The Case for D.C. General Hospital

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A situation now exists in the nation's capital, in which preventable, more or less permanent damage to the general welfare of the District and its people should be prevented.

This past year, Washington, D.C. Mayor Tony Williams, aided prominently by Eleanor Holmes Norton, brought about the closing of the only public full-service general hospital in the District. The consequences of that closing have been harmful to the general welfare, and the pretexts proffered by the proponents of that action, were dubious at best, and are still a subject of well-founded suspicions. Now, as earlier signs indicated, the area within which D.C. General was situated is the target of projected, massive real-estate speculation.

I present four leading points of direct bearing on the challenge that closing presents, to the U.S. Congress today. Some of these are readily obvious. Others are of a more sophisticated quality, but not less urgent. All four are interdependent features of a single policy-matter.

1. The general problem is situated within the context of the generally known issue, that creation of the Federal District of Columbia created a constitutionally ambiguous situation, under which the residents of the District are denied an efficient expression of the Federal representation available to citizens of the states of the Union. First, this encumbers the Congress with a twofold special responsibility. The Federal government incurs responsibility for providing the District those conditions which were appropriate for the functioning of a populated area which is the seat of our Federal government. Second, this obliges the Congress to accept certain responsibilities for the general welfare of the population of the District beyond those which the Congress otherwise bears on behalf of the citizens of the Federal states. Both of these considerations are of primary relevance in the matter of D.C. General Hospital.

2. Recent developments are pushing the United States into adoption of a radical reversal of trends of approximately three decades to date. This will work to such effect, that prevalent criteria for policy-making of our government prior to Sept. 11, 2001, will now become radically different, than those which expressed prevalent trends over the preceding quarter-century. The Congress's appreciation of the case of D.C. General today, must be significantly different than under modes of thinking entrenched during the 2000-2001 interval.

Over a period of more than three decades to the present date, there had been a trend in national policy and practice, away from the Constitutional commitment to promotion of the general welfare, toward an increasingly radical notion of what is sometimes named "shareholder value." With the rising flood-tide of global monetary-financial and economic crises, the United States, like other nations, is being impelled, of necessity, to return to what some prefer to name as "protectionist" measures, and to economy-rebuilding policies referencing successful features of the U.S.-led recovery and reconstruction programs of the Americas, Europe, and Japan during various phases of approximately the 1933-1965 interval.

Congress has inescapable responsibilities which go back two centuries, for the provision of a full-service, teaching and research hospital at the site of D.C. General (here, a March 2001 rally against its closing). LaRouche renews that fight in the post-Sept. 11 situation, and makes a new proposal.

Today, some appear to believe that flooding the military-industrial and related elements of our economy, would be sufficient impetus for resisting rising economic-recessionary trends. That belief would be seriously mistaken. A contrast of the present economic situation with the pre-war mobilization of 1933-1939 Germany, with the history of our own mobilization beginning the time, about 1936, our government knew that a war with Hitler Germany was virtually inevitable, should make clear the reasons the present form of military stimulus of the economy will not succeed. In brief, the ability of 1933-1939 Germany to mobilize, like the 1933-1945 mobilization of the U.S.A., was a potential rooted in the two nations' long-preceding potential as leading producer economies; whereas, during approximately thirty-five years to date, the United States has been transformed, at a generally accelerating rate, from a producer economy to a consumer society.

We have entered a time, when the United States can no longer rely upon its recently increasing dependency upon replacing domestic production of physical goods by imports from cheap-labor markets abroad. Our nation's recent role as an "importer of last resort," has come to a close. Our farms and industries must be revived, and there must be a rehabilitation, upgrading, and expansion of basic economic infrastructure, including relevant changes in the quality of content of the sectors of education and universal health-care, with a correlated shift in composition of employment, preferring expansion of capacity for quality physical output, and reversing recent trends for expanding relative employment in unskilled or quasi-skilled services.

We must improve our current policies, including those enacted into law, in a manner conforming to the presently urgent requirement for such a shift.

3. For a period of nearly thirty years, our nation's health-care system has been increasingly the victim of a misguided shift from the system developed under the Hill-Burton law, to the presently evolved HMO system. It should be recalled today, that the Hill-Burton legislation was adopted under the impetus of the experience of our participation in two World Wars. Thus, Hill-Burton reflected an included awareness of the kind of health-care capabilities wanted to deal, inclusively, with health-care and related challenges of even traumatic national-security characteristics. That included awareness must be reawakened in legislative and other relevant practice under the increasingly strategically perilous conditions of today.

We face three general classes of problems in this area of our nation's security: a) A pure and simple loss, through attrition, of the essential facilities and professional cadres which our health-care delivery system used to command; b) Natural, evolutionary and analogous tendencies for breeding new types of infectious and other diseases, whose existence or degree of proliferation runs ahead of present health-care capabilities; c) A dangerous world, in which malice may turn the unlikely into the unthinkable. This also means curbing the impulse of some accountants, financial executives, and others, who would tend to substitute their judgment for that of medical professionals in matters of the practice of medicine.

4. Since the area occupied by the site of D.C. General Hospital was originally dedicated to that function, that role of D.C. General should be restored by the Congress, which should have proceeded in due course to assess the implications of the proposal to close it down, and which has, therefore, the primary responsibility for a definitive decision in this matter. The following considerations apply directly to that specific matter.

The obvious choice of principal place to combat disease is in the sections of the world and national population in which the occurrence of the relevant sickness is more probable. Thus, the institutions and persons who care for the relatively impoverished, aged, physically impaired, or other needy prospective recipients of health-care must be adopted, as policy, as the front-line trenches of national health-care defense. Exceptions taken into account, the most appropriate among such trenches are the public, full-service general teaching hospitals, which, with their university affiliations and working relationships to private hospitals and clinics, and with their own associated laboratories, combine science, care and training of professionals for those sections of the population which are ordinarily in the front-line of the war against disease.

