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**Family Practice**

Long before Marcus Welby became number one in the TV ratings his forebear—an older and different mythical American doctor—dominated public perception. Tuned into a family's needs and available at any hour, he arrived by horse and buggy to remove an appendix by lantern light on the kitchen table. Wise, affectionate, self-sacrificing, he combined compassion with broad medical skills. He knew his patients and their families well.
This image of doctors has lingered well into the Twentieth Century in spite of the growing inability of organized medicine to deliver appropriately trained, sufficiently sensitive practitioners. In fact, almost as directly as people's capacity to purchase medical services grew, the number of doctors practicing such general medicine declined. Between 1931 and 1967 the number of doctors in general practice fell from 112,116 to 68,920.1

With the distance between image and reality increasing yearly, organized medicine by mid-century was under growing pressure to resurrect in modern dress the general practitioner (GP) of horse and buggy days. So it was that in 1969, after more than two decades of debate and discussion, the AMA—outspoken advocate of solo practice, fee-for-service, small town practitioners—added family practice to its growing list of approved medical specialties.

Why Did the GP Disappear?

Family practice was intended to assume the near-empty mantle of general practice. The GP had been an endangered species since the period following publication of the Flexner report in 1910, when the combined resources of the Carnegie and Rockefeller foundations led to exclusive support of medical schools which emphasized clinical research and basic sciences. As new laboratory tests, diagnostic screening procedures and complicated treatments burgeoned, medical care became more technological and the hospital became its locus.

To compete with the myth of the kindly GP, there emerged a new popular ideology which equated specialization and high technology medicine—"the newest and the shiniest"—with the best. Specialties proliferated. By the early 1960s, in fact, the number of specialties recognized by the AMA Council on Medical Education had grown to 20.

Within medical schools specialists systematically displaced generalists as teachers. The pressure to specialize was enormous. Status and salary were superior. The GP worked longer hours for less pay than his specialist colleagues, although both often dealt with identical problems. In 1970 the GP averaged $33,859 and saw 139.0 patients weekly while an internist earned $40,251 and saw 85.5 patients.2 The federal government encouraged this trend. By heavily financing research programs, the government paid indirectly for the post-graduate training of specialists. Even the Army and Navy, beginning during World War II, afforded greater rank, prestige and pay to the specialists.

Without role models and encouragement to do otherwise, most medical students elected specialized post-graduate training. The nitty-gritty common problems with which patients generally came to doctors were often seen as trivial and uninteresting. Instead, a physician's education stressed pathophysiology and elaborate investigation. The most stimulating discussions focused on "fascinomas" and the unusual.

(Continued on Page 25)
**SELF HELP FOR HOSPITALS**

Major interest groups within the health system have organized a voluntary cost-cutting campaign in the hope of pre-empting a public program such as the Administration's nine percent cap on increasing hospital costs. (See BULLETIN, March-April, 1977). The effort is spearheaded by the American Medical Association, the American Hospital Association, and the Federation of American Hospitals (representing proprietaries). Other participants include the Health Insurance Association, the Health Industry Manufacturers Association, the Hospital Corporation of America, General Electric Corporation, the Blue Cross Association and the US Chamber of Commerce. The group has agreed upon the goal of cutting the increase in hospital costs by two percent each year. (Hospital rates rose by 13.7 percent last year.)

The move came in response to a challenge by Rep. Dan Rostenkowski (D.-Ill.), chairman of the House Ways and Means Health Subcommittee, where cost control legislation has been stalled by powerful opposition. In accepting the challenge, however, the hospital sector may have put itself in a difficult situation. No sooner had it taken the bait, then Rep. Rostenkowski turned around and proposed a system of standby controls to go into effect automatically should the private effort fail.


**AND THEN THERE WERE NINE**

How very embarrassing! Back when the Carter Administration introduced its nine percent cost cap proposal for hospitals (see BULLETIN, March-April, 1977), HEW Secretary Joseph Califano, in an effort to demonstrate the reasonableness of the measure, claimed that 20 percent of US hospitals already met the cap, the most notable among which was Johns Hopkins. When the Senate Finance Health Subcommittee asked for specifics, however, HEW could only show 189 hospitals whose cost increases were less than nine percent—a puny three percent of all acute care hospitals in the country. Notably missing from the list was Johns Hopkins.


**PFFFFT FOR PSROS . . .**

It seems like the feds are losing patience with some of those clumsy dinosaurs they have created to do battle with health care costs. Following an HEW study showing that PSROs had been ineffective in cutting costs, the Office of Management and Budget scrapped the program entirely in the proposed 1979 federal budget and recommended legislation terminating the program. Following the expected flap, HEW Secretary Joseph Califano had the proposal rescinded until 1980, giving the program another year to show it can produce results. PSROs are back in the budget at $175 million—a 20 percent increase over the current budget.

BLUE CROSS: CHALLENGING THE PLANNERS

In an unusual conflict, Blue Cross of Virginia recently locked horns with state planning agencies over the approval of two hospital expansion projects—and lost. Blue Cross sued to block construction of an $8.9 million, 120-bed replacement for Mary Immaculate Hospital in Newport News and the $6.3 million expansion of the Chesapeake General Hospital in Chesapeake. Blue Cross argued that the projects were unnecessary and would result in higher hospital and insurance costs. Blue Cross lost, however, when the court ruled, first, that it had no jurisdiction since the state certificate of need laws never intended there to be appeal from decisions made by the State Board of Health; furthermore, it ruled that Blue Cross was not an aggrieved party and therefore did not have the status to sue.

Source: Hospitals, January 16, 1978

COST CONTROLLERS FEUD

Bureaucratic turf seems to have won out over cost savings in a somewhat puzzling spat between HEW’s PSRO program and New York State’s Medicaid Utilization Review program. Both programs were designed to monitor the utilization and appropriateness of hospital care provided through Medicare and Medicaid monies. The New York State program has a reputation for toughness and state budget watche are proud of its record—over $50 million saved in its first year, they claim. PSROs, many just getting under way, have a tawdry record. Most frequently they are run by local medical societies, who often delegate the monitoring to the hospitals themselves. Despite federal displeasure with the program and a study documenting their ineffectiveness, HEW officials threatened to withhold Medicaid monies unless New York bowed to PSRO authority. And bow it did, except for one upstate county and four New York City boroughs, where the two parties agreed to conduct a demonstration to compare the effectiveness of the two programs.

To New York, the stakes are high: it spends $15 billion a year on health care—40 percent more per capita than the national average. The New York State Medicaid program accounts for 25 percent of all Medicaid outlays.


MAKING PSROS PUBLIC

As if besieged PSROs didn’t have enough problems, Ralph Nader’s Health Research Group (HRG) is suing to make public the valuable data they collect on hospital utilization and quality of care. Specifically HRG is asking that PSROs be declared agencies of the federal government, thus bringing them under the Freedom of Information Act. HRG wants access to length of stay and admission rates, certification by hospital and physician for certain medical procedures, physician and hospital profiles for those with the largest number of Medicaid and Medicare admissions, and PSRO medical care evaluation studies.

When the HRG first requested this information from HEW, the agency claimed it didn’t have the data; when Nader’s group requested it of PSROs, they claimed they were private organizations and thus not subject to the Freedom of Information Act. HRG wants to broaden this provision by asking for all Medicaid and Medicare recipients.


DOUBLE DIGIT INFLATION NOT PEANUTS

Carter’s FY 1979 health budget, released this past January, though it is 14 percent higher than last year’s, contains little new. The only new program is a Califano favorite, $100 million requested to provide unspecified services to prevent unwanted teenage pregnancies. Meanwhile, HEW is starting a three-year phase-out of capitation grants to health professions schools and is replacing them with scholarships carrying commitments to work in areas of special need.

Most of the additional expenditures are, of course, the result of the expected inflation in medical costs. These are forecast to continue rising at a rate of 16 percent per year (in the case of Medicare payments), in spite of the Administration’s assumption that its cost containment bill will pass this year—a most unlikely prospect.
FTC: MARCHING BACKWARDS

Finally, if you thought a planned and regulated health sector was the name of the federal game, you'll be glad to hear there are those elements in government working to restore the dynamics of the private market. To wit, the Federal Trade Commission, after having investigated a number of professional associations, now seems to be turning its eye on government regulatory programs. The FTC will be investigating state certificate-of-need laws if they entrench certain existing health care institutions (we're glad someone noticed) and PSROs to see if they unduly restrain trade and inhibit competition.

THE ACCOUNTING BASICS

"One of the most significant developments affecting health care facilities since the inception of Medicare in 1966," is how one authority puts it. "It" is the uniform reporting of comparable financial and statistical data required of hospitals as a result of the Medicare and Medicaid Act of 1977. A manual outlining the proposed procedures is due to go into effect in 1980, will be published shortly in the Federal Register, and the program will be pioneered in New York where the State had a very similar plan of its own on the boards. "It's a real sleeper... It doesn't require much thought to predict that eventually it will be tied to some form of reimbursement, possibly within the framework of national health insurance," comments Richard W. Bowman of Peat, Marwick, Mitchell and Company, the firm that will supervise the New York experiment.


IN SEARCH OF THE PRIVATE MARKET

Latest to join the hunt for the private market is the National Chamber of Commerce. Its subsidiary, the National Chamber Foundation, is seeking massive funding for a research study aimed at "preserving private market elements in health systems delivery and development."

Principal contractor on the study will be HMO-mogul Paul Ellwood. To date the study is being heavily funded by health care insurers, including Blue Cross, Blue Shield and the commercial companies. The Chamber claims wide support of the study, including that of labor. The only labor representative on the project, however, is Martin Danziger, famed for his recent role in the demise of the UMW pension and health fund. (See BULLETIN, November-December 1977).


C + FOR HOSPITALS

Forty percent of the hospitals surveyed last year by the JCAH received a probationary one-year accreditation, reported the Washington Post recently, much to everyone's embarrassment. The reason, the JCAH is quick to explain, is that it has instituted more stringent life safety and fire codes and medical auditing requirements. This occurred in response to the previous embarrassment in which it was found sadly wanting on these counts by HEW for whom it conducts qualifying surveys for hospitals receiving Medicare and Medicaid money. (See BULLETIN Sept.-Oct. 1976.)


JOINT COMMISSION ON ACCREDITATION OF HOSPITALS?

Despite its somewhat be-smirched reputation the private Joint Commission for the Accreditation of Hospitals continues to accruze unto itself more and more public responsibilities. New York State is expected to join a growing list of states which accept JCAH accreditation of a hospital in place of state hospital licensure. The State has conducted experimental co-surveys with the JCAH over the last several months and a final and favorable decision is expected in April. Texas and Iowa already accept JCAH accreditation in place of state licensure; experimental co-surveys for this purpose have taken place in Wisconsin and are under way in California; they are being considered also in Illinois and Maryland.


LOBBY FOR SPENDING

Concerned about the growing trend toward limiting hospital capital expenditures, those with an interest in doing otherwise—hospitals themselves, suppliers, construction and banking interests, among others—have begun to organize their own lobby. Calling itself the National Committee on Hospital Capital Expenditures, the group is immediately concerned about two issues: the $2.5 billion national ceiling placed on hospital capital expenditures by Title II of the Administration's proposed hospital cost control bill and the quantitative parameters set by the national health planning guidelines.

MEDICAL SCHOOLS CREAM MANPOWER ACT

The medical empires, once more flexing their political muscle, have forced a compromise in the 1976 Health Manpower Act. The original law required that US medical schools accept virtually all qualified, foreign-trained US medical students into third year classes. The penalty was to have been loss of the $1,500-per-student capitation grants medical schools receive from HEW as well as exclusion of a school’s students from the federally-insured loan program.

Medical schools sent up a hue and cry, invoking images of Big Brother spelling an end to academic freedom and the autonomy of their admissions process. Before the compromise was reached, 14 schools had announced their refusal to comply with the original law, thus sacrificing between $458,000 and $1.9 million each in capitation funds; another 35 were considering noncompliance.

The compromise amendment provides for a small, one-time expansion of the third year class only, in contrast to the three-year expansion provided for in the original bill. Schools many accept transfers from US two-year programs, and special MD-PhD transfer students as well as foreign-trained students, for the expansion, thus calling on a pool of some 1,600 to 1,900 students, instead of the original 800 eligible foreign-trained students. Finally, the new penalty will involve the cutoff of capitation monies only.

