

hp 96059.htm

# A MATTER OF VALUE

## *Profits and Losses in Healthcare*

BY EMILY FRIEDMAN



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*This article is based on her presentations at the annual meeting of the American Academy of Hospital Attorneys in Boston on June 26, 1995, and at the annual meeting of the Forum for Health Planning in San Francisco, August 19, 1995.*

In difficult and troubling times like these, one of the natural inclinations of healthcare folk is to start squabbling among themselves. Hospital executives quarrel with physicians; system executives quarrel with hospital leaders; healthcare associations throw glancing blows at one another. Sometimes, as in the present climate, this self-destructive behavior is encouraged by those who benefit from a divide-and-conquer strategy; journalists and pundits also like to stir up the pot. As a result, minor issues are often blown out of proportion. But sometimes the issue is quite serious and deserves the attention it receives.

**Summary** In the growing debate over for-profit enterprise in healthcare, the real issues are ownership, conflicts of interest, profit margins, and what is done with those profits—not tax status or the presence or lack of a profit. Every healthcare sector—except hospitals—is now dominated by proprietary enterprise, and current attention is focusing on three types of entities: megasystems, systems and group practices, and for-profit HMOs. The question is, Do we indeed have a problem with the profit-related issues I have mentioned?

A great deal of fog surrounds the discussion. Both the public and many healthcare people feel discomfort with the idea that healthcare is a commercial commodity. But there seems to be a certain amount of hypocrisy in how the argument has been framed; only certain for-profits are characterized as posing a threat. What we are really dealing with is a massive shift of power from one interest to another. Some not-for-profit providers' loss of money and power, however, does not mean that for-profits that gain money and power are scurrilous.

Thus the debate over proprietary enterprise has

One such issue is that of for-profit enterprise in the field. A rising chorus of voices is claiming that proprietary firms have no place in American healthcare. News reports condemn HMO entrepreneurs; religious leaders speak out against profiteers. Yet Wall Street loves them, and commercial insurers certainly seem to have the ear of the current Congress.

To make any sense of this growing debate, we should specify what we are debating—in fact, it is critical that we do so. Although it is great fun to become embroiled in philosophical and semantic arguments about terms such as “for-profit,” “nonprofit,” “tax-paying,” “tax-exempt,” “volun-

been colored by extraneous concerns and hidden agendas. Nonetheless, three serious issues merit closer inspection:

1. Is the for-profit model flawed? Indeed, moral hazards certainly seem to be involved in stockholder-held entities that provide direct services to patients.

2. Is the problem making a profit or profiteering? Even if nonprofits are sometimes profiteers, the for-profits are hardly innocent. In addition to the huge sums being provided to stockholders, executives of proprietary firms often do very well indeed.

3. Do new models such as systems and HMOs pose any special problems when they are proprietary? In terms of systems, the jury is still out. Despite evidence that proprietary systems are forcing everyone to be more efficient, the question remains of who will subsidize unprofitable services like burn units and true indigent care if the system's hospitals and clinics do not provide it. When it comes to managed care, the tempting incentives to constrain access and skimp on services, combined with the requirements of for-profit enterprise, simply produce too dangerous a situation.

tary," and "proprietary," much of that is smoke.

Professor George Annas of Boston University recently stressed the symbolic importance of the language and metaphors we use in healthcare,<sup>1</sup> and he is absolutely right. Each side in this battle seeks to prejudice the argument by using terms that make the other side look bad. However, the real issues are ownership, conflicts of interest, profit margins, and what is done with those profits—not tax status or the presence or lack of a profit. After all, most supposedly nonprofit organizations make a profit, even if they call it a "margin" or "excess of revenues over expenses." Furthermore, most books in healthcare have been not only cooked, but barbecued, so that the actual amounts of money made or lost are often obscured.

In this article I use the traditional terms "for-profit" and "nonprofit," but I do so with an acute knowledge that they are, at best, inexact.

