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introduces



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wed. december 20

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honoring

ELLEN FRANKFORT

AUTHOR OF "VAGINAL POLITICS"





WOMEN'S MEDICAL CENTER announces the 4th

KNOW YOUR BODY

6 week course by and for women — at 80 irving place, n.y.c.

anatomy · self help exam · vaginal infections
menstruation · pregnancy · menopause
v.d. · birth control women & doctors sexuality

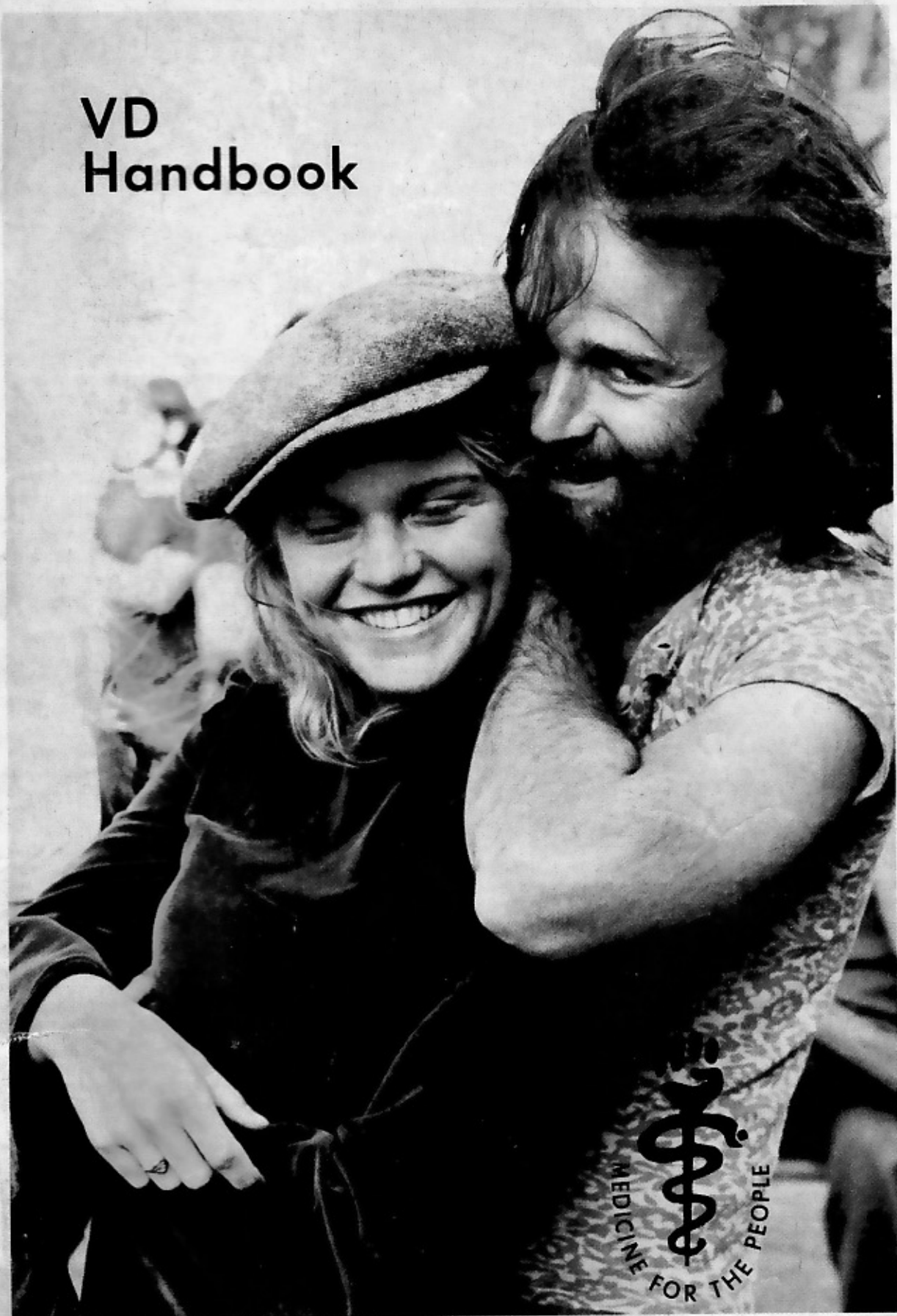


beginning Feb. 6 & 7

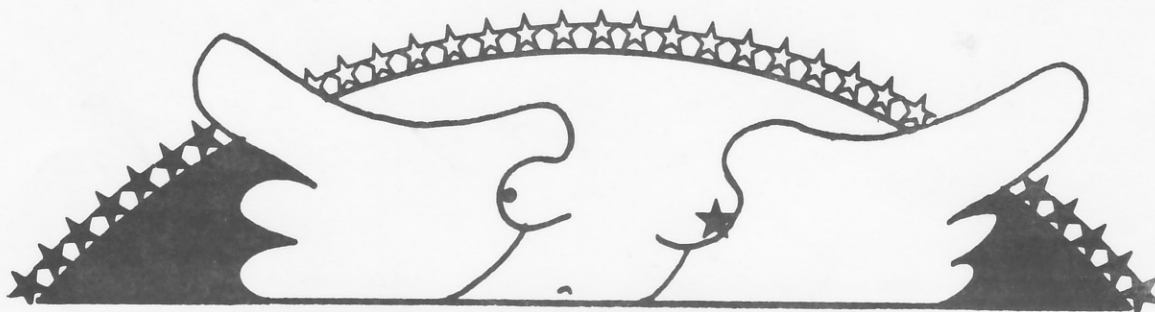
REGISTRATION FEE \$25.00

CALL 533-1100

VD Handbook



MEDICINE FOR THE PEOPLE



WOMENS HEALTH FORUM announces the

KNOW YOUR BODY

course by and for women —

anatomy · self help exam · vaginal infections

menstruation · pregnancy · menopause

v.d. · birth control

surgery · drugs

women & doctors

sexuality



8 WEEKS

For information— WOMEN'S HEALTH FORUM, 156 5th Ave.—Call 691-1140.

COURSE BEGINS WEDNESDAY OCTOBER 17.

REGISTRATION FEE \$35.00 in advance. Make checks payable to Women's Health Forum. Return registration card with payment. Call to confirm (1-4pm).

Sessions meet weekly. Wednesday eve. 7-9.

