THE TROUBLE WITH EMPIRES

SHOTS RINGING OUT IN THE STRUGGLE OVER A SOUTH BRONX COMMUNITY MENTAL HEALTH CENTER ARE BEING HEARD AROUND THE MEDICAL WORLD. COMMUNITY-WORKER FORCES ARE BEGINNING TO GIVE "THE BOOT" TO THE ARBITRARY RULE OF AUTOCRATIC GRANTSMEN AND HIERARCHICAL PROFESSIONALS.

It's being called an "Ocean Hill-Brownsville" of health and mental health—only the "insiders" are both community and workers. The "outsiders" are the medical empire-promoters themselves. Those who care about an effective reconstruction of the health services system must understand the national meaning, particular "imperial" context, and immense new insurgent social energy contained in such a situation. The striking new challenge being made by community and workers' forces, allied with progressive students and professionals, not only poses new questions, but offers the only real potential for new answers—the basis for a new kind of public service sector of health.

The Nixon Administration, like its Democratic predecessor, shows an increasing nervousness about the unfettered free enterprise system of health care and its financing. Despite the 30-years-late "Health New Deal" of Medicare and Medicaid, the nation faces a catastrophic breakdown of its health delivery and financing "nonsystem." In fact, Medicaid and Medicare have accelerated the escalation of medical costs—while barely beginning to fill widening gaps in service. In a nutshell, the financing, organization, and delivery of medical care, as centered in existing institutions for insurance, patient care, and education, are totally out of control.

The national establishment has begun a determined search for new "enlightened trustees" to pull some of the scattered pieces together into a more manageably competitive system. Recent national programs such as the Comprehensive Health Planning Act and the Regional Medical Programs are frail beginnings on this course. More dramatically, Governor Rockefeller has called for some kind of national insurance package, presumably Blue Cross-controlled (and Nixon's new HEW chief Robert Finch seems to be listening).

In NYC we first had the affiliation program to turn the City hospitals over to private "leadership," and we now have the plan for a Health and Hospitals Corporation to inject private sector "efficiency" into the public hospitals [See BULLETIN Special Issue, Winter 1969]. The rallying cry for such programs is to encourage "regionalized," rationalized and integrated hospital and health services planning and development, "centered" in medical schools and major voluntary hospitals.

These would-be saviors of the health system, the medical schools and major voluntary institutions, are facing serious internal problems: underfinancing (particularly with Viet Nam bleeding research and education budgets), under-staffing, more restricted access to interesting "teaching material," and the resultant institutional competition. Also, while national leaders look to them for long-term policy guidance, local communities are demanding that they do something immediately to get services out to people.

The challenge to the promoters of the major medical centers is then to use the growing demand for "trusteeship," rationalization," etc., to enhance their own institutional and personal positions—and to do it before the initiative passes to angry consumers and workers.

The promoters of such large institutional complexes, given a tangled internal elitist environment and the shambles of most public health administration, have chosen a high-handed path. As the Einstein-Montefiore Empire case study in this issue shows, they have tended to direct their energies for "reform" in the most arrogant, dogmatic and unaccountable fashion. Even while rhetorically...
esposing “progressive” principles of medical system reorganization, they have engaged in wasteful inter-institutional competition, hustling scarce manpower on a fee-basis, and scrapping over “teaching material.” What truly progressive projects they have sponsored have often been promoted on an opportunistic and fragmented basis without sufficiently balanced concern for the people whose lives hang in the balance. The irony is that these corporate liberals of the medical establishment have begun to imitate the competitiveness and self-interest of the solo, fee-for-service systems of which they are often so critical.

Thus, there is a growing resistance among those whose lives are most directly affected—as workers and as citizens—against the top-down approach to health services in the Bronx. This is happening despite the seductive “logic” of regionalism under major medical centers; despite some positive pioneering achievements of certain Einstein-Montefiore Empire programs; despite the desperate need for any action, from any source, to give disaster relief for the Bronx’s health crisis.

Clearly, the solution does not lie simply in the re-ordering of a thing called the “Bronx health services system.” On this both the “corporate liberals” and the “radical insurgents” agree—there is no such thing. The real question is where to begin to challenge the existing national non-system of medical mismanagement, professional privilege, and narrow “academic medicine,” rather than primary care priorities.

Still, the Bronx is a crucial arena for deciding the shape of a new health system, not only in New York but nationally. The Bronx provides a dramatic microcosm of the nation’s health crisis: the South Bronx, like ghetto and poor rural areas everywhere, is a health disaster area that will require massive public intervention to meet the crisis. Throughout the Bronx, geographical imbalances in medical resources, organization and fragmentation of care are perhaps greater than in any other borough. And for the Bronx, as is increasingly true for the nation, there is no going back to a free enterprise, solo-practice-dominated model of services distribution. The question posed by this borough is how can institutionally based and controlled resources be expanded, integrated and distributed to contribute to the maximum public welfare?

New Directions: First Things First. The present plans, priorities and organization of the Einstein-Montefiore Medical Empire, as outlined in this issue, must almost literally be “turned on their head” to achieve the kind of change needed and demanded by the people of the Bronx. The untrusted “central powers”—both the downtown health bureaucracy and private medical baronies—must be cracked. Rigid and short-sighted “affiliation” and “corporation” approaches to City health policy must be blocked. Grant-hustling “experimentation” and “demonstration” with people’s lives, as a substitute for comprehensive programs for people’s needs, must be curbed. Profit-motivated insurance-market selectivity, unaccountable elite philanthropic and academic granting mechanisms must be eliminated. Rigidly exclusive academic hierarchies—the source of the manpower shortage—must be flattened.

Alternative Directions: Towards a Public, Community-Worker-Based Health and Mental Health System for the Bronx.

■ Neighborhood Services: The immediate development of neighborhood health and mental health services for all citizens, regardless of ability or inability to pay, must take first priority. There must be public support of emergency "store-front" services. Funds and staff for more "multi-service centers," patterned after the community-controlled Hunts Point Center, should be mobilized immediately.

■ Community and Worker Control of Health Services: Existing health services institutions in the Bronx are due for a thorough shake-up. Reorganization along the lines of comprehensive, continuous and personalized service is not a "frill," but a life-saving necessity. Since such reorganization challenges the profitable academic fiefdoms of the professional elitists, workers and community people will have to lead the way. Within each institution, care must be restructured on a team basis, with all health workers (professionals and others) cooperating around the common goals of community service.

■ Community and Worker Control of Health Planning: As the City-wide Health and Mental Health Council has proposed, funds and planning power under the Comprehensive Health Planning Act should be delegated to neighborhood boards, to which the City Health Services Administration leadership should be held basically accountable. Such councils could be composed of citizens and health workers (physicians, orderlies, students, aides, etc.) related to neighborhood institutions.

■ Democratic Restructuring of Medical Education: Fragile, scattered "career ladder" programs—which always seem to leave out the upper rungs in the ladder—must be replaced by a massive public program for education in health and mental health service. A truly progressive challenge for Einstein would be to open its doors to the community and declare itself "One Big Health Sciences College." Patient care and education, now linked so as to exploit the patient, must be re-integrated along lines which optimize patient care—which is the reason for teaching medicine in the first place.

■ Democratic Control of Institutional Funding: The present potpourri of Federal, State, City and philanthropic funding
Empire Survey (II)

EINSTEIN-MONTEFIORE: BRONXMANSHIP

THE BRONX MEDICAL EMPIRE of Montefiore Medical Center and Albert Einstein Medical College (of Yeshiva University) is well known among liberal medical reformers nationally and locally as a kind of benevolent private monopoly of health services for almost 1.5 million people. The Bronx ranges from prosperous and booming in the north to desperately poor and decaying in the south. Once the front line of Jewish out-migration from teeming Manhattan, the Bronx now serves the same function for other minority groups. Half the Borough's residents are black or Puerto Rican.

