Gene Lees
# Jazzletter

P.O. Box 240
Ojai, Calif.
93024-0240

February/March 1994

Vol. 13 No. 2/3

## Change of Subject

"What do you mean, it has nothing to do with music?" bassist Bill Crow said when I told him I planned an issue on the health-care crisis in the United States. Bill, a board member of New York's local 802 of the American Federation of Musicians, continued: "It is hard for musicians to get proper medical coverage, because they don't work for the single employer. The union is one of the groups lobbying for a single-payer system."

Next to musicians, the largest group of Jazzletter subscribers are doctors. A number of them told me they would like to know more about the state-financed Medicare system of Canada, the only country that bears direct comparison to the U.S.

In the past, when some subject has required extensive research and reporting, I have taking the option of spreading it across several issues. But that seemed inappropriate to the present complex issue, which can hardly be discussed in some such format as six little pages of the Reader's Digest (of which more in a moment). Therefore I decided to do it in one double-sized issue, combining February and March. (At eighteen pages, it's actually more than that.) The larger issues sometimes take weeks of expensive research, and I fall behind schedule, though I always get caught up. I thank you for your patience when this occurs.

*No doubt this issue of the Jazzletter will be widely photocopied. The photocopiers are not sharing the research and production costs with the rest of us. But at a practical level, there is nothing to stop them. For those who would like to send the original to friends, I have my printer on stand-by to print more copies of this issue. It is available for $3 for a single copy, $2.50 each in quantities over that. However it is disseminated, I would urge you to send it to friends, for it contains information essential to seeing through the dissimulations, deceptions, and outright lies of the insurance companies, the Congressmen and Senators they control, and the AMA. And urge your friends in turn to send it on to others. It would be helpful to all of us if you sent copies to your representatives in the House and Senate. The Clinton medical plan goes to Congress in September, and it seems clear that a diversionary tactic has been set in motion to sink it. Both Barry Goldwater and Ross Perot have urged Senator Robert Dole and others to get off the President's back and let him get on with his job.*

For the most part, the kind of person who is drawn to the Jazzletter has broad interests. The most popular pieces in its history are those I almost didn't publish because they so severely stretched the mandate. If it seems strange to encounter a major investigation in the field of medicine in an ostensible music publication, consider something stranger: that you didn't see it in the Los Angeles Times, the New York Times, Newsweek, Harpers, or the Atlantic, which should be all over the story.

I must, however, apologize for this issue to readers in countries other than the United States and Canada, for whom it will doubtless hold little interest. All their countries have national medical plans and American resistance to a major social advance must seem bizarre, to say the least.

For help in researching this issue, I thank Bill Kirchner and Bill Crow among the musicians; among the writers and journalists, Cliff Hopkinson, executive editor for news of Condé Nast Traveler, my brother, David Lees, reporter and former journalism teacher at the University of Toronto and the Ryerson Institute, his friend Judy Haiven, Glen Woodcock of the Toronto Sun, and Grover Sales; my sister, Dr. Victoria Lees, secretary of the senate of McGill University and former assistant director of the Montreal Neurological Institute and Hospital; and among the physicians, her husband, Dr. Roméo Ethier, chief neuroradiologist at the Montreal Neuro, as it's called, and professor at McGill University; neurosurgeon Dr. William Feindel, chancellor of Acadia University and former head of Montreal Neuro; Dr. Bruce Waldie, chief of staff at Queensway Hospital in Toronto; Dr. Robert Litwak, senior cardio-vascular surgeon at Mt. Sinai Hospital in New York City (and a fine jazz drummer in his spare time), Dr. Barry Little of Toronto, neurologist (and a fine jazz pianist in his spare time), Dr. Richard Fraser, professor of neurosurgery at Cornell University / New York Hospital, Dr. Jack Walters, and Dr. Charles Spurgeon of London, Ontario.

One final point. Recently I had an insight that startled me. After it, everything became simplified. The world is divided into two kinds of people: those who believe life is a competitive enterprise and those who believe it is co-operative. The former are bent on defeating others, the latter on helping them. You can view most human actions through this prism, including the current medical debate in the United States.

## Northern Light

For several years we have witnessed a curious phenomenon: American politicians lying about and insulting one of the most treasured institutions of its close ally and best national friend, Canada. Since time out of memory, it has also been its biggest trading partner, buying a tenth of the G.N.P of the U.S. They say in Canada that when Washington catches cold, Ottawa sneezes, but to an extent the reverse is true: economic recession in Canada causes job losses in the United States. The two economies are inseparably intertwined. Along the border, back-and-forth passage is commonplace, and in Detroit, many of the office secretaries are Canadians who travel each day to and from homes in Windsor. Now that the NAFTA treaty has been passed, this economic integration can only accelerate.

Americans usually know very little about Canada, while Canadians know much about the United States. That's nobody's fault: it's a result of population mass. Canada's population is always a tenth of that of the U.S. With CNN now paying some attention to Canada in its coverage, this unawareness may be diminishing.

Many American politicians have been trashing the Canadian medical system, decrying the evils of "socialized medicine" and saying the people of Canada are not happy with it. This is to dissuade Americans from demanding a single-payer government-run medical system like Canada's. The reality is that their medical system is one of the things that Canadians are happy with, and many of them—and observers of other nationalities as well—think it is the best in the world, cheaper by far than the American, infinitely more efficient, and dispensing the best medical care to people of all walks of life.

American politicians of both major political parties have been active in its derogation, but the most egregious deceivers have been former president George Bush, Senate majority leader Robert Dole, former Senator Paul Tsongas, House Republican whip Newt Gingrich, and Representative Jim Cooper of Tennessee, sponsor of a bill of his own as an "alternative" to the Clinton plan. Cooper seems too ignorant of the subject even to discuss it, much less propose a health-care bill. "They suffer from a disease," said Dr. Robert Litwak. "It's called: They don't know they don't know." An exception is Representative Jim McDermott, Democrat, of Seattle, co-sponsor with Representative John Conyers (Democrat, Michigan) and Senator Paul Wellstone (Democrat, Minnesota) of the American Health Security Act of 1993. McDermott is a psychiatrist. The bill has the backing of ninety-two other House Democrats.

In February of 1992, George Bush said that the American medical system was "the best in the world." It demonstrably isn't. Business Week reported in its March 21, 1994, issue: "This year the U.S. will devote 14 percent of gross national product to health care, at least 40 percent more than Canada, Japan, or the European Community. Even so, the U.S. ranks below many of these nations in life expectancy and infant mortality. By combining huge administrative savings with caps on national health spending, the single-payer approach has the potential in the long run to cut spending more than any other plan."

Bush said that a socialized system of medicine such as that of Canada, with government providing universal health care, was "a cure worse than the disease." He said, "When you nationalize health you push costs higher, far higher." Not true.

During the primaries preceding the last American presidential election, Senator Paul Tsongas said that he might have been dead had he been living in Canada, because the bone-marrow transplant that saved his life was not available there.

It was developed by two Canadian doctors at the Ontario Cancer Institute in Toronto, with research funds from the Canadian government, and was not only available in Canada, it became available there well before it was in the United States. There are operations and procedures in Canada that still are not available in the United States. After Della Reese fell unconscious on the Johnny Carson television show, she was flown to the University of Western Ontario for a delicate brain operation by a doctor named Charlie Drake that saved her life. Neurosurgeons in the United States are now adopting it. Drake grew so tired of being flown to New York and Washington to do surgery on prominent Americans that he told them in effect, "You come here." They did.

On January 9 on *Meet the Press*, Senator Daniel Patrick Moynihan said, "I don't think there is a health crisis." Senator Alfonse D'Amato also denies that there is a health crisis.

An example of manipulative deception came in a 1989 letter from Alan R. Nelson MD, president of the American Medical Association, to 300,00 doctors. It read:

*Dear Doctor:*

*If you disagree with certain leaders in our government who think bureaucrats can run the nation's health-care system, here's your opportunity to do something about it.*

*A Canadian-type health-care system would cause rationing of medical services. Of course, "free" care has an understandable appeal. So you and I have a real challenge to inform the public about the problems lurking in this utopian promise.*

*We must educate people. And we must do it now because tomorrow may be too late. Unless you want to risk rationing, income caps, reduction of your autonomy, and other burdens of a Canadian-type experience very soon, please help us. You'll also be helping millions of patients who would likely find the level of excellence in our country's health care diminished.*

*Make your contributions of $200 (or more) payable to AMA.*

The campaign continued, with one appeal saying that "the AMA has created a program that is telling millions the facts about the Canadian health-care system." James Simmons MD, former executive vice-president of the AMA, in another letter to doctors, wrote, "Our proposal: An intensive program to alert Congress and voters to the dangers of a Canadian-type health-care system."

Though the AMA would never tell how much money it rai for this campaign of deception, it was enough to pay for ads trashing the Canadian system in the New York Times, Washington Post, Wall Street Journal, U.S. News & World Report, Time, and Newsweek.

The Reader's Digest is an unofficial house organ of the political right. Dissembling economic Darwinism with a Norman Rockwell folksiness spiced of late (to compete with the ladies' magazines on the supermarket stands) by occasional titillating articles on how to hot up your sex life, it has always been politically predictable, and it attacked the Clinton health plan in the March 1994 issue, as one could have expected.

The article, written by someone named Ralph Kinney Bennett, contained such fables and distortions that I read them to several Canadian doctors, most of whom were outraged by them.

"To control the demands of its system," Bennett wrote, "Canada has had to severely ration medical treatment, including state-of-the-art drugs, therapies and surgical procedures. Routinely prescribed

antibiotics are often years behind those used in the United States."

"That's ridiculous!" internationally respected gynecological oncologist Jack Walters exclaimed heatedly.

Toronto neurologist Barry Little said, "I know of antibiotics we were using here at least two years before they were available in the States."

Dr. William Feindel, former neurosurgeon-in-chief and head of the Montreal Neurological Institute and Hospital and now chancellor of Acadia University in Nova Scotia, said:

"That's a silly statement. Any of the antibiotics we need are available here. There might be a lag on getting some antibiotics that have been licensed by the Food and Drug Administration in the States but have to be licensed here in Canada. We've had that for the last fifty years. The States has the same problem when they come to get drugs that have been used in Europe for maybe five or ten years. They can't use them in the States because the FDA has to check them out. That's a problem of the administrative surveillance of new drugs. It has nothing to do with the economy of the Medicare system."

Analyze what Bennett wrote: he told you part of a truth, that Canadians had to wait for new drugs used in the United States, failing to mention that Americans too have to wait for drugs developed elsewhere. This is what journalists call selective reporting.

"Canadians," Bennett continued, "who need emergency treatment generally get it. But a large number face harrowing waits for heart surgery and other procedures. Some patients with treatable tumors have seen their cancers progress to the incurable state while awaiting radiation therapy. Others have died waiting."

