D.C. General Hospital Fact Sheet

Genocide Versus The General Welfare

by Lynne Speed

• On April 30, the unelected D.C. Financial Control Board, in violation of its Congressional mandate, overrode the unanimous (13-0) decision of the democratically elected D.C. City Council, and ordered the dismantling of the only public hospital in the nation's capital, and the privatization of the District's health system.

• This privatization plan was executed immediately, moving from contract signing (April 30) to implementation (May 1), without any serious implementation planning. It normally takes at least 12 months for a Medicaid contractor to work out a satisfactory implementation plan. The implementation of this "plan," as predicted, has already resulted in significant disruption in the quality and quantity of care, increased suffering and morbidity, and at least four deaths.

• Every major medical association, including the National Association of Public Hospitals, the American Public Health Association, the Medical Society of the District of Columbia, the American Medical Association, the National Medical Association, and the Nurses Association of the District of Columbia, has opposed the dismantling of D.C. General Hospital. Dr. Henry Foster, former U.S. Surgeon General designate, is on record opposing the shutdown of D.C. General. Dr. Joycelyn Elders, former U.S. Surgeon General, travelled to Washington, D.C., on April 27, 2001 to testify at public hearings, conducted by the D.C. City Council, to support D.C. General being maintained as a full-service public hospital.

• D.C. General has traditionally provided top-quality medical care to all who come through its doors—rich or poor, black or white, insured or uninsured, immigrant or citizen. As the only public hospital in the capital of the United States, and the closest hospital to the Capitol, its services are crucial, not only for District residents, but for the approximately 1 million people who visit or work in the District on a daily basis.

• Those who advocate closing D.C. General, such as the *Washington Post,* D.C. Mayor Anthony Williams, and the Financial Control Board, have all argued that the hospital is "bankrupt and hemorrhaging money, after years of financial mismanagement." In reality, the hospital, over the past several years, has never been adequately funded. U.S. Rep. David Bonior (D-Mich.), in the May 17, 2001 *Congressional Record,* states: "The financial situation of this and other public hospitals is severely impacted by Congress' unwillingness to provide additional resources and the fact our public hospitals serve most of our uninsured and poor."

• D.C. General received a budget allocation of only $45 million per year for the past several years, while delivering more than $75 million in services, a funding deficit of $30 million per year. The privatization contract, contrary to *Washington Post* propaganda, will not save money; it will cost more than $100 million for the first year alone.

• Medical services for D.C. General are being taken over by Greater Southeast Community Hospital, which is run by a private, for-profit contractor, Doctors Community Healthcare Corp. (DCHC), and its partner, National Century Financial Enterprises, which have a shaky financial record, and are facing lawsuits in four different jurisdictions for fraud, embezzlement, and racketeering, involving several other hospitals.

• The privatization contract, contrary to *Washington Post* propaganda, will not "improve the quality of health care." D.C. General is one of the highest-rated hospitals in the District of Columbia. It received a 94% rating from the Joint Commission on the Accreditation of Hospitals, compared to 84% for Greater Southeast Community Hospital. Health care under the new contract will be greatly diminished, with no guarantee of pharmacy services after the first four months, and no clear plan or responsibility for treatment of substance abuse, mental health, and AIDS cases, and prisoners.

• The privatization contract, contrary to *Washington Post* propaganda, will not "increase access to health care." D.C. General has provided access to medical care to anyone entering its doors, regardless of their ability to pay. Eligibility for "free care" under the new privatization plan is limited to D.C. residents without third-party insurance, who earn a family income at or below 200% of the Federal poverty level, and were patients at D.C. General over the last two years (200% of the poverty level will cover only 64% of the 81,000 uninsured D.C. General treats annually). This will automatically exclude 30,000 working poor people from receiving care, as well as an untold number of uninsured low-income patients, who did not happen to use D.C. General during the last two years. Enrollment and treatment now require three forms of identification. Recently an elderly woman, who had been being treated at a PBC (D.C. General) neighborhood clinic, for more than 15 years, was about to be sent home without her blood pressure medicine, because she did not have adequate identification. Her doctor, who fortunately spotted her in the waiting room, said that she might have gone home to die of a stroke, without his intervention.

• The privatization plan will eliminate inpatient services at D.C. General, and convert its emergency room into a "first-aid station." Of the 53,000 emergency room patients D.C.

