



Fact, Fiction & Fraud in Modern Medicine...

... by Thomas Dorman, M.D.

Exploring Issues of Philosophy, Principle and Conscience in Contemporary Health Care

Licensure

The bourgeois ethics of our society, the middle class standards of our civilization, are threatened on many fronts. The facade of normalcy prevails while, under the surface *change agents* are melting the foundation of our culture.¹ It is my prediction that our empire will collapse inwards suddenly catastrophically soon. By *empire* I mean everything around us - food, clothing, transport, information and comforts; they are all going to go.

No, I don't have a scenario for doom's-day; it is foolhardy, however, not to recognize what the basis of our civilization is. The basis of our civilization is *middle class ethics*. I like the term *bourgeois* because Karl Marx targeted that word, and yet the standards of individual responsibility, privacy, self-advancement through production, trade and interchange with others and, above all, the maintenance of one's own reputation, constitute the essence of this civilization.

It is founded on honor and truth. Protestant Christianity has served as the main catalyst for the advancement of these standards as we emerged from the last catastrophe of our civilization, i.e., from the Dark Ages to the Renaissance. I am not a protestant, let alone a Christian; so this recognition does not represent bias or prejudice; mere observation. The engine of our civilization, therefore, is *the individual and his rational mind*. The people who contribute to our society and to our civilization do so through their actions, and most of these actions are actions of the mind - inventiveness, production and, in the case of medicine, the provision of medical services. The consultation members of the public can receive from a private physician is the contribution doctors make to this multiple-party interchange. This circuit brings ever more goods and services to the community.

As each individual seeks his own advancement by providing ever more goods and more sophisticated services, the well being and the standard of living of the community at large grows. I contend here that this growth, this wondrous advancement of humanity from an animal-like existence to *civilization* is predicated on *individual minds* interacting through exchange for mutual benefit.

Note what I am *not* saying. I am not saying *collec-*

tive activity and herein lies a major distinction. People often agree about things, and they sometimes disagree. Discussion and review leads to reassessment of existing ideas, sometimes called 'knowledge,' and often the development of new ideas and innovations. When everybody thinks (or pretends to think) the same, no innovation will come. Absent innovation, our civilization is doomed.

Everything living consists of a balance of decay and senescence (wear and tear) on the one hand, versus growth and rejuvenation. Life, intelligence, community, and also our very society, are not static matters. Accordingly, all the philosophies which have seen what there is and attempted to *codify* it, and maintain it as it is, are doomed to failure because they deny growth and rejuvenation. It is a characteristic of despotic regimes that they harvest what knowledge there is, in some successful society or other, and proceed to regulate it. Innovation ceases immediately, of course.

We are living in interesting times. In our very time there is raging a titanic battle between these forces of regulation and the residual momentum of freedom and innovation. We speak of the *age of information*. We would be better to speak of the *age of disinformation*. Actual information is only a small part of the stream.

Introduction

In this newsletter, I will look at the role *licensure* plays in medicine. I will first review a horrendous decision, made in California, regarding an *alternative* practitioner as an example of *licensure* gone very wrong. I will then back out of the specific, to the general, and attempt to answer the question, "Does licensure play any role at all in a civilized society?;" and if it is 'necessary,' is that a reflection on a broader problem in the society concerned? Finally, I will draw the conclusion that licensure has become a *tool for tyranny*.

The perception in our society that it is necessary is false and is a special case of *pressure from below*. The tools of *pressure from above* and *pressure from below* will be reviewed in a future article. They are sentinel examples of *Leninist tools* for social transformation. Whether or not you believe that Communism is dead, observing societal changes in our own community and,



for that matter, everywhere in the world, we see that the tools of Communism and *change agents* are multiple, their influence is spreading, and their work is increasing.

Most of us are oblivious to the destruction, the melting of the foundations of our civilization, because we have been lulled into indifference by two tools. These are special instances of *pressure from above* and *pressure from below*. I am speaking specifically of claims of complexity and technicalities, on the one hand, and a barrage of fear on the other. If you analyze almost any current event, with this perspective in mind, you will hear the signature tune, the *leitmotif*, with the application of a little perspicacity.