Dr. Feindel commented: "He'd have to give chapter and verse for that. Let me tell you a personal thing. In February, I went to see my eye doctor, and I had a cataract in my right eye. He decided it should be operated on to get one of the new plastic lenses in there. He said, 'When would you like it done?' I had it done today, after a month. In the meantime, I had my lab work done, an EKG, a physical checkup, all the work preliminary to the operation. All I had to do today was to go in at 10:30 this morning, get my pupil dilated, have the operation, and now I'm back home. And the cost? Two dollars to the pharmacist for a two-weeks' supply of cortisone anti-inflammatory eyedrops. And I didn't mind paying that, because during World War II we discovered at the Montreal Neuro the healing action of cortisone for brain wounds. It's used everywhere in the world now for that purpose.

"There's a lot of wait for heart transplants because enough kind people don't die soon enough to give their hearts away. That's standard, right across North America. There's a terrible shortage of donor organs. But they have an excellent network. Our son Christopher is head of the surgical team doing heart transplants at the Toronto General. They have three transplant units in Ontario, one in Toronto, one in Ottawa, and one in London. They're in a network where donor organs get matched for potential patients waiting in a list. Now that's a long list. But everybody knows that's because of the shortage of donor organs, not because of the medical system. They have it highly organized and the minute a donor heart is available, they do it. If a patient in Toronto isn't the right match—they have this all on a computer—they get in touch with, let's say, the Heart Institute in Ottawa.

"Our son has done about a hundred heart transplants."

Of Bennett's comment, Jack Walters responded: "That's nonsense. That's pure nonsense. They just don't have to wait. I think cancer is handled far better on a general basis across Canada than in any other country that I've been in. That's nonsense. That's absolute nonsense. It's just crazy."

Walters told me of examining in Toledo a patient with cervical cancer, a black woman whose husband worked as a janitor. "They had a small apartment free and he earned something like a hundred dollars a month," Walters said. But that hundred was enough to disqualify her for public aid. Walters had to arm-wrestle politicians to get her admitted. Two weeks of precious time were lost.

Of waiting for radiation therapy, Dr. George Trusler, pediatric heart surgeon and former head of the department at the Hospital for Sick Children in Toronto, told me, "There has been some problem with that, but it's being attacked. Ontario is building a new unit for radiation." Dr. Trusler, a measured man, did complain of cuts in medical budgets, but added, "I certainly like the universal coverage." He also pointed out that when at times there is a waiting list for significant surgery, the Ontario health system sends patients across the border to Buffalo and Detroit for operations, and pays for them. That is little known.

It's always possible, of course, to find someone to say something to bolster whatever point you are determined to make, even if it's that Hitler was a nice guy who just had a bad press. For his Reader's Digest article, Bennett found an orthopedic surgeon who had left Canada several years ago to practice in the United States, quoting Walter Bobechko as saying, "The saddest thing to see is the diminished expectations of Canadians. They are settling for Third World medicine and saying over and over to themselves, 'At least it's free.' People are in pain who shouldn't be. People are dying who shouldn't die."

"Well, that's his opinion," Walters said. "I don't know where he's from. But I think some of the finest surgery and medicine is practiced in Ontario and in the hospitals I came from."

It is true that a certain number of Canadian doctors move to the United States, but it is not necessarily because the American system (or lack of it) is better. You do not hear about those who, dismayed by conditions in the U.S., return to Canada. Dr. Stanley Seah, born in Hong Kong, trained in Canada, the United States, and England, is an authority on tropical diseases. Dr. Seah, who once worked in San Francisco, returned to Canada because he could no longer tolerate the way American doctors are forced to practice. As he put it, they always had to ask not "What tests does this person need?" but "What tests can this person afford?"

Dr. Ron Stewart was practicing emergency medicine in Los Angeles, but like Dr. Seah, he couldn't tolerate the way patients

were being treated and went home to Canada. He is now Minister of Health of the province of Nova Scotia. "I've talked to a number of doctors who came back to Canada after practicing in the States," Dr. Charles Spurgeon said.

Jack Walters is another who has practiced in both countries. "I didn't move to the States for money," he said. "I went because they asked me. We're recruited by the Americans."

In London, Ontario, Walters developed the world's first high-risk pregnancy unit over a period of fifteen years. It became so widely respected that the state of Ohio asked him to set one up for them, which he did, in Toledo. Given the experience he already had behind him, he was able to do it in three years, and its model has been followed in cities throughout the United States. Walters was chairman of obstetrics and gynecology at the Medical College of Ohio, set up by the governor to provide specialized care in Northwest Ohio. Walters went back to Canada to set up another such unit in Ottawa, then established another in Saudi Arabia.

In Saudi Arabia, Walters discovered another difference between Canadian and American medicine. The hospital he led purchased blood and blood components from the United States. Then the Minister of Health issued an order that no more was to come from that source: blood from the U.S. was frequently contaminated with hepatitis B. "I was desperate for it," Jack said, "for pregnant women who were Rh negative. We looked in England, in Germany, all over Europe, and found the same problem. Do you know where we finally found uncontaminated blood? In Canada. They have a unified blood supply for the whole country, run by the Canadian Red Cross out of Winnipeg. They're now selling it to the United States."

Jack gets particularly irritated when, in their unceasing campaign to discredit the medical systems of other nations, the champions of an American medical status quo compare American medicine to that of Great Britain. "There is no comparison," Jack said. "The system over there is completely different. For example, family physicians do not practice in hospitals as they do in the United States and Canada.

"The only proper comparison is to Canada. We drive the same cars, watch the same television shows, eat the same breakfast foods, and have similar climates and economies."

And a prominent Toronto surgeon, after reading Bobechko's statement about "Third World medicine", said with ice in his voice, "Yeah, I know Wally Bobechko. Wally tends to overstate. He's a rampant free-enterpriser. He hated what we do here."

For the Digest article, Bennett also found a doctor named William Mackillop, chief radiation oncologist at Kingston Regional Center in Kingston, Ontario, whom he asked what he would do if he were on the radiation waiting list. "There's no way I'd wait," he replied. "I'd go the United States."

Of Mackillop's comment, Dr. Feindel said:

"I can only speak from our own experience. We get a patient with a brain tumor in the Neuro and decide that he needs radiation treatment, either alone or after operation. The patient gets into a computerized program, using the CT scan basis and now the MRI basis, and it takes maybe three to four days to work out the program—it's very complicated, because they have to match it to the geography of the tumor. But immediately that's done, he or she would have the radiation for the usual course of five to six weeks. We've had no patient that I've been aware of, since we've had Medicare here, where there was a delay because of a holdup in the X-ray department. The holdup is due to the new technology, because they take a lot more time to work out the specific targeting program for the type of tumor. In the old days they had to do this as a little more by a blind technique. They didn't know as precisely as they do now."

I read Mackillop's comment to Jack Walters, who lives part of the year in Florida.

Jack said, "Quite frankly, if I took sick I'd get on a plane right back to Canada, as many Canadians do."

In the Digest article, Bennett said: "Doctors from around the world come to our teaching hospitals to stay abreast of the expanding frontiers of medicine."

Jack Walters said: "Yeah, and they come to Canada too."

To which Dr. Feindel added:

"We've been doing epilepsy surgery here for a long time. My personal practice, the last ten years before I stopped surgery, was about fifty percent patients from the States, because they couldn't get the surgery there. It wasn't a question of waiting—there was almost nowhere to go. There were relatively few units. Now in the last ten years, they've developed units at the Cleveland Clinic, the Mayo Clinic, the Massachusetts General. Quite a few of those are headed by people we've trained in Montreal Neuro, who have now set up epilepsy surgery units in the States.

"This has been a two-way exchange. In neurosurgery particularly, and other forms of specialty surgery, the Canadians and the Americans work very closely together. So there are advan made in Canada, such as epilepsy surgery, which we export to the States as it were by training the people or publishing the technique or presenting the papers down there at neurosurgical conferences, and vice versa: we get advantage of their research. For example, we work very closely with the National Institutes of Health in Bethesda. We have a research grant from them to work on brain tumors. So there's a lot more communication going on all the time. They're not two separate compartments.

"We trained chiefs of departments at Massachusetts General, at Harvard, the professor of neurosurgery at the University of Chicago—in fact the last four professors of neurosurgery at the University of Chicago have been people trained here—the head of the neurosurgical unit at Charleston, S.C., the University Hospital of the University of South Carolina, the head of the neurosurgery unit at the University of Louisville, and so on and so on . . . .

"We have people coming to train at the Neuro from all over the world, because it's a special unit where you can combine the clinical and the research program. That's one of the reasons a lot of young doctors from the States come up here. We have to turn

them away, because we only have a limited number of residency posts. It's perfectly true that the good places in the States are great places to train and research, and a lot of Canadians have gone there. But it's also true that in special areas, the Americans come up to Canada to train."

For his Digest article, Bennett found a man who had had a bad experience with the Canadian system. Bennett began the article:

"When doctors told him he had a lymphatic cancer, Donald Porter's only hope was a risky and expensive bone-marrow transplant. Porter, 64, was thankful for the card in his wallet. Issued by the government, it guaranteed his medical care.

"Then Porter learned the government deemed him 'too old' for a transplant; younger people had a better chance of survival. So Porter sold his house, took out all his savings, and went abroad for the operation. His cancer is now in remission.

"Donald Porter is a Canadian. When his country's 'universal' health plan failed him, he came to the United States, the one advanced industrial country that does not have a universal medical plan. But it does have the highest standard of health care in the world."

It emphatically does *not* have the highest standard of health care in the world. It does not even have a good one, compared with other industrial countries.

Bennett noted that Porter's case was cited in the Ontario legislature as "an embarrassing failure." That's the point. It was considered such an outrageous exception that it was raised in the legislature. And, let us note, it took everything Porter owned to pay for American treatment.

Bennett of course did not cite cases such as that of Marie and Butch Roy of Liberty, Texas. The ABC-TV news magazine show *Day One* did cite it in a broadcast on March 7.

Roy, a lab technician for a company called GNI that dealt with toxic wastes, and his wife had only ever aspired to a modest life with children. They had a daughter, Sarah, and then a son, Josh, born prematurely, weighing only four-and-a-half pounds and with a hole in his heart. The baby spent his first month of life in a Houston hospital. His mother said, "I thought, At least we have insurance—I know he's gonna have the best care." In his first year, that care ran to about $60,000. Butch's boss told him that the company wasn't happy about Josh's medical bills, because they were creating problems with its insurance company. He said, "Butch, they want me to get rid of you because of the medical bills." Butch started looking for another job.

Then Marie started having migraine headaches that proved to be caused by multiple sclerosis. Butch told the plant manager about her condition and two months later, in February 1989, GNI fired him. The company claimed it dismissed him because he was looking for another job and might take trade secrets to a competitor. Butch says it had no trade secrets, and his wife said, "I knew it was because I was sick and Josh was sick."

