Un-Constitutional Medicare: Poisonous Fruit of the Poison Tree

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As previously discussed, Medicare is facially un-Constitutional.[1] Its enactment led to predictable adverse consequences, and efforts to counter them led to increasing governmental intrusion into the practice of medicine, as reviewed below. AAPS challenged the Professional Standards Review Organizations (PSROs) in 1974, in *AAPS v. Weinberger*, which was dismissed on the basis that government controls what it funds and that participation in Medicare is "voluntary."[2] The violations of Constitutional rights described below with other Medicare-related laws and rules would probably be ruled allowable on similar grounds. Based on the false premise that Medicare itself is not un-Constitutional, courts are also likely to decide that the fruit of that poisonous tree is also not un-Constitutional. Accepting the premise means accepting its fruits.

When government force establishes a program to address a supposed problem, that program and its rules and prohibitions stand between any actual problem and the creative problem-solving energies of the American people.

Americans' genius in the Revolutionary War toppled the most powerful empire of the day and created the most inventive, most charitable nation ever witnessed on Earth. American soldiers, without permission or orders, took the initiative, cutting up the Nazis' "Belgian Gates" and "Hedgehogs" on the D-Day beaches of Normandy, then affixing the metal to their tanks, to create tank-driven military "forklifts" to cut through the 15-feet-high hedges that furnished the German army an excellent defensive position while hobbling the American offensive. Today, corporate executives, such as Mike Lindell, who switched his pillow company to making masks, help to counter the COVID-19 pandemic.

Government programs, in contrast, never solve the problem that justifies their existence—and the salaries, benefits, and pensions of their staff. They simply expand, usurp private enterprises, and never disappear.

Medicare was created to solve the supposed problem that medical care of those over age 65 needs to be paid for and not everyone can afford it. In 1962, about half of those age 65 and older had medical insurance.[3] Medical insurance was becoming more common, even though there was still not much that could be done medically for many conditions. Americans have come to believe that medical care should be free. In a television ad for "Medicare Advantage" Plans, Joe Namath exclaims: "I called the Medicare Benefit Coverage helpline, and they instantly looked up my coverage and advised me that I'm not getting all the benefits I deserve!... Private home aides, free rides to medical appointments! Doctors' and nurses' visits by telephone, dental, vision and hearing, prescription drugs, and even home-delivered meals—all at no cost to you! Call the number on your screen now. It's free!"

When President Lyndon Baines Johnson bestowed Medicare on those over 65, at the expense of the second-class citizens, namely, younger working taxpayers forced to fork over their hard-earned money to pay strangers' medical bills, a predictable series of changes occurred. That intrusion into our liberty is un-Constitutional. Some assert that Medicare is a voluntary program, and that the rules and prohibitions are accepted as a condition of reaping the benefits. That is akin to saying that people taken hostage at gunpoint volunteer for their fate when they accept food from their captors.

Employer-sponsored plans, the response to President Franklin Delano Roosevelt's World War II wage-and-price controls, follow Medicare's lead.

"Managed Care"

The response to the explosion of medical costs in both government and employer-owned plans is basically to restrict patients to a "network" of physicians, who must obtain the plan's approval ("pre-authorization") for treatment. The Health Maintenance Organization Act of 1973, principally sponsored by Sen. Edward Kennedy (D-Mass.), had the stated intention to curb medical inflation—caused by Medicare and Medicaid.[4]

The cause of the cost explosion is demand exceeding supply. When someone else is paying, people use more medical care. Under Medicare and Medicaid, every trivial concern is run through the gigantic federal bureaucracy and its contracted carriers, all of whose workers get salaries, benefits, and retirement. The HMO method, as expressed by John Ehrlichman, President Richard M. Nixon's assistant for domestic affairs, is that "all the incentives are toward less medical care, because the less care they give them, the more money they make."[5] The best solution, free-market medical care, worked very well previously, but nobody can buy votes with free-market medical care.

Health "maintenance" implies that the physician maintains your health, whereas you yourself can be irresponsible.

Managed care organizations (MCOs) began to proliferate during the 1980s, when the industry began to court employers, and now increasingly enroll Medicare and Medicaid patients.

MCO plans typically employ doctors and statisticians to assess computer-generated data related to questions such as duration of hospitalization and treatment effectiveness. These data are then developed into industry standards that are referred to as "best practice" guidelines or benchmarks. The MCO, and not the treating doctor, then decides what treatments will be authorized and how much will be paid for the treatments, hospital stays, etc. In return, the MCO purports to offer lower "insurance premiums" for subscribing members.[6] Note that pre-paid medical plans are not really insurance.