Innovation

It is self-evident that innovation can only occur in the mind of one at one time. It may not be self-evident, but it is certainly true (on the basis of the empiric method) that, from such an idea, there needs to flow observation, prediction, and other forms of experimentation.

Doctor Sinaiko

Robert Sinaiko, M.D. is a San Francisco internist and allergist who is an impressively credentialed physician whose practice consists of treating difficult cases involving complicated environmental and other allergies with experimental therapies. He works on the frontiers of medicine where there are no easy or well-trod paths to clinical success.

Dr. Sinaiko's license was revoked in August 1998 by an Oakland Administrative Law judge after a 26-day hearing. The decision was approved by the Medical Board of California. He was also fined \$99,000 for the costs of the proceedings. No patient complained about Dr. Sinaiko's treatment. No patient testified against him. No patient was shown to have been harmed. Judge Ruth Astle ruled that Dr. Sinaiko was practicing "fringe" medicine because he was prescribing experimental drugs for four specific cases, including drugs for "off-label" uses - that is, for things other than what the label calls for. This, she said, constituted "an extreme departure from the prevailing standard of practice among the community of licensed California practitioners," even though many physicians assert they do this all the time.

In the case that triggered the initial investigation by the Attorney General's office, Dr. Sinaiko was caught in the cross-fire of a divorce and child custody dispute in which the parents differed over the treatment prescribed for their hyperactive child.² This text was taken from an editorial by John Jacobs in the *Sacramento Bee* newspaper published September 3, 1998. The article goes on to tell us about 10 prestigious witnesses who supported Dr. Sinaiko at the hearing and (in this writer's opinion, correctly) draws the conclusion "...all doctors

who say to a patient, 'I'm not sure what's wrong with you, let us try this,' now risk losing their licenses. All progress in medicine through clinical observations of patients in day-to-day medicine will become too hazardous. The issue here is *community standards*.

The Accusations

The accusations against Dr. Sinaiko were such as could be leveled against *any* doctor. Interestingly, the charge that he used drugs for off-label purposes seemed prominent, and yet this is a normal practice. This, therefore, represents *selective enforcement*. It is indeed selective enforcement which brings us to the nub of the matter, as far as this observer can judge. Dr. Sinaiko took over the practice of another environmentalist, a doctor who recently retired and was seemingly also previously *targeted* by the same licensing authority. A major part of the accusations deal with the validity of certain concepts. This is where the issue is of concern to the rest of us. Is the licensing authority, in this case the Medical Board of California, the right forum for conducting discussions issues of science and if, in their opinion (and as far as we can judge from their decision on this physician, this *is* their opinion) that theirs is the right forum, and they have this authority, we as a society, need to ask the broader question - do we want licensing boards *at all*? As far as one can judge from the accumulated literature around this issue,³ the decisions the judge made, presumably at the instigation of the Medical Board, were that certain "bizarre diagnoses" had no validity. These are 1) Multiple chemical sensitivities; 2) Candida Hypersensitivity Syndrome; 3) Attention Deficit Hyperactivity Disorder secondary to allergic etiology; 4) Whether enzyme potentiated desensitization is a legitimate form of treatment.

Before I proceed with this discussion, I should like to state that, for myself, I believe that the Candida Hypersensitivity Syndrome is a legitimate entity immensely overplayed, that Candida organisms are a necessary part of our intestinal milieu and, in fact, fungi are an essential part of the biosphere in the degradation processes; that the presence of these fungi, in our environment and in our intestines, is normal. It is my personal opinion (though this is not something I can verify objectively) that when people benefit from treating the Candida, and indeed there are multiple people who do benefit from these treatments, it behooves the doctor to look for a more proximal cause for the overgrowth of the fungus and its harmful effect. You see, many people respond well to the anti-Candida antibiotics, but only as long as they are in use. I have no experience in enzyme-potentiated desensitization (EPD) but am aware that this has become a topic of great interest, having been introduced not long ago from the United Kingdom, and many of the doctors on the cutting edge in environmental medicine have been using it with suc-

