Editorial...

BRINGING THE WAR BACK HOME


The searching decade of the '60s brought into question many aspects of the American way of life. We have learned that the growth of the United States into an empire with global economic, military and political ties has affected every aspect of our lives. Even the sacred “non-political” professions have not gone untouched by imperialism. The professions have been molded to reflect the priorities of this society. Each individual, as a result of the pressures and rewards of his society, has been forced to conform to the very political roles defined for him.

Some political/professional links are obvious. A variety of scientists—microbiologists, chemists, geneticists, biochemists, and many more—have seen their research used for chemical and biological warfare and for other instruments of the fine art of war. The “pure” research man has been turned into the person who helps keep imperialism functioning. The results of this type of research are not only applied to foreign situations, of course. New gasses, new means of “riot control,” new techniques for “pacifying” insurgent segments of our own population have all been developed in the best of American universities. Scientists whose work leads to developing a new chemical to be used in wars of counter-insurgency must be seen as defined politically by the application of such scientific inquiry, not in terms of the individual scientists’ good intentions.

Social scientists, too, have been used to maintain our present political structure. A few years ago, for example, the US Army initiated “Project Camelot” through a grant to American University in Washington, D.C. Social science research personnel were recruited to carry out extensive research projects on all aspects of life in Latin America. Information on socio-economic conditions, on general attitudes of indigenous populations, on legal and political structures were all to be collected and fed into a data bank here in the States. The purpose of the study? To uncover the conditions which create insurgencies and at the same time help develop a workable counter-insurgency strategy. The researchers—the sociologists, the anthropologists, psychologists, and everyone else involved in this project—were certainly performing an extremely political role.

As professional roles are defined more and more by national and international politics, medicine has not escaped unscathed. The question of the doctor in the service of a military force with very political ends focusses the issue most sharply. Is the doctor merely treating wounded soldiers, or is he in reality making the military arm of a nation, which has a definite set of political objectives, function more effectively? Moreover, since World War II the role of the military-medical man has shifted from simply caring for our troops to medicine as a means of supporting counter-insurgency programs throughout the Third World.

Even the doctor’s choice of roles outside the military is fraught with political considerations. Whether it is a matter of joining the Public Health Service or some future National Health Corps (as an alternative to the military), a political decision is implicit. This becomes more sharply apparent as these non-military medical services increasingly take on domestic counter-insurgency functions. Likewise the physician makes a political choice when he decides to work with a community controlled health clinic in a black community, to work in a hospital and relate to community groups who are trying to change the priorities of that institution, or to set up private practice on Park Avenue. Just the use or non-use of medical technology available to the doctor, in itself a neutral technology, becomes a political act which contributes to or alleviates the daily oppression of people.

The list of the political uses of all the professions does not end here. University scholars help train the technicians of imperialism; engineers keep the machines well-oiled and effective; academic and industrial researchers develop new tools for the US Army; psychologists screen out “trouble-makers” from government and industrial settings, and sociologists pull together information on the lives of people the world over to be used by the US government to develop control programs. Professionals, like all other individuals in our society, cannot escape from serving the political priorities of our society.

Not only do individual professionals choose political roles, but the professions themselves have been put to

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THE MILITARY MEDICINE

HEALERS AND WARRIORS have usually lived in comfortable symbiosis. Physicians follow the exigencies of the war machines they serve—as a wheel turns in response to a drive shaft. Different types of wars have elicited different kinds of responses from physicians, but, after all was said, the end result was the same—the healers served the masters of war well.

It's been claimed that physicians serve in an apolitical capacity during wartime—that they only treat the sick and wounded. This claim is surely specious. In conventional wars (as in the War of 1812), doctors treated primarily their own troops, and, in so doing, strengthened their army's fighting force, which, in turn, was tantamount to offering political support for the mission which that army was pursuing.

In other wars, fought on grounds which were medically inhospitable to non-indigenous troops, physicians sought to conquer the endemic diseases which often took a larger toll of soldiers than did militarily-inflicted injuries. Thus, in tropical and semi-tropical theaters of war, physicians conquered malaria and typhoid. In such instances, a definite fallout of the doctor's role was improved health of civilians.

However this effect was incidental to the physician's primary job—the protection of the lives and bodies of his own troops. As wars moved into the nuclear age, physicians were prepared to deal with the impossible task of developing medical defenses against nuclear warfare. Though humanitarian physicians might have thought a ban on nuclear war to be the ultimate cure for the destruction of human life by nuclear weapons, military physicians preferred to develop schemes for the treatment of mass casualties.

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political use. Even if the individual tries to avoid personal collaboration in the designs of government or business, it has become the function of the professions themselves, as professions, to serve those needs. Thus the individual professional confronts government, big business and his own profession. He is first pressed as a student. Decisions as to who gets what scholarships, what academic fields provide grants for study and other types of financial assistance, and which branches of the university get funded for expanding their programs—all reflect the needs of those in power at any given time. In effect, a very subtle type of “channeling” of students is carried out every day in universities throughout the country.

For the already practicing professional the pressures are often provided by the system of financial rewards. Money is more readily available for projects which the government deems necessary for its own ends than for other areas of study. It is not difficult to win a grant to study new, bigger and better ABM systems but it is hard to come by federal funds for research on the problems of mass transportation or preventive health measures. Money is there for the scholar who wants to gather information that might be important for counter-insurgency programs in Latin America, but no one seems to have the resources for the rational handling of the lead-poisoning problem in New York City.

The individual professional has had his options shut off by larger political considerations. To believe that anyone, and specifically the professional, can remain neutral is naive at best. Being a professional (like being alive in our society) involves complicity in the policies of government and industry. But this need not lead to cynicism, moral escapism or political despair. Rather it is for the individual to begin to make political decisions and take political stands within his profession as well as outside it.

The examples of many different professionals show that no matter what one's occupation it is possible to work in a conscious manner for social change. The young doctor in the military has many examples of people acting on their political beliefs—ranging from Dr. Howard Levy, a US Army Captain who refused to give medical training to Special Forces personnel, to Lt. Susan Schnall, a Navy nurse who disobeyed a Navy directive by wearing her uniform to an antiwar rally, to Dr. Alan Goldstein, the dentist who collected signatures of active-duty GI's for an antiwar ad in the New York Times. In other circumstances, countless university professors have denounced their universities and participated in campus demonstrations against university ties with such institutions as the CIA, AID and the US Army. Research scientists are beginning to organize fellow workers around the belief that science must serve the people and not be used to maintain the status quo. Caucuses in all professions are beginning to question the very nature of their disciplines and most especially to attack the role of the professions in perpetuating racism, male chauvinism and imperialism.

With the awareness that being a professional does not provide a neutral cover comes the understanding that the individual professional must place all professional considerations within the framework of political considerations. It is not possible to sidestep the highly political nature of our society; as Eldridge Cleaver (not VISTA) put it: "You're either part of the problem or part of the solution." And to quote Frantz Fanon (the Algerian doctor-revolutionary): "Yes, everybody will have to be comprised in the fight for the common good. No one has clean hands; there are no innocents and no onlookers. We all have dirty hands; we are all soaking them in the swamps of our country and in the terrifying emptiness of our brains. Every onlooker is either a coward or a traitor."
Finally, when "people's wars of liberation" became the targets of military strategists, medicine again trailed along meekly behind its master and developed techniques firstly to forestall, and if that was unsuccessful, to win wars in which the entire people of a nation became the enemy. At this juncture, not only were doctors asked to care for the troops of a combatant nation, but, in addition, physicians were called upon to placate, tranquilize and quell enemy insurgency—medicine was quietly adapted to political counter-insurgency.

