Empire Roundup: Caught in the Squeeze

"Gang invades hospital," headlines the American Medical News, reporting on the current community/worker struggle at Lincoln Hospital in the Bronx. Lincoln has been a thorn in the side of the Einstein Medical College-Montefiore Hospital medical empire for a number of years. The Einstein-controlled municipal hospital is in an antiquated building, which is inadequately staffed and poorly equipped. Community and worker groups seeking better health care have sought to wrest control from Einstein to reset the priorities at Lincoln away from Einstein's teaching, research and financial needs and towards patient care. The health establishment has been visibly shaken by this new assault on their medical fortresses—an attack challenging their competence to determine the health needs of the patients and the community. The energy generated by the struggle at Lincoln has been an inspiration to those in the health movement who believe that the health system can only be changed through a basic shift in who controls health resources.

Medical empires are going through a period of readjustment. From below, they are threatened by insurgencies such as the one at Lincoln, coming with increasing frequency and persistence. Community and worker groups are resisting cooption and repression. In reply, the medical empires are trying to consolidate their control over their existing holdings. Control is the name of the empire game. Through their monopoly of power over their network of affiliated institutions, the empires can impose their research and teaching priorities on the health system. A threat to this control is a threat to the abilities of the institutions at the core of the medical empires to function at all.

Empires are also coming under pressure from above. The federal government, busily trying to balance the budget while ignoring big city needs, has cut back on research grants and other funds for medicine. The medical schools and medical centers have been hard hit, since they rely heavily on research monies for faculty salaries. This change in federal policy may in part reflect a decline in the empires' influence over federal health policy, which was such a dominant feature of the Kennedy-Johnson era. Meanwhile, state and local government resources going to health have also been restricted, thus completing the squeeze.

In previous BULLETINS, HEALTH-PAC has traced the development of medical empires in their period of manifest destiny. Now this pincer movement of financial cutbacks and insurgencies has forced the empires to look to their defenses. This BULLETIN gives a round-up of the empires in New York City and reports on some of the various health insurgencies going on in the city.

Bronx

The Bronx empire dominated jointly by Albert Einstein College of Medicine (AECOM) and Montefiore Hospital is one of the most highly developed and consolidated medical empires in the country. Patients, medical manpower, and money flow freely amongst the dozen or so institutions which make up the empire and which include the bulk of the borough's medical resources. Because the empire is so highly developed, it is virtually a textbook study on the conflicts between the research, teaching, and financial priorities of the imperial center and the health care needs of the community. (See BULLETIN, April and September, 1969, for more details on the Einstein-Montefiore empire.) And because the empire controls two of the three municipal hospitals in the Bronx, the Einstein-Montefiore empire also experiences the conflicts between the burgeoning private sector in health and the remaining shadows of City involvement in the hospital system.

It comes as no surprise, then, that some of the country's sharpest struggles around use and control of health services have occurred in the Bronx. At Lincoln Hospital, the municipal hospital affiliated with AECOM which serves the largely Puerto Rican population of the South Bronx, a two year long struggle has been waged between radical workers and community people on the one hand and AECOM and the City on the other. (See April and May, 1969, BULLETIN for the early history of the struggle.) As reported in last month's BULLETIN, the struggle has recently sharpened, under the leadership of Think Lincoln, a community/worker group con-
cerned with the hospital, in alliance with the Young Lords and the Health Revolutionary Unity Movement (HRUM, an organization of revolutionary third world health workers). Think-Lincoln had made seven initial demands, ranging from the demand for a day care center and a grievance table to the demand for control of the hospital by a community/worker board. Two months ago, a young woman named Carmen Rodriguez died following an abortion at the hospital. Charging that her death was due to malpractice, Think-Lincoln added to its list of demands the demand for far-reaching changes in the hospital abortion program and for the resignation of the director of the abortion program, the chief of obstetrics, Dr. J. J. Smith.

By late August, top officials of the New York City Health and Hospitals Corporation and of AECCOM, who up to that time had been content to permit their local representatives at Lincoln to handle the insurgency, stepped in to spearhead a counter-offensive against the rising tide of community/worker militancy.

Events in late August centered around the obstetrics department. Think-Lincoln’s demands had not been met: No changes had been made in the abortion program, which even its director, Dr. Smith, is alleged to have admitted was “inadequate,” and Smith himself had refused to resign. The tinder was ignited when Smith refused to renew the contract of Dr. Noel Phillips, a West Indian with a fellowship in the obstetrics department, allegedly because of repeated lateness and absence. Phillips denied the charges, and some seventy non-physician members of the obstetrics staff (many of whom would have been inconvenienced if Phillips had been as unreliable as charged) signed a petition urging that Phillips’ contract be renewed. On Monday, August 24, Think-Lincoln called a noontime meeting to discuss how to respond. About twenty-five workers came and decided to go to Dr. Smith's office to demand that the appointment with English for Thursday to discuss the events with other nurses.

Thursday, the Pediatric Collective (a group of interns and residents in the Lincoln Pediatrics Department) held a sit-in in the office of Health and Hospital Corporation Executive Director, Dr. Joseph English. A few days previously, the Collective had requested an appointment with English for Thursday to discuss the Think-Lincoln demands as well as their own demands for improvements in patient-care conditions at Lincoln. English did not even answer the request, but let it be known indirectly that he would not meet with them unless invited to do so by Lincoln Administrator LaCot. The Collective decided that they would try to see English at the designated time anyway, and since in the intervening period, the injunction had been ordered, they added the lifting of the injunction to their demands. On Thursday afternoon, leaving others behind to cover the wards, the Collective descended upon English in his office.

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Meanwhile, the pediatricians' counterparts in obstetrics were still on strike. At this stage the obstetrics house staff added some demands for improvements in patient care to their original demand for an end to harassment. Think-Lincoln members believe that the patient care demands were merely added for public relations: The strikers had never shown great concern over patient care issues before the strike, nor had their concern for their patients kept them from striking, nor had they raised these issues immediately upon striking. Moreover, they eventually returned to work without the patient care demands being met. The obstetricians remained out for over a week, crippling obstetrics services at Lincoln. At this juncture, a split developed between AECOM and the City. According to the New York Times, Corporation Executive Director English put the screws on Einstein. If the obstetrics staff did not return, Einstein would face the loss of its $28 million worth of affiliation contracts at both Lincoln and Bronx Municipal Hospital. Financial self-interest and the desire of Einstein empire-builders to maintain control of the health resources of the Bronx won out over the desire of many Einstein clinical faculty members to ditch the troublesome Lincoln despite its usefulness for teaching and research. As the New York Times put it: "Since Einstein has been in a very shaky financial position for years, loss of the $28 million contract could easily result in the closing of the medical school." Einstein proceeded to pressure the obstetrics house staff into returning to work.