cess. Finally, the observation that hyperactivity in children with Attention Deficit Disorder is frequently associated with food intolerances and other allergies is so manifestly correct, from our experience at the Tahoma Clinic and cumulatively from the experience of hundreds of practitioners in Environmental Medicine, that this issue has really passed beyond the point of being a new idea; it is, therefore, particularly interesting to note that the Medical Board and the judge rolled these issues together, treated them together, used terminology such as "bizarre" in describing these approaches, a position which puts them (the board) clearly in the wrong and behind the times. However, the point that I want to focus on in this newsletter is not their error so much as it is their *power*.

Ostensibly it is the role of the licensing authorities to respond to queries and complaints from the public when someone has been hurt or injured by a medical practitioner, or at least believes that they have been so injured, due to bad practice as opposed to the natural progression of disease for which they attended the practitioner in the first place. I do actually believe that having a forum of informed medical opinion, to help the public form these judgements, is a highly valuable service; but here we have a case where there was no patient complaint. There was no complaint of harm. We are not told how all the cases came to the attention of the Medical Board, we are only told that *one* case came to the attention of the Medical Board because of custodial dispute between divorced parents.

We are also told that a doctor testified against Dr. Sinaiko, representing what I shall call the old fashioned belief of more standard medicine. You see, the arena has moved, seemingly imperceptibly, from catering to concern about negligent or faulty practice to the imposition of majority view and, almost by definition majority view and scientific methods are always old fashioned because of the nature of innovation having to start in the mind of one. Another charge, that was levied at Dr. Sinaiko was the use of *experimental methods*. Now how on earth can one develop a new method unless one experiments with it?! Clearly it is the responsibility of the clinician, using new methods, to ascertain first of all that they will not be harmful and then ascertain their effectiveness, if any. It goes without saying that there is a multitude of ideas and new methods which turn out not to be effective; that is the nature of innovation.

Notice that Dr. Sinaiko was not charged with introducing methods which he had personally invented, or ideas which are peculiar to himself. The American Academy of Environmental Medicine has hundreds of members (of which this writer is one) who have taken advantage of some of these concepts and methods to varying extent. The association provides a forum for medical discussion, publishers, newsletters, and articles on these issues, and conducts seminars and annual meet-

ings. What was the motive of the Medical Board of California in *targeting* this prominent practitioner who has harmed no one at all?

Unfortunately we will need to leave this question hanging; I do not have any evidence with which to formulate an answer. However, if we look at the broad trends in medicine and at the broad trends of changes in our society, perhaps the answer will suggest itself. It is also not without merit to suggest asking *who benefits?*

Here we need to return to some of the detailed accusations. In them, the curious term *step-ladder approach* appears. It seems to mean that there is a series of pharmaceutical agents that need to be used, one after another, to judge whether the hyperactivity of the child (the index case) would improve *before* trying more simple methods such as elimination in the diet or the use of the antifungal agent *orally*.

There was a big argument about whether amphotericin-B is safe. Well, it true that amphotericin-B has been used widely intravenously, in hospitals, for catastrophic Candida infections (in the bloodstream) and it is true that it is potentially a dangerous drug in this context. However, this substance is not absorbed from the intestines and remains a potent antifungal agent in the cavity of the intestines. Dr. Sinaiko had the child *swallow* amphotericin-B. Incidentally, a usage which has been approved by the FDA, since 1971. This route of administration is both safe and effective; however, some of the documentation available about this drug rightly points out the potential danger when it is used *intravenously*. Applying the warning in the wrong context due to a misunderstanding, or worse, seemingly was the narrow edge of the wedge which opened this case in the first place. Allowing this to develop represented either poor judgement or malice. You be the judge.

We have, then, a tragic situation where the doctor has been subject to humiliation, loss of license, loss of livelihood, a gigantic fine which is best called a 'bounty' because recently introduced laws in California allow the fine to accrue to the policing agency if *any* of the accusations is allowed to stand at the end of the hearing, even to the smallest extent. This is piracy and bounty, but it is also the law. Conclusion: The law is criminal; not a pleasant conclusion.