From time to time, healers have reflected upon the inconsistency between healing and killing. Louis Pasteur said, "Two opposing laws seem to me in contest. The one law of blood and death, opening out each day new modes of destruction, forces nations to be always ready for battle. The other, a law of peace, work and health, whose only aim is to deliver man from the calamities which beset him. The one seeks violent conquests, the other the relief of mankind. The one places a single life above victories, the other sacrifices hundreds of thousands of lives. Which of these two laws will prevail, only God knows. But of this we may be sure, that science, in obeying the law of humanity, will always labor to enlarge the frontiers of life."

Like Pasteur, physicians have always despite their occasional qualms, proudly served their countries in times of war. Historical trends, dating back at least as far as the sixteenth century, have been to create the concept of "medicine" as "international," in the abstract, while still recognizing that physicians themselves are first citizens of their own nation and only second are they citizens of the world. Physicians have therefore been expected to choose sides during wars. They have been expected to strengthen the fighting reserve of the army of which they are a part. In the words of US Army Field Manual 8-10, "The Army Medical Service is a supporting service of the combat elements of the Army primarily concerned with the maintenance of the health and fighting efficiency of the troops. The mission of the medical service in a theater of operations is to conserve manpower by recommending, and providing technical supervision of the implementation of, measures for safeguarding the health of the troops, effective medical care, and early return to duty; and to contribute directly to the military effort by providing adequate medical treatment and rapid, orderly evacuation for the sick and wounded."

Of course, when the broader, more idealistic concepts of international medicine have not interfered with military operations, there has been an increasing realization that they can and should be invoked during wars, to minimize the brutality of the conflict. Thus as early as sixteenth century Switzerland, during the wars between the cantons, the return of POW's and the wounded was permitted. Throughout the nineteenth and twentieth centuries these conventions have been strengthened to the point where, in theory at least, the doctor and corpsman and military nurse are not to be thought of as combat soldiers. They are, once again in theory, not a party to war and are therefore granted immunity from attack. It should, however, be noted that these "humanistic" conventions serve the purpose primarily of insuring the all-important existence of a medical presence for contesting armies. And, once again, as Army Field Manual 8-10 makes clear, this must be so in order to "contribute to the success of the military effort."

Thus the thrust of ethical developments concerning the physician and war has been double: On the one hand, medical skills, per se, ought to be utilized in accordance with international humanitarian ideals; on the other, the physician as a man owes his allegiance to his nation and must therefore maintain the fighting efficiency of the troops which are under his care. Of course, it was bound to happen that some physicians would note the apparent contradictory directions of this development. Dr. John A. Ryle, then Regius Professor of Physic at the University of Cambridge, had this to say about the physician, idealistic ethics and war: "It is an arresting, if at present a fantastic thought, that the medical profession which is more international than any other, could, if well coordinated, of its own initiative put a stop to war, or at least increase its uncertainties, and temper its aims considerably so as to give pause to the most bellicose of governments. It is everywhere a recognized and humane principle that prevention should be preferred to cure. By withholding service from the Armed Forces before and during war, by declining to examine and inoculate recruits, by re-fusing sanitary advice and the training and command of ambulances, clearing stations, medical transport, and hospitals, the doctors could so cripple the efficiency of the staff and aggravate the difficulties of campaign and so damage the morale of the troops that war would become almost unthinkable. Action of this kind would also produce profound effect on the popular imagination. In such refusal of service . . . there would be no inhumanity which medicine at present sanctions and prolongs." Ryle, however, in a concluding sentence, recognized, at least intuitively, the fallacy

In the Spring of 1967, Captain Howard Levy was court-martialed at Fort Jackson, South Carolina. He was charged and found guilty of three offenses: Disobeying a direct order to train Special Forces (Green Berets) medics; uttering statements whose intent it was to create disloyalty and disaffection among the troops; and conduct unbecoming an officer and gentleman.

The trial of Levy, a doctor, raised questions including free speech for GI's, responsibility of soldiers to refuse orders when such orders would make them a party to "crimes against humanity and war crimes" in Viet Nam, and the inability of a GI to receive a fair trial under provisions of the Uniform Code of Military Justice.

Of more pointed interest to medical workers was the question of the right of physicians to adhere to principles of medical ethics, military orders and directives notwithstanding. Dr. Levy's refusal of the order to train Green Beret medics was based upon his belief that the Special Forces were using their newly acquired medical skills in counter-insurgency actions in Viet Nam and elsewhere. Dr. Levy maintained that to so use medicine was in violation of long accepted medical ethical precepts and thus for him to train the Green Berets in dermatology (his specialty) would be to violate his own freedom of conscience.

During the three week court martial the Army denied that Special Forces were using medicine for political purposes. Several months after Dr. Levy's conviction Special Forces held an exhibition at the annual convention of the AMA in Atlantic City. The Green Berets exhibit depicted a large photograph of a Special Forces medic treating a Vietnamese civilian. The photograph was captioned, "Medicine—A Political Weapon."

Dr. Levy joined the HEALTH-PAC staff upon release from Federal prison last August.
of his reasoning when he wrote, "But let the dream pass and fantasy make room for facts." The facts, indeed, are that so international a medical community as would be required to make Ryle's dream a reality does not exist. Nor could one survive in a politically and economically splintered world body. It is far from reasonable to assume that class privileged physicians of even a single nation would unite in any moral action antithetical to their class interest.

Still, in the US the Armed Forces have had, until recently, a respectful attitude towards the underlying humanitarian ethical considerations of medicine as an international healing agent. Medicine has been treated in wartime in a comparatively apolitical manner. In a narrow sense the doctor's efforts on behalf of and allegiance to one fighting force in preference to the opposing army functioned tactically to strengthen that side. The political consequences of serving in such a partisan role surely cannot be ignored. But what other options could be offered to allow the doctor to share in his nation's political destiny? At the same time, a brief review of US military medicine illustrates that American physicians, while willingly sharing their nation's historic role, until very recently, have also preserved the philosophical ideal of medicine as an agent of international good will.

It is of striking importance that during the American Revolution of 1776, while some doctors served as military physicians (e.g., Benjamin Rush), other American doctor-revolutionists eagerly sought the high ground of the battlefield. One hundred eighty years before Che Guevara, these humanists acted, as later did their South American professional kinsmen, militarily to broaden the freedom and well being of their countrymen. The following doctors became revolutionary heroes performing not as battlefield surgeons, but rather as military leaders: Major-Generals Joseph Warren (killed at the Battle of Bunker Hill), Oliver Prescott, John Brooks, John Thomas, Arthur St. Clair; Brigadier Generals Hugh Mercer, Edward Hand and William Irvine. It's of interest that two physicians ultimately became Secretaries of War of the fledgling nation—James McHenry and William Eustis.

After winning the American war of national liberation, the American Army formally developed a well-defined medical corps. In subsequent wars, up until the Viet Nam War, American military physicians served not as military tacticians and commanders, but rather as doctors in support of their troops. This was the case in the Indian Wars, War of 1812 and the Mexican War. In a limited sense medicine could be said to have played a "neutral" role—it was limited to the treatment and care of wounded men on either side. It was not used directly in itself as a political weapon.

This "neutrality" was temporarily breached during the American Civil War. The Union Army's blockade of needed drugs and supplies was used to weaken not only the Confederate Army but the people of the Confederacy as a whole. The results of the blockade were serious indeed and were especially serious for Union prisoners of war. Here medicine was used tactically in a negative manner as an instrument of war policy and not merely indirectly in support of a fighting Army.

