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The Malpractice Crisis

Evading the root causes of a social problem is perhaps a natural reaction for those whose careers and mind-sets would be put at risk by facing up to them. When those same people are in a position to channel public discussion of the problem—even to determine the public's conception of what the problem is—the possibility that the larger society will effectively deal with the problem is sacrificed for the sake of particularistic interests. And ultimately the unaddressed problem will inevitably reassert itself in even more insidious forms.

Something like this process seems to be unfolding in relation to the medical malpractice issue. Long-developing signals of discontent from the patient population—aided and
abetted by bench and bar—only became a "crisis" when an economic threat to professionals and institutions erupted. Then those with the power to define the crisis presented it almost entirely in terms of the insurance industry, the legal profession and the judicial system. Problems of the medical profession and the health-care system themselves have been acknowledged only glancingly, if at all. What follows will consider the profession's and the system's reactions to the crisis, surface and subterranean, and will attempt to glean those underlying causes that have been so elusive to public debate thus far.

The Triumph of Economics

What gave the medical malpractice problem the status of a full-blown crisis in the eyes of the medical profession—and, through its reaction, in the public eye—had less to do with malpractice claims per se than with the price-hiking and withdrawal tactics of the malpractice insurance carriers. Those tactics in turn were as much a reaction to the plummeting of the stock market as to the escalation of malpractice litigation. (The 1974 bear market removed what for many insurers had been the incentive for entering the malpractice field: The so-called long tail—the long lapse of time between the paying in of a malpractice insurance premium and the paying out of a settlement or judgment—allows for a handsome profit on investment during a bullish market.)

The fact that economics more than medicine was the immediate catalyst of the crisis helped the medical profession initially to ignore the medical issues underlying malpractice claims; at the same time, however, the profession's outraged reaction to the carriers' conduct put it in the anomalous position of attacking economic behavior that simply reflected a set of free-market incentives that it had long found it in its interest staunchly to defend.

The 1975 physicians' strikes then saw large segments of the profession launching into the further circularity of exercising their own freedom to withdraw their services in an attempt to rectify the effects of the industry's unseemly withdrawal. That tactic created still another incongruity, namely the spectacle of a profession that had long argued that the least government is the best government demanding that state governments take an active role in the economics of medical practice.

The Intersection of Economics and Medicine

While the 1974 bear market wrought havoc with the reserves of all kinds of insurers, one characteristic of the economics of professional liability insurance made it a particularly unattractive business. Here the profession found it hard to avoid some consideration of problems of medical practice, for those economics made a direct connection between escalating premiums and disappearing insurers and the profession's traditional, if weakening, resistance to any limitation of its members' freedom to practice any and all forms of medicine, subject only to the laws of supply and demand. That stance became a problem for the insurers—and thus eventually for the physicians—because their risk-spreading base of physician-insureds, unlike the broad base provided by their life insurance or auto insurance customers, is dangerously narrow. Thus a relatively small number of malpractice settlements or judgments, unlike a small number of deaths or auto accidents, can throw a carrier's loss experience for an untenable loop.

That relatively small, though economically threatening, number of payments may represent an even smaller number of physicians: A study of malpractice suits filed in the tri-county Metropolitan Detroit area over the five-year period 1970 through 1974, for example, showed that 2.1 percent of the area's physicians—those sued more than once—accounted for 46.2 percent of the suits. (1) The single infamous case of Dr. John Nork in Sacramento, with its $3.7 million jury verdict, alone accounted for 12 percent of the California losses of American Mutual Liability Company, the unlucky carrier. (2)

Moreover, those physician-defendants threatening their insurers' economic security
were not necessarily totally incompetent—as Dr. Nork apparently was—but might be un­qualified to perform certain complex proce­dures and unwilling to admit their limitations. Thus a study by Empire Casualty Company of Denver of its 72 largest settlements and judgments over a 15-year period found that “Some of the biggest payouts . . . were for physicians who overestimated their ability to do such things as treat compound fractures, read X-rays, handle difficult deliveries, or perform special surgery. In each case, prompt referral to, or consultation with, an appropri­ate specialist could have forestalled a mal­practice claim.” (3)

The inherent instability of medical mal­practice insurance was not a problem for the industry (or, by extension, the profession) when malpractice suits were a relative rarity and their success even more rare and/or when a bullish stock market was inflating the carriers’ reserves. The increasing willing­ness to sue of the patient population and its allies at the bar and the increasing willing­ness of the judiciary to ease the legal bar­riers to a successful suit, when combined with the decreasing viability of the stock mar­ket, left a traditionally important segment of the profession hoisted on its own petard. Those physicians, that is to say, who had stoutly defended the inviolability of the li­cense to practice from limitation or reexami­nation found that the incompetence, absolute or relative, of some of their brothers was mak­ing that stance more expensive than they had ever foreseen.

Thus some elements of the profession, with much encouragement from the insurance in­dustry, (4) have moved from economics to medical care to the extent of beginning to sup­port legislative measures aimed at strength­ening regulation of physicians. That develop­ment augurs for an increase in the intra­professional split between primarily office­based generalists and primarily hospital­based superspecialists and for a boost to the already increasing power of the latter. The elite of the profession can well afford to rec­ognize the economic and public-relations dis­advantages of incompetents, absolute or rel­ative, practicing medicine and in fact stand to reap economic benefit from a reduction in competition from generalists practicing their superspecialized skills.

The Triumph of the Institution

Shifting the scene from the office to the institution, however, presents the profession—here joined by the hospitals—with another problem that it would prefer not to confront. American medicine has always proudly ex­hibited a bias toward high-technology treat­ment, toward inpatient hospital care and to­ward surgery. Given that an estimated 74 percent of incidents that become malpractice claims occur in hospitals and that about 57 percent of such incidents involve surgery, (5) the always questionable cost/benefit ratio of that bias is finally—in the short term at least—hurting physicians and hospitals as much as their patients. (While those statistics to some extent reflect the incompetence, ab­solute or relative, of surgeons, (6) they un­doubtedly also reflect the environmental risks unique to hospitals, the potential defects of technology available only in hospitals and the potential for harm inherent in any surgical procedure.) Physicians’ and hospitals’ malpractice insurance premiums might be lower, that is, if they had heeded the charges made by critics of the system that it is fraught with unnecessary hospitalization and unnec­essary surgery; their reason for evading that issue of course is that their incomes would be lower as well.