General treats annually, 1,500 are Level 1, severe trauma cases. There is no hospital or group of hospitals, capable of absorbing those 53,000 patients. This has already resulted in severe overcrowding, and since the onset of the "privatization transition," every emergency room in the District has been closed on several occasions, forcing ambulances to travel as far away as Prince Georges County and Baltimore, Maryland. Patients have been forced to sit in emergency rooms for extended periods of time, waiting to be treated by a doctor. In one case, a man suffering spinal compression, a condition requiring treatment within six hours, or the spinal cord could be severed, causing permanent damage and paralysis, was not treated for two and a half days. Lack of bed space, due to the shutdown of inpatient services at D.C. General, has caused people to lie on gurneys for days in the emergency room, waiting to be admitted to the hospital. Several patients have grown tired of waiting and discharged themselves against medical advice.

- D.C. General is one of only two Level 1 trauma centers in the District, meeting the criteria of the American College of Surgeons. The privatization plan would shut the trauma center at D.C. General and create a new one at Greater Southeast, within three months. A Level 1 trauma unit, which is necessary for gunshots, deep puncture wounds, automobile accidents, etc., cannot be created in three months. The accreditation process alone takes one year. Yet, the trauma center at D.C. General was closed effective immediately, with the onset of the transition, with the rerouting of all ambulances away from D.C. General. Additional travel times, to more distant emergency rooms, have already resulted in at least four deaths.
- D.C. General has one of only two Level 3 (highest level) neonatal-care units in the city: Closing this unit will inevitably increase the rate of death among high-risk and premature infants. There is no plan to replace it.
- D.C. General has one of only two biochemical decontamination units in D.C., vital in the event of a disaster or biochemical terrorist attack in the nation's capital.
- The Control Board attempted a sleight-of-hand maneuver, to get around the 30-legislative-day Congressional review period, by enacting "emergency," as well as "temporary" and "permanent" legislation, in order to begin dismantling D.C. General immediately, knowing full well that there was no "emergency," outside of the one that the Control Board itself was creating.
- All elected officials are bound by an oath to protect and promote the General Welfare. If this principle is to be defended nationally against "shareholder values," it must be defended in the nation's capital. Congress can act to reverse this assault on the democratic process and this dire threat to the health and well-being of citizens in Washington, D.C., by passing a joint resolution disapproving the temporary and permanent legislation enacted by the Control Board.

Many Nurses Striking Against RN Shortages

by Linda Everett

The shortage of registered nurses in the United States is now at such a crisis level that thousands of nurses in at least four states are hitting the picket lines or are in active battle with hospital management to address and to alleviate outright dangerous patient-care conditions. The strikes and threatened labor actions in Massachusetts, Ohio, California, and Minnesota are but a glimmer of what we can expect as the economic collapse now hitting the nation—and hospitals—heats up.

The U.S. Labor Department predicts a shortage of 450,000 nurses in just seven years, according to a new Congressional General Accounting Office report. But, even this estimate is considered far too low, according to the Federation of Nurses and Health Professionals. For every five registered nurses (RNs) retiring during those years, only two new nurses are expected to take their place. The immediate crisis is demographic—the majority of U.S. nurses are age 45 and up and cannot endure the brutal physical demands of nursing today, as referenced below. They will shortly retire. On June 5, an American Hospital Association spokesman announced that hospitals nationwide have 168,000 unfilled positions, and 126,000 of these are nurses' spots.

But, the root of the problem is both historical and systemic, extending back to the "Southern Strategy" political decision 30 years ago to shift the national economic policy from a pro-industrial base to a post-industrial austerity footing. That shift included establishing managed health care as the means to ration and deregulate health care. For over two decades, managed care and HMOs (health maintenance organizations) looted tens of billions of dollars from hospitals, took down the nation's health-care infrastructure, and maimed and murdered thousands of people by denying them medical treatment. At the time, hospitals cut costs by cutting their nurse staff, and nursing schools were "authoritatively" told to graduate fewer professionals.

The tens of billions lost from Medicare in the Gingrichite Balanced Budget Act of 1997, and the reduced state Medicaid payments to hospitals during the 1990s phony "prosperity," finished the destruction.

The result is that hospitals have major gaps in their nursing schedules, and force available nurses, no matter how exhausted, to routinely work mandatory overtime—double an eight-hour shift, or 12-hour shifts or more—for days on end—