Medicine again resumed a supportive role in the Spanish-American War of 1898. But new conditions of warfare beyond what are now the continental limits of the United States necessitated that this medical support assume new duties and responsibilities. With the Spanish-American War, the construction of the militarily and commercially strategic Panama Canal and the deployment of the "Army of Pacification" into Cuba in 1906, diseases such as typhoid and yellow fever became more serious depleters of military strength than were battlefield casualties. And physician-soldiers such as Walter Reed and William Crawford Gorgas established their military and medical reputations in successfully combating these diseases. In so doing, they preserved the fighting strength of American troops and thus were clearly prime agents of what had become by 1898 a consciously imperialistic American foreign policy. Still, agents though they were, their use of medicine was nonetheless militarily supportive and not directly offensive. Typhoid and yellow fever were controlled in parts of Latin America, not to convince the indigenous inhabitants of these parts of the world of the justice of American militarism, but merely to insure the success of imperialist expansion by preventing the death of thousands of American soldiers and civilians from diseases which were endemic to these parts of the world. For example, the death of 22,000 Frenchman from "Yellow Jack" prevented them building the Panama Canal. The investigations of Walter Reed which linked this disease to the mosquito and the subsequent practical application of this discovery by William Crawford Gorgas together with the American military intervention in Panama provided the margin of safety which permitted the American Panama Canal effort to succeed where the French had previously failed, and thus permitted the US a major imperialist expansion into Central America.

In World War I, battlefield casualties exceeded death from natural diseases. As a consequence, important innovations in the care of battlefield injuries were pursued and practiced. The supportive role of the medical corps on the battlefield was reflected by the fact that the death rate of the medical corpsmen was higher than the death rates respectively of Aviation, Cavalry, Engineers, Ordnance and Quarter Master Corps. Only Infantry, Artillery, Tanks and Signal Corps had higher casualty rates.

In World War II, the motto of the Medical Field Service School was "To Conserve Fighting Strength." And indeed this had been the operative motif of the Army Medical Corps in all wars since the Revolutionary War up until the time of the war in Viet Nam.

In Viet Nam, an important departure from this heretofore sole mission is clearly in evidence. The Medical Corps still has as its primary mission the preservation of the life and well being of American troops, but now has assumed, in addition, a direct political role, as well. Before turning to the evidence as it manifests itself fully in Viet Nam, we should first trace the theoretical development of this new role.

The genesis of America's conscious, positive utilization of medicine as a political weapon of counter-insurgency actually began in the early twentieth century but was little appreciated at the time and was to remain a practically unknown phenomenon until post-World War II. But in 1902, Col. Leonard Wood, M.D. was dispatched to the Provinces of the Moros in the Philippines. Wood had previously served as part of an American military pacification team in Cuba. (Cuba had been "liberated" from Spain by the US in the midst of a Cuban war of national liberation against Spain. The US
VA Hospitals: Military Dumping Grounds

The Viet Nam War has been, in terms of casualty rates, America's most bloody war since the Civil War. Over 15 percent of all men who have served in Viet Nam have been killed or wounded. (The rate was only 6.5 percent in WWII.) Moreover, modern weaponry produces devastating wounds, the likes of which had not been seen in previous wars. This, together with the rapid life-saving and air-evacuator helicopter system in use in Viet Nam, has produced three times the number of soldiers who are totally disabled as compared to WWII. All together 12.4 percent of all wounded Viet Nam veterans are totally disabled, compared with 6.7 percent for the Korean War and 4.4 percent for WWII.

Howard A. Rusk, M.D., dean of American rehabilitative medical programs, writing for the New York Times, in June, 1968, suggested that though injuries were mounting in Viet Nam, “fortunately, medical care in both our military hospitals and particularly the Veterans’ Administration hospitals, has improved markedly since World War II.” But while Rusk assures the American people that their disabled husbands, fathers and sons are “receiving[ing] the highest type of medical and vocational rehabilitation services,” other voices are sounding more disquieting notes.

To begin with, dovish Senators like Alan Cranston (D-Calif.) have discovered, by culling Pentagon records, that the Army has, firstly, misrepresented the number of amputees resulting from Viet Nam injuries. Cranston estimates that the true figure is more than double the admitted rate by the Army. Secondly, according to Cranston, “the Veterans’ Administration’s full-time employment of nurses and doctors is now at approximately the same level it was in fiscal 1965, although Viet Nam casualties have increased more than 300 percent. . . .” And as if that were not bad enough, the Nixon Administration has recently cut $70 million from its medical care budget for this fiscal year.

The plight of the hospitalized orthopedically disabled veteran is so bad that one National Institute of Mental Health psychiatrist, Dr. E. James Ackerman, was led to remark, “It’s easier to visit a cemetery than some [VA] hospital wards.” But the tragedy weighing so heavily on the disabled Viet Nam Vet does not end in the hospital ward. One social worker in an eastern Veterans’ Administration (VA) hospital reports that “. . . the need of the hospital for bed space is . . . primary and supersedes the needs of the human beings.” She has recounted tales of a patient being sent to a nursing home while still suffering from pneumonia; of a neurologically ill patient’s transfer to a nursing home despite the opposition of the social worker and the man’s family. The patient deteriorated rapidly and now is forced to reside in a VA chronic psychiatric hospital.

This social worker points out that to place a neurologically ill patient in an average nursing home “is often to submit him to gross body and emotional neglect.” For her trouble in acting as a patient’s advocate, the social worker in question has been asked to resign.

The effects of Nixon’s budget cuts are felt not only by those men with physical disabilities. Recent figures indicate that 29 percent of the 12,190 disabled Viet Nam returns in VA hospitals are psychiatric patients. As a result of staff shortages many of these patients are, says Senator Cranston, “tranquilized and stashed away” in nursing homes for the rest of their lives.

Dr. West, a consultant to the VA Hospital at Brentwood, California, and Chief of Psychiatry at UCLA’s Neuropsychiatric Institute, has concluded that the VA Hospital at Brentwood “is operating at a level that is mostly still at, or even below, the level of 25 years ago.”

The fact of the matter is that the entire medical budget for the Veterans’ Administration for fiscal 1970 was less than one month’s Viet Nam War expenditures—less than $1.6 billion. The US Government seems to have a new policy with regard to GIs—Do not reuse after package has been opened. We have entered a new marketing era—the age of the disposable GI.
being, in large part, the rebuilding of nations whose governments would be pliable and friendly to the interests of the United States. Medicine was a small, though not insignificant, part of that effort. But where civic action programs faltered, as in post-World War II Italy and Greece, military support was forthcoming. The ruling principle was to forestall the democratic installation of communist governments at any cost. The combination of economic and medical assistance together with military support was successful, at least for the time being.

It should be observed that following the Second World War, large areas of Europe and Japan lay in ruins. To re-habilitate these nations could be thought of as an elementary humanitarian requirement. However, a great deal of historical evidence supports the contention that United States support for the rebuilding of Japan and Western Europe was based, first, upon political need, and only second in response to human need.

Soon after the conclusion of World War II the United States became immersed in the chilly waters of the cold war. And nuclear deterrence mentality permeated foreign policy. For most of the 1950's military publications and military medical journals, when they concerned themselves with politics at all, were principally concerned with aspects of medical defense against nuclear attack. But it should not be imagined that the previous instances of at least temporarily successful counter-insurgency pacification programs had been entirely forgotten.

The spirit of medical pacification was resurrected in September 1957, when then President Eisenhower announced his "People to People Program." He said, "All of us thoroughly believe the people themselves want to be friends and it is as much the duty of professional military officers to enhance and help develop that feeling of friendliness of people as to be capable of defense in case of attack." A few years later, that innocuous-sounding sentence was to become the foundation upon which was to be built America's present counter-insurgency program.

