

**Autopsy on the AMA:
An Analysis of Healthcare Delivery Systems in America**

Prepared by:

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AUTOPSY

ON THE

A.M.A.



An Analysis of
Health-Care Delivery Systems
in America

\$1.50

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PREPARED BY

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Martin Brown Charles Turner

Jill Hill

WITH A CONCLUSION BY DR. THOMAS BODENHEIMER M.D.
of the Medical Committee for Human Rights



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"A PHYSICIAN IS ONE WHO POURS DRUGS
OF WHICH HE KNOWS LITTLE INTO A BODY OF
WHICH HE KNOWS LESS."

Voltaire

"A DOCTOR IS A MAN WHO WRITES PRES-
CRIPTIONS TILL THE PATIENT EITHER DIES
OR IS CURED BY NATURE."

John Taylor

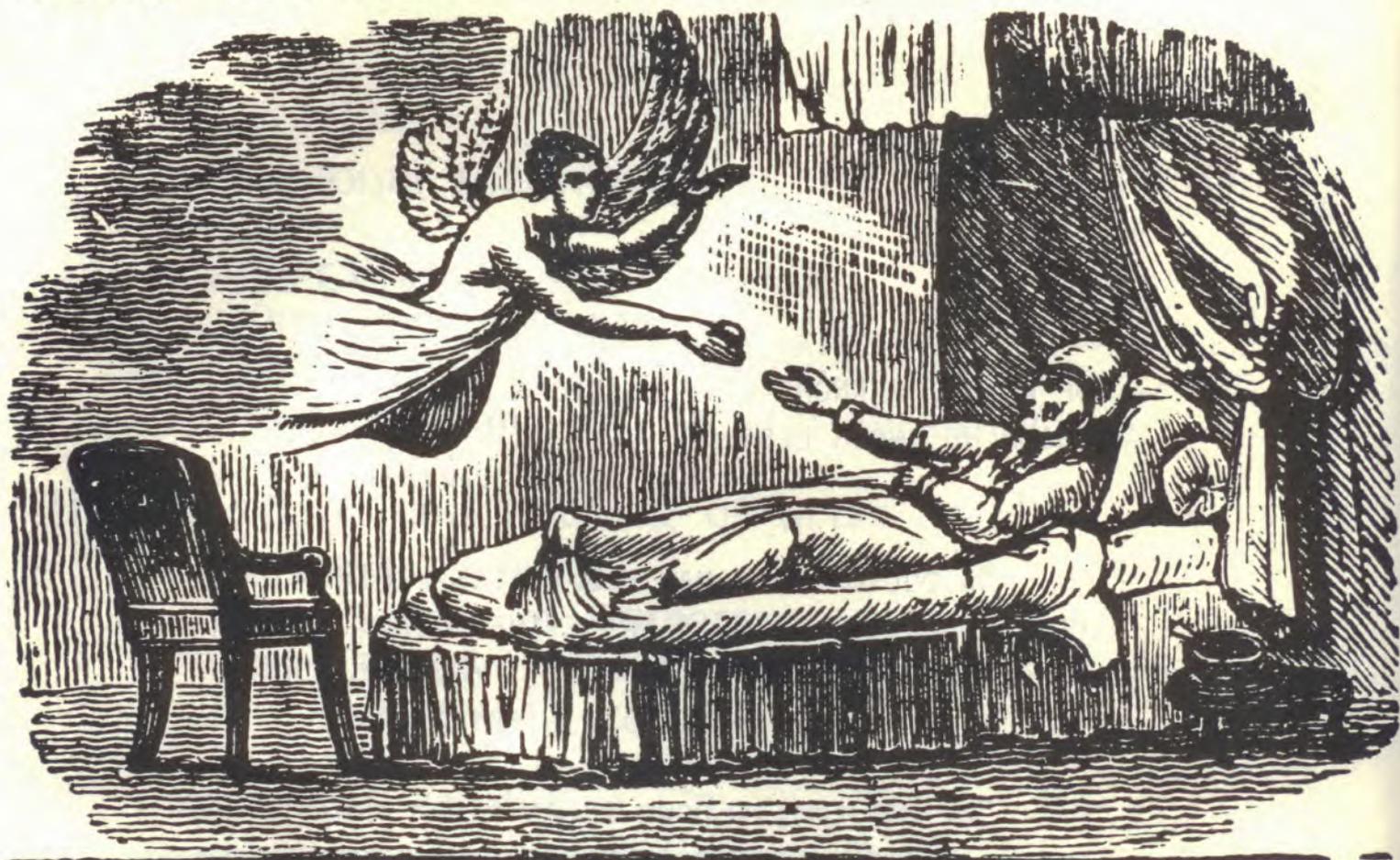
"WE MAY LAY IT DOWN AS AN AXIOM THAT
WHEN A NATION ABOUNDS IN PHYSICIANS IT
GROWS THIN OF PEOPLE."

Joseph Addison

"A WEALTHY DOCTOR, WHO CAN HELP A
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RUFFIAN WHO KILLS A RICH MAN TO SUPPLY
HIS NECESSITIES."

Tatler, October 8, 1709

Introduction



LIFE IS ONLY LIFE WHEN BLEST WITH HEALTH

"The United States (has) a quality of medical care unsurpassed anywhere," said Dr. Milford O. Rouse, President of the American Medical Association (the AMA) in 1967. His position at the pinnacle of the most powerful country's most powerful medical organization certainly gave him the authority to say that with confidence.

People respect doctors. In fact, 92% of the public feels most doctors can be trusted. People in the medical therapy professions are admired and the communities they serve reward them well for their work. Doctors averaged \$31,400 a year in 1967 and their median income was \$32,170 in 1968. These figures are approximately five times the average and median

incomes for the general population.

Medically speaking, things seem to be going well. The drama of headlines about organ transplants and new medical advances in the laboratory also serve to indicate that the System that provides health care for Americans does its job splendidly.

But does it, really?



George Bernard Shaw wrote these words a few decades ago:

That any sane nation, having observed that you could provide for the supply of bread by giving bakers a pecuniary interest in baking for you, should go on to give a surgeon a pecuniary interest in cutting off your leg, is enough to make one despair. ...And the more appalling the mutilation, the more the mutilator is paid. He who corrects the ingrowing toenail receives a few shillings; he who cuts your insides out receives hundreds of guineas.

Some young physicians find Shaw's observation relevant today. The Medical Committee for Human Rights (MCHR) read a

statement to the AMA conference in San Francisco on June 1968 after forcibly taking over the microphone:

The health care system in the United States, long failing, now may well be collapsing. This disintegration is due in no small part to racial discrimination, economic discrimination, and archaic, poorly delivered and inadequate health programs. Racial and economic discrimination, far from lessening, are actually increasing. The so-called two classes of medical care are characterized by an unconscionably bad system for the poor and an increasingly deteriorating system for the middle class.

For the technically most advanced nation in the world, a most striking feature of the American health system is its backwardness. There is an amazing failure to introduce a universal insurance system, coordinated community and regional planning and perhaps most important, there has been a tenacious retention of a fee system which has, indeed, resulted in health care becoming a privilege rather than a human right.

The Medical Committee for Human Rights takes the position that present inadequacies in health care and the disarray in planning are, in part, the result of a system which, by its own logic, consistently resists the significant changes that would make comprehensive care possible. Organized medicine in particular, has never felt responsible and accountable to the American people for its actions, and continues to



ORIGINAL AESCULAPIAN WAND

*Life is short; art is long;
experience difficult*

deny them any significant voice in determining the nature of services offered to them.

Other medical authorities agree with MCHR.

Dr. Jack Geiger, co-director of the center and professor of preventive medicine at the Tufts University School of Medicine, Boston, said in 1968:

The health of the poor in the United States is a national disaster. The poor are likelier to be sick, the sick are likely to be poor. Without intervention, the poor get sicker and the sick get poorer.

According to an article in the *San Francisco Examiner and Chronicle* on July 13, 1969:

"Any practicle, reasonable man would agree that the costs of medical care are prohibitive today for 99 per cent of the American people," says Dr. John H. Knowles, director of the Massachusetts General Hospital...

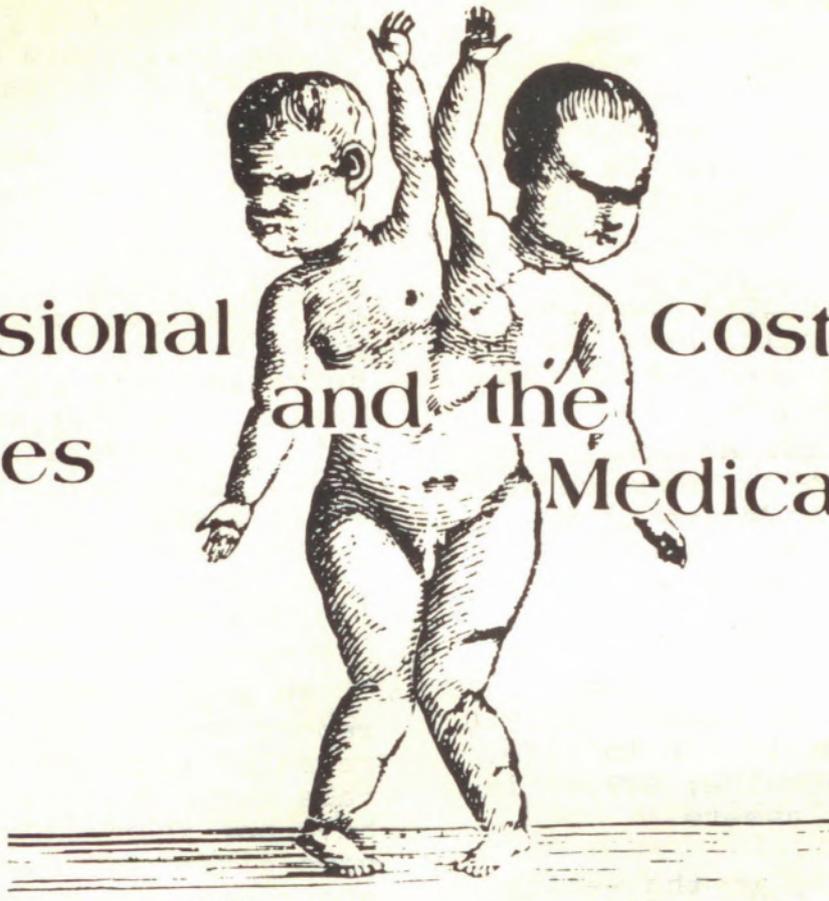
Dr. Stewart Frank, a San Francisco physician, told us:

In America there are three classes of medical care: 1) an unreasonably expensive system for the rich; 2) an increasingly deteriorating system for the middle class; 3) an unconscionably bad system for the poor.

Worse, two surveys, one conducted at Yale University in 1964, the other at Cornell in 1955, show that physicians and modern medicine have become close rivals of cancer and heart disease as a major killer of man!

In order to find out the truth about our medical crisis, let us examine the details of health-care delivery systems in America.

Professional Incomes and the Cost of Medical Care



Americans pay a high and ever-increasing price for medical care. The result, however, is not better care, but higher incomes for doctors.

The total national expenditure by consumers, government, charities and others for physicians' services in 1950 was \$2,755,000,000 and rose steadily to \$10,163,000,000 in 1967.

There were 320,450 physicians

in the U. S. in 1967.

This means that the average (reported) income of doctors for 1967 was \$31,400. (*Statistical Abstracts of the United States, 1969*)

Using figures from *Medical Economics*, a journal which conducts surveys on the incomes of non-salaried physicians under 65, we find the following increases in salary:

Between 1947 and 1964 physicians' (median) incomes rose 225 per cent. During those years the percentage rise in doctors' incomes was 72 per cent greater than the percentage rise for "managers, officials, and proprietors" and 88 per cent greater than the percentage rise in the average annual earnings for full-time employees in all industries.

From 1940 to 1963 the income of general practitioners has gone up faster than the income of specialists.

A study by the National Bureau of Economic Research in 1963 places the wealth of the typical doctor in his mid-forties at between \$100,000 and \$120,000. This can be broken down (at the higher figure) as follows: \$29,200 in common stocks; \$7,040 in bonds; \$36,960 in real estate; \$6,720 in life insurance cash value; \$39,00 in cash and other assets.

When compared to the wealth holdings of the average American family, a meager \$490 in 1963, it becomes clear that physicians constitute a highly privileged financial group.

Because of their professional positions, physicians can get fees that have nothing to do with actual services performed; and most of this income is not reported on Federal tax forms for obvious reasons.

Here are some ways to make extra income if you're a doctor:

1) In 1948 the Los Angeles Better Business Bureau announced that 70 per cent of the country's physicians were accepting financial rebates from drugstores, medical supply houses, opticians and laboratories.

2)

In 1952 the California Physician's Service, a non-profit insurance plan sponsored by the California Medical Association, revealed that at least 200 doctors had been stealing more than a million dollars a year by collecting insurance benefits for services never performed. All the money-hungry M.D.s were required by their medical societies to pay back the funds but only a few suffered other punishment. Actually what they were doing was only an exaggeration of what takes place practically everywhere else.

3)

In April, 1961, the Cornell report from Cornell University revealed that 25% of 286 hospitals surveyed permit doctors who have not seen the patient, but have given phone advice to the emergency-room nurse, to bill emergency cases.

4)

In 1967, a University of Chicago study showed that just 73 "mass production" medical men handled more than half of all physician services rendered to 285,000 welfare recipients.

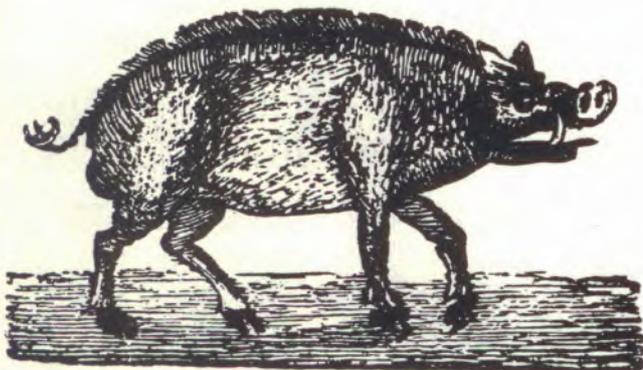


As Nicholas Von Hoffman observes in a recent column,

...the family doctor (is) a retail businessman, struggling to run a small organization which grosses anywhere from \$100,000 to \$400,000 a year.

The underlying difficulty is that the doctor has been changed from a professional into a businessman. The fee system which was supposed to keep him independent and with no loyalty save to his patients now works against his ancient status. (San Francisco *Chronicle*, November 29, 1970)

It's not hard to see that doctors are very well rewarded by: 1) the practice of medicine, and 2) the advantage that they get from associated business practices made available to them in the course of their medical career.



Now, what is the financial cost of health care to the patient, and what does he get for the price?

Dr. Gerald D. Dorman, the President of the AMA, said in the fall of 1969, "...one major illness or accident can be a financial as well physical tragedy."

This statement is not hard to understand when one considers the skyrocketing costs of medical care, especially hospital care.

Medical costs have been the fastest rising component in the Consumer Price Index for more than a decade.

Quoting study done by Lewis Harris for *Sources*, a Blue Cross publication on the health problems of the poor:

The cost of health care may be a prime concern among nearly three in every four American families. It is not an overstatement to say that for nearly all the poor it is a persistent fear.

The Harris study also revealed that most of the respondents to his inquiry, whether poor or affluent, feel somewhat isolated from good medical care. A majority stated that they would not know where to turn in the event of a serious illness in the family. Harris has said, "Now in the affluent 60's... it can truthfully be said that over one-third of this nation feels ill cared for in its medical needs. This runs to almost half the people in the South, in the cities, in rural areas, among Negroes, among people over 50, and among those with incomes under \$5,000."

Poverty in living standards accompanied by poverty in medical care seems hardly justifiable when we consider the amount of money Americans are investing in health care--\$47.3 billion. This constitutes more than six per cent of the Gross National Product (the exact figure was

6.9% in 1967) the highest percentage spent on medical care of any nation except the USSR.

