Contrary to the radical nominalism of Attorney General John Ashcroft, the Founders of our nation did not fight to preserve and protect what Ashcroft refers to as "their sacred fortunes." Rather, the Founders' Preamble to the Constitution includes a clause, "to promote the General Welfare," which was intentionally excised from the Preamble to the Constitution of the Confederate States of America. The General Welfare of the U.S. population, has now become a life-and-death issue, as witnessed by the failure of every feature of the physical economy from the electrical grid to public schools. In Washington, that issue has now taken center stage in the fight to save D.C. General Hospital.

'General Welfare' vs. Crisis Management

Founded in 1806, D.C. General was cited in a recent National Hospital Association report as among the best in the District. Why then, is it being closed? As a former D.C. mayor commented, "It's not a fiscal decision. There's a particular philosophy behind the decision."

LaRouche and his associates have briefed more than 400 D.C. residents at the recent meetings, including doctors, nurses, clergy, trade union activists, elected officials, and educators, as to exactly what this policy is: On Feb. 6, LaRouche spokesman Dennis Speed told 200 persons gathered to oppose the closing of the hospital, "There are two possible policy directions for our nation. . . . These two directions have no third alternative, no 'third way.'. . . Either our nation will go the way of Germany 1933, under the Nazis, or it will readopt the commitment to the General Welfare clause of the Constitution, adopted as the basis for both foreign and domestic policy during the Franklin Delano Roosevelt administrations of 1932-45." Emergency measures, implemented under the rubric of "crisis-management" echoing what Hitler did in February 1933, would be the future, unless the U.S. population acts in its own behalf, Speed said.

At the town meeting on Feb. 13, speaker Lynne Speed reported to activisits on what the various formal bids being made to run D.C. General—which requires expenditures of $120 million a year to run—on $60 million. She pointed out that Greater Southeast Hospital, which, on Feb. 8, won the bid to take over D.C. General, is owned by an Arizona-based private hospital group that has already shut down two hospitals in the greater Washington area; further, under the already-announced cuts, *all* Emergency Room service, as well as most long-term care, would be eliminated.

LaRouche recently emphasized to this author, that *no* plan, other than restoration of 100% of the hospital's capacities, and for *expansion* of hospital facilities, including new hospital construction, could result in anything other than death. In the accompanying articles, we document that preserving and expanding the services of D.C. General Hospital, far from being a local issue, is a paradigm for the national fight to defend the General Welfare against "shareholder values."

Interview: Kenneth Lyons

Hospital Closing Is National Catastrophe

Kenneth Lyons is president of the Washington, D.C. Emergency Medical Services Association, a non-profit community outreach and education association, and a emergency medical services (EMS) paramedic with the D.C. Fire Department, with which he's served for 16 years. He was born, raised, and educated in Washington, D.C. He received his college education at the University of Miami. Mr. Lyons spoke with Lynne Speed on Feb. 5, 2001.

EIR: Being on the front end of the health delivery services, you probably get a good opportunity to see the impact of the existing budget cuts in D.C. General Hospital, and also what the impact of shutting this hospital would be.

Lyons: Exactly. What's happened is, that the result of just the most recent downsizing of the hospital has had a dramatic impact on the health-care industry. Look at the city: Currently, there are 15 medical facilities in the District, and only five level-one trauma centers. What we see now, just with the downsizing of D.C. General Hospital, we're finding the shift in the patient load to extend from the far end of Southeast [quadrant of the city]—that's the Greater Southeast Hospital—to the far end of upper Northwest, which is Sibley Hospital. All those hospitals have felt the impact of D.C. General being downsized.

Even in the early phases of the downsizing of the facility, they are witnessing the impact, that is, no patient beds, six- to eight-hour waiting times, to extend even to ten-hour waiting times, turning [emergency] patients away at the door. The most dramatic case, is when patients are near D.C. General Hospital, and we are not able to take them there. This is true of the most serious trauma, of the most serious medical cases. We have to find other hospitals to take them to.

This is a hospital that serves at least 40% of the city's population. I don't just mean the city's population. You're talking about a population that is between 500,000 (which is the indigenous population), and the population of 1.5 million that's in the city every day. They're not just from the District of Columbia. They're from all over the world. They're from Maryland, Virginia, Pittsburgh, California, Europe, Asia. Wherever they may be, D.C. General Hospital serves those people.

