Editorial . . .

GIVE ME YOUR SICK, YOUR POOR . . .

NEW YORK CITY IS THE SHOWPLACE OF AMERICAN MEDICINE. IT HAS MORE HOSPITALS, MORE DOCTORS, MORE DOLLARS FOR HEALTH CARE, MORE MEDICAL SCHOOLS PER CONSUMER—AND MORE CONSUMERS PER SQUARE FOOT—THAN ANY OTHER AMERICAN CITY. WHATEVER'S HAPPENING IN HEALTH HAPPENS HERE FIRST, HITS HARDER, AND SENDS SHOCK WAVES OUT ACROSS THE NATION: BLUE CROSS RATE INCREASES, THE MEDICAID FIASCO, PUBLIC HOSPITAL BANKRUPTCY, HEALTH WORKER AND CONSUMER INSURGENCY.

Numbers alone don't tell the story of the New York City health enterprise. When it comes to forces which control the urban health resources, New York City actually has fewer than most cities. Here, solo-doctor power has long since given way before hospital power, and hospital power has already ceded before the might of the city's tiny handful of multi-hospital Medical Empires [see Page 9].

This centralization of health-power in the hands of a relatively few institutions is itself another New York City first. The trend to medical-corporatism is catching up across the country, as the AHA (American Hospital Association) begins to out-clout the AMA, as medical schools begin to enslave community hospitals, and as giant aircraft and defense companies begin to eye the emerging Medical Empires for sales of heavy electronic hardware. From Washington, health-head Egeberg (and his runner-up Knowles) look increasingly to the corporate strength of the Medical Empires and Health Insurance Companies to lift the country out of the debris left by 50 years of AMA hegemony, and to "rationalize" the cost-crazy health industry.

But New Yorkers have seen the previews, and they know better. So far the Corporate Giants have not thrown their weight in the interests of cost control, integration of existing services (even within single empires), expansion of services to the city's "medical deserts," or massive medical manpower production. In fact, in the city's major Medical Empires, health care itself is not the first order of business, but a by-product of elite research and training programs. Increasingly, however, the "business" of the modern Medical Empire has more to do with New York's actual business—real estate, banking and investment—than with anything medical. Boards of Directors of the institutions which head the city's major Medical Empires read like a "Who's Who in Commerce and Industry," not because the rich are charitable, but because the hospitals themselves are rich. Despite recent public funding setbacks, the city's top Medical Empires represent incredible concentrations of wealth, wealth which can be wielded on Wall Street as block investments, or exercised locally to re-shape neighborhoods through vast and profit-generating real estate and construction enterprises.

For much of this larger health "business", Blue Cross pays the bills. Through Blue Cross, funds flow from the pockets of eight million consumers into the accounts of the seven or eight key Medical Empires—no questions asked.

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New York City: A Nice Place to Visit, But

THIS FALL, as new interns, residents and medical students flock to New York City's medical mecca—and as health consumers' needs continue unmet—HEALTH-PAC attempts to provide a primer on important developments on the health scene.

That Blue Cross "makes us sick" was almost unanimously voiced by subscribers at a recent, turbulent rate increase hearing. What's really behind Blue Cross's plea of destitution? [See "Cross We Bear," Page 2.]

New York City health officials try to sell their bill of goodies—the Health and Hospitals Corporation and Comprehensive Health Planning—to the Feds as "demonstration" projects. [See "Demonstrations," Page 7.]

Medical Empires are in the news. This month, the oldtimers are revisited and the staff takes a peek at five newcomers. [See "The Empire City," Page 9.]

Is the Committee of Interns and Residents (which bargains with the City hospitals for house staff salaries) about to go the money-strewn path of the AMA? [See "CIR-cus," Page 15.]

The embattled Lincoln Hospital Mental Health Services continue to plague the Albert Einstein Medical Empire as an official investigation reveals maximum feasible malfeasantice and manipulation. [See Box, Page 10.]
THE BLUE CROSS WE BEAR

IN THE FACE OF UNANIMOUS OPPOSITION from labor groups, civic organizations, and the New York City government, the New York State Department of Insurance has granted Associated Hospital Service of New York (Blue Cross) permission to raise its rates by an average 43.3 percent. The only support for the Blue Cross proposal came from the voluntary hospitals. The rate hike was less than what Blue Cross had asked for. In fact, Blue Cross’ originally proposed rate hike was only one item in a proposal package which included benefit reductions, division of subscribers into additional subcategories for rating purposes, and a requirement for subscribers to pay part of the cost for certain benefits themselves. All of these were denied by the Department of Insurance.

Several New York politicians rose to the occasion. Governor Rockefeller announced he would again press for a system of universal health insurance in New York State. The Lindsay administration announced it would file suit in State Supreme Court to block the rate increases as “excessive.” City Controller and Democratic candidate Mario Procaccino also planned to go to court to challenge the increase on the grounds that Blue Cross was using inaccurate actuarial figures. None of these actions is likely to prevent the rate increase from going into effect by October 1.

On August 4, the State Insurance Department held a public hearing on the Blue Cross proposals. Although the immediate issue was simply whether Blue Cross should be permitted to raise its rates, many of the speakers used the occasion to raise basic questions about the current hospital cost crisis and the role Blue Cross has played in fomenting the crisis. With the decision made, the original Blue Cross proposal may seem to be of no more than historical interest. But Blue Cross, in addition to being the most important private financier of hospital care, has dreams of playing a major role in shaping and operating any expanded governmental involvement in the financing of health care. It is important, then, to examine how Blue Cross understands its dual relationship, with the public on one hand, and with the providers of care on the other.

The original proposal along with Blue Cross’ record reveals how Blue Cross, once a goal of reformers, has turned into a major obstacle to decent health care for the American people.

A Multiple Indictment

The indictment against Blue Cross has several counts. First, Blue Cross is providing less and less for the subscribers, at an even greater cost, while insisting that there are no alternatives. Second, Blue Cross has been unable or unwilling to act to control rising hospital costs, although it has the power to do so. It has not acted to protect its subscribers. Third, Blue Cross is providing less and less for the subscribers, at an even greater cost, while insisting that there are no alternatives. Second, Blue Cross has been unable or unwilling to act to control rising hospital costs, although it has the power to do so. It has not acted to protect its subscribers. Third, Blue Cross is wedged between the consumers and the corporate powers, there is a public sector. New York City’s health bureaucracy outweighs that of any other municipality in the nation, but it has never even weighed in for a bout with the private forces which control the city’s health resources. In their regulatory, functions, both State and City health officialdoms have been vague and permissive to the private sector ever since Wagner and Rockefeller set the pace of medical laissez-faire.