Even so, 80 million Americans find it difficult, sometimes impossible to get medical treatment. ("Health in America--the Problem and the Practice" KPIX radio, San Francisco, April 20, 1970)

Dr. Howard A. Rusk, in an article in the *New York Times*, October 26, 1969 titled "Cutting hospital costs," gives some idea of how out of control the medical problem is in terms of hospital costs:

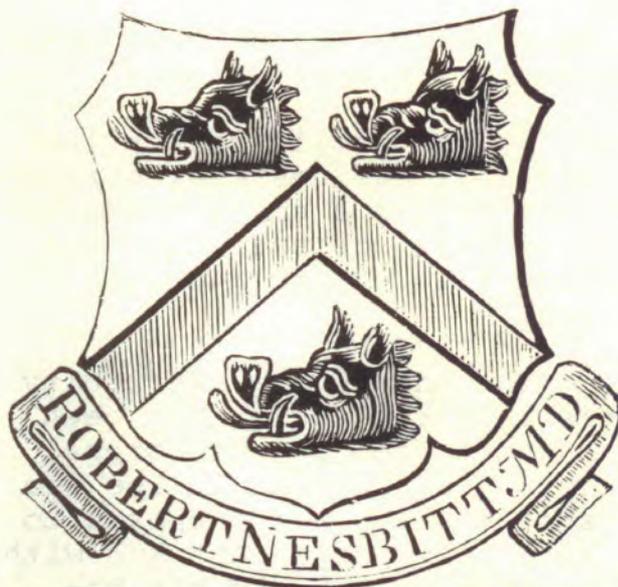
One of the most pressing problems facing our nation in the health area is the continuing spiraling cost of hospital care.

The average expense per patient-stay has continued to climb. It was \$515.59 in 1968, more than double that of eight years ago. Patient-day costs at the end of 1968 stood at \$61.38, again almost double that of eight years ago.

In 1969 the figure rose to \$67.59 per day. The American Hospital Association (AHA) has projected a cost of \$98.37 a day by 1973.

Almost a hundred dollars a day; that's what Dr. George W. Graham, president of the AHA, testified to the House Ways and Means Committee. (*Oakland Tribune*, October 28, 1969)

Even if the average patient stay is still the 1968 figure of 8.4 days, soon it will cost you about \$800 to go to the hospital.



Doctor's crest, circa 1850

The Department of Labor computes budgets for what it calls the lower and moderate standards of living for families of four in the urban setting. The three budgets, first computed in 1967, are brought up to date by applying increased living costs--as measured by the bureau's Consumer Price Index--to the items which the imaginary families were allowed under the budgets.

STANDARD OF LIVING INCOMES

	1967	1969	1970
MODERATE	\$9,243	10,077	10,930
LOW	\$5,915	6,567	7,134

More than half of all American families live below the moderate standard of living and the average family income is a little over \$7,000. However, the allocation for medical care in the two budgets is about the same.

ALLOCATION FOR MEDICAL COSTS

	1967	1970
MODERATE	\$491	\$574
LOW	\$488	\$562

But at the lower standard only \$1,331 (1967) or \$1,429 (1970) is budgeted for rent and furniture. And more is set aside for income tax than for medical care. (San Francisco *Chronicle*, December 25, 1970)

Since millions of families have little or no savings (see S.R.F.'s *Betrayal of the American Dream*) a sudden \$800 hospital bill means that housing or food must be sacrificed; or the family must go into debt and avoid medical care for the rest of the year.

Because millions of families are deeply indebted and in poor health (as we show in Section II) any of the above alternatives can be a financial disaster.



But what about medical plans-- health insurance--etc? Well--

125 million Americans are without hospital insurance. Those that have it pay on the average, \$460 a year. And health plans pay, on the average, only 36% of the health care costs of subscribers. Even a high paying plan, Medicare, only pays 45% of the health care for the aged. ("Health in America-- Don't Get Sick In America" KPIX radio, San Francisco, April 21, 1970)

These figures indicate why "The cost of health care may be a prime concern among nearly three in every four American families." (*Sources*)

What makes a distressing situation grotesque is that an official publication of professional medicine can announce that it favors the situation in which people must forego medical attention because they do not have the financial resources to meet the high cost!

The New York State Medical Association is the largest state medical society in the nation. In their August 15, 1949 issue of the *New York State Journal of Medicine*, the society printed this editorial:

An experienced general practitioner will agree that what keeps the great majority of people well is the fact that they can't afford to be ill. This is a harsh, stern dictum and we readily admit that under it a certain number of cases of early tuberculosis and cancer, for example, may go undetected. Is it not better that a few such should perish rather than that the majority of the population should be encouraged on every occasion to run sniveling to the doctor?

Section II.

Health Conditions in the U.S.



The nation spends enormous amounts of money on health care, and doctors seem to be doing exceedingly well. Considering the large sum we take out of our national pocket to pay the medical bill, how is our health?

Our Poor Health

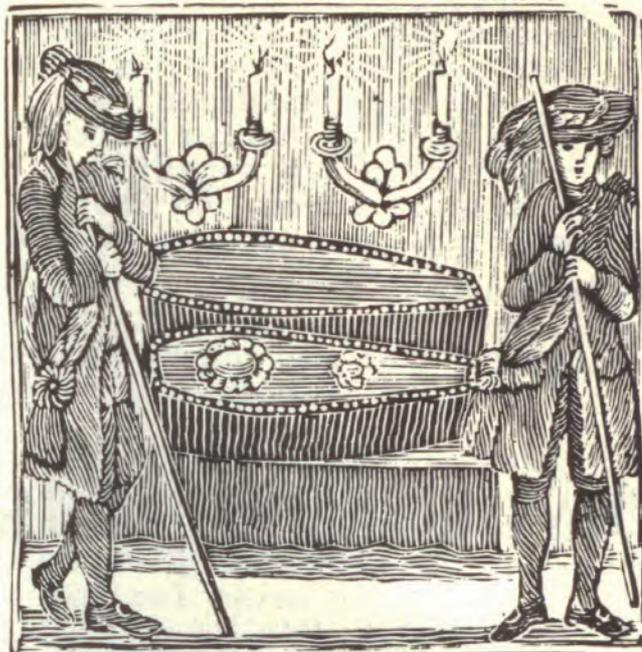
"Our health statistics in certain areas are frankly embarrassing," Dr. Knowles said. "The health of some 30 million poor people is abysmally bad and almost totally neglected." (New York Times, Fall, 1969, Dr. John H. Knowles, Director, Massachusetts General Hospital, Boston)

The most recent Health, Education and Welfare figures show that life expectancy for a man of 65 has DECREASED since 1952!

The AMA insists that Americans "enjoy health care unsurpassed anywhere on the globe." Is this really true?

According to Dr. William H. Stewart, Surgeon general of the United States from 1965 to 1969, now Chancellor of the Louisiana State University Medical Center:

There is universal agreement among public health experts that infant mortality is the best and most sensitive index of the level of health of a population, community or nation. (B. Jones, *The Health of Americans*)



WHO (World Health Organization) reports that the U. S. ranks 18th in infant mortality and 22nd in male life expectancy in the world. If America had the best care 38,000 babies and 220,000 men would not have died last year. (San Francisco Chronicle, July 17, 1969)

...20 to 40 percent of all our children suffer one or more CHRONIC medical conditions. One out of every five young men called for military service is rejected because of poor health.

According to the National Bureau of Economic Research, even if we consider just the white population in our HEALTHIEST geographical regions, we find a significantly higher death rate than in many other countries. Dr. Martin Cherkasky, director of New York's Montefiore Hospital and Health Center, points out that in the state of Utah, for example, despite a nearly all-white, middle-class population, the infant mortality rate is equal to that of Sweden's most deprived province!

60% of the total public sometimes feel worried and nervous, 52% sometimes feel lonely and depressed, and more than a quarter of the population are sometimes unable to sleep, to stop smoking, to eat, and to get up. (Sources)

This last fact is NOT coincidental with the fact that about 60% of all American families earn LESS than \$8,000 a year (the lower standard of living) and are several thousand dollars in debt.

Starvation Equals A Thriving Practice



It is a well accepted fact by public health officials in all modern nations that preventable disease, especially those which occur in women and children, are much more common among people who are

poorly educated, poorly nourished, poorly housed.

Which diseases are more common among the poor of the United States?

A. DISEASES CAUSE DIRECTLY BY POOR NUTRITION

1. Vitamin deficiency diseases: rickets (vitamin D and calcium deficiency), scurvy (vitamin C deficiency), pellegra (vitamin B deficiency) and certain anemias (vitamin B-12 and folic acid deficiency).

2. Iron deficiency anemias-- common in women and children.

3. Stunting of physical and mental growth of infants and children associated with protein deficiency coupled with other deficiencies in calories, vitamins and minerals.

4. Common complications of pregnancy: metabolic toxemia of late pregnancy, a high percentage of "premature" or low birth weight infants, abruptions of the normally placed placenta, nutritional anemias, lowered resistance to common clinical infections of liver, lungs and kidneys.

5. Cirrhosis of the liver (commonly associated with alcoholism).

B. DISEASES INDIRECTLY RELATED TO POOR NUTRITION

1. Infections such as tuberculosis, pneumonia, liver infections and kidney infections, and surgical wound infections.

2. Delayed healing of wounds of all types and broken bones. Note: Nutritional deficiencies are seldom pure in the sense of just one nutrient being deficient in the diet; the effect of malnutrition in people is often hidden but can be revealed by careful dietary histories.

C. DISEASES IN WHICH POOR EDUCATION OF CHILDREN AND YOUNG PEOPLE IN BASIC HEALTH RULES AND PRINCIPLES OF MODERN MEDICINE PLAY AN IMPORTANT ROLE

1. Venereal diseases, especially syphilis and gonorrhea (and all their severe complications) which are increasing among our people.

2. Cancer of the cervix (mouth of the womb) occurs much more commonly among women who do not get good obstetric and gynecological care.

3. Cancer of the lung and larynx (voice box) caused by prolonged cigarette-smoking-- usually 10 years or longer. This basic knowledge has been established here in the United States FOR OVER 30 YEARS, but the tobacco companies have successfully prevented the American people from learning about it.

4. Emphysema, a common disease of the lungs most commonly caused by cigarette-smoking over a period of years.

5. Severe infections and bleeding associated with abortions.

6. Certain common skin diseases such as impetigo and ringworm.

7. "Accidents," burns, and poisonings, particularly in young children.

D. DISEASES RELATED TO POOR HOUSING, OVER-CROWDING AND POOR SANITATION

1. Rheumatic fever and rheumatic heart disease.

2. Common respiratory diseases like influenza and the

common cold and their complications like middle-ear infections, meningitis; tuberculosis.

3. Infant diarrhea and dysentery with dehydration, and other intestinal infections, including infestations with worms and other parasites.

E. DISEASES RELATED TO POOR OR INADEQUATE MEDICAL CARE

In a society like ours which has a "fee for service" medical system, where it costs a lot of money to see a doctor and get complicated, modern medical care, the poor man or woman will often put off a visit to a doctor for too many months or years. When this happens, diseases which could be cured early in their courses are allowed to advance to an incurable state. This is particularly true in many types of cancer, eye diseases, chronic infections, and mental and emotional illnesses.

We have learned that good prenatal care and good diet during pregnancy are enough to prevent most of the complications of pregnancy; they are necessary for each pregnant woman so that she may remain in good health and have the best chances to have a healthy, full-term baby. Yet in many of our poverty areas as high as 50% of pregnant women receive no prenatal care.



F. DISEASES DIRECTLY RELATED TO RACIAL DISCRIMINATION AND PREJUDICE

(All of these factors under discussion here overlap each other--but the social and economic stresses and strains to the human child growing up as a "Negro," "Latin," "Oriental," or "American Indian" among our lowest class--these stresses are certainly greater than those facing the average "white" American child.) Our present American Society does not really try to make these children feel that they belong to the society except to be servants. (Caucasian children in poverty also suffer the same deprivation but at least escape the hazards of racism.) If a child isn't lucky enough to get a sense of belonging from his individual family, then he suffers alienation from other people for the rest of his life. The children of our poor do not feel that this nation, for which they are now so often expected to give up their lives in war, belongs to them because it doesn't. These children fill up our probation departments, prisons and mental hospitals.

In our southern states "high blood pressure" and death from high blood pressure occurs about 4 times more commonly among "Negroes" than among "Whites." High blood pressure has many severe complications such as brain stroke; kidney and heart failure.

In many states the maternal mortality rates (deaths in women associated with pregnancy) have been 5 times higher in "Non-whites" than in "Whites." Severe complications of syphilis and gonorrhoea are much more common among "Non-whites," both men and women. Abscesses of the uterine tubes and ovaries which result

from gonorrheal infections are very common among Blacks; so are ectopic or tubal pregnancies more common among women and girls who have had gonorrhea. (In southern hospitals I have heard gynecologists refer to operations on diseased tubes and ovaries as "nigger surgery.")



A report given recently in the U. S. Congress on the health of the American Indians is a national disgrace. In some areas one-third of Indian children suffer from trachoma, a preventable and treatable virus disease of the eyes that causes blindness; this disease is staging a comeback. Some 25% of American Indians are judged "mentally ill" by health authorities working with them. The average age of an American Indian at death is 43 years. About 90% of American Indians live in houses judged unfit for humans; 66% of them haul water from unsanitary sources in unsanitary containers, many from distances over a mile from their homes. The death rate from tuberculosis among the

400,000 original Americans surviving is five times higher than the general "European American" population.

In a recent report from Harvard School of Public Health we have evidence that some 60% of Negro families and 30% of Caucasian families have obviously inadequate diets. Only 10% of Negro families are considered obviously well-nourished.

It becomes evident from the above discussion that to really improve the health and well-being of a large number of our people who are trapped in poverty and discrimination, we will have to radically alter the entire socio-economic system as well as the medical system. We must put **PEOPLE AND THEIR CHILDREN FIRST**, before profits, prestige and property of the U. S. wealthy business class.

This difficult task can only be accomplished when the health of the American People is given the proper emphasis in political struggle. The chief end and aim of American medicine must be changed from profit and financial security for a small number of doctors and paramedical people (those who make large profits on the manufacture and distribution of drugs and medical supplies) to **SERVICE** for our people's health needs.

The present socio-economic system as it functions here in the United States is denying millions of people in poverty their basic Constitutional and human rights of "life, liberty, and the pursuit of happiness," for these are but empty phrases without good health, a decent education, and a decent job. These conditions will never change until we, the common people, organize to change them.

There is no greater nor more glaring contradiction in our modern "free, democratic, open" U.S. society than our medical system organized and run by representatives of our wealthy business class for its own interests, prestige and profits.

(The above statement is reprinted from Dr. Thomas Brewer's "Disease and Social Class")



In support of Dr. Brewer's conclusions are these facts concerning our system of food distribution.

Of the 8.4 million poor school children in the nation, at least 5 million are not benefited by the national school lunch program, according to John R. Kramer, executive director of the National Committee on Hunger and Malnutrition.

In his new book, *Let Them Eat Promises*, "...a Washington correspondent, Nick Kotz, reports President Johnson turned down recommendations for food aid reform from top officials on 12 specific occasions.

"Mr. Kotz quotes President Nixon as having said, 'Use all the rhetoric, so long as it doesn't cost any money' in advising Secretary of Agriculture Clifford M. Hardin on administration hunger policy." (New York Times, December 2, 1969)

After a year has passed, Mr. Kotz seems to be correct. An

article in the San Francisco *Chronicle*, November 27, 1970, is head-lined: "Americans Are Still Hungry," and it reads:

Last Christmas Eve, (President Nixon) pledged that every poor American child would receive a free or reduced price school lunch by Thanksgiving Day, 1970. ...Senator McGovern charged that "there are at least 12 million needy persons" not receiving Federal food aid. McGovern charged that the President's pledge of free school lunches for the poor by this Thanksgiving "has turned out to be 3 per cent food and 97 per cent empty promise."

Who does benefit from the Federal food program?

The enormously productive fields of central Iowa were clipped and cleared this week and braced for winter, great beige and black rectangles that have just yielded one of the largest corn and soybean crops on record.