Health Story

GYNECOLOGICAL RECORD

Name _____

Address _____

City _____ State _____

Phone _____ Zip _____

Birthdate:

Blood-type A B AB O RH+ RH-

Sickle Cell

Regular doctor of clinic (where medical records are)

Name:

Address:

Phone:

Clinic Card Number:

Health Insurance Coverage and Policy Numbers:

they can get away from the white coats and the high-falutin' language. We give them competent care in an informal setting.

"The best medicine I've ever seen practiced happens here. I was trained in a city hospital. The patients would wait for two hours and then be rushed through in five minutes. Here, if they need a half hour, we give them a half hour. The physicians and other workers are kind and sensitive." Although the Free Clinic is struggling for financial survival, it hopes to add counseling and social services.

Keeping Consumerism under Control

Another medical consumer split is between "radicals," who want a total restructuring of the medical delivery system and a total shift of power, and "reformists," who would be satisfied with consumer input. New York's Comprehensive Health Planning Agency—a coalition of consumers and providers—is a reformist group. Created out of the Federal Partnership for Health Act, a 1966 amendment to the Public Health Law, it is part of New York City government; consumer members, who constitute a one-person majority, were selected from already existing citywide groups.

One member, a union official, thinks it's "healthy" to have a consumer majority. In practice, he says, the consumers are overwhelmed. "When they come to the board meetings they are not knowledgeable enough, so the providers lead the discussions and dominate the meetings." But he would *not* like to see consumer control. "Consumers should be consulted and involved, but they can't direct physicians or hospital



Laboratory of St. Mark's Free Clinic, a medical facility serving New York's lower east side

Boards of Directors. There must be a partnership."

Most health care providers, although they give lip service to consumerism, are quick to point out what they consider its dangers. "All too often, consumers are well-intentioned, but just don't know what it is to take care of patients or to get care delivered," the health insurance official told me. "By working within the existing structure, given the realities of law and tradition, we can best change it."

And although Dr. Cherkasky of Montefiore says that consumers "should control the social institutions that serve them," he qualifies that belief. "For consumers to be effective, when dealing with complex, technically based activities, they need a level of understanding not readily available," he told me. "People want to make social decisions without operational responsibilities, but you must know the instrument to make appropriate solutions." Dr. Cherkasky would like to see a team effort between professional people who know the instru-

ment and lay people who are socially concerned. "The more thoughtful the community leadership, the sooner we'll achieve that day."

The Most Vital Consumer Weapon

One very thoughtful medical consumerist is Edward Gluckmann, executive vice-president of the Consumer Commission on the Accreditation of Health Services, a consumer information service. Just beginning operation, the Consumer Commission has issued its first report on proprietary hospitals in New York City, listing the owners and detailing the level of services. Mr. Gluckmann sees his organization as a countervailing force to the Joint Commission on the Accreditation of Hospitals; the board of that Commission is composed only of providers and its accreditation programs are financially supported by the surveyed hospitals.

He hopes to provide consumers with the facts which will help them become a potent pressure group and considers the New York Commission a model. In three to five years, he says, consumer commissions in every major city may be publicizing heretofore secret information, demanding the right to monitor health care delivery, and "making the damn system a little more responsive and accountable to the people who pay the bills." Mr. Gluckmann also wants to form an organization to educate consumers in the politics of health.

Education is now critical to the medical consumer movement. Consumers who want to make their partnership with providers meaningful must counteract Dr. Cherkasky's charges of "ignorance."

ent is trying to gain some control over the private medical system. Consumer participation is being mandated by both Federal and state legislation: the Partnership for Health Act, OEO guidelines for neighborhood health centers, New York State Ghetto Medicine legislation, the Health and Hospitals Corporation's requirement for community advisory boards.

Consumer Boards

However, some community boards include as consumers members of the hospital Board of Trustees; some "consumers" are appointed by the hospital, not elected by the community. Zita Fitzgibbon, a member of Brooklyn's Methodist Hospital's Ambulatory Care Services Advisory Committee, mandated by New York State's Ghetto Medicine Act, told me of the difficulties in influencing hospital policy. "You don't understand half of what they're saying, and every time you bring up something you want to improve, they say there's not enough money."

But the Methodist board is no pushover, Ms. Fitzgibbon maintains. "Some hospitals have controlled boards, but we try to make things tough. For everything we want, we hassle, we cajole, we demand, we write letters to the press." Their most potent power: if the board advises the Department of Health of non-compliance with Ghetto Medicine guidelines, the hospital loses money. Methodist has lost \$100,000 because it didn't have a Director of Ambulatory Care. "Now, they're really trying to get a Director and we're really involved. There's nothing like having money withheld for clout."

Zita Fitzgibbon does see im-

provements at Methodist: a comprehensive screening program, a primary physician in both the medical and pediatric clinics, an appointments system in the medical clinic, an enlarged role for nurses. But she also sees a lot more work to be done, including the organization of a grass-roots consumer movement. To increase their effectiveness, consumers on both municipal and voluntary city boards have joined in a citywide coalition. They hope to institute internal reforms, improving the boards to make them truly representative, and obtaining a wider perspective for consumer and facility organizing strategies.

Efforts to create coalition on a wider scale—a national consumer health movement—have failed because of factionalization and splitting. Although there is nothing inherently wrong with a lot of little local groups, says Judy Wessler, health advocate at the MFY Legal Services, they may work at cross-purposes simply because they are not in touch with each other. Most community groups are voluntary and the members unpaid. "Without staff to coordinate the effort and keep at it, it's really difficult. When you have to start scrounging around for a Xerox machine, for a telephone, for stamps, there's so much investment of time and energy in that. It's admirable that so many groups have been able to have an adequate process of communication."

Also hampering the consumer movement are the inevitable arguments. "There's a lot of politics inside the consumer movement, and a lot of differences of opinion and a lot of conflicts and infights which probably won't ever be resolved," says Ms. Wessler. A city

official in health planning put it more concisely: "When consumer groups are splintered, they become ineffective. Providers won't respond to their demands."

Struggles of a Free Clinic

In opposition to consumers who would challenge existing institutions are those who would set up alternate ones—most often, free clinics. Since the Haight-Ashbury Free Clinic opened in San Francisco in 1967, hundreds more have been formed throughout the country. They aim to give good health care in untraditional ways for little or no money. Most of them are experimenting with community/worker control and stress the transfer of skills as a way to demystify and deprofessionalize medicine.