Wedge between the consumers and the corporate powers, there is a public sector. New York City’s health bureaucracy outweighs that of any other municipality in the nation, but it has never even weighed in for a bout with the private forces which control the city’s health resources. In their regulatory, functions, both State and City health officialdoms have been vague and permissive to the private sector ever since Wagner and Rockefeller set the pace of medical laissez-faire. Only under militant pressure from powerful consumer groups, for instance, did public agencies and City mayoral candidates move to block Blue Cross’ latest, most arrogant, rate increase proposal [see this page]. In its role as a health financier, the City over the last two years poured yet-uncounted millions of Medicaid dollars into the private sector, while Municipal hospital budgets were systematically depleted. In its service function, as the largest single hospital owner in the city, the public health agencies have been content for nearly a decade to maintain the City hospitals as a reservoir of rejects from, and “clinical material” for, the Medical Empires. To perform these functions more efficiently, the City has recently embarked on a plan, long promoted by the ideologues of the Medical Empires, to restructure the Municipal hospital system as a quasi-public, quasi-private corporation.

If New York City is to provide national leadership in the organization of health services for health service, the va­anguard will not be the Medical Empires, Blue Cross, Inc. or the public health officialdom. What makes New York City exemplary is the strength and sophistication of its mounting consumer/health worker movement for quality, quantity, low-cost care. The thrust of the movement, more often than not welling up from the Empires’ ghetto colonies, has been for community control of imperial resources: the right of people in their own defense to exercise control over the means of life. Now, in the last few months as public frustration over rising costs and sinking service has mounted, we see the beginnings of a second front, composed of middle and lower-middle income consumers. These people, the bulk of the population, are oppressed more at the point of payment than at the point of delivery of care. They face, not only local em­pires, but national and often international forces: Blue Cross, the drug companies, the commercial insurance carriers, and other items in the investors’ health portfolio. Both now and in the long-run, the struggle for community defense against the Medical Empires is linked to the nascent struggle for consumer defense against the medical industries. In New York City, the Medical Empires which have their feet planted on the face of the ghetto have their hands planted in Blue Cross’ pocket: The middle class can literally no longer afford to subsidize the health system which is exploiting both them and the poor.

Published by the Health Policy Advisory Center, Inc., 17 Murray Street, New York, N.Y. 10007. (212) 227-2919. Staff: Robb Borlange, Vicki Cooper, Barbara Ehrenreich, Oliver Fein, M.D., Ruth Glick, Maxine Kenny and Howard Levy, M.D. © 1969. Yearly subscription: $5 student, $7 other.
Cross's benefit structure has warped medical practice. For example, it finances essentially only in-patient benefits; as a result, ambulatory care, preventive medicine, and extended home care have received short shrift. Moreover, Blue Cross's influence in the planning of medical care facilities in the New York region has led to an acute shortage of hospital beds. Finally, it has become clear that Blue Cross neither can nor wishes to function in the public interest—it is the tool of voluntary hospitals, serving their institutional ends, which do not always coincide with the needs of patients.

The Blue Cross Proposals

Blue Cross proposed essentially to abandon "community rating" and shift to "experience rating." When it was first founded, Blue Cross charged all groups the same rate. The hospital expenses of the entire community were shared equally by high risk groups (generally composed of older and poorer people) and low risk groups (generally composed of young and middle class people). It was this policy, more than anything else, which won for Blue Cross its reputation as a community service rather than as just another insurance company.

In recent years, however, in response to competition from the private insurance companies, Blue Cross has started acting more like a conventional insurance company. It now offers groups of more than 100 members the option of being "experience-rated," i.e., of having the rates for the group determined by the previous experience of that group alone. Low risk groups tend to prefer experience rating, since then the rate charged them does not reflect the high hospital utilization of bad risk groups in the community. The groups which remain in the community-rated category are thus increasingly those groups who use a lot of hospital care.

In its proposal, Blue Cross requested permission to divide the community-rated subscribers (currently about 60 percent of the total Blue Cross enrollment) into three major categories: direct pay subscribers, subscribers in groups of over 100 members, and subscribers in groups of under 100 members. Each of these pools of subscribers would then be experience-rated. Worst hit by this method of setting rates would have been the direct pay subscribers. This group contains many disabled, retired, unemployed, or self-employed workers plus workers in very small marginal establishments. Some of these people have never qualified for a Blue Cross group. Others were covered by a group policy in a former place of employment, but upon leaving their job received a notice from Blue Cross saying: "The privilege of continuing your protection regardless of your employment status . . . is one of the many liberal features of your contract." Blue Cross requested a 36-57 percent rate hike for this group. At the same time, they proposed to eliminate the 120 full benefit day contract for direct pay subscribers and replace it by a new contract in which the subscriber would have to pay 33 percent of the cost of his first 10 days of hospitalization and 20 percent of the cost of days 31 to 120. The State refused to cut the 120 day contract, but allowed a 30-65 percent rate increase.

The members of the larger community-rated groups would also have been hurt by the terms of the Blue Cross proposal. Experience rating has been available to these groups for some time now, and the groups remaining in the community rated category are generally the high risk groups. Blue Cross proposed rate hikes up to 84 percent (which would have meant paying $283 a year for a 120 benefit day family contract). By subdividing the community-rated groups into several experience-rated pools, Blue Cross was concentrating its rate increases on those most in need of services and least able to pay for them. The State denied permission to separately rate large and small groups, and granted rate increases of 35-63 percent for the various contracts.

The Benefits Deteriorate

Meanwhile, Blue Cross benefits are deteriorating, for all groups. In addition to the proposed (but not granted) elimination of the old 120 day contract for the direct pay subscribers, a more subtle erosion of benefits is occurring for all groups. In the past, professional services such as those of the anesthesiologist, the radiologist, and the pathologist were billed as part of the hospital bill, and so were covered by Blue Cross. But in recent years these services are increasingly billed separately, and so fall under the coverage offered by Blue Shield instead. The latter is a less comprehensive form of coverage. Thus, without any change in the language of the

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Blue Cross contract (and without State Insurance Department action), subscribers are getting less as they pay more. Further, Blue Cross made no proposal to correct even the most glaring deficiencies in benefits offered by the present contract. For example, maternity care is still essentially not covered.

As a sop, Blue Cross proposed to add an ambulatory care benefit to its contracts. Critics have often charged that Blue Cross' benefits, by covering only in-patient care, have prevented the proper development and utilization of ambulatory facilities. Medically unnecessary hospital admissions, overlong hospitalizations, inadequate preventative care, ultimately poor medical care has resulted. In response Blue Cross proposed to offer coverage for outpatient diagnostic work as part of scheduled in-hospital surgery. If such surgery was not performed (e.g., if the diagnostic tests showed the patient not to need surgery), then the patient would have had to pay most of the cost himself. Thus the benefit really had nothing to do with ambulatory care. The State Insurance Department refused this Blue Cross request too.