The medical schools, which were prepared to sue, have now taken a conciliatory stance, and virtually all are expected to participate. The battle has not been without its cost, however. Rep. Paul Rogers (D-Fla), sponsor of the original measure, is questioning how badly HEW capitation payments are needed, since schools seemed so able and ready to forego them. He has proposed a repeal of capitation payments effective in 1979 and plans to hold hearings on the issue in the spring.


Medical Efficacy: A Brief Review

The US spends an enormous amount on curative procedures, the efficacy of which has only been assumed. A closer look at two of these—coronary artery bypass surgery and the use of coronary care units—demonstrates the dynamics of the prevailing technological imperative and its curious disregard for cost, efficacy or prevention.

Almost $1 billion a year is spent on coronary artery bypass operations. In a bypass operation one or more coronary arteries which have become clogged by atherosclerosis are replaced with vessels from other parts of the body in order to improve the supply of blood to the heart. How effective is this very costly surgery? Coronary bypass operations were initially recommended for the relief of pain in cases of incapacitating angina, and they have been judged effective in this regard. It is not clear to what extent this effect is due to the placebo effect of surgery, however, since it has been shown that sham surgery can reduce the pain and symptoms of angina. Furthermore, one study of bypass operations has found that patients whose replacement blood vessels had become blocked experienced approximately the same degree of symptom relief as those whose replacement blood vessels remained open.

In recent years, the coronary bypass operation has been performed on many patients who do not have severe angina in the belief that the operation increased survival. A recent study indicates that, for most patients, the bypass operation does not significantly prolong survival. Only for the 13 percent of patients who had significant atherosclerosis in the left main coronary artery did coronary bypass surgery clearly increase survival. Among the other patients, 87 percent of those who received only medical therapy survived for three years, compared to 88 percent of those who received surgery combined with some medical therapy. These findings have been disputed on the grounds that the surgery in current use at the best centers is superior to the surgery done at the time the trial began; however, allowing for improved survival in the period immediately following surgery does not appear to affect significantly the basic conclusion—that overall survival is not substantially improved by coronary bypass surgery. A new controlled trial is currently in progress. Meanwhile, the US continues to spend more money on this curative procedure of limited efficacy than on the prevention of atherosclerosis.

Coronary care units, like coronary bypass operations, are enormously expensive and much less effective than they are widely thought to be. It has been estimated that coronary care units
use one-tenth of all trained nurses in the US. Nevertheless, coronary care units are apparently no better than home care for approximately half of patients who have a heart attack, namely those whose heart attack occurs at home and who lack certain specific danger symptoms. A random, controlled trial comparing care at home with care in coronary care units in Britain found no significant difference in survival. Apparently the benefits of intensive medical care are offset by the stresses associated with admission to the hospital and with the coronary care unit itself.

These results are not isolated, exceptional cases. Recent controlled trials of 47 innovations in surgery and anesthesia revealed that slightly less than half provided improvements over existing procedures, while nearly half actually proved worse than existing procedures. Physicians, like everyone else, are fallible and tend to remember the best outcomes of their efforts. Their training inclines them to credit their procedures rather than to consider their placebo effect with improvements. In consequence, uncontrolled trials of a medical technique generally yield much more positive evaluations than random, controlled trials. For 53 researchers testing the same procedure (postcaval shunt), those who carried out uncontrolled trials expressed marked enthusiasm in almost every case.

As a result, several conclusions must be considered:

- The placebo effect has powerful curative potential and should be mobilized by less risky procedures than surgery.
- Random controlled trials are essential to assess the technical efficacy of any medical procedure.
- Currently the US invests enormous amounts in curative procedures of limited efficacy, reflecting the financial and prestige incentives of the current medical care system. Increased emphasis on preventive medicine, e.g., reductions in environmental carcinogens, cigarette smoking, and the Coronary-prone Behavior Pattern, could be more effective in improving health. However, effective measures of this type fly in the face of technological and profit imperatives and will therefore be possible only if the determined political resistance of those whose interests are threatened can be overcome.

—Ingrid Waldron

REFERENCES

company suggested by Flood.

Last spring, however, the package began to come untied as details came to light. Shober was forced to resign, but not before generously padding his own nest as the college’s first president emeritus. Then Marston began to investigate and the affair achieved headline status when at Rep. Elberg’s urging, President Carter fired the Republican U.S. Attorney. In Philadelphia, they’re beginning to call it “Phillygate,” reports American Medical News.


The administration at Evergreen has also played on the professional conscience of its nurses. Work seven days in a row, ten hours a day, they say, and your patients will get more thorough continuity of care. The chief of the medical staff even argued that the 7-70 plan would reduce the mortality rate of heart patients. “One of the greatest obstacles to the patient’s recovery is the trauma of continually having to adapt to different nurses!”

The 7-70 Plan is the most extreme of several time schemes being bandied about. The common denominator, however, is an extension of the workday to ten or twelve hours with the inducement of extra days off.

Nurses must somehow make themselves felt in staffing decisions. They deliver the direct patient care and are in the best position to know what is needed for good, safe nursing care. The extended day is just an attempt to make the best of a bad situation.

Working ten or twelve hours a day can be harmful to the health of the worker, and detrimental to alert patient care. Winning the eight hour day was a tremendous victory for the working class. It should not be given up so easily.

— Glenn Jenkins

WHEN IS A UNION NOT A UNION?

In 1974 nurses, together with other hospital workers, were granted the right to collective bargaining under the National Labor Relations Act. The Act, however, bans supervisors from membership in a union, and this provision poses a serious obstacle to the unionization of nurses and a thorough-going crisis for the American Nurses’ Association and its state affiliates.

The American Nurses’ Association (ANA) through its local affiliates, the state nurses’ associations (SNAs), is the largest representative of organized nurses. One out of eight working nurses—over 100,000—are represented by the SNAs. Its legitimacy in representing nurses is currently under a serious legal challenge.

The crux of the problem is twofold: the ANA and its constituent bodies must admit any nurse, regardless of position, to membership; and, the extreme hierarchical arrangement of hospital nursing is ideally suited to blurring the distinctions between job categories—to making it difficult to define who supervises whom.

The most important test case thus far has been Anne Arundel Hospital in Annapolis, Md. In early 1975 the Maryland Nurses’ Association (MNA) filed for recognition as the bargaining agent for the nurses at Anne Arundel. The hospital countered by charging that the MNA is dominated by the upper strata in nursing—the supervisors and educators. They are deathly afraid of the dismemberment that the Anne Arundel situation forebodes.

The NLRB defined supervisors as anyone with the power to hire, fire, or discipline, and, most importantly in this case, to organize or direct the work of fellow workers. Hospital nursing is set up so that almost anyone can tell someone what to do. Such humble workers as LPNs have been excluded from bargaining units because they at times provide direction to nurses’ aides.

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The collective bargaining arm of the ANA, the Economic and General Welfare Commission, set up a “Blue Ribbon” committee to address the crisis. The committee rejected proposals to form separate supervisor units within the ANA, endorsed a ban on supervisors serving on E&GW bodies, and strongly supported the right of supervisors to take part in all other association activities.

For their part, the hospitals have plenty of tricks up their sleeves. A favorite tactic has been to “promote” a large segment of the nurses, including union activists, to formally-defined supervisory positions. These nurses then lose all NLRB protection, and are open to victimization.

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The solution is not that simple, however. The ANA is, in fact, dominated by the upper strata in nursing—the supervisors and educators. They are deathly afraid of the dismemberment that the Anne Arundel situation forebodes.

There is a time bomb ticking within the ANA. Two separate and distinct interests are present. One is the leadership concerned with “professional” issues. The other is a growing number of rank-and-file nurses awakened to the political and economic tasks of nurses. Unless the crisis is resolved, local secession from the SNAs over trade union questions is a short step away.

— Glenn Jenkins


UNION TALLY

You win some, you lose some, was the official tally of union progress in the health field last year conducted by the Federal Mediation and Conciliation Service. The number of strikes by health workers decreased from 66 in 1976 to 59 in 1977; the number of representation elections increased, however, from 710 in 1976 to 746 in 1977 (a 5.1 percent increase) as did the number of workers voting (from 53,671 to 58,947). The number of union victories declined from 58.5 percent of all elections in 1976 to 54.7 in 1977.

Source: Modern Healthcare, February, 1978

(Continued on Page 38.)
More and more frequently the media asserts that it is individual lifestyles, and thus individual change, that must be the focus of efforts to promote and maintain the nation's health—rather than the expensive, technology-laden and often ineffective medical system.

"Living a long life is essentially a do-it-yourself proposition," one commentator puts it. While based on the irrefutable and increasingly obvious fact that modern medicine has been oversold, these assertions avert discussion from social or environmental factors and instead locate the problem of poor health and its solution in the individual. Further, individuals, it is argued, should expect less of medicine and demand less medical care. Instead of seeking rights and entitlements to secure access to services, they should pay more attention to the heart of the problem of health and illness: their own misbehavior. The effect is to blame the victim who suffers from poor health. Such assertions are rapidly becoming a premise of public policy. How and why this is happening and what purposes are served by it are the subject of the following article.

**The Rise of a Victim-Blaming Ideology**

The flavor of this developing ideology in health care is evident in the comments of some of its more explicit proponents. As do many advocates of individual responsibility, Walter McNerney, president of the Blue Cross Association, incorporates elements of both the Illichian and radical critiques of a technology-heavy, distorted and iatrogenic medicine:

"We must stop throwing an array of technological processes and systems at lifestyle problems and stop equating more health services with better health. People must have the capability and the will to take greater responsibility for their own health."

Dr. John Knowles, president of the Rockefeller Foundation and former director of Massachusetts General Hospital, tells us that the "primary critical choice" facing the individual is: "to change his personal bad habits or stop complaining. He can either remain the problem or become the solution to it; Beneficent Government cannot—indeed, should not—do it for him or to him."
Knowles speaks more directly to the problem of expectations. "The only thing we've heard about national health insurance from everybody is that it won't solve the problems. It will inflate expectations and demands and cause more frustrations." 4

Integral to the argument about individual responsibility is an attack upon health care as a right and even the breadth of individual rights. Again John Knowles offers a clear articulation: "The ideal of individual responsibility has been submerged in individual rights—rights or demands to be guaranteed by Big Brother and delivered by public and private institutions. The cost of sloth, gluttony, alcoholic intemperance, reckless driving, sexual frenzy and smoking have now become a national, not an individual, responsibility, and all justified as individual freedom. But one man's or woman's freedom in health is now another man's shackle in taxes and insurance premiums." 5

What Knowles means by "national responsibility" is in actuality "collective individual responsibility" reflected in public policy aimed at changing individual behavior—and using economic or other sanctions to do it.

Economic sanctions on individuals, including higher taxation on the consumption of cigarettes and alcohol, and higher insurance premiums to those engaging in at-risk behaviors, are becoming a popular theme. A guest editorial appeared last year in the New York Times, for example, introducing the idea of "Your Fault Insurance." The writer asked, "How should 215 million Americans be persuaded to take care of themselves?" His answer is "a reward/punishment system based on individual choices." 6

More extreme sanctions are proposed by Leon Kass: "All the proposals for National Health Insurance embrace, without qualification, the no-fault principle. They therefore choose to ignore, or to treat as irrelevant, the importance of personal responsibility for the state of one's own health. As a result, they pass up an opportunity to build both positive and negative inducements into the insurance payment plan, by measures such as refusing or reducing benefits for chronic respiratory disease care to persons who continue to smoke." 7 (Emphasis added)

Again, the attack on rights is explicit. Kass argues that "it no more makes sense to claim a right to health than a right to wisdom or courage," let alone "the already ambiguous and dubious right to health care." Or as Robert Morrison expresses, "Cardiovascular illness...increasingly places on society the obligations to spend thousands of dollars on medical care to rescue an individual from the results of a faulty living pattern...How can we go on talking about a right to health without some balancing talk about an individual's responsibility to keep healthy." 8 Morrison goes on to complain about a system "which taxes the virtuous to send the improvident to the hospital." The message is clear. Medical benefits do not need to be expanded. What is important is health and not medicine; and health is not a right. In lieu of rights and entitlements, education, economic sanctions, and "more studies of the American family and value system" are proposed. It is an old scenario.

Coopting Self-Help

The ideology of individual responsibility threatens to incorporate and use for its own purposes the self-help movement. Self-help initially developed as a political response to the oppressive nature of the American medical system—a system characterized by professional and male domination. As such, the movement embodies some of the best strands of grassroots, autonomous action, an attempt by people at some level to regain control over their lives, a response to the overmedicalization of American life.