Emphasizing the split are their detractors in the consumer movement. Says Health-PAC's Ms. Reverby, "They don't provide decent care. They can't, because they're on a tenuous funding basis. Ultimately they fragment care because they can only provide bits and pieces. You're no better off than you were before you walked in, and you still have to deal with the health system."

Advocates of free clinics reply that they are models and instruments for change—and they *do* provide good care. To get an inside look, I visited St. Mark's Free Clinic on New York's lower east side on one of its twice-weekly open evenings. Its 20 or 25 patients a night are usually young adults who have gynecologic, dermatologic or minor medical problems. "They don't want the rigamarole, the red tape, the hassle of a hospital clinic," said a registered nurse from Cornell Medical Center who does volunteer work at the clinic. "Here,



Anatomy and physiology are taught in a "body" course at N.Y.C. Women's Medical Center

ous aspects of the health care system. Health-PAC unabashedly calls for the radical restructure of the American medical system, and espouses five principles. Health care is a right and should be free at the point of delivery; health services should be comprehensive, unfragmented and decentralized; medicine should be demystified and health care delivered in an educational manner; health care should be deprofessionalized and skills transferred to worker and patient; community-worker con-

trol of health should be instituted.

"The system must be accountable to consumers," says Ms. Reverby. "It's their money and their bodies, and that should give them ultimate control over health institutions." Worker control is also crucial, she maintains. "You need the people on the inside to feed you information, to help you understand, to be part of the policy-making machinery." Because this did not happen during the meat boycott, thousands of industry workers were laid off and prices stayed high.

A Superstructure Grows in The Bronx

A current consumer-provider struggle centers around a 7-year master plan by the N.Y.C. Health and Hospitals Corporation to merge all the health care facilities in the West Bronx, with Montefiore Hospital and Medical Center as its hub. Montefiore is expected to receive a contract from the municipal corporation to staff and operate the North Central Bronx Hospital—a modern \$95 million facility being built by the state for the city. For the past two years, Community Planning Board #7 and local health councils have been asking the corporation for information about the new hospital and for the right to participate in decisions about its services. Bronx Borough President Robert Abrams has also attacked the secrecy of the plans, and has demanded a measure of community control.

According to the *New York Post*, the master plan grew out of a private meeting initiated last August by Dr. Martin Cherkasky, Director of Montefiore. Dr. Cherkasky contends that the community will have input into the plan;

consumers and providers will be asked to suggest revisions. In a telephone interview, he told us that this was the practical way to do it: "You can't just set up a table in the middle of the Grand Central course and ask people for suggestions. Professionals first have to put their ideas together, so the consumers will have a target. Nothing has been definitely decided, committed or settled."

One of the main developments with which consumers must contend is the corporatization of medicine. As the Bronx situation suggests, power lies with medical superstructures. The AMA is shrinking in resources and prestige; hospitals and medical centers, connected through vast networks of affiliations, have become medical "empires." Power also resides in the financial-planning complex, particularly Blue Cross, says Health-PAC, and in the "medical-industrial complex," an alliance between health care providers and such industrial organizations as drug companies, hospital supply companies, hospital construction companies and banks. "Last, but far from least," says Dr. Kunen of the Medical Liberation Front, "are major governmental planning boards, agencies, and departments, including the Department of Defense."

One health administrator admits the existence of a complex and powerful medical system, "a force to be reckoned with," in his words. But he does not think that the "medical-industrial complex" is appropriate. "It is not a structurally organized phenomenon with interlocking directorates, collusion, antitrust suits. Everyone is simply doing their own thing."

Undoubtedly though, gov-

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Plans of Attack

The current aim of the Women's Health Organizing Collective is to make the health system less fragmented and more responsive to women's needs. Their most impressive project, *A Guide to Women's Health Services in Lower Manhattan, or How to Get Through the Maze with Our Feet in the Stirrups*, outlines the institutions, the services they offer, where they are and how much they cost. Ultimately, the Collective hopes to influence the institutions themselves, but this group's admitted lack of organization and information appears to stand in the way of progress on that front.

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The Women's Health Organizing Collective's plans for expansion include men. Although the group's first objective is comprehensive jobs ethics gynecology clinics with team nursing delivery and continuity of care, it also envisions total family care health centers—and other basic systemic changes. As their guide to women's health services states: "There are some larger changes we must also fight for—the basic right of patients and health workers to control health services and the right of all people to high quality care."

Health-PAC's Susan Reverby expands on this theme. "What happens to you as a woman is what happens to you as a human being, and so one has to understand the forces affecting people in society in general." In a review of *Our Bodies, Ourselves*, a book by the Boston Women's Health Book Collective, Ms. Reverby wrote, "The speculum may be a weapon to combat bad gynecological care, but it is not a substitute for an army and a battle plan." (*University Review*, April, 1973)

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tions. Dr. Bunker's conclusion: prepaid group health care in England and Wales, which offers no economic incentive to perform unnecessary operations, reduces their occurrence drastically.

To combat the small number of surgeons whom Commissioner Denenberg calls "knife-happy, incompetent and greedy," some unions have instituted compulsory consultation; the Distributive Workers Union, for example, does not reimburse members fully if they refuse to get a second opinion before surgery. Commissioner Denenberg's diagnosis: "The medical care system is not run for the public's benefit. It is designed by and for hospitals, by and for doctors. Physicians make up one big happy fraternity. Their code of ethics is to keep the truth from the public, and not to tell on one another."

His treatment: holding up rate increases to force medical third parties to set up more stringent standards for insurance-covered health care, publishing and distributing shoppers' guides to health care. This action has won him the enmity of some doctors, lawyers and insurers but, in a recent poll, Pennsylvanians overwhelmingly named Denenberg as the state official doing the best job.

Fraternal Malpractice

Even before such governmental action was in vogue, consumers had a viable tool in malpractice suits. Melvin Belli, one of the first lawyers to try malpractice cases, has strong opinions about medical men. "Not every physician gives A-1 care," he said in a telephone interview. "But the real problem is the cover-up by the good ones of the bad ones." Although he does

not believe in consumer control of medical delivery—"there would be as many and more errors as now"—Belli suggests that medical professionals should be restricted through publicity, legislation and court actions.