Helpless Middle-Man?

Blue Cross stands indicted of trying to raise its own rates while cutting its already inadequate and unbalanced benefits. Blue Cross defends itself by claiming to be only a helpless middle-man. Hospital costs have soared and so Blue Cross, which only pays the bills, must increase its premiums. This argument might hold if we accept the increase in hospital costs as inevitable. But Blue Cross must accept part of the blame for the uncontrolled rise in costs too. Blue Cross has tremendous power to force hospitals to operate efficiently and rationally. In 1967, Blue Cross paid directly about 36 percent of the bill for patient care in voluntary hospitals in southern New York State. As intermediary for the Medicare program, an additional 32 percent of the hospital's total reimbursement passed through Blue Cross's hands. Thus Blue Cross, directly and indirectly, pays more than two thirds of the hospitals costs, but it makes virtually no attempt to control them.

Blue Cross claims that it scrutinizes hospital bills carefully, limiting itself to reimbursing the hospitals for "reasonable" costs. This, they claim, has been a significant factor in keeping costs down. One measure of their failure, however, is the fantastic variation between different, although similar hospitals in the cost of providing the same services. Blue Cross itself has provided figures showing that in-patient per diem costs in New York teaching hospitals in 1967 varied over a two-fold range, from $48 to $89. This variation existed in every component of hospital costs. For example, the hotel services component (meals, linen, etc.) varied from $9 to $21 per day, and the nursing services component varied from $12 to $23 per day. These variations compel the conclusion that some hospitals are much more efficient than others. But to Blue Cross, regardless of the hospital's efficiency, incurred costs are "reasonable"—Blue Cross pays the bill.

There are other components to the varying "reasonable" costs of running hospitals, which Blue Cross also does not see fit to control. For example:

- Blue Cross reimbursements cover the cost of hiring labor relations lawyers and consultants to help keep hospital employees from organizing themselves into unions. (See "Anti-Union Hospitals: Blue Cross Pays the Bill," by Joel Seldin in The Nation, July 14, 1969.)
- Blue Cross reimbursements cover the costs of hospital public relations men and their staffs.
- Blue Cross reimbursements cover the costs of unnecessary, underutilized, expensive, but prestigious programs and equipment. For example, Raymond Corbett, president of the New York State AFL-CIO, has pointed out that in New York City there are 15 open heart surgery programs, seven of which do 83 percent of the heart surgery while the other eight do only 17 percent. Four years ago the Folsom Committee noted that the number of high energy radiation units already installed in New York City was sufficient to serve a population more than twice as big as that living in the region.

A Fundamental Challenge

It is clear that really substantial savings in the cost of hospital care depend on fundamental rationalizations of the planning and running of hospitals and, indeed, of the entire medical care system. This, however, represents a fundamental challenge to the power of the men who presently plan and run the hospitals. And this is exactly what Blue Cross has shown itself unwilling and unable to do.

Blue Cross has undertaken energetic action to control costs in one way. The organization is a great supporter of planning of facilities [see HEALTH-PAC BULLETIN, July 1969]. The absolute upper limit on Blue Cross' liability is set by the number of hospital beds available to its subscribers. Hence Blue Cross seeks to limit the number of beds. It gives the Health and Hospital Planning Council (HHPC, the agency responsible for approving hospital construction plans) $100,000 a year, making Blue Cross HHPC's largest non-governmental contributor. No less than eight Blue Cross trustees and officers sit on the HHPC Board of Trustees (five of them are HHPC officers as well). Blue Cross describes its role on HHPC like this: "There is clear evidence that the amount of hospital care and, therefore, the community's total hospital bill, including that of AHS [New York Blue Cross] subscribers, is materially influenced by the amount of hospital facilities available for use. Hospital utilization among AHS subscribers was appreciably lower than for those in other Blue Cross plans. . . . This lower utilization reflects the active support AHS has given the concept of areawide planning for hospital facilities . . . AHS's active participation in these activities . . . has indeed "paid off" both for its subscribers and for the community at large" (from Blue Cross' filing with the State Commissioner of Insurance).

In 1969, occupancy rates in voluntary hospitals in New York City soared into the 90 percent-and-up range, and it became difficult to get a hospital bed even in emergencies. This is what Blue Cross means by a cost control measure that has "paid off."

Who Owns Blue Cross?

Blue Cross's failure to act in the interests of the community in controlling hospital costs should be no surprise. Blue Cross is, in large measure, the creature of the voluntary hospitals. It was set up during the depression by the hospitals, to enable them to spread their financial risks. It was set up under special State enabling legislation, and
Hearing From The Public

The Community Rating Principle

The original Blue Cross community rate predicated on the principle of distributing the costs of hospital care among a total population has totally changed in character. It now proposes to become a rate-making mechanism that forces the highest charges on those least able to pay.

—Mary C. McLaughlin, Commissioner, NYC Dept. of Health

Small groups [the better risk groups—ed.] must be protected from being forced to subsidize large, self-selected groups [the poorer risks—ed.].

—J. Douglas Colman, President, Associated Hospital Service of New York (Blue Cross)

The Co-Insurance Principle

People with plenty of money never have much difficulty getting into a hospital, so that practically, a co-insurance feature merely discriminates against the poor for whom 20% - 33% co-insurance would either create insuperable obstacles in obtaining needed hospital services, or force them to become a burden to the taxpayers.

—Raymond R. Corbett, President, New York State AFL-CIO

The [co-insurance proposal] is the only wise and non-discriminatory solution . . . Many crocodile tears have been shed for the plight of these subscribers by self-appointed defenders . . .

—J. Douglas Colman

Who Watches the Watchman?

Why hasn't AHS [Blue Cross] been the voice of the consumer? The reason is that AHS is dominated by people with an interest in medical income.


Nobody can seriously charge that any of this money is going to line the pockets of people like myself, or of my opposite numbers in our member hospitals.

—Megr. James H. Fitzpatrick, President, Greater N.Y. Hospital Association; Exec. Dir., Catholic Medical Center

Alternatives

We believe that the Blue Cross must enter the area of in-hospital doctor practice, and that the best approach is that of a Comprehensive Prepaid Group Practice Health Insurance Plan.


We propose that the State Insurance Department encourage actively a competitive force to Blue Cross which will represent consumers and therefore be able to bargain on equal terms with the hospitals.

—John J. DeLury, President, Uniformed Sanitationmen's Association

The New York State Insurance Department should mandate that within one year Blue Cross should revise its reimbursement formula so as to establish compelling financial incentives which will cause hospitals to economize.