The counteroffensive continued with an assault on the professionals at Lincoln who supported the community/worker demands. Lincoln officials let it be known that many members of the pediatrics collective might not have their contracts renewed in June. And Dr. Michael Smith, a resident in psychiatry and a Think-Lincoln activist, is being brought up before the Lincoln medical board on a variety of charges that potentially could lose him his job and his license to practice medicine in New York State. The charges against him reveal how totally political the action against him is. Smith, it is charged, let the community know what had happened to Carmen Rodriguez, forcing the hospital to hold a public clinical conference which revealed that Mrs. Rodriguez' death was due to gross negligence by the hospital, setting off the struggle over the obstetrics department. Second, he was involved in the sit-in in J. Smith's office (several other doctors who were more intimately involved have not been charged, so far). And third, in the course of participating in a Think-Lincoln door-to-door screening program in the community (a service Einstein and Lincoln do not provide), Smith had prescribed iron pills for anemic community residents without the permission of his superiors at Lincoln.

The New York Times, a long time friend of the medical empires (see February, 1970, BULLETIN), joined in the attack on the community/worker struggle. Ignoring both the catastrophic failure of Einstein and the City to provide health services in the South Bronx and the leading role played in the struggle by the community/worker organization, Think-Lincoln, the Times blamed the whole affair on the supposed desire of the Young Lords to "see whether ghetto hospitals could be used to radicalize poor blacks and Puerto Ricans much as leftist students have used the universities to radicalize other students and faculty." But, the Times triumphantly concluded, "the experiment has not gone well for the radical cause." The obstetrics house staff's strike and the injunction forced the Young Lords to recognize "that their effort to exploit conditions in the obstetrics department had failed and that the community had lost rather than gained by their attempt to make an issue of Mrs. Rodriguez' death."

But the Times exulted too soon. The very day that the article quoted above appeared, Think-Lincoln in four hours gathered over five hundred signatures from South Bronx residents on a petition supporting the Think-Lincoln demands. And although Think-Lincoln members agree that many workers were frightened for their own jobs after the injunction was issued, they point out that for many other workers, the successful winning of a renewal of Dr. Phillips' contract showed that Think-Lincoln was serious about changing Lincoln Hospital and that workers were resentful over the banning of the Think-Lincoln grievance table and day care center. In fact, workers meetings have been stepped up since the injunction, distribution in the hospital of Think-Lincoln leaflets and the HRUM newspaper goes on and the struggle continues.

**Lower East Side**

The Lower East Side of New York has a long history of insurgency. In the past, housing and education have been the focal issues for community involvement. Today, however, health is attracting more and more community attention. This rising interest in health is due in part to the continuing deterioration of
community health services and, in part, to the accelerating expansion of medical empires and hospitals, which remain unaccountable to the community.

In response, a diverse set of insurgent forces is consolidating around health issues:
- **The Lower East Side Neighborhood Health Council-South (LESNHC-S)**, well-known as the community struggle force for better health services at Gouverneur Clinic, was recently granted $37,600 by O.E.O. to hire three staff workers. In spite of attempts by Beth Israel Medical Center (the Gouverneur affiliate), to discredit the LESNHC-S through court injunctions, police barricades, and the firing of five workers and a doctor, O.E.O. made the grant, cognizant that the health council did indeed represent the community located south of Houston Street. [See BULLETIN, February, 1970.]
- **The Northeast Neighborhood Association (NENA)**, a coalition of community organizations located north of Houston Street, established the nation's first community controlled health center in September, 1969. Over 2,500 families (8,000 individuals) are now receiving comprehensive, neighborhood-based health services at NENA. As the first community organization to receive its funding for a health center directly from the federal government rather than through a hospital or medical school, NENA has pioneered in community controlled health services.
- **I WOR KUEN**, a radical Chinese organization located in the Chinatown section of the Lower East Side, is operating a free health clinic, just opened in September, 1970. Unlike most hospital-based clinics, I WOR KUEN's health council spent two and a half years; NENA's opening by two and a half years; and rejected a detailed research report written by 11 students in October, 1969, which advocated decentralization of the Bellevue outpatient department into community clinics.
- **The Young Lords' Party, a revolutionary Puerto Rican organization**, plans to open an office soon on the Lower East Side, is operating a free health clinic, just opened in September, 1970. Unlike most hospital-based clinics, I WOR KUEN's health council spent two and a half years; NENA's opening by two and a half years; and rejected a detailed research report written by 11 students in October, 1969, which advocated decentralization of the Bellevue outpatient department into community clinics.
- **The Health Revolutionary Unity Movement (HRUM)** was born in the struffle of hospital beds—avidly desired by both institutions, but technically limited by State law. Affiliations with other health institutions bring money and power, in contrast to affiliations with community organizations, which bring demands for better health services.
- **The Health Liberation Movement (HLM)**, a group composed largely of medical students at NYU Medical School, is seeking alliances with community and health worker groups. Such linkages began during the spring of 1970, when students assisted with community-initiated preventive health screening programs and when students joined health workers from Bellevue and University Hospital in the May protest against the Cambodian invasion.

These insurgent forces face two of the most impressive medical empires in the City: NYU Medical Center and School and Beth Israel Medical Center; as well as a number of smaller health institutions, such as the New York Infirmary, Columbus Hospital and the New York Eye and Ear Infirmary. The New York University Medical Empire consists of the medical school, University Hospital, Bellevue and Goldwater Hospitals (both City hospitals), the Manhattan Veterans Administration Hospital, the NYU-Skidmore School of Nursing and the Hunter-Bellevue School of Nursing. Over the past year, affiliations have extended beyond these confines to the New York Infirmary (located on the Lower East Side) and to Brookdale Hospital (located in southeast Brooklyn—14 miles from the medical center). Yet the medical staff has staunchly refused to extend services to the Lower East Side community through satellite clinics. For example, NYU denied back-up services to NENA Health Center in 1967, which delayed NENA's opening by two and a half years; and rejected a detailed research report written by 11 students in October, 1969, which advocated decentralization of the Bellevue outpatient department into community clinics.

Imperial interests have dictated these choices. In the case of Brookdale Hospital, Mr. Arnold Schwartz, Chairman of the Board at Brookdale Hospital (and also president of Paragon Oil Company) donated close to $6 million to NYU Medical School for teaching and expansion. In the case of the New York Infirmary, there is the possibility of a truce in the two institutions' battle over expansion of hospital beds—avidly desired by both institutions, but technically limited by State law. Affiliations with other health institutions bring money and power, in contrast to affiliations with community organizations, which bring demands for better health services.

Similarly, the empire's priorities were reflected in the choice of Dr. Ivaon Bennett, Jr. as dean of the medical school. Dr. Bennett was also Vice President of the University and Director of the Medical Center when the deanship post was vacated last fall. After a brief search for a new dean, Dr. Hester, President of New York University, recommended that Dr. Bennett fill all three posts. Dr. Hester cited the affiliation with Brookdale Hospital as one of Dr. Bennett's qualifying achievements. There was an immediate uproar among students, faculty and even the Board of Trustees of the Medical School. All objected to the centralization of the University in one man, which meant that the dean would be even less accountable to the medical students, medical faculty and trustees than before and more responsive to Dr. Hester and the University (of which the Medical School is only one part).