Nevertheless, little change is expected in the earnings of farmers or in the prices housewives across the nation will have to pay for their families' food this winter. (New York Times, December 7, 1969)

...in recent years, about \$500 million, or 14 per cent of the total farm subsidies, have been paid out to big farmers representing less than half of 1 per cent of the total number of farmers receiving subsidies. The farm subsidies, dating back to the Depression, were originally designed to aid low-income family farmers. (New York Times, July 9, 1970)

The problems Dr. Brewer reveals are verified by Louis Harris in *Sources* when he shows the results of the question asked nation-wide, "Is someone in the family now seriously ill?" Mr. Harris finds that nationally 11% or better than 1 in 10 of all families currently have someone seriously ill.

Examining the results and listing them by level of family income: Of families earning less than \$5,000 a year, (about 1/4 of all families) 19% or almost 1 family in 5, have someone who is seriously ill.

Among Inner-city Blacks, Chicanos, and Appalachian Whites 1 in 4 families have someone seriously ill.

The poor feel that their chief reason for ill health is that the food they get is bad food. Many complain that they can't get enough food.

In Lebanon, Virginia, a 71 year old retired white said, "At least in the old days you could eat fresh food. Now it is too expensive to buy."

In El Paso, Texas, a 24 year old Mexican-American housewife pointed out; "Everything is so high nowadays you can't afford to eat as well as people did years ago."

A black housewife in a New Orleans ghetto complained, "The only kind of food you can afford to buy makes it easy to gain weight and hard to control weight. It's awful unhealthy food we got to eat, mainly fats and leftovers." (*Sources*)

If a doctor is concerned about the nutritional needs of the poor, he won't last long in organized medicine. Consider

the case of Dr. Donald Gatch. Dr. Gatch brought public attention to severe malnutrition and intestinal parasites among children in Beaufort County, South Carolina, in 1967.

Every other doctor in the county denied the existence of these conditions and Dr. Gatch was publically denounced by many of his colleagues. He became the subject of harassment and economic reprisals from organized medicine; finally in 1969 he was indicted on frame-up charges of illegal use of drugs, failure to keep proper records and dispensing drugs without a prescription. (*New York Times*, December 18, 1969)

Poverty and malnutrition are clearly a major cause of chronic disease in the United States. But there is no profit in treating the causes. Organized medicine insures the continuance of profitable symptoms by ignoring the social causes of misery and ill health.



The Insanity of Mental Health Care



Mental therapy procedures show the pitiful outcome of a poor system of health care; something made clear by a quote from Dr. Thomas S. Szasz, Professor of Psychiatry at the Upstate Medical Center for the State University of New York. In a paper entitled "Psychiatric Interventions as Degradation Ceremonies" he writes:

It is now becoming more widely acknowledged that persons are incarcerated in mental hospitals not because they suffer from a mental illness, but rather because they are in a disadvantaged

social position. According to Werner Mendel, for example, "A patient is admitted to a mental hospital because he is unable to find support in the community--a place to live, a clinic which will see him on a regular basis, a source of income, a family who will tolerate him..." (Expert Believes Mentally Ill Should Not Be Locked Up." *Newark Evening News*, April 20, 1967, p. 32) In short, public mental hospitals have always been, and continue to be, places of segregation, for lower-class citizens. "No mental patient has ever gotten well in a hospital. (Mendel)"

Why has no patient ever gotten well in a mental hospital?

This is one reason why:

Just north of Santa Barbara, travelers on U.S. 101 pass what appears to be a beautiful school. Its neatly chopped lawns, its unobtrusive cyclone fence, and its majestic location on a hill top add to the image of tranquil serenity.

It is in fact the Atascadero State Hospital, a maximum security facility designed to treat "sex offenders, sociopaths and cultural deviants." Most of the "patients" are plain, ordinary homosexuals who had the misfortune of being at the wrong place at the wrong time and so were selected by the monstrous lottery called morals law enforcement to fall into the hideous clutches of the doctors of Atascadero.

"Patients" at Atascadero are being tortured and used for savage medical experiments

similar to those of Dachau and Buchenwald. Victims of sadistic doctors are being turned into vegetables with brain surgeries, castrated and tortured to the point of death with pain causing drugs and electrical shocks.

The newest experiments tried out by the masters of Atascadero are with death panic and acute anxiety producing drugs. Succinylcholine is a drug causing instant paralysis of all muscles, including those needed for breathing. This drug is forceably injected into the unwilling "patient". The victim is taken to the "brink of death," and kept alive only with mechanical devices. The doctors admit that at least 167 "patients" were used for the experiments.

The purpose of the experiments or "exploratory study" was to find out if the drug was effective as "an agent in behavior modification," according to Dr. Martin J. Reimringer, Chief Psychiatrist at Atascadero.

When the drug takes effect, the victim loses all control of his muscles, but retains consciousness. Dr. Nugent, Chief Psychiatrist at Vacaville Medical Facility (who also used the drug), says "The sensation is one of suffocation and drowning. The patient feels as if he had a heavy weight on his chest and can't get any air into his lungs. The patient feels as if he is on the brink of death."

Then a technician commences to brainwash the victim, scolding him for being

"wicked." The doctors feel that the victim might connect the behavior he is being scolded for with the feeling of dying and therefore refrain from such behavior in the future.



The doctors are in a tenuous legal and ethical position. Both the state law and ethical rules of the American Medical Association prohibit experiments being performed on patients without their consent.

Dr. Grant H. Morris, professor of law at Wayne State University (Detroit) recently visited Atascadero. "The succinylcholine experiments were conducted in apparant violation of the Nuremberg Code, the Declaration of Helsinki, and the AMA's 1966 ethical guidelines for clinical investigation," Dr. Morris said.

The Nuremberg Code provides for an international tribunal to try government officials and doctors for "gross crimes against humanity." The Nuremberg tribunal was set up after the Second World War under international law. Many German doctors were tried and convicted by the tribunal for conducting similar experiments on human victims in the Nazi concentration camps. The AMA ethical guidelines call for expelling doctors who experiment on unwilling "patients."



A private psychiatrist described the drug as "worthless" as a treatment for behavior, and equated it with the worthless experiments of the doctors of Dachau. "The doctors' own statistics show that only 7% of the cases showed any improvement," he said. He also pointed out that the drug could cause severe per-

manent brain damage because it cuts off the oxygen supply to the brain. "Of course," he said, "a person's behavior can be changed if there is severe brain damage." (Don Jackson, of Gay Liberation, reporting in the San Francisco *Good Times*, November 13, 1970)

As one might expect, California "mental patients" are not the only trouble makers that receive the succinylcholine treatment. Army medics have used the identical treatment as a torture and interrogation technique in Vietnam.

The situation of mental health care is especially moving when you consider the cases of juveniles who come under psychiatric attention. Every month 23,000 young people are taken to hospitals for psychiatric evaluation. Already there are 2.6 million patients in psychiatric hospitals between the ages of 16 and 24. Over the past 10 years there has been a 150% increase in the number of young people in institutions and ONE IN FOUR of those put into institutions every year NEVER COMES OUT. ("Cry Help" Channel 4, KTVU, San Francisco, April 25, 1970)

"There is not a single community in this country that provides an acceptable standard of services for its mentally ill children." (Joint Commission on Mental Health of Children, June 30, 1969; quoted in the San Francisco *Chronicle*, April 26, 1970)

The Citizen's Committee for Children of New York, an influential civic group reported that no hospital in New York had "an adequate ratio of teachers to children," and few hospital teachers had any training in

special education. Adolescents 16 to 21, the report said, were being transferred to adult wards by new policy with "almost no educational services."

Mrs. Milton A. Gordon, president, said that children are often kept indoors all winter because of lack of warm clothing. The report quoted Dr. Alan C. Miller, Commissioner of Mental Hygiene, as citing budget problems allowing only 10 cents a day for mentally ill patients for clothing, 11 cents for other personal supplies, and 67 cents for food. (*New York Times*, April 27, 1970)

"...10 million Americans under 25 require mental health treatment. ...only 500,000 (5%) ...actually receive some attention--attention that is often indifferent, rarely helpful, and frequently harmful." (*New York Times*, April 19, 1970)



Burning demented women as witches

Perhaps the most important--and most difficult--evaluation of emotional health is the consideration of how the human personality is wasted in this society:

The society produces many useless things, and to the same degree many useless people. Man, as a cog in the production machine becomes a

thing, and ceases to be human. He spends his time doing things in which he is not interested, producing things in which he is not interested; and when he is not producing he is consuming. He is the eternal suckling with the open mouth, "taking in" without effort and without inner activeness, whatever the boredom preventing (and boredom producing) industry forces on him---cigarettes, liquor, movies, television, sports, lectures (and, we add, drugs) --limited only by what he can afford. But the boredom preventing industry--can only succeed in preventing the boredom from becoming conscious. In fact, they increase the boredom as a salty drink taken to quench the thirst increases it. (Dr. Erich Fromm, *The Revolution of Hope*)

Robot-like performance is what the society demands and it can enforce its demand with the most intensive kind of personality control. Look at education:

Charles Silberman of *Fortune* magazine, speaking to the delegates of the 108th annual convention of the National Education Association about his four-month Carnegie Foundation-sponsored study here, in England, and Japan made this comment about American education:

It is not possible to spend any prolonged period visiting public school classrooms without being appalled by the mutilation visible everywhere. There is mutilation of spontaneity of joy in learning, of pleasure in creating, of a sense of self.

We fail to appreciate what grim, joyless places most

American schools are, how oppressive and petty are the rules by which they are governed, how intellectually sterile and aesthetically barren the atmosphere, what an appalling lack of civility obtains on the part of teachers and principals, and what contempt they unconsciously display for children as children. (San Francisco *Chronicle*, July 3, 1970)

Understandably enough, more and more children don't want to "buckle down" in this kind of environment. They are called "hyperactive" since they won't act like the kind of machines they are supposed to be. Is the school changed? NO. The child is changed, and the medical profession cooperates magnificently.

A Federal agency and the chairman of a Congressional study of alleged invasions of privacy ordered separate investigations today into reports that perhaps as many as 10 per cent of the school children of Omaha, Nebraska, are taking prescribed "behavior modification" drugs.

The practice...originated with Dr. Byron B. Oberst,...

The drug most commonly used, according to reports, is Ritalin, a stimulant that Dr. Oberst was quoted as saying "increases the ability to concentrate."

...Dr. Oberst was quoted as saying that, although the way in which these drugs work was not entirely clear, the children "become more successful" (New York *Times*, June 30, 1970)



The same information comes out in an article by-lined Providence, Rhode Island, which reports that amphetamines are given to young, hyperactive children and act to slow them down and make them concentrate on their work. But no one knows how the drugs work. The measure of improvement, apparently, is how well the child does his work. Dr. Eric Denhoff of Providence, a leading authority, regards it as "sort of criminal" to withhold treatment from those who can use it." (New York *Times*, July 5, 1970)

Dr. Leo E. Hollister, a medical investigator for the Veterans Administration told a Senate subcommittee that the Pentagon has made large purchases of Ritalin. "...Undoubtedly the large purchases of this drug...reflect a major use in dependant children," he said.

"That a disorder (hyperactivity) usually believed to be relatively uncommon should suddenly become a major affliction of childhood is a mystifying matter. The normal exuberance of childhood seems to be viewed as pathological." (San Francisco *Chronicle*, November 24, 1970)

Young people are not the only "trouble makers" who are drugged into submission. Old people in rest homes are subjected to similar treatment:

The National Council of Senior Citizens accused the drug industry and doctors yesterday of promoting the use of tranquilizers in nursing homes for the sole purpose of quieting elderly patients.



Some doctors administer the drugs responsibly to emotionally disturbed patients, council president Nelson H. Cruikshank said, "But it appears that many doctors... give blanket instructions to nursing home staffs for use of tranquilizer drugs on patients who do not need them."

"Exclusive use of tranquilizers can quickly reduce an ambulatory patient to a sombie, confining the patient to a chair or bed, causing the patient's muscles to atrophy from inaction and causing general health to deteriorate quickly," Cruikshank said in a letter to congressional leaders.

He singled out an advertisement run by Roche Laboratories in the October issue of *Physician's Management* magazine lauding the tranquilizer Valium as helping to produce "a less demanding and complaining patient."

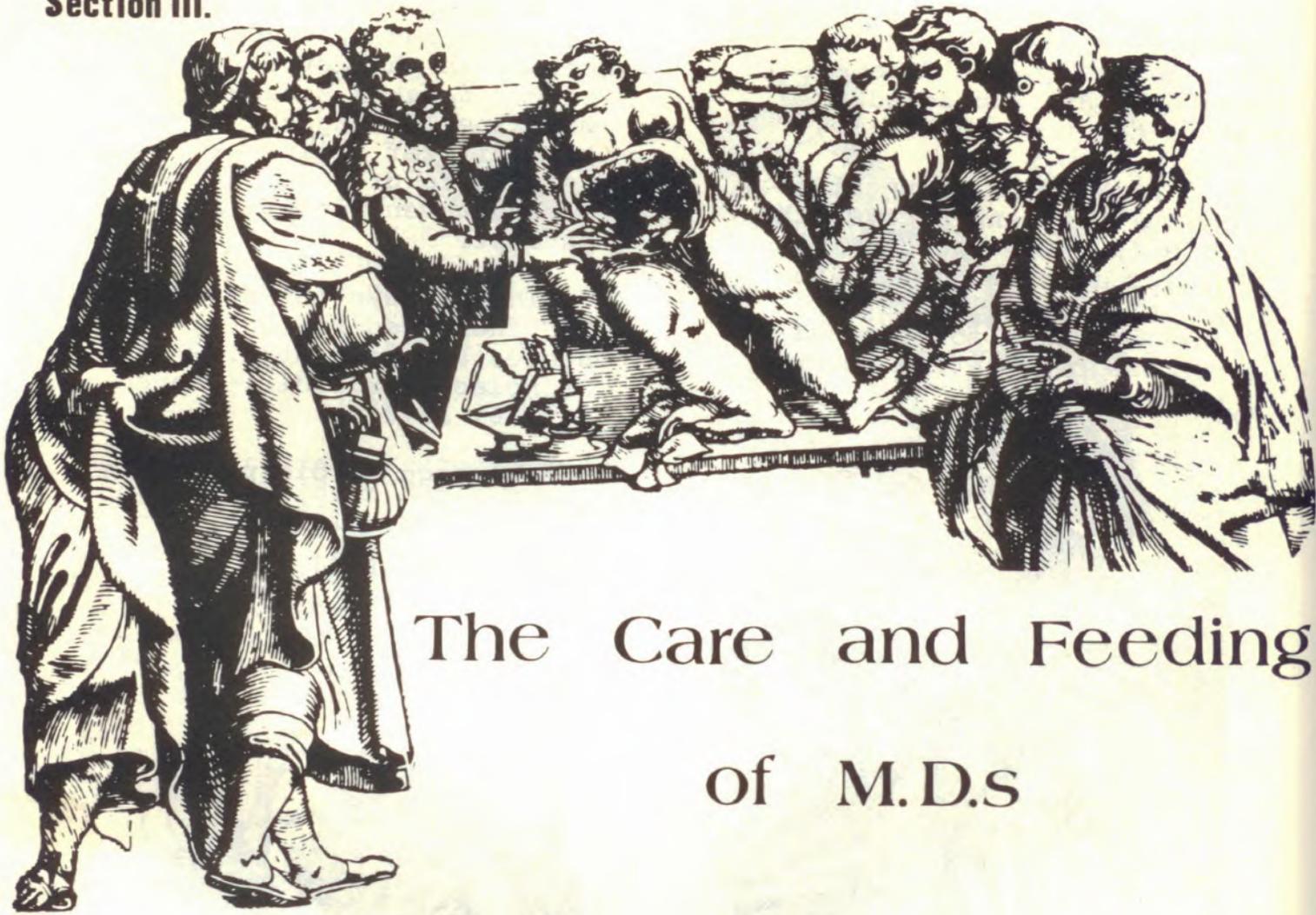
The ad says the dosage can be "increased gradually as needed and tolerated." (*San Francisco Chronicle*, November 16, 1970)

The message to old people is clear:

SHUT UP AND DIE!



So, it seems that when social and economic oppression of minority people, and young and old people results in personal frustration and rebellion, the medical profession, aided by drug companies, is all too willing to step in with drugs to suppress the personality. This is what constitutes mental health care in our country.



The Care and Feeding of M.D.s

People who are concerned about the welfare of their community feel that the health care of people with lower incomes than average is not very good. But the same people who are worried about the distribution of medical services do feel that for those who can afford it, good treatment is available.