Dr. Martin Cherkasky, for almost two decades medical director at Montefiore and now also Chairman of Einstein's Department of Preventive Medicine and Community Health, is considered the house liberal of the national medical establishment. He can frequently be found in Washington or being quoted in Time magazine—for group practice, for national health insurance, for planning, for regulating medical quality, and against the freewheeling fee-for-service style of his conservative profession.

It came as something of a shock, therefore, when numerous professional, political, and community forces chose recently to bite this hand that is supposed to feed them. When Dr. Cherkasky announced last spring that Einstein-Montefiore was developing a plan for the creation of a unified Bronx "authority" for health services, his announcement was greeted with some of the expected foundation and government financial support. Significantly, however, it has met also with cries of "fraud" and "imperialism"—with the Lincoln Mental Health Center take-over being the most recent example. Other incidents include:

- Angry residents of the Hunts Point section of the South Bronx took over David Susskind's national television show featuring Dr. Cherkasky to charge that Montefiore and Einstein were neglecting the needs of their area. This particular Susskind show had been arranged through a Montefiore public relations man and was filmed last summer. Though aired in most cities during November, the show did not reach New York viewers until March.
- City-Wide Health and Mental Health Council, the association of neighborhood-based health and mental health organizations, recently gave priority to an organizing program to "fight the monopoly of health and mental health by Albert Einstein." Especially with reference to Lincoln Hospital, it pledged to "back up the fight of Bronx community leaders and workers for control of health and mental health services."
- Students and young professionals from Einstein participated in the Student Health Organization's "rap" that literally took over the national medical school deans' meeting of the American Association of Medical Colleges in Chicago in early February. This group attacked the "elitism" and "racism" of major medical centers across the nation attempting to dictate arbitrarily the health services and medical education programs which "should be controlled by the community." They singled out Einstein's refusal to change its much-hailed King-Kennedy program of pre-medical training to provide truly broad career access to disadvantaged Bronx youth. And they attacked such gross indignities as group-observed prenatal examinations of poor mothers at Bronx Municipal Hospital clinics.

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must be amalgamated into a lump sum budget disbursed by community-worker councils at the borough-regional and neighborhood levels. As a beginning, all City tax funds, including money for Medicaid, affiliation programs and City-owned facilities, should be channeled by decentralized decision-making processes at the "regional" and the neighborhood levels. Eventually, even Federal grants for biomedical research and training should be more subject to review on the basis of community and national needs. This would be a firmer base for challenging, regulating, and transforming the totally fragmented and discriminatory present private insurance and prepayment system.

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Can the Bronx Exist Unto Itself? The "Alternative Directions" outlined all lead inevitably to conflict with city-wide, state-wide and national structures which control granting to and financing of institutions and licensing of health workers. These entrenched institutions, largely accountable to government at any level, range from the omnipresent Blue Cross, National Institutes of Health and AMA (it's still alive and well in Chicago), to the more parochial local philanthropies, County Medical Societies and the Health and Hospital Planning Council. They will not easily submit to the surveillance of insurgent groups in the borough of the Bronx. But the struggle for health system changes—local or national—must begin at the base: in the neighborhoods where the failure of the present "system" is most painfully and urgently felt. The Bronx is not an island even for the present Medical Empire's purposes. Inter-borough flow of funds, patients and health workers links the Bronx tightly to Manhattan, the capital of the nation's medical education and research "industry." Thus, whatever democratic planning and development processes are created in the Bronx must be closely interwoven with those of the city, the state and the nation. By the same token, insurgent challenge of medical monopolists in the Bronx can set the pace for national movement for an accountable, flexible, people-oriented health system.

Can the people of the Bronx, as in all communities in America, afford not to move in such a direction? Einstein-Montefiore has vast physical investments and has begun to display its version of social commitment. Thus far, the people have been waiting on the "good will" of the Medical Empire for new and better services and for new job opportunities. The central question is: How long should they wait? Who will decide what they get and when? The various challenges, resistances, and uprisings in the Bronx and in other communities are some of the most encouraging signs of "let us begin ..." in America's agonizing health non-system history.
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■ A student leader of last summer's Student Health project (under the auspices of Montefiore with Federal grants) wrote recently in the Einstein student magazine that such projects have been "enmeshed in the inherently conservative alliance of medical school, teaching hospital, and Federal government." He said it was one of a number of "'cool-it' programs" in which the participants were intimidated by their dependence on their pay checks from "any real determination of and confrontation with ghetto health issues." He was especially critical of the absolute veto power of the Montefiore medical director over the decisions of both the community representatives and the students in the program.

■ Through a campaign urging City hospital patients to refuse to pay their clinic fees, Jacobi house staff forced significant reductions in those fees, despite threats of dismissal by both City and Einstein affiliation administrators.

■ Through caucuses in the Committee of Interns and Residents, Einstein-Montefiore-recruited staffs have been increasingly critical of professional leadership and teaching, the organization of services, and the absence of patient-oriented care of the affiliating institutions. They charge, for example, increasing sub-specialization of clinics (to assist teaching and research at the expense of comprehensive patient care), lack of provision for follow-through with patients (diagnostic tests not reported to patients unless the patients happen to return to the clinic), and failure to plan for alternate emergency service during renovations (when a surgery section was temporarily closed at Lincoln, no ambulance service to take people elsewhere was even called for by affiliation staff).

■ When the Einstein-Montefiore "plan" was announced, Bronx Borough President Herman Badillo said, "A teaching institution is not primarily interested in ongoing medical care, but in teaching, which benefits more from unusual cases than from ordinary cases." He said "[as a member of the Board of Estimate] I'm putting on notice that I'm not approving any demonstration projects until we meet minimal health needs." Citing a $3.8 million grant for psychiatric services through Einstein, Badillo said, "I can't get dental services into the capital budget . . . the percentage of people who need psychiatric services is much smaller than the percentage of people who need dental care." He also attacked highly selective admissions practices (for teaching and research) at Einstein's Bronx Municipal Hospital, where the patient load is the lowest in the city.

An Einstein official replied: "I don't think there's a medical school in town that's more concerned with providing community services than we are." In answer to all such assertions of self satisfaction, Badillo declared prophetically, months before the Lincoln Mental Health action—"... the next area where community control is going to become an important factor is going to be in health services, and the reason for that is that people in slum areas have been asking for better health care over the years. There has been an inadequate response, and the people are coming to feel that if they have control of the health centers and of the hospitals, that they will be able to provide themselves better health care."

What is the Einstein-Montefiore plan for Bronx health services all about? What has this institutional complex contributed to community services? Why is such a "non-profit, academic-based" complex so "imperialistic" and expansionary, so like a profit-seeking corporation? Why are so many people in the Bronx so distrustful of its "trusteeship" of health services? What are the criticisms of the Einstein-Montefiore plan and how valid are they? Are there alternatives?

Montefiore's story goes back to the Civil War era, when medical care was largely confined to the tiny middle class, and hospital "care" was nonexistent. Montefiore's present site was originally an army camp for Confederate prisoners. One of the POWs—Bernard Baruch's father—set up a prison hospital during his stay. (Lincoln Hospital in the South Bronx, now affiliated with Einstein, was set up before the Civil War as a home for aging escaped slaves.) After the war, the ex-army camp infirmary was transformed into "Montefiore," a chronic care home, by Sir Moses Montefiore, an English banker and philanthropist. It was rejuvenated and expanded into a general hospital in the 1930's by an energetic director, Dr. E. M. Bluestone. During the 1950's Dr. Martin Cherkasky, as director, launched Montefiore on its present Empire-expanding course.

