and I was outraged at having to transfer additional costs onto these younger people—many had children in school and mortgages to pay. But my expenses were not frozen just because Medicare payments were. And I refused to engage in fraudulent activity just to compensate for my Medicare losses. The business side of my practice began to suffer, as did my morale.

I could have solved this dilemma, as many of my colleagues have, by refusing to take on new Medicare patients, or by telling my current Medicare enrollees to find another physician, or by refusing them timely appointments. But a number of my older patients were and are my friends, and I did not want to cut them off; it was not their fault that they had no alternatives to Medicare coverage. And I was troubled by the ethics of such a decision. How could I be the kind of old-fashioned doctor I had always been if I started turning away those who needed my help? How could I possibly refuse to treat a sick patient?

Confusion and Anger

Price controls and paperwork were not my only Medicare problems. The state carrier of Medicare, Blue Cross/Blue Shield of Pennsylvania, (which has a contract with HCFA to administer the Medicare program in New Jersey) often delayed reimbursement to my Medicare patients by challenging my medical decisions, denying payment for services already rendered, by requesting additional information for claims even when the diagnosis or treatment ordered was unquestionable, and sometimes by denying claims altogether, usually because of some administrative mistake originating not in my

Price controls and paperwork were not my only Medicare problems.

office, but in the carrier's. One of these letters to a patient falsely stated that I was a chiropractor in explaining why my services had been denied payment.

Unfortunately, in these cases it is often the patient, and not the doctor, who is notified of the denial. Complicated, jargon-filled, official letters from the carrier can confuse and anger a Medicare patient; when the letter refuses or delays reimbursement on the basis of an alleged misdiagnosis or treatment error by the doctor, the result is often a rift between doctor and patient, with the patient accusing the doctor of improper care, or of holding up the patient's reimbursement.

This type of misunderstanding can go to extremes. A former patient arrived in my office one day angry over a Medicare reimbursement problem. Thinking I was at the hospital, she called me dishonest in front of my office staff, other patients and, most unfortunately, my 10-year-old daughter, who happened to be there at the time. The episode angered me and my staff, but deeply hurt my child. Although this patient eventually was made to understand that the mistake was not ours, I knew that our relationship had been too severely damaged to continue. After 17 years of caring for this woman and other members of her family, I had to ask her to find a new physician. This story illustrates the aspect of Medicare that I resent the most: the atmosphere of suspicion and distrust that has grown up between doctors and their patients because of Medicare's intrusion in the patient–physician relationship.

Hassle Letters

Appealing a Medicare denial is the doctor's job, not the patient's, because the physician must write a letter to the Medicare authorities justifying his or her treatment. I have a large file of what I call "hassle" letters: copies of letters I have written to the state Medicare carrier, and in some cases to HCFA or other Medicare oversight agencies, justifying my medical decisions, challenging the delays, the "down" or "up" coding of claims to a different (and always lower) level of payment, and the intimidating and sometimes threatening language

I have spent two hours a night writing protest letters to bureaucrats who had denied my patients reimbursement.

the various Medicare agents use in communicating with physicians and patients.

My hassle file is filled with many letters defending treatments that Medicare was obligated to cover. One letter defends daily hospital visits to a patient on a respirator and intravenous fluids who suffered from complete respiratory failure and terminal cancer. The Medicare bureaucrats suggested that daily treatment of this patient was excessive. As I stated in my letter of protest:

> This is the most outrageous denial I have ever received.... This person was absolutely in need of my professional services, and required daily medical attendance. Whether you wish to pay for the medical services or not does not affect the medical need. Mrs. Jones [not her real name] was well aware of the inadequacies or Medicare during her life ... [she] always paid her bills despite Medicare denial and was in full agreement of her responsibility to pay my bills despite your attempts to cut back on your insurance obligations. In addition ... how could any reasonable person know that Medicare would not support the hospitalization of a terminally ill patient on a respirator?