#### INSTANT REPLAY

Because American healthcare, like everything else in the United States, has little or no memory, many people see the for-profit "threat" as new. But this is an old fight. In the last century and the early part of this one, large numbers of hospitals were for-profit; most were owned by physicians, including some who were Black or Jewish and thus not allowed to join many hospital medical staffs. Physicians' ownership of hospitals was accepted at the time, despite evidence even then of perverse incentives and inappropriate behavior in some instances. Virtually all these physician-owned hospitals were closed or converted to nonprofit status over time.

A debate over healthcare for-profits surfaced in the 1970s, focusing on proprietary hospitals and hospital firms. The precipitating event occurred in 1965, when Medicare included a 7.5 percent return on equity for such institutions and organizations. For its part, Medicaid offered third-party payment for nursing home care, encouraging proprietary activity in that sector. Then in 1969 the Internal Revenue Service dropped its requirement that hospitals provide a certain amount of indigent

care and instead called for some form of "community benefit" activity (which it never got around to defining). Soon nonprofit hospitals were accusing for-profits of "dumping" uninsured and Medicaid patients; the for-profits responded that the nonprofits did not always provide indigent care, either.

The biggest blast, however, was fired in a 1980 essay by Arnold Relman, MD, then the editor of the *New England Journal of Medicine*.<sup>2</sup> Echoing President Dwight D. Eisenhower's warning in his farewell address about the power of the military-industrial complex, Relman warned of a "medical-industrial complex" that was threatening the charitable mission and even the goodness of healthcare.

Relman, a nephrologist, concentrated much of his concern on National Medical Care, a proprietary firm that dominated the provision of outpatient kidney dialysis. He also questioned for-profit hospitals and other entities. However, he excluded physicians from his criticism, despite the



Cathie Bleck

fact that some of them made huge incomes. Indeed, more than a few of the proprietary organizations he was attacking were founded and owned by physicians.

Relman's essay greatly fanned the flames. Defenders of proprietary enterprise claimed that their approach offered improved efficiency, the advantages of a systems approach, lower costs (a claim that rang a little hollow, and still does), volume purchasing, and even better care. Indeed, one defender of for-profits claimed at a conference that HCA was formed because "there were no good hospitals in the South." That *must have been news to Duke, Jackson, Emory, Grady, Baptist, Parkland, and dozens of other fine institutions.*

Nonetheless, Relman's concerns resonated with a nonprofit hospital sector that was anxiously watching the rapid growth of Humana, HCA, NME, AMI, and several other proprietary chains. The nonprofits feared they would soon be overwhelmed by the Evil Empire. Their unease was aggravated by health policy pundit Paul Ellwood, MD, who predicted that soon perhaps 20 megasystems, all or most of them proprietary, would control American healthcare.

What came out of this debate was Voluntary Hospitals of America (VHA), divided and competing hospital associations, a lot of fuss and bother, and a hospital sector that remained largely nonprofit.

**THE FOR-PROFIT RUSH**

The great irony is that while everyone was fretting about hospitals going for-profit, just about everything else in healthcare did just that. From pharmaceutical manufacturers to nursing homes, from HMOs to home care, every healthcare sector—except hospitals—is now dominated by proprietary enterprise; even many Blue Cross and Blue Shield plans are converting to for-profit status. I would therefore offer a word of advice to those who plan to stand at the gate, shouting, "Don't let them pass!": You are a few decades too late.

Yet the predicted megasystems failed to materialize in the 1970s and 1980s. Only now are we seeing a hint of such a presence, with the emergence of Columbia/HCA (which does not have an insurance arm, although it does engage in direct payer

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contracting). The closest thing we have to a fully integrated megasystem is Kaiser Permanente, which is nonprofit and remains highly regional.

Nonetheless, largely as a result of Columbia's aggressive acquisition strategy and the excesses of some major HMOs, the issue of for-profit enterprise in

healthcare has emerged again. This time, those raising questions are not only provider representatives but also the public news media, politicians, and some health policy analysts.