So, to say this is a District problem, no, it extends beyond the boundaries of the District, and in doing so, with this hospital being downsized, it's impacting all of the hospitals, not

only in the city, but those hospitals in Maryland, those hospitals in Virginia, those hospitals in Philadelphia, those hospitals in North Carolina. We're seeing the epicenter of a catastrophic event, and unless we realize the importance of this one medical facility, but look at it not from the perspective that it serves this city, but we have to realize that it serves the world. It serves the nation. At the very least, it serves the nation; at the very most, it most serves the world.

So when you start looking at it from those perspectives, then it becomes more than just a problem of the District of Columbia, but a problem of this nation. And it should be addressed in that manner.

EIR: You mentioned that you're going to have an increase in the number of deaths. Have there been some recent incidents that you can cite?

Lyons: Yes. We actually saw the initial downsizing of the facility occur, we felt the burn of it, starting in 1988, and it became worse over the years. I can just point out the one incident, where D.C. General, when it was available as a full-service facility, did help. There was an individual, whose name is "Kenneth." He worked at the Rayburn Office Building. On his way home, down Pennsylvania Avenue, Kenneth suffered a head wound. He was shot in the back of the head. We took him to D.C. General Hospital, where he lived for ten hours. Ten hours to make peace with his God, ten hours to see his family, ten hours to see his daughter, and then he died. D.C. General bought him that time. He didn't live in the District, so he didn't fit the normal makeup of what you want to say of an individual who would utilize that facility.

Just two weeks ago, an individual was shot three blocks from D.C. General Hospital. Because they were closed, we couldn't take him there. We had to drive him to Med-Star Hospital, where this 16-year-old male died on the ramp of the hospital.

If you had a chance to speak to any of the medical individuals there, when asked, "Would it have made a difference if D.C. General was open?" they said, "Without a doubt": because the most important thing for a trauma patient is surgery. We delayed that transport ten minutes, because this facility was closed.

EIR: Why was the facility closed?

Lyons: Because at that particular point, they didn't have the staff to man the ER, the trauma area. They didn't have the upkeep, the maintenance in their generators, to keep the doors opening and closing. So we went to the doors and they told us, we don't have the staff, but it won't make a difference anyway, because since the generators broke, we can't open the doors.

I thought that was perfect! What a perfect illustration of the health-care crisis we have here now. The doors of a major medical facility are closed to those who need it the most. And you're left to your own devices.

EIR: And you couldn't get him directly into the hospital?

Lyons: The doors wouldn't open. The staff for the Emergency Room that particular day wasn't available. What made it even worse, though, was that the doors to the hospital were closed, because the maintenance on the generator hadn't been done, because of staff cutbacks.

The Emergency Room itself was closed. As a matter of fact, the entire hospital was closed. They weren't seeing any patients that particular day. When asked why, they simply said, we don't have the staff and personnel to carry out the basic functions of the hospital. We don't have it.

EIR: Does it also frequently happen that you find longer waiting times, even to get into the Emergency Room? In other words, it's open, but you have more patients than can be accommodated?

Lyons: When D.C. General was open, on a busy day—mind you, we have the busiest EMS system per capita in the country. We run over 130,000 calls a year. When D.C. General is open, the waiting time decreases from six to four hours. There's a four-hour waiting period in the rest of the hospitals, because they pick up the load. When they are closed, not only does it impact the waiting times, which may exceed six hours, but it also impacts on the response times of the [EMS] units that are working in the streets to transport the patients. So, we're seeing extended response times, because we don't have that facility available to the patients in that area.

EIR: What do you need for trauma care? I understand that there are a large number of cardiac arrests, and I imagine, also, shootings and other kinds of trauma cases. What's the timing? How quickly do you have to get a patient to the hospital?

Lyons: To put this into some perspective, the number-one killer in this city, in this nation, is incidents that involve cardiac disease and cardiac arrest. In this city alone, the save rate, that is, the rate at which individuals actually go to the hospital, who have suffered cardiac arrest, and leave, and walk out and live, and go on to lead productive lives, is 1% or less. The national norm is at least 7%.

