The authors present a "hard-nosed" description of an audit program for publicly funded health services provided by medical and other health practitioners. Administrative mechanisms to identify and deal with abuses in Medicaid are described and discussed. A summary is given of the legal basis for health department responsibility in this area.

POLICING PUBLICLY FUNDED HEALTH CARE FOR POOR QUALITY, OVERUTILIZATION, AND FRAUD—THE NEW YORK CITY MEDICAID EXPERIENCE

Lowell Eliezer Bellin, M.D., M.P.H., and Florence Kavaler, M.D., M.P.H., F.A.P.H.A.

SHOULD health departments audit publicly funded health care services provided by health care practitioners?

With the proviso of safeguards (a) to preserve confidentiality of records, and (b) to protect the doctor-patient relationship, we insist that health departments must audit the quality of professional services purchased from private health care professionals. If it is obligatory for government to assess the quality of the bridges, and the lunar modules that it purchases with public funds from contracting providers, then it is analogously obligatory for government, as consumer representative, to assess the quality of health services that it purchases from professional and institutional providers of care. Accountability to the taxpayer as purchaser remains the irreducible issue.

In short, the New York City Health Department remains unpersuaded by the July, 1969, nationally publicized resolution of the American Medical Association at its annual meeting placing the organization on official record as opposed to governmental auditing of quality care (see Appendix 1).

Why and Why Not of Health Department Auditing

An overview of the objections and rebuttals with respect to auditing follows:

1. *Objection:* Health departments should not audit because they lack the tools precise enough to quantify the quality of health care.

Response: It is futile to await the development of such tools by health care Academe and professional societies whose traditional preoccupations have always lain elsewhere. Only the political imperatives of enormous expenditures of public funds, plus the dynamism of an operating program will stimulate production of such tools in our time.

2. *Objection:* Health departments should not audit because they should educate and not punish practitioners.

Response: Auditing has four objectives:

(a) to assess the quality of health care in accordance with standards stipulated by the Health Department;

(b) to ascertain where there is overutilization or underutilization of services perpetrated either by the practitioner or by the patient;

(c) to identify fraud;

(d) to educate practitioners and recipients in the appropriate use of publicly funded health care programs.

Fraud and overutilization should be subject to penalty. All other irregularities call for education.

3. *Objection:* Health departments should not audit because it is better for professional societies to audit the activities of their own peer membership rather than to depend upon an outside agency, such as government with its employee auditors.

Response: Professionals working for the Health Department, and therefore directly accountable to government, remain the professional peers of the practitioners they audit. One cannot audit oneself dispassionately. Objective evaluation demands isolation of evaluation from operations. This administrative truism implies that an outside agency must do the evaluation.

4. *Objection:* Health departments should not audit because as yet there are no established norms of quality—nor even norms so primitive as number and periodicity of visits for a specific diagnosis.

Response: Judgment by competent peers remains the ultimate evaluation, so that the alleged paucity of norms is not catastrophic. Norms will develop as programmatic necessity demands. In the meanwhile, concentrating auditing activities first upon the quality of high volume practitioners can locate a profitable yield of abuses.

5. *Objection:* Health departments should not audit because physicians, dentists, nurses, and other health professionals do not ordinarily join health departments to check up on the work of their fellow professionals.

Response: Whatever their original motivation for joining health departments, health care administrators had better learn to reconcile (a) their self image as professionals—bearing loyalties to a specific professional guild—with (b) their fundamental obligation as regulatory public officials—requiring them to certify that tax supported health care accords with governmental stipulations called standards. The problem of potential role conflict here is illusory—or should be—since governmental standards of care are allegedly identical to the highest, explicit professional standards.

6. *Objection:* Health departments should not audit because the majority of practitioners are honest, prudent, and poignantly sensitive to the needs of the public welfare.

Response: By definition, what is aberrant is always in the minority. Nevertheless, society has not seen fit as yet to eliminate the accountant, the bank examiner, the policeman, and its other professional watchdogs who function to identify the aberrant individual or institution.

7. *Objection:* Health departments should not audit because monies spent in auditing would be better spent for more services.

Response: Monies saved or recovered by auditing have already justified auditing expenses many times over.

8. *Objection:* Health departments should not audit because governmental inspection violates privacy, imperils confidentiality, and erodes the doctor-patient relationship.

