
Letters to the Editor

Access to Care

To the Editor:

I have read the first issue of the new *North Carolina Medical Journal* with considerable interest.

There is a solution to the uninsured healthcare problem: National Health Insurance for *all* of our people, with some sort of means-testing, deductibles, or co-insurance, and provisions for catastrophic illnesses and long-term care. With one stroke access is solved. But that leaves us with other monumental interrelated problems: how to pay for it, and how to control costs (healthcare costs are increasing by about 15% of the GDP per year). Permit me some comments on the contributions to this issue of the *Journal* and some other suggestions for solutions.

Dr. Silberman et al. identify the access problem at the state level and describe some options, but finally provide us with a solution: ". . . provide universal coverage to all . . ." There are 40+ million uninsured—including 9+ million infants and children—in our country, and even more underinsured, for whom healthcare costs are among the most common causes of bankruptcy!

Dr. Chaplin came close to the solution when he asked, "Why can't patients have one all-inclusive insurance plan?" That is a definition of universal national health insurance.

The other contributors focus on their special interests and concerns. Mr. Pully is paid for providing services to the uninsured by over-charging paying patients. He has to do that to make ends meet. Mr. Searing describes problems with the soaring needs and underfunding of Medicaid, a government program of providing healthcare for poor people. But there are other, huge government-financed programs, including Medicare; military and veterans' healthcare; and federal, state, and municipal plans, which liberally provide for our elected officials at tax-payers' expense. Perri Morgan aptly describes the dilemma of imposing mandates on the business community. And Mr. Mahoney represents a major part of the problem: There are 1200 health insurance companies in the USA which, despite misleading labels, are all for-profit (how else are million-dollar salaries for executives explained?) with their flagrant and unnecessary duplication of administrative procedures, personnel, and expenses.

You can tell where I'm going: replace the profit- if not

greed-driven 1200 insurers with one (1) cost-effective insurer, namely, single-payer national health insurance for ALL of our people. Ours is the only country in the developed world that doesn't have it. If others can afford it, surely the richest country in the world can also. Many surveys and polls indicate a majority of Americans would prefer a single-payer system; however, despite solid empirical evidence that it would provide higher-quality care for less money, single-payer proposals are kept off the public agenda by big business (especially the insurance industry) and its allies in Congress.

How to pay for it? The same way we pay for the other programs: taxes. For example: Social Security and Medicare are paid for by means of a payroll tax: 12.4% (6.2% by the employer and 6.2% by the employee) on the first \$84,000 of wages. It is the most regressive tax in our entire tax system; many lower-income and poor people pay more payroll taxes than income taxes! It does not tax wages over \$84,000 or other sources of income such as interest, dividends, stock options, bonuses, golden parachutes, etc., thereby sparing the affluent. There is a fairer way: reduce the payroll tax by 2% or so, eliminate the cap on wages, and include all of those other sources of income. It could solve the predicted insolvency of those programs and possibly contribute to the funding of national health insurance.

Controlling costs is essential, but not at the cost of poor health care. This is where things get a bit murky. There is basic and essential health care such as prenatal, infant, and child care. And there is elective, if not frivolous, care such as some cosmetic procedures. Our high-technology-driven care is expensive. If limits are to be set, it may mean some sort of budgeting, if not rationing. Not everyone can have a cardiac transplant.

And finally there is another insidious cost problem: unrealistic expectations by some patients, their families, and lawyers, based on the myth of perfection in medicine. Perfect practice is not possible, but the expectation of it drives much of malpractice litigation and the enormous costs of defensive medicine in our increasingly litigious society. We are badly in need of tort reform.

There are serious problems with healthcare in our country, and the uninsured is one of them. Your issue of the *Journal* has drawn attention to this difficult problem, and I hope it will provoke discussion and debate. None of these

problems is insurmountable, and single-payer national health insurance is one step in the right direction.

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Caught In the Malpractice Crossfire

To the Editor:

I am a board-certified General Surgeon who has been in practice for almost 21 years, in two litigious counties in Texas. It is worth noting that Corpus Christi, where I practiced for ten and one half years, is located in a country (Nueces) with the dubious distinction of having the highest malpractice lawsuit rate in the entire state (Source: Texas State Board of Medical Examiners; based on 1987-2000 claims). I had one lawsuit in 1986 and one in 1994; both were settled out of court, for \$300,000 and \$195,000, respectively. Neither patient is suffering any long-term disability.