Through the Surgeon-General, these capacities overlap and complement the military and Public Health Service requirements.

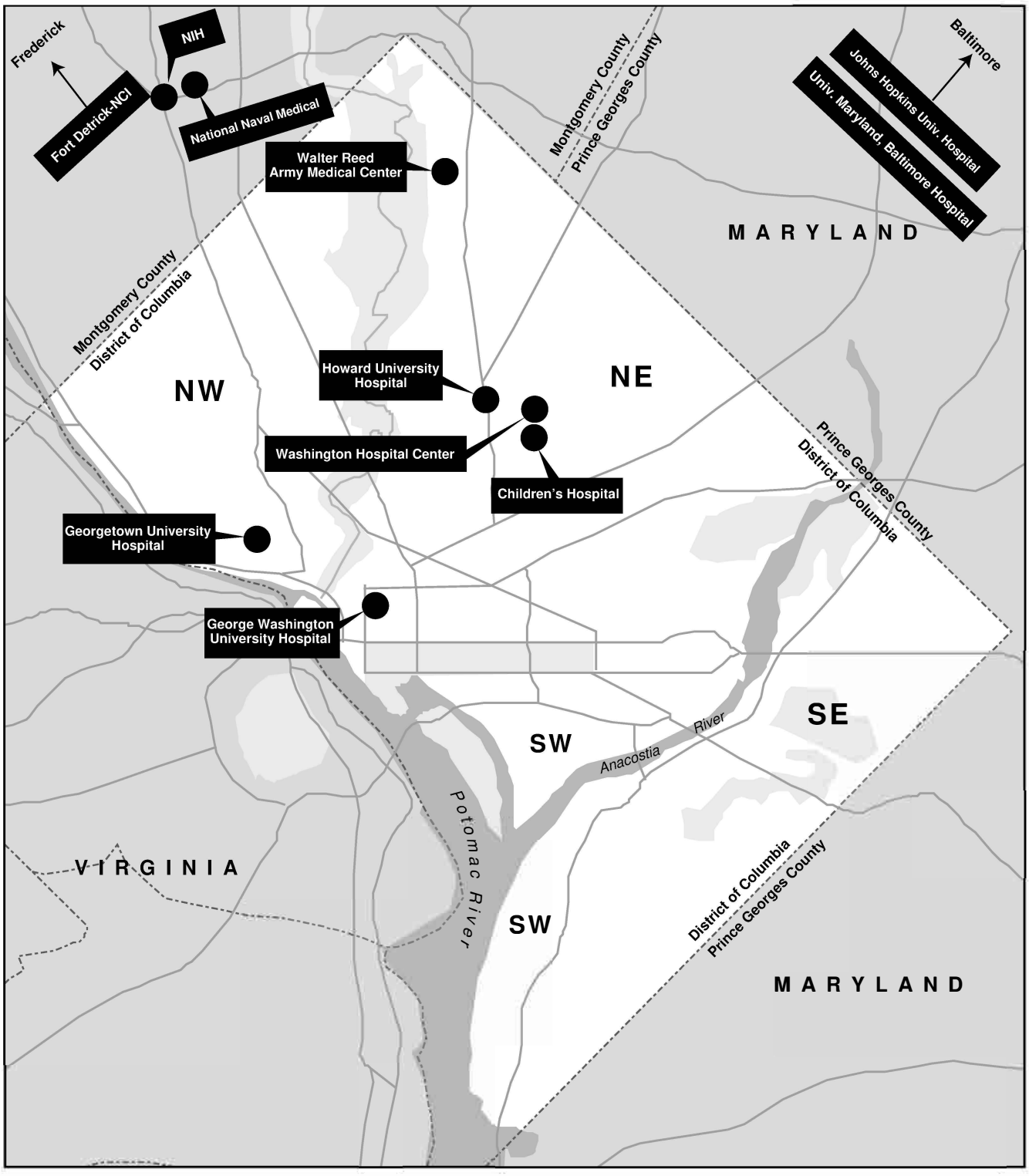
A reconstituted D.C. General should be a model of reference for national health-care policy:

As we should have learned, the delivery of health-care must never reduce medical professionals to finance-office clerks. The principle must be that a) care is delivered because medical judgment believes it is needed, and under no different rule than that; b) those who are able to pay, will; c) provision will be made to assist individuals and families in payment of a reasonably estimated life-time requirement for care; and d) those who can not pay will be cared for, as needed, anyway. Health-care must be as available, when needed, as the sidewalks and public streets and highways. The better the care, the more broad-based, the less the paper-work, the less the waste, and, in effect, the less the cost.

As is otherwise typified by the more successful periods of the U.S. space program, a strategically oriented program of national health-care security must have a defined mission as its spear-point. The area in which D.C. General had been situated, should be reserved as an area devoted to functions coordinated through the office of the Surgeon-General, which are of importance to the functioning of the Executive and Congress for policy-shaping, and for our Federal government's liaison with embassies of foreign governments.

The D.C. General Hospital should be restored, by Act of Congress, as a public full-service general hospital, with that indicated mission-orientation in view.

Major Teaching Hospitals and Research Facilities, Washington, D.C.–Baltimore Metro Area



LaRouche proposes the D.C. General Hospital area be devoted to functions under the United States Surgeon-General, for an American national and international public health mission-orientation. It would join and center the other medical/public health facilities of national importance, shown here.