Comparing family income and indebtedness with the cost of

physician and hospital care, we have shown how illness can be a financial disaster. But if somehow, you can obtain the money, what kind of medical help can you expect?

To answer this question let us examine the results of research about who becomes a doctor, how he is trained, and how he performs after training.

Medical Training



From the journal *Medical Economics*, December 1957, we find the results of a series of motivation tests given to several medical school classes by Professor E. Lowell Kelly of the University of Michigan. He found that the medical students...

...are persons who, if they were not becoming physicians, would be planning to become manufacturers, big businessmen, production managers, engineers. They are not the

kind of people...interested in doing something for the good of mankind. As a group, the medical students reveal remarkably little interest in the welfare of human beings.

Professor Kelly concludes from his tests:

...the typical young physician has little...sensitivity to or feeling for the needs of the community, and is generally not inclined to participate in community activities unless these contribute to his income.

Apparently G. B. Shaw's despair about the pecuniary reward given to the doctor turns out to be a legitimate and very contemporary concern.

Shaw feared monetary reward for doctoring but remember that M.D.s are also rewarded with the power of licensed authority and the tyranny that results from any kind of monopoly. The effect of this is described by the late Dr. Alan Cregg of the Rockefeller Foundation.

A physician is so surrounded by frightened patients, adoring families, and obsequious nurses that he will not brook criticisms by God or man... We behave as though we were a group set apart, and that attitude degenerates into professional provincialism.

How well are the medical schools functioning to educate COMPETANT physicians?

Dr John Knowles, general director of Massachusetts General Hospital, a major teaching institution of the Harvard School, said in January 1963,

"...At present the clinical teaching of medicine in our medical schools is spotty at best, fragmented, uneven, discontinuous, and haphazard."

A concrete example of what this charge means is offered by two faculty members of the Columbia University College of Physicians and Surgeons.

Drs. David Seegal and Arthur R. Wertheim reported May 12, 1962:

...conversations over the past 15 years with members of house staffs graduated from some prominent medical schools indicate that not one of these individuals had ever been overseen by a senior instructor while performing a complete physical examination prior to receiving his medical degree.

This fantastic oversight in medical training means disaster in private practice. In November 1963 Barkev S. Sanders, Ph.D., a research consultant for the United States Public Health Service, published a study titled "Completeness and Reliability of Diagnosis in Therapeutic Practice." His conclusions are;

Only 40 percent of all human ailments are found and labeled by doctors, and 60 per cent are missed. Of those that are ostensibly found, half are diagnosed in error. Given an unknown ailment in the body of a patient, then, the chances of the American physician finding it and diagnosing it correctly are ONE IN FIVE!

This is the kind of doctoring you may expect to buy. But isn't anyone doing anything about it?

The American Medical Association, professional medicine's largest and most powerful organization, has stated that it will "...maintain the quality of medical education by guaranteeing that the medical schools will be small..." As we will continue to see this effort has not done much to better medical education but it has succeeded in limiting the supply of doctors.

The Supply



of Doctors

Dr. Dwight H. Murray, who was president of the AMA in 1956 reassured the public by saying:

I am confident that we can prove conclusively to the government and to the people of the United States that a sufficient number of physicians is being produced. The extreme predictions of doctor shortages by the alarmists of a few years ago simply have not come true...

But, as in the case of every official pronouncement from the AMA, we have to look at additional facts to find the truth:

In 1949 the U.S. Public Health Service predicted that by 1960 there would be a shortage of between 20,000 and 30,000 physicians.

In 1951 the Health Resources Advisory Committee said the shortage would reach 22,000 by 1954.

In 1951 a U. S. Department of Health, Education and Welfare study showed that 1,443 of the country's 3,070 counties--and about 37 million Americans--were without local health departments.

In 1952 the President's Commission on the Health Needs of the Nation reported:

To bring the regions of the nation with the present lowest ratio of physicians to population up to the current average for the nation would require 22,000 more physicians in 1960 than the predicted supply by that year.

In 1955 the Health Resources Advisory Committee observed that the (doctor to patient) ratio was...now one active physician per 847 Americans and was not improving.

In 1956 President Eisenhower told Congress:

There are serious shortages in such specialized fields as psychiatry, pediatrics, and in physical medicine and rehabilitation, to mention only a few. Many rural areas and small towns are in need of physicians.

In 1956, according to the National Association for Mental Health and the American Psychiatric Association, state mental hospitals alone needed more than 3,700 additional physicians.

In that same year the AMA, through Dr. Murray, reassured the American public that the future of medical health care was safe in their hands. Now let's look at what that future, the future they controlled, turned out to be.

As of 1961 nearly all hospitals that lacked an adequate house staff were letting registered nurses perform many services once performed only by doctors despite the fact that this is a practice barred by a number of state laws. (E. Rayack, *Professional Power and American Medicine*)

In 1963 foreign doctors trained overseas occupied 24.6% of intern and resident positions in American hospitals. 50 to 70 per cent of foreign trained doctors fail their licensing test. Compare this to a 3% failure rate (1960) for graduates of approved American medical schools. (Rayack)

In 1964, of the nation's 7127 hospitals, only 765 had interns on their premises, and a bare 650 more had residency programs. Even the minority of hospitals with such programs had almost 6000 unfilled intern positions and 8000 residency vacancies, in addition to the 7000 positions occupied by foreign-trained doctors. (M. Gross, *The Doctors*)

Even so, a *Medical Tribune* "pulse of medicine" survey of a thousand doctors turned up the answer that 70 percent were against the full-time salaried doctor in the hospital.

HEW officials estimate that we need at least 50,000 more doctors right now! And this is considered a conservative estimate by many other sources.

In 1965 Dr. Philip Lee, the Assistant Secretary of Health, Education and Welfare, now the chancellor of the University of California at San Francisco (the medical center), said:

We need twice as many doctors as we now have (640,000 instead of 320,000 in 1967). Twenty percent of our physicians were trained in other countries, where the standards are often lower, because we don't have enough room here. This is a shocking situation.

But, in spite of the need medical schools produce only 8,000 doctors a year. ("Health in America--the Problem and the Practice" April 20, 1970)

As of 1966 almost 40% of hospitals in the U. S. did not even meet the minimum standards of the medical profession. Thousands of hospitals had no doctor at all, or one, or two foreign, often unlicensed, doctors on the hospital premises. (Gross)

The shortage, not only of doctors, but of other health workers is serious. In 1966 two of every three aides (to doctors) were not nurses or trained technicians. (Gross)

There are about 28 doctors for every 10,000 persons in New York city (that is a ratio of 1 to 357) and 13 for each 10,000 for the whole nation (that is 1 doctor to every 762 persons). The report of the Urban Research Center of the City University of New York shows a general

trend among physicians away from rural communities into densely populated areas.

(*Science*, January 31, 1969)

Most doctors, of course, prefer the sophisticated environment of the big city; which they can well afford.

What is the outlook for solving this shortage of medical personnel? To answer that question quickly one has only to look at the fate in store for many medical schools.

The Supply of Medical Schools and Treatment Centers



"Ninety medical and dental schools have requested \$247 million in Federal aid for construction (under the 1963 Congressional Health Professions Educational Assistance Act). Only \$100 million was authorized by Congress for 1965, and the full authorization for 1966 provided only \$75 million more..." (E. Rayack, *Professional Power and American Medicine*)

Senator Jakob K. Javits, as reported in the *New York Times*, said that three major schools in New York: the New York Medical College, the New York University School of Medicine, and the Albert Einstein College of Medicine of Yeshiva University; face acute financial crisis and are in danger of shutting down.

All of the nation's 94 medical schools, with 34,500 students, are facing the same problems, he said.

The 1968 Health Manpower Act allocated up to \$170 million for medical school costs, he said, but no money has yet been appropriated under the bill. (*New York Times*, October 13, 1969)

Universities with affiliated teaching hospitals care for 3.5 million people every year.

One of every nine patients admitted, one of every seven births, and one of every seven outpatient visits takes place in these 254 medical-school-affiliated hospitals.

Funds channeled through medical schools are the monetary cornerstone of medical research in this country.

"Nearly half of the 22,163 faculty members of American medical schools receive some portion of their support from research and specialty training grants and 16.3 per cent are entirely funded in this way," said Dr. John A. Millis, former chancellor of Case Western Reserve University in Cleveland.

Medical schools spent not less than \$625 million for research in 1967-68.

During 1967-68 the 89 medical

schools then in full operation enrolled 34,538 undergraduate medical students, spent \$1,175,396,186 and awarded 7,973 M.D. degrees after the usual 4 year course of study.

There are now 99 medical schools in this country. But they admitted only 1000 more students in 1969 than they had 3 years earlier.

"In contrast with rising demands," Dr. Millis said, "income to support educational programs has not risen" and when corrected for inflation has actually declined. (*New York Times*, June 16, 1970)

"It just doesn't make sense to have our medical schools on the brink of disaster..." (Senator Jakob K. Javits, quoted in the *New York Times*, October 13, 1969)

One gets the impression that the shortage of doctors makes a great deal of sense to the money oriented members of the AMA who understand the economics of artificially limiting the supply of a service to drive the fees up.

Not only medical schools but other health centers are in danger; as this article from the *New York Times* indicates:

"62 MENTAL HEALTH CENTERS, BUILT OR EXPANDED WITH FEDERAL APPROVAL, FACE DENIAL OF PROMISED FUNDS"

...in 100 communities around the country...

Each community has either just built a new neighborhood mental health center or has made plans to expand an existing one. Each has had its project approved for

staffing funds by the National Institute of Mental Health. Each has raised the necessary matching local money.

But interviews with local and Federal officials in recent days have disclosed that only 38 of the projects will receive the promised Federal grants.

The 62 others, the Government has decided, will be left to dispose of what they have done as best they can. In some cases that will mean abandoning the projects altogether.

In his 1971 budget message last January, President Nixon asked for no new construction funds for community mental health centers but he did request \$60.1 million for staffing grants.

Thus at first glance it would seem that the institute had money in the new fiscal budget to pay for new staffing grants. But that is not the case. The funds will go to continuing programs, which the institute is obligated to support. (*New York Times*, June 29, 1970)

The fund-cutting is obviously dangerous and absurd as an economy measure. The following example is a case of eliminating a health program that provided \$12 million in hospitalization in order to save about \$10 million in Federal funds.

The San Francisco Health Department said Federal funds have been canceled for its highly successful tuberculosis neighborhood clinic project, effective December 31. Unless the city supplies substitute financial support,

the cutback could mean a TB epidemic in poverty areas within two years, according to Dr. Francis Curry, assistant health director.

The imminent end of the Public Health Service projects results from plans of the Department of Health, Education and Welfare to trim \$9.7 million from its budget by rolling back its program to prevent chronic and crippling diseases.

Department officials said five of eight units of HEW's chronic disease division will lose more than half their funds this year and receive none at all next year.

Scheduled to be phased out are programs involving cancer, respiratory illness, diabetes, arthritis, heat stroke, neurological and sensory disorders.

In helping treatment of cases of TB, the chief cost of which is hospitalization, the TB program "has produced a saving of about \$12 million a year." (*San Francisco Chronicle*, September 26, 1969)



The undermining of medical schools, hospitals, and treatment centers is matched by the sabotage of health research.

The combined effects of inflation and Federal budget cuts appear to be causing alarm that sometimes almost approaches panic among scientists and medical educators.

The alarm is of two types. There is immediate concern for the survival of important research and training programs in the nation's medical schools. There is long-range concern that Federal economy measures today may be dismantling the base on which future research and ultimately the health of the nation's citizens may depend.

Dr. James Shannon, who retired in 1968 as director of the National Institutes of Health, said this attrition was likely to have devastating effect on the over-all research purposes of the nation.

Budget constraints on the National Institutes are a big factor in the problem because the Institutes are a major source of support for virtually every medical school and major biological research institution in the country.

The Federal government provides about 65 percent of all funds for health research. Most of this comes from the National Institutes.

It is also estimated that 48 per cent of all medical school faculty members have some of their salary paid through government funds; that 16 per cent receive all of their salary through government funds and that, for another 11 per cent, the

Government is the source of at least half the salary.

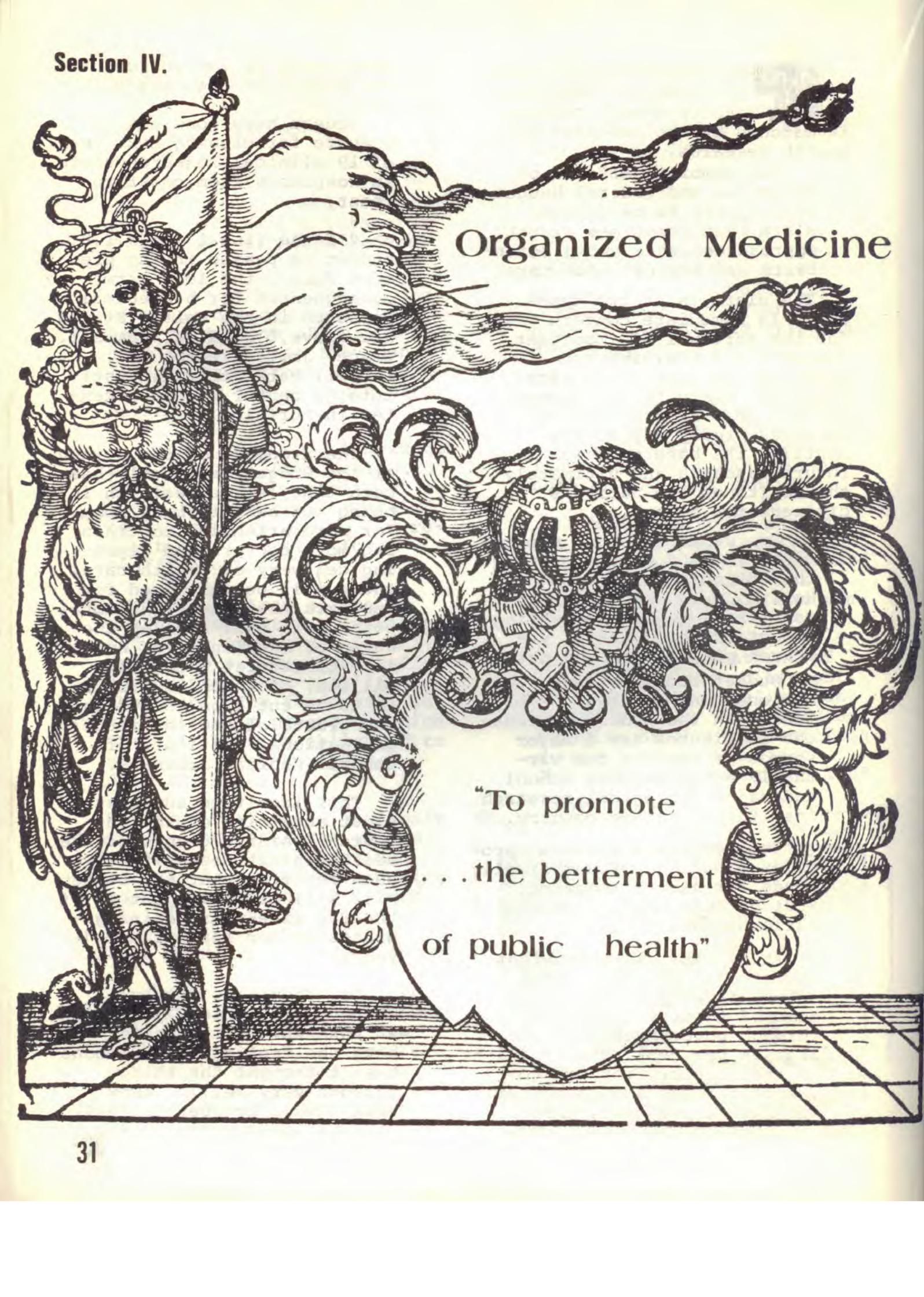
Orders have gone out to prepare for closing next year of 19 clinical research units in hospitals from coast to coast.

"If the fiscal '70 N.I.H. budget is passed in its present form, the long term consequences for biomedical research in the United States are grave," said Dr. James T. Grace, Jr., director of Roswell Park Memorial Institute, a cancer research center in Buffalo.