Moreover, some students' objections ex-
tended to the man himself. Dr. Bennett played a major role in chemical-biological warfare (CBW) research and policy, including a long history as research contract director of the Army Chemical Corps and more recently the deputy director of the Office of Science and Technology in the White House, where he is chairman of the CBW panel. His defenders view Dr. Bennett as an opponent of CBW, but as recently as November, 1969, Dr. Bennett opposed U Thant's recommendation for a ban on chemical weapons, such as tear gas, saying: "This country is using tear gas, CS, in Vietnam. At a time when our administration is trying to find a way out of Vietnam and trying to hold American casualties to an absolute minimum, any move that might be interpreted as taking an effective weapon away from our forces would surely carry domestic political risks."

Members of the Health Liberation Movement demanded Dr. Bennett's resignation. The Board of Trustees failed to give him the traditional unanimous vote of confidence. Undergraduate and graduate student activists from the NYU downtown campus blocked Dr. Bennett's inaugural address on CBW at the medical school campus. But as empire builder with links to the Pentagon and the White House, Dr. Bennett was perhaps the "ideal" choice for dean of a prominent medical school.

The second medical empire on the lower east side is the Beth Israel Medical Center. Though willing to decentralize some services into the community (such as Gouverneur Clinic, the Judson Clinic and Methadone Maintenance Programs), Beth Israel is no more willing than NYU to share its power with the community. At Gouverneur Clinic, Beth Israel rejected community demands for a greater role in selection of the clinic director and determination of clinic program and expelled the legally constituted community organization, the LESNHC-S, from the clinic by police force. Since that time, Beth Israel has continued to undercut the Health Council at every opportunity.

During the spring of 1970, Dr. Ray Trussell engineered the transfer of Gouverneur Clinic out of the Department of Hospitals into the Department of Health. This maneuver allowed Beth Israel to apply State funds (through the Ghetto Medicine Act, see BULLETIN, April, 1970) to Gouverneur Clinic, a City-owned facility. (No other City hospital or clinic was permitted to receive Ghetto Medicine money, which was reserved entirely for the volunteers.) It also meant the establishment, as required by the Ghetto Medicine Act, of a new community advisory board. Logically, the LESNHC-S should have become the board for Gouverneur Clinic. But Beth Israel, seeking to consolidate its power over Gouverneur, insisted that there be only one community advisory board to cover both Gouverneur and the outpatient department at Beth Israel. This relegated the LESNHC-S to only two seats out of 14 on the community advisory board—and both of these members were hand-picked by Beth Israel. Other members of the community advisory board include: Dr. Ray Trussell, director of Beth Israel; Dr. George Blinick, president of the Medical Board; Dr. Jefferson Vorzimer, director of ambulatory services; Dr. Reinaldo Ferrer, director of Gouverneur Health Services Program; Dr. Harold Goldman, acting director, Judson Health Center. From the community, there are representatives selected by Beth Israel (not the community groups involved) from Chinatown (one), Little Italy (one) and the LESNHC-S (two), and hand-picked patients from the clinics at Beth Israel: geriatric (one), pediatric (one), comprehensive health services (one), Morris J. Bernstein Institute (one), and one patient from Gouverneur.

The composition of this board meets all the guidelines established by the Department of Health (indicating the emptiness of those guidelines). Besides locking the LESNHC-S out of any significant role in monitoring Ghetto Medicine money, the single community advisory board railroaded through by Beth Israel was set up to counteract any meaningful community influence on the medical center.

Earlier this year, Beth Israel imposed a rigid limitation on the population to be served by its outpatient department. No one living south of Houston Street could use the Beth Israel outpatient department, but instead would be referred to Gouverneur Clinic. The formation of a single community advisory board meant that community representatives from south of Houston Street were being asked to make judgments about care in the Beth Israel outpatient clinics—clinics which they were excluded from using. Thus the community forces on the community advisory board could be more easily divided, which of course would preserve Beth Israel's power.

In this era of financial crisis, with some medical centers and medical schools claiming to be on the verge of bankruptcy, community people find it surprising that every hospital on the Lower East Side has iminent building expansion projects. NYU University Hospital, Columbus Hospital, the New York Infirmary, the New York Eye and Ear Infirmary, and Beth Israel Medical Center have all laid claim to real estate surrounding their institutions. The pattern is similar throughout the nation, as studies of Presbyterian Hospital-Columbia Medical Center [see BULLETIN, February, 1970] and of Harvard's Affiliated Hospital Complex (see New England Journal of Medicine, April 30, 1970) show. Medical institutions buy up housing surrounding their present buildings. Then, in order to force tenants to move without having to provide costly relocation programs, the medical institutions offer only minimal maintenance and upkeep of the buildings. Finally, the new institutional buildings which are constructed on the ruins of housing (now in such short supply) are often merely parking or staff housing rather than medical service buildings.

This has been the pattern in the buildings surrounding the New York Eye and Ear In-
medical center, and East Harlem, NYMC has «“silk stocking district” and the East Harlem; Westchester within the next few years but for position. New York Medical College increasing minority admissions or through available to the community, whether through magnitude of the construction program, the community-worker forces that are trying to establish some form of community control over the medical centers.

The most massive building program contemplated is at NYU Medical School and Medical Center. Since NYU cleared the land surrounding the medical center years ago, its $50 million construction program cannot be challenged by the squatter tactic. Despite the magnitude of the construction program, the community will reap no benefits from it. NYU has consistently refused to make its resources available to the community, whether through increasing minority admissions or through satellite clinics in the community. None of the three structures that have been proposed will directly improve medical services for the community of the Lower East Side. The Thirtieth Street classroom and administration building will not benefit the Lower East Side, since NYU graduated no black students last year and had only six minority students out of 125 students in the first year class. The hospital-research tower slated for the site presently occupied by the Alumni Hall will only deepen the medical center’s involvement in esoteric research programs. The Cooperative Care Unit, the only real patient care unit contemplated, appears to be designed for out-of-towners rather than the people of the Lower East Side. “Cooperative care” means that the patient is accompanied by family members who are charged with performing the basic nursing care, obviating the need for extensive nursing supervision. Included in this concept, are a cocktail lounge, swimming pool, restaurant, garage for the patients, etc. It appears that the unit will be nothing more than a motel where businessmen can come with their wives for diagnostic workups.

Will there be a fall offensive around health on the Lower East Side? The insurgent forces—community, health workers and students—are getting themselves together. But so are the empires—NYU and Beth Israel.

**Upper East Side**

On Manhattan’s Upper East Side, between the “silk stocking district” and the East Harlem Spanish ghetto, two medical empires jockey for position. New York Medical College (NYMC) has already decided to leave for Westchester within the next few years but may retain its affiliations with Metropolitan and Coler Chronic Care Hospitals, both city facilities. Mount Sinai, located next door to NYMC along Central Park, hopes to take over the NYMC "public" responsibilities, but will in any case expand its own real estate and its affiliation with Beth Israel Medical Center on the Lower East Side.

Surrounded by Central Park, Mount Sinai Medical Center, and East Harlem, NYMC has found its attempts at expansion blocked by geography and politics. Its response to this obstacle to corporate growth has been to look for a new site. In choosing a new site, NYMC faces the same problem that Mount Sinai faced first, from the City, which tried to interest NYMC in relocating in Queens—the empires—NYU and Beth Israel.

