The Impending Crisis in the Way Americans Get Their Health Care: Medicine and Rational Utility

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In July 1949, the New England Journal of Medicine published "Medical Science Under Dictatorship," a disturbing paper written by Leo Alexander, MD. Dr. Alexander, a psychiatrist, was the Chief American Medical Consultant at the Nuremberg war crimes trials. His report detailed and analyzed the process by which the German medical profession became a willing and unquestioning collaborator with the Nazi regime. How could this happen? How could a profession dedicated, since antiquity, to healing, to easing suffering—a profession of caring and compassion—a profession respected and revered by the people—be transformed into a hideous corps of scientific killers, enforcing the will of a brutal dictatorship? This is a question that has troubled many historians, humanitarians, and just plain thoughtful people. Dr. Alexander tried to answer this question. In addition, he pointed to disturbing trends in medical practice in mid-century America. Nearly 50 years have gone by since the publication of Leo Alexander's paper. But as you will soon understand, Dr. Alexander's report is, unfortunately, more relevant to Americans today than it was when it first appeared.

Dr. Alexander tells us that, even before the Nazi takeover of Germany, a subtle "attitude shift" was taking place among German physicians and psychiatrists. By the late 1920s, the idea of sterilizing and "euthanizing" those who were chronically ill and consequently physically or socially unfit became an increasingly legitimate proposal within medical and public policy discussions. Alexander states, "By 1936, extermination of the physically or socially unfit was so openly accepted that its practice was mentioned incidentally in an article published in an official German medical journal."

A cultural shift was quietly taking place among the lay population as well, as policy makers and members of the intelligentsia promoted sterilization and euthanasia. A popular movie in 1930s Germany *Accuse*, made a compelling case for euthanasia. In the film, a doctor kills his wife, suffering from multiple sclerosis to the accompaniment of soft piano music played by a sympathetic colleague in an adjoining room. A widely used high school mathematics text, "Mathematics in the Service of National Political Education," asked how many new housing units could be built, and how many marriage-allowance loans could be given to newly wedded couples for the amount of money it cost the state to care for "the crippled, the criminal, and the insane."

From these beginnings it was no great leap to a discourse on eugenics and the "purification" of German society. By 1939, the Nazi government made euthanasia official state policy. Two agencies were established to carry out the killings in an efficient manner: the "Reich's Work Committee of Institutions for Cure and Care" dealt with adults, and the "Reich's Committee for Scientific Approach to Severe Illness Due to Heredity and Constitution" dealt with children. Separate organizations were set up to transport patients to killing centers and to collect the cost of killing the victim from next of kin, who were told the victim died of natural causes.

What began as a government "mercy killing" program soon expanded to extermination of those with epilepsy, psychosis, depression, Parkinsonism, infantile paralysis, multiple sclerosis, and senility. Eventually, those simply unable to work and considered non-rehabilitable were killed. The technical arrangements, methods and training of the killer personnel were under the direction of a committee of physicians headed by Dr. Karl Brandt. Most were killed by gassing. At first, carbon monoxide was used. Later, "Zykion B," a form of cyanide was the agent of choice. Victims were herded into phony showers and told they were going to be cleansed with antiseptic. The doors were locked and the gas pumped into the chamber. Medical scientists were then given body parts from the corpses to further their medical research. One neuropathologist, Dr. Hallervorden, obtained 500 brains from the killing centers for the insane. In a grisly account of the callous, detached way medical researchers competed for parts to study, Dr. Alexander says of the victims, "All but their squeal was utilized."

Extermination was next extended to those who were racially or socially "unfit for society." The definition of illness was also stretched to include the politically unsuitable. So-called psychiatric experts were dispatched to survey the inmates of camps and pick out members of racial minorities and political offenders. From there, they were dispatched to killing centers with such diagnoses as "inveterate German hates" accompanying their death order.

The German medical profession was almost uniformly cooperative, and even enthusiastically supportive of this government enterprise. A new research discipline devoted to the study of the destruction and prevention of human life arose, which Dr. Alexander dubbed "ktenology." Alexander describes in horrifying detail the way in which "human experimental material" was used for medical-military research. Concentration camp inmates were used in "terminal human experiments," often featuring "live dissections," to determine the extremes to which the human body and mind can be stressed. These experiments were all performed, of course, for the benefit of German society as a whole.