Medicare won't even let you mourn in peace. From another letter to the Medicare administrator:

> I returned from my vacation ... to receive your letter (a "medically unnecessary" denial letter) with regard to my visit to the Emerson Convalescent Nursing Home on June 6, 1988. Please be advised that I was required to visit at that time by the administration of the convalescent center, as Mr. Smith had passed away suddenly and it was necessary and required by the nursing home that I personally come and pronounce my patient. In the past year I had received communication from the Medicare Administration that visits for the pronouncement of death would be covered.... I did not feel it was appropriate or in good taste to call Mrs. Smith during her acute grief to notify her that the visit may or may not be covered by Medicare.

Writing these letters took a great deal of time. My office staff was already overburdened with paperwork, and I could not afford to hire someone with the medical expertise to respond adequately to all the denials. Since I was threatened with unconscionable fines, I always took them home to do at night. My family paid the price for this. I would come home from a full day of office visits followed by hospital rounds at 8:00 or 9:00 P.M., eat a quick dinner left for me on the table, and then spend another two or three hours writing letters to Medicare agencies.

Forbidden Private Contracts

By 1990, I had become very depressed by these government intrusions on my practice, and was seriously considering leaving medicine. I began speaking about my Medicare problems to many of my patients. In the fall of that year, a letter written by one of these patients appeared in the local newspaper under the title, "Medicare Red Tape Is Jeopardizing American Health Care." She professed her shock at hearing that I was contemplating leaving my practice. She wrote that her physician was being "driven from the profession in which she excels by the heavy hand of government bureaucracy."

Photo courtesy of Lois Copeland

"I have traveled extensively since our victory in the freedom of choice trial, giving lectures and interviews, and encouraging patients and physicians to stand up for their rights." —Dr. Lois Copeland

Many of my older patients well could afford to pay me privately, and some wanted to make such an arrangement to help me meet my costs for providing their medical care. Under such a contract, I would provide a specific service for an agreed-upon fee—or in some cases, for no fee at all, since Medicare regulators threatened me with a $2,000 fine if I failed to charge any patient the deductible, and another $2,000 fine if I failed to file the proper form with Medicare. Several of my patients were poor, and I did not wish to charge them anything—not even the Medicare deductible. In such cases, no Medicare-reimbursement claims would be filed because reimbursement would not be sought. The Medicare regulators no longer would intrude in these patients' care when a private contract existed. I was still willing to see Medicare patients, and my own ethical standards would not allow me to turn away Medicare patients who could not pay outside the system, but for private contract patients over age 65, Medicare would not be able to interfere in the patient-physician relationship.

But such an agreement was prohibited by the Medicare carriers, who were backed up by HCFA. The justification for disallowing private contracts was that physicians would overcharge their elderly patients without the Medicare authorities acting as a watchdog. The implication was that a patient was not intelligent enough after age 65 to make his or her own decisions. So even if I treated someone privately, and no Medicare reimbursement was desired by the patient, I had to file the proper Medicare claims forms proving that I had not charged more than the maximum allowable fee on the RBRVS schedule—an insidious form of price control. No confidentiality was allowed to a patient over age 65: all visits and diagnoses had to be filed with the bureaucracy, or I would be fined $2,000 per occurrence of failure to comply.

The prohibition against such private contracts had been upheld in 1988, when Federal Appellate Judge Abner Mikva ruled in *New York State Ophthalmological Society* v. *Bowen* that a Medicare beneficiary would have to resign from Part B in order to privately contract. Judge Mikva's dictum resulted from the mistaken supposition of both the defendant and plaintiff in this case that the original Medicare law prohibited private contracting, a supposition that was stipulated by both plaintiff and defendant at the outset of the case. The Mikva ruling often has been used by the Medicare regulators to justify the prohibition of private contracts. This regulation not only unfairly restricted me, but took freedom of choice away from my patients, who could not contract for any medical services outside of the Medicare arena.

Few patients over 65 could afford to "go bare"—to risk

having no health coverage at all—and no other coverage was available to people over 65 who were not actively employed. The grim fact was that in America, if you were retired, elderly, or disabled, you were forced into Medicare by lack of alternatives, and you lost the freedom to make personal medical decisions, as did your physician when treating you.