The March 1961 issue of Army, the monthly magazine of the Association of the US Army, heralded a new phase of United States militarism. (Army's articles and themes are often later picked up by popular magazines such as Readers' Digest.) A story in that issue launched what was to prove to be a major propaganda and educational program aimed at convincing the American people that counter-insurgency was the best designed tactic to defend US economic and political interests. And what better way to pave the way for this switch of emphasis than to publish serially Che Guevara's Manual of Guerrilla Warfare?

In June 1961 Army Magazine devoted its cover story to a then little known branch of the Army—the Special Forces. The story was titled, "Special Forces—What They Are." Article followed upon article on the new tactic of counter-insurgency. One such article by George V. Tanham was titled, "Wars Without Guns." Tanham had been a former Associate Director of Provincial Operations in the Agency for International Development (AID). His office was in Saigon.

The switch in propaganda emphasis from nuclear brinksmanship to counter-insurgency was dramatic although one can be sure that the actual policy was planned well in advance. The Special Forces had, in fact, been formed in 1952. During the Korean War, they served behind the lines in Korea, though not in a medical role. It was not, however, until after the election of John F. Kennedy that Special Forces were made an object of adulation. And, under Kennedy, the Special Forces medical program probably was originated in early 1962.

If Army Magazine was used as the vehicle to launch the US Military's new propaganda offensive in March 1961, Military Medicine, an official publication of the Association of Military Surgeons, was not far behind. In April 1961 Military Medicine carried an article titled, "The Role of the Army Medical Service in America's People-to-People Program" written by Lt. General Leonard D. Heaton, M.D., the Surgeon General of the US Army. Heaton's take-off point was Eisenhower's People-to-People program but his vision went far beyond. In concluding his article, Heaton wrote "In offering our medical skills . . . we can surely receive more than we give [in terms of preventing the spread of communism]."

Other articles followed quickly on the heels of Heaton's opening salvo. Some attempted to show that counter-insurgency was but a continuation of the post-World War II European and Eastern Asian reconstruction program. The link between programs such as the Marshall Plan and active counter-insurgency for the "undeveloped" parts of the world was Korea. In an article entitled, "International Medicine" (Jan. 1962), Brigadier General Howard W. Doan, Deputy Surgeon General of the Army, alluded to the Korean experience. Quoting the previous Chief of the Military Medical Services in Korea, in 1956, Doan wrote, "By choosing kindness, charity and usefulness, US military citizens in Korea and in other countries too, have done much to reveal to the less fortunate world citizen the fruits of the principles on which our God-fearing nation was established. Citizens can be grateful for the contribution our armed forces have made world-wide to the human values of Christianity and democracy." He then equated the Army Military Medical Service with "Military Missionary Medical Work," and, as if to underscore the point, later included the Agency for International Development, Albert Schweitzer and Dr. Tom Dooley as part of America's new anti-communist crusade.

By October of 1966, Military Medicine was prepared to begin shedding the euphemisms and presented an article, "American Medicine as a Military-Political Weapon," by Captain Leonard R. Friedman, a psychiatrist stationed with the Special Forces at the JFK Special Warfare Center, Fort Bragg. The thrust of the article was that "... future American policy might well express itself in the health, education and welfare of all Vietnamese minorities and ethnic groups. Such an effort might be directed both toward the minorities and toward the Central Government, in an effort to create and maintain a bond of mutual trust between divergent cultures, through medicine." Thus a contribution might be made "to a solution of the South Vietnamese insurgency."

The following month's issue of Military Medicine carried an article by the Surgeon General of the Air Force, R. L. Bohannon, M.D. General Bohannon attempted to give legitimacy to the newly-discovered political use of medicine by quoting Sir William Osler. Osler, it seems, addressed the 1894 graduating class of the Army Medical School and reminded the recent graduates that farflung military posts
By February 1967 literary and historical reserve were finally thrown to the wind. Military Medicine reprinted a speech in which General Heaton alluded to General MacArthur—but the allusion wasn't to the MacArthur who pacified post-war Japan with public health measures. Rather, Heaton referred to the MacArthur who said, "the soldier ... is required to practice the greatest act of religious training—sacrifice." Medicine, Heaton continued, is "... today, more than ever before, inescapably inwoven in our foreign policy. ... " Medicine provides "a secure route to a greater appreciation of our peaceful intentions." the mode, the creed, the way of the Army Medical Service is "Duty, Honor, Country ... God Bless Them." So closed General Heaton.

Perhaps the definitive statement regarding the United States Army's new face of medicine was written in August 1967 by Col. Spurgeon Neel. Neel, a doctor, was the Surgeon of the United States Military Assistance Command, Viet Nam. Flat-top crew-cutted Neel's article clearly spelled out the ABC's of medical counter-insurgency. His outline bears study, since it is the operative model not merely for the US Army in Viet Nam but also for the Special Forces, AID and Peace Corps in a score of countries all over the world. Neel proceeds as follows:

Point 1 — "Medical stability operations concentrate on the pre-insurgency phase—to produce maximum results with minimum resource investment."

Point 2 — The program must provide "medical treatment for immediate impact, and preventive medicine projects to produce short-term improvement."

Point 3 — Medicine is an ideal civic action program because its "humanitarian aspects ... can be raised above the level of political turbulence." It provides an "apolitical avenue through which favorable influence may be maintained." And it "provides immediate high-impact communication. ..."

Point 4 — The program must be a coordinated effort of "the country team." The country team includes the US Army, Green Berets, US AID, and the Ambassador to the country in question.

Point 5 — As in one of the Viet Nam medical programs, a key goal is the "maintenance of the favorable image of the Central Government of Viet Nam [or Laos, Thailand, Dominican Republic, Guatemala, etc.] and of the US in the minds of the general population."

Point 6 — To assist in reaching this goal in Viet Nam, "US military hospitals admit selected Vietnamese civilians for 'high impact' surgical procedures." This phase of the program concentrates on children who suffer from major disfiguring illnesses such as "hare-lips, burn contractures, orthopedic deformities. ..." The psychological impact on the inhabitants of the village to which the restored patient is returned is tremendous."

Neel's outline was brought up to date and slightly amplified in May 1968 by Lt. Col. Chas. R. Webb, M.D. Interestingly enough, Webb pointed out that the term "counter-insurgency" was no longer in vogue and had been replaced by the phrase, (Continued Page 8)
American civilian physicians began arriving in Viet Nam in 1965. Since then over 500 doctors have volunteered for two-month tours of duty, as part of a project jointly sponsored by the AMA and the US Agency for International Development (AID). The AMA advertised the venture as a "round-the-world free trip with a stopover in Saigon." The physicians serve in civilian hospitals in Viet Nam and receive $10 a day living allowance. AID is by now an old hand at the medical missionary game. In Laos AID has had a medical division in operation since the late 1950s, when the concept of counter-insurgency was still in its infancy. AID money and expertise also maintain the presence of some 150 dispensaries ostensibly operated by the Royal Laoian Government. AID either directly or indirectly, through "Operation Brotherhood," funds most of the projects. According to a New York Times report in early March 1970, a large part of the Laotian AID operation was in fact a front for CIA-directed counter-guerrilla operations.

Operation Brotherhood was founded by Oscar J. Arellano, a wealthy Philippine architect. Originally, in 1954, Arellano provided aid for Viet Nam refugees, however, in 1957 he diverted his attention to planning and building small hospitals in Laos. His work was subsidized by John D. Rockefeller III's Asia Foundation (CIA funded), and, of course, US AID. Another medical project in Laos is entirely American-staffed and is called the Thomas A. Dooley Foundation. It operates several clinics as well as a clinic boat, "The City of San Francisco," on the Mekong River.