The focus of attention this time around is on three types of entities: megasystems such as Columbia/HCA, which could end up owning virtually all for-profit acute care facilities in the nation; proprietary systems and group practices such as Mullikin Medical Groups/MedPartners and Humana; and for-profit HMOs such as United Healthcare and Oxford Health Plans.

The question is, Are we going over old ground, or is there something new here? Do we indeed have a problem?

**THE REAL ISSUES**

A great deal of fog surrounds the discussion, which makes it difficult to determine if real issues are hidden in there somewhere.

**Healthcare as a Commodity** For one thing, both the public and many healthcare people feel discomfort with the idea that healthcare is a commercial commodity; we have erected complex legal, regulatory, and moral structures around it to keep the market from operating too heartlessly. And there is reason for that: The inability to pay for care, and thus to obtain it, is a good bit more serious than not having the money to buy a new pair of gym shoes.

Card. Joseph Bernardin of Chicago, in an address on this topic in January 1995, noted that healthcare is peculiarly given to market failure.<sup>3</sup> We keep trying to get the market to work in our sector, but the fact is that the playing field is not level, there is no equal purchasing power, there is little direct payment, and the consequences of not being able to buy your way in can be fatal. In healthcare, market theory works better than market practice.

Thus many have a negative knee-jerk response to the *idea* of for-profit healthcare, even before they know any facts.

**Historical Bias** Second, historically, healthcare has held a special place in this and most societies, and it is thought of as a charitable activity. Thus healthcare's social and historical context is biased heavily toward nonprofit providers, with the exception of physicians—even though opinion polls show that most Americans believe their local hospital is for-profit.

**Different Strokes** Third, some for-profit enterprises are apparently more evil than others. The hospitals take a lot of heat, and HMOs may end up taking even more heat. But for-profit physicians and group practices are accepted, perhaps because of their status as honor-bound professionals—and because they have always been proprietary. Pharmaceutical firms are also grudgingly tolerated, although they have been given a rough time in recent years by consumer activists, HIV patients, and Democratic Sen. David Pryor of Arkansas, who waged a long and unsuccessful battle to pass legislation limiting pharmaceutical price increases. Similarly, the for-profit status of most healthcare suppliers is accepted, even in the face of rampant fraud.

So there seems to be a certain amount of hypocrisy in how the argument has been framed; only selected for-profits are characterized as posing a threat.

**Profit Envy** Fourth, many of the attacks being launched at for-profits seem to be accompanied by a slight whine, in that the person accusing the proprietary entities of rolling up huge, immoral profits seems annoyed that he isn't the one who is rolling up huge, immoral profits. This is similar to the fight between wealthy physicians and wealthy personal injury attorneys over tort reform; the public greets this battle with a large yawn because it feels little sympathy for either side.

What is really going on here is that changes in the market have led to a different division of the healthcare dollar. Providers used to get most of it; now more and more of it is staying with payers. Many hospitals, after years of high margins, are being underpaid; with so much excess capacity, if a hospital does not take a proffered discount or capitation deal, some other hospital will. The same is true of specialists; there are so many of them that managed care and selective contracting are significantly decreasing their incomes. They are lonesome for the good old days.

Furthermore, money and power are closely related in this society, and the diminution of provider money means a parallel diminution in provider power. The metaphor that we use is profits, when what we are really dealing with is a massive shift of power from one interest to another.

Some providers' loss of money and power, however, does not mean that for-profits that gain money and power are scurrilous. There is a difference between moral outrage and envy.

**Serious Concerns** Thus the debate over proprietary enterprise has been colored by extraneous concerns and hidden agendas. Nonetheless, some very serious issues rest at the heart of this discussion. Three concerns in particular merit closer inspection:

1. Is there anything inherent in the for-profit model, especially the publicly held model, that could be counterproductive to healthcare or patient welfare?

2. Is the problem the making of profit, or is it profiteering, which is not necessarily tied to the organization's ownership or tax status?