So while at least passing concern is ex­pressed for the problem of medical incom­petence, the problem of inherent systemic risks
is not only ignored but flouted. For there appears to be a movement, inspired by various ramifications of the economics of malpractice insurance, toward increasing numbers of physicians relating to an institutional base in preference to a solo private practice. There are, for example, the repeatedly reported cases of academic physicians giving up their part-time private practices because their increased malpractice premiums (which fail to distinguish between full-time and part-time practice) make such practices hopelessly uneconomic to maintain. There is the advertisement by a medical employment agency in which the inducement “Free Malpractice” appears in type twice as large as the inducement “Med School Affiliations.” (7) There is the report from the Defense Department that the incentive of malpractice insurance as a fringe benefit is bringing the armed forces record numbers of applications for medical commissions. (8) Or there is the announcement by a South Dakota insurance carrier that doctors coming to that state will only be insured by it if they join an established group practice. (9) A collection of incentives and disincentives, all ultimately related to the malpractice crunch, thus seems to be accelerating the movement of medical practice from office to group and institution.

As doctors increasingly move to an institutional base, that base is likely to exercise control over their medical practice within it, again for reasons relating to the economics of malpractice. That control may itself take an economic form, as in an insistence that physicians not provided with insurance by the institution obtain it in adequate amounts on their own; thus a federal district court in New Orleans has upheld the right of a hospital to suspend the privileges of a member of its medical staff for failing to comply with its requirement that staff physicians maintain a minimum amount ($1 million) of malpractice insurance coverage. (10)

In terms of medical practice, the increased willingness of the judiciary to hold hospitals liable for the conduct of their medical staffs has given hospitals an economic incentive to increase their scrutiny of that conduct. According to one commentator, “This concern [about their potential liability] has been a tremendous impetus for hospitals to demand that their medical staffs undertake more effective auditing procedures of their members.” (11) Here the hospitals are being forced to juggle the need to minimize their liability by instituting review and regulatory mechanisms affecting their medical staffs and the need not to jeopardize the good will of those same physicians, on which they depend for the maintenance of occupancy rates that alone guarantee an adequate cash flow. Thus the most advantageously situated institution is the one that is least dependent on private practitioners for its patient supply, a fact that may further reinforce the trend toward institutionally based medicine. Conversely, the most disadvantageously situated practitioner is the one lacking the preference or the talents for maneuvering in an increasingly bureaucratic setting.

The incentive of malpractice insurance as a fringe benefit is bringing the armed forces record numbers of applications for medical commissions.

A Healing Relationship or a Market Transaction?

While ignoring the increased risks of high-technology, institutionally based medical care, those with the power to define the content of the malpractice crisis have equally ignored a more fundamental problem: A perceived medical injury is a necessary but not sufficient ingredient of a malpractice claim, the essential catalyst being that quantum of resentment that can transform an unfortunate state into a hostile act. If the patient perceives his physician as being primarily motivated by a concern for his well-being (a concern that would include an unwillingness to risk performance of a procedure beyond the scope of the physician’s skills), the patient will have no reason to seek a pound of flesh when the results were not what he and his doctor had hoped for. But if the patient sees the physician as a highly paid entrepreneur (or employee) who in turn seeks him as a defective commodity
to be repaired for the sake of a profit, his re-
action to an untoward result will be the same
as is his reaction when his auto mechanic
charges a hefty price for failing to fix his car.
(The probability of the latter perception is
recognized by the insurance industry, which
advises its physician-customers: “Keep your
charges reasonable—the doctor who has the
biggest fees can be the biggest target, too.”
(12))

The fact that American medical practice is
based on a system of economic incentives
(whether the fee-for-service system or the pre-
payment system) creates an inherent conflict
of himself as a damaged commodity, what-
ever it can offer him in terms of reduced mor-
bidity and mortality. Scientific medicine is
most markedly market medicine when its
practice overlaps with the profit-based mar-
et for the products of a technological age.
Thus the patient risks ceasing to be half of a
social relationship and becoming instead an
appendage of a machine whose use increases
the income of the corporation that manufac-
tured it, the hospital that bought or leased it
and the physician who has prescribed its use.
This result is not inherent in the machine per
se but stems from an economic and social
of interest for the physician—an altruistic in-
terest in his patients’ maximum well-being
frequently conflicts with his economic self-
interest in maximizing his patients’ profitabil-
ity. The larger society, that is, has created an
occupational group that it expects to exhibit
an altruistic concern for the welfare of others
but has simultaneously placed that group
within a system of market incentives having
no necessary relationship to the degree to
which that welfare is furthered. (The profes-
sion itself of course has been an active par-
participant in the creation of this dilemma.)
Insofar as an injured patient perceives the eco-
nomics as dominating the altruism, it is not
surprising that he seeks an economic solution
to a therapeutic problem.

In the context of a capitalist economy, the
practice of scientific medicine can only
heighten the patient’s uncomfortable sense
system in which the incentive for the devel-
opment of new technology is to maximize
profits rather than human potential.

Or the incentive for use by the mystique of
scientific medicine on the practitioner’s part
may be to maximize his status, which thereby
increases the psychic distance between him
and his patient: In their classic study of Yale-
New Haven Hospital, Duff and Hollingshead
found that “Sometimes...‘scientific’ medi-
cine was used as ‘insulating’ medicine be-
tween patients and physicians. In that proc-
 ess the physician assumed superior knowl-
edge and discounted or even ignored the
report of the patient.” (13) Thus science be-
comes identical with mystification instead of
furthering human autonomy.

Financing mechanisms exacerbate the
commodification phenomenon even further.
The economic incentives of insurance-based
payment mechanisms distort the choice of what care to provide in what setting from being a matter for doctor-patient agreement based on therapeutic and human considerations to being a matter of channeling care into those modalities that the insurance company has made an economic decision to cover. And the economic incentives usually coincide with that modality—inpatient hospital care—that is both most risky and most depersonalized.

Social policy in the form of Medicare and Medicaid, because based on the payment principle rather than the service principle, has extended the economic incentives of the market to new arenas. Thus Medicaid has brought us free enterprise with a vengeance, in the form of scandal-ridden Medicaid mills in New York, prepaid health plans in California and nursing-home chains all over. It has also extended to the poor the same risks of excessive hospitalization and excessive surgery to which the American medical system has long subjected the middle class. Medicare has abolished as superfluous the altruistic (albeit patronizing) medical tradition of treating the elderly poor at rates they could afford to pay. The loudly heralded rights to care these programs were said to have created were more accurately rights to call on government to pay for a bureaucratized commodity rather than rights to enter freely into a healing relationship.