The Dooley Foundation provides medical programs for Laos, Thailand, Viet Nam, Nepal and India. Prior to his death, Dr. Dooley, together with Dr. Peter D. Comanduras, formed MEDICO, INC., affiliated with CARE. MEDICO-CARE operates medical facilities in Afghanistan, Kenya, Honduras, Malaya, Tunisia and the Dominican Republic. All of these projects are interrelated with the more overt counter-insurgency programs of the AID, and, not infrequently, as in the Philippino-staffed example cited above, are funded directly by AID.

Professional militarists' acute consciousness of the relationship between medicine and foreign policy is illustrated by a candid letter to the New York Times written by Bedford H. Berrey, Colonel, USMC. Berrey, a doctor, wrote, "The US has the power . . . to do what she wants to do, needs to do or is required to do in her national interest." Foreign aid, he maintains, is in the interest of the US, but to be effective it must be constructed. "Medicine," he continues, "is a virtually untouched foreign policy resource with unlimited potential as an instrument of US foreign policy."

Berrey's letter was written in late 1968. It is apparent that his advice, reflecting the Army's medical counter-insurgency approach, has been adopted by the US Government. It is somehow fitting that the world's technological leader, the US, should substitute medical technicians for the religious missionaries of yesteryear. No matter though, the intent is the same—to provide a fitting facade to hide the plunder of the world's riches.
BANDAIDS FOR THE HOMEFRONT

PROPOSALS FOR A NATIONAL HEALTH CORPS have been all but obscured by the National Health Insurance ballyhoo. Yet the drive for a National Health Corps (NHC), a plan in which young physicians would serve in rural or ghetto areas as an alternative to military service, appears to be a major component of the liberal medical reformers' plans to reshape American medicine. It offers reformers a politically viable, possibly high impact reform, while at the same time helping them defuse the rising wave of student and community insurgencies.

A growing constellation of establishment forces has gathered to push for some form of a National Health Corps. It ranges from the Student American Medical Association and the Association of American Medical Colleges to Walter Reuther of the United Auto Workers. Each group has its own reasons for wanting a National Health Corps and divergent notions about what shape it should take.

So far, the only concrete proposal for a National Health Corps is that of Laurence J. Platt, M.D., a commissioned officer of the Public Health Service. Platt's plan proposes:

(1) Composition: The NHC should include both physicians and non-physicians. Training programs would permit the non-physician manpower to advance to licensed nursing, technical or doctors' assistants positions. Dr. Platt estimates that 2500 physicians and approximately 20,000 non-physicians should be recruited. All would receive salaries comparable to their military counterparts and would serve for a 24 or 25 month tour of duty in fulfillment of their military obligation.

(2) Services: The NHC should provide direct medical services to needy communities. Some of the present direct service programs of the Public Health Service, such as the Indian Health Service, would be incorporated into the Corps' program.

(3) Organization: Central administration of the NHC would be managed by an executive council. Its functions would include: (a) recruiting personnel; (b) selecting the communities to be served by the program; (c) lending expertise to community groups to establish autonomous community agencies that would contract for personnel with the Public Health Service; (d) evaluation of the quality of services.

Locally, the communities would administer the National Health Corps. To facilitate this process, communities desiring services would be encouraged to establish non-profit corporations to run the local programs, including the financing and collection mechanism. Local communities would also be asked to provide a health facility base and to develop affiliations with the teaching institutions primarily for training the non-physicians.

Other proponents of NHC do not have plans with as much detail as Dr. Platt's. For example, at its 80th Annual Meeting in Fall 1969, the American Association of Medical Colleges was mandated by its members "to study mechanisms for establishing a broadly oriented voluntary national health service, perhaps through the Public Health Service, for the provision of health care wherever it is most needed in the United States and its Trust Territories. This service should be available to graduates of health professional schools in lieu of military service."

The current proposals for a NHC are based on a two part political rationale. First, medical students are increasingly restive over the war and over the health care system itself. NHC would offer the politicized students a new alternative to military medical service, and one which would meet their demands for social relevance. Medical students' draft options have been shrinking since 1967, when Congress excluded service in the Food and Drug Administration, the Peace Corps and the Office of Economic Opportunity as Public Health Service alternatives to military service. In addition, over the past three years the number of two-year Public Health Service "commissioned corps" personnel—those whose service in the Public Health Service fulfills their military obligation—has been decreasing. For these reasons there are fewer non-military options for the medical student. It is not surprising, therefore, that even such a conservative group as the Student American Medical Association at their Spring 1969 Convention passed a resolution to expand the Public Health Service to include the functions of a National Health Corps.

The second rationale for a NHC stems from the widespread realization that health services are effectively unavailable to a large cross section of American people. One reason advanced for this is the maldistribution of physician manpower in the country. In Central Harlem there are 73 physicians/100,000 people; in 758 rural counties (mainly in the South and West) there are 50 physicians/100,000 people. In contrast, New York State has 222 physicians/100,000 people. Most health reformers realize that the uneven geographic distribution of doctors will not be solved by any of the proposed National Health Insurance programs. A National Health Corps appears to be a relatively inexpensive and simple reform, they argue, that tackles this problem head-on, while avoiding the politically charged issues of poverty, racism and maldistribution of other health resources such as hospitals, clinics, etc. For this reason Walter Reuther, President of the United Auto Workers and initiator of the Committee of 100 for National Health Insurance, proposed the establishment of a National Health Corps at the Fall 1969 meeting of AAMC. Other health reform advocates are also getting on the bandwagon, including Senators Yarborough and Kennedy. Even the AMA is mixing in. Though they have not supported a National Health Corps, they did endorse a plan for a "Project USA" campaign to get physicians into the ghettoes under joint AMA-government sponsorship, and high AMA officials expressed interest in a NHC-like plan proposed in an August 1969 Urban Coalition conference. Belatedly, the AMA has become cognizant of the scarcity of physicians for the poor.

The chief governmental health official in the nation also favors some form of a National Health Corps. When he became Assistant-Secretary for Health Affairs, Dr. Roger O. Egbert, told the New York Times, "The nation might consider drafting young doctors to serve a year's term in medical practice in communities that need doctors, but are unable to entice one to set up permanent practice. The service might be scheduled after internship and some of the doctors would probably volunteer to stay more than a year after..."
they had set up practice."

There are other advocates of a National Health Corps, for reasons other than those mentioned so far. For example, Dr. Milton Bankoff, consultant to the office of Group Practice Development in HEW, suggests: "From the standpoint of the Group Practice Program . . . [a National Health Corps] . . . utilizing the group practice concept in delivery of the best possible quality health care to poor communities, both rural and urban, could be stimulating to the formation of group practice on a nationwide basis."

A National Health Corps, on the face of it, appears to offer something to almost everybody: draft alternatives for young physicians; young physicians for undoctored rural and urban communities; the opportunity to correct the maldistribution of physicians without enormous financial outlays; a stimulus to group practice; a showpiece medical "reform" for the Nixon administration. But many insurgent health professional groups have begun to question what the reality of a National Health Corps would really be like. Three years ago the Medical Committee for Human Rights (MCHR) said: "We believe the United States should take the lead in separating health care from allegiance to military establishments . . . by creating a voluntary civilian Health Corps." But now, many MCHR members disagree with this position which, they say, grew out of opposition to the war in Viet Nam. Yet, they point out, a National Health Corps of the type described in Dr. Platt's proposal fails to challenge American military priorities. First, it is too small: With an estimated Corps consisting of 2500 doctors and 20,000 non-physicians, hardly an ounce of military manpower is extracted. Second, it may backfire, by imposing the military on medicine. As one MCHR member points out, "Involuntary conscription was instituted with the aim of democratizing the military, yet it has resulted in the militarization of democracy. Analogously, might not a National Health Corps result in the militarization of health?" This is not so far-fetched an idea. One high HEW official has suggested that a National Health Corps could be instituted instantly by assigning medical corpsmen to communities as more important than discipline." Yet his plan contains little to ensure that this will not happen. Rather, the tour of duty is similar to the army (24 or 25 months) and it is stipulated that "real pay and privileges (according to rank) will be commensurate with that offered by the Armed Services." Even recruitment through the CORD (Commissioned Officer Residency Deferment) Program is recommended. Third, some fear NHC is a purposeful attack on the military anti-war movement, providing the government with a new tool for "coopting" medical student anti-war activists. One Student Health Organization (SHO) member opined, "A National Health Corps is a real cop out, as bad as emigrating to Canada or joining the Public Health Service. But lots of physicians without enormous financial outlays; a stimulus to group practice on a nationwide basis."