Butch and his family were suddenly without health insurance. When he got other jobs, his new employers could not insure him because of the prior medical problems of his wife and son. Marie began to lose her eyesight but could not afford to see a doctor. Finally, while Butch was away working, she went blind.

Butch asked the Social Security Administration to declare her disabled so that she could receive health coverage under Medicaid. The SSA said that to qualify, she would have to have a "very severe disability" that made it impossible "to do any substantial work for at least a year," as one of its bureaucrats put it. Blindness, apparently, is not a "very severe disability."

The Roys turned to the state for Medicaid for the children. A case worker ruled that, with an income of $375 a week, Butch earned too much money for them to qualify. Marie asked, "What would it take for the kids to be able to get it?" She was told Butch's income would have to be reduced to $250 a week.

So Butch gave back $125 a week to his employer—and got medical insurance for his children. They had been without it for more than four years.

The Roys were being forced to become more dependent on the system and use more of the taxpayer's dollar. With Butch's income lowered, the family became eligible for $185 a month in food stamps. Had he earned another $185 a month to pay for his groceries, his children would have been disqualified for Medicaid.

"It is unreal," Butch said.

Butch asked the state what he had to do to qualify Marie for help. The answer: abandon her. As long as he remained in their little house, she could not get help. So Butch lied: he told the state he had left Marie. Suddenly she too had Medicaid. But Butch Roy, uncomfortable with the lie, told the state he was still living there. Marie was dropped from Medicaid. So Butch divorced her, but continued to live in the house. The state said that if he wanted her covered, he would have to leave the house. He refused.

If her condition deteriorated further—and multiple sclerosis is a progressive disorder—she might at last get Medicaid. But they would still be in a trap, because if the children were to remain eligible, Butch would have to keep his income below the poverty level, about $250 a week before taxes. "So there's no chance of ever climbing any higher," Butch said. He said that if he were offered a job at $75,000 a year, he would have to refuse it. He would lose coverage for his wife and children. Marie might require as much as three weeks a year in hospital. After taxes, he would have about $45,000 for the year, and, he said, "A week in the hospital would be $15,000 minimum, I'm sure," he said. "And three times that is forty-five."

As one of the social workers pointed out, there is no way out of the trap for that family.

Butch Roy said, "Joshua's great-granddad is in a grave in Nacogdoches, Texas, from injuries he received in the Second World War, fighting for this country. If he could see what the state is requesting of his grandson and great-grandson, I wonder if he'd be willing to give his life for this country again."

To see how truly capricious Medicaid is, consider a case in Colorado reported on the PBS McNeill-Lehrer News Hour a few days later: March 18, 1994. The program explored what it termed "futile medicine," focussing on the final hours of Erik Sanchez, a man of thirty-four whose life was being sustained by extraordinary medical measures. HIV positive, he was comatose and suffering from pneumonia and a massive infection. Heavily sedated, unaware of his surroundings, he was irreversibly moribund in Denver's Presbyterian St. Luke's Hospital.

The hospital is one of fourteen in Denver whose physicians and other staff are trying to establish guidelines for the use of "heroic" measures in desperate and predictably terminal cases. Dr. Russell Simpson, one of those treating Sanchez, said: "I think it's only humanitarian to people to be able to have these guidelines in place. And I think everybody involved, from the nurses to the physicians, it takes its toll, just in emotion, watching someone go through this."

Geriatric physician Donald Murphy, another of the doctors at Presbyterian St. Luke's, is one of those pressing for guidelines. He and other Denver physicians have been holding meetings in search of a common ground on the issue. He thinks the cost to society as a whole of extraordinary medical measures must be considered. He said the issue, which has been around for some time, has reached the level of urgency. "A lot of us feel," he said, "that if we're really going to have a just health-care system, we're going to have to set some boundaries on care at the margins. If we want to bring everyone into the fold and give fair care to everyone, we're going to have to set some limits where care is very marginal."

One physician commented, "Some doctors say putting patients like Sanchez on life support in the first place can be cruel and unethical. They say continuing such care is inhumane."

Twenty-eight percent of the costs of Medicare are spent in the last twelve months of recipients' lives, when the effort often is vain, prolonging not only costs but pain. A dozen states have legislation pending to legalize what Dr. Jack Kevorkian has done in Detroit: helping those in agonizing terminal conditions to check out of life that no longer has value. The ethicists are weighing such questions as: Do you do coronary bypass surgery on someone eighty-five years old; and do you do cataract surgery on an advanced and unaware Alzheimer's sufferer? These procedures cost money that might better be allocated elsewhere.

The problem is legal, not medical, for doctors fear that if they do not exert extraordinary measures, even in futile cases, they may be sued. The fear is well-grounded, which is why malpractice insurance has reached crippling heights in the United States.

On the PBS broadcast, attorney Susan Fox Buchanan said: "Each provider is on the firing line every time he or she makes a decision, for example, not to use advanced life support or tube feeding or ventilators for a permanently unconscious patient." Buchanan favors guidelines.

"In classic malpractice cases," she said, "now, whether the physician deviated from the acceptable standard of care is based on what the community standards of care are. In formulating the guidelines here, (they) are attempting to provide that benchmark, so that a physician treating a permanently unconscious patient would have some support, some measurement by which the decision could be compared."

Opposed to this viewpoint is another attorney, Allison Page Landry, who represents the disabled in Virginia. Arguing that guidelines give doctors the power to decide whose lives are worth living, she said: "Not all decisions made by health-care providers are medical decisions. To the extent that a physician is uniquely qualified to opine as to whether a particular drug is going to cure or ameliorate an infection, that is essentially a medical decision which we can safely defer.

"However, there are other types of decision such as whether or not someone's life is *worth* preserving, or whether someone's life is worth sustaining, mechanically or otherwise, that are really beyond the expertise of physicians to make. They are essentially moral questions, and they are best left to the patient, and if the patient is incompetent, to the patient's appropriate surrogate, their parent or family."

But doctors are always facing moral decisions. The classic example is an overcrowded military surgical tent after a battle. when doctors must look over badly wounded soldiers and decide which have the best chance to survive and which do not — and let the latter slip away while devoting their desperate efforts to the others. At such moments, the decision is neither medical nor moral but a painful alloy of the two. And physicians are far better equipped to make such decisions than attorneys.

But what made the Sanchez case most interesting is that he was on Medicaid. And keeping him alive, an insensate vegetable, was costing Medicaid $12,800 *a day*. His family accepted the counsel of the doctors and the ventilator was removed, the life-support system turned off. He was gone immediately.

About the costs, his sister Terri, told PBS: "You don't think about that. When you want to save your brother's life. You don't think about the money. You think about your brother. You can't think about the money. What's money? What's money?"

It would be interesting to pose that question to Butch Roy in Liberty, Texas. A Medicaid system that could find $12,800 a day to sustain a man who was for all practical purposes dead could not find enough to help the blind wife of Butch Roy.

And even in cases that are not horror stories, the cost of American medicine is staggering. John O'Hara is a successful Chicago advertising man who has just been through a rough year — "a year of adventures," as he put it. "Heart attack, triple bypass. My chest sprung a leak, and nine days after the first surgery, they had to open me up again." Then he had a pulmonary embolism. Total cost of his care: $150,000. He had a $2,000 deductible policy, and fortunately the rest was paid.

Because he had used his policy, of course, the insurance company raised his rate — by 30 percent, to $4,500 a year.

"I can afford it," John said. "But what about those who can't? It's the lower middle class, the people with twenty-five to thirty thousand a year income, who are hurt most."

Dr. Samuel O. Freedman is director of the research institute at the Jewish General Hospital in Montreal, one of the finest hospitals in a city crowded with fine hospitals, and a former dean of medicine at McGill University. The Gourman Report, which evaluates universities and professional faculties, ranks McGill as one of the top five in North America and the top ten in the world. McGill's eminence in medicine dates from the time of William Osler, a Canadian who taught there before teaching at Johns Hopkins (1889-1904) and Oxford University, where he was regius professor of medicine from 1904 until he died in 1919, one of the most revered figures in medical history.

Dr. Freedman took issue with the slanders of American politicians, the AMA, and the Health Insurance Association of America, in an interview with the New Yorker published April 20, 1992.

The writer noted that a friend who had lived in Canada said he was "baffled when I hear politicians explain how unsuccessful the Canadian health system is, and how wretched it makes Canadians." Though the magazine doesn't identify him, the friend was Adam Gopnik, whose father, Irwin Gopnik, was dean of students at McGill.

Adam Gopnik called Dr. Freedman, a family friend. As Gopnik put it, Dr. Freedman "is almost legendary in Montreal for his reasoned good sense on all kinds of issues." Gopnik asked if he had been following the American election campaign and the debate about health insurance.

"I have," Dr. Freedman said. "It says something very strange about the nature of American politics, since just about everything that has been said about Canadian medical care—well, I wouldn't want to call it a lie, but there must be an incredible fund of willful ignorance at work."

Dr. Freedman invoked the Tsongas case, and continued:

"Then, there was President Bush saying that you had to wait six months for heart surgery in British Columbia. British Columbia had delays like that years ago, but there's simply no way that British Columbia has those kinds of waits any more—the system is pretty good at responding to problems. The trouble with our system isn't that people don't have enough access to health care. If anything, it's that they have too much access to health care; they're inclined to go to the doctor too often, get too much minor surgery, and so on—have too much faith in doctoring . . . .

"And when Mr. Bush says that costs are higher in a system like Canada's, I'm not sure where he's getting his figures. The costs of a single-payer system, like ours, are lower, because there's only one insurer—the government—and that cuts down on paper work and administrative duplication and all that . . . .

"More important, we end up spending about twenty percent less per capita on health care than you do, and we're still ahead in the two most crucial public-health indicators, life expectancy and infant mortality."

According to figures released by Statistics Canada (the equivalent of the U.S. Census Bureau) in March 1994, Canada spends 10 percent of Gross Domestic Product on health care, the U.S. 13.4 percent. Dr. David Himmelstein of Harvard Medical School said in 1991 that Canada spent $1,400 per capita on medical care, the U.S. $2,000. All Canadians have medical coverage. An estimated 35 million Americans have none, and millions more are underinsured.

"It's true that taxes are higher here," Dr. Freedman said, "but when you figure in the real costs of the American system—the burden on the G.N.P., and the high costs to employers who have to provide insurance, and so on—over all this really is a cheaper system.

"And the irony is that more and more private insurance companies in (the United States) have these managed-care programs, in which you don't have any choices about what doctor you see, while here you do.

"It's true that Canadian doctors make less money than American doctors, but that was true before our Medicare system went into effect. There are probably doctors here who wish they were making more, but how much more do you really need? There are plenty of doctors—you're talking to one—who are just grateful every day to be out of that damned business of billing and collecting.