Given that patients see medical care being furnished and financed as a product, whether dispensed by an individual entrepreneur or a large corporation, it is not surprising that they increasingly seek economic satisfaction when the product turns out to be defective. Here they receive reinforcement from the legal system, where the sanctity of property rights on which it is based reifies human existence and makes the ghoulish equation between pain and suffering and monetary damages.

But if the patients, who have few if any alternatives, are chasing an illusion, the profession, which is appreciably more powerful, is exacerbating the commodification of health care—and the "legalized and legitimated doctor-patient hostility" (14) that goes with it—even further. In part that exacerbation relates to the apparent trend already noted of increasingly providing health care in an institutional, and therefore further depersonalized setting. More concretely, it relates to the physician's common reaction to the alienation and hostility of the patient turned plaintiff. (That reaction can be quite colorful, as in the statement of a physician-member of the HEW Commission on Medical Malpractice: "The doctor feels put upon. He feels nude on the corner of the Main Street of life.

He often tries to cover himself with pride, and even occasionally arrogance, only to find himself being castrated. He really doesn't want to believe the hostility he feels." (15)) In terms of conduct, that reaction duplicates the patient's alienation and hostility in the form of what has come to be known as defensive medicine.

Of course one practitioner's defensive medicine may be another practitioner's standard practice. What distinguishes the phenomenon is not its content but its motivation: The patient is not an object of altruistic concern but a potential enemy against whom defensive measures must be taken, which must in turn be disguised as procedures undertaken for the patient's benefit. Thus outright deception joins economic motivation in insuring that
what should be a healing relationship will have more of the character of a market transaction, and one between parties with opposing interests at that.

**The Foam-Rubber-Pillow Syndrome**

Ultimately the evasiveness of the malpractice debate is destined to get its participants—and the American public—only a bad case of the foam-rubber-pillow syndrome (attack the problem here and it pops up there). The smorgasbord of purported solutions to the crisis that the medical profession and its allies in the insurance industry have been dishing out, aside from the admittedly short-term expedients for patching up the insurance market, address patient hostility as expressed in malpractice claims by seeking either to suppress it (e.g., by shortening the statute of limitations and abrogating various common-law doctrines of liability) or to channel it into hopefully less expensive outlets (e.g., arbitration or compensation systems modeled on workmen's compensation).

Perhaps it is to be expected that the medical profession will treat symptoms rather than causes, but for the sake of pursuing its short-term self-interest it is ignoring the importance of starting with a correct diagnosis. Thus patient hostility is obtusely blamed on the avariciousness of that other profession, whose members, however greedy, don't have a case until they have a client angry enough to undertake the ordeal of a lawsuit.

The doctors' dilemma of course is that the alternative to such short-sightedness is perhaps as painful as the hostility of the patient-litigant. The commodification of medical care, despite its inherent cycle of risk-alienation-injury-hostility-counter-hostility and so on, has brought ample economic rewards to the profession and to the delivery system within which it operates. When those rewards are threatened by the economics of patient hostility, the natural reaction is to seek to render that hostility less economically rewarding rather than to call into question the economic basis of one's own well-heeled livelihood. What threatens an onset of the foam-rubber-pillow syndrome is the fact that the hostility is not going to go away but is going to seek new channels for its expression with the help of a profession that thrives on hostility. Thus the malpractice crisis in one form or another is destined to be a permanent feature of the American scene unless and until social conditions make possible a solution based on social and ethical values rather than on the crudities of economic motivations.

—Louise Lander

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"The doctor feels put upon. He feels nude on the corner of the Main Street of life. He often tries to cover himself with pride and even occasionally arrogance, only to find himself being castrated."

George W. Northup, D.O.

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References

1. Physicians Crisis Committee, Court Docket Survey (Detroit: The Committee, 1975), calculated from data at pp. 42-46.
4. One insurance official is quoted as telling the AMA Board of Trustees that "this is not an insurance problem but a medical-insurance problem. We need the medical profession's help in weeding out those physicians who are contributing to the problem." "AMA Trustees Seek a Solution," American Medical News, June 23-30, 1975.
6. That hospital-linked malpractice statistics need to be analyzed in terms of the types of practitioners involved is suggested by the Detroit-area study, which examined the number of patient admissions per malpractice case for 55 hospitals and found that of the 17 university-affiliated teaching hospitals that sample included, 12 had better-than-average malpractice case ratios. Physicians Crisis Committee, op. cit., p. 39.
12. Eisenberg, op. cit., p. 163.
14. From "We have been concerned to show the connections between the growth of commercial practices in certain sectors of medical care and the increasing application by the law of the marketplace—of legalized and legitimated doctor-patient hostility. The second is a logical consequence of the first." Richard M. Titmuss, The Gift Relationship (New York: Pantheon Books, 1971), p. 170.
Overbedding the Suburbs

While unchecked hospital expansion has resulted in a surplus of acute-care beds in many urban centers (see BULLETIN, May/June, 1975), many surrounding suburban communities still suffer from a shortage of beds. Since World War II many private physicians have abandoned their downtown offices and followed their patients to the suburbs. But inner-city hospitals, with their vast capital investment in plant and equipment, have been slower to move, leaving many suburban residents without ready access to care, particularly in cases of medical emergency.

This absence of competing institutions plus the affluence of suburbia have made it a good market for proprietary (private, profit-making) medical-surgical hospitals. Moreover, suburban hospitals offer lucrative development opportunities. Local government officials are usually more than willing to make the necessary sewer hookups and improve access roads for new hospital projects. Hospital developers are then in a position to build adjacent shopping centers, office buildings and motels. A case in point is the Greater Laurel area in the Maryland suburbs of Washington, D.C.

Laurel is a small Maryland town (population 11,000) located in the northwest corner of Prince Georges County on what was once the main road connecting Baltimore and Washington. In the past the economy of the surrounding area was based on milk and horse racing (at the Laurel Raceway). But the expansion of government operations has brought major new federal installations nearby, including the Goddard Space Flight Center at Greenbelt and the Agricultural Research Center at Beltsville. Meanwhile, neighboring University of Maryland at College Park has expanded enormously since World War II.