The argument of the Bureau of the Budget reportedly has been that, since research is being cut back to make room for more attention to training more doctors and improving delivery of health care, there will be less need for research training. The total cutback in this area at the National Institutes of Health is estimated at about \$18 million, of which \$6 million is to be cut from the training grants of one institute: The National Institute of General Medical Sciences.

This institute administers about one-third of the research training grants of the health institutes. It has been reported that the budget will kill all but about 10 of the 300 five-year training grants up for renewal this year.

Dr. Thomas D. Kinney, director of medical education at Duke University, said, "We have the feeling that someone hasn't thought the thing through very well." (New York Times, October 5, 1969)

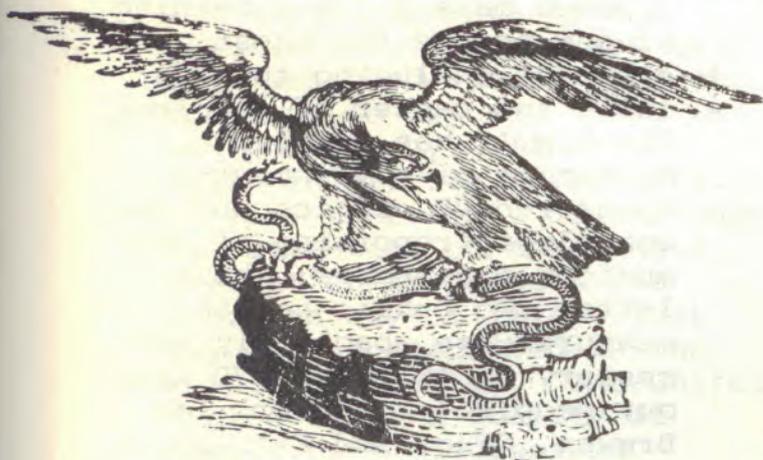


Organized Medicine

"To promote
...the betterment
of public health"

It's clear that the legislatures cannot be counted on to do anything to improve either the quality of medical education or the supply of trained doctors. What about the American Medical Association? It is certainly the largest medical society and was founded on very humanitarian principles: "To promote the science and art of medicine and the betterment of public health."

The A.M.A.'s Size and Power



AMA membership statistics:
1947--132,224 members; 1963--
over 200,000.

Approximately 75 per cent of American M.D.'s are now in the ranks of organized medicine. Non-members are primarily physicians outside private practice--those in the armed services, medical professors, physicians engaged in research, doctors-in-training, and public health officers. A 1960 study indicated that only 35 per cent of the physicians not in private practice were AMA members. Of physicians engaged in private practice, however, probably about 90 per cent are members of the Association.

The AMA's budget for 1964 was \$23 million, about 45 per cent coming from the advertisements of drug companies and medical supply houses in AMA publications, 32 per cent from the \$45 annual dues of its members (which has since been increased to \$70) and 13 per cent from subscriptions to its numerous technical journals.

The AMA maintains the largest and richest lobby in Washington--spending \$1.1 million in 1965, an amount 10 times larger than the second largest lobby (AFL-CIO). Last year AMPAC, the AMA's front for political contributions gave \$680,000 to conservative candidates for national office who support wars and guns over clinics and hospitals. An estimated five times this amount is spent on the local levels. (*Health Rights News*, August, 1969)

History of A.M.A. Social Action

What kind of policies does the AMA fight for? According to the *San Francisco Examiner and Chronicle*, July 13, 1969:

Dr. Knowles, a fund-raising Nixon Republican and protege of HEW secretary Robert Finch, the most liberal man in the cabinet, was blackballed by the American Medical Association in the shabbiest deal since Mr. Nixon took office.

The *AMA Journal* became the implacable opponent of forward trends in social medicine and reached a kind of frenzy under Franklin

Roosevelt when the British adopted their own National Health plan and AMA feared the U.S. would follow suit. It would lead, it was charged, to "socialism, communism, and even inciting to revolution!"

When Congress in 1930 granted Federal funds to state health agencies to reduce death rates of mothers and children, the AMA said it "tended to promote communism." In 1939 Dr. Fishbein, AMA President, denounced Federal unemployment insurance systems as "the first step toward the breakdown of American democracy, a definite step toward either communism or socialism." Extension of Social Security to embrace the totally and permanently disabled at age 50 was "a serious threat to American medicine."

In the '40s public opinion polls showed two-thirds of the people wanted health costs covered by Social Security, but the powerful AMA helped to kill President Truman's legislation.

"The AMA opposed child-labor laws, social security for the aged, the minimum wage, the 40 hour week, all pro-labor legislation...and recently it fought a losing battle against Medicare!" (Dr. Tom Brewer, "Fact and Fiction...the AMA")

Instead of losing on Medicare and Medicaid, the AMA really won. They only fought it, apparently, because they didn't realize what profit they could make through it. Now they know, and have come to love it.

Internal Revenue Service Commissioner Thrower announced a special audit of income tax returns of about 10,000 doctors

who made more than \$25,000 per year in Medicare and Medicaid payments. The names were made public despite HEW objections. (New York Times, July 3, 1969)

Senate informants revealed 30 of the doctors who made \$25,000 a year or more from Medicare in 1968 are AMA officials, presidents of State Medical Societies, and members or alternates of the AMA's House of Delegates. (New York Times, September 26, 1969)

In the fields of public health the A.M.A. has no better record. It actively opposed mass X-ray screening of our people for chest diseases including tuberculosis and cancer of the lung. The A.M.A. has opposed operation of government--sponsored VD clinics and the compulsory reporting of communicable diseases; these latter two public health measures are absolutely necessary to eradicate VD from our people. ..." (Dr. Tom Brewer, "Fact and Fiction... the AMA")

The A.M.A.'s Social Attitude



The best example of the Association's attitude is a speech by Dr. Milford O. Rouse, the President of the AMA, who said in his Presidential Address, June 20, 1967:

The American Medical Association says: "We are faced with many problems and many challenges. We are faced with the concept of health care as a right rather than a privilege.

"Several major steps have already been taken by the Federal government in providing health and medical care for large segments of the population. Other steps have been proposed--these we must continue to oppose. What is our philosophy? It is the faith in private enterprise. We can, therefore, concentrate our attention on the single obligation to protect the American way of life. That way can be described in one word: Capitalism. The United States (has) a quality of health care unsurpassed anywhere."

Member Support of A.M.A. Policy

The widespread support for the Association's policies is reflected in a 1956 AMA-sponsored survey of a "statistically significant" sample of U.S. physicians. Only 10 per cent thought that the AMA policies were at odds with the goals of the membership, a mere 3 per cent objected to the AMA's opposition to government health insurance, no more than 6 per cent thought the AMA exercised too much control over physicians,

and only 9 per cent objected to the AMA's political activity. Although it is tempting to discount heavily the survey's validity because of AMA sponsorship, there is no substantial evidence to indicate that it does not present a reasonably accurate picture of the attitudes of American physicians.

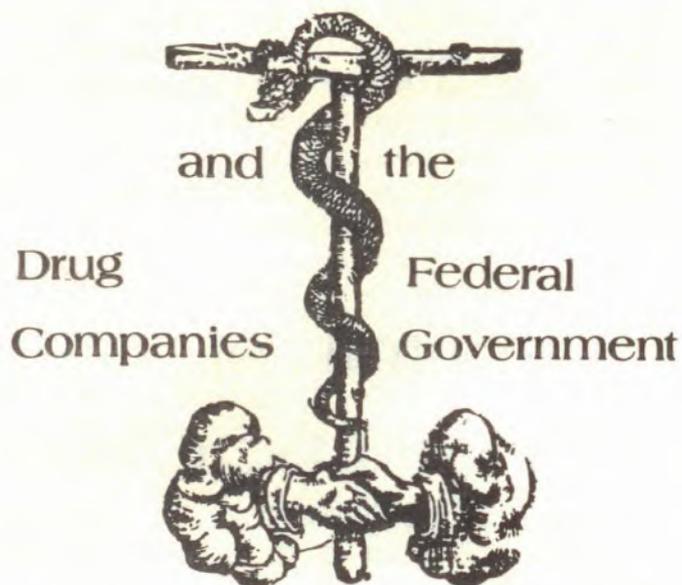
Control of a Physician's Career

To function at all, a medical school must be accredited by the AMA. This allows the AMA to control the number of M.D.s enrolled and graduated, and to heavily influence the curricula. Once the M.D. degree is obtained, a doctor is under heavy pressure to join the AMA or he cannot have access to hospital facilities or get referrals, the typical way in which doctors build a clientele.

Opposition to AMA policies can mean ouster from the membership and, of course, the resulting limitations on one's practice.



The A.M.A.



A Conspiracy!

The AMA does influence members of the medical profession in more far-reaching ways than by just granting privileges of membership.

A great deal of modern medicine is based on drug therapy. The AMA, the drug industry and doctors combine to shape modern therapy practices.

Dr. Hussey, Dean of the Georgetown University School of Medicine in Washington, gives us this optimistic picture of physicians' pharmaceutical training:

A physician is trained during his many years in medical school, internship, and residency, and continuously learns after he enters into the practice of medicine, to use his professional judgement in determining what particular drug is best for a particular patient suffering from a particular disease or condition.

But, the reality is quite different:

In a survey conducted by United Marketing Services among 1552 physicians and surgeons and reported by the Pharmaceutical Manufacturers Association in December 1960, the question was asked, "To what extent do doctors make decisions about whether to prescribe a drug on the basis of medical literature, rather than on the basis of advertising and promotion?"

The answer:

The preferred source of information about new drugs, in all geographical regions of the United States, is literature detailed by manufacturer's technical representatives. (detailmen)

In 1963, according to an analysis published by the *Chicago Sun-Times*, the AMA's total income was \$22.5 million. Almost half, or \$10.1 million, came from advertisements in its 12 journals and in its laymen's monthly, *Today's Health*. During that year the *AMA Journal* carried 5262 pages of advertisements--more than in any other national weekly except the *New Yorker* and the *Oil and Gas Journal*.

In 1965 the AMA received over \$9,000,000 from pharmaceutical advertising.

This advertising, we have shown, is highly influential in persuading doctors to write prescriptions for certain drugs. But doctors know what they are doing, don't they?

Dr. Harry F. Dowling of the AMA Council on Drugs said in July 1963; There are "sound" and "unsound" reasons for prescribing a drug, but apparently

at least 76 percent of physicians are dominated by the unsound."

In 1968, a task force reporting to the Department of Health, Education and Welfare charged that although American doctors write about 900 million prescriptions every year, "The greatest deficiency of the average physician today" is perhaps his "lack of knowledge and sophistication in the proper use of drugs," particularly his inability to prescribe "the right drugs for the right patient at the time in the right amount." For many doctors, the task force charged, this failure was traceable to medical schools which often offer only a single course in drugs and their uses. (*Good Housekeeping*, February 1970)

Dr. Richard Burack of the Harvard Medical School testified before the Senate drug price hearings:

The large brand name pharmaceutical manufacturers are quite evidently a very much interested third party which has intruded itself into the doctor-patient relationship.

Well over three-quarters of a billion dollars a year is spent by the drug industry on advertising and promotional material addressed exclusively to the nation's 200,000 prescribing doctors or at the rate of \$3,000 to \$4,000 a year for each doctor--to persuade the doctors to specify brand name drugs in prescriptions that they write.

Much of this material is false or misleading according to the Food and Drug Administration. (W.R. Hutton, "The Drug Price Scandal" July 1967)

Only four times in its memory, perhaps in a quarter-century, FDA informed Senator Humphrey in February 1964, has any medical organization--or any informal group of two or more doctors--bothered to ask FDA to re-evaluate the safety of a specific drug.

Dr. William B. Bean, of the University of Iowa's College of Medicine, told the Kefauver Antitrust subcommittee that some American journals had "refused to publish articles criticizing particular drugs and methods of therapy, lest advertising suffer. (M. Mintz, *Therapeutic Nightmare*, 1964)

Dr. Haskell Weinstein, who had been on the medical staff of Pfizer and of its Roering division, told the Kefauver subcommittee that "...a substantial number of the so-called medical scientific papers that are published on behalf of...drugs are written within the confines of the pharmaceutical houses concerned."



The intrusion of corporate special interests into the doctor-patient relationship has hardly been resisted by the medical profession.

The health services industry has not been an unwilling host to the growing health products industry. Executives of the health products companies sit on the boards of medical schools and medical centers and on prestigious commissions to study health policy. Research physicians consult eagerly and profitably for the health products industry. ...Out of the growing rapport between the delivery and the products industry is emerging a single, American, Medical-Industrial Complex. (J. and B. Ehrenreich, of N.Y. Health Policy Advisory Committee, *New York Review of Books*, December 17, 1970)

Since 1962 Dr. Austin R. Stough and corporations he controls conducted between 25 and 50 percent of the initial legal drug tests, on all drugs.

Austin Stough has no formal training or education in pharmacology and has been repeatedly blamed for the use of dangerous methods and inadequate equipment. He has tested drugs for the FDA involving the products of the following companies:

Wyeth Laboratories Division of American Home Products Corporations;

Lederle Laboratories Division of American Cyanamid Company;

Bristol-Myers Company;

E. R. Squibb Beech-Nut Inc.;

Merck, Sharp, and Dohme Division of Merck and Company;

and the UpJohn Company.

There is hardly an American citizen who doesn't annually take at least one drug manufactured by one of these companies.

The Alabama Medical Association investigated the quality of Stough's work and found it "bluntly unacceptable."

Out of 130 drugs tested for 37 leading drug manufacturers by Dr. Stough there was never a negative report on a single one of the drugs.

People, alerted by personal experiences and news stories to the dangers of legal drugs, have begun to doubt the safety of modern medicines.

Increasing public pressure on drug companies about such dangers have caused these companies to take action. The Pharmaceutical Manufacturers Association has turned to its public relations firm and it has printed ads like this one:

IF A DRUG COULD RESTORE
YOUR HEALTH WOULD YOU ACCEPT
THE RISK OF SIDE EFFECTS?

The ad boasts the honest efforts of hard-working pill pushers who are trying to bring better products to you, the American people.

A version of this message appears in the *Saturday Review*, October 11, 1969, and it includes the following curious logic:

...The truth is that every potent drug can cause side effects. If it didn't have any at all, it couldn't possibly do any good.

Finally, the ad reassures the reader that:

...The pharmaceutical industry will continue to provide (the physician) with useful data--reliable and current information on favorable and adverse effects of drug products. Guided by this type of full disclosure, the most logical decision can then be made on whether the benefits outweigh the risks.

The drug companies admit they produce harmful drugs by offering out-of-court settlements which amount to a small percentage of profits--certainly a reasonable fee for peddling poison.

There are more than a "score of pending damage suits against the three companies; Chas. Pfizer and Company; Bristol-Myers Company; and the American Cyanamid Company."

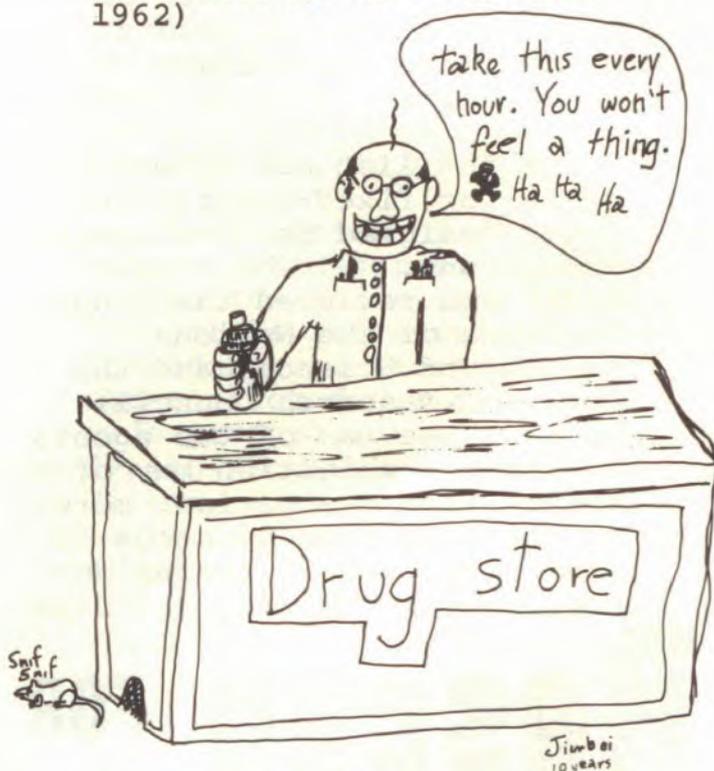
The three companies and two others have offered a package of \$105 million to settle damage claims by 43 states, hundreds of cities and thousands of individual consumers. It includes a \$5.6 million offer to New York City. (New York Times, April 17, 1970)

...new drugs are being placed on the market with no requirement that there be either advance proof that they will be effective in treating the diseases and conditions for which they are recommended or the prompt reporting of adverse reactions.