3. Does anything about the new structures, especially systems and HMOs, pose special risks when for-profits are involved?

### IS THE MODEL FLAWED?

In terms of the first issue, moral hazards certainly seem to be involved in stockholder-held entities that provide direct services to patients.<sup>4</sup>

First, the boards of these organizations have a legal, moral, and fiduciary duty to have as their first priority the enhancement of stockholder's profit; this responsibility is entirely appropriate in a market-capital economy. Unfortunately, this duty can and does conflict with the healthcare giver's compassionate duty to protect patients first and foremost.

Second, much of the profit made by publicly held organizations makes only a brief stop in healthcare before leaving this sector for stockholders' wallets. Approximately half that money is derived from taxes. This seems too great a loss in a nation that claims it cannot afford to provide even basic health services to 13 million uninsured children and is seeking to cut public financing for healthcare. At least the money made by tax-exempt organizations must stay in healthcare, even if those organizations do not always spend it wisely.

Third, there is a certain discomfiting instability in the constant buying and selling of healthcare entities. For example, a HealthTrust hospital probably started out as a freestanding institution. It was then bought by HCA, which was publicly held, then went private, then went public again. The hospital was then spun out into HealthTrust, which has been acquired by Columbia. And it may have even been sold one or two times in side deals along the way.

Furthermore, for-profit healthcare has a distressing history of get-rich-quick opportunists,

with a here-today, gone-tomorrow approach. Hit-and-run artists whose only focus is the price of the stock can do a large amount of damage in a small amount of time.

The inevitable changes in administrative leadership, board structure, board membership, medical staff relations, mission, and finances that accompany all this cannot help but play havoc with planning, continuity, and community relations. They can also have a negative impact on the quality of care, if for no other reason than *employees' insecurity, which tends to lead to higher turnover.*

Although these are not insurmountable problems, they present serious challenges to those for-profits that claim their presence in healthcare could not possibly be detrimental.

**PROFIT AND PROFITEERING**

Many of the harshest criticisms of for-profit healthcare have involved how much money is made by proprietary organizations. But *profiteering* and *for-profit activity* are two different things. Few organizations that do not make a profit last very long, especially in these days of reduced philanthropy; children's hospitals are among the few exceptions. By this standard, the difference between nonprofits and for-profits is more one of degree than of kind.

And the for-profits can argue that they do much good with their allegedly ill-gotten gains. For one thing, most of them pay at least some local, state, or federal taxes. Many of them claim, with some justification, that they pay their own way to a far greater degree than nonprofits. It must be noted, however, that some for-profits are based in states that have no corporate income tax, and others have cut deals with localities that reduce or eliminate many of the taxes they would otherwise pay.

Nonetheless, it is frustrating, if not infuriating, to watch allegedly nonprofit providers, insurers, and others pile up huge amounts of money on which they do not pay taxes, and then spend it on themselves. More than one "nonprofit" hospital has provided chauffeured limousines to top executives. "Voluntary" hospitals and insurers own luxury sky boxes at sports stadiums. Some orga-

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nizations have buildings dotted with antiques and plush appointments that would put Ritz-Carlton hotels to shame.

Most important, however, is that many nonprofits have a poor record when it comes to indigent care. Several years ago, the Texas legislature had to pass a bill to get one nonprofit hospital to provide even a minimal amount of care to the uninsured poor. An-

other well-known institution with \$100 million in the bank announced that it could not afford to provide even emergency care to the medically indigent. The CEO of another hospital, conveniently located near a county facility, announced that his organization earned its tax exemption by providing the best care possible to patients who could pay.

This is the height of hypocrisy, and such organizations should lose their tax exemptions; no matter how loosely one defines "community benefit," this is not it. Furthermore, it represents a violation of the basic charge of every board of trustees: to husband responsibly the monies entrusted to it. To disdain the poor and pile up huge profits, calling them "excess of revenue over expenses," is organizational and moral corruption; we have tolerated it for years by keeping silent about it (and, often, being envious). We should not do so any more, if for no other reason than the loss of public support.