Stewart vs. *Sullivan*

My frustration and rage grew, but I decided I would not give up my practice or my Hippocratic ethic without a fight. I began a letter-writing campaign to my congressional delegation, to officials in HHS and HCFA, to other members of the medical and insurance communities, and even to the White House. The letters helped air my complaints, and I received replies to some of them, but the replies did not offer solutions, and nothing changed.

I attempted to stimulate private-sector interest in an alternative private insurance policy to replace Part B, and travelled to Connecticut to meet with one insurance executive who told me, "The golden age of medicine is dead." His vision of the future was clinics with hard benches and whatever doctor was on call that day taking care of the poor and the Medicare-enrolled. He saw no future for the private practitioner because we were "too inefficient."

It was then that I called the Library of Congress and found that the original Medicare statutes were still intact. I sought advice and support from medical and legal experts, and talked to my Medicare patients. A number of my Medicare-insured patients volunteered to join with me in a lawsuit to establish their freedom of choice of medical care and their right to contract for medical care outside the Medicare system. Of the 20 or so patients who volunteered to participate in the suit, my attorney and I chose five who represented a wide cross-section of my practice and of Medicare enrollees.

The five patients formed a diverse group, with different reasons for pursuing the case, but in common was their belief that their personal freedoms had been abridged by the Medicare regulation against private contracting. James Stewart had just turned 65 and entered into the Medicare system, and was angry at his sudden loss of the right and freedom to select the medical care and the doctors he desired and could pay for, a right he had enjoyed at age 64. Some physicians had stopped taking Medicare patients, shrinking the pool of care available to Medicare patients. When I asked him if he would go to court with me, he agreed on the condition that we found a good lawyer. As he said later, "Why should I wake up with fewer rights on turning 65 than I had the day before?"

One insurance executive told me, "The Golden Age of medicine is dead."

Joan Kennedy Taylor, my patient and a writer knowledgeable about constitutional law, was convinced that allowing private contracting might actually save the Medicare program. With Medicare outlays so far outpacing income, she argued that the Medicare trust fund soon could be bankrupt; private contracting by those who could afford to pay for their own care would save Medicare funds for those who were needy.

Connie Streich, my retired former office assistant, had helped hold my practice together when I first arrived; she remembered the days when Medicare transactions had been generous and simple, and was shocked at the monster that Medicare had become. Miss Streich had suffered her own problems with Medicare reimbursement since her retirement, requiring me to justify much-needed reimbursement; she was also my friend. She told a reporter later that she saw the toll the Medicare battles were taking on me, and said, "Really, I wanted to get involved to help Lois." Connie Streich was also one patient for whom I wanted to waive my fee, and therefore her deductible payment, but Medicare forbade me to do so or I would incur a $2,000 fine.

"Why should I wake up with fewer rights on turning 65 than I had the day before?"

Trudy Drucker, a patient of great devotion, was worried that I would have to stop taking Medicare patients or leave my practice, and did not want to lose me as her physician. Ms. Drucker also loved the prospect of a good fight, and she was willing to fight hard to keep the liberties she believed were essential to being an American.

Warren Klose, the last of our group, had been told by Medicare that he could not pay me for a visit he requested because the bureaucrats felt the visit had been medically unnecessary. His wife was upset that she could not appeal Medicare's decision because the amount was less than $100—the minimum allowable in the appeals process. Mr. Klose was angry at his and my abuse by the Medicare system, and wanted to protest the degrading treatment we had received.

Kent Masterson Brown, legal counsel for the Association of American Physicians and Surgeons, who had successfully battled the Medicare bureaucracy in Ohio, agreed to represent us, and began an intense study of the original Medicare statute and subsequent changes in the law. The American Health Legal Foundation, which supports litigation to resist compulsory political medicine, recognized the importance of this case and volunteered to help support the legal expenses. The Freedom of Choice Fund was initially started by many patient contributions, and the staffs of my area hospitals donated to it generously. With this backing, on January 31, 1992, these five patients and I filed suit in federal