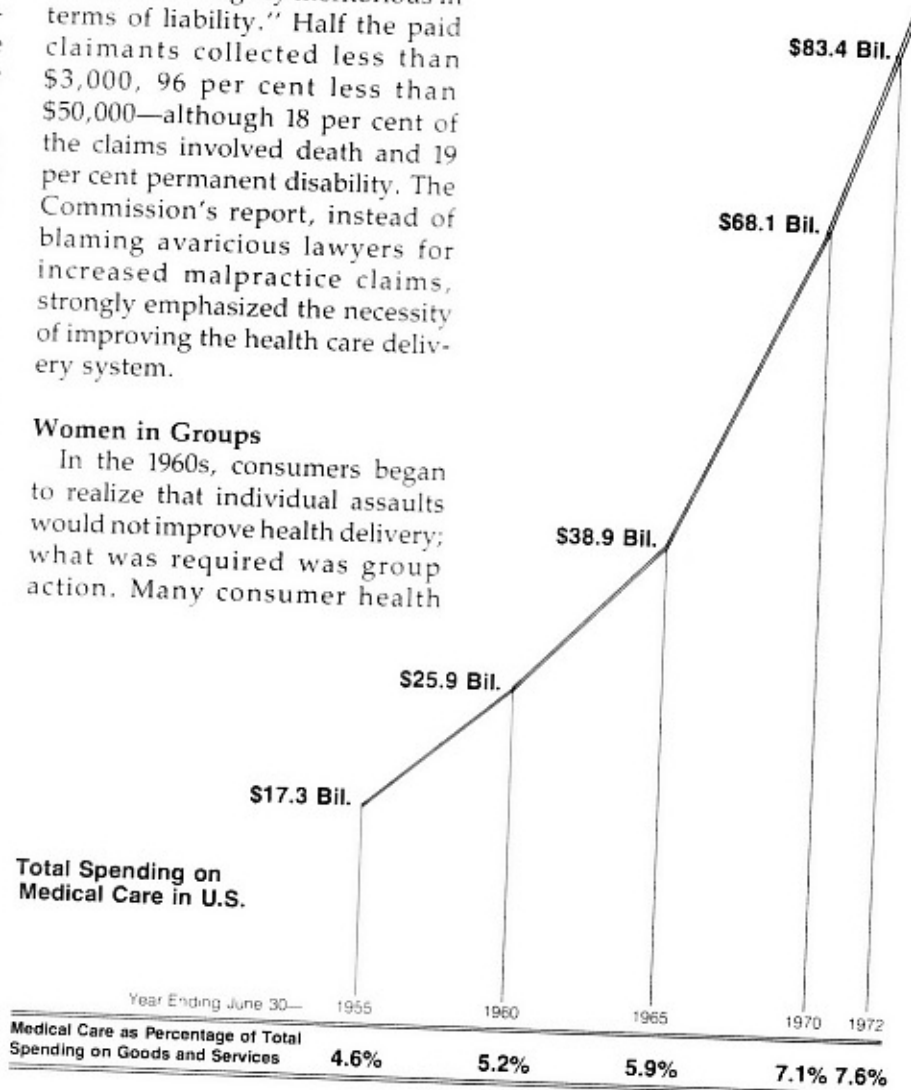
However, court action is not invariably effective. According to a recent report of the President's Commission on Medical Malpractice, only 41 per cent of patient-claimants received any payment—although insurers themselves judged that 46 per cent of the claims were "legally meritorious in terms of liability." Half the paid claimants collected less than \$3,000, 96 per cent less than \$50,000—although 18 per cent of the claims involved death and 19 per cent permanent disability. The Commission's report, instead of blaming avaricious lawyers for increased malpractice claims, strongly emphasized the necessity of improving the health care delivery system.

Women in Groups

In the 1960s, consumers began to realize that individual assaults would not improve health delivery; what was required was group action. Many consumer health

groups are also women's groups, not surprising because women make, on the average, 25 per cent more visits to the mostly male doctor population than men do. "The health system is absolutely sexist," contends Pam Booth, a worker at the Women's Medical Center, a New York City health information and counseling organization. "Men run those institutions, whether an office or a hospital or a clinic."

Ms. Booth's interest in health



U. S. health delivery: prices up

Health Care: A Buyer's Market?

The quality of
mercy has been strained

by Joan Solomon

DURING the first week of April, consumers across the country took a stand on the skyrocketing price of meat; they wouldn't buy that. The price of a different commodity has risen more sharply than almost any other over the past decade but, unlike meat, health care cannot be boycotted. Using an arsenal of alternate techniques, consumer activists hope to do more than bring medical costs into line: they want the treatment of disease to become the promotion of well-being.

The United States spends more money per capita on health than any other country in the world. The nation's health bill exceeded \$83.4 billion in 1972 and is expected to hit \$100 billion by 1975; since 1960, the cost of a day in the hospital has gone up 204 per cent, doctors' fees 74 per cent. As increasing costs begin to devastate the average pocketbook, middle class people are joining poor ones in demanding that health care be a right, not a privilege.

But what is being done with the money? A statement by Henry Jones, President of Massachusetts Blue Cross, provides a clue: "Probably no activity in the United States today displays more paradoxes than the health industry. On the one hand, it has made incredible advances in human skills and technology; on the other,

its actual *delivery system*, except in rare cases, has made little or no progress during the past few decades and, in some cases, has even retrogressed." (*Trial*, March-April, 1973)

Not Rich in Health

Health statistics support his assertion. Compared with other Western countries, the United States shows up poorly in such telling health indices as infant mortality and life expectancy. Even health service deliverers are cognizant of a crisis in care. "The health system fails to meet the needs of the patient," says a major health insurance plan official, who is also a former hospital administrator. "It is left too much to the medical profession to police themselves, to educate themselves. It is an awesome responsibility and physicians have failed to develop the capacity to meet it. So there are many examples of bad care, of unnecessary care."

Militant consumers point out that the health system is an industry, a profit-making industry. The profits are not in curing disease, but in treating it. Writes Dr. Richard Kunnes, psychiatrist and a founder of the consumer-professional Medical Liberation Front, "It's simpler and more profitable for the doctor to prescribe the wrong treatment, forcing

the patient to return, than to take the time to make the right diagnosis. There's no profit in curing, only in treating—and treating—and treating." (*Your Money or Your Life*, Dodd, Mead & Company, 1971)

Very Radical Surgery

One concern of the medical consumer movement: unnecessary surgery. A number of studies indicate that tonsils, uteruses and other assorted organs are often removed needlessly. Pennsylvania Insurance Commissioner Herbert Denenberg recently estimated that only 12 million of the approximately 14 million operations performed each year may really be indicated. In 1960, the Columbia University School of Public Health, studying surgery on the families of 238 Teamsters Union members, found that 20 of 60 hysterectomies were unnecessary and six more were questionable; seven of 13 Caesarian sections were seriously questioned.