Partners in Progress

Einstein Medical College, Montefiore's "partner in progress," grew out of Yeshiva University's post-World War II plan to promote a new Bronx general City hospital, and then to graft on a medical school with full rights to the hospital's "teaching material." As Commissioner of Hospitals in the mid-fifties, Dr. Marcus Kogel engineered the actual development of the 1400-bed Bronx Municipal Hospital Center. Opening cost of the City "grant" to the future medical school was $40 million for construction of Jacobi and Van Etten Hospitals, $8 million for a nursing school building, and 63 acres of City park land. Kogel went on from his stint with the City to become the first dean of the newly opened Einstein.

Since its opening in 1955 and its affiliation with Montefiore in 1961, the College has grown tremendously in influence and resource control. These two major private medical centers are increasingly closely associated. Although there are some tough in-fights between the "private hospital management" orientation of Montefiore vs. the more "academic" orientation of Einstein, together they preside over the nation's most nearly consolidated "medical region." Unfortunately, "consolidation" refers far more to control over resources and institutions than to coordination and equal distribution of services.

Since the mid-1950's, Montefiore has increased its physical development around the original buildings about fourfold, and it now even has Health and Hospital Planning Council approval to move the 400-bed Morrisania City Hospital from a low-income southwest neighborhood to the Montefiore grounds in the middle-class upper northwest. As a result, institutional and professional resources are heavily concentrated in the upper part of the Bronx, while the low-income population is concentrated in the South Bronx. [See "Empires" map in BULLETIN No. 6, Nov.-Dec. 1968.]

Considered "eminent domain" for Einstein-Montefiore are the two other significant voluntary hospitals in the Borough, 570-bed Bronx-Lebanon in the west Bronx (also part of the Federation of Jewish Philanthropies) and 330-bed Misericordia in the northeast (a Catholic institution currently the private affiliating hospital for 400-bed Fordham City Hospital in the west-central Bronx). Dr. Cherkasky has physicians
whom he considers his "own people" (part-time faculty in Einstein's Department of Community Health), in key program development spots at these two voluntary hospitals. Various approaches are being made by Empire promoters toward a Montefiore merger with Bronx-Lebanon (proposed for years by various Federation officials as a "Bronx Jewish Medical Center") and toward a Misericordia-Fordham affiliation with Einstein-Montefiore.

The only apparent hitches to these further absorptions at present, other than the independent-mindedness of these voluntary hospitals, surround the new plans of New York Medical College to move from Manhattan's upper east side to Westchester County and the City's plan to move, to rebuild, and perhaps to reaffiliate Fordham City Hospital [See BULLETIN No. 6, news story reprint]. New York Medical College is apparently especially interested in arrangements with Voluntary hospitals, surround the new plans of New York Medical School to move away from Manhattan's upper east side to Westchester County and the City's plan to move, to rebuild, and perhaps to reaffiliate Fordham City Hospital [See BULLETIN No. 6, news story reprint]. New York Medical College is apparently especially interested in arrangements with Misericordia, a new, growing facility situated near the Westchester County border, and probably, therefore, in arrangements with Einstein-Montefiore.

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What Makes It Run?

Columbia Presbyterian Medical Center is withdrawn and patrician about its meager inroads into Harlem and Washington Heights [See BULLETIN No. 6]. Einstein-Montefiore aggressively promotes a borough-wide framework with itself at the helm. Columbia P&S shrinks from further public involvement through affiliations. Einstein-Montefiore aspires to control the Bronx, hospitals, health centers and all. Columbia, especially since its cigarette filter advertisement and student explosion of the last two years, shyly avoids the press. Einstein-Montefiore employs a full-time PR staff plugged into TV, national magazines and major newspapers.

In short, Einstein-Montefiore does not behave like a traditional medical school/hospital complex. What gives a non-profit, academically-based organizational complex the "profit-motif" of an Einstein-Montefiore? To most observers, the dynamics of Einstein-Montefiore expansionism are beyond economic law or organizational logic, and Einstein-Montefiore is written oft as a case of "medical liberalism" run wild. Liberalism is part of the answer. The Einstein-Montefiore trusteeship network, centered in the Federation of Jewish Philanthropies, does not exactly correspond with the predominantly WASP banker/financier/internationalist world of the more "downtown" medical school trusteeships.

Liberalism, however, is only the permissive atmosphere in which an Einstein-Montefiore thrives—the motivating force surges out of the inner logic of the new government and philanthropic granting and funding system. Einstein-Montefiore has been riding the cycle of grants and demonstration projects. It spawns a medical demonstration which advertises for and justifies the next grant, hence the next project, and so on. As dependence on public funding has grown, so has Einstein-Montefiore's need for ever greater public trust and appreciation—always wooed with new, more dazzling demonstrations. The price of this reliance on public support is the continual fear of being upstaged by a yet-unconquered institution, or dethroned by an angry community.

Einstein-Montefiore must always be one step ahead of the competition and the public—it must plan, erecting vast frameworks of control and defense. Plans, in turn, are marketable to the federal/foundation funding axis, which is increasingly nervous about the chaos of our national medical non-system.

Einstein and Montefiore, both separately and in association, were among the first institutions in the country to make well packaged "medical progress" their product. They have sold "pioneering," "breakthroughs," "demonstrations" and "social commitment" and gained the reputation for being where the scientific and social action is in medicine. "Demonstrations" have been underwritten as kinds of philanthropic good will and advertising costs—from the "Family Health Maintenance Demonstration" in the 50's to the "Neighbor-

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Medical Control . . .

Beds

The Empire controls about two-thirds of the general care and almost all of the long-term care hospital beds in the Bronx; it controls about 2000 of the 2400 existing City hospital beds in the Bronx and will hold about 2850 of 3300 beds currently projected for the Bronx. Its total present holdings include:

- Montefiore Medical Center 800 beds
- Einstein College Hospital 340 beds
- Bronx Municipal Hospital Center (Jacobi and Van Etten Hospital, affiliated Einstein) 1400 beds
- Lincoln Municipal Hospital (affiliated Einstein) 350 beds (planned for 900)
- Morrisania City Hospital (affiliated Einstein) 400 beds
- Bronx State Mental Hospital (affiliated Einstein) 1400 beds
- Federal Veterans Administration (affiliated Einstein) 1200 beds
- Beth Abraham Hospital and Home (affiliated Montefiore) 510 beds

Physicians

Approximately 2000 of the 2700 physicians in the Bronx work at, or are affiliated with, Einstein-Montefiore-linked facilities. Of these, about 1500 work full-time in the hospitals and in affiliated neighborhood health and mental health centers, medical groups and City Health Department centers.

- 750 interns and residents
- 200 psychiatric or neurological specialties
- 250 full-time administrative, research, faculty
- 250 full-time hospital chiefs of staff
- 550 part-time or affiliated

and about 13,000 other paramedical employees under their general direction

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hood Medical Care Demonstration" today. This latter project, a "continuous, comprehensive, family-oriented" health center in the southwest Bronx, is staffed and controlled by Montefiore Hospital and serves perhaps as many as 10,000 persons now, with 30,000 more projected (perhaps over-optimistically). Neighborhood Medical Care Demonstration has been much lauded in many major magazines and has the highest reporter-patient ratio in America.

Who's Hustling?

The academic counterpart of the field demonstrations is Dr. Cherkasky's mushrooming Department of Preventive Medicine and Community Health at Einstein. (The retainer list of "faculty" for this department reads like a Who's Hustling in New York City health politics—from the Borough President's health affairs aide to Dr. Cherkasky's scouts at Misericordia and Bronx-Lebanon Hospitals.)