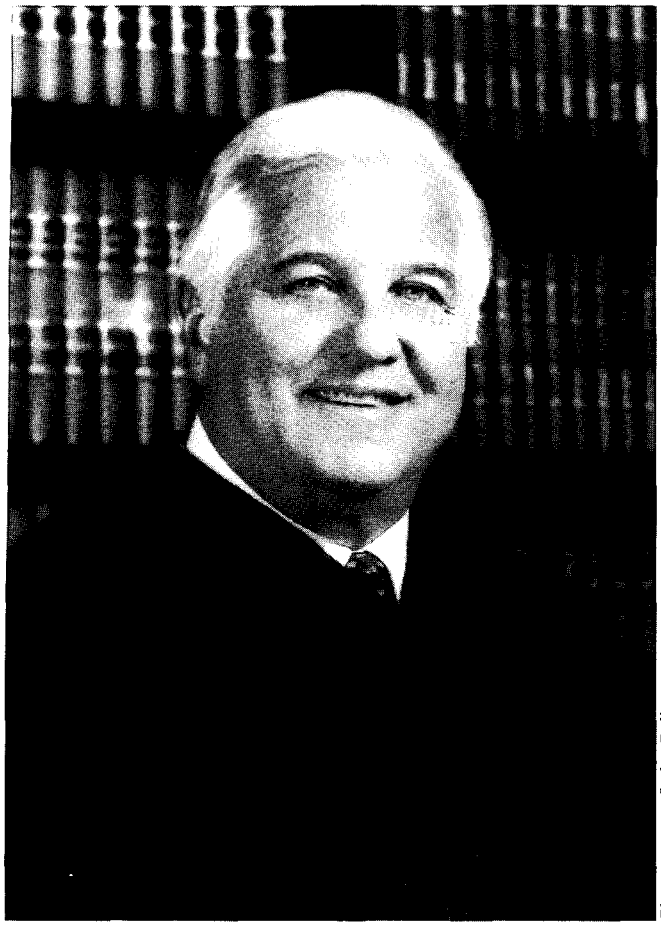

Photo courtesy Judge Politan

Judge Nicholas Politan ruled that the Secretary of Health and Human Services had not articulated a clear policy against private contracting.

court in Newark, New Jersey, to enable Medicare patients to contract privately for medical care outside Part B without resigning from Part B. Our case became known as *Stewart* v. *Sullivan.*

Our Honesty Used Against Us

Kent Masterson Brown was confident that we would win the freedom to contract because his research had revealed no explicit prohibition in the Medicare law or regulations published in the *Federal Register* against such arrangements. Medicare law repeatedly states that with respect to Part B, Medicare is an entitlement, not a compulsory requirement, and the original Medicare statute specifically states that nothing in the Medicare law prohibits a beneficiary from obtaining health-care services through any other means of payment or insurance. It appeared that HCFA and the carriers formulated their prohibition of the private contract by leaving out the implied "if" in the law discussing physician submission of claims. Services "for which payment is made under this part" does not translate into "all services for any medical need must be paid under this part." The bureaucrats then enforced their interpretation with threats and intimidation of physicians who may have wished to deal with their senior-citizen patients privately.

It may seem unbelievable to those who do not deal with government programs and the bureaucracies that administer them that physicians actually were coerced into following a regulation that did not exist. But physicians across the country had been told by their carriers and by HCFA that private contracts were prohibited by Medicare law. Physicians believed this must be true if we were so told. Physicians did not ask for proof, or check the statute itself, or ask to see the citation in the *Federal Register.* They made their judgment based on what they were told by the appropriate authorities. Until the lawsuit challenged this prohibition in court, physicians naturally assumed the prohibition was in the law. The great majority of physicians have honest, ethical natures, and the bureaucracy used these attributes against us.

An Absolute Victory

Our freedom-of-choice lawsuit, *Stewart* v. *Sullivan,* was heard in oral arguments on September 14, 1992, in federal court in Newark. Judge Nicholas Politan asked the U.S. attorney representing HHS to identify the source of the carriers' statements that seemed to prohibit private contracting. Mr. Robbins replied, "We don't know where those statements came from." Mr. Robbins also could not verify that Louis Sullivan, then-secretary of the Department of Health and Human Services, interpreted the Medicare Act to prohibit private agreements, or whether Dr. Sullivan would try to sanction me for treating patients outside the Medicare program.