The medical care is rendered by medical professionals who

have entered into contracts with the pre-paid MCO plan to treat the MCO patients in accord with "guidelines" and various constraints. The reason why physicians would enter into such contracts is the difficulty in dealing with the minefield of regulations, constraints, trip wires, and obstacles placed in their way by the government. Large entities can bribe the government, and can fight government with less chance of being destroyed.

The plan assigns patients to a "primary care" physician, who then must approve the patients' seeing a specialist, according to the plan's guidelines. So, while patients theoretically have unfettered medical care for a low pre-paid fixed price, in reality they must play "Mother-May-I" to get access to a specialist. Some HMOs pay the physician a set (capitation) fee for each "covered life" so the physician has a perverse incentive to do the least for the patient, thereby setting the patient and physician against each other.

The doctors' work undergoes "utilization review" by administrators looking for excessive services. Physicians might receive a missive from the Utilization Review Committee, which is likely to contain warnings about Recovery Audit Contractors, who are paid according to the amount of "waste, fraud, and abuse" that they "find." Note the absence of such "Recovery Audit Contractors" to ferret out bribery and corruption in government "entitlement" programs on behalf of taxpayers.

HMOs cover "preventive services" like vaccines, mammograms, and yearly physicals. This was thought to be a genius idea to save money in the long term. However, far more important are patients' behaviors such as refraining from smoking, drinking in excess, over-eating, violence, irresponsible sex, and so on. Patients are not required or incentivized to make efforts in their own behalf.

Several cost-sharing ministries exist, with voluntary membership of people who do not drink excessively, smoke, engage in "recreational" drug use, violence, or extramarital sex. Federal law denies their members the freedom of having tax-advantaged Health Savings Accounts.

Prospective Payment by Diagnosis-Related Groups

In the 1980s, in another desperate cost-containment effort, government instituted "Diagnosis-Related Group" payment. It treats diagnoses as if the patients with the medical conditions are standardized widgets, and pays a fixed fee for each DRG, regardless of the treatment that is rendered. There is nothing in the Constitution authorizing the federal government to interfere in medical care by grouping diagnoses or to decree that payment is determined by group membership, or in any way at all.

A central theme in the advocacy of DRGs was that this system would oblige hospital administrators to alter the behavior of the medical staffs.[7] Hospitals were forced to leave the "nearly risk-free world of cost reimbursement"[8] and face uncertain financial consequences. Although virtually unnoticed by the general public, the change was nothing short of revolutionary.

There is nothing in the U.S. Constitution that allows the federal government to shift the balance of power between suppliers and consumers, to empower administrators to influence professionals' behavior, or to require persons or institutions to become risk-bearing entities like insurance companies in order to do their work. These un-Constitutional activities are an effort to correct the problems created by an un-Constitutional program. The government could not compel free actors to submit to such a system. They are simply a condition for receiving government payment, because it is an inescapable fact that whatever government pays for, it controls.

DRGs are supposed to represent homogeneous units of hospital activity. They are based upon "the patient's principal diagnosis, ICD diagnoses, gender, age, sex, treatment procedure, discharge status, and the presence of complications or comorbidities."[9] Why isn't there a flat charge, for example, for defense against a charge of first-degree murder by a male, age 30-55? An argument like that for DRGs could be made: "As legal aid budgets…have declined…approaches to address the gap in civil legal services have gained traction."[10] However, the challenges to professionalism that non-lawyer ownership can create are recognized, including "conflicts of interest and the potential for regulatory capture by new actors who can profit from legal services…. [O]pponents of non-lawyer ownership… assert that opening up the profession to outside owners will undercut lawyers' independence and professionalism."[10]

No non-lawyer, as yet, is allowed to try to "influence the behavior of" lawyers, even though they cost everybody in the U.S. money. Legal problems are even more likely than medical problems to destroy a person's life, but there is no "Legicare." Government is run by lawyers, who do not care that physicians' independence and professionalism are shredded, with adverse consequences for all clients.

Under DRGs, hospitals taking care of more complex patients lost money. Hospitals went broke and closed. Patients were discharged from the hospital as soon as possible, "quicker and sicker," with no margin of safety, to avoid the unpaid expense of another day in the hospital. Some were not ready and had complications. Naturally, the hospital and doctors were blamed and often punished by nonpayment for care of the complications.