"Of course the government is involved in medical care here. There's no denying that. The Quebec government may say, 'Well, we've got five magnetic resonance imagers in the Montreal hospitals. We just don't need another—can't afford another.' But that doesn't mean that people don't have access to MRI. What it does mean is that we won't be spending our money competing with each other while downstairs in the emergency room we're turning away people who aren't insured."

A Seattle physician, curious to know why medical costs were so much higher in that city than in nearby Vancouver, British Columbia, made a study of the two cities. He found that one important factor was the duplication of expensive high-tech equipment at Seattle hospitals, equipment that was often standing idle. In Vancouver, a pool system was in effect, and by intelligent scheduling, the equipment was in constant and effective use. And Quebec moved to further reduce spending when it announced in March 1994 that doctors will be allowed to perform only one major physical examination per patient per year. This was negotiated with doctors. This effort to restrict what Dr. Freedman calls "overdoctoring" will save an estimated $2.13 million per year.

The Quebec medical bureaucracy seems to be far more ponderous and onerous than that in other provinces. It is particularly detested by Dr. Roméo Ethier, chief neuroradiologist at the Montreal Neuro and a professor at McGill University.

"We haven't had a physician as Minister of Health in years," he said. "We had one during the Parti Québecois administration, but he was a psychiatrist, and he was crazier than his patients. Who needs that?"

On March 19, the Quebec Ministry of Health announced that it will no longer pay for the surgery to reverse vasectomies, prompting Dr. Ethier to comment, "They shouldn't have covered vasectomy in the first place—it's not a disease.

"We spend money on crazy things. The system is being abused. There is no coverage for women who want to have their breasts jacked up. If they want to have their breasts rounder and firmer, fine, but it's not a disease. At the beginning, the government was paying for this. Ridiculous."

Dr. Freedman said, "You know, it's not just a question of health care. We have a system here that is really accepted by the whole spectrum of political opinion. We have conservatives who are as far to the right on most issues as any American conservative, but they're just as staunchly for the Medicare system as anybody. It has become a national value—the principle that everybody who needs medical care can get it, and nobody asks if you're rich or you're poor, or where you work. Knowing that everybody gets the same care helps to hold a society together—it makes everybody feel equally valued."

Supporting Dr. Freedman's position was a recent report from Toronto in Business Week, quoting Angus Reid, a Canadian pollster, as saying, "More than 90 percent of Canadians favor our system," and Thomas P. d'Aquino, president of the Canadian Business Council on National Issues as saying that even corporate chief executives "are very strong supporters" of the system. He added: "I can't remember the last time a CEO told me he was going to the U.S. for treatment."

Dr. Freedman said, "There aren't many things in the world that just *work*—that just make sense. I mean, here are two contiguous countries, and one has a system that everybody is more or less happy with and the other doesn't, and yet the one that doesn't is determined not to learn from the one that does. I don't understand it."

House Republican whip Newt Gingrich has said that "the Canadians control costs by letting people die." That remark contains, in Edmund Burke's wry phrase, an economy of truth. Consider some figures.

Life expectancy at birth in Canada is 73.8 years for men, 80.4 for women. In the United States it is 72.6 for white males, but only 68.4 for black men; 79.3 for white women versus 76.3 for black. There is no such ethnic discrepancy in Canada, since everyone has equal access to the medical system. In the United States, there are 10.3 deaths per thousand live births. In Canada the figure is 7.1 per thousand. Canada's death rate from various diseases, including cancer and cardiovascular problems, is the lowest of eight industrialized countries, at 953 per 100,000 of population for men, 554 per 100,000 for women. The countries are: Australia, Canada, Finland, France, Germany, Sweden, the United Kingdom, and the United States. In Canada, 99 percent of the labor force is insured for damages or income loss caused by injury; in the United States the figure is 56.5.

In 1991, writer Judy Haiven compiled these figures:

Per capita expenditure for physicians services in U.S. dollars: Canada $202, U.S. $347.

Percentage of physicians who are general practitioners: Canada 50 percent, U.S. 10 percent.

Availability of short-term hospital beds: Canada 4.4 per 1,000 patients, U.S. 4.1 per 1,000 patients.

Deaths from heart disease: Canada 348 per 100,000 person[illegible] U.S. 434 per 100,000.

Percentage of U.S. population covered by health insurance: white 76 percent, black 12 percent, Hispanic 9 percent. Canada: 100 percent, all ethnic groups.

Physicians' fees are 234 percent higher in the U.S. than Canada.

Number of patients per physician: Canada 463, U.S. 488.

This last figure is deceptive, for the discrepancy is much worse than that. There are undoubtedly far fewer patients per doctor in the wealthy areas of the United States, including Park Avenue in New York City. But in the South Bronx, there is only one doctor for every 9,000 persons. That disparity does not occur in Canada, since *everyone* has access to the medical system.

Haiven found figures showing that while three out of four Americans favor a national health-insurance program, ninety-four of the top hundred executives in the country are opposed to it.

What do these statistics mean in personal terms? Let us consider two cases that have occurred close to me, examples of the long waits for inferior treatment, as described by George Bush.

Paul Spurgeon is a Toronto drummer, percussionist, a[illegible] vibraharpist. He is also a lawyer, and as such he is legal counsel to SOCAN, the Society of Composers, Authors and Publishers of Canada, the opposite number of ASCAP in the United States.

In May 1988, Paul attended an international conference of performing rights societies in Xtapa, Mexico. During a noon recess, he went body surfing in the warm Pacific waters. A powerful wave caught him, snapping his neck. Unable to move his arms or legs, he was buffeted by the water, expecting to drown and thinking that this is how death comes. But two friends pulled him ashore and, after a time, he was taken to a Mexican hospital.

Though the funding of the Canadian medical system comes from the federal government, it is administered by the provinces. There is some regional variation. However, it is important to note that the system is portable: if you get sick in a province other than your own, your health card still gets you entry to the system. In a discussion I heard on American television, one of the panelists said that since you could use an ATM or credit card, with a magnetic strip on the back, in banks all over America and even the

world, surely it should be possible to develop such cards for medical use. Canada has been using them for years.

Paul's medical care is administered by OHIP, which stands for Ontario Health Insurance Plan. The Canadian system not only covers you when you are in another province, up to a point it will cover you when you are abroad. What it will not do is pay American medical fees and hospitalization costs, which I have heard two Canadian physicians describe as "obscene." It will pay only the Canadian equivalent fees. To make up the difference, many, perhaps most, Canadians carry supplemental insurance during periods when they are away, particularly when they are in the United States. The snow-birds, as Canadians call them, who winter in Florida carry these policies.

OHIP maintains a small fleet of aircraft to rescue Ontarians who get into medical trouble abroad, including Lear and Citation Jets, several Beech Kingairs, and two Piper Navajos. The Navajos are used for medevac work in the north. Dr. Jack Walters' mother had a heart attack in Arizona; OHIP sent one of its planes to bring her home. After his accident, Paul called his father, Dr. Charles Spurgeon, in London, Ontario. "I made the arrangements," Dr. Spurgeon told me, "and Paul was flown home in a Lear 25. It cost $19,000 Canadian. OHIP paid it."

"It was amazingly fast," Paul said. "I was flown out the night after the accident." Forty-eight hours after the accident Paul was in University Hospital in London, Ontario, under expert care. As he recovered, he was transferred to Parkwood Hospital. "It's an excellent hospital devoted to rehabilitation medicine," he said. Paul has recovered.

The Quebec health insurance system also maintains aircraft because it, too, has to fly in patients from far northern regions, including what once were known as Eskimos. (The term they prefer, Inuit, is now in general use in Canada.) Not infrequently the health service flies into Florida to rescue Quebeckers who have fallen ill or had accidents there. Saskatchewan had the first air ambulance system in North America back in the 1950s.

Dr. Feindel said: "They compare us sometimes to Germany or Sweden, but those people don't have the geographic problems of transporting patients or supplying outlying regions, as Canada does. The mileage itself is an important factor in supplying care for a very scattered population. We have to provide those services for the native peoples. There are not—relatively speaking—3.5 million people here who don't get health care at all, which would be our equivalent of the States, where there are more than 35 million people without protection. That just doesn't exist here."

As Europeans who have never been here have little grasp of the size of the United States, they and most Americans alike have little grasp of the size of Canada. It is not only the largest nation in the western hemisphere, 6.5 percent bigger than the United States and 17.2 percent larger than Brazil, it is the second largest on earth, being exceeded only by Russia. China is slightly smaller than Canada. The necessity to provide full medical services over Canada's immense and empty distances would, one might think, make this care more costly per capita than it is in the United States. But the reverse is true: it's cheaper.

This is the other example of long waits for inferior medical care in Canada described by George Bush:

My sister Pat, four years my junior, lives with her husband, Paul Buchanan, in Fergus, Ontario, one of those lovely little towns that time forgot, with old brick or limestone houses shaded by maple trees. A small river gorge runs through it. She is a freelance journalist and editor, Paul is a painter and sculptor. People in such professions in the United States find medical insurance prohibitively expensive. "Oh, there's no question in my mind," Pat told me, "that if I'd been living in the States, I'd be dead." Paul Tsongas was lying; she's probably right.

"I woke up one morning and felt odd," she said. "I asked Paul to take me to the hospital." Fergus has a good small hospital. "When we got there, I had this unbelievable pain in my leg.

"They tested me and said I'd had a heart attack and there was a blood clot in my leg. They sent me by ambulance the next day to McMaster-Chedoke Hospital." It is a teaching hospital attached to McMaster University, which has yet another important medical school. It is about thirty-five miles from Fergus, in Hamilton, Ontario. "I was there overnight," she said. "Gangrene had set in and they told me they had no choice but to amputate the leg.

"The operation was done about forty-eighty hours after I felt the first pain."

Pat was kept there a short time, then sent back to Fergus to recover in its local hospital so that she could be near her husband. Over the course of the next year, OHIP sent to her home a physiotherapist, an occupational therapist, and a housekeeper. It offered to provide her with a prosthetic limb, which she declined, but it gave her a wheelchair, and even offered her a motorized wheelchair, which she also declined. What did it cost her?

"Not a cent," she said.

She had that operation in March 1992, a month after George Bush derogated the slow and inferior Canadian medical system.

Is there any way to get a true comparative cost of medicine in the United States and in Canada? Yes, and the subject was thoroughly researched by a Canadian writer and film-maker named Judy Haiven, who told the story in an article published in the March-April 1991 issue of Mother Jones. Haiven lives in Saskatoon, Saskatchewan.

On New Year's Day, 1990, her husband Larry, a forty-one-year-old university professor, suffered a heart attack. He was put in a cardiac monitoring unit and given tests, including blood work, electrocardiogram, X-ray, ultrasound, angiogram, exercise stress tests, and more. After a period of recovery, he was discharged from the hospital. The Haivens paid not a penny for this treatment: it was covered by their national health plan and the Saskatchewan government.