Judge Politan did try to "flush out" the intent of the suit as a means for me to charge more than the limiting charges of the Medicare RBRVS schedule. Our attorney pointed out that private contracting would allow the doctor to charge more or less than the RBRVS rates, and that in any event, freedom of choice, and not allowable charges, was the point of the lawsuit.

Based on this testimony, as well as various internally contradictory statements in correspondence from HHS, Judge Politan ruled on October 26, 1992 that he did not believe that the secretary had clearly articulated a policy against private contracting. Judge Politan dismissed the case after finding for us on a critical point: if Secretary Sullivan had articulated a clear policy against private contracting, such a policy would constitute an "injury in fact," giving both me and my patients standing to sue. He stated that we, the plaintiffs, would find relief in his court.

We considered this ruling to be an absolute victory. Kent Masterson Brown stated in a press release after the decision, "If the Secretary does come forth with a clear policy [against the private contract], we'll be back in court immediately.... At present, there is nothing to prevent patients from seeking private care on a case-by-case basis. On reaching 65, patients become entitled to use Medicare benefits. This entitlement does not require patients to use those benefits to the exclusion of all other methods of providing for medical care."

The opinion in *Stewart* v. *Sullivan* upheld the idea that we citizens of the United States have the right to do that which we are not expressly prohibited from doing, as stated in the Ninth Amendment and as articulated in the Declaration of Independence. To say otherwise creates the dangerous context in which the citizen acts

only by permission of the government or state, rather than by right.

After the Ruling

Since Judge Politan's ruling, I have accepted new Medicare patients with the understanding that, at some times and for some services, I might seek a private contract with them outside of Medicare to provide payment to me. This has not driven patients away, although patients who want to use Medicare exclusively are, of course, free to go to another doctor who will agree to that. Certainly it is far more ethical for a physician who cannot deal with Medicare for a particular service to offer the private contract to a person seeking medical help than to refuse to see the patient altogether. The plaintiffs all have remained in my practice.

Oddly, the case has received little publicity from the lay media. I have traveled extensively discussing the case with physicians, giving speeches and interviews in the medical press, and encouraging doctors and patients to stand up for their rights. Private contracting is spreading, but many physicians, still unfamiliar with the case, are afraid to cross the Medicare carriers and HCFA. I receive many calls each week asking me about the suit and the waiver form that I now use with private patients over the age of 65. As recently as March of this year, one of my wealthy older patients was denied care in Durham, North Carolina, because the clinic she went to for help in an emergency was not accepting new Medicare patients, even though she wanted to pay for treatment herself. She had to make a number of calls and obtain help from a friend to find a doctor who was willing to make a contract with her privately to provide her care. This patient was well aware that the private contract was lawful, because she had contributed $500 to the Freedom of Choice Fund.

Succeeding in this lawsuit has by no means solved all my professional problems. My income continues to shrink, and the regulations, paperwork, and expenses continue to increase. And I miss the special relationship I had with the senior citizens in my care before the imposition of coded claims, fines, and threats.

I still seriously consider leaving the profession that I love and for which I have sacrificed. As my son enters his first year of college this year, I cannot encourage him toward a career in medicine, even though both of his parents are dedicated physicians. Many young people of talent and ambition look at the health-care system in America today and see no future for themselves; many physicians in private practice are seeking other options. My hospital staff is giving a dinner this summer for a physician considerably younger than I am who has had the "courage" to leave medicine.

A Warning to the Health Task Force

The Medicare headaches that I and many other physicians have suffered are not unusual in the current system—in fact, they are routine. Medicare is really not a partisan issue, since both Republicans and Democrats have helped build the system. My problems with Medicare began during the Reagan administration, and it was George Bush's bureaucrats who denied my patients freedom of choice.

Folio

Problems with bureaucracy and red tape are likely to intensify under the Clinton administration.

But it seems likely that these problems will intensify under the Clinton administration. Having witnessed first-hand the ensnarement of doctors and patients in the Medicare web, I dread the prospect of government health care management. My chief concern about the Clinton health plan, whatever form it eventually takes, is that it will politicize the entire health-care delivery system, and dramatically increase restrictions on the way physicians are able to treat their patients, interposing the bureaucrat in all patient–physician encounters.