It would be un-Constitutional for the federal government to write orders to discharge sick patients from hospital, or to order doctors to do so. It is simply allocating funds that it controls under the un-Constitutional Medicare program.

Medicare Advantage Plans

There have been many more efforts to hold back the tide of rising costs, but none, until recently, has addressed the inescapable economic fact that when a behavior is subsidized, it is encouraged, and there will be more of it. In this case, Medicare and Medicaid subsidize the demand for medical care, which is paid for by forcibly taking the earnings of working taxpayers. In effect, Medicare and Medicaid gave control of the U.S. Treasury to "entitled" people who are older than 65 or who are adjudged too poor to pay anything for their medical care, even when they have money for cruises, vacation homes, golf, cigarettes, alcohol, tattoos, nail salons, and so on.

"Medicare Advantage" plans are an underhanded way of partially addressing the economic problem. The program

relies on medical corporatists who ration medical care while advertising free eyeglasses and other desirable items noted above. Medicare Advantage plans are like the Eagles' *Hotel California*: "You can check out any time, but you can never leave."[11] If you develop a serious illness and the top physician for treating it is not in your "network," you cannot go to see that physician. Physicians, like patients, are treated as interchangeable standardized widgets.

Medicare Advantage plans are a part of the corporate practice of medicine, which is illegal in many states, although the statutes are generally ignored. In such plans, the patient visit is for the purpose of generating a billing document, and the physician is there merely to legitimize the billing document for the benefit of medical corporatist overlords. Health care corporations are publicly traded, and answerable to shareholders, not to patients.

"Healthcare Exchange-Traded Funds" and investing in the "healthcare sector" are now spoken of as if our patients were aluminum pipes and ingots, or oil and gas. The medical corporations are flush with cash extracted from us and our patients. CEOs of these medical corporations take millions of dollars a year in salary, and millions more in stock options and benefits.

Strategic sourcing is a technique to reduce costs and increase revenues by addressing suppliers. In this case, the revenues are to medical corporatists, and the suppliers are physicians. In cases of products and services where production is known, output is well understood, and there is no life at stake, the method makes sense. But when this method is applied by medical corporatists to medical care by third-party payers, it causes problems for patients and is dangerous to the medical profession. It results in a massive wealth transfer from physicians, who do the work, to administrators, who do not.

A common technique of strategic sourcing uses data mining and looks for deviations from a mean. This finds the lowest cost for providing a currently offered service and determines the variance and standard deviation. From this pile of data, groupings are found along with trends that can be identified. Then a game theory technique called "prisoner's dilemma" is used to apply pressure to reduce market prices (J. Behar, personal communication).

In a prisoner's dilemma, two or more competing parties are enticed to submit to the keeper. They would be better off if they cooperated with each other, but those who do not defect to the keeper will suffer more harm if one does defect, and less harm if all are complicit with the keeper's wishes. Workload, supplier cost structure, and capacity are researched by the keepers, in order to fully understand the supplier's power and willingness to conform. The weakest suppliers are targeted to provide a lower price, and this information is quickly distributed to other suppliers with threats of reduced business. This leads to a spiral downward in prices, with the keepers winning at the expense of the prisoners.

Other strategic sourcing techniques include supplier report cards (Pay for Performance), coordination and control of market data (national data warehouse), standard terms and specifications (CPT codes), and grouping purchases to optimize purchasing (preferred provider lists). These techniques are very threatening for a fragmented supplier base such as physicians.

Why are these techniques bad for medicine but good for industries? Strategic sourcing assumes that product manufacturing processes are known, and that parts in a batch are the same and do not have relatives or react with their environment much. These assumptions are not true for patients.

Through Medicare and Medicaid managed care, which enrolls a large and increasing number of beneficiaries, the federal government is supporting the corporate practice of medicine and the commoditization of patients and physicians through strategic sourcing. There is no Constitutional authority to interfere in patient-physician relationships and subjugate them to corporate keepers that use data mining and game theory for their own financial advantage. Again, these are derived from the un-Constitutional Medicare and Medicaid programs and are tied to receipt of the benefits—or what remains of them after passing through the middlemen.

Medicare Price-Fixing

Economist Paul Craig Roberts reported on a letter he received from his doctor at the time of his annual visit. "Medicare fixes the prices…. All office charges for Medicare, including office visit charges, have been set by the Federal government since 1984. In real terms (adjusted for inflation), these fixed prices are less today than they were three decades ago."[12]

The letter noted that the practice's overhead had constantly increased and that services formerly provided in-house were now out-sourced to corporate facilities at higher cost and greater inconvenience to patients.