A month later, they flew to Southern California for a brief

holiday at the home of friends. Larry Haiven had more chest pains. He was taken to Scripps Memorial Hospital. The Haivens had taken an insurance policy to protect them while traveling in the States. They had trouble even getting Haiven admitted to Scripps Memorial: the clerk in charge wanted cash in advance or a credit card; he wasn't interested in their Canadian insurance coverage. Under pressure from the Haivens' friends, who vouched for them, Larry Haiven was admitted.

"Fortunately, it wasn't a second heart attack," Judy Haiven wrote. "But by the time the cardiologist determined this, Larry had spent four nights in the hospital, including one in intensive care, receiving virtually all the same tests and medications as in Canada. For the hospital stay, specialists' fees, private lab work, and the ambulance, the charge was $12,590.34. Everything had been itemized, right down to the sample-sized tube of tooth-paste ($5.25), the aspirin pill ($4.14), and the laxative ($17.04), which Larry didn't take.

"I knew that a similar course of treatment in Canada would be 'free' to the patient. But I wondered what it would really cost the system as a whole. I consulted the authorities and learned that Larry's treatment in Saskatoon had cost the system $3,500 (U.S.)."

Why the difference? One factor is the insurance companies. "The Cleveland Plain Dealer," Haiven wrote, "found that Mutual of Omaha, Golden Rule, and Aetna . . . spent an average of 27 percent of every health-care dollar on administration in 1989. In the same year, Ontario's government spent just 1.8 percent of every dollar on administration."

Senate minority leader Robert Dole said not long ago that he didn't see Americans lined up to get medical care in Canada. This was reiterated by Representative Jim Cooper of Tennessee in a speech to doctors broadcast on C-SPAN.

But many Americans do go to Canada for medical treatment, many to Shouldice Hospital in Thornhill, Ontario, renowned for hernia surgery. Steven Dixon, assistant administrator of the hospital, told me: "People come here from all over the world, more than ninety countries, including Russia and China. From the United States we get them from every state of the union. Currently about 12 percent of them are from the United States, but at times the figure has run as high as 55 percent."

Dixon, like many Canadian medical professionals, points out that the Canadian system has money problems, even though it is much cheaper than the American. I asked him, as I have asked every Canadian I interviewed, if he'd trade it for the American system. He laughed. "Not a chance!" he said.

Let us consider another case of the alleged ineffectiveness of Canadian medicine: what happened when the Salk vaccine against poliomyelitis was developed.

Through the 1930s, '40s, and '50s, polio was on the increase, recurring in great rising waves of epidemic. In the U.S. in 1951, there were 10,037 paralytic cases and 18,349 non-paralytic. The next year the figures doubled: 21,269 paralytic and 36,944 non-paralytic occurred. That year, 1952, paralytic polio killed more children in the United States than any other communicable disease. It was the worst polio epidemic in history.

Persons born after 1955, the year that Dr. Jonas Salk announced the efficacy of the polio vaccine he had developed, have little idea of the terror that filled parents every year from June to September. A nurse who worked close to Salk in Pittsburgh during the period of his research, vividly described duty in a polio ward:

"In all my career there has been no experience like Municipal Hospital before the Salk vaccine. One year the ambulances literally lined up outside the place. There were sixteen or seventeen new admissions every day. One of our resident physicians never went to bed for nights on end, except for stretching out on a cot in his clothes. We nurses could never get home on time either. To leave the place you had to pass a certain number of rooms, and you'd hear a child crying for someone to read his mail to him or for a drink of water or why can't she move, and you couldn't be cruel enough just to pass by. It was an atmosphere of grief, terror, and helpless rage. It was horrible. I remember a high-school boy weeping because he was completely paralyzed and couldn't move a hand to kill himself. I remember paralyzed women giving birth to normal babies in iron lungs. I remember a little girl who lay motionless for days with her eyes closed, yet recovered, and I can remember how we all cried when she went home."

In April 1955, the effectiveness of a vaccine developed by Salk and his staff was announced. Salk never took a patent on the vaccine: he gave it to the world as a gift.

In Toronto, Connaught Laboratories, whose directors had been watching Salk's work, immediately went into production of the vaccine. It was administered to children across Canada in a program of free inoculations. In the United States, however, the medical establishment quibbled and equivocated. If it were to be given free by the government, this would amount—God forbid!—to socialized medicine! Many doctors stood on their inalienable right to make a profit on vaccinations. And so in 1955, the year Salk announced its efficacy, there were 13,850 paralytic polio cases in the U.S. In 1956, there were 7,911, in 1957 2,499, in 1958 3,967, in 1959 6,289, and so forth. The argument went on as children died. There are thousands of Americans crippled by polio contracted after 1955. But in Canada, polio was eradicated virtually overnight.

Around 1980, it was noticed that many persons were having recurrences of symptoms thirty or so years after they had had polio. No one knew why, and indeed there is no certainty about it even now. The best theory is this:

Polio kills some of the nerves. After the disease has run its course, a process called collateral reinnervation occurs. The surviving nerves put out collateral shoots that begin to operate the muscles. A certain number of nerves die off as we age. But in polio people, the surviving nerves have been carrying extra load and they atrophy faster than those of normal persons. The impair-

ment of nerve signal leads to weakening of the muscles.

The Hospital for Sick Children in Toronto is famous for innovative work. Dr. Robert Litwak of Mt. Sinai Hospital in New York points out that the operation for the transposition of the great vessels in babies with severe cyanosis was developed there by Dr. William Mustard. (The hospital is close to the Banting Institute, named for Sir Frederic Banting, the Canadian scientist who, with another Canadian, Charles H. Best, discovered insulin. It is also close to Connaught Labs, and to the home of Dr. Wilfred Bigelow, whom Dr. Litwak calls "the father of hypothermia"—the technique of lowering the body temperature to the point where the heart stops, to permit difficult surgery on it.)

Dr. Karen Pape, a handsome woman with a streak of gray in her straight dark hair, was a pediatrician at the Hospital for Sick Children, commonly called Sick Kids' in Toronto. She was confronted with the tragedy of spina bifida. This is a natal condition that often leaves children crippled for life. The nervous system is not fully developed at birth. Eventually it does develop, but by then the unused muscles have atrophied. When the muscle fiber has thinned to a certain point, the conventional wisdom held, it could not be restored.

Dr. Pape read about the use of heavy jolts of electricity to build muscle mass in athletes. She wondered if in low voltage, it might help children with spina bifida. She focussed her attention on a baby girl whose parents had been told that the child was beyond help and would be institutionalized all her life. The girl could not even hold up her head.

Dr. Pape attached electrodes to the girl's skin. Very low electrical current was sent into her muscles during her sleep. And the child began to recover. She is now a teen-ager who walks and talks normally.

Dr. Pape set up the Magee Clinic, which she heads. It treats spina bifida, cerebral palsy—and post-polio syndrome. Dr. Pape eventually wondered if TES, as its called, for therapeutic electrical stimulation, would be effective with older persons, including those with post-polio syndrome. It was, and some persons confined to wheelchairs were restored by TES to normal lives.

American doctors commonly send patients to Magee. Indeed, between 50 and 60 percent of its patients are from the U.S. They have to pay for treatment, of course, since they are not covered by the Canadian health system.

They go anyway, often for advanced and innovative treatment not available in the U.S., as in the case of Della Reese. Or they go simply because the quality of medicine is so high, as at Shouldice Hospital. And they go because it is cheaper. A hysterectomy that can cost anything up to thirty thousand dollars in the United States will cost about six thousand American dollars when performed in London, Ontario, by Dr. Hugh Allen, considered by many doctors to be the finest gynecological surgeon in Canada, and possibly in the world.

On what information, then, do people like Senator Dole and Representative Cooper say that Americans aren't lined up to use the Canadian medical system. Did they go there and look? Did they ask? Did they haunt any Canadian medical waiting rooms? Are their statements the expression of unforgivable dishonesty or unforgivable ignorance?

Between August 1992 and February 1993, according to a story from the Los Angeles Times reprinted in the March 3, 1994, Montreal Gazette, 60,000 patients making improper claims on the Ontario medical system were found to have U.S. drivers' licenses. A report to the province's health minister said that Americans leaching on the system were costing $700 million a year in Ontario alone. An obstetrician in Windsor, whose downtown area is ten minutes from central Detroit, was quoted as saying, "I would estimate that from twelve to twenty of my patients at any one time are ineligible Americans."

The provinces may soon affix photos of their owners to medical cards to halt this abuse.

One reason for the higher costs of care in the United States is that so many hospitals are run as businesses for profit. In Canada, 93.4 percent of hospitals are operated by government, and some are owned by cities. Only 6.6 percent are privately owned hospitals for profit. In the U.S., private non-profit hospitals account for 47.6 percent and private for-profit hospitals for 25 percent.

"In Canada," Dr. Jack Walters said, "the ideal is to keep patients out of the hospital. In the United States, it is to keep the beds full. Tonsillectomies are done as out-patient surgery, but in the States they have been done as a hospital procedures."

This is now changing in the U.S., but Walters was particularly scandalized by an incident that occurred some years ago in Las Vegas. The American Hospital Association awarded a Vegas hospital its prize for the best public-relations gimmick of the year.

The names of parents bringing their children in for tonsillectomies were entered into a lottery. The prize to the winner: a trip to Freeport in the Bahamas for the parents and child. But the children were admitted to the hospital on Fridays for surgery to be performed on Mondays. This gave the hospital three extra days of billing per child. Whether paid for by the parents or by their insurers, it still contributed to the high medical costs extant in the United States.

Americans who live along the Canadian border often are well aware of the benefits of the Canadian system. In the meantime, Canadians, who can receive all the American television networks and many of the local ones from cities such as Detroit and who read Time and Newsweek and USA Today, are well aware of the continual trashing of their medical system by American politicians, not to mention the recent Harry and Louise television ads paid for by the Health Insurance Association of America. The association has spent $20,000,000 in its campaign to discredit the Clinton health plan, apparently successfully: support for the bill is falling.

The Toronto Sun is essentially a conservative newspaper. One of its columnists, John Downing, wrote a piece published in that

paper August 22, 1993.

When talking to American colleagues, Downing wrote, "I find myself only being borderline polite since American journalists often display a dumb insensitivity . . . when they write about us and our Medicare.

"In May, I was bouncing around the foredeck of a cruise boat on Lake Como . . . .

"A feisty little lady spent her time arguing . . . about the drawbacks of Canadian medicine. After all, she knew all about the lineups and the shortcomings because she had read it on the front page of the New York Times.

"I suggested that this was hardly definitive proof even though she is a member of the Times editorial board and her husband, listening with pleasant attentiveness, is Max Frankel, the Times' executive editor . . . .