A National Health Corps, as suggested in Dr. Platt's proposal? From the failure of O.E.O. to support community control in most O.E.O. Neighborhood Health Centers, where community participation was mandated by law, the prognosis for the community's role in NHC is poor. Who will decide which communities will receive a physician? It seems certain that a central authority will make these selections. And, it seems likely that insurgent community clinics such as SALUD in Woodville, California, or the Black Panther Clinic in Chicago will be excluded. By siphoning off activist doctors, a National Health Corps might cut back the limited manpower presently available to these fledgling community clinics. If experience with the Peace Corps and the Indian Health Service can be taken as a model, the probability that NHC could even be used directly for counter-insurgency is great. For example, one physician serving in Thailand with the Peace Corps reports that he was asked by the CIA to report all information regarding guerrillas turned up through treatment of Thai citizens and Peace Corps volunteers. Could a National Health Corps be used to gain information on insurgent communities in the US? This is not new to SHO experience. In summer 1968, leaders of the nine Student Health Projects were asked by the Regional Medical Program to evaluate community groups and leaders as potential grant recipients.

Even if not overtly counter-insurgent in the community, a National Health Corps has the potential of reinforcing the dual system of health care in America: a full-time private doctor for the middle class and rich; but a young, government corps doctor on a short tour of duty, or a partially-trained medical corpsman for the poor. Of course, the National Health Corps doctor imbued with idealism may stay on in the poor community. But since many doctors who would join the NHC would do so primarily as a military alternative, most NHC physicians will be lured by the fee-for-service incentive away from poor communities after their tour of duty is completed.

A National Health Corps also evades the pressing problems of physician supply, which must be overcome simultaneously with redistribution of physicians throughout the population. A National Health Corps doesn't speak at all to the doctor shortage. As another student put it, "Open admissions to medical school for all blacks and browns and even poor whites would do more at this time to shift the pattern of doctor distribution in the nation than any National Health Corps." A National Health Corps also doesn't cope with the problem of dead-end careers for physicians assistants. "The entire non-physician program under Dr. Platt's proposal looks like it's grafted on to prevent criticism of a National Health Corps as enhancing doctor privilege through draft alternatives," claims one intern.

Even with all these objections, many health activists have found it difficult to oppose a program that may provide a doctor where there was none before. But others object that even as a superficial solution to the problem of doctor mal-distribution in America, a National Health Corps is no answer. Even if all the 2500 doctors in Dr. Platt's plan were assigned to the six most doctor-poor states, it would leave those states with a doctor to population ratio less than half that of the big industrial states like New York. As one student pointed out, "A National Health Corps picks on the most vulnerable doctors—those just graduating from internship and residency—and lets all the other doctors scott free to continue to do what they please. Any program for delivering health services to all Americans must deal with all the health resources—
CORPORATION GRINDS TO A START

FOR ALMOST A YEAR now, the big question about the New York City Health and Hospitals Corporation has been: Can they really pull it off? The Corporation, a joint venture sponsored by the City Budget Bureau, Department of Hospitals and private health establishment, was described—to the opposition—as "just a new management structure for the Municipal hospitals." [See BULLETIN, special winter issue, 1969.] But to Federal health officials, the Corporation has been touted as the biggest, most modern "experiment" yet in "the management of multi-hospital systems." [See BULLETIN, September, 1969.] The plan is to take the City's 18 Municipal hospitals out of the City government and put them into an "efficient businesslike" quasi-public Corporation—by July 1, 1970. Delayed first by heated community opposition, the Corporation next ran into internal political tangles: For more than six months the Mayor and City Council could not agree on appointments to the Corporation's 16-member Board of Directors. People began to worry (or to hope) that July would roll around and find no Corporation ready to toss the Municipal hospitals into.

Then, in March, with only five months left to plan the Corporation, the Mayor and the City Council produced a Board of Directors. Anyone hoping for a roster of local and national health dignitaries got a stunning letdown—with only a few exceptions the appointees are distinguished only by their anonymity. The New York Times, which had previously played up the slightest rumor about the appointments, was so disappointed with the real story that they put it on page 78 of an 80-page paper! Here they are, the men (and woman) who will head up the half million dollar a year City hospitals' corporate enterprise:

Serving as of the Board of Directors:

Appointment by the Mayor are:

- Dr. Daniel Paulo, a private physician from Staten Island with no record of public service. He was the choice of the City Councilmen from Staten Island.
- Dr. Vernal Cave, a private practitioner from Brooklyn and a Director of the Health Department's Bureau of Venereal Disease Control. Best known as the brother of Harlem Hospital medical board leader Dr. Herbert Cave, Dr. Vernal Cave was the choice of Brooklyn Democratic County Leader Meade Esposito.
- Milton Kirchman, an architect who has worked for the City in planning for Kings County, Coney Island, Bellevue and Gouverneur Hospitals. A resident of Queens, Kirchman was the choice of Queens Democratic boss Moses Weinstein, who is also a relative of Kirchman.
- Charles Bensley, president of the Citywide Petroleum Company and a member of the board of the Federation of Jewish Philanthropies (an organization which includes some of the city's most prestigious private hospitals). Bensley, a Bronx resident, is the choice of Patrick Cunningham, the Bronx Democratic boss.
- Dr. Edmund O. Rothschild, a research physician connected with NYU and Memorial Hospital. A Manhattan resident, he is the selection of Manhattan Democratic boss Frank Rossetti.

Appointed by the City Council are:

- Dr. Oliver Fein, M.D.
the hospital establishment, Michaelson for labor, and Logan for the blacks. For Lindsay himself, there's Badillo, who supported Lindsay's mayoral bid, and Katzenbach, a lead into the national Kennedy camp. For the consumer, who knows? Badillo, Logan, Michaelson, and Katzenbach are all liberals. How they face up to New York's close knit establishment of medical schools, major voluntary hospitals and Blue Cross remains to be seen.

The relative anonymity of the new appointees may be an indication that the board of directors is not intended to be the seat of power in the Corporation. Already, most of the planning for the Corporation has been carried out, sans Board, by a special task force composed of Hospitals Department, Budget Bureau and Mayor's Office personnel. For months this behind-the-scenes task force has been taking over more and more of the powers supposedly being reserved for the Board of Directors. For instance, Hospitals Department spokesmen previously claimed that no contracts to consulting firms could be signed before the Board was appointed. (Most of the detailed planning for the Corporation is to be done by private management consulting firms rather than by City or Corporation planners.) But recently the task force went ahead and contracted out for the design of seven "program areas," including "electronic data processing," "procurement," and "program, planning, budgeting"—a total cost estimated in the hundreds of thousands of dollars. So the Board of Directors will probably find that, by the time they reach their first meeting, most features of the Corporation are already a fait accompli. Then once the Corporation starts rolling, real operating power will almost surely reside in the full-time lavishly salaried Executive Director—not in the unpaid and underworked Board.