"The cost of sloth, gluttony, alcoholic intemperance, reckless driving, sexual frenzy and smoking have now become a national, not an individual, responsibility, and all justified as individual freedom. But one man's or woman's freedom in health is now another man's shackle in taxes and insurance premiums."  
— Dr. John Knowles, President, Rockefeller Foundation

"It no more makes sense to claim a right to health than a right to wisdom or courage," let alone "the already ambiguous and dubious right to health care."  
— Leon Kass

"It no more makes sense to claim a right to health than a right to wisdom or courage," let alone "the already ambiguous and dubious right to health care."  
— Leon Kass
However, because the movement has focused on individual behavior without changing the social and economic environment, and because it has not built a movement which goes beyond self-care to assuring for everyone the medical and environmental prerequisites for maintaining health, it lends itself to the purposes of victim-blaming. Just as the language of help obscured unequal power relationships of a growing therapeutic state (in other words, masking political behavior by calling it therapeutic—a “superimposing of a political relationship on a medical one, while still depicting it as medical.”) the language of self-help obscures the power relations underlying the social production of disease and the dominant interests which now seek to reorder popular expectations of rights and entitlements for access to medical services.

A certain portion of illness is, at some level, undoubtedly associated with individual behavior, and if that behavior were altered, it could lead to improved health. It is also clear that the self-help movement could become an effective vehicle for health education; concurrent with an expansion of access to primary medical services, health personnel could be trained to work with patients in altering behavior injurious to health. Offered in a vacuum, however, such efforts will achieve only marginal results.

McKinlay has convincingly argued that the frequent failure of health education programs designed to change individual behavior is attributable to the failure to address the social context. He concludes that, “certain at-risk behaviors have become so inextricably intertwined with our dominant cultural system (perhaps even symbolic of it) that the routine display of such behavior almost signifies membership in this society . . . To request people to change or alter these behaviors is more or less to request the abandonment of dominant culture.”

Thus what must be questioned is both the effectiveness and the political uses of a focus on lifestyles and on changing individual behavior without changing the social and economic environment. Just as the Horatio Alger myth was based on the fact that just enough individuals achieve mobility to make believable the possibility, so too, significant health gains might be realized by some few of those able to resist the incredible array of social forces aligned against healthy behavior; but the vast majority will remain unaffected.

Why this ideology is gaining so much popularity at this particular historical point can only be understood by examining the growing tensions within the health care system and the role such an ideological approach will play in resolving them. Most simply stated, the crises of medicine and health in the late 1970s are three: the crisis of cost, the crisis of access and the crisis of medical efficacy which has begun to focus attention on the social causation of disease.

We are witnessing a transformation of the entire political landscape in the health sector—a transformation from the politics of growth which dominated the previous period to the politics of curbing that growth in the present period.

The Cost Crisis

The late 1960s and early 1970s was a period of remarkable growth in the medical sector. The sustained expansion of the economy enabled and fed that growth. Government expenditures, private insurance and corporate investments provided the capital. The result of a decade of nearly unrestrained growth on the economy is all too well-known.

While high medical costs have always been a problem, the cost crisis of the mid-1970s has acquired an entirely different dimension. Not only has the rate of inflation raised new barriers to access and improved services—despite the advances in socializing the costs—it has become a threat to corporate capital as well. As a result, public expenditure for human services have become the primary targets of a strategy aimed at restoring “optimal conditions” for investment and growth of the monopoly sector. The costs of medical services to government have aggravated a fiscal crisis in which the direction of public spending is the issue and raising taxes is considered inimical to corporate priorities.

Corporations feel the pinch of medical inflation even more directly through skyrocketing health benefit settlements with labor. Corporate leaders are up in arms. General Motors claims it pays more to Blue Cross/Blue Shield than to US Steel, its principal supplier of metal. Standard Oil complains that its health costs have tripled in seven years. Chrysler estimates it spends $1,500 per employee for health benefits. In testimony, they lament that “unlike other labor costs, medical costs continue to rise in bad times as well as good.” In a period where consumption and investment are stalled and foreign competition stands as a barrier
to raising prices, these problems become critical.

Thus, substantial and broad-based political pressures are being mobilized to control health care costs. Consequently, we are witnessing a transformation of the entire political landscape in the health sector—a transformation from the politics of growth which dominated the previous period to the politics of curbing that growth in the present period. Just a few years ago the political emphasis was on increasing utilization. Now it is on reducing utilization. Besides regulatory measures, the strategies being adopted include cutbacks in public programs, especially Medicaid and public hospitals, and shifting the burden of costs back to employees, old people, and consumers in general.

Most important is the growing consensus among corporate and governmental leaders that at current cost levels, national health insurance is unacceptable. In his campaign for the presidency, Carter, aware of its popular appeal and importance to organized labor, committed his Administration to comprehensive national health insurance. But in reminding the nation last April that balancing the budget by 1981 is his paramount domestic goal, Carter warned that national health insurance, given current inflation, would double in cost in just five years. Califano more explicitly argued that cost control is a necessary precondition for the time that national health insurance or "some other system" is in place. These and other signs indicate that the prospects for comprehensive national health insurance are receding behind a shield of rhetoric.

The Crisis of Access

Another legacy of the late 1960s and early 1970s was the rise in political demands for unhindered access to medical services. Growth reinforced these demands as did years of propaganda by a medical and research establishment which promoted medicine in almost religious terms. Bolstered by occasional spectacular successes, modern medicine promised deliverance from pain and illness—even a "death of death."

Access came to be considered an essential component of family and personal security and an integral part of the wage bargain for organized labor. The idea of medical care as a right became widely accepted in a period where rights were forced onto the political agenda of the nation. Protests against a tiered system of care which relegated the poor and minorities to inferior and less accessible services and treated women in degrading and abusive ways were followed by conflicts over who would control the Great Society health
programs which were offered to quell these protests.

The health care crisis of this period was one of access, equality and participation. The rebels' demands literally forced a redefinition of the priorities of public policy—mostly on a symbolic level—although in some respects significant (if only temporary) gains were made as well. People talked about a cost crisis, but high costs were primarily seen as a barrier to access—not as a problem in their own right.

Thus for years people fought for more access to care—conditioned by providers and profit-hungry corporations to believe in the value of consuming high levels of medical products and services. And now, just at the point that medical care had become broadly viewed as a right and people were increasingly favoring the extension of those rights through national health insurance or a national health service—the situation suddenly calls for people to use the system less. Suddenly, because of the crisis of costs, entitlements are being withheld, even reduced. Whatever small gains were won in the 1960s are being rapidly destroyed and people's "right to accessible care" and the inherent value of that care are seriously being challenged.

If people are to modify their expectations, if legislators and other policy makers are to be convinced of the necessity for retrenchment, a new ideology which can both replace the mystifying power of medicine and break the link between the provision of services and popular political demands must be found. People will not relinquish their expectations unless their belief in medicine as a panacea is broken and the value of access is replaced by a new preoccupation with bootstrapping activities aimed at controlling at-risk behaviors. In a political climate of fiscal, energy, and cost crises, self-sacrifice and self-discipline emerge as popular themes. In lieu of rights and entitlements, self-help and holistic medicine* move to the center.

The Crisis of Ineffectuality and Recognition of Social Causation

A third aspect of the crisis in our health care system relates to the social causation of disease. As real and as threatening as the crisis of cost, it is characterized by a growing awareness and politicization of environmental and occupational sources of disease in the face of the failure of medicine to impact on the modern epidemics, especially cancer.

Industrial corporations are beginning to feel the pressure generated by a growing recognition of the social factors involved in disease. The deepening fear of cancer is now combined with a widely-reported scientific and popular critique of environmental and occupational sources of carcinogens, a constant flow of environmental warnings and disasters, and a growing environmental consciousness and occupational safety and health movement. Even though there is a great difference between awareness and the sense of political efficacy required for a broad-based political movement, the issue of public health has become politicized. Government agencies are expanding their programs, the courts are being flooded with cases, and the Environmental Protection Agency, the Occupational Safety and Health Administration and the Food and Drug Administration have become the most embattled agencies of the 1970s.

The threat to corporate autonomy is clear. One reads daily of corporate threats ranging from production shutdowns and plant closings to investment strikes if regulations are imposed. Corporations move their plants to more tractable communities or countries. And for those who stay, advertising campaigns increasingly promote the image of public-spirited corporate activities in the attempt to counter the ever more apparent contradiction between people's health and corporate profits.

The political constraints placed on the growth of the nuclear power industry are not lost on other industries. Steel, in particular, is under increasing pressure to clean up its operations. In short, the "manufacturers of illness" are on the defensive.

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* The holistic health movement believes "disease is usually a stop sign, telling the individual to stop some process in life which is damaging to health. Disease is the teacher." It includes therapies such as stress relaxation, acupuncture, polarity massage, meditation, nutrition, biofeedback, yoga and dance. Upon joining one center, persons are surveyed "on their time-management habits and "asked if they perceive the world as hostile or friendly or indifferent."**
They must seek new ways to blunt the efforts of the new health activists and to shift the burden of responsibility for health away from their doorstep. The ineffectiveness of medicine and thus its inability to alleviate people's sense of vulnerability to the new dreaded diseases, in addition to the threat posed by runaway medical costs, makes medicine less attractive to corporate leaders eager to divert attention from their health-denying priorities.

In the face of such constraints, the proliferation of messages stressing personal responsibility for health, attacking unhealthy lifestyles and various at-risk behavior patterns is not surprising.

**Diverting the Argument**

Again the nature of the ideology can best be illustrated by example. Leon Kass, fearing the consequences of a focus on social causation, warns of “excessive preoccupations, as when cancer phobia leads to government regulations that unreasonably restrict industrial activity.”\(^{12}\) Or, as Robert Whalen writes: “Many of our most difficult contemporary health problems, such as cancer, heart-disease and accidental injury, have a built-in behavioral component . . . if they are to be solved at all, we must change our style of living.”\(^{13}\) (Emphasis added.)

One after another the lifestyle proponents admit to the environmental and occupational factors which affect health, but then go on to assert their pragmatism. The focus of health efforts, they argue, should not be on overhauling our work or community environments, nor on changing the structure of work in our capitalist economy; instead, the focus must be on changing individuals who live and work within those settings. In the name of pragmatism, efficacy is thus ignored. Further, by focusing on the individual, victim-blaming assertions perform the classical role of individualist ideologies in obscuring the class structure of work and workers’ lack of control over working conditions.

Workplace illness and injury can thus be attributed to some personal flaw. The fact that more than 2.5 million people are disabled by occupational accidents and diseases each year and that 114,000 are killed is not explained by the hazards or pace of work as much as it is by the lack of sufficient caution by workers, laziness in wearing respirators or other protective equipment, psychological maladjustment including accident proneness and the inability to minimize stress, and now even by the worker’s genetic susceptibility. Correspondingly, insofar as the overworked, overstressed worker is offered anything at all, it is transcendental meditation, biofeedback, psychological counseling, or some other “holistic” approach to healthy behavior change, leaving intact the structure of employer incentives and sanctions which reward health-denying behavior and the retention of workplace hazards.

Corporate management, always quick to pick up on a “good thing,” increasingly integrates victim-blaming themes into personnel policies as health becomes a rubric for traditional management strategies aimed at controlling the workforce. Holding individual workers responsible for their susceptibility to illness or accidents is not only a response to growing pressures over occupational hazards, it also complements management attempts to control absenteeism and enhance productivity.

Job dissatisfaction and job-induced stress (in both their psychological and physical manifestations), principal sources of absenteeism and low productivity, will more and more become identified as lifestyle problems of the worker. Workers found to be “irresponsible” in maintaining their health or psychological stability, as manifest in attendance and productivity records, will be cast as having employee health problems and will face sanctions, dismissals or early retirement. The push toward corporate health maintenance organizations will further reinforce managerial use of health criteria for control purposes.

Health screening, both pre-employment and periodic, is also gaining in popularity among large corporations. New businesses sell employee risk evaluations, called by one firm “health hazard appraisals.” The availability to employers of computerized information from health insurance companies for purposes of screening has drawn criticism from groups concerned about invasion of privacy.

Among the specific advantages cited for health screening by the Conference Board is the selection “of those judged to present the least risk of unstable attendance, costly illness, poor productivity, or short tenure.”\(^{14}\) Screening also holds
out the possibility of cost saving from reduced insurance rates and compensation claims. It also raises, however, the specter of a large and growing category of "high risk" workers who become permanently unemployable.