Often, the press and the public no longer distinguish between for-profit and nonprofit healthcare organizations, for the difference is no longer clear. In a phrase that, more and more, reflects public opinion, historian David Rosner described one city's nonprofit hospitals as "a once charitable enterprise."<sup>5</sup> In too many cases, nonprofits have forgotten their history and heritage.

However, even if nonprofits are sometimes profiteers, the for-profits are hardly innocent. In addition to the huge sums being provided to stockholders, executives of proprietary firms often do very well indeed.

Once it was physicians with seven- and eight-figure incomes who inflamed the public and did irreparable harm to the profession. Today it is people such as Richard Scott, the head of Columbia, and Malik Hasan, MD, the head of

HSI (a for-profit HMO), whose incomes are being splattered all over the *New York Times*. In July 1995, CBS News devoted an entire "Eye on America" segment to the incomes and lavish estates of for-profit HMO executives.

This is something of an invasion of privacy, of course. But one cannot help but be a bit dismayed by these healthcare leaders' amassing of huge personal fortunes, especially when they involve stock options that offer the constant temptation to do whatever is necessary to run up the price of the stock. Thomas Frist, MD, before he sold HCA to Columbia, made \$127 million personally in 1992, something that raised eyebrows even at the *Wall Street Journal*.<sup>6</sup> In 1993 the CEO of Travelers Insurance was paid \$52.8 million.<sup>7</sup> In 1994 Norman C. Payson, MD, head of the HealthSource HMO, earned \$15.5 million.<sup>8</sup> It has been rumored that the executives of the proprietary group practice Mullikin Medical Groups, in selling their organization to MedPartners, made \$10 million each.

On the other hand, in 1994 David Lawrence, MD, president of the nonprofit Kaiser Permanente, the largest HMO in the United States, made \$600,000.

Similarly, the world is full of consultants, speakers, utilization review entrepreneurs, academics, and others who have belied up to the healthcare bar, drinking their fill, and making very handsome incomes indeed. When I hear of \$1,000-an-hour consultants (many of them based in academic settings) and \$30,000-a-speech lecturers, I wonder who the offenders are: they who charge such prices, or the providers and organizations that use patient care money to pay them.

Compared with the more than \$1 trillion we will spend on healthcare this year, even the most sizable of these incomes appears negligible and would, in fact, disappear into the rounding error of the total. On the other hand, tens of millions of dollars is hardly peanuts, and with so much unmet need in healthcare, it should lead us to question our priorities.

Besides, a backlash is coming—if it is not already here. As we have seen in defense and in agriculture, when huge fortunes are built up from public monies, sooner or later a day of reckoning arrives, and public policy is changed. After all, one justification for slashing public funding for healthcare is that an enormous amount of money seems to be floating around our field but not going to the care of patients.

### **PARTICULAR THREATS**

The third question is whether new (or at least reinvented) models, such as healthcare systems

and managed care, pose any special problem when they are proprietary.

In terms of systems, the jury is still out. There is some evidence that proprietary systems are forcing everyone to be more efficient. Whatever one feels about other aspects of Columbia's operations, at least it is trying to shut down excess hospital capacity—and community pressure is being exerted to see that this is done with some sensitivity. An unfettered market would shut the public hospitals and other major indigent care providers first; it is obviously preferable to reduce boutique capacity.

However, the idea of a for-profit healthcare system is a break with history and leaves many unanswered questions. Among them is: Once a proprietary system comes to dominate a market, as Columbia is doing in several metropolitan areas, who subsidizes trauma, burn, and true indigent care if the system's hospitals and clinics do not provide it? Who pays for medical education if the system chooses not to be involved in it? Will employers, insurers, and HMOs provide the subsidy by paying the higher prices of nonsystem hospitals that do provide these services? History tells us no.