Just because NYMC will be staffing a large public hospital doesn’t mean that it is primarily interested in community health. NYMC already has responsibility for the medical care of a large number of public patients. Through a $19 million contract with New York City, NYMC runs the 1000-bed Metropolitan Hospital and the 1800-bed Coler Hospital on Welfare Island. East Harlem residents, however, may be surprised to learn that NYMC’s catalogue claims that NYMC has “pioneered in health programs for residents of densely populated urban areas.” Community residents complain that, despite its medical responsibilities, NYMC has taken no initiative in developing significant programs to deal with such major community problems as lead poisoning in children and massive drug addiction or in developing ways to involve the community in solving its own health problems.

While NYMC officials like to cite as an example of community-hospital cooperation the fact that several Metropolitan house staff and NYMC students assisted the Young Lords in a door-to-door lead poisoning detection program last winter, the community and the participating staff and students are quick to point out that Metropolitan’s and NYMC’s only contribution was permission to use hospital labs for processing the tests. And even that came only after several demonstrations by the Young Lords at the hospital and a sit-in at the City Health Commissioner’s office to get the test kits which Metropolitan had refused to provide. Both staff and students volunteered their own time for both the door-to-door and lab parts of the testing program.

NYMC fails to provide significant community programs; it also fails to provide its students with the opportunity to experience medicine in a community-oriented context. After many years as a straight-laced, undistinguished medical school with a very tradi
tional curriculum, NYMC is in the process of timid revisions which will allow more electives and put greater emphasis on the "family, sociological and community aspects of patient care." But when NYMC moves out of the city, its students will be even more isolated from the community—even if the affiliation with Metropolitan survives the move. This increased isolation from the problems of the poor urban community insures that the curriculum's new emphasis will be virtually meaningless.

In contrast to the traditional and slow-moving NYMC, Mount Sinai Medical Center (right next door) is busy hustling grants and territory. Mount Sinai, New York City's newest medical school, promised students a pioneering curriculum. In place of the traditional two years of basic science and two years of clinical experience, students were promised an integrated program of 1/3 basic science, 1/3 clinical science, 1/3 community medicine. Now, however, many students express resentment that nothing of the sort has happened. Community medicine has turned out quite different from what they expected. The students found that much of the Community Medicine Department's work consisted of surveys and "research" done by reading medical records of people who had already managed to get served by Mount Sinai or Beth Israel, rather than active attempts to change Sinai's delivery of medical care to East Harlem. Students found that instead of pressuring the hospital to reach out to the community, the Community Medicine Department was an academically oriented department striving for legitimacy and status within the medical center itself and striving not to rock the boat.

Mount Sinai's growth industry is not community medicine, but its Community Medicine Department. To promote the new department, Sinai grabbed up Dr. Kurt Deuschle, fresh from setting up the community medicine program at the University of Kentucky. Best of all, it not only seduced the full-time Washington grant lobbyist, and the classic academic and professional view of community. Thus the Department's first annual report noted that "to diagnose and treat the community calls for many skills." And a recent public relations release quoted Dr. Deuschle: "What we are doing is applying [our] multi-faceted expertise in scientific fashion to identifying health needs as we find them in East Harlem, and developing and testing new programs to meet them, utilizing existing health resources and adding whatever new components we think might make for a better system."

The outcome of this philosophy has been a complete failure to change the health services experienced by the people of East Harlem with the result that some community residents wonder what the Community Medicine Department does. It is not only community residents who can't tell what the Department is up to, however. Several staff members report that for the past two years, most people in the Department have had very little idea what anyone else was doing. Then last spring, just before negotiations with Local 1199, when the hospital would be in the news and the community might be asking questions, the Department began systematically asking people what they were doing and published a slick four-page section of the medical center's News describing how much Sinai does for the community.

Some community groups and medical students have expressed disappointment that the Community Medicine Department has not only failed to offer services to the community but has, perhaps more importantly, failed to press Mount Sinai to change the way it delivers services to the poor people of East Harlem. Stories abound of ambulances sent on to Metropolitan or Bellevue, and of discrimination in the outpatient department and in admissions to the hospital. (There are about ten times as many private inpatient beds as there are ward beds.) This is seen by the community as just another illustration of Mount Sinai's attitude toward the community.

In fact, even the projects claimed by the Community Medicine Department are of dubious reality. For example, the Mt. Sinai News notes that "recently, the Health Department asked Community Medicine's Division of Environmental Medicine to explore the development of a more rapid screening test for blood-lead." Though a team was assigned to work on that problem, the project rapidly passed into informal oblivion.

For the community, the surveys, research and academic reputation have little impact. And resentment of the OPD, where patients are funneled through many subspecialty clinics, and of the emergency room remains high. During the past year, the OPD has been in the process of rearrangement "for teaching purposes." Exactly what that means is not clear. One thing it clearly does not mean is rearrangement for better service to the community. Sinai staff describe as one illustration of this a staff meeting to discuss the "rearrangement." At the meeting, a doctor suggested that one improvement that should be made immediately is automatic admission to Sinai of every Sinai OPD patient requiring hospitalization. The administration's instant response was "impossible." In fact, many OPD patients are sent elsewhere if they need to be admitted to a hospital. Very few Sinai inpatients come from the East Harlem community, whereas nearly all the outpatients do.

One community organizer from Sinai remains in regular touch with the East Harlem Health Council, a neighborhood-constituted group that relates to both Sinai and NYMC. But despite this contact, Mount Sinai's basic attitude toward the community is wariness. When two representatives of the Young Lords came to speak about the Lords' health program to the Sinai chapter of the Medical Committee for Human Rights, Sinai sent extra security guards to patrol the meeting area.
Mount Sinai is affiliated with Elmhurst (a City hospital in Queens), the voluntary hospital for Joint Diseases, the Bronx VA Hospital (recently the subject of a Life Magazine expose of the inadequacy of veterans' care), and Beth Israel Medical Center (a blossoming empire in its own right). In addition to running or helping to run these other hospitals, Mount Sinai is currently trying to get its own 1350-bed hospital in order: in spring 1970, the Joint Committee on the Accreditation of Hospitals gave Sinai only provisional accreditation because of inadequacies in its medical record room.

Recent financial events, however, may turn much of the question of community role into a purely theoretical question. While most medical schools are currently feeling a squeeze from the combined effects of inflation and the cutbacks in federal research grants (which sometimes pay as much as 80 percent of salaries), both Sinai and NYMC made Business Week's recent list of "some of the sicker patients."

**Downstate**

Dominating the hospital system for the greater part of Brooklyn's two and one-half million population is the Downstate Medical Center (DMC), a New York State-supported medical school and 350-bed hospital. DMC has teaching affiliations with ten hospitals in Brooklyn, including Kings County, Long Island College Hospital, Brooklyn-Cumberland Hospital, Brooklyn VA Hospital, Jewish Chronic Disease Hospital, Jewish Hospital and Medical Center of Brooklyn, Long Island Jewish Hospital, Methodist Hospital of Brooklyn, Maimonides Hospital and Brooklyn State Hospital. The Downstate empire is huge, comprising over two-thirds of the 15,000 hospital beds in Brooklyn. But its interest in providing patient care for Brooklynites is less impressive. The DMC sees itself as a teaching and research center and treats its affiliates accordingly.