Response: This allegation has been extensively discussed and refuted in a previous paper with respect to on-site office visits by governmental staff.[1] Suffice it to say that such theoretical dangers are peculiarly remote in an

agency that throughout its history has routinely processed hypersensitive data with no adverse consequences to privacy, confidentiality, and doctor-patient relationships.

Auditing Staff and Financial Payoff

Previous papers have described the context of the New York City Medicaid program.[1-3] Our present auditing staff encompasses: 134 professionals, 60 para-professionals, and 143 clerks. Representative examples of Medicaid auditors on the payroll may be any one of the following:

(a) the staff health care professional who visits private offices of practitioners to review patients' records at random;
(b) the staff health care professional who re-examines the patient who already has received care;
(c) the staff pharmacist who scrutinizes every prescription for signs of tampering;
(d) the staff health care professional who reviews and suggests modification of treatment plans submitted by dentists, podiatrists, optometrists, and chiropractors before granting prior authorization to render care;
(e) the clerk who reviews invoices for irregularities such as overcharges, double billing, or overutilization;
(f) the para-professional who supports any of the above activities.

Besides using its own staff auditors, the New York City Medicaid administration has entered into agreements with the New York Optometric Center and the M. J. Lewi College of Podiatry to perform audits of quality of care on samples of Medicaid services of optometrists and podiatrists respectively.

In 1968, the New York City auditing program for Medicaid, at an over-all cost of $681,475, saved a total of $27,398,737.82. Every dollar invested in auditing produced a saving of $41. We turn over any recovered monies to the city comptroller. We maintain liaison with his office at all times because our decisions with respect to how much is appropriate to recover in a specific case ultimately must be subject to his approval.

On-Site Visitation in Private Offices

In a previous paper we discussed the on-site visitation program.[1] Peer group professionals from our staff visit the offices of high-volume practitioners to evaluate the offices and about 10 to 15 office medical records selected at random. The New York City Medicaid Administration is the only agency in the country doing this.

In 1968, complaints from some private practitioners about this activity provoked review of the on-site visitation program by officials from the U. S. Department of Health, Education, and Welfare. The reviewers supported our position and suggested that the office visit techniques might be worthy of imitation elsewhere.

Overutilization, Fraud, and Poor Quality Care

Dentistry

The recipient of service is the ultimate source for evaluating quality of care. Over 6,000 letters have been sent to Medicaid patients who received private dental care, inviting them to come to our branch offices to have our staff dentists assess the quality of their care. The 6,000 patients (although not a random sample of dental patients) were cared for by private dentists whose quality of practice we wished to scrutinize for one or more of the following reasons: (a) high volume, (b) patient complaints, (c) questionable invoices.

Of the 6,000 patients, approximately 1,300 (about 20%) responded and were examined. Of those examined, 120 patients (or 9%) showed evidence of poor quality dental care. Similarly, about 120 patients (or 9%) revealed discrepancies between the work performed and

the services claimed to have been performed on the invoices.

It is important to reiterate that the 1,300 examined patients cannot be considered a random sample, as they were a self-selected group. Therefore, we cannot apply the finding among this group of 18 per cent questionable care to the entire dental program. Rather, we estimate that poor quality dental care plus alleged fraud would be in the range of 5 per cent to 10 per cent.

Our policy of authorizing high quality but less costly alternatives in dental prostheses had a dollar value in savings in 1968 of about $27 million. This figure is not based on a sample because every request for dentures is subject to professional review. There was a potential expenditure of $110 million for dental care which was reduced to $83 million through modification of treatment plans.

Overutilization in terms of unnecessary fillings, extractions or use of general anesthesia has been minimized through professional review of pre- and post-treatment radiographs, and through restriction of general anesthesia to qualified specialists. Review of pre- and post-treatment x-rays in all cases with fillings costing over $100, or with fillings or extractions in deciduous teeth around the time of expected exfoliation, has produced additional significant savings.

Optometry

The New York City Medicaid program has entered into agreement with the Optometric Center of New York to re-examine patients and assist in the peer evaluation of optometric care being rendered. In 1969, 2,500 patients were selected and requested to appear for re-examination at the center and 500 (20%) responded.

Each patient is examined, and a report on the quality of the care as categorized by the center is presented to the Health Department for review by the Director of Optometry of the Medicaid program.