...They are promoted by aggressive sales campaigns that may tend to overstate their merits and fail to indicate the risks involved in their use. For example, over 20 percent of the new drugs listed since 1956 in the publication *New and Non--official Drugs* were found,

upon being tested, to be incapable of sustaining one or more of their sponsor's claims regarding their therapeutic effect. There is no way of measuring the needless suffering, the money innocently squandered, and the protraction of illnesses resulting from the use of such ineffective drugs.

By 1960 at least 40 new diseases or syndromes had been attributed to drugs used in therapy. (President Kennedy's Consumers' Protection Message of March 15, 1962)



And now, eight years later, the FDA lists 369 drugs as ineffective or perilous:

The drug agency has sought to remove each of the 369 products from the market during the last 2 and 1/2 years and many have been withdrawn, but many others are still in use. Among those listed are several that have been among the 200 most--prescribed drugs in recent years.

The drug agency's list includes many prescription drugs as well as products sold over the counter. Among the former are drugs designed to be used against infections, to lower blood pressure, remove excess fluid from the body or to achieve such combination effects as relaxing muscles and relieving inflammation.

Inclusion on the list signifies that the drug agency believes the product in question lacks "substantial evidence of effectiveness" or that its potential hazards outweigh its potential benefits...

On the list are a large number of fixed-combination drugs designed for use against infections. ...The specialists who reviewed the drugs (members of the National Academy of Sciences and the National Research Council) believe the use of two agents in fixed combination may often either give the patient more of one drug than he needs or else less than is useful for him, thus increasing the risk

of the drug treatment without adding any benefit.

The classic case of this sort concerned the widely used antibiotic combination sold under the trade name Panalba. It was finally withdrawn from the market this year after a long court fight. (H. M. Schmeck Jr., writing in the *New York Times*, November 28, 1970)

The Panalba case only serves to illustrate how difficult it will be to get the rest of the fixed-ratio antibiotics, and other dangerous or useless drugs off the market.

Panalba was one of the most popular items pushed by Upjohn and Company. 23,000 physicians regularly prescribed it. Since it first entered the market in 1957 750 million doses have been prescribed.

When Dr. Herbert Ley, then FDA Commissioner, first tried to get Panalba removed from the market, he was opposed by the Pharmaceutical Manufacturers Association whose members make up 95% of the drug industry; and

Rescue FOR Weak Men

Prof. Jules Laborde's Wonderful French Preparation of
"CALTHOS" that Restores Lost Manhood.



FIVE DAYS' TRIAL TREATMENT

Absolutely Free by Sealed Mail.

NO C.O.D. OR DEPOSIT SCHEME.

The marvelous French remedy, "CALTHOS," recently introduced in this country by the Von Mohl Co., of Cincinnati, Ohio, one of the largest,

the AMA, which derives \$9 million a year in advertising from the PMA, and even by then Secretary of Health, Education and Welfare, Robert Finch, whose opposition to the ban was triggered by Rep. Garry E. Brown of Kalamazoo, Michigan, the home of Upjohn Company. (*Science*, August 29, 1969)

For all these Ills

Clogged Liver, Billious Fevers,
 Deterioration of Kidneys,
 Enlargement of Liver,
 Indigestion, Dropsy,
 Jaundice, Piles,
 Eheimatism,
 Costiveness and Billiousness,
 Sour Stomach, Flatulence,
 Foul Breath, and Colics,
 Failure of Appetite,
 Constipation,
 Eruptions,
 Dysentery,
 Anæmia, Nausea,
 Diarrhoea, Worms,
 Pimples, Sties, Bolls,
 Inflammation of Bowels,
 Nervousness, Ennui, Insomnia,
 Dyspepsia,
 Melancholia,
 Nervous Debility,
 Torpidity of the Liver,
 Heart Disease, Headaches,
 Stomach, Back and Side Pains.

**TAKE
AYER'S
PILLS**

The FDA list is notable for the drugs it does not list. Darvon is absent from the list. Darvon, which has been the most frequently prescribed drug in the United States since 1967, is one reason why its producer Eli Lilly and Company, is among the nation's 16 most profitable corporation's.

Many authoritative and documented reports describe Darvon to be inferior to aspirin as a pain killer, yet Darvon costs 75 times as much. The *Medical Letter*, published by Drug and Therapeutic Information, Inc., reports that there is no evidence "to establish the superiority of propoxyphene (Darvon) to two tablets of either aspirin or aspirin-phenacetin-caffeine." Even the *Journal* of the AMA concurs with this conclusion. (August 1970)

Darvon wholesales at \$12.75 for 500 units; aspirin wholesales at 35 cents per 500. Darvon may retail as high as \$75 per 500, a mark-up of about 600%. Now we have a clue to the practice of over-prescribing this ineffective drug.

Who gets the mark-up? The drugstores for one. But are our physicians going to prescribe Darvon for nothing? Remember, according to the Los Angeles Better Business Bureau, 70 per cent of that county's physicians accepted financial rebates from drugstores.

This is not to mention that as many as one in twenty doctors owns or partly owns a drug store. (*San Francisco Chronicle*, November 22, 1970)

The practice of accepting rebates is widespread and goes beyond the individual doctor: "Hospitals and nursing homes are demanding and receiving 'kick-backs' from drugstores to provide prescriptions under Federal Health programs," says J. W. Miller, a spokesman for the American Pharmaceutical Association.

"Cash was passed under the table from drugstore owners to institutions to win lucrative drug contracts in Medicare and Medicaid programs." Mr. Miller said that the kickback demands were being made "in every state." (*New York Times*, November 10, 1970)

If doctors were to recommend aspirin, available to the consumer at 20 cents for 100 tablets instead of Darvon at \$15.00 per 100, the profit to the drug manufacturer would be considerably less, and since aspirin is available without prescription, there would be no rebate for the doctor.

Darvon is just one of many examples which explain why the American public spends seven billion dollars per year for often ineffective drugs. But the straw that should break the camel's back is the fact that our greedy drug peddlers not only milk us dry, but kill us in the process; for many of our expensive drugs are also dangerous.

According to Dr. Herbert Ley, "1,500,000 persons are admitted to hospitals every year for treatment of adverse reactions to legally prescribed drugs."



This figure dwarfs a thousand-fold the number of hospital admissions for illegal drugs.

Dr. George Lundberg, associate professor of pathology at the University of Southern California School of Medicine, reported that of 90,733 consecutive admissions to the medical

center, only THREE could be attributed to marijuana: Many more emergencies were due to drugs like Sominex, Sleep-Eze and Nytol.

This is not to say that once you get to the hospital you are free from the threat of dangerous drugs.

In November 1964, physicians at the Johns Hopkins Hospital reported an intensive, two-year study that there, too, patients had been admitted because of adverse reactions to medicines-- 1 patient in 20. Excluding patients brought in with drug reactions, 3 out of every 20 patients under drug therapy developed side effects.

Of the 3, one was serious enough to prolong the patient's stay in the Baltimore hospital by two or more days. In addition, the number of adverse reactions was said by Dr. Leighton Cluff, who directed the study project, to have increased in proportion to the number of drugs administered.

If this is the case with legal drugs, and the medical profession and the drug companies conspire to push them on the public, why doesn't the Federal regulatory agency, the FDA, step in? Because its vested interests are not in regulating drugs!

Between January 1, 1959 and December 31, 1963, 813 scientific, medical, and technical employees had left FDA: 83 took positions with companies the FDA regulates. So in a four year period 10% of the people who previously regulated the drug industry went to work for it. (M. Mintz, *Therapeutic Nightmare*)

The inevitable result is summed by Dr. Herbert Ley, former FDA Commissioner:

The thing that bugs me is that the people think the FDA is protecting them--it isn't. What the FDA is doing and what the public THINKS it's doing are as different as night and day. (San Francisco *Chronicle* on January 2, 1970)

Of course some drug companies have influence with public officials in higher authority. The drug firm of Warner-Lambert is a former client of former Wall Street lawyers President Nixon and Attorney General John Mitchell. (San Francisco *Chronicle*, November 26, 1970)

In the rare case that the use of a drug is discouraged by the medical profession or the FDA influence of the pharmaceutical industry extends deeply enough that an alternative market will be found. For example:

The United States gives South Vietnam large quantities of a powerful antibiotic not recommended for routine use in U. S. military hospitals because of its occasionally fatal side effects,...

Gifts of the drug, chloramphenicol, amount to more than \$700,000 a year, according to the figures provided by the defense and state departments. Officials of both agencies said no restrictions are imposed on its use, in sharp contrast with guidelines laid down for U. S. servicemen. (San Francisco *Chronicle*, November 18, 1970)

Chloromycetin (chloramphenicol's brand name) is the "drug of choice" according to the FDA

for only one disease, typhoid fever. But while enough of the deadly drug was shipped to Vietnam from 1969 to 1970 to treat 150,000 to 200,000 typhoid victims (1 per cent of South Vietnam's population) only 3,480 cases of the disease were reported in 1969, WHO officials say.

The drug companies, the medical professions, and the Federal Government conspire to sell ever increasing amounts of dangerous drugs to the American people.

Such conspiracies are typical of other AMA involvements.

The AMA receives large amounts of money from the tobacco industries for cigarette and cancer research. (Dr. Stewart Frank, President of San Francisco MCHR, 1969)

Deaths from cancer of the lung and larynx (voice-box) are soaring here in A.M.A. America; likewise deaths from emphysema in both men and women are rising rapidly. At the present rate of increase by 1990 (barring nuclear holocaust) we can expect that 200,000 Americans will die or become critically ill each year--all the direct results of their years of inhalation of cigarette smoke. The role of cigarette-smoking in contributing to the disease and death of the American people has been established for many years: yet until very recently when humane physicians in several other organizations began to cry out against this insanity, the A.M.A. has remained silent. (Dr. Tom Brewer, "Fact and Fiction...the AMA")



THE HEALTH CARE SITUATION IS NO MORE REASSURING WHEN WE LOOK AT OTHER FACETS OF HEALTH CARE DELIVERY IN THE UNITED STATES.

Paramedical Aids



A brief look is enough to convince one that things have gone wrong in this area. The *New York Times*, September 7, 1969 reported that the Presidential Assistant for Consumer Affairs, Mrs. Knauer, had said to the National Conference on Medical Devices (in a speech read by F. McLaughlin) that defective medical equipment is needlessly killing Americans. This has come about, in part, because Federal legislation says that a device must injure enough people to be shown unsafe before corrective action can be taken. This law makes prosecution of doubted equipment impossible unless defensive charges are made after injury and death have already occurred. A Brooklyn survey showed 40% of several thousand instruments checked were defective.

The National Research Council reported many accident victims die needlessly because most ambulances lack equipment, supplies, and trained attendants for emergency care to the critically injured (*New York Times*, January 14, 1969)

Hospitals

If you make it alive to the hospital, what are your chances then?

It is clear from previous facts that hospitals are grossly understaffed or have staffs that are badly trained for what they are doing.

Remember, "almost 40 percent of hospitals do not even meet the minimum standards of the medical profession." (1966)

The effect on health care is predictable and alarming though difficult for the layman to realize. In fact, in one of the New York hospital surveys, 75 percent of the patients who had received the WORST care thought they had actually received the BEST. (*Good Housekeeping*, February 1970)

The rate of accidents is expectably high. At Beth Israel Hospital in New York, a hematologist (blood specialist), Dr. Leon Sussman believes that preventable "human failure" in the hospital accounts for at least 50 per cent of blood transfusion accidents. (February 1960, reported by Gross)

A serious problem especially for a profession that relies so heavily on drug therapy, is medication error. George F. Archambault, former chief hospital pharmacist of the U.S. Public Health Service says that "Medication error is now the leading cause of accidents in hospitals." (M. Gross, *The Doctors*)

Dr. Archambault's view has been confirmed by many studies.

John Hopkins researchers reported in May 1960, the results of a seven month study in a 1100 bed hospital. In that hospital the nursing staff reported 178 medication errors. At another general hospital 360 medication

errors were reported in a twelve month period. If these figures are extrapolated to all 7000 hospitals in the United States, taking the size of the studied hospitals into account, then there are over 100,000 hospital medication errors that are detected each year.

But his figure is dwarfed by the number of medication errors that annually go UNREPORTED. In 1962, Kenneth Barker (a hospital pharmacist) and Warren E. McConnell, set up a disguised observation system in a university-affiliated hospital in Florida.

In June of that year the KNOWN recorded medication errors amounted to thirty-six. But Barker and McConnell detected unreported medication errors amounting to 4,266 in that month. This would project to 51,200 medication-dispensing errors per year in the Florida hospital, most of which go undetected.

The kinds of errors are categorized as: 37% omissions--drugs ordered but not given the patient; 18% additions--drugs given but not ordered; 13% overdoses; 10% medication given at the wrong time; and 4% wrong dosage form.

Barker and McConnell state in their *Modern Hospital* article, "The average nurse makes one error for every six medications given." The typical patient receives six to eight medication doses a day, so he will get an incorrect dose at least once a day.

When these figures of unreported medication errors are extrapolated to the national level, they amount to 100,000,000 hospital medication errors per year!



Sounds unbelievable, doesn't it? Similar results were obtained in another study though. Kenneth Barker conducted another disguised observation experiment at an Arkansas university-affiliated hospital in 1960. He found medication mistakes in one out of every seven doses. Voluntary general hospitals are supposed to be better, but they aren't. Surveys of 300- to 500-bed institutions revealed about the same thing--15% of all administered hospital medications are incorrect.

Supposing one doesn't stay in a hospital to be treated but is cared for in the emergency room. Watch out!

The Cornell report (March--April 1961) looked at the emergency facilities of 286 hospitals and found out that 21 hospitals (7%) had no emergency facilities.

Only 6% had their own ambulances. 67% had no signs indicating the direction to the emergency room. In 37 hospitals (13%) the emergency area was not even accessible from the street, a situation that could prove fatal in treating an emergency.

Doctors



That the American physician enjoys a professional monopoly is clear from the nature of the licensing procedure itself. It is in no way a guarantee of competent practice. Once a doctor has his state license, the state has nothing more to do with him as far as regulation is

concerned. All the doctor has to do is pay his license fee and steer clear of illegal abortions and obvious drug addiction. No state requires him to be re-examined for annual licensing.

Dr. John Knowles reported recently in the *Journal of Medical Education* that half the full-time specialists in internal medicine are not certified--nor are 45% of the specialists in obstetrics--gynecology. Half the psychiatrists and anesthesiologists, 30% of the general surgeons and 20% of the pediatricians are not certified in their specialty.

These practitioners are simply M.D.s with general practice training who have kept to one area of medicine. They have had no specialized training or at least have not qualified for state certifications in the medicine they practice, yet they call themselves specialists.

What do these facts mean to the health care consumer? The following figures give some idea:

Dr. Martin Cherkasky, director of New York's Montefiore Hospital and Health Center has said;

When early cancer of the cervix is operated on by qualified board-certified gynecologists, there is an 80 percent cure rate. When it is operated on, as it often is, by doctors without these qualifications, the rate of cure is only 50 percent. (*Good Housekeeping*, February 1970)

As the information already presented suggests, most doctors are not prepared by their background and schooling to be healers, but rather some sort of

money collectors. The results, as far as the patient is concerned, often makes disease seem preferable to treatment.

Dr. Osler L. Peterson, who was a staff member of the Rockefeller Foundation in 1960, conducted an analytic in-the-doctor's-office study of general physicians in North Carolina. He found the quality of care was shocking with more than 60% of the therapeutic treatment graded as below acceptable medical standards.

Since, geographically, American medical education is the same everywhere, it appeared to Dr. Peterson that the American doctor can't practice medicine.