Ten years later, anesthesiologist John Bunker compared the number of operations performed per capita in the U.S. with the number performed in England and Wales, then related these figures to the number of surgeons practicing in the respective countries. There are about twice as many surgeons for every 100,000 people in this country and about twice as many opera-

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tions. Dr. Bunker's conclusion: prepaid group health care in England and Wales, which offers no economic incentive to perform unnecessary operations, reduces their occurrence drastically.

To combat the small number of surgeons whom Commissioner Denenberg calls "knife-happy, incompetent and greedy," some unions have instituted compulsory consultation; the Distributive Workers Union, for example, does not reimburse members fully if they refuse to get a second opinion before surgery. Commissioner Denenberg's diagnosis: "The medical care system is not run for the public's benefit. It is designed by and for hospitals, by and for doctors. Physicians make up one big happy fraternity. Their code of ethics is to keep the truth from the public, and not to tell on one another."

His treatment: holding up rate increases to force medical third parties to set up more stringent standards for insurance-covered health care, publishing and distributing shoppers' guides to health care. This action has won him the enmity of some doctors, lawyers and insurers but, in a recent poll, Pennsylvanians overwhelmingly named Denenberg as the state official doing the best job.

Fraternal Malpractice

Even before such governmental action was in vogue, consumers had a viable tool in malpractice suits. Melvin Belli, one of the first lawyers to try malpractice cases, has strong opinions about medical men. "Not every physician gives A-1 care," he said in a telephone interview. "But the real problem is the cover-up by the good ones of the bad ones." Although he does

not believe in consumer control of medical delivery—"there would be as many and more errors as now"—Belli suggests that medical professionals should be restricted through publicity, legislation and court actions.

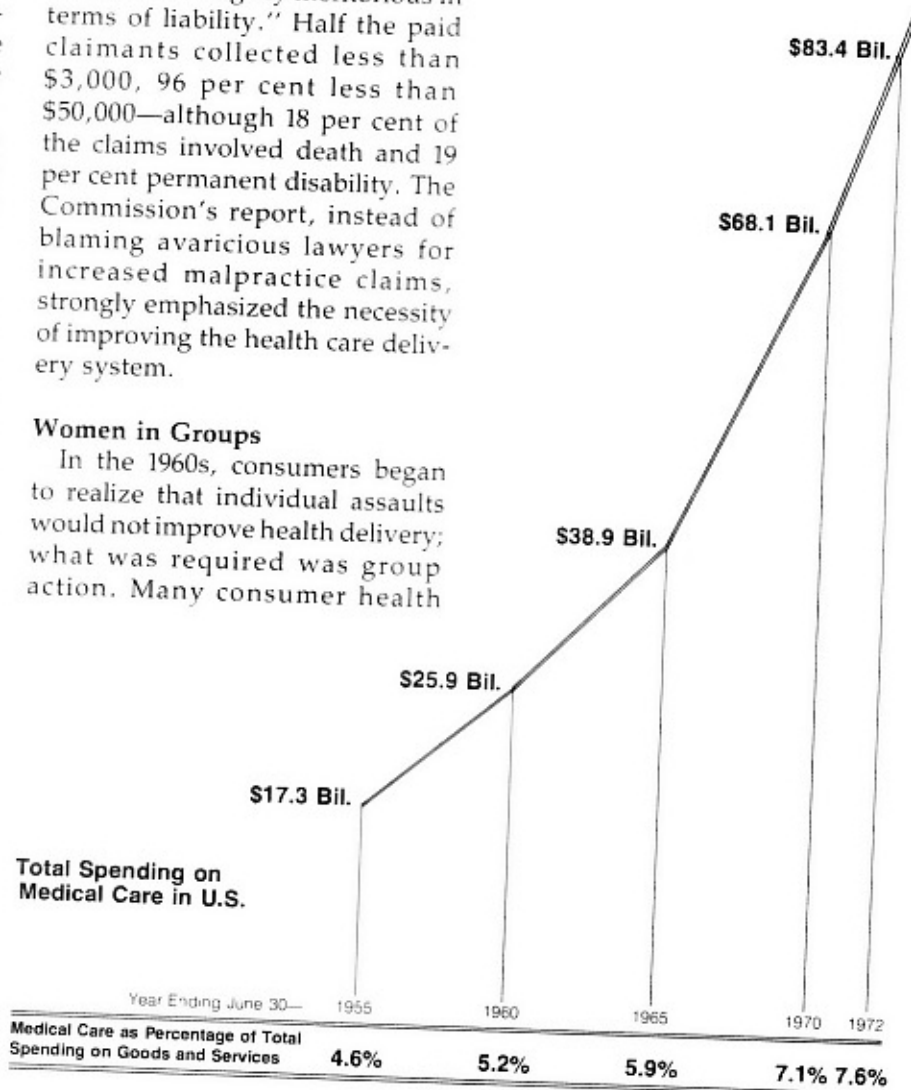
However, court action is not invariably effective. According to a recent report of the President's Commission on Medical Malpractice, only 41 per cent of patient-claimants received any payment—although insurers themselves judged that 46 per cent of the claims were "legally meritorious in terms of liability." Half the paid claimants collected less than \$3,000, 96 per cent less than \$50,000—although 18 per cent of the claims involved death and 19 per cent permanent disability. The Commission's report, instead of blaming avaricious lawyers for increased malpractice claims, strongly emphasized the necessity of improving the health care delivery system.

Women in Groups

In the 1960s, consumers began to realize that individual assaults would not improve health delivery; what was required was group action. Many consumer health

groups are also women's groups, not surprising because women make, on the average, 25 per cent more visits to the mostly male doctor population than men do. "The health system is absolutely sexist," contends Pam Booth, a worker at the Women's Medical Center, a New York City health information and counseling organization. "Men run those institutions, whether an office or a hospital or a clinic."