I have worked extraordinarily hard throughout my career to provide the best possible care to all of my patients, regardless of race, color, creed, or ability to pay. I have worked hard to improve hospital care by providing in-service education for nurses and CME conferences for physicians. I have a Physician Recognition Award from the AMA, and I have accumulated 150 hours of CME as I prepare to take my recertification examination.

Yet, as I seek new malpractice insurance for my recent relocation to North Carolina, I find myself caught in the crossfire between plaintiff's lawyers and juries and the malpractice insurance industry. Because of the huge awards and frequent lawsuits in Texas, the malpractice insurance companies are unwilling to provide me with prior acts coverage. They have given me a quote of \$96,000 for one year of \$1 million-\$3 million coverage; additional tail coverage from my present liability carrier will cost \$64,855 for \$200,000 of coverage for one year. So, as a General Surgeon, I'm being asked to pay an obscene sum of \$160, 855 this year for malpractice insurance—precisely 62.25% of my guaranteed income this year.

This is the reason why physicians are leaving Texas and other states. This is the reason why physicians are leaving medicine, or are refusing to care for high-risk patients. This is the reason why St. Paul's Insurance Co. in Minnesota abandoned the malpractice insurance arena. As reimbursement to physicians and hospitals is being reduced in spite of rising malpractice and health insurance costs, physicians often have no choice but to close their doors or restrict their practices. Malpractice companies are incurring record losses because of huge awards and lack of tort reform.

After almost 22 years in Texas, my wife and I came to North Carolina to be closer to our families and old friends. We came to this area of North Carolina, with its large indigent community, to fill a need—not to become rich. For that, I could have gone to law school!

In 1990, at age 40, I went back into training for one year in order to become board-eligible and subsequently board-certified—and this was after nine years in practice. I realized how important board certification was in this medicolegal and managed-care environment. I have strived for excellence, as do most of my colleagues. I feel now as if I'm being punished for staying in Texas and for coming to North Carolina. I am faced with the dilemma of whether I can continue the practice of medicine and surgery to which I have given 31 years of my life. Was it worth it? Yes—a resounding yes! Is it worth it now? No, it is not. Not worth nearly \$161,000 a year. More physicians will be facing this same dilemma as the crisis mounts and gains momentum. More physicians will be forced to leave medicine, and the malpractice crossfire will claim another fatality. And another. And another.

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Screening for Prostate Cancer

To the Editor:

I read with interest the article on prostate cancer as a public health issue in North Carolina, submitted by the "Early Detection Subcommittee of the North Carolina Advisory Committee on Cancer Coordination and Control" [Stark et al. NC Med J 2001;62:286-90]. I note that of the four members of this committee who are charged with making recommendations to the general public, none seems to have ever seen or treated a case of prostate cancer. My first question would be, "Would it not be appropriate to have a Urologist on this particular panel, as they are the physicians who see and treat prostate cancer on a daily basis?"

Secondly, I quote from the recommendation accepted on April 28, 2000: "It is possible that PSA screening of asymptomatic men detects prostate cancer at an earlier stage than prostate cancers diagnosed after symptoms occur." It is known by every Urologist in the country that if one waits until symptoms occur with prostate cancer, the disease is by then, by definition, incurable. Data are rapidly accumulating, particularly some recent data out of Europe, indicating that PSA screening, without doubt, finds prostate cancers at a significantly earlier stage. In a homogeneous population in one European state, screening and aggressive treatment with radical prostatectomy have reduced mortality from the disease even over the first several years of the study. I fear that the politics of how we spend our limited healthcare dollars are short-changing half of our population. If one simply looks at the number of dollars spent on research and treatment of breast cancer versus prostate cancer, this becomes self-evident.

My contention would be that any group currently recommending against screening men for prostate cancer with PSA and digital rectal exam simply does not understand the

data or has selectively reviewed the data to support its own conclusions.

I apologize for the cynicism herein, but I felt that having cared for patients with this disease for the past 30 years allowed me the latitude to make these observations.

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Eastern North Carolina Medicine

To the Editor:

In reference to the special issue on medicine in Eastern NC [NC Med J 2001(Suppl);62], I am amazed at the volume of faithful and verbal readers of the *Journal*. If our goal was to disseminate knowledge (granted, somewhat limited in scope) and stimulate interest, the issue was highly successful. A more complete reporting of the medical history of Eastern North Carolina, including all the segments we were unable to cover previously, would probably be well received. Thanks for doing a good job, and we all owe Dr. Anagnostou a big vote of thanks for doing this.

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