The preliminary results of the first group of 500 patients examined, presented in Table 1, showed that 361 patients (72.2%) received satisfactory care; 86 patients (17.2%) received unsatisfactory care. Possible erroneous claims of potential fraud requiring further investigation and follow-up was indicated in 12 patients (2.4%). In these alleged fraud cases, patients suggested that services optometrists claimed for payment were not actually provided.

Other Professional Areas

A program of evaluation of podiatry care has begun by agreement with the M. J. Lewi College of Podiatry. Results are not available for this presentation.

Table 1—Results of evaluation of optometric care in the first 500 patients examined

	No.	%
1. Satisfactory care	361	72.2
2. Unsatisfactory Care		
A. Professional		
1. Totally inadequate	36	7.2
2. Partially adequate	21	4.2
3. Pathology referral necessary	6	1.2
B. Materials or Dispensing	23	4.6
1. Materials dispensed varied from acceptable standards		
2. Materials provided not the same as materials claimed		
3. Uncategorized		
A. Professional discretion	25	5.0
B. Visual training evaluation indicated	16	3.2
4. Possible erroneous claims	12	2.4
Total	500	100.0

Overutilization in podiatry has included such areas as the use of x-rays, compression bandages, and prescription orthopedic shoes. Statistics are not available as to the degree of these abuses except as they are noted in the Appendix.

Prior approval is needed for orthopedic shoes of over $40 per pair, and for the use of appliances (molds). This is a control which is useful for potential overprescribing.

A caveat: On the basis of these preliminary statistics, it would be ill advised at present to try to compare the ethical behavior or competence of one health profession with another. After all, it is technically easier for auditors to identify a poorly fitted denture by a dentist than a poorly performed physical examination by a physician. We are not necessarily correct, moreover, when we operationally equate the skill in filling a tooth with the skill in refracting. Furthermore, the dollar value of fraud or poor quality may be higher in one profession than another, not necessarily because its practitioners are more fraudulent and less competent, but simply because the dollar values for the potentially fraudulent and badly performed procedures are more expensive.

As yet, we have no analogous statistics on the incidence of poor quality, fraud, and overutilization among the patients of physicians. Data on our on-site office review of physician practice in the ghetto have already been published.[1] A recent state budgetary increase will now permit us to expand our monitoring activities of physicians in order to assess and deal more adequately with physician abuses.

Patient Abuse of Medicaid

The chief areas of potential abuse by patients are as follows:

(a) the Medicaid enrollee may illegally transfer his Medicaid identification card to a non-Medicaid enrollee for use in a practitioner's office;

(b) the Medicaid enrollee may obtain duplicate professional services from separate practitioners, e.g. more than one pair of glasses from different optometrists, or more than one set of false teeth from different dentists;

(c) the Medicaid enrollee may overutilize services from a specific provider.

Without the means to identify such patients, it is impossible to be precise about the magnitude of such abuse. Within one year we expect to be able to do so when we receive computer equipment to identify Medicaid services provided any individual patient.

But, in comparison to the abuse emanating from providers of care, we estimate the dollar cost of patient abuse to be relatively negligible.

Informal Hearings

We invite allegedly errant practitioners to the central Medicaid office at the New York City Health Department to discuss apparent irregularities. Practitioners are entitled to bring their attorneys.

The chairman of these informal hearings has been the executive medical director of Medicaid, either of his two deputies, or the director of the "specific service." The Department of Health or Social Services investigator on the case presents the evidence in support of the alleged irregularities. The chairman asks the practitioner for an explanation. A peer colleague of the practitioner, from the city Medicaid staff, customarily attends the hearing to provide technical consultation to the chairman. Minutes are taken and discussion follows.

If the practitioner's explanation is satisfactory, the chairman advises him to modify his practice in such a way as to avoid future misunderstandings. If the practitioner's explanation is untena-

ble, the chairman will suggest any one or a combination of the following:

1. Recovery of monies
2. Financial penalty
3. Temporary or permanent elimination of the practitioner as a provider of services from the Medicaid program
4. Referral of the practitioner to a formal hearing within the City Health Department
5. Referral of the practitioner to the city commissioner of investigation
6. Referral of the practitioner to the district attorney
7. Referral of the practitioner to the State Board of Professional Licensure.

Accompanying documents summarize recent actions of the City Health Department with respect to practitioners accused of violating Medicaid regulations and policies (see Appendix 2).