Up until his resignation on March 4, the post of Executive Director of the Corporation seemed made to order for Hospitals Commissioner Joseph Terenzio. He'd been promoting the Corporation idea for years and was, at least in September, the Mayor's choice for the top job. Now the guess is that whomever is appointed to take Terenzio's job as Commissioner will be the de facto choice for the Executive Directorship, a post which will carry national prestige and a salary estimated at $75,000 a year. The three current front-runners for the commissionership are, in order of the Mayor's preference: Dr. Martin Cherkasky, director of Montefiore Hospital [see BULLETIN, April, 1969], Dr. Ray Trussed, director of Beth Israel Medical Center, [see BULLETINS, December, 1968, and February, 1970], and Dr. Robert Mangum, now head of NY State Division of Human Rights. The first two need no introduction: no two men have done more to shape New York City health politics for the last decade than Doctors Cherkasky and Trussed. Magnum, the dark horse candidate, is apparently more of the powers supposedly being reserved for the Corporation. For instance, Hospitals Department spokesmen previously claimed that no contracts to consulting firms could be signed before the Board was appointed. (Most of the detailed planning for the Corporation is to be done by private management consulting firms rather than by City or Corporation planners.) But recently the task force went ahead and contracted out for the design of seven "program areas," including "electronic data processing," "procurement," and "program, planning, budgeting"—a total cost estimated in the hundreds of thousands of dollars. So the Board of Directors will probably find that, by the time they reach their first meeting, most features of the Corporation are already a fait accompli. Then once the Corporation starts rolling, real operating power will almost surely reside in the full-time lavishly salaried Executive Director—not in the unpaid and underworked Board.

Why either Trussed or Cherkasky would want to give up his current high-paying, autocratic position for the uncertainties of public life is not altogether clear. According to some insiders, Trussed's key backers are the trustees of Beth Israel Medical Center, who have been job-hunting for Trussed since his confrontations with the Lower East Side community began in the fall of 1969. Cherkasky, surprisingly enough, has been promoting himself for leadership in the Hospitals Corporation for months. His first move was to publicly endorse Chase's appointment—at a time when most other health establishment leaders were quietly protesting it. Next in February when the Lincoln Hospital Community Advisory Board clashed with Terenzio over the choice of a new administrator for Lincoln, Cherkasky secretly rushed in to mediate between the Advisory Board and the Mayor's office—a move which some observers interpret as a calculated attempt to demonstrate his pacification skills just when Terenzio was looking worst. Apparently, Cherkasky is now so confident of a new job downtown that he has purchased a co-op apartment on Park Avenue.

If, for some reason, Cherkasky decides not to accept the Hospitals Commissionship, hence presumably the post of Corporation Executive Director, the Mayor may have to import a new man. One name being mentioned is John Knowles of Massachusetts General Hospital in Boston. Knowles won a national reputation as a health liberal when the AMA nixed his appointment for a top HEW post last year, but in Boston he is known to be conservative on labor and community involvement issues. Last fall, Mayor Lindsay interviewed Knowles for the post of Health Services Administrator, but passed him over for Gordon Chase. In private conversations, Knowles has let it be known that he is still in the market for a top New York City health post.

So far, consumer groups have had little say about the new vacancy in City hospital leadership. Most community health organizations were too opposed to the formation of the Corporation in the first place to care now about who heads it up. They feel that the Corporation will be a bust no matter who heads it, so why put in a good man as a fall guy? At the same time, a strong, consumer-oriented Corporation Executive Director might be able to prevent the Corporation from being a total sell-out of the Municipal hospital system to the private sector. Herman Badillo, ex-Borough President of the Bronx and a long-time critic of the Cherkasky Bronx medical empire, already has considerable support, despite his recent appointment to the Corporation's Board of Directors.

Emperors Meet Industrialists

Remember the Arden House Conference on Welfare in 1967? It was the summit conference of industrialists which laid down what is now the Nixon welfare policy. There will be an Arden House type conference on health at the New York Hilton, May 13-15, 1970. If it meets expectations, it will lay down the Nixon policy on health cost controls and national health insurance.

What is remarkable is the similarity between the two conferences. Governor Rockefeller, a lead actor in the welfare conference, remains in the wings. Victor Weingarten, a PR man, is pulling together the $250,000 show, just as he did for Arden House three years ago. Labor wasn't represented at the welfare conference and will probably be excluded from the health gathering. Apparently only industrialists should be brought in to set broad health policy.

Herbert Lukashok, right hand man of Montefiore Hospital Director Martin Cherkasky, is acting virtually as a staff man...
for the conference. Is it possible that Dr. Cherkasky aspires to be the Patrick Moynihan of health? The Weingarten PR firm which is directing the industrialists' conference on health has held a lucrative public relations contract with Montefiore for several years.

What's in it for the Governor? Publicity on health problems for which his State Universal Health Insurance Act will be a solution may be his main goal. And if his bill doesn't pass the legislature, at least the conference will establish health as a campaign issue.

Lead Paint and Politics

Recent pressure from the Young Lords organization and other community groups has finally prodded the City into launching a "massive lead poisoning detection" program. The Health Services Administration (HSA) has created a new separate Bureau of Lead Poisoning Control, and a new health code went into effect in mid-January, changing the procedure for handling lead-containing apartments.

In the kind of reorganization that functions to befuddle consumers, and obscure responsibility, the new Bureau of Lead Poisoning Control is administratively part of the Health Department (within HSA) but is also directly responsible to HSA. This is so that the Bureau Chief can have some authority over hospitals as well as health centers, since hospitals are expected to do much of the actual testing for lead poisoning.

The new health code is a timid attempt to deal with the relationship between health and housing. Lead poisoning in young children comes mainly from lead contained in the old paint in old buildings. Where the walls of the apartment are not well maintained, the paint and plaster chip off the walls, and children eat the paint chips. Until January, the lead poisoning problem was defined administratively as a health problem only. Health Department sanitarians would inspect an apartment only after a child was found to be suffering lead levels over 0.06 mg percent. Then a tedious process of letters to the landlord, re-inspection, summons and possibly a fine, which might go as high as a whopping $35, might or might not end in a repaired apartment. With the new code, the Health Department and its sanitarians would still be responsible for the first part of the process—inspecting the apartment, writing the landlord, and re-inspecting to see if the repairs were made. At that point, however, if the apartment had not been repaired, the Health Department would turn the case over to the Emergency Repair Program (ERP) of the Housing and Development Administration. The ERP, however, would then have responsibility for repairing the apartment and billing the landlord—just as it does in cases of uncorrected boiler failure or other housing problems. One potential administrative snag: the new code says that the Health Department shall "request" ERP's intervention. ERP will not have to move in automatically and make repairs. Responsibility can be shunted back and forth.

In its two and a half months of existence, the lead poisoning program has produced a new network to monitor the number of tests done in the various hospitals and health centers. However, the question of treatment is nowhere near resolved. One major snag is the nature of the tests for lead poisoning. The two main tests used are the urine test and the blood test. The urine test has come under fire as unreliable—producing false positives and false negatives. False positives are no problem because a child who tested positive would be given further tests. False negatives, however, could lead to overlooking a seriously ill child. The blood test, though more reliable, is more difficult to implement. HSA's solution to this dilemma has been to go ahead with the blood test for the time being and to begin seeking a new test that would use smaller amounts of blood or perhaps hair. A number of medical laboratories, including some at major medical schools, have been asked to look into the problem of a new test.