—Teamsters Joint Council No. 16

We are profoundly concerned lest the application . . . should be rejected by the Department of Insurance in response to what may seem to be understandable but what are actually logically, socially, and economically unsound arguments.

—Clarence W. Duryea, representative of the Westchester County Hospital Association; Administrator, Yonkers General Hospital

I know of no workable alternatives.

J. Douglas Colman

Summary

Blue Cross acts as a front for the medical-industrial complex in order that it may use illness as a marketable commodity . . .

In spite of the fact that Blue Cross is a publically re-regulated public utility, it increasingly has hidden behind A Blue Shield of accountability and secrecy, increasingly functioning as a private, profit-making corporation, excluding those who most need care and charging most to those who can least afford it.

—Medical Liberation Front

although it receives all of its funds from its subscribers, there is almost no consumer representation on its Board of Trustees. The members who could be considered as “consumers” include three big businessmen (Con Edison, International Nickel, and Federated Mortgage Investors), several educators and cultural figures (who represent no one) and five labor leaders, at least two of whom come from unions most of whose members are not covered by Blue Cross. No less than ten out of 23 Board members (as of January 1969) were doctors, hospital administrators or trustees, or otherwise intimately associated with the medical establishment. A student who went to Blue Cross for information was struck by the information officer’s continual references to the hospitals together with Blue Cross as “we.” Thus when hospitals negotiate reimbursement contracts with Blue Cross, they are often essentially negotiating with themselves.

A petty example illustrates Blue Cross’ relation with the hospitals. The day after Blue Cross filed its rate increase proposal with the State Department of Insurance, a letter went out from Blue Cross Vice President Mark A. Freedman to administrators of its member hospitals, enclosing a copy of the filing and a lengthy question and answer sheet explaining it. To this date, three months later, Blue Cross has not seen fit to notify its eight million subscribers informing them that a rate increase was in the works. Indeed, when a member of the HEALTH-PAC Financing Workshop requested a copy of the filing from Blue Cross, he was informed by a high ranking Blue Cross staff member that he could not have it because “it hasn’t been approved yet” and, moreover, “he had no need of the information.”

The alliance of Blue Cross and the hospitals was demonstrated clearly at the hearings held by the State Insurance Commissioner on August 4 [see Box, this page], for some of

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the testimony). In opposition to the Blue Cross proposal was every group that could be construed as representing consumers: unions such as the International Union of Electrical Workers, Teamsters Joint Council 16, the Drug and Hospital Workers, and the Sanitationmen's Union, community service groups such as the Citizens Committee for Children and the Community Council of New York, and the New York City Department of Consumer Affairs and Department of Health. The opposition was virtually unanimous in going beyond the narrow issues and demanding that basic solutions to rising hospital rates be found. Most of the speakers put the blame for the uncontrolled rate rise squarely on Blue Cross in league with the hospitals.

Positive Genuflections

Speaking in support of Blue Cross were the hospital administrators. Msgr. James Fitzpatrick, President of the Greater New York Hospital Association, director of the Catholic Medical Center (and a director of Blue Cross) heaped scorn on the opposition. To those who questioned whether the money the hospitals receive is entirely used for patient care, he gave the less than relevant answer: "When was the last time you heard of a hospital administrator taking off for South America with a suitcase full of negotiable securities?"

Fitzpatrick was followed by Clarence Duryea, administrator of Yonkers General Hospital and representative of the Westchester County Hospital Association. Duryea considered demands for "efficiency" and good management as equivalent to demands for cuts in service, and commented that, to a sick person, "efficiency in hospital care is something that would be good for somebody else."

For finishers, Blue Cross president Douglas Coleman attacked those who shed "crocodile tears" for the direct pay subscribers, flailed at those who want to wave "magic wands," and disparaged those who made basic critiques of the Blue Cross-hospital axis: "Both the people and their government are threatened when the true dissenters, those who want to improve something, get out-shouted by the phony dissenters, those who want to destroy the whole business."

Blue Cross was once a great social reform. For millions of Americans, faced with the threat of economic catastrophe should they get sick, it has meant that their hospital bills are in large part paid for. But Blue Cross has grown up into a monster. It has priced itself out of the market, first for old people, who it happily relinquished to Medicare in 1966, and now for lower income people. By its abdication of responsibility for controlling medical costs, it is pricing almost everybody out of the medical care market. By its consistent supineness before hospitals, it has permitted a hopelessly antiquated and unbalanced medical system to survive. Blue Cross has, by now, forfeited all of its claim to being a community service.

The Medicaid Blues

In July, Nixon discovered the American health crisis and assigned Walter McInerny, president of the Blue Cross Association (the national association of Blue Cross plans), to bail us out. McInerny has just finished drafting his shock troops for the battle against costs and chaos—the 27-member Task Force on Medicaid and Related Programs. Few of the names are familiar: this is definitely a working committee, not a blue-ribbon panel. The approach it will take is clearly indicated by the heavy representation of corporate medical forces, hospitals, medical schools and insurance companies, with only a token voice for the AMA.

The task force is the usual line-up of provider, planner, third party, union and industry representatives, plus a sprinkling of economists and consultants. The United Auto Workers, which has been agitating for a national health insurance [see BULLETIN, June, 1969] is on, so is the AFL-CIO. Industries represented include AT&T and Hallmark Cards (which manufactures get-well cards for victims of the American health crisis). Consumers will have to depend on Mrs. Ruth Atkins, chairman of the East Harlem Health Council [see June, 1969 BULLETIN for story of their confrontation with Metropolitan Hospital administration], for representation, unless a mysterious Spanish-named "pharmacist and medical student" from California will be wearing his consumer hat to Task Force meetings. Altogether, New York is sending a pretty liberal team, including Margaret Mahoney from the Carnegie Foundation (which funded the Student Health Organization this summer) and Dr. James Haughton from the New York City Health Services Administration. Dr. Haughton, who spent the spring blasting doctors for Medicaid-profiteering, was the one who had the idea for a top-level Medicaid Task Force in the first place.

Nixon's choice of McInerny, rather than Haughton, to head up the Task Force, is being read by many as a presidential go-ahead for a Task Force proposal featuring Blue Cross management of Medicaid. Blue Cross already manages Medicaid in a number of states, and has been jockeying for the others through an expensive national public relations campaign.

Blue Cross: Fiscal Freakout

Blue Cross is the central mechanism for financing hospital care in America. The entire structure of the hospital system as it is now—its finances, its manpower policies, and often even its medical policies—rests upon Blue Cross as a base. Blue Cross ensures the hospitals that they will have a reasonably stable income. It ensures the hospital supply companies and drug companies of a stable market. It ensures the hospital empire builders that their priorities will remain unchecked by their sources of financing. Blue Cross is not, any longer, if it ever was, an equitable or efficient way of financing the hospital services that people need.

