

Letter from . . . Chicago

Red tape and regulations

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"Militarily, politically, economically, and in spirit, the state of our Union is sound," declared President Carter in his State of the Union Message to Congress and the nation—but unlike earlier Democratic presidents he offered a cool assessment of the limits of government. He pointed out that government cannot solve all our problems—and that it cannot eliminate poverty, reduce inflation, save our cities, cure illiteracy, provide energy, or mandate goodness. He declared that only a partnership between government and the people can achieve these goals—and he admitted that government had become as strange and distant as a foreign country, requiring people to deal with it through unduly influential ambassadors such as lawyers, accountants, and lobbyists. He promised to restore "government for the people" by reorganising the Federal bureaucracy and abolishing almost 500 advisory commissions and boards. Claiming to have already cut the public's paperwork by 12%, he said that his administration had made a good start on turning the gobbledygook of Federal regulations into plain English. "But I know that our people are still sick and tired of Federal paperwork and red tape" said Mr Carter, and he promised to chop down bit by bit the thicket of unnecessary regulations by which government interferes in our lives.

Among these regulations possibly none are more cumbersome than those governing medical care; and the need of complying with third-party and government red tape greatly increases hospital costs. This problem was recently illustrated by a hospital administrator with insights into the delicatessen business.¹ Imagine your favourite grocery, writes Mr William J Watt of Syracuse, NY, being required to conform to the regulations of several authorities governing the trade. These regulations will require the grocery store:

- (1) To record and report each year the number of cans of peas sold by brand, by customer age, and by employer of the consumer.
- (2) To certify in writing that the consumer "needs" groceries before allowing him into the shop.
- (3) To set up a committee establishing a time limit for each customer—with customers exceeding this limit not being required to pay for the groceries.
- (4) To keep a record of all customers, items purchased, amounts paid, name of shop assistant who placed each item on the shelf, time of arrival and departure of each customer, and name of employee who carried the groceries out to the car.
- (5) To obtain approval of the authorities before adding or deleting any particular brand of product.
- (6) To employ a store manager with a master's degree in marketing.
- (7) Periodically to determine and report the racial breakdown of the customers on a particular day.
- (8) Periodically to report the total number of customers broken

down by employer, by time spent in the shop, by whether they used a shopping cart, by number of items purchased, by type of item purchased, and by whether on entering the shop they turned right or left or sauntered down the middle aisle.

(9) To give away \$50 000 worth of groceries each year and be forced to post this fact in three languages.

(10) To have the authorities set the prices for one-half of the customers and be allowed to bill their employees only on receipt of written permission to do so.

(11) To have the store fined if the records prove to be inaccurate.

(12) To hire an independent accountant to check the accuracy of the data.

(13) To make the store manager responsible for planning each customer's meals, and be sued if he fails to judge what is best for the whole family, etc.

And so the list goes on, and after pointing out that each imaginary grocery regulation had a counterpart in hospital regulations Mr Watts concluded that now we know why hospital costs are so high. And elsewhere too there have been noises about the high cost of Federal paperwork. According to a study by the Michigan Hospital Association, compliance with Federal regulations and paperwork adds an average of \$36 to the daily cost of keeping a patient in hospital. One Chicago hospital devotes half of its budget to administrative costs. Everywhere extra jobs have been created and extra people have been hired to fill in pages of useless reports, comply with the complicated accounting methods required by Medicare, and conform with all the standards and rules created by the Federal agencies regulating medicine. And from one New York hospital it was reported that the utilisation review system designed by the bureaucracy to reduce hospital stay had discovered only six patient overstay per 9500 charts reviewed—at a cost of \$34 212 per patient identified by the audit.

In topics other than medicine, however, red tape and administrative confusion are not necessarily as harmful—at least not for some people. In Chicago last year the newspapers reported the case of a 30-year-old man who in 1970 was convicted to three years in prison on a charge of aggravated battery, but was freed on bond while his lawyer appealed the conviction. For some strange reason the appeal was never filed, the man remained free, and the clerk erroneously noted that the man was in jail. Two years later the mistake was discovered and a warrant for his arrest was issued but never delivered. The man remained free for seven years and waited. In fact he led an exemplary life. He married, had two children, took a job, and never moved from his original home. Yet he knew that some day they would come back to him. Last October, as he was returning from work, he was arrested. But the judge thought that seven years was too long a time for the police to catch up with their paperwork, and ruled that the man would not have to serve the sentence.

Smoking and drugs

At a higher level, the Federal Government, which spends \$80m in subsidies to tobacco farmers, has recently decided to spend another \$30m telling people not to smoke. This lavish

gift comes from health secretary Mr Joseph Califano, who himself smoked three packs of cigarettes a day until he stopped in 1975 as a birthday present to his children. Calling smoking a "searing national tragedy," "public health enemy No 1," and "a killer of thousands of Americans," Mr Califano announced a vastly increased effort to increase the public's awareness of the hazards of smoking, with particular emphasis on teenagers. In addition he also banned smoking in most areas of his department, asked for a ban on smoking on aeroplanes, and suggested possible increases in taxes on cigarettes, more stringent warnings on cigarette packages, special insurance premium discounts for non-smokers, revised labelling of oral contraceptives, and more antismoking announcements on television and radio.