The human side to the demonstration-project proliferation is the gathering in to the imperial fold of bright, dedicated personnel. Dr. Cherkasky is particularly well-known as a recruiter of potential innovators to "do their thing," as long as "their thing" is a grant-lucrative demonstration project and they are willing to do it through his channels and under his command. This view of progress as an individual project-hustle pervades the Einstein-Montefiore "sheltered workshop" for social progress, leading even the most socially-dedicated people to function in a constricted, elitist style. They learn to accept crushing compromises in their original conceptions because they appear to feel there's nowhere else they could get paid as well to do their thing as well. Despite peteles and frustrations, the bright young men keep coming, and, as they accumulate, it becomes easier to attract new ones; hence, new project-grants; hence more bright men, etc.

Central to this progress-packaging and personnel processing is, of course, an increasing need to mobilize public tax dollars and public opinion for the support of Einstein-Montefiore's needs and agenda. We have already noted the degree to which, as "private" institutions, Einstein and Montefiore have built their institutional empires on public tax dollars, land and institutions. Nowhere else in the City is the private regional consolidation of municipal hospitals as pronounced. Fordham is the only City hospital outside the Einstein-Montefiore grasp, and many say the months are numbered until either it or its private affiliate, Misericordia, falls into the network.

Floating Crap Game

With such heavy reliance on public resources, Einstein-Montefiore has had to take an increasingly active role in molding opinion and policy determination. William Glazier, Einstein's associate dean, served previously as staff director for the Piel Commission, whose Corporation idea for City health services was later promoted by Dr. Cherkasky—or vice-versa? Dr. Cherkasky also serves on the City tax-supported Health Research Council (which recently awarded Einstein-Montefiore a major grant for borough-wide planning), on the Blue Cross Board of Directors and on Health and Hospital Planning Council committees. Concerned with popular opinion as well as public policy, Cherkasky maintains a hefty public relations staff to handle and arrange interviews for TV, Congressional Hearings, and national magazines.

A consequence of Einstein-Montefiore's heavy public funding, especially of the special-project variety, is considerable freedom for the administrators from the prestigious and busy lay trustees. The trustees have little to say about the extramural activities funded directly from Washington or out of individual private family or foundation pockets. Many of the research and program grants come through Montefiore's Administrator's or Einstein's Dean's office as lump sums and are mixed in mystic financial ways, impenetrable by post factum audit, let alone by priority-setting. Other grants come through "in the name of" individual faculty or staff and are outside the purview of trustees. As one trustee reportedly described his role, "We are sitting on top of a floating crap game and all we can do is say yea or nay to the administrator or dean being check-signers."

Thus, the relationships which individual administrators and staff develop in the system of financial support—from HEW advisory committees and NIH project committees, to foundation, philanthropic, Blue Cross, regional Health and Hospital Planning Council and State-Local government command posts—frequently become the de facto base of
personal power within the institution. Internally, the Einstein-Montefiore institutions are structured along the now classic lines of post-war biomedical research grant baronies built in particular departments. In addition, at the top levels, general administrators are able to do their own empire-building on a massive scale outside even the control of the lay trustees. At all levels, institutional leaders are essentially accountable to no one but their own professional honor—even for that extra electron microscope stored in a crate in the basement, or for those sub-specialty clinics they’ve organized to match their research needs rather than the needs and convenience of the community. Unaccountable and unfettered by lay or public supervision, the Einstein-Montefiore departmental and institutional leaders have become the avant garde of the new class of bio-medical and socio-medical entrepreneurs.

Absorb And Pre-empt

Having accumulated such vast resources and power, the empire builders have found it in their interest to begin “rationalizing” and “consolidating” the empire. One reason for rationalization is to lower the Empire’s overhead costs and maximize its funding base (although some private trustees are complaining that, for example, Montefiore is “escaping” its alarming costs at home base by new enterprises elsewhere). An overriding objective is to carry out preemptive organizational reform (at least in rhetorical terms): (1) to prevent the development of any serious movement for a broadly accountable, truly public health system for the Bronx, and (2) to prevent the emergence of insurgent community and health-worker forces demanding control over the health services on which they so urgently depend.

The consolidation-rationalization effort is itself a kind of demonstration project, with a special grant (from New York City’s Health Research Council, the Rockefeller Foundation, etc.), and burgeoning special staffs. The market for the “Bronx plan” and similar efforts is the national corporate managers and local power structure leaders. In their growing concern about ghetto rebellions, urban fiscal crises and uncontrollable costs of medical care, they are turning to the more activist and prestigious wing of medicine (exemplified by Einstein-Montefiore) to cure our sick medical system. Another source of encouragement for these kinds of “rationalizing” efforts is the growth of the health hardware and “systems” industries. Aircraft companies such as North American, conglomerates such as Litton Industries, and consulting firms, such as Einstein-Lincoln Hospital’s contractual management consultant, U. S. R. & D. Corporation, Bill Haddad’s operations firm, are realizing that the existing chaotic health non-system must be in more integrated entrepreneurial hands to be a good market for heavy computer hardware or for sophisticated private consultation services. Thus, for a variety of reasons, national corporate leaders are encouraging Einstein-Montefiore’s “rationalization” of the Bronx.

Less Than Meets The Eye

A natural law of many well-promoted medical demonstration projects is that the farther one gets from the project’s patients, the better the project looks. Einstein-Montefiore is perhaps as much or more involved in service than any other major medical center in the nation—but it is no exception to this law. For all its declarations about social commitment, the Empire has barely scratched the surface of meeting the desperate needs in its “region,” especially in the South Bronx. As this and other medical empires are under more and more public attack for their failure to deliver even with what they’ve got, the promoters become all the more “radical” at laying the blame elsewhere. They cite the City’s bureaucratic red-tape; severe national underfinancing (and mis-regulation) of research, care and education; and, of course, the general social chaos of the nation. These exogenous difficulties are, of course, part of the story. But the empire-promoters are seldom able to face their own responsibility honestly, and to say, as Pogo was once quoted as saying, “We have seen the enemy and it is us...”

Einstein-Montefiore’s claims for its borough-wide network of City hospital affiliation programs are staggering. And well they might be. Affiliations are the glue that holds its many facilities together as an Empire. Dr. Cherkasky was a prime mover behind Commissioner Trussell’s Affiliation Plan to attach all City hospitals to private centers through affiliation contracts which are little more than loose, cost-plus gentlemen’s agreements. [See HEALTH-PAC’S BURLAGE REPORT for a detailed critique of the Affiliation Plan.]

Claims have been lofty. Dr. Marcus Kogel, now vice president of Yeshiva University for Medical Affairs, has been quoted as praising the Einstein-Lincoln City Hospital affiliation (from Pediatrics alone in 1958 to full affiliation of professional services by 1966), with reference particularly to “demonstration” programs in the community:

“... not only in furthering program development on a community level, but in repairing the image of Lincoln Hospital in the community—an image that had been deteriorating during the 10 to 15 years prior to affiliation.”

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In 1967, Dr. Cherkasky said of Montefiore's affiliation to Morrisania, a City hospital:

"The affiliation has, over the past five years led to a vast improvement in the level of care. The provision of professional services and the sophistication of certain services parallels an enormous increase in the utilization of Morrisania... The improvements that have been realized at Morrisania are a result of continual pressure exerted upon the Department of Hospitals." [Both quotes above from the United Hospital Fund's report, "A Partnership in Progress: The Affiliation Programs of the Municipal and Voluntary Hospitals Serving New York City." November 1967.]