And Blue Cross, is seeking to expand its power. It is now the intermediary for Medicare and in many states for Medicaid, and has been lobbying to become the intermediary for all Medicaid money. Now its sights are set on controlling any future expansion of Medicaid or any future national health insurance plan—both of which become increasingly likely as medical care becomes more expensive and more fragmented. It has priced itself out of the market. By its consistent supineness before hospitals, it has permitted a hopelessly antiquated and unbalanced medical system to survive. Blue Cross has, by now, forfeited all of its claim to being a community service.

If vast new amounts of public money are going to pour into health, the hospitals will want to control that money, just as they control the funds now. They have their own priorities, which do not always coincide with the needs of the patient. With their ally Blue Cross controlling the funds, the hospitals can attend to business as usual. Blue Cross and the hospitals are well aware that he who pays the piper calls the tune. Self-employed pipers choose their own melody, however.

—The Financing Workshop

[See "Workshops," Page 16]
NYC As A Demonstration Project

THE NEW YORK CITY Health and Hospitals Corporation, after a brief public appearance for hearings last April, went back underground for the summer. Conceived in secret back in early 1967, revealed briefly for the April hearings before the City Council, the Corporation seems likely to gestate in secret until unveiled, full-grown, sometime next spring. Chief among the top security projects for the summer was an effort to sell the Corporation to the US Department of Health, Education and Welfare (HEW) as a "demonstration project" worthy of planning grant support.

For those who are unfamiliar with New York City hospital politics, the Corporation's present invisibility is entirely consistent with the philosophy which led to its creation in the first place: Namely, that if the Municipal hospitals are going to work, they'll have to be cut loose from the City government and run like a private business. The rationale was that most decisions about the hospitals' operation are not of a "public" nature, and can be made more efficiently by invisible bureaucrats who do not have to account to public officials or to the public itself. Community forces who had witnessed Hospital Commissioner Tenerzio's four year "reign of error" had to agree that the hospitals should be liberated from the City Department of Hospitals, but felt that they should be set loose in the direction of greater community management, not pushed back, as an Authority, even farther from public view. At the April public hearings, the Department of Hospitals/private medical establishment axis won the Corporation, but the consumer groups gained a foothold: the promise of community advisory boards to watch the Corporation at its delivery end, the individual Municipal hospitals.

The task for the summer was to begin to fill in the nebulous enabling legislation for the Corporation with some brass-tack plans for how it will actually work. The issues involved range from picayune—like how the Corporation will order paper clips—to overtly political—like how decision-making power will be divided between local hospital administrators, the central Corporation directorate and the still-public Health Services Administration. Hunched over the drafting boards is a time-tested team consisting of the Department of Hospitals (represented by Henry Manning, Deputy Commissioner in charge of affiliations), the Bureau of the Budget's ace program-planning force (hired originally to rationalize City services through Defense Department-style program-planning-budgeting), and Mackinsey Corporation, a private, profit-making management consulting company (hired originally to rationalize the Budget Bureau's attempts to rationalize the City).

Strangely enough, two of the key actors in the framing of the Corporation bill have shown no interest in the current pre-planning phase. Dean Lewis Thomas of NYU Medical School, who initiated plans for the Corporation in 1967, lobbied for the bill in the winter of 1968, and redrafted it to appease the consumers in the spring of 1969, is cutting out for a top post at Yale Medical School. Commissioner Tenerzio, chief public sector engineer of the Corporation bill, lit out for Europe as soon as it was signed into law in June and is not expected back till early September.

Actually, much of the planning that has gone on this summer has been of the pre-preplanning variety: planning how to get a fat HEW grant to plan how to set up the Corporation. Even before the Corporation had been approved by the State Legislature, way back in November, 1968, the Department of Hospitals had been feeling out HEW on the possibilities of support for planning. In June, the Department of Hospitals hit HEW with its proposal, requesting $4.5 million, to be spent mostly within the next two years.

The proposal (which needless to say is not a public document) exceeds in vagueness even the enabling legislation which created the Corporation. The one point which comes through loud and clear is that HEW is being asked to regard the NYC hospital system as a demonstration project, an experiment in running urban hospital systems. For starters, the proposal is entitled "Demonstration and Study through Extensive Reorganization of Delivery of Personal Health Services in a Large Urban Environment." Lest anyone underestimate what an important experiment the NYC Hospital system can be, the proposal says:

"The implementation of the NYC Health and Hospitals Corporation will be an event without precedent for its potential impact upon the organization of total health services in a large urban area. While it ostensibly only involves reorganization of public hospitals and health facilities, it has great implications for future development in the private health sphere...As an experiment in reorganization of total community health services, it will be the most expansive and total effort ever undertaken in the United States." (Emphasis added.)

A further selling point is the freedom the Corporation will have from ordinary governmental control: "The widest possible legal powers and freedoms have been provided to the Corporation in its legislation." Thus, cut loose from public surveillance, the entire City hospital system will be a lab for experiments in the management of multi-hospital systems—experiments which the nation's private Medical Empires will be watching with great interest.

At the heart of the proposal is the design for planning, a galaxy of interlocking task forces, back-up committees, consultants, and special panels, all neatly laid out in a flow chart. Just so no one will forget what the Corporation is really about, there is a special panel to set goals. And just so the goals don't become an eventual embarrassment to the Corporation, "the individuals involved (in the goal-setting panel) must be seasoned experts who are capable of being imaginative and idealistic, but who can appreciate the hazards of excessive ambition." (Emphasis added.) No "free health care for all!" nonsense, goal-setters! Backing up the goal-setters, and keeping them down to earth, will be two panels of experts in medical care and health administration, respectively. These in turn will be backed up by a host of "medical administrators, biostatisticians, accountants, engineers and a management consulting firm"—Mackinsey, no doubt.