It's been known for years, that the most important part of treatment, besides education, once it's recognized that an individual is suffering a cardiac event, is to get them the most intensive treatment necessary in a very short period of time. That time-span is between 8 and 14 minutes—*8 and 14 minutes*. We know that we can have a definite impact on an individual's life, who's not breathing, who has no pulse, if we can get the equipment there that we need within eight minutes, and that, basically, is a transport unit.

But what we're finding out, is that, even though we may get these individuals in a unit and transport them to the hospitals, there's a waiting period, and that waiting period is the difference between life and death.

EIR: So, once a person goes into cardiac arrest, the save-rate, the people who actually live, nationally, is 7%?
Lyons: It's around 7%.

EIR: And that means 93% don't make it?
Lyons: Ninety-three percent don't make it at all.

EIR: But in D.C., the rate that don't make it is 99%?
Lyons: Between 98 and 99%. What's even more significant about D.C. General Hospital, is that they had, to my knowledge, one of the most successful community outreach and educational programs to address issues involving hypertension, cardiac disease, diabetes—all of those are significant in this section of the city, whose geriatric rate we saw grow, I think, by 35%. To now say that we don't have that ability to go out and reach out to the community to educate them, leaves it on the shoulders of a few small non-profits, or whatever organizations there may be, to go out there and impact the community. I tell you, it's virtually impossible.

EIR: So, there have also been massive cutbacks in the preventive and educational services?
Lyons: Oh, most definitely. The community outreach program at D.C. General included an outreach center—actually, they had a van, which went around and took blood pressures, did cardiac checks, and did diabetes checks. It was a useful tool, if not educating, at least pointing out those specific areas that needed to be addressed, in specific areas of the city. This van served the entire city, not just one section.

They also had several clinics that they had available, where individuals could actually come in. They were community outreach clinics. I know of three, where people could come in and have blood pressure checks, and you could identify the problem, and then, say, refer these individuals to other medical facilities.

Those have been cut back. So, there's a direct correlation between the cutback and phasing out of those programs, and our cardiac save-rate.

EIR: Are any of the vans functioning now?
Lyons: No.

EIR: The paramedic unit is run through the Fire Department. We've pointed out in some previous articles how the cuts in the Fire Department, in the case of New York, related directly also to a disruption in health services and overall services in the city, with a very dramatic effect. Have you seen that kind of thing also in D.C.?
Lyons: Yes. The cutbacks in the Fire Department are a case in point: Not a day goes by when you can go past at least five to six firehouses, and find ambulances sitting in those firehouses unmanned. No manpower. So what you have, is a small fleet of units left to do the job that D.C. General used to do. If we don't transport, we're left to educate. In a city where you have 130,000 calls, and people are calling at a rate of ten calls every 10 or 15 minutes, you don't have time, even though you would like to do it, to do a job that a single hospital used to do.

So, we see that there seems to be a phasing-back or cutback in all of the major services, but the most important of those services, which directly affect the health and well-being of the citizens, or again, those 1.5 million people who visit and work in the city every day.

EIR: How many cardiac arrest cases do you get per year?
Lyons: Between 800 and 900.

EIR: What percentage of these 130,000-plus calls have traditionally used the services of D.C. General Hospital?
Lyons: Between 28 and 38%—it's huge. The majority of our units are located either in very close proximity of D.C. General Hospital, or on the fringes there. A large majority of our patients are transported to that facility.

EIR: So, despite the fact that it's one of 15 hospitals, since it's one-third of the caseload of the city, you can't simply transfer that.
Lyons: No, you can't. Not without seeing what we see now. Not without going to hospitals in the far Northwest and their telling us: "Look, we can't handle this patient load any more." Not when you go to hospitals outside of the District of Columbia, like Washington Adventist Hospital. They're saying, "we have our own concerns." Not when you're transporting patients that would normally go to D.C. General Hospital, and we're now taking them to Prince George's County [in neighboring Maryland]. They're saying, "We can't handle this caseload."

So, we hear the same thing time and time again, even though individuals are saying that the patient caseload can be handled by the surrounding hospitals. You need but step into any Emergency Room on any day, at any time, and just see the impact of this one hospital being downsized. The tentacles reach out, again, as far as Maryland and Virginia.