"Corporate lobbies are using their whores in Congress to shift income from physician offices to corporate labs, corporate medical service providers, and hospitals that are owned by national corporations…. The physician's income is diverted to shareholders, CEO bonuses, and Wall Street. Health care is being replaced with health business."[12]

In 1992, government imposed the Resource Based Relative Value Scale (RB-RVS).[13] It is a fee schedule, determining the fee for Medicare patient visits. Basically, it is an application of Marx's Labor Theory of Value. As usual in government bureaucracy, it is mind-numbingly stuffed with variables and so is difficult to sum up. The concept is that the value of a physician's work is now the value to the government, which relies on votes of people whose medical care is being paid for by taxes imposed on working people. Government attempts to keep both taxpayers and Medicare recipients ignorant and pacified.

The RB-RVS sets the value of a physician's work according to its supposed difficulty and the estimated resource requirements. The government relies largely on the AMA/Specialty Society RVS Update Committee (RUC) to set the value of services. If the person receiving the service were paying for the service, the value would be different—and fewer services would be obtained. Other third-party payors now use the same scheme. A physician's knowledge, judgment, skill, compassion, and dedication are of no value to the government or third-party payer.

The federal government has no Constitutional authority to determine the relative value of medical services, or to delegate this authority to a private entity. It is again simply allocating the un-Constitutionally seized money and seeking "recommendations" that it need not accept.

Merit-Based Incentive Payment System

In defiance of the fraudulent, intended-to-pacify-resistance clauses in Medicare prohibiting federal interference in the practice of medicine (Sec. 1802 [42 USC 1395]), Congress passed the Medicare Access and CHIP Reauthorization Act, (MACRA), replete with the Merit-Based Incentive Payment System (MIPS). The federal government uses MIPS to "grade" physicians and assigns each a score of 0 to 100. The Composite Performance Score (CPS) is used to financially bribe or penalize physicians, and then the scores are posted publicly for all to see. "MIPS is the ultimate conflict of interest: the very lives and well-being of America's patients vs the money and power of the medico-industrial complex run by a small group of insider elites, implemented and run by entrenched, faceless deep-state bureaucrats. Physicians must choose sides," writes Kristin S. Held. M.D.[14]

The federal government has no Constitutional authority to interfere in medical care in any way whatsoever—not to "provide" medical care, or to force one citizen to pay for another citizen's medical care. Medicare is completely un-Constitutional. Therefore, to grade medical professionals or to delegate this authority, or to do any other thing along such lines is also un-Constitutional. MACRA, MIPS, and all such other additions to the scheme, are simply dishonest attempts to ameliorate the horrible effects of the un-Constitutional Medicare scheme on the national debt.

Physicians are Suffering and Dying under the Government and Corporatist Medical Takeover

Currently, practicing medicine in these United States is like living a Russian novel. I feel like Professor Philippovich in *Heart of a Dog*, by Mikhail Bulgakov, who came of age as a physician shortly after the Russian Revolution of November 1917.

In the novella, Philip Philippovich was visited by the "new house management committee," which demanded that he give up his dining room and examination room.

The doctor then telephoned a patient: "Pyotr Alexandrovich, your operation is canceled. And all the other operations as well. This is why: I am discontinuing my work in Moscow, and in Russia generally…. Suffice it to say that they suggested that I give up my examination room. In other words, they make it necessary for me to operate on you in the place where I usually dissect rabbits. I…cannot work under such conditions. Therefore, I am discontinuing my activities, …and leaving."[15]

A pandemic of government rules, regulations, constraints, mandates, obstacles, trip wires, and nooses has been clamped upon the medical profession, which stress, obstruct, and distract physicians from the critical vocation of taking care of their patients. These were heralded by journal warnings that physicians were not ready for the new International Classification of Diseases (ICD-10) or "Electronic Health Record" mandates.

Physician "burnout" is rampant, and physicians currently have the highest suicide rate of any profession, including the military, and more than twice that of the general population.[16] One company concerned about the problem said: "They're also working to reduce bureaucratic frustrations. A significant portion of required corporate training hours are now deemed optional. And the company has allocated millions of dollars a year for scribes, the medical staffers who trail ER physicians and enter notes into often-finicky electronic record-keeping devices."[17] These measures do not begin to alleviate the daily frustration of dealing with government and corporatist bureaucracy in medical care.