Managed competition, which now seems to be the cornerstone of the Clinton plan, is supposed to be a way to give all Americans access to health care. In reality, it may cause a number of serious side effects: individuals will have less choice in their health-care decisions; there may be less access to certain providers and fewer services overall; and development of the new technologies that have made American health care the best in the world will stagnate. The massive new bureaucracy that will be required to administer such a system will increase red tape and delays as well as costs. Price controls on health services will force doctors out of practice.

I cannot imagine continuing under such conditions; the danger is that the pool of talented, dedicated, innovative physicians will give way to doctors working not for their patients, but for a government or corporate paycheck. The civil servant mentality will predominate, rationing will be inevitable, and the Hippocratic ethic, which emphasizes the good of the patient, will disappear. Under such a system, the profession of medicine that Americans have known and come to rely on will cease to exist.

Sarah is discovering that snails sometimes "grow" on trees. That's only the beginning. Her visit to Everglades National Park will include lessons on alligators and exotic birds like herons and egrets, too.

But Sarah won't just learn about wildlife. She'll also learn about protecting our environment. Through a recycling program of the National Park Service and its recycling partner, Dow.

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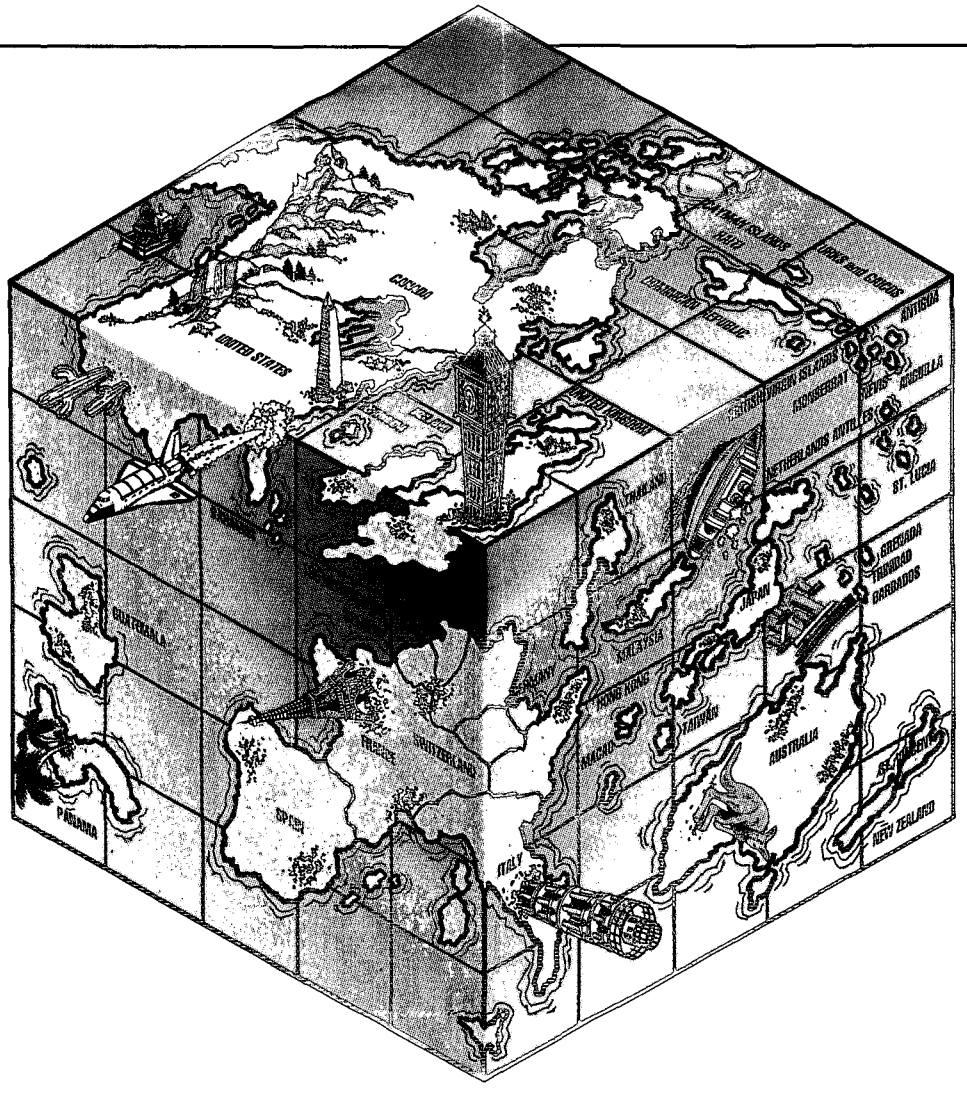