That conclusion is confirmed by the Trussell Reports. These were two studies conducted by the Columbia University School of Public Health and Administrative Medicine in 1962 and 1964 under the direction of Drs. Ray E. Trussell and M. A. Morehead. Evaluating two samples of medical and surgical care provided by both specialists and family doctors in the New York area, the study surveyed the care given to hundreds of patients in some 100 cooperating hospitals--from the largest medical-center complexes to doctor-owned profit making hospitals.

The care was rated by a group of outstanding doctor-auditors, including three internists, one pediatrician, one obstetrician--gynecologist, one pathologist, and one surgeon.

Almost half the care (43%) was rated less than "good." Almost a fourth of the patients (23%) received "poor" care. Some opinions from the auditors were "shocking case," "medical igno-

rance," "gross violation of medical ethics," "completely unjustified surgery," "sloppy performance, diagnostically and therapeutically."



Surgery, as George Bernard Shaw foresaw, presents a grotesque picture.

Writing in the *New York State Journal of Medicine*, Dr. Arthur James Mannix Jr., a Fellow of the American College of Surgeons says, "Errors in judgement or technique concerning either the anesthesia or the surgery, or a combination of the two, contribute close to 50 percent of the mortality in the operating room." (March 1960)

Dr. Edward G. Stanley-Brown, a pediatric surgeon at St. Luke's Hospital in New York, wrote in the February 1962 edition of *Surgery, Gynecology and Obstetrics* that, of 21 surgical deaths of infants and children that he and colleagues examined, 90% were the result of doctor error.

Dr. Leroy H. Stahlgren of the Philadelphia General Hospital believes that at least 40% of death in surgery of elderly patients may be avoidable. (September 1961, reported by Gross)

When Dr. Paul R. Hawley was director of the American College of Surgeons in the early 1960's he said, "It is reliably estimated that one half of the surgical operations in the United States are performed by doctors who are untrained or inadequately trained to undertake surgery." (Gross)

It is not just that surgery is done poorly, but that often it is done for no other reason than to collect a fee. Dr. Martin Cherkasky charges that huge amounts of unnecessary surgery are being performed.

The victims most often are women and children because the operations most commonly performed without medical reason are hysterectomies, cesarean sections, appendectomies and tonsillectomies.



Tonsillectomy is still the most widely performed operation even though it is no longer desirable for most cases.

"Experts have estimated that at least one-third of the hysterectomies and half the cesarean sections also are unnecessary." (*Good Housekeeping*, February 1970)

Doctors hush up a lot of medical accidents, so the real picture may be much worse than we can project from some detective work.

A spot check was made by the Food and Drug Administration in 1952-1953 of 95 hospitals in 11 cities. FDA found 84 unreported cases of penicillian shock, of which 25 were fatal. (Mintz)

A decade later, (1962-1963) in Baltimore, the Committee on Pharmacy and Therapeutics of the Johns Hopkins Hospital, where there is a reporting system, said in its July 1962 *Drug Letter*:

The reporting of drug reactions during the past 12 months has been variable and it is estimated that no more than 10 per cent, at the most, of all drug reactions have, in fact, been reported. ...In addition to failure to report, there is little doubt that occasionally the fact that one is dealing with a drug reaction that may be entirely missed...

A thing which is even more frightening is the rather commonplace way doctors can cover up the deadly results of their treatment by publishing lies about the results.

In Surgery, Gynecology and

Obstetrics, April 1963, surgeon George E. Moore of Buffalo, New York, writes;

It is my personal opinion that 80 to 90 percent of all articles relating personal, departmental, or institutional 'experiences,' whether by surgeons or by physicians in general, are of little or no value.

Dr. Moore, who is a Fellow of the American College of Surgeons, is not basing his statement on anecdotes he has heard but the solid fact that when records documenting published articles by doctors were standardized in the Surgical Adjutant Chemotherapy Studies and then given to statisticians to analyze, "...it was found that many patients died within 30 days after extensive operative procedures." This was not shown in the doctors reports.



The one thing that the public depends most on the medical profession for is diagnosis. Recall the fact, though, that the chances of getting correct diagnosis and treatment is only 20 percent. The outcome of this is serious illness and death.

For instance, "...A check of 911 death certificates in Pennsylvania showed that doctor diagnosis of heart disease was incorrect at least 27% of the time, and perhaps as often as 63%." (1962, reported by Gross)

Many people are seriously ill and their doctors don't know it because they are too incompetant to diagnose the disease involved. That is the result of a 12 year study (1948-1960) of 10,709 apparently healthy adults between the ages of 30 and 49, 97% of whom had their own private doctors.

They were examined at the Tulane University Cancer Detection Clinic which has an exceptionally good diagnostic wing. The Score: 77 had cancer, 444 had benign growths that might be premalignant; 804 had different kinds of heart disease; 1302 had vascular problems; thousands more had anemia, nephritis, prostatitis, arthritis, chronic asthma, penumonia, active TB and other diseases, all previously undetected or not diagnosed.

The famed Strang Clinic in New York City got the same results after examining a thousand employees of Grumman Aircraft who were over fifty years of age. 104 had polyps (growths) at the colon and rectum that needed immediate excision.

In San Francisco multiphasic health screenings of 818 long-shoremen disclosed 265 men with undiscovered diseases, and 323 more with ailments which were revealed in a follow-up examination. (Gross)

Dr. K. A. Elsom, *et al*, writing in the *Journal* of the AMA confirms the other studies. 1513 executives were put through extensive routine examinations at the University of Pennsylvania Diagnostic Clinic and 612 of the men were found to have previously undiagnosed ailments--57 percent of which would result in death or major disability if not treated and stopped. The patients all had private doctors who should have known better.

Iatrogenic illness and death result, from the medical treatment, not the disease. Not surprisingly, doctors not only miss seeing a lot of diseases in patients, but they cause a lot of misfortune.

An apocalyptic report by Dr. Elihu M. Schimmell, then chief resident at the Yale-New Haven Hospital, an institution connected with the Yale University School of Medicine was published in the *Annals of Internal Medicine* in January 1964. The article is a survey of the joint, semi-underground reporting efforts of 33 members of the house staff. They brought Dr. Schimmell the details of iatrogenic "episodes" which are defined as "noxious response to medical care."

Out of the 1014 patients "there were 240 iatrogenic episodes" occurring in the 198 patients. "20 percent of the persons at risk suffered one or more episodes of medical complication in the hospital." One in

five of the patients was made ill by medical treatment and it caused or contributed in large part to more than ONE IN TEN of all hospital deaths.

The national extrapolation of the Yale work is shocking. The sample shows 240 episodes in 1252 admissions. Doctor-caused disease, projected against 28,000,000 annual hospital admissions and 1,000,000 annual hospital deaths, is developed in over 5,000,000 people annually. It kills, or contributes to the death of 100,000 Americans, in hospitals alone, each year.

But Dr. Schimmell's estimate is a conservative one. He eliminates all errors made by doctors and nurses, and he does not include complications and death from surgical error or faulty anesthesia (which we have seen is significant).

Further, the study only looks at the toll in hospitals. Also excluded are those cases whose original reason for admission was iatrogenic (about 1,500,000 victims every year). Adding all these additional "episodes," death from doctor-caused disease could be as high as 200,000 people a year.

THE MEDICAL PROFESSIONS HAVE
BECOME AS DEADLY AS CANCER AND
HEART DISEASE!



Justice Is Sick

Doctors make it as difficult as possible to get any justice against this kind of murder.

Attorneys estimate that there are more than six thousand malpractice suits filed against physicians each year. ...an AMA survey shows

that aggrieved patients win a majority (53.1%), with judgments ranging from a few hundred dollars to recent record decisions that cost physicians up to \$725,000. (1963, reported by Gross)

This amounts to only 3,000 suits that are won in the face of 200,000 deaths and 1,500,000 iatrogenic admissions to hospitals every year. Why?

While medical organizations vehemently deny the "conspiracy of silence," physicians themselves openly admit it. The Boston University Law--Medicine Institute asked physicians if they would testify for the plaintiff in a malpractice case in which the surgeon had mistakenly removed the wrong kidney. 70 percent of the physicians admitted that they would refuse despite the obvious merits of the case. (Gross)

Insurance companies, who have a lot of money at stake, put pressure on doctors to keep their mouths shut in court. Attorney Melvin Belli filed a \$200 million antitrust suit in Federal Court, San Francisco, against 13 insurance companies for allegedly conspiring to overcharge for malpractice insurance and keep doctors from testifying for injured persons. (New York Times, October, 30, 1969)

M.D.s would like to get around the problem of malpractice by suspending the due process of justice altogether.

The New York Times carried an article on September 22, 1969 relating that Southern California doctors, concerned over soaring malpractice insurance fees, are considering a plan to have the patient sign an agreement not to sue the doctor. Imagine what license of maltreatment a doctor would have if the patient agreed.

The Truman report of the AMA (August 1955) tells the story in cautious language:

We conclude from these studies that the present supervisions of organized medicine over the ethical standards of doctors is not adequate to protect the public, or the good name of the profession.





Some Current Reforms

IT MUST BE CLEAR THAT ANY REFORM, TO BE EFFECTIVE AT ALL, MUST CHANGE NOT JUST A PART OF THE SYSTEM OF HEALTH CARE, BUT ALL OF IT. IT IS NO GOOD TO TRAIN MORE DOCTORS WITHOUT BETTER MEDICAL SCHOOLS. IT IS NO GOOD TO BUILD MORE HOSPITALS WHEN NO ONE CAN AFFORD TO GO TO THEM FOR TREATMENT. IT IS NO GOOD TO REMOVE SOME DANGEROUS DRUGS FROM THE MARKET WHEN THE DRUG COMPANIES CAN TURN AROUND AND FLOOD THE COUNTRY WITH MORE LETHAL STUFF THE NEXT YEAR.

BUT, LET'S SEE WHAT THE ESTABLISHMENT HAS IN MIND.

Short-Range Reforms



Unfortunately, these kinds of reform are either silly or deadly.

A. The AMA version of medical reform is, not surprisingly, a well financed con:

The AMA's official hierarchy persists in viewing widespread hostility to organized medicine as little more than a pesky problem of image building.

Right now, for example, AMA doctors pay \$70 a year in dues. The AMA's board of trustees wants to raise it to \$150.

Believe it or not, here's how the AMA trustees want to

spend some of that money: a million dollars a year for a couple of "demonstration projects" in health planning and emergency care; and \$10 million for five years to buy television programs and ads designed "to bring credibility to the AMA and pride of belonging to physicians."

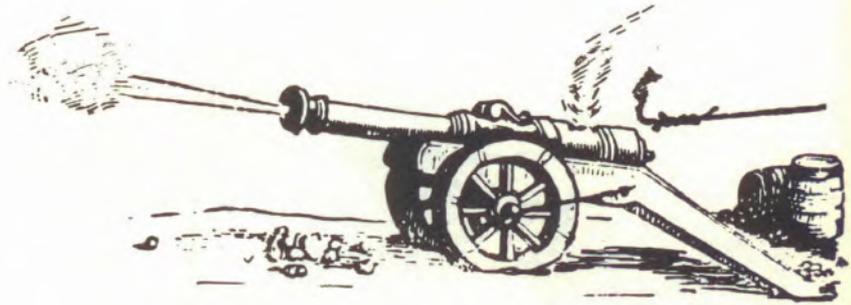
(David Perlman commenting on the 1970 AMA convention in the *San Francisco Chronicle*, June 23, 1970)

B. Eric Mood, assistant professor of public health at Yale University and former director of environmental studies of the New Haven Health Department, testified at a public hearing on pollution in Long Island Sound (conducted by U.S. Senator Abe Ribicoff) that some polluted beaches in Connecticut are being deliberately kept open illegally by health officials to avoid possible rioting in the slums.

C. The American Psychiatry and Neurology Board waived the internship as a requirement for professional certification of psychiatrists and enurologists. This action was aimed at shortening the training period. The move resulted from 1966 AMA conference recommendations to eliminate internships for all specialties. So far 32 states refuse to legally recognize the license of doctors with no internship. Many training centers have yet to approve the change. (*New York Times*, February 1, 1970)

This last idea is after the fact, in that many specialists are not board certified which means that most have not had any specialized training, even though they have served a general internship.

Long-Range Reforms



President Nixon forecast a massive health care crisis in the next 2 to 3 years unless prompt steps are taken. He urged the private sector (whoever that is) to join with the Government (we know who that is) in producing the health care revolution.

But HEW Secretary Finch and Assistant Secretary Egeberg reported that the Federal program package is a mixture of steps already initiated, previously announced, and current ideas in the medical field that the Government had not previously embraced. (*New York Times*, July 11, 1969)

In other words, even though Nixon was fully aware of the problems in July 1969, nothing was going to be changed. But in November the "private sector" formed a committee to make a study of the problem.

A committee of 11 business leaders, credited with influencing the Nixon administration's move for Federal minimum welfare standards and aid for the "working poor" is to take up another national problem-- medical and hospital care.

One member has left-- Gilbert W. Fitzhugh, chairman of the Metropolitan Life

Insurance Company of New York --as a result of new duties as chairman of a committee to study reforms in Defense Department operations, a post to which he was named last July by President Nixon.

In addition to Mr. (Joseph C.) Wilson, (chairman of the Xerox Corporation), the others are;

Robert A. Bernhard, partner in Lehman Brothers,

C.W. Cook, chairman of General Foods Corporation,

Harold E. Gray, chairman of Pan American World Airways,

Philip M. Klutznick, chairman of Urban Investment and Development Company,

Gustave L. Levy, senior partner in Goldman Sach and Company,

Baldwin Maull, vice chairman of Marine Midland Banks,

Arjay Miller, dean of Stanford University Graduate School of Business,

Alfred C. Neal, president of Committee for Economic Development,

Harvey C. Russell, vice president of Pepsico,

Samuel J. Selberman, president of Gulf and Western Foundation.

(New York *Times*, November 9, 1969)

B. The most recent idea that has been forthcoming from men with such upper class interests as these gentlemen is a national health insurance plan. In July of this year the health security plan was announced.

(In 1969) ...the Federal Government spent about \$9.2 billion for all its programs that provide personal health service for Americans.

Had the health security program been in effect then, it would have taken over the major part of those programs, totaling about \$8.8 billion, and would have required \$6 billion additional from general tax revenues.

The proposed program would get 40 per cent of its funds from general tax revenues, 35 per cent from an employer payroll tax and 25 per cent from individual contributions, most of this in employee payroll deductions. The employer payroll tax would be 2.8 per cent and the employee portion would be 1.8 per cent on gross income up to \$15,000.

This would approximately triple what the employee pays for Medicare at present, bringing it up to a maximum of \$270 a year, but the program would replace private medical insurance, on which the employee now pays premiums. (New York *Times*, July 8, 1970)

Will this program provide better medical care and can the medical consumer afford it?

From 75 to 85 percent of our population carries some health insurance (not hospital insurance). Yet, according to HEW, this insurance covers only about one-third of the total of medical bills. The patient pays the rest. And as medical costs spiral upward, insurance premiums also climb, but there is little broadening of benefits. The result: more and more middle-income families are finding it impossible to pay the bills.

Also there is nothing in the way many policies are written to prevent your coverage from being entirely negated. Many surgeons, for example, collect from an insurance company the flat rate it allows for a given operation and also bill the patient an equal amount. Some surveys have revealed that as many as three out of four patients receive such extra bills. Thus the patient is worse off than if he had had no insurance, because he is stuck not only with the surgeon's extra charges but with the policy premiums as well. (*Good Housekeeping*, February 1970)

The Federal program to be effective, therefore, has to prevent the doctor from this practice of billing both patient and plan. Otherwise, the consumer will be about 3 times worse off than when he was on Medicare.

In any event, the catch in the whole thing is that, even if the payment of the doctor bill is guaranteed, that doesn't guarantee better medical care. Actually, what it almost guaran-

tees is more profit for doctors. Look at what has happened in the past.

Remember that 10,000 doctors made \$25,000 or more on Medicare and Medicaid, and some of them were ranking AMA officials.