In fact, at both Lincoln and Morrisania there have been some improvements in physician staff numbers and education levels. (Although numerous physicians have been dis-affiliated; actual consulting, attending, and supervisory physician-time has been padded; and service organization has often been even more fragmented.) More certified training programs and more specialty services for patients are "available." (But the patient remains helpless before the hospitals' fragmented organization.) On its part, the City has accelerated some renovations, equipment purchases and other procedures for these and other hospitals. (It is questionable whether this is necessarily due to the affiliation program.)

But the affiliation program was touted to achieve much more than these limited benefits. In their early advertising for (and recent defenses of) the affiliation program, private medical leaders promised to provide effective leadership to totally re-shape Municipal hospital services. Recent quantitative indicators, on-site interviews and observations, however, show that Einstein-Montefiore has seriously defaulted on these crucial leadership functions of total services reorganization and outreach in programs. For instance, Dr. Cherkasky has stated that Montefiore is responsible (under the affiliation contract) for "the same ideal of clinical excellence that prevails in Montefiore." But, notwithstanding Montefiore's own limitations in delivering comprehensive patient care to the neediest population, a study by Yale Public Health School hospital administration analysts three years ago stated that house staff rotating between Montefiore and Morrisania hospitals considered Morrisania a secondary responsibility. Both observation and recorded evidence revealed that the staff also treated Morrisania patients with less skill and concern. Where do house staff learn such explicit discriminatory thinking, if not from their academic and professional superiors?

Who Heads Services?

Some of the more concerned house staff members in both institutions have protested the lack of leadership for comprehensive medical care shown by the private hospital and college medical chiefs and supervisors.

There is little or no encouragement by the teaching "faculty" supervisors to integrate services to meet the patients' needs. The faculty could, for instance, demand that primary care can be given in specialty clinics, so that for the large number of patients in such hospitals under special treatment and with practically no other sources of medical attention, routine problems (colds) and preventive tests (pap tests) or preventive medicine (immunizations) would be coordinated and assured. The faculty could emphasize continuity of care which would insure both primary care and adequate followup (as it is now, lab tests may show abnormal results, but there is no attempt to locate the patient and treat him). Continuity of care could be improved by introducing a system wherein fellows, residents and interns see the same patient in the outpatient clinic. Communication with the patients could be improved if all students training at Lincoln, Morrisania or Jacobi hospitals were required to know Spanish. (In the Lincoln pediatric outpatient clinic, for example, there is only one interpreter, and she was hired in December 1968.)

Despite all the self-congratulations about academic and teaching hospital-staff recruitment, even this record is not as shiny as the promoters insist. Much larger contingents of "American-trained" interns have been attracted to Morrisania and Lincoln. (It is questionable whether "American-trained" automatically assures good medical care—not to mention the implicit racist slur against "foreign-trained.") Out of the 24 pediatric house staffers at Lincoln only two are American-trained persons—one intern and one resident. Furthermore, of 70 existing resident positions at Lincoln (1966-67 figure), only 49 have been filled and 37 of these by foreign-trained people.

Despite the fact that prestigious Montefiore held the only City hospital affiliation contract for professional nursing—with lucrative overhead and recruiting charges—a 1967 study showed that only 28 out of 140 authorized professional nurse staff positions were filled by Registered Nurses. (Although some improvements have been made since that time, this only about matched the dismal recruiting record of the City—34 of 176 such staff positions—at Lincoln).

Proud To Be Popular

The Empire promoters like to point to the increased clinic utilization at Lincoln and Morrisania as evidence of how "popular" these hospitals have become since the affiliation programs began. True, emergency room and outpatient department visits at these hospitals practically doubled between 1960 and 1967. However, many close observers (including house staff, attending physicians and paramedical personnel) attribute these visit increases not to increased hospital "popularity," but to the deterioration of alternative sources of care and to the growing fragmentation of hospital clinic care. As sub-specialty clinics multiply, in accordance with academic interests, patient visits multiply in the increasingly desperate search for comprehensive care. Visits are also wasted on unnecessary diagnostic procedures—sometimes performed for research purposes—and because of sheer confusion—missing charts, language problems, etc. Of course, it is impossible to determine just how many visits and procedures really are unnecessary because the keeping of medical records has been so chaotic and episodic. Thus, what the promoters call a "broad spectrum of new services" and "excellent opportunities for establishing new integrated programs in specialties" (Dr. Trussell in UHF report cited above) turn out to be an unscannable spectrum for the patient.

The affiliation programs have achieved some new administrative contact among the various hospitals (and have also created dual City-Empire administrative snarls). But there has been far too little real service coordination. There is no continuity of medical records between the
Empire's hospitals and sometimes not even much cooperation. For instance, if a patient is referred from Lincoln to Jacobi for specialized treatment, Lincoln does not send his medical record with him, nor does Jacobi bother to send Lincoln a record of what happened during specialty treatment. Women who have received prenatal care at Lincoln are often sent out of the Empire, to Manhattan's New York Hospital, to deliver—again without records.

But the harshest indictment of the Empire's performance in its affiliation programs can be heard from the people who have to use its Municipal hospitals. People know that Morrisania and Lincoln are used by Montefiore and College Hospital as "dumping grounds" for medically uninteresting and poor patients. The people whose lives depend on Lincoln still call it the "slaughterhouse" (the same old image) and often refuse to go there until they have no other choice. For example, because of their experience with Lincoln, the Hunts Point People's Health Center leaders want Jacobi as their back-up hospital, even though Jacobi is much farther away than Lincoln.

The South Bronx is a disaster area for personal and environmental health. Its proportion of "dependent age" health services users (over 65 or under 16) is the largest in the city. Its general dependence on Municipal hospitals, "general service" baby deliveries, and public ambulance service is the greatest in the city. Its rates of too-late and no prenatal care are among the worst for Municipal hospitals. The area's venereal disease, chronic disease, and infant and maternal mortality rates are among the highest in the city; early findings of recent studies reveal the city's highest rates of lead poisoning in children; dilapidated housing, garbage-heaped streets, and polluted air are as serious as anywhere in the city. Certain areas of the South Bronx have less community-physician coverage than the physician-to-black-citizen ratio in Mississippi. One-third of the borough's residents must go to Manhattan for hospitalization, even in emergencies, primarily because of the shortage of medical resources in the South Bronx. Clearly, without massive amounts of direct public disaster-area relief, the people of this area face a catastrophic social breakdown.

The Empire claims that if anyone can solve the health problems of the Bronx, it can. The managers of the Einstein-Montefiore Empire have been working in the Bronx for many years. How has the Empire "solved" these problems? Can the Empire perform competently even those tasks it sets for itself? Let us look at the record.

Battle of the Beds

In the late '50s and early '60s, certain Einstein-Montefiore leaders supported a plan to close all three Municipal hospitals serving the South and Southwest Bronx. This plan, revealed in early reports of the Hospital Review and Planning Council (now the Health and Hospital Planning Council), would have shifted Morrisania's beds north to Montefiore, revealed in early reports of the Hospital Review and Planning Council, would have closed Lincoln and Fordham, and would have left South Bronx residents almost completely dependent on Bronx Municipal Hospital. This plan (had it been implemented), coupled with the subsequent closing of St. Francis Hospital, could only have been described as a policy of genocide via medical slum clearance. [See, e.g., Peter Rothstein's 1968 study, "The Closing of St. Francis Hospital."

Community leaders came to the rescue of Lincoln and Fordham. Herman Badillo, then candidate for Borough President, made Lincoln one of the key issues in his campaign. Fordham required Mayor Wagner's intervention against an adamant Hospitals Commissioner Trussell during the 1961 mayoral election. Morrisania was later parcelled out by City, HHPC, and Montefiore officials between Montefiore's grounds and the possibility of a new building on the old site, but later.