In a period in which we have become accustomed to ozone watches in which "vulnerable" people are warned to reduce activity, workers are being screened for their susceptibility to job hazards. While alerting individuals to their higher risk, these programs do not address the hazardous conditions which to some degree affect all workers. Thus, all workers may be penalized to the extent that such programs function to divert attention from causative conditions. To the degree that the causative agent remains, the more susceptible workers are also penalized in that they must shoulder the burden of the hazardous conditions either by looking for another, perhaps nonexistent, job; or, if it is permitted, by taking a risk in remaining.

At a UAW conference on lead, Leonard Woodcock summed up industry's tactics as "fix the worker, not the workplace." He further criticized the "exclusion of so-called 'sensitive' groups of workers, the use of dangerous chemical agents to artificially lower workers' blood lead levels, the transfer of workers in and out of high lead areas, and the forced use of personal respirators instead of engineering controls to clean the air in the workplace." These struggles to place responsibility will undoubtedly intensify.

Conclusion

In summary, on the one hand, America has become a society ridden with anxiety about disease and yet infatuated with the claims of scientific medicine. Access to medical services has come to be considered a basic right—a notion which has emerged from a long history of union and popular struggles. The campaign for national health insurance has gained a new vitality. In some quarters, a national health service is being seriously considered (e.g. the APHA endorsement of the concept last fall). On the other hand, the costs of medicine, in the context of economic and fiscal crises, are making services more difficult to obtain and are forcing a retreat from public programs. Corporate and governmental opposition to the extension of entitlements is becoming more pronounced.

At a time when people feel vulnerable to epidemic-proportion diseases, and powerless to do much about them, the tendency is to want medicine all the more. Ironically, it is just such a time that its continuing availability and expansion are threatening powerful economic and political interests. Further, medicine is showing itself more and more inadequate in dealing with the contemporary social production of disease, and is, therefore, increasingly unable to perform its traditional functions of resolving societal tensions which arise when people identify the social causes of their individual pathologies.

The unique dilemma facing dominant interests is that people want both medicine and health and the present social arrangement can give them neither. In the face of these trends, it is fascinating and revealing that we are witnessing the proliferation of a new ideology which tells us that the problem is our individual lifestyles, and what we need is more individual responsibility for our own health.

— Rob Crawford

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"We're in the driver's seat. We've pulled back the planning process to the White House."

—Peter Bourne, White House Staff, on National Health Insurance

WHISTLING DIXIE: THE MYSTERY "CARTER PLAN" TUNE

"I will submit to Congress later this year a National Health Insurance proposal. While Congress will not have the time to complete action on this proposal in 1978, it is important to begin the national debate on the many complex issues involved in National Health Insurance."

—Report Accompanying Carter's State of the Union Address

"Government cannot solve our problems. It can't set our goals. It cannot define our vision. Government cannot eliminate poverty or provide a bountiful economy or reduce inflation, or save our cities, or cure illiteracy, or provide energy. And government cannot mandate goodness."

—Carter's State of the Union Address

The White House number, 456-1414 (Area Code 202) is listed auspiciously among the "frequently called numbers of the U.S. Government" in the Washington, D.C. telephone book, between listings for "Walter Reed Hospital" and the "Zoo." An operator there connects us to Dr. Peter Bourne, assistant to the President and a reputed member of the new White House Troika on Health, consisting of himself, Bert Lance's drawing substitute—Budget Director McIntyre, and Chief Domestic Advisor Stuart Eizenstat.

In answer to our query about national health insurance (NHI), Bourne answered, "We're in the driver's seat. We've pulled back the planning process to the White House," although HEW is still doing the detailed program development. Earlier in December, Bourne says, he wrote an internal memorandum arguing that any action on national health insurance would be down the tubes unless it was undertaken immediately. Carter met with Senator Edward Kennedy and United Auto Workers President and Chairman of the Committee for National Health Insurance, Douglas Fraser. Carter then called HEW Secretary Joseph Califano and said there would be no delay—he would have a bill up by July 1.

The White House is now plying all affected federal agencies about particular questions which the President left undecided two years ago when he made his major policy statement on national health insurance in a campaign speech before the Student National Medical Association. Those questions include the staging, financing mechanisms, and the role of private insurance companies in a proposed bill.

Mystery Tune

As the White House ponders these questions, there emerges a mysterious political conundrum: What national health insurance plan will:

- Be "universal, comprehensive, cost and quality controlling," though "staged" in coverage;
- Have "some kind of financial mechanism off the federal budget, giving a role to private insurance companies;"
- Be introduced in outline, at least, by a crusading President by April 1, 1978?

Bourne was obviously deeply worried about the United Auto Workers and other labor advocates of the Kennedy-Corman Bill who see national health insurance as a "must" political priority and who would be on a collision course with the President if no Administration bill
were forthcoming this year. Bourne has found Senator Kennedy himself “extremely flexible, politically realistic, and wanting to see something happen,” even if that means allowing a role for private insurance. In contrast, however, he has found some union people “wanting to start with a high, tough bargaining position to negotiate with Congress.” Some are “ideologues with a 20-year position...it’s almost a macho thing for some of them—any compromise is defeat.”

**The State of the Union(s)**

Bourne’s view reflects a growing restiveness concerning NHI on the part of labor. AFL-CIO

“I think right now that it is an obligation of the federal government to get into this health picture and see if we can’t possibly bring the delivery of health services and medical services to the people at a price they can afford.”

—George Meany, AFL-CIO President

President George Meany, not known for a fighting stance on health issues, recently declared in an interview on the Today Show that, “the federal government, under our system, is obligated, I feel, to put itself into any picture that represents a threat to the welfare of the great mass of the people...so I think right now that it is an obligation of the federal government to get into this health picture and see if we can’t possibly bring the delivery of health services and medical services to the people at a price that they can afford.” Meany named national health insurance as now being among the top three priorities of the AFL-CIO, and its Committee on Political Education has, for the first time, made NHI a priority issue for its spring regional conferences.

Max Fine, Executive Director of the labor-backed Committee for National Health Insurance, foresees a Carter-Kennedy-labor NHI compromise encompassing a national program financed primarily off-the-budget, phased in over a period of years and attempting to capture funds going currently into private premiums. It would emphasize comprehensive cost controls and strong consumer participation, tying control of reimbursement to health planning.

The two contending options for such a compromise appear to be:

- A “public protection plan”—universal, mandatory and in the public sector, but allowing employees and individuals to opt out by buying private insurance that is federally regulated with regard to reimbursement policies, cost containment and quality assurance; and
- A “quasi-public corporation plan” created within HEW along the lines of the Kennedy-Corman Health Security Act and requiring employers to purchase coverage from the corporation for their full-time employees.

—Robb Burlage and Len Rodberg

**NHI: LOOKING IN THE MIRROR**

HEW in early January released its “National Outreach Report,” a summary of its scantly-publicized national health insurance hearings held across the country last fall. What can be concluded seems very much to be in the eye of the beholder. HEW’s Executive Summary found that “a significant proportion of the testimony strongly opposed” national health insurance and that “there was a clear consensus” for a mixture of public and private financing. What HEW does not emphasize is that a “significant proportion of the testimony” also came from providers or insurance companies—1,019 witnesses to be exact, compared with 181 witnesses representing labor and consumer groups. This may be why on Page 81 of the report HEW refers to testimony of the latter as a “minority view.” The labor-backed Committee for National Health Insurance retorted that the report was “totally unscientific,” being “merely a report on the views of those who were invited or showed up to testify.” The report is available from the Department of Health, Education and Welfare in Washington, D.C.

**ONLY 39 PERCENT FOR HEALTH SERVICE**

A Louis Harris Survey, released January 2 says that “only” 39 percent of the people polled find acceptable a “national health service under which everyone would get free health care paid for out of taxes; in such an arrangement, doctors would work for salaries paid for by the government, and hospitals would be managed by the government.” Fully 31 percent expressed positive, “excellent and pretty good” feelings about this idea, currently expressed in the Dellum’s Bill (see BULLETIN, September-October 1977). Including the 12 percent who were “not sure,” one could say a “majority of Americans polled” do not look negatively upon a “national health service!”
Sterilization Guidelines

Across the country, particularly in poor and minority communities, women have been sterilized without their full knowledge or consent. Some have told of being approached to agree to the operation while in labor. Others have been threatened with loss of welfare or medical benefits if they refused to consent to surgery. Many women have reported being misinformed about the effects or finality of the procedure.

In early December, the Department of Health, Education and Welfare (HEW) proposed a set of guidelines to stem the abuse of those being sterilized under HEW-funded programs. The guidelines came as a surprise to many. They are broad in the safeguards they offer—resembling closely the prototype adopted by the New York City Council (see BULLETIN, May-June, 1977)—and incorporate many of the demands of groups working against sterilization abuse.

Why the Guidelines?

What led HEW to make this surprising move? Its own explanation is that, "New rules are appropriate in light of the Department’s accumulating experience with the current rules governing sterilizations and in light of the recent decision of the US Court of Appeals for the District of Columbia Circuit in Reif v. Weinberger."

In the Reif case two Alabama children, Minnie Lee and Mary Alice, ages 12 and 14, were sterilized without their own or their parents’ knowledge of the nature of the operation. The family successfully sued HEW and one outcome was the mandate that HEW establish procedures assuring that federally-funded abortions be voluntary.

While the Reif case may have precipitated the decision to issue new guidelines, HEW’s "accumulating experience" was becoming a log of political embarrassments, which required action. Both the American Civil Liberties Union and Nader’s Health Research Group have issued reports in recent years on the prevalence of sterilization abuse. Most recently a General Accounting Office report on sterilization practices in the Indian Health Service shocked readers with the extent of their impact upon the small and beleaguered Native American population.

The embarrassment of sterilization abuse was undoubtedly exacerbated by the cutoff of Medicaid funds for abortion, a move supported by Secretary Califano. With abortions unavailable, many poor women will undoubtedly feel pressured into accepting sterilization as a means of birth control. Moreover the image of HEW fully funding the sterilization of poor women while denying them abortions is an unsavory one at best. Thus the time was ripe for a show of humanitarianism on the part of HEW.

Although the guidelines are good and HEW is to be commended, they are extremely limited. They apply only to sterilizations which are federally funded—some ten percent of the total—and determine only whether the procedure is reim-

Guideline Summary

HEW’s proposed guidelines for federal reimbursement of sterilizations will:
- Require the patient to sign a consent form, in the patient’s primary language, indicating that the decision is voluntary and that the patient fully understands the nature of the procedure.
- Require the physician performing the sterilization to certify in writing that the patient has been informed about the nature of the procedure and her rights to continued welfare benefits if she declines to be sterilized.
- Extend the waiting period from the time of signing the consent form to the time of the operation from 72 hours to 30 days.
- Prohibit payment for sterilization operations on anyone under the age of 21.
- Prohibit hysterectomy as a form of birth control.
- Prohibit sterilization of mentally incompetent persons, unless there is a determination that a mentally incompetent person is still capable of giving informed consent for the sterilization.
- Provide federal funding for sterilizations of persons in penal or mental institutions only if they are approved by a special review committee and a court.
bursable. Thus if a physician is willing to forgo federal reimbursement he or she may forgo the guidelines as well. How HEW plans to monitor compliance with the guidelines is very unclear and there are some indications that no funding has been planned for this purpose. Finally, criticism has also focused on loopholes in the protection of institutionalized and mentally incompetent persons.

The image of HEW fully funding the sterilization of poor women while denying them abortions is an unsavory one at best. Thus the time was ripe for a show of humanitarianism on the part of HEW.

The Line-Up

The guidelines have received broad support, including that of women’s and third world groups, several farmers’ groups, civil libertarians and some physicians, in hearings that have taken place around the country. March 13 is the deadline for public comment, when work on the final guidelines will begin.

Opposition has come from the same groups which fought the New York City law—physicians and populationists. The medical profession—represented particularly by the American College of Obstetrics and the American Medical Association—is adamantly opposed to the sterilization guidelines, arguing that they discriminate against poor women and interfere with the doctor-patient relationship. Opposition has focused particularly on the 30-day waiting period.

Population groups, as well as many physicians, oppose the guidelines simply because they are likely to reduce the numbers of women undergoing this highly-effective, if irreversible, method of birth control. Planned Parenthood, which operates a large network of birth control clinics in the US and abroad, took an uncharacteristically veiled stand in contrast to the ferocious opposition staged by its New York City affiliate against the New York City guidelines. The Association for Voluntary Sterilization (AVS), another pillar of populationist opposition, also softened its voice. Smaller than Planned Parenthood, the AVS conducts educational campaigns in the US and, like its larger ally, operates clinics abroad with the assistance of State Department money.