When it comes to for-profit managed care, however, it is not necessary to wait for the jury; the verdict is already in. The tempting incentives of managed care to constrain access and skimp on services, combined with the requirements of for-profit enterprise, simply produce too dangerous a situation. The moral hazard is just too great. This is particularly true when the enrollees are unsophisticated or powerless because of poverty, dependence on welfare, or physical or mental disability.

Already, reports from all over the country attest to abuses in Medicaid managed care. Florida has sanctioned more than two dozen HMOs for violating enrollment rules and, in one case, for failing to disclose the criminal past of the president. A California HMO has been sued for deceptive sales practices and shoddy care. Another proprietary HMO in California has been signing up the homeless, who will have great difficulty negotiating the often Byzantine access barriers of managed care. An East Coast for-profit plan has heavily recruited members in a low-income area located three bus rides away from the nearest site of care. The abuses go on and on, and the press is beginning to take notice, with exposés in papers from California to New York City to Florida.

Furthermore, proprietary plans take an awful lot off the top. This is especially true of those that do not provide care, but simply take a percentage of the premium and then pass what is left—along with all the risk—on to providers. The California

Medical Association reports that as little as 73 percent of the total premium goes to patient care in some plans.<sup>9</sup> None of the top seven for-profit plans in the state spent more than 80 percent on care in 1994 and 1995.

In contrast, administrative overhead for the two California Kaiser regions is 2 percent; for the Group Health Cooperative of Puget Sound, it is 6 percent; for the Health Alliance

Plan in Detroit, it is 8 percent to 9 percent; for the much-maligned, "inefficient" Medicare program, it is 3 percent. Although this is something of an apples-and-oranges comparison because of differences in cost accounting and plan structure, the pattern is consistent no matter whose data one uses. Given the massive differences in money available for patients, one is hard pressed to believe that the same quality of care and level of access are being achieved in all cases.

Statistics like these have led several state insurance and corporation commissioners to argue that the percentage of premiums that must be spent on patient care should be specified by law. As it is, in many states, no one seems to be minding the store. This is particularly troubling when the state itself is contracting with HMOs for care of welfare families and the disabled—and when the state is saving money on those contracts.

The abuses that we are seeing in for-profit managed care are not acceptable, and if proprietary HMOs are to continue to be allowed to operate, standards must be established for them to meet—and oversight must see that they do so.

### WHAT WE ALL SHARE

It is a complex debate, to be sure. In reviewing the evidence to date, at least four conclusions are possible.

First, the public is right: Healthcare *is* different; it is not a commodity. And nonprofit healthcare has characteristics that are worth preserving and strengthening. As Pope John Paul II has said, otherwise we risk "an idolatry of the market that ignores the existence of goods which by their nature are not and cannot be mere commodities."<sup>10</sup>

Healthcare historian Rosemary Stevens, at the end of her telling history of how nonprofit hospitals became rich and often arrogant over the years,

**N**onprofit health-care should not be allowed to disappear under a hail of stock options.

found herself offering "a defense of the voluntary hospital, warts and all, as an instrument of social policy in the United States, justified by the historical record and in the absence of any better alternative."<sup>11</sup> These institutions are, she writes, inherently conflicted, often hypocritical, and overly fond of money; but they are also deeply embedded symbols of what can be, and often is, good and generous

in this society. I concur. They should not be allowed to disappear under a hail of stock options.

Second, income distribution in healthcare is too much of a pyramid. For every executive or consultant at the top, there are thousands of home health aides and other underpaid and exploited direct care givers, often women of color, often uninsured, working in a field largely controlled by for-profits.

We all need to rein in our appetites as we shove each other around the feeding trough. We should also give something back to healthcare. George Lundberg, MD, editor of the *Journal of the American Medical Association*, has argued for years that every physician, and every attorney, should give at least 50 hours of free service to the poor—not "professional courtesy," not "contractual allowances," but true charity. So should everyone in healthcare.