As Bismark pointed out over a century ago, people with delicate dispositions should go neither to sausage factories nor legislatures. We in America, however, have validated that cynical remark a thousand times in the last twenty years. Almost all legislation arrives pre-packaged from the Uniform Law Commission⁴ or from a less well defined national master plan, the details of which are unknown to this writer but, from reviewing the parts of the puzzle in several proposed legislations, it is clear that many of the proposed new laws have an interrelationship amongst themselves.

A current example of that is the drive for a National ID number and, what is most interesting to medical

doctors is, a national "Provider" number. This will facilitate tracking everything doctors do and all the effects on patients. Perhaps even more alarming is that it will track everyone's malady in a manner not dissimilar from the tracking a farmer would use in following his domestic herd.

The Ostensible Role of Licensure

You will find, wherever the issue is discussed, that the role of licensure is to *protect someone from something*, and it is always the government, and amongst governments, always more central governments with greater control, and yet we are entering into the phase of world government which is doing the 'protection.' In the age of *laissez faire*, most of the protection was in the name of the *person*. Medical licensure was introduced with this in mind, but we have protection of the nation, protection of property, protection of the value of money, protection from stimulants (drugs), protection of the environment, and nowadays we have protections of other species, protection of sexual sanctity, of food, water, air, travel, business, energy utilization and, most recently, communication. I contend that the charges against Microsoft and its president Bill Gates are also a special case of an attack by the forces of evil, by tyranny, on the forces of innovation, freedom and reason.^{5,6} Our society developed wondrously during a time when all these issues were *not* protected by licenses and government. It is my belief that the business of licensing is a mere excuse for power, control and ultimately tyranny. However, in the case of medicine, we have a somewhat special scenario.

Platonic vs Hippocratic Medicine

The miasma of thinking Platonic, thinking in terms of community and group, practice guidelines, standards of care, thinking of the herd rather than the individual, has spread widely. For instance, the recent "reports" from the Washington State Medical Association⁷ contains a lead article by the newly elected president, Dr. Mark Adams, in the form of questions and answers. I will quote from this only briefly to illustrate the point. Q: Accountability is a buzzword in medicine right now. What do you mean by accountability? A: Physicians need to demonstrate they can deliver "value" in a scientifically reproducible way. Value, in this context, means quality of care for a given price. Accountability also means physicians have to responsibly direct patient's care. The only way physicians are going to retake control of patient care is by developing accountability [Do you understand what this means? - Ed.] Q: Physicians should be accountable to whom? A: To the payers, the people paying the bill.... This is a very interesting article. I do not know Dr. Adams; his biography indicates he is a vascular and thoracic surgeon working at Harrison Memorial Hospital here in Washington State. I use this

initial fragment of his article to illustrate the point that, what seems to me muddled thinking, leads to a very clear definition of whom doctors are accountable to. They are accountable to the payer. Now the payer, of course, is the government, behind the facade of insurance, e.g., Medicare, or a private insurance company which harvested its income (premiums) respectively from taxpayers or producers respectively. That is, you and me in one form or another. The intermediary status of insurance is an issue with which I have dealt.⁸ We have then a clear acknowledgement by a leader in medicine that *accountability goes to the payer*. We have to conclude, therefore, that the introduction of the intermediary payers (the third party payers, as they are sometimes called), although masquerading as our 'friends' providing us with insurance for unexpected catastrophies, a form of voluntary deferred gratification ostensibly, are in fact taking control of us. By *us*, I mean both the public at large, and the medical profession.