As a result, the population of the Greater Laurel area has shot up to 125,000, most of it in Prince Georges County and the remainder in the three neighboring counties (Montgomery, Howard and Anne Arundel). By 1980 200,000 people are expected to be living there. Despite this growth there is no general hospital within 15 miles of the area. The hospitals currently serving the area are all near the Maryland-D.C. border, at least 20 minutes away. (Kimbrough Army Hospital at Fort George G. Meade is closer, but serves only military personnel and their dependents.)

Residents had long expressed the need for a local hospital and tried to induce one to locate there. The only offers, however, had been proprietary hospitals which would not
have met community health-care needs and which failed to generate the necessary local financing. By the late 1960's local residents had become desperate and turned to the State government for help.

They're Off and Running at Laurel

In the Spring of 1970 the Maryland State Legislature created the 12-member Greater Laurel Hospital Authority (GLHA) and charged it with determining the health facility needs of the four-county Laurel area through a comprehensive health planning study. The Authority was also empowered to develop specifications for any recommended hospital or other health facility.

The GLHA’s role was strictly advisory. Sole power to approve or disapprove new health facilities was vested in the Director of the State Comprehensive Health Planning (CHP) Agency under Maryland's 1968 certificate-of-need law. (Similarly legislation was passed in many states during that period to regulate hospital overbedding.) Under the 1968 law State CHP Director Dr. Eugene Guthrie was to receive plenty of advice—from a special State CHP Advisory Committee and from local advisory committees set up in every single Maryland county. (The county committees had originally been established as so-called areawide comprehensive health planning agencies under the 1966 federal comprehensive health planning legislation.)

These county CHP committees were further mandated to hold hearings on each request for approval of a new health facility. If approved, the new facility would be given a so-called certificate of need for one year. It was then required to be recertified annually until the facility opened its doors, a procedure designed to keep the pressure on builders to move quickly. Creation of the Greater Laurel Hospital Authority just added another bureaucratic layer to this structure, ostensibly to help smooth over disputes in the four-county Laurel planning area.

The first entrepreneur to leave this problematic starting gate was Dr. J. Allen Offen, a local Laurel obstetrician and highly successful real estate developer. In December, 1969, just before the GLHA was set up, Offen announced plans to construct the Parkway Medical Center, a 250-bed for-profit hospital, in a rural area served by a narrow winding country road seven miles from any population center. Offen's group, Intercity Hospital Corporation, had acquired over 100 acres of land there. It planned to use 22 acres for the hospital and accessory buildings and to develop shopping centers, professional buildings and motels on the remaining property. Financial support came from the S. L. Hammerman Organization, Baltimore mortgage bankers, headed by I. H. (Bud) Hammerman II. (Hammerman was later sentenced to 18 months in prison in the construction kickback scandal which forced then Vice President Spiro Agnew from office.) Lawyer for the project was Robert L. Weinberg, a prominent Baltimore Democrat.

Offen enlisted the support of prominent local politicians as well. Foremost among them was Gladys Spellman, then member of the Prince Georges County Board of Commissioners and chairperson of the State CHP Advisory Committee, and now a member of the US House of Representatives. As a member of the Board of Commissioners, the County’s ruling body until 1970, she argued Offen’s case for the special exception zoning he needed for his site. She then got herself appointed

Crass Cash Crash

Competition to build hospitals is not limited to the Laurel area in the northern part of Prince Georges County. In southern Prince Georges County, Mary Hayes, owner of the 33-bed for-profit Clinton Community Hospital, has spent four years trying to sabotage the application of Dr. Francis Chiaramonte for a certificate of need to build his for-profit 300-bed Southern Maryland Hospital in Clinton.

In August, 1974 a State's Attorney announced the arrest of Ms. Hayes on charges that she hired a private detective to break into Dr. Chiaramonte's office. Later the detective placed his wife there as an office worker to gather confidential information to be used against Chiaramonte. The Washington Post reported that Ms. Hayes had also discussed with the private detective the possibility of his arranging to have an airplane crash land on Chiaramonte’s building site to back up her argument that the site was dangerously located in the flight path of Andrews Air Force Base.
to the County CHP Committee just prior to its 1970 certification hearings on the Parkway proposal. In addition she had accepted Offen's help in her successful 1970 campaign for County office. Eventually, she admitted a conflict of interest, but only at the local level. She then resigned from the County CHP but remained on the more powerful State CHP Committee.

Similarly, the Laurel Mayor and City Council have loyally supported Offen. Among them, too, conflicts of interest abound. One City Councilwoman, for example, sits on the Parkway Medical Center's board of directors; her nephew, just out of law school, serves as Offen's paid local attorney. Another City Councilman, who was also a Laurel physician, a former Prince Georges County CHP chairman and a member of the Citizen's Advisory Committee to the GLHA, suddenly became a vigorous supporter of Offen. Later it was learned that he was a partner in a professional office building to be erected near Offen's site.

**Parkway Leads at the First Turn**

In April, 1971, before the Prince Georges County CHP had even released its recommendations on the Parkway proposal, State CHP Director Guthrie unexpectedly granted Parkway's certificate of need. At no time did he hold state hearings, as he was permitted by law to do, nor did he require the Parkway group to submit health planning studies of any sort. His move was an obvious attempt to head off the County committee's report, released just days later, which recommended that Parkway not be approved because it was inaccessible and did not provide adequate outpatient services, adequate arrangements for treatment of the poor or consumer participation. (Earlier that month the Maryland National Capital Planning Commission, yet another suburban planning agency, had rated the Parkway site last among 14 proposed hospital sites.)

Then in July, 1971, the GLHA further undercut the Parkway proposal. It submitted its report, recommending another site, a few miles south of the town of Laurel, and urging construction of an entire health campus, consisting of a 250-bed nonprofit hospital with provisions for outpatient care, community health education, extended care, home care and para-medical, medical and nursing education. A citizens advisory committee was to play a key role in the planning for the hospital.

The GLHA urged Offen to locate on their site and build the proposed health campus there. Later Maryland Governor Marvin Mandel intervened with Offen on behalf of the GLHA site. But Offen was not interested in outpatient care or medical education. He would only consider the GLHA site, he said, if he received a no-strings land deal which would permit him to build a proprietary medical-surgical hospital along with office buildings and a shopping center. This was too much for the State government and it refused.