Ms. Booth's interest in health



U. S. health delivery: prices up

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they can get away from the white coats and the high-falutin' language. We give them competent care in an informal setting.

"The best medicine I've ever seen practiced happens here. I was trained in a city hospital. The patients would wait for two hours and then be rushed through in five minutes. Here, if they need a half hour, we give them a half hour. The physicians and other workers are kind and sensitive." Although the Free Clinic is struggling for financial survival, it hopes to add counseling and social services.

Keeping Consumerism under Control

Another medical consumer split is between "radicals," who want a total restructuring of the medical delivery system and a total shift of power, and "reformists," who would be satisfied with consumer input. New York's Comprehensive Health Planning Agency—a coalition of consumers and providers—is a reformist group. Created out of the Federal Partnership for Health Act, a 1966 amendment to the Public Health Law, it is part of New York City government; consumer members, who constitute a one-person majority, were selected from already existing citywide groups.

One member, a union official, thinks it's "healthy" to have a consumer majority. In practice, he says, the consumers are overwhelmed. "When they come to the board meetings they are not knowledgeable enough, so the providers lead the discussions and dominate the meetings." But he would *not* like to see consumer control. "Consumers should be consulted and involved, but they can't direct physicians or hospital



Laboratory of St. Mark's Free Clinic, a medical facility serving New York's lower east side

Boards of Directors. There must be a partnership."

Most health care providers, although they give lip service to consumerism, are quick to point out what they consider its dangers. "All too often, consumers are well-intentioned, but just don't know what it is to take care of patients or to get care delivered," the health insurance official told me. "By working within the existing structure, given the realities of law and tradition, we can best change it."

And although Dr. Cherkasky of Montefiore says that consumers "should control the social institutions that serve them," he qualifies that belief. "For consumers to be effective, when dealing with complex, technically based activities, they need a level of understanding not readily available," he told me. "People want to make social decisions without operational responsibilities, but you must know the instrument to make appropriate solutions." Dr. Cherkasky would like to see a team effort between professional people who know the instru-

ment and lay people who are socially concerned. "The more thoughtful the community leadership, the sooner we'll achieve that day."

The Most Vital Consumer Weapon

One very thoughtful medical consumerist is Edward Gluckmann, executive vice-president of the Consumer Commission on the Accreditation of Health Services, a consumer information service. Just beginning operation, the Consumer Commission has issued its first report on proprietary hospitals in New York City, listing the owners and detailing the level of services. Mr. Gluckmann sees his organization as a countervailing force to the Joint Commission on the Accreditation of Hospitals; the board of that Commission is composed only of providers and its accreditation programs are financially supported by the surveyed hospitals.

He hopes to provide consumers with the facts which will help them become a potent pressure group and considers the New York Commission a model. In three to five years, he says, consumer commissions in every major city may be publicizing heretofore secret information, demanding the right to monitor health care delivery, and "making the damn system a little more responsive and accountable to the people who pay the bills." Mr. Gluckmann also wants to form an organization to educate consumers in the politics of health.

Education is now critical to the medical consumer movement. Consumers who want to make their partnership with providers meaningful must counteract Dr. Cherkasky's charges of "ignorance."

ent is trying to gain some control over the private medical system. Consumer participation is being mandated by both Federal and state legislation: the Partnership for Health Act, OEO guidelines for neighborhood health centers, New York State Ghetto Medicine legislation, the Health and Hospitals Corporation's requirement for community advisory boards.

Consumer Boards

However, some community boards include as consumers members of the hospital Board of Trustees; some "consumers" are appointed by the hospital, not elected by the community. Zita Fitzgibbon, a member of Brooklyn's Methodist Hospital's Ambulatory Care Services Advisory Committee, mandated by New York State's Ghetto Medicine Act, told me of the difficulties in influencing hospital policy. "You don't understand half of what they're saying, and every time you bring up something you want to improve, they say there's not enough money."

But the Methodist board is no pushover, Ms. Fitzgibbon maintains. "Some hospitals have controlled boards, but we try to make things tough. For everything we want, we hassle, we cajole, we demand, we write letters to the press." Their most potent power: if the board advises the Department of Health of non-compliance with Ghetto Medicine guidelines, the hospital loses money. Methodist has lost \$100,000 because it didn't have a Director of Ambulatory Care. "Now, they're really trying to get a Director and we're really involved. There's nothing like having money withheld for clout."

Zita Fitzgibbon does see im-

provements at Methodist: a comprehensive screening program, a primary physician in both the medical and pediatric clinics, an appointments system in the medical clinic, an enlarged role for nurses. But she also sees a lot more work to be done, including the organization of a grass-roots consumer movement. To increase their effectiveness, consumers on both municipal and voluntary city boards have joined in a citywide coalition. They hope to institute internal reforms, improving the boards to make them truly representative, and obtaining a wider perspective for consumer and facility organizing strategies.

Efforts to create coalition on a wider scale—a national consumer health movement—have failed because of factionalization and splitting. Although there is nothing inherently wrong with a lot of little local groups, says Judy Wessler, health advocate at the MFY Legal Services, they may work at cross-purposes simply because they are not in touch with each other. Most community groups are voluntary and the members unpaid. "Without staff to coordinate the effort and keep at it, it's really difficult. When you have to start scrounging around for a Xerox machine, for a telephone, for stamps, there's so much investment of time and energy in that. It's admirable that so many groups have been able to have an adequate process of communication."

Also hampering the consumer movement are the inevitable arguments. "There's a lot of politics inside the consumer movement, and a lot of differences of opinion and a lot of conflicts and infights which probably won't ever be resolved," says Ms. Wessler. A city

official in health planning put it more concisely: "When consumer groups are splintered, they become ineffective. Providers won't respond to their demands."

Struggles of a Free Clinic

In opposition to consumers who would challenge existing institutions are those who would set up alternate ones—most often, free clinics. Since the Haight-Ashbury Free Clinic opened in San Francisco in 1967, hundreds more have been formed throughout the country. They aim to give good health care in untraditional ways for little or no money. Most of them are experimenting with community/worker control and stress the transfer of skills as a way to demystify and deprofessionalize medicine.

Emphasizing the split are their detractors in the consumer movement. Says Health-PAC's Ms. Reverby, "They don't provide decent care. They can't, because they're on a tenuous funding basis. Ultimately they fragment care because they can only provide bits and pieces. You're no better off than you were before you walked in, and you still have to deal with the health system."