Attention Deficit Hyperactivity Disorder

The medical community is seeing an increasing number of these cases. The diagnosis is usually provided by a school psychologist. Almost certainly this disorder is in fact a *syndrome*; in other words, children's misbehavior at school, inattention and sometimes erratic and hyperactive behavior, is probably the result of more than one cause. I think in the list of possible causes, we should include at least the following: 1) Boredom; unsatisfactory schooling techniques which fail to keep the children's interest and attention.^{9,10} 2) Sick Building Syndrome; this is a situation in which the ventilation system does not filter out pollutants satisfactorily. Some individuals are more sensitive than others, and the sensitive portion of the community in the building, typically schools in cold climates, are subject to disturbances in brain function. This often affects teachers as well as students.¹¹ 3) Food intolerances. 4) Other gastrointestinal dysfunctions, often classified under the umbrella term *Leaky Gut Syndrome*.¹² 5) And perchance, associated with some of these conditions, overgrowth of *Candida* which clearly responds to anti-*Candida* antibiotics and seems to have been the situation in the index case in Dr. Sinaiko's hearing.

The Free Market versus Licensure

The following paragraphs are excerpted from the writings of an enlightened practicing urologist, Dr. Murray Feldstein:¹³

Doctors are fond of blaming government programs, such as Medicare and Medicaid, and the attendant morass of regulations that followed in their wake, for our present predicament. However these welfare programs were merely the logical response to events that originated long before. The sad truth is that the medical profession is as much responsible for the socialization of medi-

cine and the loss of our professional freedom as any politician or bureaucrat. Self-interest blinds our vision, fashions our assumptions, and casts us in the role of reactionaries. A review of the history of licensure in this country is essential to comprehending the origins of the Health Care Crisis.¹⁴

The Evolution of the Crisis: Pathophysiology

Licensure was not important in this country until almost the turn of the twentieth century. In colonial times the apprenticeship was the cornerstone of medical education. As immigration and westward migration increased the need for physicians, medical schools were founded to augment the apprenticeship. There was a paucity of scientific knowledge. Physicians were more often comforters than providers of curative care. Many physicians were clergymen. It hardly mattered what was taught because most of it was wrong.

In the nineteenth century America was home to more than half the medical schools in the world. The majority were proprietary and organized for profit. Faculties earned their money directly from the students, so the schools admitted anyone who could afford the entrance fee. The schools kept the class numbers large, tuition low, and expenses down. There were almost no entrance requirements. During the Jacksonian era there was a strong feeling of democratic egalitarianism and *laissez-faire*. Almost anyone could become a physician. The proprietary schools catered to the working class, women, and ethnic minorities, including blacks after the Civil War. Licensing boards were established in some of the original colonies, but these were comprised of political appointees and ineffective. Most states had abolished them by mid-century.

The usual medical school curriculum consisted of didactic lectures for two terms of sixteen weeks each, after which a student graduated with an M.D. There was no organized laboratory or clinical training. Very few schools were associated with universities, and in those the association was nominal. Hospitals were independent of the schools. To complete their education many students would arrange an apprenticeship with an established practitioner. A fortunate few were able to obtain a clerkship in some hospital, but these positions were highly competitive, and not a part of the standard curriculum. Wealthier students would study abroad. No licensing examinations were required before a graduate entered practice.

The weaknesses of this early American medical system became obvious during the Civil War. Many doctors inducted into the military could neither read nor write. Casualties might be operated upon by a physician who had never before witnessed or performed surgery. Doctors were considered crude and undeserving of respect. The dismal experience with the profession during the war, and the growing awareness that medicine had a scientific basis, inspired a reform movement.

Exciting discoveries were being made in Europe. Pasteur formulated the germ theory. Lister proposed antiseptic for surgery. Anesthesia became available. Laboratory experimentation proved its worth as one after another of the deadly infectious diseases became treatable or preventable. The wealthy American students who were trained abroad looked disdainfully upon the academic deficiencies of their native schools, as well as the lower class students who inhabited them. They formed the nucleus of an educational elite who gradually reformed the system after the Civil War. Schools such as the University of Pennsylvania, Michigan, and Harvard upgraded their facilities, constructed laboratories, began to hire full-time faculty in the pre-clinical sciences, and imposed academic prerequisites as a condition for admission. The length of training gradually increased

to four terms. In 1893 the Johns Hopkins Medical School was founded. It had its own teaching hospital and full-time faculty. It was considered the prototype for all other schools to emulate.