"My parting shot was that it would be nice if a great newspaper dealt with the vice-president who has been emotional so often about the life-changing experience when his six-year-old was thrown into the air by a car and battled death for weeks.

"Al Gore . . . has told us how he moved into Johns Hopkins too. Arguably it is the most famous recent testimony as to the virtues of modern medicine, but the vice-president, who prides himself on being a master of detail, has never got around to telling the world about the contributions Canadian medicine made to the technique of his son's operation and recovery. But he does love to run down our system."

Major contributions to the development of neurosurgery were made in Canada. Wilder Penfield, an American physician (though Americans and Canadians alike usually think he was Canadian) obtained a Rockefeller grant to build a hospital devoted to the nervous system. He considered various cities for its location, finally deciding on Montreal because he found the Canadian medical atmosphere amenable and the city cosmopolitan. When Penfield began his work, the brain-wave recording technique was not available. A scientist who knew about brain waves was a Rhode Island inventor who wrote to Penfield to say he had developed a machine that would measure them. Penfield invited him to bring his device to Montreal. Penfield soon found that the inventor was right. Refinement of the device began. It is the electroencephalogram.

(The inventor was Herbert Jasper. He stayed in Montreal, learned to speak French, and continued his work at Montreal Neuro and the Université de Montréal. Now in his eighties, he still lives in Montreal.)

Formerly, the Montreal Neuro had a huge American patient load, but this has gone down: it is policy of the Quebec Ministry of Health to discourage non-Canadians from coming there by charging them very high fees (which Canadians of course do not have to pay) for treatment. It is a policy Dr. Roméo Ethier, the Neuro's chief neuroradiologist, thinks is short-sighted.

Roméo says that American medicine is the best and the worst in the world. Roméo was trained in part in the States. But, as he pointed out, the best of American medicine is available only to the rich or the poor: the working and middle classes have limited or no access to it.

Echoing Roméo, Jack Walters too used the words "the best and the worst" to describe American medicine.

"I know that sounds like a paradox," he said. "Children's Hospital in Boston is one of the finest in the world. You can watch children getting superb care and look out the window and see children in the street who are suffering from scurvy."

John Downing, in his aforementioned column, described attending last August a Freedom Forum developed by Al Neuharth of the Gannett newspaper chain. He ended up, as he said he always does in such encounters, trying to explain the Canadian medical system. "Now," he wrote, "if only we can just get all these illustrious colleagues to return home and say that, despite all the stories . . . about fraud, Canadians have, as I said, 'one of the best medical systems in the world,' the evening will have been a real accomplishment.

"Actually I think it's the best. I was being polite."

Downing's point about the failure of the New York Times to give fair and accurate coverage to the Canadian system is most interesting. John Glasel, too, finds the silence interesting.

Glasel was president from 1983 through 1992 of New York City local 802 of the American Federation of Musicians. He became thoroughly educated in the dimensions of the American health-care crisis as a trustee of the local's Health Benefits Plan and through his efforts to find affordable medical insurance for union members who did not qualify for the plan. He also was a member of the steering committee of the New York Jobs with Justice Health Care Campaign, a coalition of labor organizations advocating a single-payer health insurance program like Canada's.

On March 15, 1994, Glasel published a twenty-page pamphlet consisting entirely of letters he had written on this question to the New York Times, thirteen of them, not one of which the paper printed. In a play on the motto of the paper, All the news that's fit to print, Glasel called the pamphlet *Unfit to Print*. On September 3, 1992, he wrote a letter containing this paragraph:

"Single-payer, government-run health insurance is the best way to control expenditures while guaranteeing universal access, quality service, and free choice of providers. Several surveys have found that most Americans want such a Canadian-style health insurance system. Why don't Bush, Clinton, or the Times? Could it have something to do with the health industry's multi-millions in political and advertising spending?"

In a letter September 21, 1993, Glasel wrote:

"The government's own General Accounting Office has estimated that cutting out the overhead, red tape, and profits engendered by our 1,500 private health insurers would save enough money to provide comprehensive services (including long-term care) to all Americans, including the 37 million now uninsured."

After pointing out that HMO network, which would be part of the Clinton plan, would limit the patient's choice of doctors, Glasel, in a letter September 24, 1992, said:

"To really control health care costs, we should eliminate the insurance company middlemen altogether, instead of adding a new layer of bureaucrats on top of them. The Canadians have proven that government-run, single-payer health insurance can provide universal, comprehensive care at less cost, without limiting choice of providers. If they can do it, why can't we? Why try to re-invent the wheel?"

On June 9, 1993, Glasel took the paper to task, saying, "I was recently appalled to learn that your insurance company-dominated editorial board refused to publish an op-ed piece by Representative Jim McDermott, one of the chief sponsors of H.R. 1200, the single-payer health reform act with many co-sponsors and much public support that has received so little attention in your pages."

Glasel is probably correct in suggesting that the interests of the advertising department are an influence on the Times. Like the tobacco lobby, the insurance industry—the major beneficiary of the American medical mess—has enormous power. It is not only the New York Times that has remained silent on the single-payer issue —or dishonest, when it mentions it at all. The major television news broadcasts rest similarly mute. Yet many of the TV newscasters in the United States are Canadian, including Peter Jennings, Morley Safer, Ray Pizzi, and Thalia Assura, who does the overnight news on ABC. And you will catch the Canadian "out" and "about" and "house" in reporters on CNN. So these people know about the Canadian system and its benefits. Why have they not covered the story, which is a big one? One can only assume that they are not allowed to. The insurance industry is a major television advertiser.

It is curious that those who fly into paroxysms of horror at the term "socialized medicine" never pause to think that they are not bothered in the least by socialism as applied to the maintenance of police and fire departments, public education, highways departments, and the military, whose members already get socialized medicine in military and veterans' hospitals, as does the president of the United States, who goes to Bethesda Naval Hospital. The medical situation in the United States comes into perspective if you make this act of the imagination:

Your house is burning down. The fire engines arrive. The captain says, "Let's see your insurance policy. Or your credit card. Haven't got one? Can't save your house."

That's what you've got. The most vindictive enemies of a single-payer plan are the insurance companies. Contrary to legend, Canadian socialized medicine was not started by the government. It began with doctors in Windsor, and gradually spread through Ontario. Government medicine began in Saskatchewan in 1962, grew in other provinces, and finally was funded by the federal government. At one time you paid a modest fee for your insurance, but a few years ago this was abolished and the funding now comes from general revenues, just like that of the military. Doctors want to see financial reform in the system, possibly the imposition of a user fee for those who can afford it, though none for those who can't.

When Canadian medicine went government, the insurance companies were kicked out, outlawed except for services not covered by Medicare, including travel outside Canada. This would happen here, if a system like Canada's was adopted, which is the reason for the insurance industry's campaign of disinformation. Unions, some doctors' groups, and some political figures, including West Virginia's Governor Jay Rockefeller, favor a system like Canada's, but it is doubtful they will be effective against the insurance lobby, given the record of the House and Senate.

Every twenty seconds a handgun injures someone in the United States. A firearm suicide occurs every twenty-eight minutes. The cost in medical treatment and lost productivity in firearm injuries and deaths is $20 billion a year. Gunshot wounds are a leading cause of death in young people in many parts of the country, including California. Murder has become so common that it is being discussed as a public health issue. What has the Congress done? Under the lobbying pressures of the armaments manufacturers and their propaganda agency, the National Rifle Association, almost nothing. It has passed the feeble Brady Bill, which requires a five-day checkup on anyone buying a handgun. The checking is only local. There is no national system in place to do real checking, and no money to do it with if there were.

Or consider the tobacco industry, which maintains one of the most powerful lobbies in Washington. It recently was revealed that cigarette companies manipulate the quantity of nicotine in cigarettes to make them more addicting. Yet cigarettes do not come under the jurisdiction of the Food and Drug Administration. The cigarette industry has gone completely unregulated, with Congress acquiescing to its every wish and rejecting any legislation that would bring it under control. Its power is enough to destroy the political career of anyone who opposes it. Joseph Califano, Secretary of Health, Education and Welfare in Jimmy Carter's cabinet, make the mistake of attacking the cigarette manufacturers.

"It ultimately cost me my job as Secretary of HEW," Califano said. "I remember Senator (Ted) Kennedy said to me, 'There's no way the President can run for re-election with you in the Cabinet.' Speaker (of the House Tip) O'Neill told me that . . . Since then (President Carter) has talked to me, and indeed he said to me, 'You were right and I was wrong about cigarettes.'"

ABC-TV reporter John Martin, on the March 7 broadcast of the news magazine program *Day One*, said, "There's no better example of the power than the story of 'the list' of additives manufacturers put in cigarettes. Under the law, the list is provided to the government but kept secret from American consumers. What's on the list and what's not on it tell much about the power of the tobacco lobby, its demands for secrecy, and the government's

failure to regulate this industry."

Congressman Ron Wyden (Democrat, Oregon) told Martin: "We now know that there are chemicals in tobacco products that are so toxic they wouldn't be allowed in a landfill under the federal environmental rules."

And Matthew Myers, of the Coalition on Smoking OR Health, said:

"The tobacco industry is the only industry in this entire nation that is permitted to put chemicals and other additives into its products without first proving that those chemicals are safe and effective."

"The list" is kept in a safe in the Atlanta office of the Department of Health and Human Services. Anyone who revealed its contents would not only lose his job but could face felony charges. According to Dr. Michael Erickson, head of a division of the DHHS, the Federal Office of Smoking and Health—surely an oxymoron—probably not even the president of the United States could see the list unless he had been designated an employee of the DHHS.

Dr. Erickson did, however, tell Martin that the list contains "thirteen ingredients that are not allowed to be added to food but which are added to cigarettes."

His predecessor in his position, Dr. Ron Davis, said, "I think it's absurd that a product that's used by 45 million Americans is used without their knowing what's in the product."

A product that kills 400,000 Americans a year.

To put this in perspective, that is about seven-and-a-half times the Viet Nam American death toll of 58,000 men. While Americans were appalled by those 58,000 deaths, during the eight-and-a-half years when they occurred smoking took the lives of about 3,400,000 persons in the United States. The comparison is not fully accurate. Almost all the Americans who died in Viet Nam were young, while tobacco took the lives of the middle-aged and older persons. The figure is nonetheless arresting. And the Congress and federal regulatory agencies were helpless to oppose the tobacco industry. Those who tried, like Joseph Califano, were destroyed.

A study by Dr. Sidney Wolfe, a leading public health advocate, revealed that the tobacco industry contributed millions of dollars to the campaign funds of members of Congress, particularly those from tobacco-growing states and key leaders in both houses. Among the heavy recipients, Dr. Wolfe found, were Senate minority leader Robert Dole, House majority leader Richard Gephardt, and House Ways and Means chairman Dan Rostenkowski.