In analyzing the motivation behind the medical community's enthusiastic support of state policy, Dr. Alexander points out that, as in any authoritarian society, ulterior political and personal factors were at play—not just the ruthless and callous pursuit of legitimate scientific goals. The fear of being suspected of disloyalty motivated doctors to participate in an act that would definitely and irrevocably tie them to the government policy.

Fascinating yet unexplained, Dr. Alexander highlights the fact that physicians in the German occupied Netherlands successfully resisted attempts to cooperate in the extermination program. A December 1944 order was issued by the Nazi authorities to all Dutch physicians: "it is the duty of the doctor, through advice and effort, conscientiously and to his best ability, to assist as helper the person entrusted to his care, in the maintenance, improvement and reestablishment of his vitality, physical efficiency and health. The accomplishment of this duty is a public task." The Dutch medical profession, aware of the exterminations taking place in Germany, seemed to realize that this order would serve as the basis for a new standard of care that placed first priority on return of patients to productivity for the state, rather than relieving suffering. Dutch physicians unanimously refused to comply. As a result, the Nazis threatened revocation of their medical licenses. All Dutch doctors then turned in their licenses, but continued to see patients in the privacy of their homes. The Nazis even arrested 100 Dutch doctors and sent them to concentration camps. Still the Dutch medical profession refused to comply with the order. Not a single euthanasia or non-therapeutic sterilization was recommended or participated in by a Dutch physician.

In seeking, to explain what happened to Germany's medical profession (but, presumably, not to the Dutch medical profession) that would persuade it to participate in such a gruesome enterprise, Dr. Alexander cites a change in the medical profession's ethical mission. He argues that "science, under dictatorship, becomes subordinated to the guiding, philosophy of the dictatorship." The guiding philosophic principle of modern dictatorships (again quoting) "has been Hegelian in that what has been considered 'rational utility' and corresponding doctrine and planning has replaced moral, ethical and religious values."

In the early 1900s, the physician viewed his main function as that of easing the suffering of his patient. But, as we have already seen, by the early 1930s, this attitude had changed to one more concerned with utilitarian issues. The likelihood of cure, the prospect of rehabilitation for productive participation in society, began to color the physician's perspective. Dr. Alexander remarked in his study that, by the 1930s, physicians had become "dangerously close to being mere technicians of rehabilitation."

One can say that the "Hippocratic Ethic" had given way to the "Veterinary Ethic," i.e., concern for the patients' comfort and well-being yielded to the utilitarian concerns of the "master," in this case, "German society."

In his 1949 paper, Dr. Alexander pointed to trends in American medical practice that he considered ominous. Those trends are even more obvious today. Budgetary constraints on Medicare and Medicaid are causing these programs to indirectly ration the care given to beneficiaries through cutbacks and changes in compensation to providers. "Usefulness" and the likelihood of rehabilitation are increasingly the criteria for the delivery of care. Oregon's new indigent health care system overtly rations care to those who have diagnoses sanctioned by the state. HMOs are an excellent example of the Veterinary Ethic writ large. "Decision trees," drug

formularies, and practice guidelines govern the physicians' practice of medicine, with the ultimate concern being that of the "master," in this case the third-party payer.

Dr. Alexander suggests that the American medical profession must reaffirm its commitment to its original ethical credo if it hopes to avoid degenerating to the level of the medical profession in Nazi Germany. Dr. Alexander is right of course, but his analysis is too superficial. The correct solution to the problem rests with an understanding that health care is not a "right." An examination of this "right" is critical.

The notion that health care is a "right" began, not just coincidentally, in Otto von Bismarck's Germany, in the late 19th century. Bismarck believed if the government provided the vast middle class with "entitlements" to basic human wants—such as health care, a minimum wage, and pensions—the majority of the citizenry would become docile and dependent on the state. This would ensure stability for the regime.

But health care is not a right. It is what Sheldon Richman calls a "pseudo-right," i.e., a claim, expressed in rights language, which expands the power of the state at the expense of actual rights.