**Now They're Neck and Neck**

In October of that year State CHP Director Guthrie granted a certificate to the GLHA to build its proposed Greater Laurel Hospital, citing its more ready accessibility to most of the population in the Greater Laurel area compared to Parkway. Nevertheless his earlier approval of Parkway remained in effect. So Laurel residents, who had previously failed to convince a single hospital to locate there, now were faced with the prospect of two 250-bed hospitals. The obvious questions—whether the Greater Laurel area had enough patients to support two such hospitals—was not even addressed by Guthrie in his rulings. The task of organizing the financing and construction of the Greater Laurel Hospital was taken on by the GLHA. It worked with the four county governments having jurisdiction in the Greater Laurel area in an effort to get them to finance and run the hospital. In late 1972 the GLHA decided it was most prac-
tical to turn management and financing responsibilities over to the Prince Georges County Department of Hospitals.

**Parkway Stumbles**

Meanwhile Parkway had run into financial troubles. The money originally promised to finance the hospital had dried up in the depressed economy of the 1970's. By November, 1973, after three years of trying, Offen had not raised the $2.5 million necessary to begin construction. Facing another annual recertification hearing later that month, at which he would have to defend his inability to break ground for the hospital, Offen made a desperate move. He unveiled a prospectus, since dubbed the November Bombshell. Offen proposed to sell 100 physicians limited partnerships in the hospital at $26,250 each. This group would share 80 percent of the annual profits while Offen would get the remainder (estimated at $130,000 per year). Offen would also get a developer's fee of $200,000 and an annual $120,000 management fee. Further income would accrue from leasing X-ray, laboratory and pharmaceutical facilities and 39,000 square feet of examining rooms. The Washington Post estimated (November 8, 1973) that Offen's profits on the deal would add about $40 a day to patients' bills.

The public was outraged and pressure for decertification mounted. Having tried the proprietary route, Offen made a last-ditch effort to save Parkway by transforming it into a non-profit institution. He worked with Gladys Spellman over the next several months to develop such a proposal and maneuvered the Governor's office into making a public
announcement of Parkway's change of status. State CHP Director Guthrie used the change as an excuse to recertify Parkway once more.

In March, 1974 the Prince Georges County CHP held further hearings on Offen's plans. At that time Offen announced a further change—the nonprofit hospital would now be managed by the profit-making Hospital Affiliates, Inc. (HAI) of Nashville for a reported $800,000 annual fee. (HAI is the leader in the growing international hospital management contract industry. Of the 62 hospitals it operates around the world it owns 28 and manages 34 under contract with the owners.) The appointment of this firm to operate the hospital further aggravated the hospital's already weak standing in the community. Again, the County CHP issued a decertification recommendation, but again it was ignored at the state level.

Four Hospitals Fight for the Lead

Soon the public was in store for another bombshell, this one launched by State CHP Director Guthrie and reported by Victor Cohn of the Washington Post in a series of articles in early 1974. Cohn reported that the Agency had granted certificates of need to not two, but four hospitals, with a total of approximately 900 beds, lying within a 10-mile radius in northern Prince Georges County. In addition to the Greater Laurel Hospital and Parkway Medical Center, certificates of need were granted to a group of physician-investors led by Dr. Leon Levitsky to build a 208-bed for-profit Prince Georges Doctors Hospital and to a group in Bowie to build a 185-bed nonprofit community hospital patterned after the GLHA model. (While hearings had been held for each, they had not been extensively reported in the press and had largely escaped public attention.)

Thus the State CHP Agency, set up in 1968 to prevent hospital overbedding, had contributed to just the opposite effect, a surplus of hospital beds, in the Greater Laurel area. The County Health Department predicted that a 319-bed surplus would result in northern Prince Georges County if all four hospitals were built. The surplus would also adversely affect hospitals in neighboring areas which had previously been used by Laurel residents. Separate reports from the National Capital Area Hospital Council and the Johns Hopkins University called for a moratorium on hospital construction.

In May, 1974 Dr. Neil Solomon, Maryland State Secretary of Health and Mental Hygiene (HMH), stepped into the picture. Solomon, an academic M.D.-Ph.D. endocrinologist who still spends a good deal of his time in research and publishing, denounced Guthrie for "utter mismanagement" of the State CHP Agency, citing the glut of approved hospital beds in Prince Georges County as an example. (Solomon, however, had been aware all along of the multiple certifications and could have prevented them had he wanted to.)

Actually, Solomon's anger more likely stemmed from his discovery that Guthrie, fearing that Solomon might veto some of his certifications, had been covertly working with state legislators on a bill to make the State CHP Agency independent of the State Department of Health and Mental Health. Solomon dismissed Guthrie for "general poor performance" and named Leonard Albert, an HMH fiscal officer, as his successor.

Albert's first act in office showed that the differences between Solomon and Guthrie were rooted in policy differences. Albert immediately recertified Parkway, claiming that the Prince Georges County CHP had lost its objectivity and could no longer be taken seriously. In June, 1975, bowing to growing public pressure, Albert finally decertified Park-
way, citing its inability to obtain financing and lack of a viable citizens advisory committee—two shortcomings that had existed all along.

**Appealing the Decision**

In another eleventh-hour effort Gladys Spellman, now a member of the US House of Representatives, recruited former US Senator Joseph Tydings of Maryland to represent Parkway in its appeal of the decertification to Secretary Solomon. Solomon, however, promptly sustained the decertification decision.

At this point Dr. Offen resigned as President of Parkway Hospital for “personal reasons.” Tydings nevertheless appealed the Secretary’s decision to the next higher level—a seven-member State Board of Review within HMH. The Board voted unanimously to overturn the earlier decertification decisions and reinstated Parkway.

By the end of 1975, Greater Laurel Hospital was under construction and Bowie Hospital was in the final stages of financial planning. Prince George’s Doctors Hospital opened its doors in May, 1975.

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The County Health Department predicted that a 319-bed surplus would result in northern Prince Georges County if all four hospitals were built.

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After years of struggle, Parkway hospital is still alive in Laurel. It remains to be seen whether other suburban communities will be able to halt similar health-care profiteering and wanton overbuilding of hospital beds, for which they will pay in taxes and unnecessary treatment for years to come.

—Jay Herson (Jay Herson is a member of the faculty of the Department of Community Health at Howard University College of Medicine and a Laurel, Maryland community activist.)

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**MORE ON THE WASHINGTON, D.C. AREA**

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Health/PAC, 17 Murray Street, New York, N.Y. 10007
Peer Review

FMGs: A CASE OF RETRIBUTIVE JUSTICE

Dear Health/PAC:

During the past two decades, foreign medical graduates (FMGs) have been recruited to the US health care delivery systems in ever-increasing numbers. Now, in complete disregard of the important medical contributions they have made, the US State Department has ruled that they are no longer needed here and large numbers of them face deportation. Effective January 1, 1976, all foreign medical graduates who have entered the US under the Exchange Visitors Program (EVP) and have since applied for permanent residence will lose their Exchange Visitors status and are subject to deportation unless they receive permanent resident status within 60 days.