Advocates of free clinics reply that they are models and instruments for change—and they *do* provide good care. To get an inside look, I visited St. Mark's Free Clinic on New York's lower east side on one of its twice-weekly open evenings. Its 20 or 25 patients a night are usually young adults who have gynecologic, dermatologic or minor medical problems. "They don't want the rigamarole, the red tape, the hassle of a hospital clinic," said a registered nurse from Cornell Medical Center who does volunteer work at the clinic. "Here,



Anatomy and physiology are taught in a "body" course at N.Y.C. Women's Medical Center

ous aspects of the health care system. Health-PAC unabashedly calls for the radical restructure of the American medical system, and espouses five principles. Health care is a right and should be free at the point of delivery; health services should be comprehensive, unfragmented and decentralized; medicine should be demystified and health care delivered in an educational manner; health care should be deprofessionalized and skills transferred to worker and patient; community-worker con-

trol of health should be instituted.

"The system must be accountable to consumers," says Ms. Reverby. "It's their money and their bodies, and that should give them ultimate control over health institutions." Worker control is also crucial, she maintains. "You need the people on the inside to feed you information, to help you understand, to be part of the policy-making machinery." Because this did not happen during the meat boycott, thousands of industry workers were laid off and prices stayed high.

A Superstructure Grows in The Bronx

A current consumer-provider struggle centers around a 7-year master plan by the N.Y.C. Health and Hospitals Corporation to merge all the health care facilities in the West Bronx, with Montefiore Hospital and Medical Center as its hub. Montefiore is expected to receive a contract from the municipal corporation to staff and operate the North Central Bronx Hospital—a modern \$95 million facility being built by the state for the city. For the past two years, Community Planning Board #7 and local health councils have been asking the corporation for information about the new hospital and for the right to participate in decisions about its services. Bronx Borough President Robert Abrams has also attacked the secrecy of the plans, and has demanded a measure of community control.

According to the *New York Post*, the master plan grew out of a private meeting initiated last August by Dr. Martin Cherkasky, Director of Montefiore. Dr. Cherkasky contends that the community will have input into the plan;

consumers and providers will be asked to suggest revisions. In a telephone interview, he told us that this was the practical way to do it: "You can't just set up a table in the middle of the Grand Central course and ask people for suggestions. Professionals first have to put their ideas together, so the consumers will have a target. Nothing has been definitely decided, committed or settled."

One of the main developments with which consumers must contend is the corporatization of medicine. As the Bronx situation suggests, power lies with medical superstructures. The AMA is shrinking in resources and prestige; hospitals and medical centers, connected through vast networks of affiliations, have become medical "empires." Power also resides in the financial-planning complex, particularly Blue Cross, says Health-PAC, and in the "medical-industrial complex," an alliance between health care providers and such industrial organizations as drug companies, hospital supply companies, hospital construction companies and banks. "Last, but far from least," says Dr. Kunin of the Medical Liberation Front, "are major governmental planning boards, agencies, and departments, including the Department of Defense."

One health administrator admits the existence of a complex and powerful medical system, "a force to be reckoned with," in his words. But he does not think that the "medical-industrial complex" is appropriate. "It is not a structurally organized phenomenon with interlocking directorates, collusion, antitrust suits. Everyone is simply doing their own thing."

Undoubtedly though, gov-

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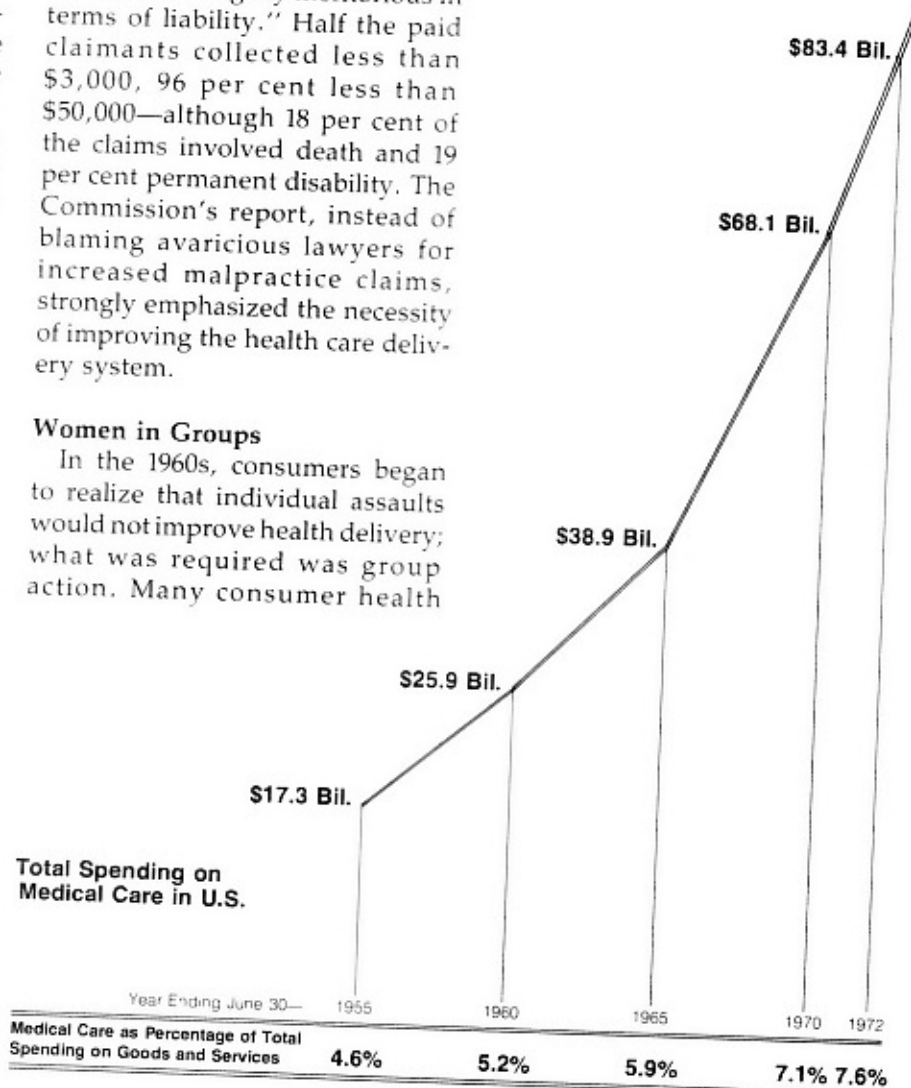
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U. S. health delivery: prices up

Health Care: A Buyer's Market?