But is it affecting the hospitals directly in the District of Columbia? Yes, it is. We have Med-Star, a premium trauma facility, closing its doors. That's Washington Hospital Center, closing its doors, because it can't take any more patients. Where do we send them? We have Howard University putting patients in hallways—trauma patients in hallways—because their trauma rooms are packed. Where do you go? What do we give the patients?

Again, a true indication of the success of any city government, or any country, is its ability to care for its weak, its injured, its sick, and its young, and its old. The ability to care—compassion.

At EMS, we have a saying: "Do no harm." Can we say we're doing that now? No, we're not. We're doing anything and everything but that. So, are we really showing any com-

'Budget Cuts Killed My Baby Sister'

Rev. Clarence Turner III, pastor of Fruit of the Spirit Baptist Church in Washington, D.C., addressed the Feb. 6 emergency Meeting to Save D.C. General, where he announced that he would begin a vigil and fast at D.C. General Hospital the next day. Rev. Turner was a delegate candidate for Democratic Presidential candidate Lyndon LaRouche in the May 2, 2000 Washington, D.C. primary election. Here are excerpts of his remarks.

Rev. Clarence Turner III

I was treated at D.C. General Hospital, in 1959. If you look carefully, you'll see I stand straight. My back was broken in three places. My neck was broken. But on the third day, I got up out of the bed at D.C. General Hospital, when I thought I was going to die. But God chose to allow me to live.

But let me take you a little further. I've got a son that had been beaten almost to death, about five years ago. He works as a fireman and a paramedic now. We got him to D.C. General Hospital in about eight minutes. Finally, they were able to work on him. He stayed in intensive care for five days, [with an] induced coma because of brain swelling. He survived, and he's now doing everything he can to make sure people live.

I've been in Code Blue [inpatient life-threatening emergency, such as cardiac or respiratory arrest] seven times. Four of those times were in D.C. General Hospital. Those doctors got on their job. They found out the problem, worked right on it and got me out of there.

My baby sister had all kinds of insurance. My baby sister did not have to die. Somebody said it was D.C. General's fault, but the biggest problem, was because of the budgetary cuts, and some doctors that were so busy trying to save money, that they didn't deal with her situation: She was sent home, and in an hour and a half or two hours, she was dead. The same ambulance crew that delivered her, had not even gotten off their shift, came back to pronounce her dead.

I've watched them in those ambulances fighting to try to save somebody's life, trying to keep blood from running out of people's bodies. They suffer harder than you do about somebody dying. And can you imagine, they have to go another 10 or 15 minutes somewhere—it's not going to work, folks.

A change has to happen in our system. Our system is set up for you to die. If they snatch D.C. General Hospital, what do you think they're going to put in there? High-rises and beachfront condominiums and properties. How many of you are willing to die, because somebody wants to make a few extra million dollars?

Whatever way you do it, you'd better take it back now, because tomorrow might be too late.

passion to these people? Or, are we turning them away and saying, "Get your compassion elsewhere, because you just don't matter to us"? I think, at the end of the day, we are all measured by what we've done in life. How will the District of Columbia and its leaders answer up? You turned your back on your very young and your very old. How will you answer? I don't think you can.

To be honest with you, I see the faces of those individuals I can't help, because the system has failed them, and they ask me for help. What do I tell them? You never want to lie to a patient. You want to be honest and up-front with this patient. But you reach a point where, in some cases, it's best that you say nothing. How can I tell a family member sitting across from me, in the back of my ambulance, with their loved one lying on my cot as I do CPR [cardiopulmonary resuscitation] on them, "Ma'am, I'm sorry, we're going to have to go on the other side of the city because D.C. General is closed"? Then, when we get there, the doctors come to the family member and say, "I'm sorry, your husband, your son, your daughter, your child, has died."

I explain that to them: We passed the hospital that may have made the difference in this case. The ability to care, to show compassion: It's just apparent to me that that just doesn't exist now.

EIR: There are various schemes and plans, that people have tried to come up with, around the hospital. Of course, it all boils down, as Mr. LaRouche has said, to a question between

whether you believe the general welfare is primary, or shareholder or slaveholder values are primary. He has stated that there is no plan that can function, except the plan to have a full-service hospital; and that, in fact, there should be a Federal emergency renewal project in the city immediately, to make the nation's capital a national model, as opposed to a national shame. What is your response to his proposal? And do you think that the degredation of services so far, that that is workable, or does that have to be reversed?