Dr. Wolfe told John Martin: "One would have to look at thirty years since the surgeon general's report and say the tobacco industry has had a nearly perfect victory record in terms of defeating any kind of legislation that's come across. And the way in which they've done it is by buying out members of Congress."

Ted Kennedy said, "The cigarette industry reminds me very clearly of the National Rifle Association—the power of an industry of extraordinary corporate wealth and influence."

The 1,500 companies providing medical insurance in the United have a lobby at least as powerful as those of the NRA and the tobacco industry, who simply destroy politicians who get in their way.

In view of this power, what can you expect the Congress to do about a medical system in such disarray that doctors are quitting in discouragement over the red tape, the endless fights with health insurers to collect their money, and the crushing cost of malpractice insurance? Exacerbating the matter is that hospitals often resort to "heroic" measures to prolong the lives (and agony) of patients who are indisputably dying, squandering money better used elsewhere. They do this because they fear law suits from the families of the deceased if they do not.

Most legislators are lawyers, and it would be naïve to expect them to pass law that would impede the members of their profession from preying on the members of another, namely doctors. Bloated malpractice awards are unknown in Canada, which is another reason its medical system is cheaper.

We can only guess at the strength of the health insurance industry lobby. But there are clues to its power.

In May 1993 in Boston, a consumer-advocacy group proposing a single-payer medical system like that of Canada tried to run a paid television advertisement explaining their position. The ad showed an elderly woman sitting in her living room and saying that by getting insurance companies out of health care, the U.S. could save $100 billion a year. The contention was based on a June 1991 report by the U.S. General Accounting Office that said, "If the United States were to shift to a system of universal coverage and 'single payer' as in Canada, the savings in administrative costs would be more than enough to offset the expense of universal coverage."

The insurance industry, as we've noted, is a major source of television ad revenues. Four Boston stations, WBZ-TV, WCVB-TV, WHDH, and WLVI-TV refused to run the ad. The idea that they had arrived at their positions independently, simultaneously, by coincidence is hardly credible.

The AMA generates an impression that all American doctors are against adopting a system like Canada's. All physicians are not members of the AMA, and I have known doctors who detested it. Representative Pete Stark (Democrat of California) referred to them as "troglodytes" in an interview with Judy Haiven for her Mother Jones article. He told her: "In 1965, when Medicare came in, the AMA was against it. They were also against the surgeon general's report that said smoking caused cancer."

One group favoring a system modelled on Canada's is Physicians for a National Health Program, founded in 1986 by Dr. David Himmelstein, associate professor of medicine at Harvard, and Dr. Steffie Woolhandler, assistant professor (they are husband and wife). The organization proposed it in the January 1989 issue of the New England Journal of Medicine, and Dr. Himmelstein told Judy Haiven in 1991 that eight states had proposals in the

works for adoption of such a system. Dr. Himmelstein, once a student at McGill, was fully familiar with the Canadian system.

Physicians for a National Health Program is by no means the only organization of medical workers in favor of a single-payer plan. In February 1994, the American College of Surgeons announced its support of the concept. Dr. David Murray, its president, said, "Single-payer provides the best assurances that patients would be able to seek care from any doctor of their choice," shooing away the specter of patients being told by bureaucrats what doctors they can go to and what treatment they can have. Ironically, it is in the United States that these freedoms are being lost as HMO's tell you what doctors to go to and faceless clerks and accountants in the insurance companies, concerned only for their profit margin, dictate what treatment you can or cannot have.

Support for the single-payer system came recently from a surprising source. Business Week, in its March 21 issue, carried a long story extensively examining the Canadian system and its possible application in the U.S.

It quoted Vickery Stoughton, an American who had been chief executive officer of Toronto Hospital and the Duke University Medical Center as saying that "the Canadian system has served society, and the average citizen, better than the U.S. system."

The headline on the story read: **Whither a Health-Care Solution? Oh, Canada.** A sub-head read: *A Canadian plan would preserve bedrock U.S. principles — and it may be the cheapest approach.*

The magazine's correspondent, William C. Symonds, who had been posted to Toronto in 1991, wrote in a sidebar story:

"The system is remarkably easy to use. For covered services, there are no insurance forms, deductibles, or bills. All you need is your health-insurance card. Last year I experienced all this firsthand, when our second child was born in Toronto. When my wife became pregnant, she had complete freedom to choose an obstetrician. She chose one of Toronto's leading specialists, who went on to perform many high-tech procedures, including amniocentesis. Her choice paid off when she went into labor. Our son presented in the 'breech' position. In the U.S., that almost certainly would have dictated a C-section. But her doctor expertly delivered our son the old-fashioned way.

"Canada's system is far from perfect. The Vancouver-based Fraser Institute, a conservative think tank, says Canadians wait an average of five weeks to see a specialist and even longer for some nonemergency surgical procedures, such as hip replacement. And access to high-tech medical equipment is restricted. Many Canadians worry such problems will worsen as a result of record budget deficits. But the quality of care is exceptionally high.

"And for all the cutbacks, there's still no wait to see your family doctor or for emergency care. Every year, fewer Americans have the freedom to choose their own doctor. Meanwhile, Canadians never worry about losing their insurance or losing their freedom to choose their doctors. Canadians spend a lot of time in the U.S. But almost all of them say they would rather get sick in Canada. After three years living up north, I can understand why."

Many doctors—and others—have reservations about President Clinton's Health Security Act on the grounds that it doesn't go far enough. It is a compromise. The American Civil Liberties Union is concerned about it. In a February 25, 1994, letter to members, Ira Glasser, its executive director, wrote that on any given day 39 million persons were without health insurance and millions more were without it in transition between jobs. He might have added some chilling figures Judy Haiven uncovered: "About 300,000 times a year, people are turned away from U.S. hospitals. Over a million families who seek medical attention are rebuffed, and a higher number never seek it out at all due to lack of money or no insurance."

A Canadian equivalent would be 30,000 a year turned away. If that many patients were turned away from Canadian hospitals in a year—and that is inconceivable—the government would fall.

"Equal protection of the law," Glasser wrote, "is one of the central constitutional issues raised by health care reform. Once the government undertakes to provide universal and comprehensive health care, we believe the constitution requires that everyone have equal access to the same quality care."

One of Glasser's reservations is a possible further erosion of privacy. He wrote, "The President's plan requires the creation of a vast electronic health data network containing detailed medical information on every person. Such a system needs to be strictly protected. Each individual must have full access to his/her own records, but this information should not be available to anyone else—employers, other family members, or anyone—without the person's knowledge and consent. Safeguards are also needed to prevent the exploitation of this mother lode for everything from marketing to law enforcement. While the plan does recognize most of these principles, it lacks any sort of enforcement mechanism."

The ACLU is cautiously supportive of the Clinton plan.

The plan is ponderous. Indeed it runs to 1342 pages. It has one compelling advantage: it leaves the states free to set up single-payer systems of their own. It should be remembered that it was at the provincial level that the Canadian system started. It may be that it will have to be started in the U.S. at the state level.

To be completely fair on the subject, I thought, it was incumbent on me to find a Canadian doctor practicing in and living by choice in the United States. Perhaps I could get him or her to deplore the Canadian system. For a moment I thought I had found him: Richard Fraser, neurosurgeon and professor of neurosurgery at Cornell University / New York Hospital and for the past three years president of the New York State Neurological Society. He was trained in medicine at the University of British Columbia (always called UBC by Canadians) and Stanford.

Dr. Fraser said:

"My two positions have given me an insight into the health-care delivery system that I otherwise wouldn't get. My other hat is being a Canadian-trained physician with a daughter who was recently desperately ill in a hospital in North Vancouver. She came through after abdominal surgery with flying colors, and I got billed zero for it. I am extremely grateful for all that. I also feel a little guilty about it: I'm not living there.

"During that time, I was visiting professor at UBC, and a more dispirited group of neurosurgeons I have never seen.

"Most people go into medicine because they want to help people. Some of that social motivation gets eroded away in some people with time, and not with others. But doctors are generally a pretty good group of people. The neurosurgeons in British Columbia have had their incomes capped at a pretty low level. They for the most part will earn their allowed capped income in half a year, and they can't earn any more. In British Columbia a neurosurgeon is allowed to earn something like $200,000." (That's about $160,000 American.) "When you have billed that much," he continued, "you are not allowed to bill any more. But you can't stop working.

"It's my understanding that the number of neurosurgeons in British Columbia has declined by almost 50 percent in the past decade. Most of them have come here.

"On the flip side of the system, I think you have very good quality medical care in Canada—better, I think, than the mean here, though if you go for the very best medical care, the States is all over Canada. That's for high-tech expensive stuff."

I told him that I had heard two doctors say that the United States had both the best and the worst medical care of the world's industrial nations.

"Oh, I'd agreed with that completely. What I do mostly is take out brain tumors, and I think we do it here better than anywhere in the world. It also costs a ton more."

"What about Charlie Drake in London, Ontario?"

"Charlie Drake has done some of the fanciest neurosurgery around."

I told him about the Reader's Digest statement about Canadians rationing medical treatment.

"I don't know that that's true. I can tell you that I've had many patients come down here from Canada for various motives, one being that we can MRI somebody at the drop of a hat. We have four MRI facilities in my own institution. In Vancouver there's only one in the entire city, and that's used mostly for research purposes at the university."

Dr. Ethier in Montreal concurs. "If you're sick and if you don't have too much money," he said, "the Canadian system provides very good health coverage across the board. It is expensive because of the very redundant, inefficient bureaucracy. In the high-tech field it's terrible. We have very few magnetic resonance scanners, for example.

"People suffering from multiple sclerosis, for example, are very anxious, and sometimes they have to wait six months to get access to a magnetic scanner, which has become the gold standard in the diagnosis of that disease.

"At Montreal Neuro, we *had* the money to buy a magnetic resonance scanner, to replace our machine. It took a year and-a-half to get the permission from the Minister of Health. And we had to have the previous Minister of Health, who happened to be on the board of the Montreal Neuro, kick his ass. The bureaucrats stall everything. They can't make decisions. In Quebec, the Minister of Health had decided that he was going to approve the purchase of magnetic resonance scanners.

"Nôtre Dame in Montreal is the main university hospital and it hasn't got a magnetic resonance scanner — in 1994! The technology has been around for the last ten years. This is the type of thing that makes me so bloody mad. Academic medicine is badly treated here; regular medicine is okay.

"Practically all the CT scanners in Quebec have been donations from rich people, or people who have organized and run raffle after raffle to collect the money. The government didn't do anything. The only scanner they gave in the early days was ours at the Neuro, and that was because I knew the Minister of Health.

"And they didn't give that. They gave one third, and we contributed two thirds from a private donation.