Montefiore officials were also closely involved in the HHPC's decision to limit the new Einstein College Hospital to 329 beds for highly specialized treatment, thus denying vital treatment services to severely needy patients. Another result of this limit has been the creation of a backlog of critical cases in other less specialized hospital services in the borough. HHPC, with Montefiore's nudging, has also discouraged the building of more nursing home beds in the borough, especially under proprietary or non-Empire auspices. Meanwhile, the effective demand for such beds and services is skyrocketing, especially since the enactment of Medicare.

After literally standing back and watching the financial deterioration of College Hospital (chiefly because of low reimbursements from Blue Cross—of which Dr. Cherkasky is a Board member—and the City), Montefiore management "offered" to take over the Hospital to raise its reimbursement rates to the current Montefiore level. At the orientation session for the new Montefiore regime at College Hospital early this year, Dr. Cherkasky hinted that it was only a matter of time until Jacobi and all of Bronx Municipal Hospital Center also enjoyed Montefiore's managerial embrace. Some people see Lincoln coming into the embrace too. However, numerous chiefs of services at College Hospital believe that this kind of big-business "conglomeration" lowers morale rather than improving internal institutional functioning.

Montefiore runs the only operating "Neighborhood Medical Care Demonstration" in the borough on OEO funds, while...
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Einstein opened the first operating decentralized community mental health units in the City, including the recently embattled Lincoln Mental Health Center. But these are currently "covering" only about 10,000 persons each in areas where perhaps 700,000 need such convenient service coverage. In the face of cuts and fragmentation of State Medicaid funds, private institutions' lack of interest in serving a back-up function, uncertainty about national OEO and HEW funding, and HSA under-staffing and foot-dragging, one HSA official estimates that more new services for the South Bronx are at least a decade away. Some new Federally-funded hospital-based maternity, infant, and pediatric programs have been established at Lincoln and Jacobi, but so little convenient primary ambulatory care is available in the South Bronx that most residents flush with anger when they hear the usual exaggerated reports of its delivery. Some close observers in the South Bronx suspect that in all such new programs under Empire auspices, compounded overhead costs and sheer juggling of funds are producing tremendous waste of resources. They cite as an example, a $500,000 grant (for a new multidisciplinary clinic) that most residents flush with anger when they hear the usual exaggerated reports of its delivery. Some close observers in the South Bronx suspect that in all such new programs under Empire auspices, compounded overhead costs and sheer juggling of funds are producing tremendous waste of resources. They cite as an example, a $500,000 grant (for a community mental health program component) which resulted in only one new professional on the payroll. Despite general sympathy for the medical empire approach, one member of the Community Mental Health Board has been quoted as saying, "If we want to have any idea of the actual use of public funds, we shouldn't give all the grants to [Einstein-Montefiore]."

Counter-Insurgency

The quasi-monopolist's position is never entirely secure. There is always the need to consolidate the organization more closely: to move into new areas of control; to preempt or play off against each other potentially independent forces.

Hunts Point (Southeast Bronx) residents' struggle to develop their own decentralized community-controlled "People's Health Center" through their Community Corporation was given a year-long runaround by the Empire, through which it sought back-up facilities cooperation. (Hunts Point has other problems too: Lacking the fund-raising acumen and resources of the giants, it has recently received a Federal grant of half the amount it requested.)

At Co-op City (now being occupied although lacking vital medical and social services), planners are discovering that medical costs are so inflationary and hospital and physician revenues so scarce that even middle-class people simply cannot afford a comprehensive, prepaid, group practice medical program without large Federal grants or reinstatement of Medicaid. The attempt of the Co-op City developers and citizens' board to plan an independently-controlled program with its own contract with Einstein-Jacobi was reputedly headed off by Montefiore officials who saw this new market as essential to beefing up their own sagging Montefiore Medical Group. MMG is the most expensive such medical group practice in the City. It is so expensive that its backbone subscriber, the Teamsters Union, is pulling out. Evidently to preempt the development of an independent medical program in Co-op City, Dr. Cherkasky is putting MMG-related physicians in fee-producing offices in the new housing area.

Officials and program promoters of both Einstein and Montefiore have responded to the Lincoln Mental Health strike and takeover with intensive manipulation. As one prominent New York City health affairs reporter put it, based on his observations during the Lincoln challenge, "They aren't used to being straight with the public—they're just for press releases and making their own deals on the phone."

Community residents were particularly angered by the attempt to play off ethnic and organizational groups against one another. The Lincoln Hospital Community Advisory Board was called together by the Einstein-Lincoln administrators for its first real meeting in three years. This was an attempt to create an instant buffer between the Einstein-Lincoln administration and the community workers at the mental health center. The Lincoln "board" was chosen by the Administration from among "visible" leaders of a community that is predominantly Puerto Rican; much of the leadership of the workers movement at the mental health center is black.

Residents of the Hunts Point and Lincoln Hospital areas depend on the Einstein-Montefiore Empire for vital health services; both groups, therefore, were extremely vulnerable to threats and promises "from above" regarding those services.

In recent years, the Empire has been the home of the health and mental health "new careers" rhetoric and "movement." The Federal legislation supporting such programs was pushed through by Bronx Congressman James Scheuer. Frank Riessman, head of the national New Careers organization and author of the "bible" of new careers, did his original thing with community mental health aids around the Lincoln Mental Health Center. Dr. Tom Levin is doing a major foundation-funded report on a new health careers program and curriculum based at Lincoln Hospital.

The King-Kennedy program for boosting the disadvantaged into medical school has been launched by Einstein. However, only one disadvantaged Bronx resident was admitted in the small crop of such medical school entries this past year, although the number is due to increase next year. And the Einstein administration and faculty have turned down student-community demands for expanded and guaranteed medical school admission for program participants.

Medical Miseducation

Einstein student groups have expressed through direct action their dissatisfaction with the obvious irrelevance and the elite bias of their curriculum, even the "community and social medicine" curriculum. The students want to hear more from the surrounding community itself.

Both community residents and students are demanding a totally new system of medical educational opportunity and content.

The contradictions of empire promotionalism also come in more direct forms. While Dr. Cherkasky praises the voluntary, regionally-planned, non-fee, scientific approach to medical care before one Senate subcommittee, the chairman of the Einstein Pharmacology Department responds to a request from the Pharmaceutical Manufacturers Association and writes to another Senate committee as an apologist for brand-name drugs. This department head also serves as a consultant to three drug companies. Physicians associated with the Montefiore Medical Group collect fees in Co-op City, and physicians split fees with each other and the Montefiore administration to produce just about the costliest medical service in the city.

Meanwhile, Montefiore recently purchased the old Riverdale Motel. Holiday Inns, Inc. is moving rapidly into the nursing
home business as the Medicare market grows. Should one expect a merger over the next decade or so?

This situation's existence is the result of Empire priorities: academically-interesting over primary medical care, managerial solutions over service solutions, elite grantmanship and "expertise" over control by those most dependent on and therefore most intensely concerned about the quality and accessibility of medical care. With all its liberalism and non-profit promotional rhetoric, the Einstein-Montefiore Empire in many ways fronts for the same old kind of medicine show.

"The Plan"

"The Bronx is Einstein's community," states one of the Medical College's successful foundation proposals, which goes on to lay out a sweeping plan for reorganizing and developing the borough's health services. The overall idea has been to back up the creating of a regional health "authority" or "corporation" through which skilled administrators could use public funds to mobilize private institutions to pool their efforts and solve the Bronx's problems. Dr. Cherkasky has maintained in the past that the key to successful regional services development would be delegation of full control of City, State and Federal monies to such a borough-regional "authority."