Lyons: The degradation of services, is it workable? Ask that 16-year-old. We should be setting the trend, not following the trend. This is the nation's capital. I think Mr. LaRouche hits it right on the head, when he says that, not only should this hospital be reinstated as a full-service medical facility, by those who use the city's services the most—it is basically the Federal employees. But all those services, those outreach services, in which D.C. General used to participate, that had such an impact on the community—all of those should also augment the total reinstatement of a full-service center.

You mention that there are plans. I ask you, plans for what? Again, ask that 16-year-old what the plan was. Ask "Kenneth" what the plan was. Ask that family member who sits on that bench next to me, as I do CPR on his loved one, what the plan is. I'm sure, at that particular time, they will agree with me, that the hospital must be—it's not a question whether or not we should, whether or not we could—we've reached a point where we have to. We are at the bottom looking up. For us to turn our back on that hospital—and all these convoluted plans to somehow address the needs of the community, which we all know don't work—I see it every day.

If we turn our back on that hospital, we turn our back on the nation, at the very most, and we turn our back on those individuals who live here, the most important.

The plan, again, Mr. LaRouche is right on target. The only plan is quite simple. It's the plan that's worked, and that is, to reinstate the hospital. Other states have fought to keep their hospitals available. When I was in Florida recently, in the small town of St. Lucy, the question came up as to whether or not they should close their general hospital. The statement from the city leaders was: Whatever it takes. The city hospital not only cares for the community, it truly represents how much we are willing to care, what our compassion for the community is.

That's what the answer should be, in the case of D.C. General Hospital: What it really represents. To sign off on anything less is to simply say, we turn our back on the community, we turn our back on the nation. To do that, is to give away what makes us human. I think now is the time that we make that decision: Whether we are unwilling to turn away from what makes us human, or give in to those individuals who seek to benefit from others' miseries. Those individuals know who they are. I think now is the calling time. Now the horn is being blown, and we've got to answer. But first, the failure of every part of civilization is first, the inability to care for its population. From there, it tends to go downhill.

This is a national problem, but we should be setting the trend, we should set the example for the entire nation, that hospitals like D.C. General do more than just care for our sick and injured. They represent our capacity to care. There is a duty to act and a passion to care.

EIR: You were saying that D.C. General was the most successful in the city in dealing with trauma, and of course, this is a relevant issue, because you have everybody concerned with biological terrorism, the threat of that. Since this is the nation's capital, it's a legitimate concern. How does this function?

Lyons: First of all, D.C. General is only one of two medical facilities in this city actually constructed to deal with bioterrorism and weapons of mass destruction. That was one of its primary duties. But the way it dealt with trauma, in being one of the more successful hospitals in dealing with that, because it saw so much of it, other medical facilities, teaching medical facilities, realize that. So, what they started to do was send their [medical] residents there. It became such a successful program, that the U.S. Army and Walter Reed Hospital became a partner program. So the benefits of this hospital then expand even more than what we've discussed in the past.

It's a teaching hospital, where individuals came through, because of the type of patients that were being brought to the facility. They handled the most trauma in the city, and they did it well. It was one of the most successful in dealing with trauma in the District of Columbia, so much so, that it was actually recognized throughout the country as that.

In the District of Columbia, we're sitting on a time bomb, with the downsizing of services at D.C. General Hospital affecting, like an octopus, every agency service that we have now. What happens is, as long as key individuals in certain areas can keep the true gravity of the situation quiet, then the public truly won't know the extent of the crisis. Because, if they knew, you would come very close to having riots in the street. This is not something that I'm condoning, but individuals, if they truly knew how it would impact their lives, they would be up in arms. Because they would then realize, it's not just the District of Columbia. It's Maryland, it's Virginia, it's my next-door neighbor. Or it's me.

As long as they're able to keep it quiet, people go along their merry way, thinking that it won't touch me. But I'm here to tell you today, it has. It touches every visitor, every employee, every citizen of this city, every day. You don't have to get involved. Just go to an Emergency Room. Just go to Children's National Hospital, which has accepted an overwhelming number of kids, because D.C. General has downsized their pediatrics. Walk through their doors. Kids are no longer being handled as children or humans. They're being handled like merchandise. Stick them in, stick them up, and stick them out. That's what this system has come to.