Both organizations can be accused of having a vested interest in sterilizations, which is perhaps why they softened their stance. Recently they contributed $150,000 each and, together with bank financing, set up a $750,000 loan fund for the establishment of a network of “mini-lap” clinics. Minilaparatomy, commonly called “mini-lap,” is a new, quick and inexpensive method of female sterilization which can be done on an outpatient basis. Planned Parenthood’s share of the capital reportedly comes from its fund for establishing abortion clinics.

The most outspoken opposition to the guidelines was left to the National Abortion Rights Action League (NARAL) which is not a service organization. Like many of the populationist groups, NARAL wrapped its opposition in a feminist cloak, attempting to equate sterilization to other methods of birth control and to abortion. Thus they argue that the guidelines pose an obstacle to women’s control of their own lives—an obstacle weighing particularly heavily upon poor women.

Marching Backwards?

Meanwhile in New York City where the guidelines were pioneered, the opposition has not been idle. Mark Allen Siegel, New York Assemblyman from Manhattan’s Upper East Side and board member of AVS, has introduced a bill into the New York State Legislature which would roll back the protections of the NYC guidelines. Siegel’s bill would provide a 72-hour waiting period (except if the consent is signed in-hospital or the procedure is to be performed concurrent with another medical procedure, when the waiting period is 30 days). There is no age limit set, no provision for who can counsel, leaving open the possibility of physicians acting as counselors; and the data collection required is highly inadequate, making it impossible to examine the incidence of sterilization by ethnic group, income, reasons, etc.

The prototype of this bill was drafted by AVS last year. The bill is receiving strong support from the AVS (which calls it “our draft compromise”) and from Planned Parenthood, which is planning to open a mini-lap clinic in New York City this summer. The opening has been stalled for some time because of Planned Parenthood’s refusal to comply with the NYC guidelines. Planned Parenthood is hoping that those guidelines will no longer pose a problem by that time.

— Ruthann Evanoff
Emerging relations between the new Koch administration, New York City's Health and Hospitals Corporation (HHC) and the City’s Department of Health were still in flux as this issue of the BULLETIN went to press. While Koch shuffled and reshuffled agency heads and responsibilities, however, some clear policy direction has already become quite clear.

Koch’s designation in January of Philip Toia, former NYS Deputy Welfare Commissioner, as both Deputy Mayor for Finance and Health Services Administrator (thereby HHC Board chairman) proved to be only temporary. But it clearly signalled the Koch administration intention to elevate immediate fiscal solvency to the status of guiding philosophy for City health policy. Toia—previously distinguished as an aggressive trimmer of welfare budgets—was the source of the unfortunate suggestion last year that New York consider returning to the “soup kitchen” approach to welfare services.

We will probably never know if Mr. Toia’s fondness for dispensing soup would ultimately have led to vending machines replacing welfare offices. But if Koch’s goals are immediate reductions in the City’s $1 billion annual health expenditures and a corporate approach to “better management,” he should find willing accomplices in the current HHC administration. In fact, if one reads with care the transition papers prepared for Koch by HHC President Joseph T. Lynaugh’s “new management team,” a tunnel vision obsession with converting public services into marketable commodities is quite striking.

**Transition to Solvency**

The transition document painfully reveals the inherent conflict between short-term solvency and long-term service or even cost-effectiveness criteria. Although clearly stating that “approaches taken to HHC’s short-term problems may undermine the HHC’s long-term viability and reduce hopes of systemic solutions for the problems of the City’s health care system,” (P.3), the report proceeds to recommend precisely the kind of short-term HHC policies that will worsen the City’s long-term health care crisis.

The report sets out three main goals: “(1) To maintain financial stability in 1978 and to present a balanced budget for 1979. (2) To achieve long-term financial stability for 1980 and beyond. (3) To serve as a catalyst for creating an effective regional health care system for the City.” (P.3) Unfortunately, it takes a good deal of reading between the lines in the remaining 53 pages plus a familiarity with NYC health policy history to detect the significance of these apparently rational policies in practice.

The solvency the report seeks, of course, is the solvency of HHC—not necessarily that of the City as a whole. Unfortunately, these two goals alone are quite distinct, not to mention conflicts between solvency and service. HHC’s managers, for example, spell out an intricate and elaborate battle-plan for the 17 municipal hospitals aimed at “a new and competitive role for municipal hospitals.” (P.3) It includes:

- **Immediate cost-cutting through managerial reforms, increased pressure on the work-**
force to increase productivity, and closings of low-occupancy (and thus higher cost) services and facilities. The operational definition of “regionalization” at both HHC and the NYC Health Systems Agency (which Lynaugh formerly headed) as well is consolidation around those institutions with the highest occupancy rates.

Many initiatives to increase revenues through computerized billing, more aggressive collections policies, and recruitment of both more private, paying patients and more reimbursed patients—especially those on Medicaid. The latter is spelled out in an ambitious marketing agenda that includes a bevy of ploys such as municipal-hospital-based group practices, new ambulatory care facilities, senior citizen outreach programs, and conversions of some existing facilities (e.g., the Neighborhood Family Care Centers) into more efficient generators of inpatients.

**Health Department Takeover?**

We have previously criticized this strategy as nothing less than a conversion of the municipal hospital system into a voluntary (perhaps even a proprietary) one. The question we will explore in future BULLETINS is, “Why not?” We will focus on the conflicts between this institutional-solvency approach at the HHC and a cost-benefit strategy for New York City health policy as a whole. We must also look at the voluntarization strategy as part of a larger trend in City policies aimed at abandonment of low-income populations, i.e., the same neighborhoods abandoned by City health services are targets of high rates of housing abandonment and other City services as well.

Most crucially, however, we hope to examine health policy alternatives available to the City in the late 1970s and in the 1980s. Voluntarization and vendorization of public services are neither the best nor the only options available.

The importance of exploring these issues in some depth is suggested—quite ominously, we feel—by the last item on the list of the HHC’s new marketing tools. HHC, the transition report informs us, is “planning to investigate the possibility” of directly taking over the Department of Health’s Child Health Stations.

With its facilities spread paper-thin and its personnel decimated, the Department of Health (DoH) remains the only City health service agency with a non-institutional orientation. While the municipal hospitals increasingly imitate the privates’ institutional-survival mentality, the Department of Health maintains a health-levels-of-the-population (epidemiologic) orientation. The latter—the only basis for a “health outputs” definition of service—is essential to the rational delivery of services. No amount of private sector entrepreneurship will ever compensate for its absence. In fact, as cities such as Newark have found, more effective public policy may well result if the DoH were to take over much of the existing mix of hospital-based services.

Meanwhile, one community activist could be forgiven last month wondering aloud last month whether the real genius behind the HHC marketing strategies might not be that senior planning official from Kentucky, Colonel Sanders himself.
WORKERS’ RIGHT TO KNOW

On February 14, eight workers in Chicago were killed in a tragic industrial accident. Their deaths highlight a fundamental flaw in the effort to control workplace hazards: workers have not yet won the basic right to know the materials with which they work. If workers had this simple right, the eight men in Chicago and many other victims of occupational hazards might well be alive today.

The accident occurred at Horween Leather, a tannery on Chicago’s North Side. A tank truck driver, on his first trip to the plant, was delivering a corrosive solution of sodium hydrosulfide, for use in the tanning process. An employee stationed at the gate told him to drive ahead to a nearby set of valves, to which he connected the hose from his tanker and began pumping.

There were no signs to warn him of this fatal error. The valve was not labelled, nor was it locked to assure only authorized use. It was, in fact, an intake valve leading to a tank of acid chrome tanning liquor. The ensuing reaction sent lethal fumes of hydrogen sulfide throughout the plant, killing eight workers and sending 36 others to the hospital.

Workers have not yet won the basic right to know the materials with which they work.

Grassroots groups are developing with longer memories and less tolerance of industry negligence than the various regulatory agencies. Union locals and pro-labor professionals are forming community-based Committees on Occupational Safety and Health, known as COSH groups. One such group, CACOSH (the Chicago Area Committee on Occupational Safety and Health), moved quickly to gather the facts behind the incident and help publicize them on television and in the press. CACOSH and the Amalgamated Meat Cutters union, which represents production workers at the tannery, have petitioned Dr. Eula Bingham, Assistant Secretary of Labor for Occupational Safety and Health, to issue an emergency temporary standard requiring all chemical valves and containers to be labelled clearly, and all valves and fittings to be designed to prevent improper coupling.

Grassroots groups are developing with longer memories and less tolerance of industry negligence than the various regulatory agencies.

This marks another effort in the long campaign to win the right-to-know, guaranteed in the Occupational Safety and Health Act of 1970, but never systematically implemented except in the 16 new standards adopted since then. Many local worker groups are actively pursuing mechanisms such as health hazard evaluations by the National Institute for Occupational Safety and Health (NIOSH), OSHA inspections, contract bargaining, National Labor Relations Board complaints and strike threats in an attempt to find what they are working with. Now CACOSH has joined with other COSH groups—in Philadelphia, Massachusetts, Rhode Island and North Carolina—in a national petition and organizing campaign to win the right-to-know. Professionals, Congressmen, environmental groups, community groups and unions are also involved in pressuring OSHA for swift action. The petition states:

“We demand employers make available to workers and their representatives generic names (chemical, not trade names) of all substances we, the workers, may be exposed to.
"We further demand that the Occupational Safety and Health Administration issue a new standard that requires employers to: (1) Make available to employees chemical names, hazard monitoring data, personal workplace medical records, and all other information necessary to evaluate the safety of substances workers may be exposed to. (2) Post in the area of use a summary of the harmful effects of all chemicals used.”

Even the regulating agencies often do not know the substances used in the workplace. This came to light in the recent National Occupational Health Survey by NIOSH. NIOSH estimates that one out of every four workers is exposed to dangerous toxic substances on the job. It also found that 70 percent of all materials used in the workplace were identified only by trade names, so that even these government researchers could not adequately assess the extent of worker hazards.

Seventy percent of all materials used in the workplace are identified only by trade names, so that even government researchers could not adequately assess the extent of worker hazards.

limits workers’ compensation costs and helps avoid law suits and worker demands for direct input into health and safety decisions.

But pressure is growing for action on this issue. In 1977 NIOSH and the National Academy of Sciences issued reports supporting the right-to-know concept. The Health Research Group has pressed this issue on the legal front and the COSH groups have actively been building grassroots support through their campaign. Now the current OSHA administration is firmly committed to the idea and is circulating a draft of a proposed “chemical identification standard,” incorporating the right-to-know principles. Comments on this document will be incorporated into the proposed standard.

According to Barbara Corson, OSHA project officer for the proposal, the standard is likely to be split into at least two parts. The proposed guidelines for access to environmental and medical records will probably be announced in late February or early March, Corson says, while the generic labelling standard is being revised and will be issued separately later. This guideline-splitting maneuver is probably a tactical move by OSHA to win the easier battle first while anticipating strong opposition to the generic labelling standard with its threat to trade secrets.

Once a proposed standard is promulgated, comments will be invited and hearings set. The COSH groups are pushing for hearings in Philadelphia, Chicago and other places outside of Washington where there is strong worker concern. The hearings should help focus public attention on the right-to-know issue. Meanwhile, keep watching your local newspaper for reports on new occupational health disasters.

For further information on the Right-to-Know Campaign; contact PHILAPOSH, 1321 Arch Street, Room 607, Philadelphia, Pa. 19107.

—Tony Bale
Family Practice

(Continued from Page 2)

A study done at Cornell in 1952 (and repeated many times) clearly illustrates the pressures on medical students. Upon beginning medical school, 60 percent of the first year class planned to enter general practice; by the fourth year only 16 percent still desired such a career.

By 1963 less than 25 percent of all physicians in the United States were general practitioners. These 69,000 doctors were concentrated in suburbs and small towns. The urban rich usually opted for fancy specialists while the poor were left to emergency rooms and outpatient departments staffed by house officers. Many rural and isolated communities—as well as urban ghettos—had no doctors at all.

Who Needed GP's Anyway?

With the American public sold on high-technology, highly-specialized care, the interesting question is why the GP didn't join the horse and buggy as just another historical oddity? The answer is that, even by the mid-sixties, the maldistribution of primary care physicians, the increased demand for care and medicine's promise as cure for all ills had coalesced to focus public attention on the need for new generalists.