In addition to the personal hardship inflicted on FMGs, such a deportation will adversely affect the health care services available to the American people. A massive deportation of FMGs would remove thousands of practicing physicians from rendering valuable medical services in community hospitals.

HEW figures show that in 1971 one out of five licensed physicians and one out of three hospital-based physicians was an FMG. Despite the high percentage of FMGs providing health care services for the US, the need for more housestaff in American hospitals remains especially great. Each year, as many as 10,000 slots remain vacant. If the 70,000 FMGs in the US cannot fill the gaps in the American health care system, their deportation will just exacerbate the shortage of trained physicians.

Who Are the FMGs?

FMGs are doctors who obtained their medical education and licensure in countries other than the US. The majority of them come from India, the Philippines, Korea, Taiwan and Thailand.

In recent years FMGs have entered the US in increasing numbers through the Exchange Visitors Program. (They are called Exchange Visitor Foreign Medical Graduates or EVFMGs.) The Exchange Visitor Program (EVP) was created in 1948 under the US Information and Educational Exchange Act. It “sought to provide an opportunity to students from different countries to get together and learn from each other’s culture and provide high quality education to people from developing countries.”

The benevolence contained in its aims is commendable until we consider the political and economic conditions prevailing in the US in the 1950s, the period of the Cold War. The US wished to gain favorable international public opinion and to develop political allies. In the same period, the US suffered from a serious lack of medical manpower which motivated hospital administrators to begin recruitment of FMGs to fill this shortage.

The Inequities of the EVP

The EVP has never functioned according to its originally stated goals. First of all, the “exchange flow” has been grossly one way—with more participants entering the US each year than Americans going to other countries. An av-
erage of approximately 4,700 EVFMGs enter the US each year, while only 2,500 US citizens obtain grants to study abroad. It is often argued that this one-way flow still benefits developing nations by educating some of their citizens in advanced medical techniques which they can apply when they return. This is where the EVP’s real aims are unmasked.

FMGs who came to obtain more advanced medical training all too often ended up in the slums of America’s health care system—working with limited licenses in state penal and mental institutions, nonaffiliated hospitals (those without any full-time teaching staff) and congested municipal hospitals in depressed inner-city areas, where training is nonexistent. They conveniently fill those vacancies which American doctors generally do not desire. Working as many as 110 hours per week, FMGs perform scutwork while receiving salaries lower than their American counterparts in affiliated and high-ranking hospitals. Thus, the EVP is not a training program. It is a service program providing low-skilled and routine patient care, a fact reflected in the general dissatisfaction expressed by the FMGs with their educational experience. A study by J. Haberstam in the June, 1971 Journal of Medical Education reported that only 10 percent of the FMGs questioned were satisfied with the EVP.

The Foreign Residence Requirement

Between 1956 and 1970, US immigration law required a two-year absence from the US if FMGs wanted to change their J-1 temporary visa (granted under the EVP) to permanent residence status. After 1970, though, this requirement was relaxed in most cases and the FMGs were usually allowed to begin the adjustment process without leaving the country. Then a long and complex series of maneuvers by the Immigration and Naturalization Service (INS) and State Department ensued. The first action came in 1972 when FMGs from countries with critical shortages in health manpower were told they must return home for two years before applying for permanent status in the US. But this policy was not fully implemented, and the INS allowed exceptions for countries like the Philippines. Then in April, 1975, the State Department announced a new ruling which halted the practice of granting waivers. This reversal of policy means that FMGs who are on temporary visas, such as the J-1 visa, face deportation if they cannot obtain alien status within 60 days of the ruling’s effective date, January 1, 1976.

Implications and Consequences of the State Department Ruling

The State Department ruling is unfair and discriminatory to FMGs in two major respects: First, the ruling’s effect is retroactive. FMGs, applying to the EVP in their home country, may very well have agreed to comply fully with the two-year foreign residence requirements should they desire to obtain permanent residence in the US. Many FMGs, however, learned through official channels when they arrived that it was possible to obtain waivers from the INS and/or State Department and to remain in the US while awaiting their alien number. With this understanding, they filed an application in the full belief that no legal violation was being committed. Now, over 800 Filipino physicians, one of the largest FMG groups, who applied for permanent residence under the waiver policy as far back as July 31, 1972, are affected by the new ruling.

Second, the ruling, by stipulating the 60-day time limit, discriminates against nationalities with a protracted waiting period. Under the quota system, nations are given a limited number of applications per year for alien status. FMGs from countries with a large number of applications and relatively few openings will have a waiting time longer than the two-year home residency requirement stipulated by the EVP. At present, Filipinos who applied as far back as 1970 are still awaiting their alien numbers and are included with those who are threatened by the State Department ruling.

What we face now are the complications which have arisen out of the inconsistent practice of the INS, State Department and Educational Commission for FMGs in implementing the provisions of the immigration law. They waived or relaxed implementation of certain sections when they needed the FMGs; they have decided to implement it strictly when they felt that the US did not need them.

The Interests of the FMGs and the American Public Are One

FMGs perform valuable services, especially in those areas where doctors are in short supply and also in general or primary care specialties. An HEW
study titled "Foreign Medical Graduates and Physician Manpower in the United States" documented (page 11) that "In 1972, for example, over 70% of the residency positions in non-affiliated hospitals in general practice, pathology, neurology and anesthesiology were filled by foreign-trained physicians; at least 60% of the residents in non-affiliated hospitals in obstetrics and gynecology, general surgery, pediatrics, and internal medicine were FMGs. In every case, the proportion of foreign medical graduates in these specialties was much lower in university-affiliated programs."

The East Coast, in particular New York City, will suffer most with a reduction of FMG staff. The HEW report continues (page 37): "Of the 14,440 residency positions filled in 1972 by FMGs, 5,835 (40%) were in the States of New York (26.8%) followed by New Jersey, and Pennsylvania. New York leads all other States in numbers of foreign-trained residents as it does in the number of foreign-trained physicians as a whole. Among other 'high' States on percentage of FMGs in filled residency positions were Delaware, Rhode Island, Illinois, and West Virginia. In these States, hospitals are substantially dependent on foreign medical graduates."