Ayn Rand defined a right as "a moral principle, defining and sanctioning a man's freedom of action in a social context." A right is only the moral sanction of one's freedom to act. It imposes no positive obligation on anyone else—only a negative one: non-interference. For a right to be genuine, one must be able to exercise it without anyone else's affirmative cooperation.

Again, quoting Rand: "Thus for every individual, a right is the moral sanction of a positive—of his freedom to act on his own judgment, for his own goals, by his own voluntary, uncoerced choice. As to his neighbors, his rights impose no obligations on them except of a negative kind: to abstain from violating his rights."

A simple way of stating this principle of "negative" rights is: "My rights end where yours begin."

There can be no right to health care any more than there can be a right to food, clothing, or shelter. Such desires need to be provided by someone. To compel someone to serve another, even indirectly through taxation and wealth redistribution, amounts to the imposition of servitude. There can be no "right" to enslave.

Most attempts to provide these "rights" to the people do not overtly result in indentured servitude or slavery. Since the compulsion is in the form of taxation spread across large numbers of people, it is less noticeably noxious. But another problem arises when trying to enforce any of these "rights." The problem is scarcity. At any given moment, our wishes exceed the supply of the things we want. In a pure free market, the problem of scarcity is addressed through the price system.

But if the government is the guarantor of a particular "want" by proclaiming it a "right," then the government must deal with the problem of scarcity. By declaring health care a "right," the provision of health care becomes, in effect, costless to the individual. When the government guarantees health care for everyone, there is no way all the people can get all the health care they want. What seems like urgent and critical health care to one person, might be considered elective or a luxury to another. How, then, do we decide who gets what? The government will have to decide how to best distribute this scarce "resource" based on the interests of the society it governs.

We cannot escape this fact: the right to medical care means the government has the power to determine who gets what. When government controls medical spending by way of "the right to health care," then politicians and bureaucrats, not patients and doctors, decide who gets heart transplants, joint replacements, and dialysis. "Rational utility" becomes the guiding principle.

The rationing of health care we see incipiently developing in Medicare and Medicaid is a direct consequence of the right to health care. The health care "cost-shifting" to the private sector that is pushing up insurance premiums—a result of the underpayment of Medicare and Medicaid providers—has led to the rise of government-promoted HMO's a private-sector experiment in central planning, as a market response. And now we hear the likes of former Colorado Governor Richard Lamm speak of non-rehabilitable patients' "duty to die." Taking it even further, John Hardwig, noted medical ethicist, states "there may be a fairly common responsibility to end one's life in the absence of any terminal illness. . .a duty to die even when one would prefer to live." How long will it be before this attitude becomes mainstream in our medical schools, and then overtakes the medical profession? How can this drift be stopped?

There are some encouraging signs of rebellion against the state as final arbiter of health care distribution. The recent passage of "medical marijuana" initiatives in Arizona and California translate into a revolt against the Food and Drug Administration, the Drug Enforcement Administration, and the medical/government complex (including the American Medical Association, the American Cancer Society, and the rest of the "organized medical establishment"). The explosion in popularity of "alternative medicine," which is not government sanctioned, and usually not recognized or approved by third-party payers, is another visceral expression of rebellion. But these may be nothing more than the last gasps of a people whose heritage of liberty and autonomy still glows dimly in the farthest recesses of their cultural memory.

Would the doctors of today's Netherlands refuse to comply with the euphemistically worded order of 1944? I doubt it. Today, all the welfare states of Europe accept the notion of health care as a right. Bismarck's cynical vision was indeed prophetic. And we can hardly avoid other, even more troubling questions: would America's doctors unanimously, or even by a majority refuse to comply? And, would the American Medical Association, knowing what happened in Germany

and the Netherlands warn its member-physicians of the dangers of complying? I'm almost afraid to guess the answer.

The issues raised by Dr. Leo Alexander in 1949 are more urgent than they were at the close of World War II. But they cannot be properly addressed through the marrow lens of "medical ethics." The impending crisis in the way Americans get their health care will only be confronted by returning to first principles—the principles of "natural rights" and the proper role of government in a free society.

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