The massive increase in hospital insurance coverage during the post-World War II period, culminating in the passage of Medicare/Medicaid in 1965, put new strains on the health system's primary care resources. The number of generalists continued to drop precipitously. For example, between 1963 and 1967, while the number of specialists increased by 18 percent (from 201,651 to 238,050) the number of GPs fell by 6.2 percent (from 73,489 to 68,920). The GP was a dying breed.

Medicine, meanwhile, had been sold to the public as a panacea for everyday ills: all manner of personal and social problems were subject to creeping medicalization. People brought complaints of all kinds to doctors: broken bones and broken marriages, heart failure and heartaches, stomach pains and sexual failures. All fell into medicine's domain, as did heart disease, cancer, stroke—a host of "new killers" which were claiming more and more lives annually.

Doctors found themselves simply unable to cope with the majority of their patient's complaints. With the cost of each doctor–patient encounter rising rapidly, some medical spokes-

men began to fear a period of public disaffection with the profession. As the 1960s and 1970s chorus of debunkers grew—culminating, perhaps most ominously, in a new, more militant and sometimes anti-medicine women's movement—the mismatch between patient need and physician training, between the expectation of care and the capacity to pay for services, between population centers and doctor distribution, led to renewed calls for increasing the number of primary providers.

From GP to Family Practice

Concern about the disappearance of the GP had begun long before family practice was born. In 1946, when the number of GPs had already fallen to only 30 percent of all practitioners, the AMA founded a special section on general practice. Dr. Wingate Johnson, its first chairman, inaugurated the new section with a clarion call for the resurgence of the nonspecialist.

"Those who would substitute the family doctor by specialists—even group practice—overlook the fact that 85 percent of the ailments for which people consult doctors can be cared for by a
competent general practitioner," Johnson argued. He felt the future doctor should be taught "not only the techniques of modern medicine and surgery but also the relationship of disease to personality, to economics and social problems."  

The American Academy of General Practice (AAGP) was independently established a year later. For the next twenty years it acted as a lobby both within and outside organized medicine, attempting to increase the status of general practitioners. To legitimize the role of general practice within the profession, the AAGP repeatedly called for the creation of special training programs and recommended compulsory exposure of all medical students to general practice.

Within a decade, however, this call for a new brand of generalist had been transformed into a demand for a new specialist—a general practitioner with the prestige of a surgeon, internist or pediatrician. Discussion began to turn around issues of content as well as training. In 1956, the AMA created another committee on general practice—The Committee on Preparation for General Practice. Two-and-a-half years later the Committee reported that the distinguishing characteristic of this new general practice ought to be its potential for a continuous doctor/patient relationship. "The Committee is of the opinion that the needs of the public are well served through comprehensive medical care. By its very nature such care is based necessarily upon a close interpersonal relationship that most readily develops through long association between a physician and a patient."

The Committee's report recommended the creation of special post-graduate training programs in general practice. By 1969 six two-year programs had been established. Nine more programs were added the following year.

The turf-conscious AMA, however, refused to recognize the certification bestowed on graduates of these programs by the independent American Board of General Practice. Rather, it continued to quibble about adequate provision for "grandfathering" practicing GPs into the specialty. Lacking AMA endorsement, specially-trained general practitioners could never achieve parity with other specialty-trained doctors.

**The AMA Makes a 180 Degree Turn**

Primary care was increasingly an idea whose time was due. Continued opposition by the AMA risked losing the turf altogether and with it control of medical training. Significantly, pressure by the early 1960s health reformers began to lead to increasing reliance on non-physician primary care practitioners—physicians' assistants, nurse practitioners and other "physician extenders" as MDs preferred to call them.

Responding to such potential threats, the AMA formed another committee to study the question and during this same period, at least three other major studies looked at the question of primary care practitioners, their training and availability.

The four resulting reports (by the World Health Organization, 1962, the Millis report, Graduate Education of Physicians, commissioned by AMA, 1966, the Folsom Report, Health is a Community Affair, by the Commission on Community Health Services of the National Health Council and the APHA, 1966, the Willard report, a report of the Ad Hoc Committee on Education for Family Practice, of the AMA Council on Medical Education) reached similar conclusions. The need for primary practitioners was evident. Medicine should proceed to establish post-graduate training programs leading to board certification. Primary care practitioners should be accorded equal status and income with other specialists. It was already evident in these reports that the new general-practice specialty was to be christened "family practice." The Willard report defined the family physician functionally and is most frequently cited in answer to the question, "What is family practice?" (See box.)
Simultaneously committees were established to define the training which would be required. A joint committee of the AAGP and the AMA published a description of 26 areas of interest to family practice. The AMA in 1968 established a Family Practice Committee to implement the suggestions of all these reports, particularly the Willard Report. The National Board of Medical Examiners completed work on a certifying exam in 1969. All that remained to complete the birth of the new specialty was an agreement between the AMA and the AAGP on requirements for certification. That agreement was quickly reached and in February, 1969, the AMA approved family practice as the newest specialty. At the same time, the American Academy of General Practice adopted its current name, the American Academy of Family Practice.

The Emperor Has New Clothes

The Willard Report and leaders in the field insisted that family practice was to be more than glorified rotating internships or better training programs for general practitioners. Earlier efforts to revive interest in general practice had foundered when it became clear that general practice could never successfully compete for money and status with the specialties. This time around general practice would adorn itself in new raiment. Family practice—the new specialty—would claim unique knowledge and expertise: "[i]t studies the effects of illness upon family members and family life and the role of the family in the etiology of illness and the maintenance of health... [its] unit of diagnosis and treatment [has] changed from attention to the person to focus upon significant relationships and whole families in the context of relevant communities and immediate environments... [it views the] family system just like any other organ system." 10

Interest in the family didn't originate with medicine. By the late fifties and early sixties "family" had become a buzz word for social scientists, social workers, psychologists and psychiatrists, many of whom found the root of all social ills buried within it. Schizophrenia, autism, juvenile delinquency, alcoholism, ghetto riots, and the decay of the inner cities were all thought to be products of the "dysfunctional family." The ultimate expression of the family as a causative agent was the Moynihan report in which the Black family structure was said to be "the fundamental source of the weakness of the Negro community at the present time."

Within some segments of psychiatry and its allied fields, the family had long been a focus of research and treatment. Family therapy had been used to treat the families of many children with problems ranging from schizophrenia to bed wetting. Family therapy, borrowing heavily from cybernetics, portrayed the family as a system always striving to maintain equilibrium, often at the expense of individual members' health. Dysfunctional families were alternately families in which the system was totally chaotic or families which could only maintain the family equilibrium by fostering sick roles. Other tendencies in psychiatry accounted for a wide range of somatic disease as the physical manifestations of intra- and interpersonal conflicts.

Out of this political and ideological climate, family practice took much of its theory and language, not to mention its currency. A wide range of problems continuously encountered in ambulatory settings were seen both as stemming from the family and as clues to family functioning.

Federal Infusions

Officially established and having received the blessings of the AMA, family practice began to receive christening gifts. The federal government...
had granted no money directly to post-graduate medical education since World War II. Congress, seeing in family practice answers to constituents' complaints about doctor shortages and the high cost of medical care and responding to lobbying efforts of the AAFP (successor to the AAGP), began to invest heavily in family practice training programs. A total of $99.2 million was spent in fiscal years 1972-1977; another $140 million will be spent by September, 1980. Originally this money was granted only to community hospitals with established training programs. University hospitals, quickly sensing huge amounts of federal aid in the offing, mounted an effective campaign to be included in the give-away. Additionally, the feds began to fund undergraduate family practice training programs.

The results of this massive infusion were quickly apparent. Eight years after the establishment of family practice and six years after Congress first appropriated money, 325 residency training programs were in existence with 5,400 residents (17 percent of the nation's first-year residents) participating. The vast majority of the medical schools—85 percent—now have departments of family practice (some of these are joint family practice-community medicine departments). Most of the 325 residency training programs remain within community hospitals: 58 are community-based; 161 are community-based and university-affiliated; 38 are community-based university-administered; only 52 are university hospital-based; the remaining 16 are run by the military. This infusion of federal money left a legacy of acrimonious debate within medicine. Internal medicine, pediatrics, and obstetrics-gynecology vehemently argued that they too delivered primary care (often arguing, in fact, that they delivered better primary care or that the family practitioner was a fad without substance) and demanded that, if the feds were suddenly getting into the post-graduate training business, they had better get their piece of the pie. "General" or primary care internal medicine, pediatrics and ob-gyn were included in the next round of monies. Congress finally decided that by 1982, 50 percent of the nation's medical school graduates are to be in a "primary care" training program. Thus the debate over who delivers primary care and how the money should be apportioned remains heated.

Identity Problems

Family practice's ability to win the primary care sweepstakes rests in part on its ability to convince Congress and the public that its training programs produce the best physicians for the money. Family practice training programs, however, are hardly cohesive. They combine rotations through various medical subspecialties with mandated outpatient clinic experience and a potpourri of classes, seminars and practicums.

The American Academy of Family Practice, which certifies training programs and administers specialty board examinations, requires a minimum of twelve months of internal medicine, six months of pediatrics, two months of surgery, one month of psychiatry and two months of obstetrics and gynecology. In conjunction with the American Board of Obstetrics and Gynecology additional "competencies" within ob-gyn have been outlined, specifying how many deliveries, etc., should be performed by any resident who intends in future practice to cover ob-gyn problems. Months not spent doing required rotations are often spent in elective specialty training, e.g. ear, nose and throat or orthopedics.

In most training programs this means that family practice residents assume the traditional role of an intern or resident while rotating on services controlled by other specialists. Thus the future family practitioner's position is often ambiguous. She or he faces the hostility of many specialists, who begrudge time spent teaching family practice residents, and relatively short exposure to each medical discipline.

A partial solution proposed by the AAFP is for all family practice programs to run their own hospital floors—the "family practice service"—to which adolescents and adults with all types of problems would be admitted. Family practice pro-
ponents clearly hope that the establishment of such floors will serve to legitimize and strengthen their presence within the hospital.

Besides in-hospital rotations, all residents must participate in "continuity clinics," throughout the three-year course of their residencies. These clinics are set up as model family practice outpatient ambulatory centers. The AAFP requires that they be geographically separate from hospital OPDs. All residents follow a panel of families for their entire training period. The equivalent of one-half day a week the first year and three-half days the second and third years will be spent by each resident at the continuity clinics.

Such clinics and the populations they serve vary, but most are easily accessible to the hospitals where residents do their inpatient rotations. The largest number serve white, generally middle-class, and generally suburban populations. The University of Minnesota, for example, has six affiliated programs; four of the clinics involved explicitly state they draw on middle class populations. The majority of patients seen at one of the others are neighborhood residents living within one mile of the university plus faculty and staff. Some clinics serve more economically and racially mixed groups. The Medical College of Virginia has four affiliated programs, one of which draws on a mostly indigent population. Montefiore Hospital has family practice residents located both in the working class North Bronx and the burnt-out South Bronx. The first of these is a module located within the outpatient facilities of North Central Bronx Hospital and is distinguished from other modules by the presence of family practice residents and special efforts towards team development. If the signs were removed, however, many patients might find it difficult to differentiate between the Family Practice Unit and other units within the OPD.

All family practice clinics see both adults and children for routine medical care. They differ as to whether they provide specialty consultations on the premises, what problems they refer, and how closely they follow patients referred to specialists or to hospitals. Most of the programs state that a resident—not necessarily the same one who cared for the patient at the clinic—will follow a hospitalized patient. Most programs admit, however, that this is often not done, especially if the patient is admitted to a specialty service.

Despite claims that family practice embodies a unique discipline with diagnosis and treatment centering on the family, many programs are bewildered about exactly where the family fits in.

Is There a Family in Family Practice?

Unlike the time requirements for in-hospital work and continuity clinics, AAFP guidelines for developing "psycho-social skills" remain vague. HEW requires funded programs to have one "psycho-social" faculty for each six residents. Faculty are generally psychologists or social workers, but there is wide variation. Despite claims that family practice embodies a unique discipline with diagnosis and treatment centering on the family, many programs are bewildered about exactly where the family fits in.

Programs attempt to put "family" into family practice in a variety of ways. Some include formal course work, preceptorships, and elective periods in areas like family therapy, communications, psychosomatic medicine, dynamics of marriage and family, quantitative methods, practice management, and community health. In some the discussion is limited to periodic seminars on the "dysfunctional family." All stress behavioral sciences and some variant of family or crisis intervention and psycho-social skills.

In practice this may mean that a psychiatric social worker is present in the clinic; in others, a resident is expected to learn how to do her or his own evaluation and treatment of individuals and families in crisis. Residents may be offered formal course work or vaguely encouraged to think about "family and community resources" when planning a therapeutic regimen.