The quality of
mercy has been strained

by Joan Solomon

DURING the first week of April, consumers across the country took a stand on the skyrocketing price of meat: they wouldn't buy that. The price of a different commodity has risen more sharply than almost any other over the past decade but, unlike meat, health care cannot be boycotted. Using an arsenal of alternate techniques, consumer activists hope to do more than bring medical costs into line: they want the treatment of disease to become the promotion of well-being.

The United States spends more money per capita on health than any other country in the world. The nation's health bill exceeded \$83.4 billion in 1972 and is expected to hit \$100 billion by 1975; since 1960, the cost of a day in the hospital has gone up 204 per cent, doctors' fees 74 per cent. As increasing costs begin to devastate the average pocketbook, middle class people are joining poor ones in demanding that health care be a right, not a privilege.

But what is being done with the money? A statement by Henry Jones, President of Massachusetts Blue Cross, provides a clue: "Probably no activity in the United States today displays more paradoxes than the health industry. On the one hand, it has made incredible advances in human skills and technology; on the other,

its actual *delivery system*, except in rare cases, has made little or no progress during the past few decades and, in some cases, has even retrogressed." (*Trial*, March-April, 1973)

Not Rich in Health

Health statistics support his assertion. Compared with other Western countries, the United States shows up poorly in such telling health indices as infant mortality and life expectancy. Even health service deliverers are cognizant of a crisis in care. "The health system fails to meet the needs of the patient," says a major health insurance plan official, who is also a former hospital administrator. "It is left too much to the medical profession to police themselves, to educate themselves. It is an awesome responsibility and physicians have failed to develop the capacity to meet it. So there are many examples of bad care, of unnecessary care."

Militant consumers point out that the health system is an industry, a profit-making industry. The profits are not in curing disease, but in treating it. Writes Dr. Richard Kunnes, psychiatrist and a founder of the consumer-professional Medical Liberation Front, "It's simpler and more profitable for the doctor to prescribe the wrong treatment, forcing

the patient to return, than to take the time to make the right diagnosis. There's no profit in curing, only in treating—and treating—and treating." (*Your Money or Your Life*, Dodd, Mead & Company, 1971)

Very Radical Surgery

One concern of the medical consumer movement: unnecessary surgery. A number of studies indicate that tonsils, uteruses and other assorted organs are often removed needlessly. Pennsylvania Insurance Commissioner Herbert Denenberg recently estimated that only 12 million of the approximately 14 million operations performed each year may really be indicated. In 1960, the Columbia University School of Public Health, studying surgery on the families of 238 Teamsters Union members, found that 20 of 60 hysterectomies were unnecessary and six more were questionable; seven of 13 Caesarian sections were seriously questioned.

Ten years later, anesthesiologist John Bunker compared the number of operations performed per capita in the U.S. with the number performed in England and Wales, then related these figures to the number of surgeons practicing in the respective countries. There are about twice as many surgeons for every 100,000 people in this country and about twice as many opera-

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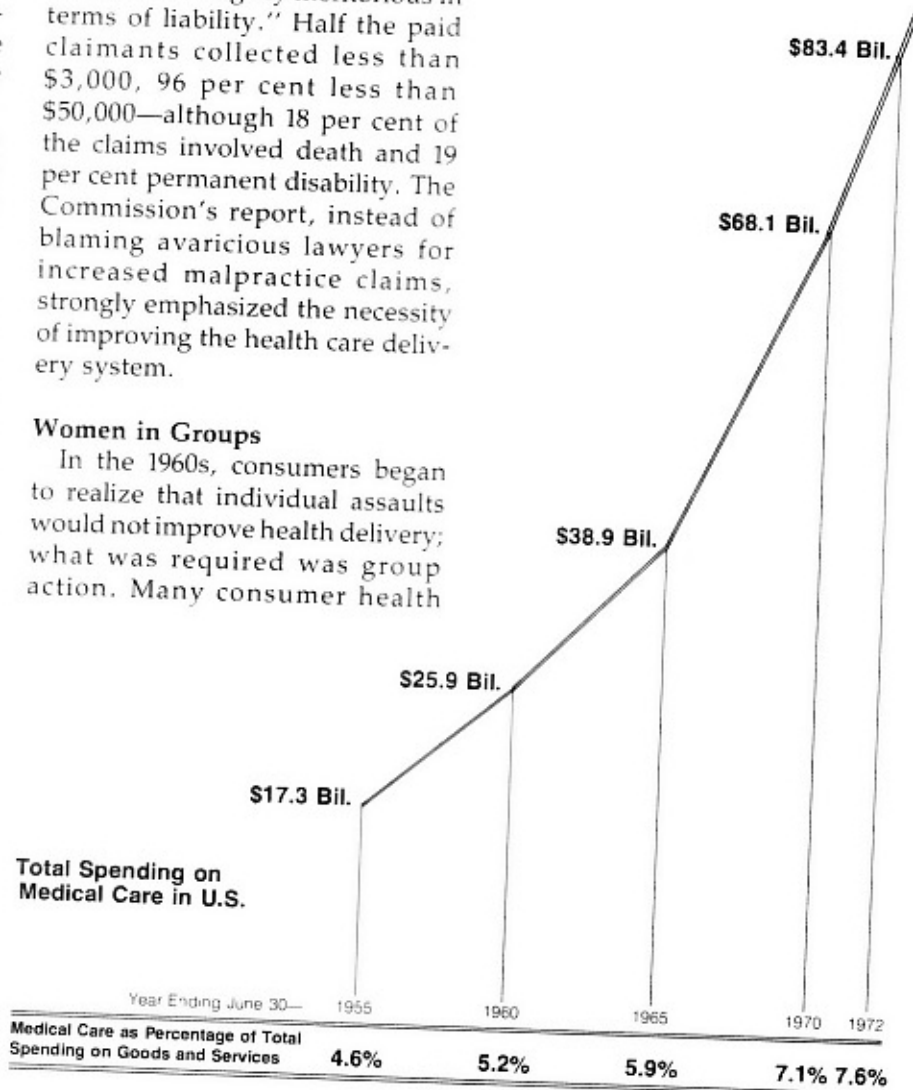
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