Richard Fraser said, "We have material advantages which are huge. It's my understanding that about $175 million a year is spent by Canadians to purchase health care in the U.S. Some of that is sanctioned officially by institutions. For instance, I think the Ontario government has a relationship with a Buffalo hospital to do cardiac bypasses when they can't supply the need in Canada." I would add that some of that insurance is purchased by Canadians to protect them when they are traveling in the States.

Dr. Fraser said, "The American system is now breaking down with the recession. So many people who previously had good incomes are now out of work and are without health insurance. Just this morning I saw a fifty-five-year-old executive, who comes from a nice family, previously had a big income, all of a sudden is between jobs, and so has no health insurance. He had a seizure. A seizure at that age means a brain tumor, and that's what he's got. And I have told him of course that I will admit him and do his surgery for no remuneration, which I do all the time. But he's still going to be hit with the hospital bill."

"And it's going to be a staggering one," I said.

"You know it!

"The first thing that worries me about the Clinton plan," Dr. Fraser continued, "is that I don't know that anybody understands it, and I've gone to a ton of health care seminars. It happens to be the subject I wrote my thesis on when I was graduating from UBC and I've had an interest in it for years. And I don't know anybody that understands that plan. But I'm very suspicious of the way they're trying to finance it.

"Any reasonable person thinks that for there to be 37 million uninsured Americans is outrageous. But how are you going to pay for it? Raise taxes. That's what we're going to have to do."

"What would you do to fix everything?"

"I'd go to a single-payer system."

"Like Canada's?"

"Yeah. But improve it. After a massive policy of education to tell everybody, 'Look, this is going to cost.' And I'd take away the fee-for-service system. If you put doctors on salary, you'd remove the economic incentive to do things that aren't necessary. In my specialty, neurosurgery, the most common operation is to take out a disc, either the neck or the back. My guess is that 80 percent of those operations are totally unnecessary, and that's a national disgrace in the United States. The main motive behind unnecessary surgery is money. I think if you paid doctors just a flat salary, unnecessary surgery would disappear on the spot."

So, perhaps, would unnecessary medication. In Nova Scotia, Dr. Feindel told me, the computers revealed that about 80 percent of the medication was being prescribed by about 20 percent of the doctors. They were advised of this. There was no willful wrongdoing involved: it had merely become habit. Overmedication promptly declined. This detection of abuses, including unnecessary surgery, is not possible in the United States with 1,500 companies in the medical insurance business. It is only possible in a single-payer system.

Dr. Ethiér said, "The catastrophe is not the doctors' fees. It's the hospitalization of patients. Hospitalization should be covered, no question. People who want private rooms, pay extra, fine. But this is the killer, hospitalization.

"You know, in Canada doctors' fees are very reasonable. My fee is five dollars for interpreting a skull x-ray, two dollars for a chest x-ray, less than forty dollars for the CT scanner interpretation of the brain. Peanuts. It's not the doctors' fees that are killing the system, it's the hospitalization. That and the high-tech we need now, these should be covered and paid for by the medical system.

"I think a fixed fee is not a bad idea."

Gastroenterologist Mark Feldman of Kingston, New York, told me, "The Clinton bill is, I think, in the right spirit, but I can't tell the direction it's heading in. There's a real fear of the bureaucracy on the part of physicians. With a single-payer system, you'd have to deal with the government, which is a disaster. Nobody has addressed the problem of malpractice suits and the cost of the insurance. The Clintons say they have, but they haven't."

Dr. Ethier (who is French Canadian) detests the Quebec bureaucracy. "In Canada," he said, "we have a heavy bureaucracy that doesn't know about medicine, and can't makes decisions.

"When I trained as a resident, Montreal was a beautiful medical city. We're still pretty strong at McGill, but the Université de Montréal has been suffering a lot, especially from the high technology point of view."

Roméo views the problem of malpractice suits in the U.S. with bafflement. He said: "The problem should be dealt with. In Canada, we're less crazy about law suits. In the United States everybody is litigious. They're so money-oriented. In Canada, the justice system is different. The judge is going to have the final word, not a bunch of uneducated people on a jury.

"A case in the United States that flabbergasted was a psychic who had a CT scan with an injection of intravenous contrast. They claimed that after the scan, she lost her powers. She sued. She was accorded a million bucks! Insane. It was reversed, finally, but what did it cost the system? You have to be out of your mind to tolerate that. This is one problem that has to be tackled in the United States."

The Canadian system isn't perfect because, as Dr. Feindel observed, it's run by human beings. Every Canadian doctor I talked to wanted the system improved; not one wanted it abandoned. Even my brother-in-law Roméo wanted to retain most of it while fixing the parts of it he deplored. Dr. George Trusler would reorganize it along the lines of that in Great Britain.

"I would go to a two-tier system," he said.

By law, a Canadian cannot pay a medical bill; a doctor in turn can't give you one. He can collect only from the government. In Britain, Dr. Trusler said, doctors work three or so days a week for the public health system and the rest on their own.

Like every other Canadian doctor, he held the opinion that medicine in the United States was "the best in the world at the top." His reservation, held by all, including Dr. Fraser, is that it is not available to all.

"The fact that any doctors at all stay here, given the salary differential," my sister, Dr. Victoria Lees, observed, "speaks volumes for Canadian medicine."

Her comment led me to a startling thought. By weeding out the greediest Canadian doctors, that profit differential could actually have the effect of raising the level of Canadian medicine while lowering that of the United States and raising its cost. Many of those who leave Canada out of avarice doubtless are part of the pool of physicians performing lucrative unnecessary surgery, including hysterectomies and Caesarian sections (one of the most widely-abused procedures) in women and prostate-gland excisions in men, while raising U.S. medical costs to the present astronomical levels. It is startling to think that a doctor would needlessly take up a knife and carve up another human being, then hand the victim a huge bill for doing it, or send someone for unnecessary, fancy and expensive high-tech tests at some institution in which he is a shareholder. But it happens all the time.

I believe, as Dr. Fraser suggests, that most doctors enter the profession out of idealism, and most even retain it. Talking to so many of them in a short time, I found myself almost awed at the high level of intellect, expertise, and ethics, not to mention a general magnanimity, of these doctors in both countries. But then I was dealing with the upper strata of the profession, not wandering among the hacks, butchers, and frauds. They're out there too.

The New Yorker article concluded:

"(It) occurred to me . . . that the reason President Bush and Representative Gingrich, and even Senator Tsongas, were misrepresenting Canadian health care was simple. To admit that it is better than ours would be to admit that there are important things (other than fighting wars) that governments can do uniquely well, and for the past decade the whole ideological structure of American 'conservatism' has depended on constant, relentless reiteration of the claim that all government is necessarily evil . . . .

"The compulsion that drives President Bush to distort the facts about Canadian health care suggests that official American policy is in the process of becoming what conservatives, in discussing the Soviet Union, used to call 'a total ideology'—a system blindly convinced of its absolute truth, and yet so fragmented in its relationship to reality that it is incapable of considering even the most obvious reform. Surely we should have learned by now what happens to ideological systems that begin to deny facts that their people can discover for themselves just by crossing a border."

And that's just what thousands of Americans are doing, the Reader's Digest, Senator Dole, and Representative Cooper to the contrary notwithstanding: crossing the Canadian border to get medical care.

The argument that health care is rationed in Canada is a sophism. It is rationed everywhere, by one criterion or another, less so in Canada than in the United States. In Canada it is rationed fairly, in the U.S. it is rationed unfairly — along the cruelest social fault line: money. Those who can afford it can get the best medical care in the world. Those who can't don't get it at all, or get poor medicine, or get it at last in the most wasteful of all ways, in emergency wards when what could have been ameliorated has reached the point of the desperate or terminal. Ask Butch and Marie Roy whether medical care is rationed in the United States. It is, and it's rationed irrationally.

One of the greatest problems in both countries is bureaucracy, ponderous, faceless, uncompassionate, inept and incompetent bureaucracy. In Canada, the bureaucrats are employees of ten governments, one federal and nine provincial. In the United States, they are employees of approximately 1,500 insurance companies, and given the hours of each week that secretaries working for doctors and pharmacists must fight with these companies to get their money, they necessitate a second tier of employees, further raising the cost of doing medical business. In the U.S. these people are making medical decisions, affecting the lives and deaths of patients they have never seen. Some accountant or secretary at an insurance company can dictate whether one can have this or that medical procedure, the basis of this peremptory decree being not the patient's medical needs but the company's financial interests.

The medical bureaucracies in both countries obviously have to be curbed. Medical decisions need to be given into the hands of medical professionals. Surely we can establish governing bodies compromising appropriate professionals, doctors, hospital administrators, medical ethicists, and medical economists. I have not encountered a proponent of this idea in either country, although it seems obvious enough.

What will happen to medical America?

Only a fool would predict, with the Republicans fighting an obstructionist campaign of unparalleled ferocity and with a concern for facts and the health of Americans about equal to that they have shown in their obeisance to the tobacco and gun lobbies.

In an article titled *The Low Art of the Thinly Disguised Bribe*, published in the Christian Science Monitor March 14, Washington attorney Skip Kalenheuser wrote:

"Consider President Clinton's task in revamping an $800 billion-a-year health industry. Its 200 political action committees gave $60 million in PAC contributions to congressional candidates, plus individual contributions, during the 1980s.

"In the mid-1980s, the American Medical Association's PAC dumped hundreds of thousands of dollars of 'independent expenditures' (a clever sidestep around contribution limits) to attack a couple of popular Congressmen who sought ceilings on Medicare fees. The failed attempt to dump them was viewed as a victory because, as the PAC chairman said, it send 'a message to everyone in Congress who won by 51 percent.'"

What Ted Kennedy said of the tobacco industry applies equally to the vested interests, particularly the insurance industry, moving with such naked power to impede and if possible completely prevent reform of the medical system. Kennedy said:

"In order to make progress in terms of legislation, you have to have the real support of the American people, the willingness to over-ride the power of the special interests. That will be the basic question: whether we'll be able to get that kind of support."

## And on a Lighter Note . . .

Last July I had the joy of singing, mostly my own lyrics, at The Senator in Toronto with a brilliant quintet comprising Guido Basso, fluegelhorn; Rick Wilkins, tenor; Don Thompson, piano; Neal Swainson, bass; and Barry Elmes, drums. The club was sold out two sets a night for six straight nights. I don't know what we did right, but audiences loved it. We're booked back May 10-16, in case you're in Toronto and feel like falling by. There's a high likelihood that this time we'll record an album there.

A lovely club with a great piano and sound system, The Senator is at 249 Victoria St. in downtown Toronto, and the phone number is 416 364-7517.

**The Jazzzletter is published 12 times a year at PO Box 240, Ojai, California 93024-0240 at $60 per year U.S. for the United States and Canada, $70 for other countries. Subscriptions are for the current calendar year, January to December inclusive, regardless of starting date.**