For an organization which is going to have trouble just buying syringes for the next few years, the Corporation's proposed planning budget looks excessively rich. Executive staff for the planning effort outlined in the HEW proposal will gross $25,000-$40,000 a year, and over a million dollars a year will go to private consultants. Even the intellectually bankrupt New York Metropolitan Regional Medical Program [see July/August HEALTH-PAC BULLETIN] wants to get on the

(Continued Page 8)
trenched private planning forces. City officials expect to be
come the planning agency itself, HHPC will function as the

upon the City by the New York State Health Planning Com­

mission was designated the agency to approve comprehensive
health plans in response to the Federal Act of 1966.] Perhaps more significantly, HHPC may manage to retain
much of its effective power even after a public planning
agency surfaces in the '70's. A decade ago the State granted
veto powers over all hospital and health facilities to HHPC.
At that time the State Health Department (the State Hill­
Burton agency) established a procedure whereby a favorable
recommendation by HHPC was a prerequisite to its approval
of a construction grant. Under the more recent Metcalf-Mc­
Closky and Folsom Acts, HHPC was designated to plan and
set priorities for the New York City area for all Federal and
State money for health services. In passing these laws (New
York state is one of the few states to have done so) the
Legislature gave HHPC and other regional health facility
planning agencies quasi-legal responsibilities with respect to
the establishment and construction of hospitals and other
health care facilities. Before the State Health Planning Com­
mission would ap­

prove the City's application and send it on to the Feds, it
demanded that HSA give "firm assurances that the experience
and knowledge of HHPC be utilized, and that definite ar­
rangements will be developed during the organizational period

to assure continuity and excellence in facilities planning." HSA
responded by giving assurances that "the City has com­
mitted itself . . . to the continued utilization of HHPC to per­
form its Article 28 [Folsom Act] responsibilities as a function
of comprehensive health planning." Article 28 spells out
HHPC's power to "recommend" (in practice, to approve) any
facility plans. Such HHPC "recommendations" in the past were
responsible for the decision to close down St. Francis Hospital
(Bronx) and for the 10-year delay in building a new Gouver­
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HSA, Mayor Lindsay's "supergency" for health, can hardly
be described as a bold imaginative "voice" for the public. Last
spring it was made still more impotent by the City
Council's approval of a plan to turn all City hospitals and
facilities over to a "public benefit corporation." HSA will sup­
posedly set policy for the Corporation, but the lines of
authority are yet to be drawn. HSA officials still persist in
seeing the creation of a public comprehensive health plan­
ing agency as a way to wield power over elite private forces.
The City has not, however, been willing to go all the way
toward an alliance with the consumer forces in New York
City. Even HSA concedes its boast about a "consumer majority"
(30 consumers—29 providers) on its planning agency or­
ganizational task force is inflated—according to its own defini­
tion of "consumer," even Consolidated Edison counts itself in.

Opposition to the HSA design has been raised by the City­
wide Health and Mental Health Council, a coalition of neigh­
borough health councils, because (1) it did not have a
majority of true consumers, let alone provision for blacks
and Puerto Ricans to be represented in proportion to their
respective populations in New York and (2) it planned to
spend its staff money on high-paid professionals and bureau­
crats. In its unsuccessful opposition to HSA's proposal, the
Council demanded a truly consumer-dominated organizational
task force under HSA auspices; a reorganization and redeploy­
ment of HSA's present planning, development and resource
staff so that 75 percent of the task force's new funds would
be earmarked for staff and training on a neighborhood level,
and the eventual formation of a City Comprehensive Health
THERE IS A "SYSTEM" to the outwardly chaotic, patient-puzzling New York City health scene. Last December's HEALTH-PAC BULLETIN pointed out that health facilities tend to be linked, through various kinds of affiliations, in networks centered around a medical school or a major voluntary hospital. There are seven major medical empires in New York City: the Einstein/Montefiore empire in the Bronx, the Columbia Medical Center empire in upper west Manhattan, the New York Medical College empire in upper east Manhattan, the Cornell Medical College empire further south on the east side of Manhattan, the New York University Medical Center on the lower east side of Manhattan, the Catholic Charities empire in Brooklyn and Queens, and the Downstate Medical College empire in Brooklyn. Two newcomers striving for imperial status are Beth Israel Medical Center on Manhattan's lower east side and Mt. Sinai Medical Center on Manhattan's upper east side. [See Empire map, HEALTH-PAC BULLETIN, December, 1968.]

Empire-building is on the up-swing, in the nation as well as the city. In New York, the contours of the present empires began to emerge only in the last decade, as affiliation programs knitted the 21 Municipal hospitals into the private sector. Then, in the mid-sixties, as government funds created neighborhood health centers, community mental health centers and other "outreach" programs, these facilities have followed the hospitals into the "trusteeship" of one or other of the city's medical empires. Medical corporate liberals have heralded the growth of empires as a "rationalization" of otherwise disjointed health services, and as the only way to disseminate quality out from the "centers of excellence."

Too often the centralization of managerial control under a single major institution has served neither to rationalize nor to upgrade care throughout the empire, but has meant a centralization of power over health resources—with less and less voice for the consumer or the frontline deliverer of care. Too often the empire-builders have been driven, not by the pressure of community needs, but by the dynamics of turf-fighting with other institutions (for facilities or teaching material) or of real estate speculation.

New York City boasts a full range of medical imperial styles. Some are aggressively expansionist; some are academically withdrawn. Some are tightly, almost militaristically organized; some are far-flung and permisive. Some are flexible and susceptible to community pressures; most are not. HEALTH-PAC BULLETIN has carried lengthy case studies of two widely differing empires, the conservative, patrician Columbia Empire [December, 1968] and the expansive, hustling Einstein/Montefiore Empire [April, 1969]. Here we revisit these empires, catching up on developments since last spring. In addition, we take a glance at five empires new to the BULLETIN's pages: aristocratic Cornell; Downstate, the "public" empire; fleeing New York Medical College; NYU; and the upstart Beth Israel. Some of these empires will be the subjects of thorough case studies in the coming months.

EINSTEIN/MONTEFIORE EMPIRE

In the Bronx, money-hustling and expansion of control through regionalization has continued unabated; but the empire has recently become uncharacteristically shy of publicity. All checks from College Hospital now bear the signature of Martin Cherkasky—fiscal mismanagement of the institution having forced its officers to yield to the smooth managerial competence and control of the Montefiore chief. Over the summer, the Faculty Senate of the School of Medicine has met in executive session every two weeks to deal with similar problems relating to financial solvency of the school. The following programmatic and financial finagling may have precipitated the "blackout":

When Drs. Pollack and Einhorn at Lincoln Hospital publicized the renovation program at the Hospital, as cutting out vitally needed patient services without substantially improving patient care facilities, a short story was carried in the New York Times, but the word quickly came down to cool it. At Lincoln, Dr. Ira Lubell, Acting Director of the Hospital and member of the Department of Community Medicine (of which Dr. Cherkasky is chairman), strongly denounced the Pollack/Einhorn announcement to the press of problems at Lincoln.

Little publicity has come to Dr. Howard Brown's success in garnering federal grants to reorganize ambulatory care at Fordham's emergency and outpatient departments. The development of a borough-wide ambulatory care organization, stimulated by Dr. Brown, also occurred in silence.

The lack of publicity surrounding the on-site visit of the NIMH (National Institute of Mental Health) investigating team to the Lincoln Mental Health Services also suggests an uptightness within the empire. The New York Times story, buried in a Saturday paper, reported recommendations for improving services with little review of what had prompted 200 out of 250 workers (from secretaries to psychiatrists) to take over the services last March. [See Box, Page 10.]