In all fairness to the interests of the American public, the presence of FMGs in the medical system in the US must cease to be presented as negative. The functions and services heretofore rendered by FMGs should instead be recognized and accorded the credit they deserve. After serving the medical needs of the American public, FMGs do not deserve to be treated as objects which one simply discards when they no longer serve a purpose.

**Last Ace in the Game**

The underlying and subtle tones of racial and national discrimination can be felt when we consider that most FMGs come from Third World nations, most of them being Asians (Indians, Filipinos, Koreans). Moreover, this move may be the "last ace" in a concerted and many-faceted effort by the elite and white-dominated American medicine to bar FMGs from full integration in the medical profession in the US. It would, in fact, take another complete study to repudiate the string of discriminatory attacks lashed out on FMGs around their "incompetence," "inability to communicate and relate to American patients," etc.

One cannot help but remember past incidents resembling the present FMG issue. In the industrial unrest and populist opposition to the growth of monopolies in the 1880s and 1890s, Chinese—no longer needed after their labor in building the transcontinental railroad — were targeted as threats to the livelihood of the American people. In the 1900s, this role was assigned to Italians and to Eastern European Jews. Arbitrary immigration rulings were similarly enacted to legalize their speedy deportation.

The EVP has also served as a source of a huge rip-off, not only of manpower but also of money invested in education and training that manpower. The estimated cost of educating and training a physician in the US today is $100,000 or more. The US, by enlisting the FMGs into its hospitals, saves $800 million for every 10,000 licensed foreign physicians.

More important than these savings, however, is the fact that the EVP has also served to forestall the resolution of a long-standing problem involving the medical needs of the American people and the interests of the profit-motivated medical industry. In their desire to maintain medicine as a closed shop, the medical profession has enforced highly restrictive admission policies so as not to "overcrowd" the profession. Hence, the US is continually faced with a physician shortage. To forestall the basic rectification of this problem (i.e., by educating and training more Americans to become physicians), FMGs are instead recruited on a temporary basis (under the guise of training) to answer the patient care needs of America. Out of the 150,000 physicians added to the US health labor force from 1962 to 1971, only a little over half were US graduates. The rest were FMGs.

**Broader Representation in EVP Policy-Making**

In this connection, a national body must be formed with the task of formulating all policies relating to the EVP. It must:

- Be composed of not only representatives of American medical organizations but also representatives of FMG associations and community persons representing the public;
- Monitor and evaluate the educational quality of the training provided by the program;
- Also ensure that exchange visitors who return to their countries of origin will be able to fully utilize their potential. This would mean making regular and thorough evaluations of what particular fields of medicine are most needed in other countries. This would as-
sure that the EVP would truly be relevant and beneficial to the critical medical needs of the participating underdeveloped nations.

- This body must also contain the proper mechanisms for FMGs to air their grievances and to have access to due process procedures whenever necessary.

Legal Status for All EVFMGs

In light of the above, the Emergency Defense Committee for the FMGs believes that FMGs, having provided valuable service to the American public, must be recognized for their actual functions and contributions. Because they have worked as any other US resident, FMGs now deserve to be legally recognized as such.

All EVFMGs who applied for permanent residence between 1970 and 1975 must be allowed to remain in the US while awaiting their alien numbers. None of them should be arbitrarily asked to leave and none of them should remain under such a threat.

For more information on the plight of FMGs, write to EDC-FMG, 204 E. 25th Street, Apt. 2B, New York, N.Y. 10010 or call (212) 889-2705.

—The Emergency Defense Committee for the FMGs.

"CON GAME" COMMENDED

Dear Health/PAC:

I finally cleared enough time to read "The Mental Health Con Game," published in the July/August 1975 issue of Health/PAC BULLETIN. I think it is probably the most informative, concise, and sophisticated analysis of the New York Department of Mental Hygiene that I have seen.

I could quibble with a few small points. For example, at page 2 you note a 58% decline in state hospital population in New York State compared with a 56% decline nationwide since 1955. That may well be accurate, but it suggests that New York State is continuing to depopulate its state hospitals somewhat faster than the nationwide average. In fact, in the last few years, New York State has lagged behind the national average in the rate of depopulation. Other small criticisms could be made, but they would only be small objections to what is a genuinely excellent article.

—Bruce J. Ennis
Staff Counsel
New York Civil Liberties Union

FRIENDSHIPMENT

Friendshipment, a broad national coalition seeks the support of interested people and groups in its program of reconciliation and reconstruction in Vietnam. In particular, Friendshipment is engaged in fund-raising campaigns to meet two requests from the Vietnamese government:

- VD Treatment: The Vietnamese are seeking aid in ridding the country of a particularly virulent form of venereal disease left as a legacy of the war. Requested are funds to send large quantities of detection kits, laboratory equipment and penicillin.

- Steel tubing, which will be used in the production of desks for reconstruction of the educational system and for the manufacture of wheelchairs for thousands of severely injured war victims. Steel tubing is inexpensive and its use provides jobs as well as the needed products.

In addition, Friendshipment offers films, books and other educational materials on life in Vietnam and seeks to build support for reconstruction aid promised by the US in the Paris agreements as a condition for ending the war.

Finally, Friendshipment is organizing observances of the first anniversary of the war to take place April 30 in cities and on campuses across the country. For more information on Friendshipment, and its program, nationally and locally, contact:

Friendshipment, People to People Aid to Vietnam
235 East 49th Street
New York, New York 10017
or call: (212) 486-0580

Contributions are tax deductible.
We mourn the death of Harry Becker, December 23, 1975. Harry was a friend of Health/PAC from its inception. His wealth of experience in the health system, his wisdom and insights were reflected in much of Health/PAC's past work and will be missed in the future.

MEDICARE DEDUCTIBLE RISES

Medicare, which now covers only 38 percent of health-care costs of the elderly, will soon cover even less. The Social Security Administration announced in November that the inpatient deductible—the amount Medicare patients must pay for the first 60 days of hospitalization—would jump January 1 from $92 to $104, a 13.1 percent increase. The deductible is equal to the average cost of one day of hospitalization. Also increasing is the amount patients must pay for hospitalization exceeding 60 days and for stays in skilled nursing facilities exceeding 20 days.

(Health Lawyers News Report, November 1975; American Medical News, October 6, 1975.)

MAKING HOME CARE SAFE FOR PROFITS

HEW is changing its regulations to open the provision of home health services under Medicaid to private, profit-making companies—a move which critics charge will invite the same abuses which have plagued nursing homes.