Third, the debate over for-profit enterprise has been laced with hypocrisy, self-interest, and bad data on all sides. The quality of the discussion needs to improve. Those who participate in it should be honest and should not bring in extraneous agendas that only confuse the discussion. We also need reliable data, not the questionable survey results and ideologically tainted studies currently being thrown around.

Fourth and finally, in this as in all debates in healthcare, we should keep in mind what we share as well as what we differ over. At a time when our great public healthcare programs are at profound risk of underfunding or destruction, when racial bigotry threatens the health and even the lives of our children, and when American healthcare is facing convulsive change, we all face a shared challenge: To keep the faith with those who have entrusted this healthcare system to us

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and with those who must trust us with their very lives—most of whom know nothing of tax status or medical loss ratios.

We also share a responsibility to keep healthcare as a commons, as something that is here for all of us, belongs to all of us, and must be protected by all of us. None of us—for-profit or nonprofit—has the right to violate that trust or betray that responsibility. In a time of fear, suspicion, and dishonor, that is the one promise we all must keep—together. □

### NOTES

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4. Many of the thoughts expressed in this section, and several others in this essay, were originally published in Emily Friedman, "How We Keep Score," *Healthcare Forum Journal*, July-August 1994, pp. 13-17.
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## THERAPEUTIC TOUCH

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• Therapeutic Touch can be employed by staff members who have completed a formal course provided by the hospital's Wellness Institute.

• A practitioner need not have a physician's order to treat a patient.

• The practitioner must document the treatment in the patient's record.

• The Therapeutic Touch treatment must be based on the model developed by Kreiger and Kunz.

Nurses at St. Mary's have provided Therapeutic Touch to patients with cancer, AIDS, acute trauma, preoperative anxiety, postoperative pain, and migraine headaches, and to dying patients. Numerous patients and their family members have reported that Therapeutic Touch has brought significant relief from suffering. One woman, whose husband was dying of cancer, said, "Therapeutic Touch eased a difficult time. It relaxed him immediately, and he went to sleep. It was just amazing to see. I learned how to do Therapeutic Touch and was able to relieve his symptoms many times before he died."

As director of St. Mary's Wellness Institute, I have developed a community-based practice and have provided Therapeutic Touch to persons with

chronic fatigue syndrome, anxiety, upper respiratory infections, chronic pain, cancer, asthma, multiple sclerosis, and grief. Before providing a Therapeutic Touch treatment, I interview the patient concerning his or her medical history, stress level, coping skills, and support system.

Since December 1994 I have presented 13 one-day seminars, during which nurses, family members, and other healthcare professionals learn and practice the process of Therapeutic Touch. The New York State Nurses' Association grants 6.4 contact hours for this seminar.

The responses of patients and their families evidence the need for this non-toxic, noninvasive intervention of love and compassion in a technical healthcare system. □

☎ For more information, contact Sr. Rita Jean DuBrey, CSJ, at 518-842-1900; Nurse Healers Professional Associates, Inc., PO Box 444, Allison Park, PA 15101-0444 (412-355-8476); Colorado Center for Healing Touch, Inc., 198 Union Blvd., Suite 204, Lakewood, CO 80228 (303-989-0581); or American Holistic Nurses' Association, 4104 Lake Boone Trail, Suite 201, Raleigh, NC 27607 (919-787-5181 or 800-278-2462).

## CEO ENDORSES THERAPEUTIC TOUCH

"I can say with conviction as we enter managed care and capitation, and our aim is to keep people healthy, that Therapeutic Touch and other complementary therapies will become more important," says Peter E. Capobianco, president and chief executive officer, St. Mary's Hospital, Amsterdam, NY.

Capobianco says he is proud that his hospital has taken a leadership role in promoting alternative therapies, which are becoming accepted by managers and clinicians. "CFOs and CEOs will be finding out anything they can to keep people out of the hospital as capitation becomes more prevalent around the country," he predicts. Capobianco notes that physicians have begun to refer patients to Sr. Rita Jean DuBrey, director of St. Mary's Wellness Institute, for Therapeutic Touch treatments.