Publicity-fear reached its peak during the citywide Municipal hospital budget crisis in June. A coalition of medical board, house staff and Local 1199, called a "partial shutdown action" to pressure the City for more funds for Jacobi. The call stemmed from a suggestion by the medical board, and was supported by department heads, house staff, union officials, and, at first, even Dr. Cherkasky. A rally at Jacobi on April 30 drew more than 1000 health workers and patients to discuss the possible effects of the threatened budget cuts.

(Continued Page 10)
WHEN NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH), State and City officials visited Lincoln Hospital Mental Health Services (LHMHS) in June they found that "an identifiable community mental health center...does not exist; loosely administered or programmatically." They scolded Yeshiva University (and its fiscal intermediary, Albert Einstein College of Medicine) for the most blatant breaches in the $4.5 million a year program—but made no mention of funding a more responsible, alternative structure.

In a letter to Commissioner Fill of the City's Community Mental Health Board (which has negotiated the public funding for Lincoln Mental Health Services with Yeshiva University since 1963), NIMH said: "These deficiencies are of such a magnitude as to ordinarily warrant suspension of the grant until the Community Mental Health Center can achieve compliance...however [we] recognize the critical need for mental health services in the six health areas [of the South Bronx]...and were impressed with the many dedicated staff members of the Center and the strong desire of the community residents...who sincerely wish to see the services continued and made more effective."

With this warning NIMH gave LHMHS deadlines ranging from August to November to shape up.

A month before the investigators arrived on the scene, HEALTH-PAC, with the cooperation of disinterested workers who had taken over the center in March (see April BULLE-TIN), published a preliminary investigative report entitled "LHMHS: Maximum Feasible Malfeasance and Manipulation." It documented the free-wheeling-dealing of the Einstein-Yeshiva Empire as it shifted Lincoln funds and staff from one institution to another. Albert Einstein administrators explained lamely to the site visitors that it was never given a copy of the staffing plan which designated who was to be hired to perform what specific services. When Lincoln workers questioned Einstein, they had been told such a loose "global approach" was necessary and proper.

The HEALTH-PAC report revealed some of the following Einstein hustles:

- The Empire had skimmed off over $500,000 in overhead alone since 1965. Hidden benefits in the form of staff salaries, new positions and additional facilities were accumulated through padding. Not only did Einstein not pour personnel time into the Lincoln program, but they took an additional $45,000 per year to pay for a battery of accountants, bookkeepers, etc. to work at Einstein.

- It was not unusual for LHMHS to wait for up to six months for its money to be passed on by Einstein. An administrator working closely with Einstein says the reason for the delay was not the work load or lack of administrative capacity, but that Einstein had greatly underestimated the deficit to be incurred from its own College Hospital—and Einstein simply preferred to use the Lincoln money, rather than dig into its own capital funds.

- Bronx State—another institution within the Empire—also took its share. Last year $25,000 went to supplement the drug addiction ward at Bronx State where LHMHS was to be allotted 24 beds for detoxification. The doctor in charge of the service allowed only four beds to be utilized. More outrageous was the disappearance of an additional $137,000 which was to be used to hire a "liaison staff" for Bronx State's 90-bed Lincoln ward. Only one psychiatrist was hired, and even he did not relate directly to LHMHS.

- Three Neighborhood Mental Health Unit outposts @ $70,000 were to have been established, and only one was in existence. Similarly, a mandated $64,000 Precare/After-Care Liaison staff was nonexistent. Perhaps the most spectacular phantom funds caper was the disappearing $372,000 partial hospitalization program which was to provide weekend, evening and daytime services.

- Though $136,000 was provided for emergency room service, sporadic care was provided at the same entry point as all other medical emergencies—one need only realize that the Lincoln emergency room is the second busiest in the nation, to appreciate the insanity of the situation. When the government team visited the emergency room, it found that psychiatric staff was not even present—only available "on call." The mental health emergency service had neither a telephone listing nor a telephone answering service.

- To date, the Empire has authorized a $400,000 renovation of an annex to house part of LHMHS, as well as extensive refurbishing of two separate temporary quarters for the one existing Neighborhood Mental Health Unit. All the contracts were let to Miller and Raved, builders who formed a special corporation for the project: "The 966 Associates" (the neighborhood unit is located at 966 Prospect Avenue). Charles Miller of Miller and Raved, interestingly enough, is the son-in-law of Sidney Shultz, general counsel for Yeshiva University.

- Before the investigation, all Lincoln mental health funds were mixed in one administrative pot. Now the Feds have insisted that the funds be separated—with a column for the NIMH staffing grant (for the community mental health center) and another column for the City Hospitals Department affiliation contract (for the Lincoln Hospital-based psychiatric services). The Einstein Department of Psychiatry—which would like to preserve its year-old residency program at Lincoln—made its position more secure in June when it created a Lincoln Hospital Department of Psychiatry. The Empire will name its new director soon.

- Since the loose NIMH funds have been pinned down, the Empire has been a major contributor to administrative chaos in the community mental health center—thus giving the workers little time to think beyond how to hold the services together for another day. LHMHS workers returned to their jobs in April with Einstein's promise that an Interim Community Board would have a voice in the selection of a new director. Within two weeks, and with no prior notice, The Empire installed an interim director, Dr. Leonard Licht (from Bronx State). Dr. Licht has been less than a dynamic leader in the last two months, and the workers have heard Einstein is tired of his bumbling and is looking around the Empire for a new recruit. As has been the Empire's paternalistic attitude toward its Lincoln Colony in the past—he who gives, can take away.

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Since no one bothered to seek community support, a hastily called "community meeting" on May 28 drew only 10 people to hear the medical board's announcement: It was closing Jacobi's outpatients clinics and emergency room to all but "real" emergencies. Patients requiring chronic care follow-up were to be sent to other hospitals. The Board did not mention that clinical lab budgets were to get hit twice as hard as research facilities. (Subsequent reports from Jacobi interns indicate that the clinic cuts have indeed been severe.) But the "partial shutdown" called by the coalition was short-lived. Though no additional money was forthcoming, the clinics were open within seven days. What had happened?

Apparently, on the second day of the clinic shutdown Dean Gordon (dean of the Einstein School of Medicine) had called a meeting of the medical board and announced that
he opposed the closing of the clinics. He gave all the good, "liberal" reasons for his opposition, including the injury that patients might suffer from lack of available health care. Just as the decision to conduct the shutdown had been a top-down decision from the medical board, so too the decision to open the clinics was made by the medical board. This left the union and the house staff demoralized, but not the community since it had not really been involved.