Dr. Cherkasky stated in an interview last fall that he foresaw a strong board for such a borough health "authority," including trustees and medical leadership from private institutions, City officials, union representatives, and "the community." He expressed confidence that Einstein-Montefiore has the quality and commitment to provide effective leadership for the authority, although Einstein-Montefiore need not run it directly. (Dr. Cherkasky does keep pointing out, however, that expertise is required to accomplish the task, implying that people must finally turn to Einstein-Montefiore, since that is where the expertise is. He also asserts that the community "better be ready," because he and others plan to "really do things" through the new regional authority.)

The key rationale for the regional authority, based on interviews with its chief architect(s), is to achieve economies of scale, by centralizing services such as laundry and laboratories, and to prevent wasteful duplication of large capital investments (such as cobalt units) and medical capacities (such as for heart transplants). Presumably, the costs saved through these efficiency measures could be applied to creating new services for desperately needy areas such as most of the South Bronx.

About $1 million has been promised to Einstein-Montefiore over the next five years to support this "regionalization and development" planning process for the Bronx. These grants have gone to the medical school, and in some cases directly to Einstein's Community Medicine Department, including such new units as an "Urban Health Affairs Research Unit" and a "Hospital and Health Authority Planning Unit."

Regional Solo Practice

Strangely enough, no one seems to know what this "Bronx plan" or authority is really all about. Even the officials of the Health Research Council and the Rockefeller Foundation, which together have committed the lion's share of the dollars on the basis of vague prospectus language, profess to know no more than what they read in the papers. Staff in the Montefiore Administrator's and Einstein Dean's offices and in the Einstein Community Health Department declare that nothing has gotten underway except a few chats, although a number of persons have been hired as "urban health research planners," etc. Dr. Cherkasky's leadership in this mythic planning process—as chief promoter and head of both the key College department and the principal hospitals involved—has been described by some skeptics in the same terms Cherkasky reserves for the fee-for-service solo practitioner: episodic, fragmented, arbitrary, unaccountable, and not done on a team basis.

Supposing, though, that the Empire's leaders are serious about a super-plan for the Bronx—are they capable of doing it? Can the staff people in the Empire really know all problems and find all the answers, as Dr. Cherkasky seems to imply? Can we believe that they will no longer rely on hit-and-run "demonstration" projects, or on bed-ratio rationalizations cooked up by the Health and Hospital Planning Council? Are they capable of planning services, as opposed to legal structures, such as "corporations," which are assumed to

—Mills Matheson
Medical Student Intern

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get the job done just because they're there? Let's take a look at the assumptions of the Empire's super-planners—is their planning really a "science"?

First, the Empire's leaders assume that "the Bronx" can be planned for as a single homogeneous region. Is "the Bronx" really homogeneous or is it a fictional region that covers over the true social and political diversity of its people? Within the Bronx, the range of communities goes from suburban middle-class Riverdale and sub-Westchester to the medical environmental and economic disaster area of the South Bronx. Going southeastward from Riverdale, the infant mortality, TB, VD and drug addiction rates rise more than double. Who should have the clout and the "capital" for health planning in this polyglot "planning unit"? The suspicion is that any new borough-wide authority would be dominated by "Riverdale and Westchester," which is where these major private institutions and "their" doctors are, but not where the most acute problems are, although striking unmet medical need is borough-wide. In a vast and unwieldy "planning unit" like the Bronx, who would set priorities, who would guarantee equality of services?

Second, the Empire's leaders assume that only they have the expertise and skills to offer efficient, modern leadership to the Bronx. But Einstein-Montefiore already has a near-monopoly on health services in the Bronx. It has had opportunities to rationalize and streamline services within the Bronx—to achieve continuity and comprehensiveness of care. Still, as noted above, the Empire has hardly begun. Has the Empire been waiting to be formalized as an "authority" before revealing its reputed "expertise" at rapid, efficient, equitable delivery of health services?

No one could deny that there are many clear gains to be realized by more borough-wide planning and regionalization. Considerable economies of scale could and should be achieved by centralizing resources such as laundries, laboratories and computers, and by rationally distributing certain specialty services. But to whom will such economies accrue? Will the benefits, if any, pour into basic service improvement? Or will they flow back to support research, planning, "systems" development and sub-sub-specialty staffs at the nerve center of the already top-heavy Empire? (Of course, even super-planners can't sustain themselves on funds alone for long—they need data. When the health delivery system deteriorates of the already top-heavy Empire? (Of course, even super-planners can't sustain themselves on funds alone for long—they need data. When the health delivery system deteriorates.

"Cherkasky's Law"

Recently, Dr. Cherkasky has begun to show a new modesty about the "Bronx plan," suggesting that he may no longer want a formal "authority" or even a master-planning process. In fact, he may have begun to consider it as more of an obstacle than an opportunity. Even without an "authority," centralized lab, laundry and computer capacity probably could be developed under the Empire's control, particularly if its own private hospital management network were tightened (known as "Cherkasky's Law" of empire expansion). First tighten Jacobi and Lincoln affiliation management—then the world. "Loose ends" among the Bronx's health facilities, such as Misericordia-Fordham, St. Barnabas, Bronx-Lebanon and a few neighborhood health centers, could be folded under the Empire's umbrella in some private "affiliation" capacity. The planning and regulatory demands of the City could be temporized or rhetorically absorbed indefinitely. And maybe even the service and control demands of the community and workers can be kept at bay (or played off against each other) for a long time to come. If so, maybe it's just as well not to tie up the Empire in some kind of legal structure which would have to involve public officials, neighborhood people, union leaders, etc. If you already have the authority, why bother with an "authority"?

Many promoters and staff in the Empire have been more "modest" all along. William Glazier, Assistant Dean for Community Affairs at Einstein and former staff director of the Piel Commission [See BULLETIN No. 1 and special Winter 1969 issue on the Corporation], has said that there are no easy answers for the Bronx's problems. According to Dean Glazier, Einstein-Montefiore's most important role might be in cleaning up its own house, rather than asserting borough-wide leadership. Community-oriented health professionals like Dr. Howard Brown (former City HSA chief and now at Misericordia and Einstein's Community Health Department), Dr. Harold Wise of the Montefiore Neighborhood Medical Care Demonstration, and Dr. Tom Levin of the Lincoln Mental Health Services all contend that the only solid building blocks of regional health services development are new programs at the neighborhood level.

Thousands of Bronx residents, from Co-op City to Mott Haven, share their view: Planning regional super-structures before planning primary care at the neighborhood level is putting the cart before the horse. To be sure, services must be coordinated and regionalized on a borough-wide and even a city-wide basis under clear public control—but the services which are most needed must be created as top priority before an effective "basis" for regionalization is achieved. The question is not how to prevent duplication of heart transplant and cobalt units, but how to create access to basic, routine care. The question is not how to curb waste of facilities, but how to stop the waste of lives.

Paper Dinosaur

Dr. Cherkasky refers to the Hospitals Department and City Hall as the fiscally-choked "dinosaur." Is his own institutionally and professionally-choked Empire any less of a "dinosaur" in the path of the delivery of health services to people?

A dinosaur, if its true nature is recognized, can be deeply vulnerable. From its small brain center it may appear that the capacity to serve grows only out of one's direct proximity to the upper granting echelons and the most prestigious scientific and institutional elite. But, once people recognize that the decisions are not only about complex scientific means to achieve well-known ends, but about who shall live and who shall die, and who shall pay and who shall profit—then they will demand to participate in and shape these decisions.