Some of the most caring, compassionate, and intelligent doctors choose suicide rather than continuing to work in callous, uncaring, and ruthlessly greedy medical corporations, writes Dr. Pamela Wible. Doctors develop on-the-job post-traumatic stress disorder (PTSD).[18] Dr. Wible details the scene of a suicide committed by a physician who jumped off a 32-story building. A tarp covered the gruesome remains of what had been a young physician. No cards, no flowers, no candles. Exhaustion and endless pressure to meet absurd administrative and medical corporatist financial demands are big contributors.[19]

Physicians struggle with many problems: ever increasing educational debt, unrealistic patient expectations, medical malpractice worries, demands for continuing education, loss of social status, and competition from nonphysician providers. The third-party payment system plays a part in most, especially pressures for higher patient quotas, questionable performance assessments and rankings by insurers, and dwindling fees. Among the physicians surveyed by the American College of Physicians in the Physician Morale Survey in 2006, nearly 60 percent indicated that they had at some point considered leaving medicine.[20]

In the third-party payment system, physicians are portrayed as "muggers" and co-conspirators in "taking money away from the rest of us." Patients think that if an operation took only 35 minutes, a sign of an efficient and experienced surgeon, less payment is justified.

A large number of physicians' comments were compiled by KevinMD.com. For example, Karen S. Sibert, M.D., writes that "the loss of respect and the constant threats to fair payment are making physicians regret that they ever chose medicine…. They…wanted to help people, and their reward is insult." This is why many physicians get an MBA degree. The real rewards go to CEOs—the CEO of Anthem made more than $14 million in 2018, while insurers do everything possible to avoid or delay signing fair contracts and paying physicians who care for patients.[21]

"Things have gone from bad to much worse over the past 20 years,… as insurance companies inserted themselves more and more as an intermediary and ultimately as a decision-maker," writes Baird Brightman, Ph.D. The transformation in words to calling physicians "providers" served the strategic intent of shifting power from the health professional to the corporate profit-taking class.[22]

Physicians have always suffered from stress over difficult patient problems, complications, and the loss of patients to

death. However, ever since the advent of employer-provided, pre-paid medical "coverage" and especially since passage of Medicare in 1965, physicians have been burdened by a never-stable barrage of un-Constitutional government interference, coercion, bribes, trip wires, and constraints. Medical corporatists, given the green light when they were made government contractors administering portions of Medicare, have also greatly encumbered and damaged medical care. The "burnout," which currently causes so much suffering and death of physicians, is moral injury of physicians caused by this hijacking of our profession for vote-buying and greed.

How Do We Return to Constitutional Government and Sanity?

We must advocate vigilance. "Eternal vigilance is the price of liberty," Thomas Jefferson warned us.

Every government program should be viewed a priori with alarm and suspicion. Schemes such as Medicare impose a burden on some citizens for the benefit of others. The "beneficiaries" become exposed to moral hazard. The time course in human affairs, and long-term consequences must never be ignored.

Medical care is not a proper function of government, and it is not an enumerated power in our Constitution. It was never thought of as a governmental role until "progressive"—socialist—concepts came into vogue.

There is nothing in the Constitution that authorizes a scheme that creates second-class citizens, as Medicare does—the younger taxpayers who are burdened to support retirees and others. Nor does it authorize burdening future generations with a non-payable mortgage on their labor. Nor does it permit the central government to take over and regiment the practice of medicine.

It would have been far easier to block the Medicare scheme than it will be to reverse it. But racial segregation was reversed, proving that such reversals are possible.

The Constitutionality of Medicare must be challenged. We may lose, but we know we are losing now. The case has never been made. The case against slavery had not been made at one time; the case against segregation had not been made at one time. When the case was made against each of those long-standing monstrosities, they were vanquished.

In the meantime, everything possible must be done to escape the grip of Medicare. Medicare has slowly, but inexorably, taken medical care out of the hands of patients and their physicians, and put it into the hands of those who know nothing about medical care or the patients who need care. The methods used in a futile effort to constrain Medicare costs have destroyed the private medical economy as well.

Physicians and patients should secede from Medicare and/or Medicaid totally, or to the extent that they can, and avoid contracts with all third parties. Alternatives to managed care include direct-pay arrangements and Christian and other cost-sharing ministries. Samaritan Ministries does not coerce people to join Medicare.