The following cases are representative of recent informal hearings:

1. An internist with a highly skilled background in nuclear medicine was performing an inordinately large number of liver and brain scans on his own Medicaid patients as well as those referred to him for this purpose by other physicians. We told him that Medicaid could no longer reimburse him for such expensive diagnostic procedures on patients whom, in effect, he was referring to himself. Henceforth, Medicaid would limit reimbursement to regular patient referrals. The physician acknowledged the reasonableness of this decision.

2. A general practitioner was almost routinely injecting intramuscular iron into patients afflicted with iron deficiency anemia. We reminded him that less expensive oral iron is as therapeutically effective, assuming neither a peculiar patient contraindication nor a malabsorption problem. The practitioner pledged to alter his prescription policies.

3. A general practitioner was seeing the majority of his Medicaid patients on house calls rather than in his private office. We declared that we preferred he use his valuable professional time dealing directly with patients, rather than sitting behind the wheel of his car on the way to an apartment house. Most assuredly Medicaid could no longer reimburse for $8 house calls when $5 office visits would suffice without risk to the patient—particularly when the physician in question had been making house calls for such non-emergency diagnoses as "hypertension," "anxiety neurosis," "birth control," or "insomnia." The physician agreed to make his house calls more selectively in the future.

4. A group of podiatrists routinely x-rayed the right and the left foot of almost 100 per cent of their patients. In our estimate, this represented 60 per cent overutilization of x-rays. We recommended the following: (a) return of 60 per cent of the x-ray monies paid or due the podiatrists since the onset of their Medicaid practice; (b) acceptance by the podiatrists of a penalty of three months of total income confiscation by the city. On the advice of their attorney, the three podiatrists accepted these recommendations, turning back to the city excess monies they had billed Medicaid during their total of seven months of practice.

5. A pharmacist "kited" and "shorted" a significant percentage of prescriptions. "Kiting" refers to the pharmacist's forging upward the number of pills originally prescribed by the physician, charging Medicaid for the increased amount but providing the patient with the originally prescribed quantity. "Shorting" refers to the pharmacist's providing a lesser quantity of prescribed medication to the patient but charging Medicaid for the originally prescribed amount. The pharmacist was dropped from further professional participation in Medicaid.

Formal Hearings

Should the practitioner reject the recommendations of the informal hearing or refuse to participate in the informal hearing altogether, then he may exercise his legal right to proceed directly to a formal hearing before a City Health Department hearing officer.

The formal hearing takes place before a hearing officer chosen by the city health commissioner. The formal hearing employs the adversary technique of the American courts together with the usual rules of evidence and cross examination. The hearing officer ultimately makes his ruling and recommendations to the health commissioner. If the defendant is dissatisfied with the outcome of the formal hearing, he may take an "Article 78," and the case will proceed to trial in district court before a judge without a jury. Under Article 78 of the Civil Practice Law and Rules of New York State, the complainant may peti-

tion the State Supreme Court to review and reverse the decision of an administrative official on the grounds that such decision was either contrary to law, arbitrary, or capricious, or on the grounds that the punishment imposed was too severe for the offense charged. The decision of the district court judge is subject to further appeal to a higher court by either side.

The following cases are representative of those that have come to formal hearing:

1. The work of a group of dentists who had billed the city for more than $500,000 in less than a year was of inexcusably poor quality and showed significant evidence of fraud.

2. A group of podiatrists had seriously overutilized x-rays, had performed inadequate follow-up, and had prescribed orthopedic shoes excessively. On advice of their attorney, these podiatrists chose to circumvent the informal hearing and to proceed directly to the formal hearing.

Informal vs. Formal Hearings

We prefer informal hearings. They consume less staff time than formal hearings. There is but a single full-time attorney in the New York City Health Department. The New York City Health Services Administration (the super-agency encompassing the Departments of Health, Hospitals, and Mental Health) has but one additional attorney. As a result, the City Health Department has been obliged to call upon the services of attorneys from the City Legal Department for the formal hearings. Nevertheless, the mechanism of the formal hearing must be kept available as an option for accused practitioners, lest they validly charge that the Health Department uses the informal hearing as a kangaroo court where it simultaneously sits as judge and accuser. While a case is under litigation, the Health Department, as a matter of policy, refuses to authorize payment to accused practitioners.