By 1910 most of the reforms had been accomplished voluntarily. The better students went to university medical centers that either had established relationships with teaching hospitals or were preparing to do so. Faculties were paid by the university and there was increasing emphasis on research. Education had improved to the point that Europeans were now coming to this country to complete their education. The worst of the proprietary schools had been driven out of business and many others were teetering on the edge of extinction. The number of medical schools had decreased from 160 in 1900 to 131 in 1910. Homeopaths, Eclectics, Herbalists, and other traditional competitors fell out of favor with the public by the turn of the century. Their schools passed from existence.

These reforms had not come easily and were not without sacrifice, hard work, or expense. They had come about without government intervention, because the market was responding to the dramatic changes in American society. We had become a wealthy, mobile, industrial nation, in tune with the latest scientific achievements of the young twentieth century. The medical system still had many problems to solve: arranging for financing of basic and clinical research, construction of laboratories, and hiring of an ever increasing educational and administrative bureaucracy. The relationship of medical schools with teaching hospitals had not yet been finalized, as the schools still had not achieved administrative control over the wards. A debate still raged whether some schools should exist as "practical schools," devoted primarily to the education of practitioners of medicine, or if all schools should become research centers with the teaching of students an important, but not essential, function. Finally, many physicians felt they were woefully underpaid considering their newly upgraded status as scientifically trained practitioners. The AMA wanted to remedy this situation.

Until now the AMA had little to do with the evolution of the medical system. It now advocated reforms that would allow it to gain control of the various state licensing boards that were established after the Civil War. The AMA's Council on Medical Education published a report outlining these recommendations in 1904, but it was largely ignored. The AMA increasingly looked to government to redress its grievances. Something else was needed to galvanize a complacent public.

The AMA realized its dreams by engineering the famous Flexner Report, a piece of muckraking journalism.¹⁵ Abraham Flexner was an obscure educator who worked with the Carnegie Institute for the Advancement of Teaching. His brother, Simon, was the director of the Rockefeller Foundation for Medical Research and had ties with the AMA's Council on Medical Education. The AMA convinced the Carnegie Foundation to sponsor Flexner's study of American medical schools. This prestigious philanthropic organization promoted Flexner's report as an independent, dispassionate, and objective work by an expert in medical education.

None of this was true. Flexner had no personal knowledge of the medical profession besides the relationship with his brother. He gained his expertise at the offices of the AMA. He read their 1904 report and then toured 69 medical schools in 22 states over three months. He spent only a few hours at many of these schools. Not surprisingly, his findings and conclusions were similar to that of the AMA a decade earlier. His method was simple: he compared all schools to Johns Hopkins which he held as the gold standard. Ignoring the great accomplishments of the previous thirty-five years, Flexner concentrated on the problems that remained. He ranked schools by their deficiencies and identified them by name. Even great institutions like Pennsylvania, Harvard,

Yale, and Michigan came under criticism. The report caused a public furor.

Flexner recommended that only top-flight universities with teaching hospitals be funded, that medical school faculties be exclusively comprised of full-time salaried personnel, that research rather than teaching be the primary institutional priority, that only graduates of these medical schools be eligible for medical licensure, that all proprietary medical schools be immediately closed, and all other schools, even the better “practical” schools, be closed down if they did not comply with his criteria within a short period.

Historians have argued over the actual importance of the Flexner report. It probably has received more credit and blame than it deserves. Over the ensuing decades, however, its recommendations were generally enacted. There were 131 medical schools with 22,000 students in 1910, the year the report was published. Ten years later the number of schools had fallen to 85, and the number of students to 14,000. The medical schools that survived assumed the characteristics prescribed by Flexner, as state legislatures and the large philanthropic institutions the schools had come to depend upon gave money only to those that complied. Flexner oversaw much of this funding himself after he was appointed the head of the General Education Board of the Rockefeller Foundation, the single largest source of medical funding in the Progressive Era.

One by one the states turned over the effective operation of their licensing boards to organized medicine. Only graduates of medical schools certified by the AMA’s Council on Medical Education could sit on these boards. Only graduates of these schools were eligible to take a licensing exam. Further restrictions were enacted. In many states a practitioner’s ethics and moral standing had to be approved by his county’s medical society as a condition for licensure. County societies engaged in activities that today would violate anti-trust statutes. For example, they refused to consider physicians who practiced “contract medicine” (the forerunners of HMOs).