We need to eliminate middlemen who add no value to the system. As economist Thomas Sowell pointed out, it is not possible to make anything less expensive by interposing a gigantic bureaucracy between the person who wants or needs a service, and the person who provides the service. Middlemen include government and corporations that "manage" patients and physicians.

Physicians need to learn to make our arguments forcefully. We must turn off our accommodating and sympathetic selves when it comes to government intrusion, and become like hardened lawyers when dealing with government, which always and everywhere tends toward tyranny, as the pandemic in these times has made so clear.

We must advocate for a return to true insurance, rather than prepaid "health" plans and to individual responsibility for our health. We need to mentor patients and medical students to understand how payment methods affect care.

We should allow true medical insurance to be sold across state lines, to bypass the state Insurance commissioners' power to force people to spend money on things they do not need or want, such as maternal care for men or older women, or substance abuse treatment for those who will never be a substance abuser.

We should teach in schools and advertising campaigns that people are responsible for their own health and medical care. An ad campaign worked for deodorant use; it can work for medical responsibility. Smoking, excess alcohol use, harmful drug use, violence, over-eating, and bad sex decisions all cause preventable medical problems, often serious and expensive medical problems. Avoiding such problems will lead to less need for medical care.

Seema Verma, Administrator of the Centers for Medicare and Medicaid Services (CMS), says that she is relaxing some rules, regulations, and constraints "because of the emergency" of COVID-19. We must point out forcefully that she seems oblivious to the fact that physicians deal with emergencies daily, and those monstrous rules, regulations, and constraints have been obstacles to medical care for decades now. COVID-19 has suddenly made that fact visible to those who deal with abstract bureaucracy, not with actual medical care, and we must make that case.

The opportunity in the COVID-19 crisis is to show how the un-Constitutional Medicare statute and its progeny have brought us to medical fascism, a system of government marked by a centralized authority with economic and social regimentation and forcible suppression of opposition. It is past time to overthrow the Administrative Deep State and restore Americans' independence, under a Constitutionally limited government

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AAPS Principles of Medical Policy

Medical care is a professional service, not a right. Rights (as to life, liberty, and property) may be defended by force, if necessary. Professional services are subject to economic laws, such as supply and demand, and are not properly procured by force.

Physicians are professionals. Professionals are agents of their patients or clients, not of corporations, government, insurers, or other entities. Professionals act according to their own best judgment, not government "guidelines," which soon become mandates. Physicians' decisions and procedures cannot be dictated by overseers without destroying their professionalism.

Third-party payment introduces conflicts of interest. Physicians are best paid directly by the recipients of their services. The insurer's contract should be only with subscribers, not with physicians. Patients should pay their physician a mutually agreed-upon fee; the insurer should reimburse the subscriber according to the terms of the contract.

Government regulations reduce access to care. Barriers to market entry, and regulations that impose costs and burdens on the provision of care need to be greatly reduced. Examples include insurance mandates, certificate of need, translation requirements, CLIA regulation of physician office laboratories, HIPAA requirements, FDA restrictions on freedom of speech and physicians' judgment, etc.

Honest, publicly accessible pricing and accounting ("transparency") is essential to controlling costs and optimizing access. Government and other third-party payment or price-fixing obscures the true value of a service, which can only be determined by a buyer's willingness to pay. The resulting misallocation of resources creates both waste and unavailability of services.

Confidentiality is essential to good medical care. Trust is the foundation of the patient-physician relationship. Patient confidences should be preserved; information should be released only upon patient informed consent, with rare exceptions determined by law and related to credible immediate threats to the safety or health of others.

Physicians should be treated fairly in licensure, peer review, and other proceedings. Physicians should not fear loss of their livelihood or burdensome legal expenses because of baseless accusations, competitors' malice, hospitals' attempts to silence dissent, or refusal to violate their consciences. They should be accorded both procedural and substantive due process. They do not lose the basic rights enjoyed by Americans simply because of their vocation.

Medical insurance should be voluntary. While everyone has the responsibility to pay for goods and services he uses, insurance is not the only or best way to finance medical care. It greatly increases costs and expenditures. The right to decline to buy a product is the ultimate and necessary protection against low quality, overpriced offerings by monopolistic providers.

Coverage is not care. Health plans deny payment and ration care. Their promises are often broken. The only reliable protection against serious shortages and deterioration of quality is the right of patients to use their own money to buy the care of their choice.