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Calm After Desert Storm

Dick Cheney on Tax Cuts, Price Controls, and Our New Commander in Chief

An Interview by Adam Meyerson

Dick Cheney is one of the strongest potential contenders for the Republican presidential nomination in 1996. He is a man of national and international experience: best remembered for his distinguished performance as secretary of defense during America's Desert Storm victory, he was also White House chief of staff under President Gerald Ford, and then House Republican Whip, one of the top leadership positions in Congress. Elected six times to the House of Representatives from Wyoming, he has proven vote-winning ability in a state that went 26 percent for Ross Perot last year. He comes from the West, a region where Republicans are now in trouble—and which they must recapture if they are to win back Congress and the presidency. He is one of the few Republican leaders widely respected by Democrats and independents. An economic conservative and a moderate on social issues, he probably also would be acceptable—no small feat—to all factions of the GOP.

His greatest challenge, should he aspire to national leadership, is to be a little bolder, a little more imaginative, a little more stirring in his rhetoric. His message is plain, no-nonsense, conventional, center-right Republicanism—lower taxes, limited government, freer markets, a strong defense. This message could prove very attractive to Americans after four years of Bill Clinton. But will it be enough to galvanize the political coalitions Mr. Cheney would need to win—and then to govern effectively? He already has won his countrymen's respect; can he now move them to action to cure America's economic ills and arrest its cultural breakdown?

I talked with Mr. Cheney in late May in his office at the American Enterprise Institute, where he currently is a senior fellow.

—A.M.

Policy Review: **It is now two years after the spectacular victory of the United States and its allies in Desert Storm. What objectives were achieved during this war?**

Cheney: The best way to evaluate Desert Storm is to consider what the world would be like today if we hadn't fought and won this war. If we had taken a pass on Saddam's occupation of Kuwait, by today he would have the eastern province of Saudi Arabia and would sit astride about 50 percent of the world's oil reserves, which he could control directly when you add up Kuwaiti, Saudi, and Iraqi oil reserves. He'd be able to dominate the rest of the reserves in the Persian Gulf. And he'd have nuclear weapons. We had to stop this from happening. And we did.

We did exactly what we set out to do in Desert Storm. We liberated Kuwait, and we destroyed Saddam's offensive capability. Those were the two objectives we talked about repeatedly in the run-up to the war, and once we achieved those objectives, we stopped operations.

P.R.: **What were President Bush's most important contributions to this victory?**

Cheney: The president laid out the broad strategy. He took a personal hand in organizing the international coalition that gave us political and military support. He managed the Soviet account. He worked with the United Nations and the major Arab leaders who sent troops to fight alongside U.S. forces. He gave the Defense Department clear direction in terms of the objectives. Then he let us fight the war and refrained from micromanaging the military campaign.

He also deserves credit for having the courage to avoid some of the mistakes that Lyndon Johnson committed in Vietnam. When I told him we wanted to call up a quarter of a million reservists, he never hesitated. He said, "Do it." When we said we needed to put a "stop-loss" order in effect so that everybody currently in the military would stay in for the duration, he said, "Do it." He consistently gave us the kind of political support that we needed to use military force to maximum advantage. That's one of the reasons we were so successful.

P.R.: **By contrast, how would you evaluate President Clinton's handling of the conflict in Bosnia?**

Cheney: I've been very nervous watching President Clinton deal with the Bosnian conflict. This has been his