The number of medical schools continued to fall until 1944, when there were only 69 remaining. Only then, under intense pressure from the public, did they again begin to increase. It wasn’t until the 1960s, after the federal government started to subsidize medical education, that the physician/population ratio again reached the level of 1910.

Many a baby has been thrown out with the bath water because humans are naturally attracted to the disadvantages of a situation without comprehending the advantages. So it was with the Flexnerian reforms. With the benefit of hindsight I shall enumerate some good features of the medical system prior to Flexner.

1. Before Flexner, medical care was relatively cheap. The first complaints of the high cost of medical care were not heard until ten years after the Flexner report, when supply did not keep up with demand. The drastic reduction in the number of physicians occurred at a time when the population was expanding from an influx of immigration. The demand for physicians’ services had also increased because doctors could now do more for their patients. One economist has likened giving the medical profession *de facto* control over the number of physicians as being the same as giving the National Steel Board the right to set steel production quotas.¹⁶

2. Before Flexner, medical care was generally abundant, even in backwater outposts along the expanding western frontier. After Flexner, the supply of physicians began to dwindle in less affluent (particularly rural) areas, as these had traditionally been serviced by the now defunct proprietary and practical schools. Foreign medical graduates have traditionally gravitated to those areas shunned by their American colleagues.

3. In spite of the dramatic professional deficiencies demonstrated during the Civil War, most patients were satisfied with

their physicians. (Did they even have malpractice suits?) If patients didn’t like the purges and bloodletting practiced by orthodox physicians they were free to visit their local cultist or sectarian, such as eclectics, homeopaths, chiropractics or herbalists. The unscientific practices of these irregular practitioners were often less harmful than the more heroic unscientific practices of the orthodox medical profession.

When M.D.s began to improve their image by incorporating scientific principles into their practices, irregular practitioners fell out of favor (competition works!). Patients were not writing letters to the editor asking politicians to overhaul the system the way they do today.

It wasn’t until Flexner that people began to complain that their physicians lacked sensitivity, or that they cared more about diseases than human beings. Education in the post-Flexnerian schools became uniform and regimented. The schools concentrated on turning out highly trained, hospital based, technologically oriented, graduates. Now that these graduates were the only people legally permitted to provide medical services, the rest of the system—the hospitals, insurance companies, etc.—were forced to adapt to their needs.

4. Prior to Flexner the impetus for change came from within the profession, not from our patients, which is the way it should have been. A market-oriented system is very adaptable and constantly adjusting to the needs of consumers. Most reform before Flexner was voluntary, effective, and subject to market forces.

Today’s orthodox medical education may or may not be the most cost-efficient way of training excellent physicians. For the time being, it is illegal to find out. For all the obvious advantages of our present medical schools, they are decidedly not good judges of public need.¹⁷ The numbers of physicians and the nature of their training are more dependent upon intrinsic institutional concerns than on market forces. What recourse does society have to change the behavior of these large, bureaucratically inert, physician factories? One glance at a newspaper will tell you. Politicians are threatening to dictate how the schools will train doctors.¹⁸ Until the medical schools themselves have to compete with alternate training institutions that can legally produce medical practitioners, this situation will only get worse. Ultimately physicians will be trained according to politically derived criteria.

Resolution of the Crisis: Therapeutic Alternatives

The commonly offered solutions to the medical crisis are symptomatic treatments only. None of them address the root cause of the problem, which is that our present licensing laws, by distorting the supply side of the equation, hampers the price mechanism. Whether you are “liberal” and want the government to control the medical system by command, or “conservative” and want the government to tax us differently, the price is being left a matter of negotiation by various bureaucracies: governmental regulatory agencies, insurance companies, and professional organizations. Ultimately, then, the factors of production and consumption remain politically controlled from the top down.