As the Lincoln Mental Health Center community-workers have so dramatically demonstrated, the capacity, the commitment, the knowledge, and the energy to generate a new service environment in the system can rather start at the feet, most sensitized to the actual environment, its challenges and its potential new human resources.

—Robb Burlage
THE WORKERS WHO TOOK CONTROL of the mental health services at Lincoln Hospital on March 4 no longer talk about "whether," but "when" to escalate the struggle for worker-community control to the entire hospital. What began as a para-professional revolt for redress of grievances, spurred by the firing for four fellow workers, has grown significantly—both in professional and community support and in awareness of the powers they are up against.

More and more South Bronx community people—including patients who use the services, local priests and nuns, members of the Black Panther Party, and members of local social service agencies in the Lincoln Hospital area—are attending worker strategy meetings. The central demands of the occupying forces are that former administrators, Drs. Harris B. Peck, Seymour R. Kaplan, and Melvin Roman, be officially suspended; and that a representative community board with responsibility for setting all policy for mental health services be instituted.

A negotiating team (including blacks, Puerto Ricans and whites, para-professionals and professionals) has steadfastly carried these demands to the other parties involved: Albert Einstein College of Medicine-Yeshiva University, and New York City's Department of Hospitals and Community Mental Health Board. At the same time, the revolting workers and professionals are continuing to provide services in the mental health clinics and day hospital.

Shortly after the workers' takeover, the City declared the services closed, saying the ousted Einstein administrators could not be held medically responsible for the services. Within a few days, knowing that State and Federal funds were jeopardized by the closing, the City ordered the services reopened.

Threats of malpractice suits and loss of salaries and manipulated moves on the part of Albert Einstein to pick off and co-opt some of the leadership (hoping thus to create a black-Puerto Rican split) has galvanized the worker-community struggle. Power is the name of the game. Ironically, the workers on the negotiating team found themselves feeling sorry for Dr. Peck. When the doctor attempted to explain his position during negotiations, his superiors in the Einstein Empire rudely cut him off. Commented one worker: "If they don't even take care of their own, how can we expect them to take care of us?"

The para-professional workers (almost all black and Puerto Rican and from the community) are angry. In taking control of the mental health services, they charged the (white) administrators with "malfeasance, inefficiency, chaos and racial discrimination." Many had been hired over three years ago as part of a "new careers" program designed to train indigent community mental health workers. One of the top rungs on the para-professional ladder which a worker was supposed to be able to attain was "community organizer." But an administrative decision was made that no one without a college degree could hold this position. (In fact, a middle-aged, white organizer without a college degree was hired on the basis of his experience as a union organizer.) Several of the community mental health workers were given the opportunity to go to school in order to qualify. In retrospect, the workers interpret the "college education plum" as a device to pick off and neutralize the more militant workers. In the meantime, the so-called "Community Organizing Department" of Lincoln mental health services, according to a dissident worker, "has been sitting on its hands...most of the mental health workers assigned to that unit have been farmed out to other units because they don't have anything to do!"

The mental health services actually became bogged down in the liberal rhetoric in which they had been floating since the inception of the center. As a result, within a few hours after the worker takeover, the cries of "worker power" became "community control." One of the workers from the day hospital (who had been picked to attend Yeshiva University) accompanied a group of strike-supporting Albert Einstein medical students to a confrontation meeting with Dean Harry Gordon. He demanded to know from the Dean: "Is this Yeshiva's program, or is this a community mental health program?" This worker, who is ready to sacrifice his college "education" and his paycheck, wants a new boss. He described the decay in services: "When I first came here we dealt with the people's needs. If a man was depressed and he lived in a rat hole, we went out and we helped move him. We carried his bed on our backs. In other cases, we started putting pressure on landlords. And then the word came down from the 'man...'. We don't move patients anymore—Einstein says we're not covered by insurance. Pressure on landlords? We've been ordered to cool it. In the case of one of the landlords, word came from high up. We found out later that the landlord was a big contributor to Yeshiva..."

Rumors have been flying that the workers will be busted. Police and paddy wagons have been plentiful. With a bit of black humor, one worker commented: "They [the administration] don't know their own power. They would just have to threaten us with violence. If we thought we were going to be injured this close to Lincoln—and be taken there—we'd all throw up our hands." Then another worker added, "When we're ready to go to jail for the mental health clinic, we'll be ready to go for the whole thing."

—from a leaflet distributed by the LHMHS workers following the "bust" predicted in the story on this page.
Letters to Editor

And In This Corner . . .

Dear HEALTH-PAC:
I wonder if you are not too far over in the community involvement corner. I wonder if you have tried to work within the medical framework.

You say you believe in the “public turnkey.” I don’t believe you are realistic or totally correct. This is based on my experience working for a City hospital where we WANTED the community to be involved. I am currently working for an organization whose goal is to get the producers and the consumers of an area of health service to at least talk to one another.

First let me take a shot at the St. Francis Hospital. The only mistake made here was that the community was not involved in making the decision to close the hospital. The building was outdated, the staffing shortage acute and the finances a mess. Were I a citizen living in that area I would NOT trust my life to such an institution. When dealing with my life it should not be a matter of convenience but a matter of the best possible medical care. Isn’t that what medical planning is all about—with the addition of making the gap between the two a little less?

Now to community involvement. I was in an area that needed a Neighborhood Health Center. There were only three practicing physicians in the area. The neighborhood was fairly well organized but with limited cooperation between the organizations. It was a severely depressed area.

We went after non-government funding to eliminate so many of the strings. We went out in the community for six months and talked to anyone and everyone. Then we started to hold meetings in the hospital to elect a Board who would DETERMINE POLICY for the program. The Board was elected by the community with reasonable representation from each of the political factions. The Board elected its own officers, determined a chart of work, and asked for some training in finances.

What has happened? The community is happy because it is involved. There is no improvement in the medical care because there is no functioning Neighborhood Health program.

They cannot agree upon a site that also meets building codes. They have hired a staff of not just one or two key people but also the Home Health Aides. These are from the community, are on full salary, and are in continuous training. The result will soon be that they have blown their initial grant without ever improving medical care. They will have provided jobs and overtrained for them, but there are other programs for this.

When administration moves to give suggestions or pressures for action (like a site), there are loud meetings where the Establishment is accused of reneging on their agreements.

This is only one example. There are others less dramatic. They all point out you must put planning where the expertise is. BUT YOU MUST ALSO MAINTAIN AN OPEN DIALOGUE. The consumer and the producer must communicate . . .

Let me give one more simple example. A new Pediatric Clinic was being built, and the architects wanted to make life more pleasant for Mama during the always long and inevitable wait. So they planned cradles. Mama was then involved and said NO. We will not use them, but would find rocking chairs a marvelous help. This involvement is proper use of expertise and brings improvement.

Why don’t you evaluate your battlefield?
—Marie Hanson
240 East 32 St.,
New York City

Community Advocate

Dear HEALTH-PAC:
I have been receiving your HEALTH-PAC BULLETIN with a great deal of interest and I was delighted to see the recent issue on decentralization.

I, of course, agree with the ideas you express. There is every need for this kind of movement. I only hope that some of the experiences in the education system in New York are rubbing off on the health system as well. My own experiences lead me to think that the process is going to be very difficult and its success will depend upon the amount of advocacy and training given to community people themselves . . .

—Robert C. Bauxbaum, M.D.
Family Health Care Program,
Harvard Medical School, Boston

WE REGRET that the reference to the accreditation of the Columbia School of Public Health and Administrative Medicine on Page 11 of the November-December BULLETIN was in error. The school did not lose its accreditation in the early 1960’s, though it is rated weak in many departments by most people knowledgeable in the fields of public health.—Ed.