Legal Landmarks

Besides our own Health Service Administration and Health Department attorneys, the staff of the City Department of Investigations and the District Attorney prosecutes our cases. Both of these latter offices are concentrating their energies exclusively on fraud. They prefer that the City Health Department deal with the abuse of overutilization where health care professional judgment is indispensable.

The rulings of three recent cases in 1969, involving the New York City Health Department as respondent, are legal landmarks with respect to Health Department authority and responsibility in the field of tax-supported private health care.

In Bernstein v. Department of Health of the City of New York (New York Law Journal, June 2, 1969, the State Supreme Court for New York County, Special Term, Part I), Justice McCafferey ruled that the City Health Department had the following authority: (a) to establish a Medicaid fee for chiropractors lower than the state's maximal reimbursable Medicaid fee, and (b) to add administrative controls more stringent than those imposed by the state, to wit, the requirement of progress reports to determine whether the proposed number of chiropractic visits is necessary.

In the matter of Fisher v. New York City Department of Health (New York Law Journal, May 27, 1969, Supreme Court for New York County, Special Term, Part I), Justice Gomez ruled that the City Health Department had the authority to hold a hearing to determine the validity of charges that the petitioner, a private dentist, had submitted fraudulent invoices for Medicaid dental services to the New York City Department of Social Services.

In Ross, et al., v. City Department of Health (July 7, 1969, Supreme Court

for New York County, Special Term, Part I), Justice Hellman ruled that the City Health Department had the authority to suspend or eliminate podiatrists from the Medicaid program for inadequate quality. The court stated:

"Despite petitioners' arguments to the contrary, this Court believes that the recent decision in Matter of Fisher (New York Law Journal, May 27, 1969, Page 2, Gomez, J.) furnishes compelling authority for dismissal of the petition and for upholding respondents' rights to act in the manner challenged. The fact that in Fisher it was claimed that the petitioners' acts were fradulent while, here, it is asserted, only, that the care provided was of unacceptable quality, unprofessional and often unnecessary, constitutes a distinction without a difference. Recipients of the treatment can be as harmed as much in one case as in the other and respondents' obligations to regulate the quality of care afforded recipients do not vary depending upon the characterization of the wrong allegedly done."

The last sentence of this decision clearly spells out the regulatory responsibilities of the City Health Department with respect to quality of care rendered by private practitioners—according to the opinion of the Supreme Court of New York County.

Such juridical mandates for increased aggressiveness must prove to be an irresistible goad to public health agencies to start or augment their auditing programs.

Summary

1. Arguments are reviewed buttressing the view that health departments must audit the quality of tax-supported health care.

2. New York City Medicaid administrative mechanisms to identify and deal with Medicaid abuses are described.

3. Categorical Medicaid abuses are discussed and quantified on a preliminary basis.

4. Recent legal landmarks in crystallizing Health Department responsibility in auditing quality of health care are summarized.

APPENDIX 1

American Medical Association House of Delegates

Resolution: 115
(A-69)

Introduced by: New York Delegation

Subject: Auditing of Physicians' Records in Government Programs

Referred to: Reference Committee A (H. Close Hesseltine, M.D., Chairman)

Whereas, Government financed health care programs usually place the responsibility for the quality and availability of health services on state and local government officials or other program administrators; and

Whereas, In many instances, those administrators or officials have considered this to require that audits of the quality of medical services be conducted; and

Whereas, The responsibility for the audit of in-hospital services has generally been delegated to hospital audit committees which conduct such audits on a peer review basis; and

Whereas, Peer review audit systems applicable to ambulatory services rendered in physicians' offices have not been developed; and

Whereas, This lack of an established system has encouraged some local program administrators to institute on-site audits in physicians' office; and

Whereas, Such audits do not necessarily include peer review; and

Whereas, Such audits raise the question of the physician's responsibility for the confidentiality of his patients' records; and

Whereas, The medical profession, through the AMA and the constituent and component medical associations, has assumed responsibility for maintaining the quality of patient care in general, including that rendered under government supported or sponsored programs; and

Whereas, Physicians have demonstrated their impartiality, objectivity and reliability in auditing and self-policing in their conduct of in-hospital audit committees and can be expected to perform equally well in the field of office audits, once appropriate procedures have been established; therefore be it

Resolved, That the American Medical Association request its Counsel to study the legality of on-site audits in physicians' offices, their permissible extent and nature, and how they affect the confidentiality of physicians' records on their patients; and be it further

Resolved, That the American Medical Association express its firm opposition to on-

site auditing in physicians' offices of tax-supported programs by representatives of governmental agencies; and be it further

Resolved, That auditing procedures be developed as a Peer Review program where required by tax-supported plans; and be it further

Resolved, That the American Medical Association urge that any problems which may arise between physicians and intermediaries or between physicians and local, county, state, or Federal governmental agencies be referred to the local Peer Review Committee.