At the core of the empire, namely the medical complex which includes DMC and Kings County Municipal Hospital, one sees a familiar scenario, with a change of costume. Though wearing the costume of a publicly supported state institution, DMC acts exactly like a private institution. The dual system of health care is nowhere more dramatically demonstrated than on the opposite sides of Clarkson Avenue in Brooklyn. On one side of the street is the 2,700 bed City-owned Kings County Hospital, under-financed and understaffed (patient to nurse ratios sometimes reaching 30 to 40 to one). The patients at Kings County are primarily black (50 percent) and Puerto Rican (23 percent); they are all poor. In recent years, the only substantial improvements in patient services have been those related to crisis health care (e.g., renal dialysis units, intensive care unit, and cobalt unit). These are reasonable facilities for a large city hospital to have. But they are not the highest priority items on Brooklyn's agenda of health care needs.

On the other side of Clarkson Avenue is DMC's 350-bed State University Hospital. This shiny edifice, completed in 1966, is almost exclusively a private hospital for the private patients of the clinical faculty of DMC. That means that the majority of the patients are white, that 76 percent of the patients are private, that only two of the more than 80 clinics are open to patients who do not have private doctors. Such patients can generally only get into this hospital if they represent a particularly interesting case. This hospital operates at only 67 percent occupancy because admissions are rigidly limited in order to preserve a patient to nurse ratio of less than 4 to 1, thereby maintaining a superior level of patient services. It is stated in the Downstate Medical School catalogue that State University Hospital is the nucleus of the clinical teaching program, but in fact the bulk of clinical training is done on the poor patients in Kings County Hospital, and the interns and residents are more restricted in their responsibilities at the State hospital because it is filled with private patients. Mr. Chalef, Director of the State University Hospital, says, "Although State University Hospital is a government hospital, it is the only one I know of classified by the state as a voluntary hospital." The message is clear: Public funds have been used to establish a dual system of health care on Clarkson Avenue with first rate care going to private patients in the State University Hospital and second rate care going to the poor patients at Kings County.

DMC has been plagued with administrative difficulties in recent years, especially with regard to filling empty positions. The chairman of the Biochemistry Department has had to stay on three years beyond his retirement age while the chairmanship has been offered to and refused by at least 24 professors of biochemistry. The Radiology Department was non-existent for over a year while a new chairman was being sought. Joseph Hill is currently serving as both President of the Medical Center and Dean of the Medical School, but he is hospitalized and is not expected to return to his posts. No names have yet been suggested as candidates to fill these crucial vacancies.

DMC, plagued with its own staffing and administrative problems, has shown little enthusiasm for taking responsibility to improve and reorganize health services at Kings County, much less throughout its Brooklyn empire. Isolated examples of true community service exist (e.g., a program for recruiting black students for Downstate Medical School, and an innovative pediatrics department which was responsible for setting up a lead screening program), but DMC's general trend is one of "retreat" from community responsibility. Because the various departments of DMC have established themselves as independent and unaccountable baronies, they have been able...
to preserve themselves as enclaves of research and training free from community control and involvement. For example, the Department of Medicine at Kings County (controlled by Downstate through its teaching affiliation) allegedly has a policy of turning away "uninteresting" patients (e.g., patients with hepatitis, drug addicts) and admitting only those patients whose diseases are interesting for teaching or research purposes.

When the affiliation program was first initiated by the City back in 1961, Kings County was overlooked, ostensibly because it was not in as bad condition as some of the other City hospitals. At that time it already had a teaching affiliation (involving no money) with the Downstate Medical School. As the health services steadily deteriorated at Kings County, the City began to press Downstate to assume some responsibility. It did so, but in a limited way, starting in 1966 when the first contractual affiliation agreement was made. As of this year the affiliation contract covers only three services, radiology, pediatric out-patient care and psychiatry, at a cost to the City of only about $6 million, or 15 percent of Kings County's $38 million budget. (By contrast, Einstein Medical College's affiliation contracts at Lincoln Hospital and Columbia's contracts at Harlem Hospital comprise about 40 percent of the City hospitals' budgets.) Despite the relatively small size of the contractual obligations of DMC at Kings County, DMC exercises virtually total control over the City institution through its teaching affiliation. But the commitment of DMC to Kings County and its patients is small.

Community insurgency has been slow in developing around DMC, especially owing to the fact that Kings County Hospital is geographically separated from its service population. The majority of its patients live in the Bedford-Stuyvesant, Crown Heights, and Brownsville ghettos, an average of three and one-half miles from the hospital. However in the past year an ad-hoc community group did struggle successfully for improved lead screening of children. Other active community groups involved in health issues include the Bedford-Stuyvesant Restoration Project, the Bedford-Stuyvesant Development and Service Project, and a Kings County Community Advisory Board.

Nevertheless, DMC's ventures into the community have been circumspect and often exploitative with the general strategy amounting to a retreat from community responsibility. For example, DMC has proposed construction of a child psychiatric center on Clarkson Avenue with between 100 and 200 beds. They envision it as a traditional research and training facility consisting of traditional and limited catchment area population. Interestingly enough, they are meeting resistance only in Albany, where State planners wish to see not another enclave of research and training but an outreach program with community service and development of new modalities of out-patient care as its first priorities.

The new recreation center at DMC provides another example of the empire's attitude towards the community. The official policies for use of this recreation center amount to a tri-level caste system. The "elite" (students and faculty at DMC) are permitted free and unlimited use of the facility. The second level (workers at either Kings County or the State University Hospital who are on the State civil service system payroll) must pay $25 per year to use the center. And everyone else (such as community residents) is permitted to use the center only at specific and limited times during the week. In retaliation, many young neighborhood people have vandalized the recreation center, which to them is a symbol of privilege and elitism.

These are only isolated examples of the much bigger issues regarding the reorganization of health services in Brooklyn. DMC has consistently been reluctant to respond to community needs and pressures for improved and reorganized services. Downstate's empire remains the number one health power in Brooklyn and therefore the principle roadblock to necessary change.

**Columbia**

The Columbia-Presbyterian Medical Center continues to be challenged by the opposition it arouses in its community and among its workers and students. The Columbia empire is centered at the College of Physicians and Surgeon (P. and S.) and Presbyterian Hospital in upper Manhattan. It has affiliations at Harlem and Delfield municipal hospitals and St. Luke's and Roosevelt hospitals in the midwest side. Columbia-Presbyterian is one of the oldest of the N.Y.C. "empires" and the first to aggressively buy up land for a medical academic campus floating in a black and Latin community. Its white, Protestant, elite image and traditional concern with interesting "teaching material" rather than with the needs of the surrounding community has made it seem alien and hostile to the people of nearby Washington Heights as well as those downtown near Harlem Hospital.