It's not because they want to. It's because they're being put in a position where they have to. The impact stems from simply the downsizing of a major medical facility like D.C. General Hospital. To think that if you plan on wholesaling out parts of it, that there won't be any repercussions—they'll knock on my door today, they'll knock on yours tomorrow.

Documentation

House GOP Enforces 'Shareholder Values'

The following report (#106-786), on the District of Columbia Appropriations Bill for 2001, was adopted by the House Committee on Appropriations on July 25, 2000, as presented by Committee Chairman Rep. Ernest Istook (R-Okla.), speaking for the Republican majority on the committee. We offer it here as evidence of the commitment to shareholder (or slaveholder) values over the general welfare that predominates among Congressional Republicans. It also makes clear that the plan to close D.C. General Hospital has been a long time in the making, despite the charade to make the public believe that the decision was only made in February 2001.

The Committee is deeply concerned that the District must act immediately to stop the fiscal hemorrhaging that is occurring at the Public Benefit Corporation (PBC), which operates D.C. General Hospital. For the past 30 months the PBC has run a monthly deficit, now reaching $2.5 million per month. During this time, rather than confront difficult decisions to keep the PBC from going bankrupt, the District and Control Board have used a facade of "loaning" money to the PBC. During this 30 months, these loans have reached $90 million beyond the $40 million annual subsidy which had been budgeted and approved. The Committee finds it insulting to hear anyone now seek to call these loans "receivables," as though the euphemism made any difference in their nature. Past practice reveals that these "loaned" monies then are routinely written off as bad debts. Nor can any title conceal the fact that this was unauthorized and unapproved spending, especially since the payments were not accompanied by any promissory note, repayment agreement, security interest, collateral agreement, agreement of interest to be charged, nor any other documents to demonstrate the due diligence which should accompany financial transactions of this magnitude. These were not *bona fide* investments of funds, which by law, were not authorized to be spent.

By failing to address the problem of the PBC and the associated hospital, the District and Control Board have made matters worse. They have lost the opportunity to correct the underlying mismanagement, cost taxpayers many millions of dollars, and destroyed any confidence that any new proposed solution would be better than past proposals. The greater threat to public health in the District is not the potential closing of D.C. General Hospital, but in letting it continue to siphon off precious health care dollars without providing an equal value of benefit to the public. Other hospitals have indicated their readiness to assume the burden, and likely at lesser cost to taxpayers.

Just as bad as the financial failure, is the failure of political will to address this problem. The Committee is disappointed that officials have preferred to procrastinate and spend, rather than risk the unhappiness of the political constituencies involved in the PBC and D.C. General Hospital. District officials have failed to muster and demonstrate political will power or courage, and for more than the 30 months mentioned above. The problem dates back beyond ten years. The PBC was created in order to bail out a failing hospital, namely, D.C. General Hospital. District officials have had more than ten years to undertake the necessary operational or management reforms so badly needed. A recent report by the Cambio Group stated that the PBC should reduce its staff by 30%, and then, even this rightsizing of the workforce at the PBC would not totally eliminate the monthly deficit incurred by the PBC. The recently announced staff changes are but a tiny fraction of the savings now needed.

Leaders in the District have been asking, "What can we do to get through this without upsetting anyone?" when they should have been asking, "How can we prepare today to make a better tomorrow?"

No matter how good any current proposals may sound in this area, the Committee has no faith in the political will power of District officials to follow through with them. The Committee questions the legality of the so-called "loans" or "receivables," and even if this were somehow a legal loophole, the Committee has acted to close it.

Dissenting Views

The following is from the Democratic Committee members' dissent:

The second provision bars the Public Benefit Corporation from using its existing lines of credit to borrow funds above its budgeted amount. While the minority shares the majority's concerns about the grave financial condition of the Public Benefit Corporation, which operates D.C. General Hospital, emergency-care services, and health clinics for some of the District's poorest residents, it does not believe Congress, by fiat, should force its insolvency. Policy experts within the Control Board, the Mayor's office, and outside consultants, who are currently working on a remedy, were never consulted prior to inclusion of this provision. Moreover, the full ramifications of this provision are still not known, but certain to disrupt, and probably eliminate, health-care services to some of the District's neediest residents.