APPENDIX 2

Medicaid—New York City, Summary of Investigations as of September 1, 1969

	Total	M.D.	Med. groups	D.D.S.	Pod.D.	Optom. disp.	Pharm.	D.C.	Labs.	Misc.
Number of practitioners involved	425+	60	55+	100	40	50	69	7	15	29
Number of practices involved	342	60	10	85	25	44	67	7	15	29
Source of original inquiry										
a) Patients	82	13	1	21	2	4	31			10
b) Invoice auditing	192	40	1	49	20	32	23	5	14	8
c) On-site office auditing	16	5	1	4		3	2	1		
d) Patient evaluation	4			4						
e) Review of prior approvals	1				1					
f) Other state, city agencies	9						7	1		1
g) Miscellaneous	38	2	7	7	2	5	4		1	10
Reason for investigation										
a) Unusual pattern of practice	71	27		10	19	3	4	2		6
b) Alleged poor quality of care	41	4	1	29		2				5
c) Alleged unethical procedure	57	14	8	14	6	3	3		3	6
d) Office facilities	7	1		1		1		1		3
e) Qualifications for practice	9	2		4		1	1			1
f) Abuse of billing codes	52	4	1	17			8	4	12	6
g) Alleged fraud	74	8		10		3	51			2
h) Question of self-employment	31					31				
Hearing										
a) Informal	116	18	2	47	8	3	29	3	1	5
b) Formal	4			1		1	2			
Substantiation of case										
a) Yes	207	36	2	59	21	13	40	6	15	15
b) No	64	18	3	10	3	10	11			9
c) Pending (at D.H., S.S., D.A., D.I.)	71	6	5	16	1	21	16	1		5
Disposition of substantiated cases										
a) Temporary suspensions	17	1		2	3		11			
b) Warnings and restrictions	100	20	1	30	13	11	14	4	2	5
c) Restitutions/fiscal adjustments	86	15		24	9		13	2	13	10
d) Referred to state board	12		1	2	1	1	7			
e) Suspensions	3			1		1	1			

D.H. = Dept. of Health
S.S. = Dept. of Soc. Serv.
D.A. = Office of Dist. Attorney
D.I. = Dept. of Investigation

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Dr. Bellin is First Deputy Commissioner, and Dr. Kavaler is Deputy Executive Medical Director, Medicaid, City of New York Department of Health (125 Worth St.), New York, N. Y. 10013
This paper was presented before the Medical Care Section of the American Public Health Association at the Ninety-Seventh Annual Meeting in Philadelphia, Pa., November 11, 1969.

Sociodental Research Training Program

Social and economic factors, knowledge of social sciences, and of methods of social research are important in dealing with problems of dental health and care. There is a need for persons trained to apply social science theory and methods to problems related to dental health, including the organization of dental care and dental health of communities and other populations. Bearing these premises in mind, Columbia University School of Public Health and Administrative Medicine is offering a sociodental doctoral program designed to prepare students for careers in teaching, research, research administration, and dental public health administration, with emphasis on research and evaluation.

The program is intended for dentists, dental hygienists, health services administrators, students from the various social sciences, social work, health education, or other disciplines, with career interests in fields related to dental education. For further information, write: Dr. Mata K. Nikias, D.D.S., M.P.H., Ph.D., Assistant Professor, Division of Sociomedical Sciences, Columbia University School of Public Health and Administrative Medicine, 630 West 168th Street, New York, N. Y. 10032

Mental Research Institute Plans Summer Workshops

Three summer workshops to be held in Palo Alto, Calif., are planned by the Mental Research Institute: The Family in the Hospital (July 27-31), Conjoint Family Therapy (Aug. 3-14), and Brief Therapy with Individuals and Families (Aug. 17-28). For details, write: Director, Mental Research Institute, 555 Middlefield Road, Palo Alto, Calif. 94301