Having coopted the ideology of the sixties, family practice is expropriating the technology of
The impulses which gave rise to family-oriented medicine were motivated by an attempt to relocate medical practice in human social life. Family practice serves to at least legitimate this attempt.

Where Do They Practice?

Not surprisingly, most graduates of family practice residences (34,000 to date) are going into private or small group practice with 53.2 percent settling in rural areas or small towns of less than 25,000 population. Indeed most seem to be staying in their home states or the states in which they took their residencies. At this time only 3.2 percent of family practice residents are settling or planning to settle in inner-city areas. Of 239 former residents in the University of Minnesota family practice programs, for example, 168 (70 percent) are now in private practice; 110 (65 percent) of these practice in Minnesota with 25 or more (15 percent) practicing in the surrounding states; 19 changed specialties; 2 entered academic medicine. Remaining graduates are either in the military or alternative public service and will probably enter private practice within a few years.

What Do They Do?

Regardless of where they practice, it is difficult to assess what family practitioners actually do in their offices. Some undoubtedly incorporate their interviewing, crisis intervention and therapy skills into daily patient management. Many more find that the pressures of productivity combined with the traditional need to see as many patients as possible to maximize income force numerous short visits with precious little time for attention to the emotional and familial aspects of patients' problems.

Family practitioners differ as to how they make referrals to specialists. In some areas their hospital admitting privileges are extensive. In others they have been sharply curtailed. Family practitioners claim that refusal to grant admitting privileges is based on unfounded superstition, hostility and economic protectionism. Many specialists and hospital administrators challenge the adequacy of family practice training and the competency of graduates; they claim the denial of admitting privileges is an attempt to protect patients.

In a possibly precedent-setting case, the AAFP has recently promised legal aid to Dr. Steven Barrett, a Board-certified, residency-trained family physician who has been denied permission to perform deliveries unless he has an obstetrician's supervision at Beverly Hospital in suburban Boston. The court will be asked to judge the adequacy of training programs and on what basis a physician can be denied admitting privileges. Consequently the case is attracting national attention within medical circles.

Conclusion

In the end, however, the question of what family practice means is not likely to be decided by the courts. The main contribution from the new
specialty, in fact, is a growth in the overall number of physicians practicing primary care—a trend that may even begin to counteract hospital dominance in shaping medical practice. This trend toward primary practice promises to create a more equitable distribution of physician services in rural areas in the near future. In urban areas the outcome is less clear, due to the absence in family practice training of any real preparation for the cities and particularly for the ghettos.

The major question remains, however: can family practice programs succeed in creating a new breed of doctors, one for whom the pathophysiology of disease is envisioned as organically and intimately connected to social and environmental relationships? Will the incorporation of family practice into medicine as a whole make medicine more responsive to families' and communities' needs? Will its establishment as a specialty reverse the continuing concentration on high technology super-specialized medicine? Or, will current clinical practice simply make minor adjustments, allowing family practice to lay claim to the 70 to 80 percent of problems doctors have heretofore conveniently labelled psycho-social? In short, does family practice promise to humanize medicine, or simply to create a new, isolated specialty of "humanistic medicine?"

The impulses which gave rise to family-oriented medicine—and lead many of the more progressive medical students to choose family practice as a specialty—were motivated by an attempt to relegate medical practice in contemporary social life. As a specialty, family practice serves to at least legitimate this attempt. But the tentative steps to look at patients, health and disease within the context of family, community, environment and the workplace have only too quickly given way to the rigid adoption of various schools of family theories. The pattern is all-too-familiar: the need to gain credence for claims of special expertise push the specialty to rely on and exaggerate the notion of the family, its role in transmitting and maintaining mainstream culture and its relationship to other levels of social organization. Meanwhile, such epidemiologic realities as poisonous food additives, job-related stress or air- and water-borne carcinogens and disease breeding ghettos—none of which are transmitted through families—escape attention by the new family practitioner.

Multiplying new medical specialties, in fact, are an unlikely route to a new, more humane medicine. Rather, serious attention to occupational, environmental and other social etiologies must ultimately call into being a wholly different model of medical care—one envisioning a community larger than the patient or patient's family and locating its practice squarely within that social and political world from which any people's diseases—or health—spring.

—Joanne Lukomnik

( Joanne Lukomnik is a physician enrolled in the Residency Program in Social Medicine at New York's Montefiore Hospital. She is also a member of the Health/PAC Editorial Board.)

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12. Ibid
13. Ibid.
15. Haynald, op. cit.
Dear Health/PAC:

As a person who is actively opposing passage of the New York State Nurses' Association (NYSNA) "1985 Proposal," I am of course glad to find others who are also opposed. However, I can find no merit in sharing the stump with the author of your article "Closing The Door on Nurses, New York Style" which appeared in the September-October 1977 issue of the Health/PAC BULLETIN. Mr. Jenkins seems to be an antieducationist, socially irresponsible, and frequently misinformed as are those persons who are supporting the NYSNA "1985 Proposal."

The evolution of nursing takes place within the larger framework of social change. The recipients of nursing services are as entitled to knowledgeable nursing services as they are entitled to knowledgeable services in medicine, dentistry, engineering, law, social work and the like. Licensure exists to safeguard the public, not the worker. Unfortunately both the NYSNA and Mr. Jenkins seem to ignore this point.

Nursing's educational system prepares persons for three clearly different levels of practice. Licensure to practice is provided for only two of these levels: specifically, (1) the registered nurse level (for which hospital schools and associate degree programs prepare) and (2) the practical nurse level. No licensure is provided for the baccalaureate level of practice although human safety requires the knowledgeable judgments afforded by valid baccalaureate education in nursing.

That baccalaureate graduates currently take the same licensing examination as do hospital school and associate degree graduates is no more valid than if dentists were licensed according to their performance on a licensing examination for dental hygienists or medical doctors according to their scores on a physician's assistant examination or engineers according to how they achieved as engineering technicians.

Further Mr. Jenkins' suggestion that to require a baccalaureate degree in nursing is discriminatory against nurses who got their baccalaureate in some other field is at best very strange. Would he suggest that the engineering technician who secures a baccalaureate degree in sociology is qualified to practice as an engineer? Will a degree in psychology qualify the physician's assistant to practice as a medical doctor? Will a degree in biology for the dental hygienist create a dentist?

Failure to establish legal standards and to license at the baccalaureate level of practice in nursing leaves the public to be victimized by (1) persons granted baccalaureate degrees in the absence of a baccalaureate education in nursing, (2) unreasonable expectations of associate degree, hospital school, and practical nurse graduates and (3) a health care system that endeavors to deny persons holding a valid baccalaureate degree in nursing their rights and responsibilities to use their knowledge for human betterment.

Concomitantly, there is continuing need for licensure of nurse graduates of associate degree and hospital schools (as long as the latter shall continue). These graduates are prepared for a career in nursing that society values and needs—a career worthy of honor and respect in itself. These graduates do not need to be "upgraded" in order to be socially significant. The words "Registered Nurse" and the letters "RN" identify this population.
These nurses make decisions within the scope of their preparation. Certainly they function with appropriate direction from nursing’s baccalaureate and higher degree graduates. But to propose this is a unique role (as did the author of this article) is to deny that knowledge makes a difference.

Further Mr. Jenkins seems unaware that baccalaureate education in nursing prepares a general practitioner—a person who works directly with people, who gives direct nursing services, and who makes those intellectual judgments demanding substantive nursing knowledge. Equally the assignment of responsibilities to associate degree and hospital school graduates when said responsibilities require the knowledge base provided in a baccalaureate program can spell danger to the public.

The grandfather clause which Mr. Jenkins refers to as a myth is in reality a way of maintaining the status quo under new labels for years to come. Most seriously, the public would be faced with large numbers of people labelled as something they would not be and lacking the knowledge necessary to fulfill the responsibilities society would have a right to expect.

Grandfather clauses are appropriate means of protecting the rights of persons and in this instance persons holding baccalaureate degrees in nursing acceptable at the time of their graduation should be grandfathered in under a bill that would license for the baccalaureate level of practice. Mr. Jenkins seems quite confused as to the purpose of this legislation since he indicates that the grandfather clause “fails to assure jobs” for example. The purpose of licensure is not one of assuring jobs. The grandfather clause proposed by NYSNA does fail to protect the public, however, which is a derogation of the purposes of licensure.

Mr. Jenkins’ reference to “faith healing” as representing an area of uniqueness in nursing knowledge seems to be a statement without foundation. I know of no accredited nursing program at any level which teaches or prepares their graduates to practice “faith healing.” If Mr. Jenkins is referring to the work of Dolores Krieger, PhD, RN in the area of Therapeutic Touch he is indeed ignorant of both her research and its translation into nursing practice. Human touch has been a sine qua non of nursing from before Florence Nightingale introduced modern nursing. To provide a scientific base for this intimate caring function places touch squarely within the framework of nursing’s therapeutic modalities. In an age of mechanistic proponents and technological overabundance, nursing’s long established humanitarianism finds significant expression in the establishment of scientific principles to underwrite practice.

I would not argue with the need for critical concern in the area of opportunities for minority groups. However I would point out that this is a major issue that has to be dealt with on many fronts. To deny knowledgeable nursing to the public because we as citizens have not confronted and acted on the real issue serves neither society nor minority groups. The problem will not be solved by passage or non-passage of the NYSNA “1985 Proposal.”

The economics of nursing as presented by Mr. Jenkins deserves criticism as well. In a period of marked inflation, salaries for multiple groups have risen dramatically, including those voted themselves by legislators and others. Is it not reasonable that persons with equivalent preparation and equivalent responsibilities should find these manifest in their pay checks? Is Mr. Jenkins proposing that if nurses want jobs they had better keep their salaries down? As for a shortage or non-shortage of nursing personnel, Mr. Jenkins reflects his own lack of information rather than reality. Gross numbers do not tell the story. There continues to be a critical shortage of nurses prepared at the baccalaureate and higher degree level. In the employment market there is approximately one baccalaureate and higher degree graduate to nine associate degree, hospital school, and practical nurse graduates. The field of medicine has three times as many prac-
As a final point I would note that there can be no unity that does not allow for and value diversity.

I find it most distressing to find such an uninformed, inaccurate article in Health/PAC, an organization for which I have had considerable respect and to which I have referred many people. Many more comments relative to errors in the article could be made. Suffice it to say that this article is a disservice to nursing, to your readers, and to a public sorely in need of safe health services, a commodity which seems to be in short supply these days.

—Martha E. Rogers, ScD, RN
Professor, Division of Nursing,
New York University

THE AUTHOR REPLIES:

Dr. Martha Rogers is an internationally recognized nursing educator and theoretician. Her position on the 1985 Resolution and professionalism in general is of great influence. She expresses an extreme, but logically developed, position in favor of the elitism which I argued against in “1985: Closing the Door on Nurses, New York Style.” If I had attempted to frame her position in the same terms as she does herself, I would have opened myself to charges of using hyperbole. Dr. Rogers’ candor is most welcome.

Dr. Rogers’ principle contention is that the BSN is a new species of health worker. I use the term health worker because she carefully avoids drawing any connections between BSNs and RNs, except to imply that RNs are a lower order requiring close supervision. Dr. Rogers would like to see a new, separate license for the baccalaureate level. After all, a BSN is to a RN what a dentist is to a dental hygienist, we are informed.

Somewhat paradoxically, she then goes on to say that the term “Registered Nurse” adequately describes the AD and Diploma nurse. She concedes that these nurses are prepared for “a career worthy of honor and respect in itself”—but then so are domestics. Perhaps the key to the dilemma is in her use of the term “Registered Nurse” for AD and Diploma graduates. In the parlance of nursing associations and state licenses, the usual term is “Registered/Professional Nurse.” I can only guess that Dr. Rogers has distilled out the “Professional” for sole use by the BSN, but does not have the audacity to say so. She leaves us in the dark as to what we are to call this new creature.

Dr. Rogers pulls no punches in her argument for the elevation of BSNs above other nurses. Today non-BSNs are just not safe. They are, we are told, a menace to public safety. In my article I spoke of the difficulties that supporters of the BSN have in documenting the differences and advantages of a baccalaureate education. Dr. Rogers has invented a new mechanism for vaulting over this question by simply raising the specter of physical mayhem by incompetent practitioners.

Today non-BSNs are just not safe. They are, we are told, a menace to public safety.