In the past two years, starting approximately with the University strike in spring 1968, a series of challenges have been made to the elitist and repressive orientation of the medical school and Presbyterian Hospital. Student groups have leafleted patients at Vanderbilt Clinic, the outpatient clinic for Washington Heights, citing the double standard of care and the expansionism of the Medical Center in the face of crying community needs for primary and preventive care. The Washington Heights Community Mental Health Council, starting with a takeover of a Columbia-sponsored meeting in the fall of 1968, has challenged the in-patient and teaching orientation of a proposed Columbia-run community mental health center. An attempt by Local
199. Drug and Hospital Union, to unionize research workers at P.&S. in the summer and fall of 1969 expressed the discontent of the P.&S. workers, although it was at least temporarily beaten back by the union-busting tactics of the University administration. (The "Supporting Staff Association," which states explicitly that it is not a union and wants to co-operate with Columbia, won the right to represent the workers in a bitterly contested, close election.)

In the past nine months, several new groups have emerged and have challenged Columbia in new ways. Chief among these groups are the Coalition Against War, Racism and Repression and the Black Caucus within the Medical Center, the Freedom and Peace Party and a community coalition in Washington Heights, and the United Harlem Drug Fighters at Harlem Hospital.

- The Coalition Against War, Racism and Repression grew out of the nation-wide turmoil after the invasion of Cambodia last May. It has sponsored meetings and rallies about the war, has had protests on the campus, and has begun to plan a "New York Panther 21," and especially on Dr. Curtis Powell, one of the 21, who was a researcher in biochemistry at the Medical Center before his incarceration. The Coalition also puts out a muck-raking and issue-raising newsletter, I-O-9, named after the room it uses as a headquarters in the research building.

- The Black Caucus co-sponsored a Curtis Powell support rally. It sponsored a day of mourning for the Augusta and Jackson State slayings, and has begun a survey of hiring and student admissions policies at the Medical Center.

- The Washington Heights Freedom and Peace Party, together with a community coalition, co-sponsored a community meeting last December to talk about the state of health care in Washington Heights. Since then, Freedom and Peace has challenged specific policies in the dental clinic, has set up a grievance table in the Presbyterian emergency room and has provided free ambulance service home from the hospital on weekends. Major confrontations with the hospital have come over the defense of a patient beaten by medical center guards for complaining of a long wait [see May, 1970, BULLETIN], in demanding the return of a young mother's allegedly battered child who was taken by the hospital and the Bureau of Child Welfare for adoption without telling the parents.

**AIR POLLUTION TAKES ITS TOLL**

In what must be one of the nation's first strikes against automobile air pollution, New York City's Bridge and Tunnel officers staged a three-day walkout at the City's tollbooths and tunnel catwalks on August 18, 19, and 20. Basically, the men contend, the air pollution is killing them. And they cite impressive medical and environmental statistics to prove it.

At the Brooklyn Battery Tunnel, for instance, the carbon monoxide level is as much as 12 times the level in the outside air. Employees at the Brooklyn Battery and Queens Midtown Tunnels are exposed to as much as 100 parts per million of carbon monoxide—more than twice the amount considered "dangerous." Five of the 22 men men whose blood carbon monoxide hemoglobin was measured had levels over four per cent—enough to produce psychological effects such as reduced ability to judge time.

Data on the tunnel pollution first appeared in July, 1969, when the tunnel officers' union (Local 1396 of District Council 37, American Federation of State, County and Municipal Employees) released an analysis of a study prepared four years earlier for management, the Triborough Bridge and Tunnel Authority (TBTA). With characteristic unconcern for the health of either its workers or its "clients," the TBTA had been sitting on the study for over four years until the union finally obtained and released it. Embarrassed by the facts contained in the study, the TBTA agreed to conduct further medical studies, the results of which were to be released to both workers and management simultaneously, and to shift responsibility for monitoring air quality from the TBTA to the City's Department of Air Resources. While all that was going on, the TBTA was also attempting to silence a particular union member, George Carroll, who had been quoted in the newspapers as saying that tunnel air was "unhealthy." The TBTA's silencing tactic was quite straightforward: Mr. Carroll was suspended without pay.

By August 1970, the air in the tunnels and at the entrances had not improved, the TBTA was stalling on the question of medical studies, and the men were getting angrier. The final blow came on August 18, in the midst of converging air pollution and electric power crises. As every New Yorker will recall, Con Edison several times this summer appealed to major power users to cut their power consumption during peak hours—which includes the afternoon rush hour when auto pollution is high. In compliance with Con Ed's request, the TBTA reduced the power and thus the effectiveness of the already inadequate fans.

At 5:30 PM they walked away from their posts. Bridge and Tunnel Officers had had enough. That ventilate the tunnels and toll booths. The final blow came on August 18, in the midst of converging air pollution and electric power crises. As every New Yorker will recall, Con Edison several times this summer appealed to major power users to cut their power consumption during peak hours—which includes the afternoon rush hour when auto pollution is high. In compliance with Con Ed's request, the TBTA reduced the power and thus the effectiveness of the already inadequate fans that ventilate the tunnels and toll booths. The Bridge and Tunnel Officers had had enough. At 5:30 PM they walked away from their posts.

For three days the newspapers focussed on the question of how many motorists were paying the toll in the absence of the toll collectors and all but ignored the air pollution issue. But at the end of the three days, the TBTA agreed to get the medical studies underway and to install (and presumably to use) high speed ventilation fans on tunnel catwalks and in toll collection booths. The men went back to work, but with the implicit threat that if the TBTA fails to live up to its obligations to protect the health and safety of the workers, the workers will again have to strike.
• The United Harlem Drug Fighters, a coalition of Harlem groups concerned with wiping out heroin addiction, sponsored a rally on July 25. The rally proceeded to the K building of Harlem Hospital (the psychiatric service) and began a month-long sit-in. The upwards of 300 addicts and supporters in the K building demanded that the Psychiatry Department set up a 100-bed detoxification unit and that the hospital greatly expand ambulatory and half-way facilities in the community. The Drug Fighters, in cooperation with some activist doctors, set up a methadone detoxification program on the spot. After a month's occupation, the final agreement committed the Health and Hospitals Corporation to funding a 100-bed detoxification unit on two floors of the old Harlem pediatrics building, the City's Addiction Services Agency to providing a half-way hotel in the community, and the Harlem Hospital out-patient service to expanding its out-patient methadone facilities. Dr. Elizabeth Davis, head of the Columbia-affiliated Department of Psychiatry, successfully blocked the use of Psychiatry Department beds for the detoxification program agreed upon.

In response to the community's challenges around Presbyterian's Vanderbilt Clinic, Columbia is apparently hoping to turn Delafield Hospital, a neighboring, Columbia-affiliated, City-owned cancer hospital, into a general care hospital for the poor people in the area. That would permit Presbyterian to get out of the business of taking care of non-private patients and so hopefully get the community off Columbia's back. Already, Columbia is trying to shift its family planning programs onto Delafield's strained facilities. But even turning an affiliated City hospital into a patient care centered facility does not come easy for Columbia; a lonely struggle is currently being waged by the administrator of Delafield to free up space for patient care from the space required for the cancer research programs of Dr. Solomon Spiegelman.