Medicaid director, acting Commissioner Bellin estimates that in New York state a minimum of 5% of the bills from private practitioners contain instances of fraud and other abuses. (New York *Times*, July 17, 1969)

An audit of dental work in the New York State Medicaid program revealed fraud at 9%. (New York *Times*, June 20, 1969)

The Lent Committee says abuses by unscrupulous doctors, dentists and pharmacists in the New York State Medicaid program are siphoning off as much as \$60 million per year from a \$1 billion program. (New York *Times*, December 19, 1969)

A Senate Finance Committee staff analysis of Medicare and Medicaid revealed widespread faults in the program. The staff found that many and possibly most doctors are charging as much as 4 times more for Medicaid services than they charge private insurance plans, such as Blue Shield. (New York *Times*, February 9, 1970)

In 1968, a Detroit osteopath's clinic got \$203,000 in Medicaid payments and a Miami osteopath got roughly \$190,000 in Medicare payments. (New York *Times*, July 3, 1970)

Other Federal plans get the same treatment.

A San Diego psychiatrist made \$176,000 on a military health

insurance program in 1968. The program is called Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). The Pentagon judged that all but \$11,000 of this fee had been earned and the doctor had to repay that amount. The overpayment was the result of "poor book-keeping."

The House Service Benefits Committee headed by Rep. James A. Byrne (D. Penn.) found that 88 doctors around the country received \$20,000 or more in 1968 from the CHAMPUS program. They found also that the military had no figures for 1969. (New York *Times*, July 3, 1970)

Insurance fraud is not limited to individual doctors. Hospitals also participate.

It was Medicaid and Medicare and, to a certain extent, Blue Cross which propelled the health industry from the remote periphery to a more central position in the national economy. All of these programs reimburse health care institutions essentially on the basis of the institution's total annual costs of providing care, multiplied by the fraction of the institution's total annual bed-days used by the "eligible population," e.g., by the Medicare patients. The institutions are accountable to no one in determining what will go into the average "cost" per patient per day.

Commonly listed as "administrative expenses" are salaries of \$50,000 a year and up for administrators and physicians, public relations men to clean up the hospital's image in the community, and staffs of lawyers to fight

worker attempts to unionize. Depreciation on a \$40,000 piece of equipment is a legitimate charge to the cost of patient care even if a \$20,000 machine would have done just as well, or even if the machine itself is of little medical or social utility.

With no limit to expenditures, so long as they could somehow be justified as "patient care," the hospitals went wild. "Medicare," exulted an electronics trade journal in 1969, "is the computer manufacturer's friend." It made no difference that Medicaid and Medicare did not lead to significant increases in the use of hospitals. It did lead to vast institutional and corporate growth, in which the individual (whatever his tastes, psychology, or effective "demand") is an increasingly incidental participant. (John and Barbara Ehrenreich, of Health Policy Advisory Committee, in the *New York Review of Books*, December 17, 1970)

What can we conclude from this information? Only one thing: The newly projected Federal health security program is inadequate and incompetent, as one might anticipate from its origin.

The plan is more in the nature of a public fraud than a benefit. It is a compulsory contribution plan and will saddle the public with the double burden of a compulsory premium and fantastically inflated medical costs. It will do nothing about better medical care.

In any event, as of this writing (December 1970), John Veneman, assistant Secretary of Health, Education and Welfare,

has, on behalf of President Nixon, turned down the plan for Federally controlled national health insurance as "not a major priority at this time."

C.

Highly touted health service centers like Kaiser or coverage like the Harvard Plan are just as fraudulent as National Health Security Insurance would be.

In the Harvard Plan a family of four pays \$51.00 a month, which amounts to \$600 a year, for access to a group of physicians with auxiliary lab testing and pharmacy service.

This monthly milking of \$51 only guarantees a regular income for doctors from lower income people who might otherwise only pay a physician's fee when they absolutely had to.

This subscription treatment doesn't in the least affect the quality of medical care or the efficacy and safety of drugs.

It is just another way for the medical profession to clean up, and is no social solution for our health care crisis.



The Future of Health Care

Now ready for the A.M.A.'s crash program to solve these health care problems?

This account from the prestigious *Science Magazine's* December 18 issue spells out the A.M.A.'s latest positions on health care.

"Health Care: AMA White Paper Offers Traditional Solutions.

"Boston. In response to increasing demands for better health care in the United States, the American Medical Association still offers its time-tested solution: the well-paid private practitioner, free from government constraints. At its semi-annual meeting held here 30 November to 2 December, the AMA's ruling body -- the House of Delegates -- adopted as official policy a report already submitted to the Nixon Administration by the AMA's Board of Trustees. The report, titled 'Considerations in Devising an Overall Health Plan,' is intended as a 'white paper,' spelling out the AMA's expectations for federal action in the health field. It lists in order the following four priorities for meeting the medical service needs of the nation:

Effectively using those practicing physicians we now have.

Increasing the productivity of physicians.

Augmenting the number of physicians.

Using the physician effectively in his role as conservator of his patients' expenditures.

"While the first three priorities are hardly controversial, the suggestions offered for their implementation will appease few critics of the American health care system because they amount to little more than a defense of medical private enterprise. In expounding on the first priority, the report states that physicians, particularly general practitioners, have been fleeing from practice and that young doctors have not been motivated to 'enter into direct patient care.'

"No solutions for this dilemma are offered; however, the report mentions several factors which could increase the exodus of doctors from patient care. For example: 'In the existing climate of the United States, efforts to regiment, conscript, or apply economic sanctions to the medical profession are destined to make matters worse rather than better. They have the effect of driving even more physicians from active practice into research, teaching, administrative medicine, more narrow specialization, or premature retirement.' Or, 'measures which would freeze the income levels of physicians, eliminating their ability to adjust to the economic environment, are discriminatory and lead to still further departures from active practice.'

"Another factor threatening to reduce the number of practic-

BY
DR. THOMAS BODENHEIMER M.D.

ing physicians, according to the report, is the establishment of prepaid group practices such as the Kaiser Health Plan in California. While the report concedes that such plans should be given a chance to prove themselves as competitive mechanisms, it warns that 'to attempt to force all physicians into a rigid pattern of salaried group practice could be the most destructive move made by the government.'

"The president of the AMA, Walter C. Bornmeier, proposed at the Boston meeting of the House of Delegates that the AMA allow doctors to seek and accept financial assistance from the federal government to help them set up practices in the nation's ghettos. The report of the board of trustees, however, rejects such a program, claiming that 'highly trained physicians probably cannot be attracted into practice in rural areas or in many slum areas, and alternative mechanisms for the provision of adequate medical service should be developed.' No specific programs are mentioned.

"As to the second priority, the report suggests nothing to increase physicians' productivity. But, several aspects of federal and state medical assistance programs (Medicare and Medicaid) are listed as detrimental to productivity. These include provisions in the program making it economically unfeasible for the doctor to delegate responsibilities to others -- especially interns, residents, and office assistants; governmental antagonism towards those physicians who allegedly earn too much money from such programs; low compensation; excessive paper work; and adverse publicity because

of payments received.

"In commenting on the third priority the report mentions neither an increase in medical schools nor an increase in financial support to medical students. It does, however, suggest legal reforms to reduce the risk of malpractice suits and 'a positive program of public relations dedicated to making the clinical practice of medicine attractive to oncoming generations of young Americans [which] would be more productive than a campaign to picture physicians as entrepreneurs requiring regimentation and control' -- the implication being that certain politicians are currently conducting the latter type of campaign.

"Many people, upon receiving their doctor's bill, would hardly view him as 'the conservator of their expenditures.' The report, however, suggests that, for the physician to maintain such a role, a system of peer review should be instigated to guard against excessive charges and that it would not be helpful 'to dilute it with lip service to consumer representation.'

"The report concludes with the statement, typical of AMA arguments over the past several decades, that 'when a physician is salaried, or otherwise divorced from the fee-for-service method of compensation, he is insulated from a specific interest in how his services or his authorizations for services have impact upon the economics of medical care.'"

Obviously the recourse to reform is frustrated at every turn by the professional societies who wish to defend their monopolies; by the legis-

latures and administrators who have sold out to them; by the corporate interests who make huge profits off the system as it is; by the regulatory agencies who are controlled by the very industries they are supposed to police; and by the tragic condition of the 95% of our population who need more than "adequate" care to patch up physical and emotional wounds that are reopened every day by just existing in the society.

Certainly there are solutions to problems developed within the system, but the solutions can never be compatible with the interests of those who dominate the system. Therefore those who are the victims must begin to institute on the most feasible level, probably the smallest or lowest political level, their own institutions which they can cultivate as alternatives, and demand with growing strength the right to control their destinies on ever wider and broader political levels.

No reform--whether minor or major--will succeed in patching up the American health care system. What American health care needs is a new vision.

The vision has at its center the community-controlled clinic. In it, all patients from the surrounding neighborhood receive medical care free. Those who work in the clinic live in the clinic's own community. Community people--both those working in the clinic and those using the clinic--run the clinic.

The health workers are community people; the community people are workers. The distinction be-

tween providers and consumers is obliterated; as many people as possible both receive and help to provide medical care.

The decision-making hierarchy of doctor-nurse-technician aide-patient disappears. All work together as equals in making the clinic's decisions. Who should be hired? Who fired? What hours? What services provided? All these policies are agreed upon by frequent meetings open to all, or by a clinic board elected from the neighborhood.

Decentralization and community control replace the current principles of profit-making and doctor sovereignty.

The neighborhood clinic provides comprehensive care: educative, preventive, diagnostic, treatment, and rehabilitative services. Each patient has his own personal doctor, with general training, who works with a technical assistant and a community worker to provide and coordinate the care. The various doctors in the clinic work closely together: seeing each other's patients if necessary during off-hour emergencies, looking over each other's shoulders to check on the quality of care, continually teaching and helping one another. No doctor is allowed to work in isolation, free from stimulation and criticism of his colleagues. And doctors are supervised not only by each other, but by other health workers and *patients as well*. Only in this way can the huge burden of doctor-induced illness be lifted from the population.

Eighty to ninety percent of medical care can be provided in

the neighborhood clinic. But all patients must also have easy access to the most advanced techniques of specialized twentieth century medicine. Thus the clinic is linked to a district hospital. Each district hospital--backing up 7 or 8 clinics--has out-patient facilities and beds in all specialties. The patient, after referral to the specialist for consultation, is generally returned to his personal doctor in the neighborhood. And in the process, the specialist teaches the general doctor more about his specialty. Knowledge must constantly diffuse outward--from specialist to general doctor, from general doctor to other health workers and patients. In this way, the monopoly on knowledge can be broken.

In rare instances, patients will require the services of super-specialists and vastly expensive equipment not available at district hospitals. Thus every 8 or 10 district hospitals are linked to a regional hospital, equivalent to the present-day university medical center. Both district and regional hospitals are governed by community boards, chosen from each neighborhood clinic. These boards set policies for the hospitals, and coordinate the linkages between hospitals and clinics. By this system of regionalization and linkages, every patient in every neighborhood (or rural area) has easy access to the most advanced knowledge and techniques, yet does not lose the continuity of a personal physician in the neighborhood. And those who use and work in the system control policy at every level.

Who will pay for such a

health care system? Ideally, each neighborhood would tax itself to support its clinic, and would contribute to the running of its district and regional hospital. However, such local financing is impossible in a society where some neighborhoods are destitute. Thus, until an equitable distribution of wealth is achieved, health care must be financed by a mechanism of regional or national taxation. None of the present proposals for financing national health insurance is adequate or acceptable. A health care financing scheme must be based on three inviolable principles. (1) Taxes collected for health care must be truly progressive; i.e., the rich must pay their share. At present, the tax burden is disproportionately placed on the lower-middle classes. (2) All money collected by the national financing mechanism must be paid to community-controlled clinics and hospitals. (3) No money may be paid to profit-making institutions. Thus drug companies, nursing homes, and corporations producing health-related equipment are not allowed to profit from the sickness and death of human beings. These corporations must take on a public, non-profit status.

This is the vision of a health care system for America. But how can we transform the vision into reality?

First, we must set up alternative health institutions--institutions as much like the community-controlled, neighborhood-based, comprehensive, non-doctor-deifying clinics as possible; as little like the hierarchical corporate, bureau-

cratic, centralized, fee-conscious type of outfit as possible. The essence of such alternative institutions are the free clinics. We must support, utilize, and work in existing free clinics, and create hundreds more.

But a single free clinic, isolated in a ghetto neighborhood, is very limited. It needs linkages to hospitals, laboratories, X-rays, etc., so that it can provide truly comprehensive care. In order to force institutions of the present health care system to provide such linkages and services to free clinics, these existing institutions must be changed. Thus free clinics--in order to guarantee their own effectiveness--must be springboards from which established institutions are challenged and confronted. Demands that hospitals truly serve their clients must constantly be escalated, with the ultimate goal being community control of the hospital.

And finally, in addition to creating alternative institutions and challenging established ones, we must expose any so-called reforms (such as current national health insurance proposals) whose effect is to further tax the lower-middle classes and channel this money to profit-making health care providers.

Yet it is not sufficient to create islands of visionary health systems in the midst of the present structures. A public, regionalized health care system cannot co-exist with a private, entrepreneurial system; the latter will always win out. Doctors, able to make more money from the private system, will leave--or never enter--the pub-

lic system, will set up offices, and charge fees. These doctors will receive patients because the public system, undermanned due to the greater attraction for doctors of the private system, will offer long waits and poor quality. More patients will choose to pay private fees, more doctors will set up offices to collect such fees, and the public system will enter a vicious spiral downward. The shameful performance of public municipal hospitals today is an expression of just this process.

To realize our vision, then, the decentralized, community-controlled health care system must supersede the present structures. Only with the complete replacement of the old system by the new will American health care institutions serve those who receive the care, rather than those who provide it.

If you would like a list of free health care clinics and movement medical organizations we can send you a xeroxed copy of our 16 page directory. Please help us cover our cost of reproduction and mailing by including 60 cents.

READINGS

- Dr. David Barr, "National Projection of Admissions for Drug Induced Illness," survey of New York Hospital -- Cornell Medical Center, 1955
- Dr. Thomas Brewer, "Disease and Social Class in the United States" and "Fact and Fiction, the Truth About the American Medical Association." Richmond, California, 1968
- Richard Carter, *The Doctor Business*, Doubleday and Company, New York, N.Y., 1958
- Dr. Erich Fromm, *The Revolution of Hope, Toward a Humanized Technology*; Harper and Row, October, 1968
- Martin L. Gross, *The Doctors*, Random House, New York, N.Y., 1966
- William R. Hutton, "The Drug Price Scandal" in the *New England Free Press*, Boston, Massachusetts, July 1967
- Boisfeuillet Jones, *The Health of Americans*, Prentice Hall, New Jersey, 1970
- Morton Mintz, *The Therapeutic Nightmare*, Houghton-Mifflin Company, Boston, Massachusetts, 1965
- Elton Rayack, *Professional Power and American Medicine*, World Publishing Company, 1967
- Charles and Bonnie Remsberg, "Why You Really Can't Get Good Medical Care," in *Good Housekeeping*, February 1970
- Dr. Barkev S. Sanders, "Completeness and Reliability of Diagnosis in Therapeutic Practice," United States Public Health Service publication, November 1963
- Sources*, a Blue Cross publication on the health problems of the poor. To obtain copies, write: Editor; Richard M. Ralston, 840 North Lake Shore Drive, Chicago, Illinois, 60611
- Dr. Thomas S. Szasz, "Psychiatric Interventions as Degradation Ceremonies"
- Erratum: KPIX radio should be KPIX TV.

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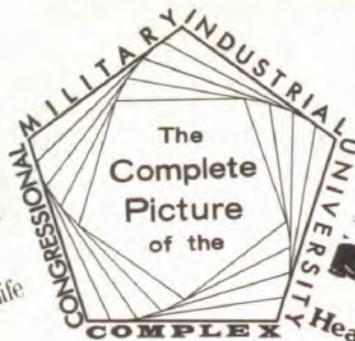
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...MORE VARIED...OR MORE EXALTED VIRTUES..." (DR. NATHAN SMITH DAVIS,
HISTORY OF THE AMERICAN MEDICAL ASSOCIATION, 1855)

THE PURPOSES OF
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BE "FOR CULTIVATING
AND ADVANCING...;
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FOSTERING FRIENDLY INTERCOURSE BETWEEN THOSE ENGAGED IN IT." (FROM THE
CONSTITUTION OF THE AMERICAN MEDICAL ASSOCIATION, WRITTEN IN MAY, 1847)