In the past Medicaid, like Medicare, allowed participation of profit-making companies providing home health care only if they were licensed. Since only 11 states have licensing laws, however, this has meant the virtual exclusion of such companies. The new rules allow participation by proprietary companies if they meet federal standards unless states specifically act to exclude them. While HEW admits being unable to enforce standards, it justifies the measure in terms of increasing accessibility to home health services.
Critics, which include among others groups representing the elderly and the professional staff of HEW (not the policymakers) argue otherwise. "Expanding these services to the proprietary agencies... without the requisite enforcement, which the department says it doesn't have, will be opening it up to the abuses we have in nursing homes," says Lawrence Lane of the American Association of Retired Persons. Others argue that the risks are much greater at home, where the individual is isolated and unable to protect himself, than is the case in nursing homes, which come under at least minimal review.

(New York Times, November 28, 1975.)

PRISON GUINEA PIGS

About 85 percent of all initial testing of prescription drugs on human subjects is done on prisoners, the president of the Pharmaceutical Manufacturers Association (PMA) testified recently. This testimony surprised the group to which it was presented—the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, established by Congress to investigate and chart policy on human experimentation. The PMA president characterized as low the finding of a Commission survey that biomedical research on prisoners was being done in only seven state and federal prison systems. The Commission did not even survey county and municipal jails, it said, due to lack of time and money. The issue being argued before the Commission is whether truly voluntary informed consent is possible in a coercive environment such as a prison. Most experiments are conducted in the most coercive of penal institutions—medium and maximum security prisons. The Commission recommendations will go to HEW, which funds most biomedical research.

(New York Times, January 10, 1976.)

VALIDATION: SUSPENDING THE EMBARRASSMENT

The Social Security Administration has halted its controversial efforts to validate findings of surveys conducted by the Joint Commission on Accreditation of Hospitals (JCAH), which are accepted by the SSA as qualifying a hospital to receive Medicare. Of the first 101 hospitals surveyed by the SSA, 65 flunked, embarrassing the JCAH and the SSA and angering the hospital establishment. Violations occurred mainly in fire and safety standards. The validation surveys were ordered by 1972 legislation and will be suspended at least until the Senate Finance Committee responds to a report on the first surveys. (See BULLETIN, July/August, 1975, page 31.)

(Hospital Week, October 31, 1975; Washington Developments, November 7, 1975.)

Rx FOR A SORE THROAT?

Sore Throat continues to plague the American Medical Association (AMA) despite vigorous attempts to root him out. Jestfully named after Deep Throat of Watergate fame, Sore Throat continues to leak purloined AMA documents to the press, the Administration and various congressional committees, bringing the AMA trouble and embarrassment on many fronts. (See BULLETIN, July/August, 1975, page 30.) The AMA has attempted to involve the FBI and the Chicago police in an effort to identify the person, has put officers and staff through lie detector tests and most recently has unofficially spread the rumor that Sore Throat is, in fact, the Church of Scientology, whose views on health and disease are at odds with those of the medical profession. Sore Throat has caused sufficient embarrassment for the AMA to issue a "white paper" refuting the implications of leaked documents.


BLACK EYE FOR SSA?

The General Accounting Office (GAO) dealt a black eye to the Social Security Administration (SSA) and to advocates of public administration of national health insurance when it found the cost of administering Medicare by SSA to be considerably higher than costs of administration by either Blue Cross or commercial insurance companies. The audit, conducted in 1973, found the cost of processing a claim was $12.39 for the SSA, $7.31 for Travelers Insurance Company, $7.28 for Mutual of Omaha, $3.81 for Blue Cross of Chicago and $3.55 for Blue Cross of Maryland.

GAO charged that costs are higher for SSA because of the high pay and low productivity of government workers. SSA countercharged that the GAO study was done when it was in the midst of switching from manual to computerized claims processing and that cost has subsequently dropped to $4.11 a claim. Both parties agree that 19
the reason costs to Blue Cross are so low is that it handles the least complicated claims.
(Washington Post, October 28, 1975 and November 12, 1975; Washington Developments, October 24, 1975.)

UNTying THE BIND

The chairmen of obstetrics and gynecology of New York City’s six medical schools and two unidentified women patients have brought suit against federal, state and local sterilization guidelines for women in municipal hospitals or receiving Medicaid. (See BULLETIN, January/February, 1975 and July/August, 1975 concerning New York City sterilization guidelines.)

The challenged guidelines bar sterilization for women under 21 and for those who are mentally incompetent; require a 30-day wait for voluntary sterilization and prohibit eliciting patient consent during hospitalization for childbirth, abortion or other procedure. The guidelines have been pronounced by civil rights and feminist groups concerned about women, particularly poor black women, being coerced into sterilization.

The suit charges that guidelines violate the rights of women who want sterilization and are unconstitutional because they apply only to women who cannot pay to have the procedure done privately. The physician plaintiffs also assert “injuries to their First, Fifth and Fourteenth Amendment rights to privacy, liberty and property.”
(New York Times, January 11, 1976.)

SPEAKING OF STERILIZATION...

What is likely to be the first compulsory sterilization law in the world is presently being drawn up by the State of Punjab in India, and is slated for passage early this year. The law would require sterilization after a couple had a specified number of children, probably two or three, although details such as which partner would be sterilized are still being worked out. The measure is certain to be a controversial one, and the government of Prime Minister Indira Gandhi, which has promised its own “strong steps [on family planning] which may not be liked by all,” is keeping a close eye on the experiment.
(New York Times, January 2, 1976.)

CATCH-22 CUTBACKS

The November, 1975 Health Law Newsletter reports on some of the more innovative approaches states have taken to cutting back their Medicaid programs. Last September the Alabama authorities decided not to mail out Medicaid cards because the state legislature had not yet adopted a state budget appropriating Medicaid funds. Without cards, Medicaid recipients could not obtain services and the state would thus not have to pay for them. After threat of a suit the cards were mailed out, but each bore the stamped notation “Subject to Availability of Funds,” warning doctors that they might not be paid for services to Medicaid patients. The legislature subsequently adopted the budget and appropriated the funds, but meanwhile no other program in the budget suffered from these back-handed cutbacks.

Likewise in early summer Florida imposed a regulation requiring that Medicaid prescriptions exceeding $20 a month have prior authorization. It failed, however, to set up an authorization mechanism, making prior authorization impossible. The issue is now in the courts.

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