So while the Columbia-Presbyterian Medical Center continues to buy up land, emasculates the Community Mental Health Council, declines to commit itself to drug treatment in the Washington Heights area beyond a 10-bed unit at Delafield, increases its security force, and reluctantly balances its multi-million dollar house staff residence with a new emergency room, community and worker groups see the NLF flag raised on the Presbyterian flagpole on the eve of July 4 as symbolic of the struggles to come. —The empire stories were prepared by the staff, Dick Clapp, and Dale Hiltgen, Health-PAC Student Interns.

Hidden Persuaders: New York City's Health Consultants

While consumers and workers are struggling for grassroots democracy in the institutions which affect their lives, the trend in city government is to remove larger and larger areas of decision-making from public view, much less from public participation. City governments, such as New York's, are virtually dismantling themselves in their haste to hand vital service and planning functions over to public authorities (modeled after private corporations) and to private consulting firms.

In most cities, mass transportation has long since passed out of the public area and into the hands of quasi-public corporations, or authorities. More recently, New York City surrendered the management of its 19 municipal hospitals to the newly created Health and Hospitals Corporation. As authorities and corporations take over the operation of public services, only planning and policy-making functions are left behind in city government. But increasingly even these core functions are being contracted out—to private consulting firms which are closely linked with the Defense Department and to the nation's largest private corporations.

New York City's dependency on private consulting firms is growing at a rate which even some public officials find alarming. Between 1965 and 1970, the City's expenditures on outside consultants have increased from $8 million a year to $75 million. Formerly, the City hired consultants only occasionally and on a one-shot basis, but today consulting firms are firmly entrenched in a range of City problem areas including fire, police, health and overall City planning and budgeting. Few New Yorkers had any inkling of the extent of the City's reliance on consulting firms until last June, when City Comptroller Beame disclosed the huge sums involved and threatened to cut off payments pending an investigation.

In contracting out basic analytical and planning work to private consulting firms, the City is following a trend which has also been gaining momentum in private industry and the Federal government. Over the last five or ten years, consulting has grown from a small business dominated by freelancers and accounting firms to a $1 billion per year industry, dominated by large, consulting-only firms which employ hundreds of professionals. Highly profitable (charges for single studies range into the millions) and totally unregulated, the consulting business is, according to Business Week, growing by leaps and bounds. In addition to the profit-making consulting firms, which specialize in corporate management problems, the sixties spawned a host of more "academic" nonprofit outfits, the so-called "think-tanks," some of which were originally set up by the Defense Department. Both types of firms are pulling down major contracts in urban problem-solving, especially in New York City.

The assumption behind the City's growing use of private consultants is that City govern-
ment as it is now structured is cumbersome, inefficient, and ill-equipped to deal with complex problems. Private industry and the military, on the other hand, are seen as efficient and eminently capable of handling the most difficult issues. Therefore, according to this line of reasoning, the solution for the cities is to borrow the analytical and decision-making techniques which seem to work so well in industrial and military settings. Indeed, much of the work now being done by private consultants for New York City is not on substantive problems, such as how to improve services, but on the problem of how to restructure and "rationalize" the City decision-making process itself.

The problem with this line of reasoning is that the decision-making methods appropriate to industry and to the military are not, or should not be, appropriate to the governmental process—even if one grants the questionable assumption that industry and the military are really efficient and smooth-running. To the extent that industry and the military do appear to be "efficient," it is because of inherent features of their goals and structure, rather than because of any superior decision-making techniques. In the first place, both are oriented towards single goals—profits in industry, high kill-ratios in the military. Decision-making is simply a problem of maximizing profits in the one case, kill-ratios in the other. City governments, on the other hand, appear to have complex and often conflicting sets of goals. In the second place, industry and the military are both rigidly hierarchical operations. What appears to be an efficient decision-making technique is often simply an autocratic one, and unsuitable to what should be democratic governmental procedures. The danger is that city governments may, under the prodding of their private consultants, try to emulate the anti-democratic but seemingly efficient functioning of industry and the military.

"Health was one of the first areas to be staked out by the major consulting firms operating in New York City. Which firms they are, what they are paid, what they are paid to do—none of this is accessible public information. HEALTH-PAC's probes, conducted over the last year and a half, reveal that:

• The management consulting firms working on health for the City include some of the nation's largest and most profitable firms which, when they're not working for the City, are straightening out management or marketing problems for such corporate giants as IT&T, Western Electric, US Steel and Metropolitan Life Insurance. McKinsey and Company, whose total City contracts add up to $1.5 million, is the nation's fifth largest management consulting firm, with a gross income of about $25 million. McKinsey's assignment appears to be nothing less than the task of setting up the organizational structure for the Hospitals Corporation, which gives the firm a key role in determining the shape of the City's health system for years to come. Other firms under contract to the Corporation for bits and pieces of health planning include Peat, Marwick and Mitchell, the nation's fourth largest management consulting firm; Planning Research Corporation, the third largest; and H. B. Maynard and Company, the tenth largest.

• The think tanks which are working or have worked on health for the City include some of the Defense Department's most reliable advisors. Best known, of course, is the Rand Corporation. Originally set up by the Air Force, Rand in 1968 was pulling in about $800,000 in health contracts in New York City, and $19 million in consulting contracts for the military. Systems Development Corporation (SDC), which produced a 1966 study entitled "Systems Development and Planning for Public Health in the City of New York" under contract to the City, made $17 million in defense contracts in 1968. SDC was also originally established by the Air Force. Research Analysis Corporation (RAC), a child of the army, worked on health planning for the City in the late sixties, while it was making $10 million per year through defense contracts. Technomics, Inc., the Santa Monica firm which did the staff work for the 1966 mayoral commission which first proposed a corporation to run the Municipal hospitals [see BULLETIN, special winter issue, 1969], originally specialized in defense work.

Many of these companies are working, or have worked, for the City on short-term, limited assignments. But the heavy weights in terms of contract dollars and manpower, Rand and McKinsey, are well on their way to becoming permanent fixtures of the City's billion dollar per year health enterprise. Both were hired initially as part of Mayor Lindsay's drive to "rationalize" City government through the use of "PPBS" (Program Planning-Budgeting System), a Rand-designed planning and decision-making technique first sold to the Defense Department under McNamara in the early sixties. Lindsay's first budget director, Fred Hayes, brought Rand in to help the City budget bureau institute PPBS in 1967. A year later, he contracted with McKinsey to supervise the Budget Bureau's efforts to switch over to the PPBS method of budgeting. Both firms have spread out from the PPBS business to the congenial area of health—which is considered by the Lindsay administration to be so highly "technical" that outside consultants are indispensable.

Both firms are now so closely tied in with the City administration that their staff men are almost considered part of the "family" of Lindsay's bright young men and women. For example, applicants for City health planning jobs report being referred by City employees and officials to Rand and McKinsey as other sources of jobs. Rand-men have been known to move over into City jobs, and one McKinsey employee, Carter Bales, held the position of Deputy Budget Director while remaining on the McKinsey payroll. With this kind of intimacy with the City administration contract renewals are practically guaranteed.
The Rand Corporation enjoys an especially privileged relation to the City. Top Rand-men do not take just any assignment from the City—they participate in the framing of projects of interest to themselves. Thus, in health, Rand has dabbled in a wide range of subjects: mental health, community health centers, narcotics, home care, emergency care. Over the winter of 1969-70, Rand did a detailed study of the municipal hospitals, which (according to one of the Rand-men on the assignment) was oriented towards saving money through bed-reductions and other service cuts. Current Rand projects for the Health Services Administration include studies entitled "Cost and Performance of Suppliers of Health Care" and "Direct and Indirect Mental Health Services"—both probably geared to discovering cheaper ways of delivering health services.