Supporters of the BSN do not feel obligated to prove anything. For too long Dr. Rogers, the NYSNA, and their supporters have been in unquestioned control of decision-making bodies for nursing, both public and private. They become confused and petulant when their concepts are challenged. In the absence of proof of value, the push for the BSN can be boiled-down to the time worn argument that “more education is better.” Workers in all fields, not just health, are familiar with the narrowing and divisive effects of such a policy.

Dr. Rogers, as a former dean of one of the most theoretical baccalaureate programs in the country, would probably agree that one of the advantages of a BSN is the provision of a liberal education. Other supporters of the BSN have a similar position as quoted in the article. I used the example of the working nurse getting a baccalaureate degree in a social science as an example of these educators’ inflexibility. On the one hand they glorify the diverse and intellectually stimulating environment of the university. On the other hand they write off recognition of university work by the working nurse that is not under their narrow control. A careful reading of my article will reveal that I do not support any particular educational program. I can only point out the inconsistencies of those educators and Pooh-Bahs trying to ram their concepts down working nurses’ throats in the form of legislation.

The wide gulf between Dr. Rogers and myself is most obvious on the question of jobs. Dr. Rogers couldn’t care less about the future of AD and Diploma nurses. Her main concerns, again, are an imaginative fear for public safety, and vigilance in maintaining an impenetrable barrier between BSNs and non-BSNs.

My position is that passage of the 1985 Resolution, despite the grandfather clause, will create the possibility for the de facto down-grading of the vast majority of working nurses. It is necessary to oppose the entire concept of the 1985 Resolution for this reason. I would not accept some modified version which would “assure jobs” as Dr. Rogers implies. The task at hand is to halt this threat.
before it passes. On the positive side, job security and increased economic benefits are best attained by united labor action. Dr. Rogers and the NYSNA oppose this strategy by promoting increased professional compartmentalization.

Dr. Rogers and the NYSNA are in strategic agreement, but have

**A BSN is to an RN what a dentist is to a dental hygienist, we are informed.**

tactical differences which stem from their respective bases of support within nursing. The NYSNA is in the more contradictory position. While promoting the interests of the nursing bureaucracy, its membership base consists of working nurses, the vast majority of whom do not have BSNs. It is also a base that is awakening to such “unprofessional” behavior as labor action. The NYSNA must include a grandfather clause to calm the fears of its ranks. It must also not imply that nursing is currently unsafe, but instead talk of future needs.

Dr. Rogers and the segment of nursing she represents need no such restraints. Their base of support starts in the baccalaureate and graduate programs. The faster they can pull away from the mass of nurses the better for them. These deans, directors, and graduate students have no interest in the vast ranks of working nurses except to supervise them. They can function freely in support of their own perceived professional interests without being caught in the bind of trying to be a voice for all nurses on the one hand, and of being a protector of the interests of the bureaucrats on the other.

**BIZGROUP CORRECTS THE RECORD**

Dear Health/PAC

First, let me tell you how much I enjoy receiving HEALTH/PAC and think that you are performing a most important service. Also, the article on our organization in the September/October issue was interesting and well-done.

In the interest of maintaining the quality of your publication and its coverage of our endeavors, I would like to make one small correction concerning the article in the November/December issue which reported on the participation by Professor Alain Enthoven in our November conference. The article was written in a tone that implies our endorsement of the Enthoven national health insurance proposal and in fact you specifically state that industry "loves Enthoven." You also state that he "keynoted" our conference. We had no keynote speaker. Professor Enthoven was there to present his national health insurance plan and was just one of a group of speakers which included HEW's Under Secretary Hale Champion, Senator Schuweiler, Goodyear's Chairman Charles Pilliod, and Senior Congressional and Administration Staff. It should be evident from this list that Professor Enthoven, for all the quality of his work, was not the keynote speaker.

Our organization has not taken a position on Dr. Enthoven's proposal although we certainly consider it one that warrants serious attention as would any other conscientiously developed proposal on this terrify complex topic. There are many in industry who clearly oppose this plan and others that find its cost containment elements and lack of dependence upon delivery of care by the federal government quite attractive. I might further add that [in] the meeting Dr. Enthoven addressed representatives from the Committee for National Health Insurance, American Medical Association, American Hospital Association, a spectrum of the government agencies and other business and provider organizations, so it was far from a single interest audience.

I realize this is a small complaint and I don't mean to suggest any concern, but I did think the matter should be brought to your attention.

Sincerely yours,
Willis B. Goldbeck, Director, Washington Business Group on Health

**IN PRAISE**

Dear Health/PAC:

I am a junior Pre-medical student at Tuskegee Institute in Alabama. I am writing this short note to praise your very fine publication, Health/PAC BULLETIN.

As a potential member of a health profession, I recognize the importance of being abreast with health care policies and issues affecting health care. I think that yours is a very informative publication which covers the controversial as well as the overlooked and neglected aspects of health care, such as payment of care, varying qualities of care based on income within an institution, minority care, etc.

As a student with limited funds, I do not own a subscription to your BULLETIN but I often get old copies from one of my former instructors. Despite this I could not miss this opportunity to commend you on your superb publication.

Keep up the good work!

An avid reader,
—Jacqueline Perry

35
Books Received


Harris, Seymour E., The Economics of Health Care: Finance and Delivery (Berkeley: McCutchan Publishing Corp. 1977).


Kallstrom, Marta and Stephen Yarnall, M.D. (Eds.), *Advances in Primary Care* (Seattle, Washington: Medical Communications and Services Assoc., 1977).


Somers, Anne R. (Ed.), *Promoting Health/Consumer Education and...*


Zoog, Spring, Ruth Jacobson and Stephen Yarnell, M.D. (Eds.), New Approaches to Counseling and Communication: How to Improve Your Skills in Patient Care (Washington: Medical Communications and Services Assoc., 1977).


Vital Signs

(Continued from Page 9.)

OCCUPATIONAL HEALTH

COURT AFFIRMS ACCESS TO WORKER MEDICAL RECORDS

In the first court contest of a key provision in the 1970 Occupational Safety and Health Act, a US district court judge has upheld the right of federal investigators to gain access to company medical records and work histories.

Previously the DuPont Company had refused the request of officials from the National Institute for Occupational Safety and Health (NIOSH), the federal research agency established under the OSHA Act, to turn over the records of 3,000 employees in its Belle, West Virginia plant.

NIOSH was called in a year and a half ago to make a hazard evaluation at the plant by a number of workers who were disturbed by the pattern of relatively rare cancers experienced there. NIOSH inspectors found 13 suspected cancer-causing agents in the plant and decided to conduct a full-scale study on death and illness among the employees. DuPont refused, arguing that turning over its records to NIOSH would violate the right of privacy for employee medical records.

Judge Dennis Knapp in Charleston, W.Va. said that the issue "isn't whether a right to privacy exists respecting the information sought, but rather whether the record indicates that such a right will be abridged. We think not."

In his decision Judge Knapp specifically ordered NIOSH not to disclose information in the records to any other government agency or personnel or, through the Freedom of Information Act, to other individuals.


CHEMICAL FIRM SUES SCIENTIST—AND LOSES

Soon after his arrival in Elkton, Maryland, pathologist Dr. Pietro Capurro observed an unusual incidence of rare lymphatic cancers in his practice at a local hospital. He soon became convinced that the cancers were linked to the disagreeable odors coming from Galaxy Chemical Company, a small Elkton firm that reprocessed waste materials from nearby DuPont chemical plants.

After years of indifference by local and state health officials, Dr. Capurro turned to the local press. Galaxy Chemical, stung by the publicity and then hit by State Health Department investigations, was nearly pushed to bankruptcy.

In an unusual and closely-watched move, Galaxy brought a $2.1 million libel suit against Dr. Capurro charging that he was reckless in release of his findings to the media, rather than to public health authorities, and thereby "ruined a business and made a community hysterical." Capurro's lawyers argued that, confronted with new cancer victims and growing evidence of a link between them and the chemical plant emissions, Capurro had a legal and ethical obligation to air his views. Nationally prominent scientists testified for both sides in the case.

After a 12-day trial, the Cecil County jury found Capurro not guilty. As for Galaxy Chemical Company, it no longer exists. A new company, Solvent Distillers, Inc., now runs the plant, operated by Paul J. Mraz, formerly president of Galaxy.

ABORTION: ADDING INSULT

Ever wonder why HEW Secretary Joseph Califano was so roundly praised for his "fairness" in drawing up guidelines to implement the recently passed Hyde Amendment banning Medicaid reimbursement for abortions? You guessed it! It's because for a while it certainly looked as though the opposite would pertain.

The Hyde Amendment bans the use of HEW funds for abortion except (1) "where the life of the mother would be endangered if the fetus were carried to term," (2) for "such medical procedures necessary for victims of rape or incest when such rape or incest has been reported promptly to a law enforcement agency or public health service" or (3) "in those instances where severe and long-lasting physical health damage to the mother would result if the pregnancy were carried to term when so determined by two physicians."

For a while trial balloons wafted from anti-abortionist Califano's office testing the feasibility of combining the provisions. On two different occasions while the guidelines were in preparation, Califano made statements interpreting the amendment as providing Medicaid fundings for abortions for women subjected to rape or incest who reported it promptly to a law enforcement agency or public health service" or (3) "in those instances where severe and long-lasting physical health damage to the mother would result if the pregnancy were carried to term when so determined by two physicians."


ACOG REAFFIRMS THE NEED FOR DOCTORS

Be sensible and give it up now, girls, says the American College of Obstetrics and Gynecology to those who would have their babies at home. That is the message of an ACOG survey of 47 state health departments on the dangers of home birth. Information from 11 state health departments showed the risk of death to be two to five times greater among home births than among hospital births. California data on stillbirths showed 25 per 1,000 homebirths compared with 9.9 per 1,000 hospital births. In perinatal deaths, data from Hawaii showed 35.4 per 1,000 home births compared with 9.6 per 1,000 hospital births and Michigan showed 42.7 per 1,000 home births compared with 10.5 per 1,000 hospital births. Reports of the survey did not discuss the quality or comparability of the data or such issues as the class background of the mothers, whether they had received prenatal care or whether home births were attended and, if so, by whom. As to reports of safety among low risk populations, ACOG says they are "not representative of the true picture."

The study will no doubt become fodder in a campaign to curb the growing demand for home births. Home births now constitute a little more than one percent of the total of all births in the US.


SOCIAL CAUSATION

SOCIAL ISOLATION AND POOR HEALTH

Any doubts about the relation of the mind to the body? A study done by Lisa Berkman and reported in Medical World News should help put them to rest. She found that socially isolated people are two to four times more likely to die of major causes than are those who are married, have good friends, or belong to social or religious groups. Those who were socially isolated also tended to have poorer health habits such as overeating, smoking and drinking, but the effect of social isolation on death rates was shown to be independent of health habits. Those who were both socially isolated and had poor health habits were found five times more likely to die. Ms. Berkman also found that city people are no more likely to be socially isolated than are those who live in small towns and in the country.

NEW YORK

Hospital beds are nothing if not prolific. Remember when the BULLETIN wrote about New York City's 5,000-bed surplus back in the summer? Well, by February the surplus had grown to 8,000 and one state health planning official believes it will reach 10,000.

If you think this reflects additional beds or even changes in utilization patterns, you're wrong. It simply means they've changed the formula for how you calculate such things. "Health planning is at best a young art," commented that official, and apparently not nearly as vigorous as the excesses it seeks to throttle.

Latest to bite the dust is Brooklyn's 207-bed Unity Hospital, an old and not well-known institution.


FISH OR FOWL?

It might have been a foul trick, or possibly a fanciful fish story, but it surely wasn't "Fish, Wildlife, Marine and Coastal Resources." Specifically, claimed the Hospital Association of New York State (HANYS), it didn't belong with the construction fund for the Salmon River Fish Hatchery at Altmar, NY.

But the ever-wary eye of the hospital lobbyists was keener than that, and HANYS promptly flushed out and shot down the hidden amendment, leaving onlookers wondering who is the hunter and who is the hunted on the health care scene in New York.

Announcements

IHS: STUDENT RATES

The International Journal of Health Services announces that it has just established student subscription rates. Student subscriptions will cost $20.00, and must be accompanied by proof of student status; regular rates are $41.00 per year. Write IJHS, Division of Health Care Organization, School of Hygiene and Public Health, Johns Hopkins University, 615 North Wolfe Street, Baltimore, Md., 21205.

POLITICAL MAGAZINES

A catalogue of 12 of the nation's leading political magazines is now available. For copies, write to Health PAC. Include 25¢ postage.