Another major snag is what to do with the lead-infested apartments. Everyone agrees that new housing is the answer, but no new low-income housing is on the horizon and the HSA is in no position to create any. The Housing and Development Administration is presently testing wall repair techniques in four apartments, though the Scientists Committee for Public Information has been explaining for years that only two basic methods are possible: scraping off all the old layers of paint before repainting or covering the walls with wallboard so that children and lead cannot get to each other.

Community groups watching the sudden growth of a "massive lead poisoning detection program" express some skepticism. They note the Health Department's past irresponsibility. For example, HSA is only now looking for a way to transport blood samples to the City labs without losing, spilling or contaminating them. They are also concerned by the fact that the program is funded only one month at a time. And recently they learned that the City would not agree to having an independent Citizens' Board to oversee the program.

Ghetto Medicine Fills Bill

The Ghetto Medicine Bill gets a little worse every day. Tossed into the 1968 State legislative package as a "sweetener" for the '68 Medicaid cutbacks, the bill has turned out to be a straight cyclaminate. Like so many other health measures for the poor, the Ghetto Medicine Bill has been transformed into a glad-handed subsidy for the voluntary hospitals.

In its infancy, the Ghetto Medicine Bill showed considerable promise: The State and City would jointly finance publically run ambulatory care centers provided that those centers offered high-quality, comprehensive care, and provided that the community participated actively in the running of the center. The idea was to stimulate city governments to upgrade their existing free clinics (such as district health centers and hospital out-patient departments) and to make excellent care available to poor people, regardless of whether or not they had been cut off Medicaid.

For a year after its passage, New York City ignored the Ghetto Medicine Bill. (Health Commissioner McLaughlin claimed she didn't "understand" the bill.) The "ghettos," the proposed beneficiaries of the bill, were suffering under the impact of '68 and '69 Medicaid cutbacks, but the City didn't see fit to take any action until the voluntary hospitals announced that they were in trouble. All of a sudden, the City "remembered" the Ghetto Medicine Bill and found the money to match the State's $6 million appropriation for it. There was still a hitch—the law stipulated that the money could only be spent on public health facilities. But Governor Rockefeller saved the day, for the voluntaries, with an administrative edict that in New York City, Ghetto Medicine Bill money could only be spent on voluntary health facilities.

To make this "legal," the City was to use the formality of contracting out to the voluntaries for their services.

(13)
This sudden reversal of the intent of the law brought on a smattering of protests, including a law suit to force the State and City to redirect the money to the chronically underfinanced Municipal hospitals and health centers. But for many the big question was: If the money had to go to the voluntary hospitals, how would the City force the voluntaries to offer comprehensive continuous, family-centered care? And how would the City get the voluntaries to submit to community participation?

The answer, which came in early 1970, was that the City wouldn't require the voluntaries to do anything. In January the City released, with some embarrassment, model contracts which had been drawn up for voluntary hospitals wishing to receive Ghetto Medicine Bill money. The sections of the contracts which dealt with quality of care are studded with phrases like "to the extent possible," and "whenever practicable." In fact, all the voluntaries really have to do to get Ghetto Medicine Bill money is to promise to "formulate a plan" for upgrading the quality of out-patient care.

The only remaining hope was that the community participation required by the Ghetto Medicine Bill would force the voluntaries to accelerate their planned improvements in out-patient care. That hope died in early March, when the City issued its guidelines for community participation under the Ghetto Medicine Bill. The very first words of the guidelines, dated March 2, show how far the Ghetto Medicine Bill has come from its original purpose. The State's 1968 guidelines for the bill had stipulated community participation "in order to insure that the organization and operation of the health center is of maximum value to the community served." The new guidelines say that the purpose of community participation is "to enhance the ambulatory services of a voluntary hospital through the involvement of the voluntary hospital with its community." In other words, even community participation has become a way of serving the hospital, not the people.

But the big shocker in the guidelines is that they do not even recommend community advisory boards, however weak; they recommend the formation of joint community-hospital administration advisory committees. These Ambulatory Services Advisory Committees as the guidelines call them, must include the local District Health Officer, the hospital's Director of Ambulatory Care and the hospital's Executive Director. A total of 49 percent of the advisory committee members may be hospital or City officials. One can't help but wonder about the peculiar psychological dilemmas this will pose for the hospital directors. As members of the advisory committee, they will be in the position of advising themselves.

With all the hospital brass sitting in, there is little danger of the advisory committees' getting out of hand. But the guidelines don't take any chances. The list of topics which the Ambulatory Services Advisory Committees may concern themselves with includes a number of topics such as "physical plant standards," "patient registration," and "review of patient grievances." Not a word about reviewing the hospital budget, enforcing high standards of care, or the hiring and firing of hospital employees. But then, as the guidelines say, the Ambulatory Services Advisory Committee is "neither to be interpreted as having 'community control' nor as performing a perfunctory role." Their purpose is to increase the sensitivity of the three parties [City, hospital and community]" (emphasis added). Nothing perfunctory about that!

No one seems too eager to take credit for the guidelines. Deputy Health Commissioner Gil Bernstein, who was responsible for drafting them, says the actual writing was done by a four-man advisory committee including Dr. Pomrinse, director of Mt. Sinai, Dr. Stanley Bergen of Brooklyn-Cumberland Hospital, and Mrs. Mary Robinson and Miss Ana Dumois, both staff members of the Community Council of Greater New York, a city-wide philanthropic organization. Miss Dumois has formally given Bernstein notice that she "cannot fully endorse the guidelines as promulgated," since they do not reflect her actual input to the drafting committee. Mrs. Robinson also claims that the printed guidelines are a surprise to her. That leaves Pomrinse and Bergen with a lot of explaining to do.

Undeterred by the controversy over the Ghetto Medicine Bill contracts, the voluntary hospitals have been tripping over each other to get in line for the money. So far 27 hospitals have applied for their share of the $13 million ($7 million in City funds and $6 million in State funds). Now even the word "ghetto" has been forgotten and the Health Department is signing up all takers. Some of the small, fiscally starved, ghetto-based voluntaries may be lost in the scramble as the big boys elbow in: Beth Israel, Mount Sinai, St. Lukes, Montefiore, Long Island College Hospital, etc. There's still a chance that the contracts will be blocked by the New York City Board of Estimate, but odds are that the Ghetto Medicine Bill money will continue on its steady course into the bank accounts of the voluntary hospitals.

**Trussell Robs Ghetto Till**

Two flies with one swat. That's what Ray Trussell is after in transferring the Gouverneur-Beth Israel program from the Department of Hospitals to the Department of Health. This technical shift, which will permit Ghetto Medicine Bill funds to be allocated to make up the deficit at Gouverneur, is also designed to relegate the Lower East Side Neighborhood Health Council-South (LESNHC-S) to oblivion. LESNHC-S, the official OEO health council for Gouverneur has been at loggerheads with Beth Israel over the past months [see February, 1970 BULLETIN].

Ghetto Medicine Bill guidelines call for an advisory council containing community members. Dr. Trussell has already announced his plans for fulfilling this requirement. Since Beth Israel is the sole recipient of funds for both Gouverneur and Beth Israel's outpatient department, Dr. Trussell reasons there should only be one community advisory council. Since LESNHC-S represents only one-half of the area served by Beth Israel and Gouverneur (the area south of Houston St.), they should be entitled to no more than half the seats on the advisory council, at best. Dr. Trussell has started out by suggesting that they have two seats out of 17. Dr. Trussell insists on this amalgamation of the community, in spite of the fact that patients who live south of Houston are not permitted to use the Beth Israel outpatient department. If they turn up at Beth Israel, they are sent to Gouverneur. Once again, Ray Trussell turns legislation that brings more money for health to the community against those community forces that would hold him accountable for what he does with the money.

—HEALTH-PAC Staff