A free market works from the bottom up. Supply and demand are terms synonymous with the aggregate of voluntary actions of millions of individual human beings, each motivated by self interest to do the best they can for themselves. Bureaucracies also act in their own self interest. They react to yesterday’s problems slowly, and have no real knowledge of what problems the morrow will bring. In a free market, supply and demand continually fluctuate in relation to each other, and the resulting price determines the next moment’s response. The results are instantaneous. The demand for medical care changes whenever

new drugs, surgical treatments, methods of diagnosis and concepts of disease are introduced. The supply of medical care should adjust to public attitudes, immigration, natural disasters, and new epidemics. Any discussion of an “optimal” physician/population ratio is pure babble in this era of rapid technological change.

Take my specialty of urology for example. [I am still quoting Dr. Feldstein – Ed]. What is the optimum number of urologists? Would that number change if BPH were cured with a simple pill? Or if a new risk-free surgical cure for prostate cancer, requiring three years of intensive training, were introduced? Does it really take four years of college, four of medical school, and four or five years of residency to become qualified to do vasectomies? It takes two days to learn the marvelous new technique of lithotripsy. A ten year old who has mastered Nintendo can learn it in half the time, but he can't send the patient a bill. This is white collar featherbedding. Our current system forces us to adapt technology to fit the practice patterns of licensed physicians rather than adjusting the number and training of practitioners to most efficiently use the technology. Is it any wonder that when it comes to medicine, technology drives up costs, while in market-driven systems technology makes things cheaper?

Later Feldstein finishes his article with:

What happens to the character of a people and to their political system when they no longer can depend on the market?¹⁹ To whom do people turn when their own efforts in a free economic system fail to meet their needs and redress their injustices? The answer in this country in this century has been politicians. To justify political action we must invent new rights—such as a right to health care. When it became clear that a medical education was available only to the wealthy, the government had to provide financial assistance to needy and minority students under the banner of a right to education.²⁰ The welfare state and the institutionalization of poverty is the result of people's attitudes. The federal government has usurped and is usurping power because no other mechanism seems capable of providing for the public welfare. This is also a legacy of the elitist mentality that gave us the Flexner report.

Flexner himself believed that the medical system should never be run for personal gain or profit. He saw hospitals and medical schools as public utilities and physicians as public servants. In this opinion he was joined by many other notables, such as Bismark, Lenin, Stalin, Hitler, and the left-wing socialists and right-wing statists of today. Unless or until a market for medical services is effectively reestablished, this viewpoint will, by necessity, logically prevail. Reinstate an effective market mechanism and the right to health care will become a moot issue. Those physicians who understand the value of professional freedom and individual liberty, who cherish private practice and the dignity of honest labor, should be in the forefront of the struggle to reform medical licensing laws.

In Conclusion

The thrust of this article was that our civilization is a bourgeois civilization - a middle class civilization. The ethics are *laissez faire* individual responsibility and mutual respect. A multitude of issues, which are seemingly plaguing us sociologically, are apparent problems because we are disorientated. We have been separated from our intellectual roots. The thin excuse of ‘protecting’ the public against bad doctors is a current fashion. It is one of the many examples of pressure from above and pressure from below closing in on our freedoms. In a future newsletter, I hope to address *change agents*, who they are, how they operate, on behalf of whom, how to recognize them and perhaps, if we are lucky, what we can do about it.

References

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- 8 *Fact, Fiction and Fraud in Modern Medicine - Managed Care*; Nov. 1996.
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- 16 Kessel, Reuben A., “Price Discrimination in Medicine,” *Journal of Law and Economics*, I (October) 1958, p. 29
- 17 Showstack, Jonathan, et. al., *Health of the Public: The Academic Response*. J.A.M.A., 267:2497, 1992.
- 18 I've selected the following three articles to illustrate my point. Their only virtue is that they came across my desk within the past month.
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“Primary Care Shortage? It's all in the eye of the beholder.” *American Medical News*, AMA, September 7, 1992.
- 19 Epstein, Richard A., *Medical Contract: The Case for Contract*, The Center for Libertarian Studies, Occasional Paper Series #9, New York, 1979.
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