In 1969 Rand Corporation and the City administration cemented their relationship through the joint formation of a nonprofit corporation called the New York City Rand Institute, a Rand spin-off dedicated solely to urban problems. Formerly, Rand-men working on New York City problems were supervised from the Rand Corporation's Santa Monica headquarters. For the Rand team in New York, the device of forming an independent, City-linked "institute" has two big advantages over the old arrangement: First, the City has promised to finance the Rand Institute to the tune of $3 million/year (an additional $1 million will be raised from private foundations). With a guaranteed income of $4 million/year, the Institute can settle down to "academic" pursuits, free of the pressure of hustling individual contracts. Second, formal independence from Rand Corporation should give the Institute a clean, non-military image attractive to potential clients. (The Institute will probably retain extensive informal relations to the Rand Corporation.) In the health field, the Institute's prestige is assured by the presence, on its Board of Directors, of Yale's Dr. Lewis Thomas, former Dean of NYU Medical School, and William Golden, a director of Mt. Sinai Medical Center and of New York Blue Cross.

No one questioned the City's relation with its consultants until Comptroller Beame's disclosures last June. Now, the Lindsay administration is on the defensive. In public and private statements, they justify the use of private consulting firms on three grounds:

- They argue that the advice obtained is well worth the money. But, despite all the mystique about "systems analysis" and other "technologies" of problem solving, the performance of the top firms doing health work has been consistently shoddy, even when measured by their own standards. Rand-men themselves have admitted privately that they "never really got on top of the health thing" despite three years' and over a million dollars' worth of trying. McKinsey is proud of the volumes of flow charts and computer forms it has produced for the Hospital Corporation and the Health Service Administration. But in terms of McKinsey's original assignment—to make PPBS and other sophisticated techniques an operational reality in the City health bureaucracy—there has been almost no progress. City officials and planning staff complain they can't comprehend much of McKinsey's guidelines, memos and flow charts, much less apply them to everyday, practical problems. According to one insider, when a top McKinsey executive gave the Hospital Corporation's Board of Directors a presentation of McKinsey's plans for the Corporation's management structure—complete with illustrative slides—the Directors' response ranged from boredom to open skepticism. In a similar performance for HSA staff in late 1968, the McKinsey team's explanation of PPBS was greeted with giggles from the audience. One lower echelon Budget Bureaucratic staffer, mystified by McKinsey directives despite his own training in systems analysis, said "What McKinsey's doing, we call PP-B-S."

- They argue that private consulting firms are indispensable because they are "above politics," capable of giving truly "neutral" advice to harried City officials. The neutrality of any advisor, no matter how academic or detached he purports to be, is open to question. But the kind of men doing most of the health consulting work in New York City can make no pretense of academic detachment. Whether they work for a defense-oriented think tank or a private industry-oriented management consulting firm, they are ideologically and intellectually rooted in American imperialist and profit-dominated values. McKinsey men assume without question that the kinds of management structures and decision-making processes suitable to private industry are suitable to City government. One consulting firm staffer working on health openly expressed his bias: "I'm for private enterprise. It works. Most problems that government can't handle can be handled by private enterprise." Of course, alternative solutions to health care delivery problems, such as community-worker control of health facilities, simply never arise in the decision-making framework of a Rand Corporation or a McKinsey Company.

The political assumptions of Rand's "academic" analysts are especially questionable. Many of the Rand-men who have worked on health for the City have also worked on military problems for the Department of Defense. One, interviewed in late 1968, did both simultaneously: two days a week in Washington working on secret problems related to the war in Vietnam, three days a week in New York working on health. He, like other Randmen, saw himself as just a "technician"—capable of designing methods of genocide one day, and working on narcotics and mental health problems the next day.

- They argue that, after all, the real policy decisions are still made by City officials: Private consulting firms only provide the information and the framework for decision-making; they list the alternatives, the City of-
ficial chooses among them. It almost goes without saying, however, that a particular policy decision is largely determined by the information that goes into it, and the kinds of alternatives that are presented. With the consulting firms now working on health for the City, the information "input" is bound to be limited by the knowledge and experience of the firms' upper middle class staff men. (For example, one Randman who was attempting to apply a highly abstract branch of mathematics called stochastic analysis to the problem of patient flow in emergency rooms, admitted he had never been in a City hospital.)

In a practical sense. City officials and staff members are seldom in a position to objectively judge the data and the "framework" prepared for them by private consulting firms. As mentioned above, the links between City staff and consulting firms are many and tangled. Comptroller Beame revealed that the City’s Environmental Protection Administrator, Jerome Kretchmer, accepted a free weekend in the Poconos resort area from McKinsey. What Beame did not know was that Rand Corporation has hosted dozens of City health staffers on free trips to Santa Monica. Finally, many City officials and staff people know that one of the most lucrative jobs they can get when they leave the City government is with a private consulting firm. Building a friendly personal relationship with the outside firm is worth more than the temporary satisfaction of being honest and critical about the consulting firm’s work.

With the arrival of the private consulting firms on the urban health scene, one more link in the growing Medical-Industrial Complex has been forged. The consulting firms, with their ties to the nation’s largest corporations, to the aerospace and defense industries and to the military itself, are now tied, in turn, to local health systems. The links are still tenuous, but the possibilities for profitable exploitation are already clear: In its search for new markets, industry and especially the defense industry, is turning increasingly to health [see November, 1969, BULLETIN]. There, one step ahead of them, are the management consulting firms and think tanks, ready to please their industrial clients by scouting out and developing new markets for medical electronic hardware, computers, industry-run training programs for health paraprofessionals, etc. (Already, one can discern an insistent emphasis on computers and related hardware in the advice New York City buys from its consultants.) As the medical-industrial complex and its ally, the consulting firms, gain hegemony over the health system, the consumer, with his demands for high quality, dignified services and public accountability, is increasingly irrelevant.—Barbara Ehrenreich.

CORRECTION: We wish to thank Conservation of Human Resources at Columbia University for calling to our attention some omissions and errors in last month’s chart on medical and nursing school admissions [see BULLETIN, September 1970, p. 10]. The corrected chart is reprinted here. Medical school figures are from an unpublished article by Dennis Dove, Administrative Assistant for Minority Student Affairs of the American Association of Medical Colleges. The article is titled "Minority Enrollment in U.S. Medical Schools for 1969-70 Compared to 1968-69." The figures for nursing program admissions are from a draft of the National League for Nursing’s annual article on Educational Preparation in Nursing to be published in Nursing Outlook. For black student admissions, the figures are based on admissions in programs which answered the question about blacks ("total" column). Actual total admissions in each type of program are given in parentheses. The percentages of men admitted to the various types of programs are based on those programs which answered the question about men. However, the total admissions to and actual numbers of men in the programs which answered the question about men have not been released. Thus the percentages of men in each program are approximate.

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