His programme ran into immediate opposition from the Tobacco Institute, from the tobacco farmers, and from those resenting any government interference with their daily lives or with their right to destroy themselves. Dr Peter Bourne, President Carter's special assistant for health issues, argued against efforts to "make outcasts of smokers." White House press secretary Jody Powell said the families and communities depending on tobacco-growing should not be allowed to become economically ruined. Others called the programme phoney, ineffective, a drop in the bucket. Yet many people felt that a government that spent millions on the care of patients with lung cancer, bronchitis, emphysema, and heart disease had the right if not the duty to encourage Americans not to smoke. And, on the same subject, several Chicago hospitals recently banned the sale of cigarettes on their premises, despite large expected financial losses. Smoking is also on the decline among doctors, dentists, and pharmacists. Currently only one doctor in five still smokes, compared with one in three some 12 years ago. No such decline has occurred among nurses, and unfortunately women are catching up with men in rates of lung cancer.

Meanwhile, the Federal Government has announced that barbiturates are associated with nearly 5000 deaths a year and that having sleeping pills in the family cabinet is like having a loaded gun in the house. Wisconsin has banned the use of amphetamines for weight control; any doctor violating this ruling could have his licence suspended or revoked; and amphetamines may be prescribed only for narcolepsy, hyperactivity, and cases of depression when all other methods have failed. The American Medical Association has come out against the overuse of vitamins, this after a 4-year-old boy developed hypervitaminosis A from taking massive doses of vitamins from his grandmother's food store. Congress has for the time being reinstated saccharin; the Commission for the Control of Huntington's Chorea has asked President Carter for over \$50m to combat this disease—almost twice the amount being spent on the antismoking campaign; and 'flu troubles live on, with the country being invaded by the Russian 'flu and the Government being stuck with 90 million doses of swine 'flu vaccine and facing \$1.3 billions' worth of malpractice claims.

There has been a bitter fight between surgeons and family practitioners about the right to perform surgery, with the family practitioners accusing the surgeons of wanting to protect their incomes, and the surgeons charging that most family practitioners were inadequately trained to do surgery. But the family practitioners also complained that many surgeons had moved into general practice to earn a living. No early rapprochement between the two factions is expected, but at least everybody agreed about the weather, which this winter was particularly abominable. And with Chicago buried under 30 cm of snow, the health commissioner warned that no man over 45 should be shovelling snow lest he develop a heart attack. He explained that shovelling snow is one of the greatest stresses a man can put on the heart, and that the unaccustomed exertion plus the general vasoconstriction from the cold constituted a deadly risk for the average 40-year-old overweight, cigarette-smoking, and possibly hypertensive man, especially after eating a big dinner. So that shovelling snow should be left to the young and to well-conditioned women, the commissioner recommended.

Surrogate patients and prisoners

In September the *New York Review of Books* carried an advertisement from a man offering himself as a surrogate vacationer. For select people whose importance prevents them from taking vacations, the surrogate offers to take your vacation for you, stay at the hotels you prefer, eat in the restaurants you select, order the dishes in which you delight, take your photographs, gather your perceptions, have your adventures—and on his return present you with a detailed report bound in leather. The offer brings to mind a whole host of possibilities, such as surrogate surgical patients parting with their stomachs or gall bladders and presenting their experience—inclusive of the pathology report—bound in high-grade leather. Better still, surrogate patients, living at home and sending in regular reports and cheques, might fulfil the ultimate bureaucratic dream: a patientless hospital with no crises or interruptions but with plenty of meetings, hearings, and other administrative games.

Such an ideal was recently realised in the penal system—and the person who tells the story swears that it is true. It seems that one of the eastern States hired as director of prisons a man who firmly believed that jails were an unnecessary evil, that they perpetuated criminal behaviour, and that society would only benefit from their abolition. Given the opportunity to put his theories into practice he set out to prove his point by quietly emptying out one of the jails housing hardened juvenile criminals. Careful advanced preparations were made to accommodate the youngsters in hostels, dormitories, and private homes. Then on a certain day the buses came all at once and quietly took everyone away, with no fuss and no publicity.

A month later the director visited the now prisonerless jail and was met by the local warden, who was able proudly to assure his superior that since the departure of the inmates considerable administrative progress had taken place. Staff meetings were being held promptly, all reports were ready on time, absenteeism among the guards had been reduced to almost zero, and the morale of the staff was higher than ever before.

Reference

- ¹ *Congressional Record*, 1 March 1977, p 1042.

WORDS Everyone knows what a cough is. The huff is perhaps less well known. It is a forced expiration without prior glottal closure. Huffing is advised in the Brompton Hospital booklet on physiotherapy for the chest as an aid to expectoration. As a chest specialist I can testify to the occasional efficacy of huffing when coughing has failed to shift an annoying pellet of mucus. The word **COUGH** is clearly echoic. The **c** mimics the opening of the glottis under pressure from air within the chest. The **f** sound of **gh** serves for the air travelling at **speed** in the trachea. **HUFF**, too, is echoic.

Let us see whether our fellow Europeans are coughers or huffers. The Romans were coughers as are the modern speakers of the Romance languages, but here the abrupt opening of the glottis is mimicked more anteriorly with **t**; L *tuss/ire*, F *touss/er*, Sp *toser*, It *toss/ire*. By contrast the Teutons are huffers; Ger *hust/en*, Dan *host/e*, Sw *host/a*. So are the Slavs. The Dutch are versatile and do both with *hoest/en* and *kuch/en*, though the latter is more of a throat-clearing action. The ancient Greeks were coughers, like their modern counterparts, but here the mimicked glottal opening is placed **right** at the front, with *bēss/ein* (anc) and *vicho* (ch as in loch) (mod) though still starting with **beta**. The Hungarians have a double-action with *köhög*, which suggests *ahem*. The Germans do have a cough-type word in *keuchen*, but this means wheeze or gasp, and they perform both actions in *Keuch-husten* (whooping cough). I suspect that the German *Hauch* (breath, in the sense of exhalation) is related to huff. But could someone please tell me: is English the only language to have a word for forced expiration without prior glottal closure?