What were the real reasons for Dean Gordon's absolute refusal to go along with the action? Among them certainly, is the vulnerability that Einstein presently feels to public exposure. Some damning facts might have been revealed, for instance that many affiliated department chairmen at the Medical School get their entire salaries from the City payroll at Jacobi. But it is also clear that this information implicates the City which has tolerated this process of interrelated support for so long. Neither the City nor the Einstein-Montefiore Empire can afford close scrutiny of their tangled fiscal relationship.

**COLUMBIA/PRESBYTERIAN EMPIRE**

Columbia Presbyterian Medical Center (one of the richest medical centers in the world) has remained an island in a community of 250,000 people. Though more than half of the area's population is low-income, and must rely on the hospital for routine care, Columbia operates only one outpatient clinic—the Vanderbilt Clinic. Rather than train medical professionals to deal with the urban health crisis which is virtually at its doorstep, the medical center continues to stress research, teaching and the care of private patients.

Columbia medical center's financial underpinnings are sturdy, but increasingly based on public funding sources. In 1968 the operating income of the hospital was $53 million, more than double what it was in 1960. The assets of the Medical Center have grown steadily with an average increase of 10 percent each year. With the influx of large amounts of government money ($41 million since 1965) the total assets reached $180 million in 1968. Every year since 1958, with the exception of one, the hospital has made a profit (this does not include income from investments). Over 40 percent of patient care income is from government sources such as Medicaid and Medicare. The income from private patients (including Blue Cross) has dropped to 51.5 percent of all income while philanthropic contributions have plummeted to 1.2 percent of income.

Institutional priorities are graphically illustrated by the construction of new buildings. Eye Institute's new addition, Atchley Pavillion (a doctors' private office building), a married students dormitory and a new library have mushroomed up in the last few years. But long-standing promises to the community that Columbia intends to build a new emergency room and more clinic space have gone unfulfilled. Meanwhile, Columbia continues to buy up tenements in the Washington Heights area, at the phenomenal rate of $500/hour.

In the past, the members of dissident groups—students, workers, community—have waged separate, narrowly defined battles against Columbia's medical monolith. Students who have analyzed the admissions and curriculum policies of both the medical and nursing schools accuse Columbia of deliberately nurturing elitism and professionalism, which militates against serving the community and maintains the hierarchical medical institution. For example, medical students are faced with a curriculum that refuses to acknowledge even the most basic team practice concepts and includes no courses in community medicine. Community residents are virtually excluded from the nursing school—a prerequisite for admission is two years of study in a top-flight undergrad college or a B.S. degree. Nursing classes are completely separated from the medical school, even though some of the courses are identical and often taught by the same lecturers.

Workers found themselves up against the laboratory wall during a recent Drug and Hospital Workers Union Local 1199 organizing drive among medical school employees. The administration of P&S pulled out all stops against union organizers who approached their technical, service and clerical staffs. Besides making it difficult for the group to obtain meeting rooms and sabotaging leaflet campaigns, the hospital administration set up an informal spy network made up of "loyal" employees of the medical center "who can be counted on in times of crisis." This counterinsurgency force was described in a captured document, which included the dossiers which had been compiled on the workers. Excerpts include: "Dr. X is a rabid civil rights advocate and very pro-union. Fortunately, however, his group [of co-workers] is very small. Mrs. Y's thought concerning Dr. X is that he may oversell the union and antagonize people." . . . "Recently this group [of co-workers] signed a petition asking for wages comparable to the Presbyterian Hospital. At this point it is not certain whether Miss A's sympathies lie entirely with the University."

Community hostility is nothing new. Columbia has even hired a public relations firm to improve its image—especially in the black and Puerto Rican communities. Its Urban Center (Ford Foundation money) has funded a Committee on Health Priorities for Harlem to conduct professional and community workshops to smooth the rough edges. But there is trouble in the Columbia Empire. Relationships have deteriorated to such an extent that Columbia has been blocked by the community from buying property for nurses residences near the site of the new Harlem Hospital.

Now students, professional workers and community groups are getting together for an all-out offensive. The coalition picked Vanderbilt Clinic as its first target. Vanderbilt symbolizes the second-class care provided low-income residents by the Columbia Empire. [See Vanderbilt campaign details, "News Briefs," Page 10, July/August BULLETIN.]

So far, the medical school's only response to the demands has been increasing threats and harassment of the students. It is reasonable to assume that the demands upon the medical school can only escalate—especially considering that even if Columbia met all the present demands, Columbia would still only be coming into line with the inadequate practices of most other hospitals in the City and around the country.

**CORNELL/NEW YORK HOSPITAL EMPIRE**

The Cornell University Medical College-New York Hospital medical barony is a tight complex of some twenty buildings located along the river on Manhattan's prestigious upper East Side. Alongside Rockefeller University (the elite scientific research institute with whom Cornell-New York Hospital has some limited ties) and Sloan-Kettering Institute for Cancer Research, these facilities comprise New York's most impressive concentration of research, training and private care facilities.

New York Hospital, with its 1230 beds, is literally an ivory tower of excellence in clinical medicine and research. A large portion of the beds in the hospital are taken up by rare, unusual or difficult cases, often those which contribute to the innumerable research activities carried on under foundation grants and federal aid. The oldest hospital in the city (char-
tion to the hospital itself, is a marketable securities port-

tered in 1771 by King George III), New York Hospital is under
the control of a small number of NYC's most elite citizens.
Such names as Laurance Rockefeller, John Hay Whitney of
the Whitney publishing empire, Kenneth Hannan of Union
Carbide, former Secretary of the Treasury C. Douglas Dillon,
and William A. M. Burden, a Columbia trustee and chairman
of the board of directors of the infamous Institute for De-
fense Analysis, head the list of powerful figures who share
control over New York Hospital. At least 23 of the 27 Board
members are either members of NYC's social elite as rep-
resented by their presence in the Social Register, members
of the upper echelons of Wall Street, or both (18 are listed in
Who's Who in America alone). Banking, investment, aircraft,
communications, and chemical interests are well represented,
along with many powerful private foundations. Among the
items under the purview of the Board of Governors, in addi-
tion to the hospital itself, is a marketable securities port-
folio of $50,000,000.

Cornell University Medical College is formally tied to New
York Hospital by a Joint Administrative Board consisting of
the president of Cornell University proper, four members of
Cornell's Board of Trustees, four NYH governors, and one
member elected by the rest of the board.

The Cornell-New York Hospital Medical Center, as the entire
complex is called, is presently engaged in an active physical
expansion plan at its York Avenue site. Nine floors of gleam-
ing laboratories in the William Hale Harkness Medical Re-
search Building were built in 1968. Word is out that con-
struction will begin soon on a new 1400-bed hospital west
of York Ave. near a recently completed 35-story apartment
building for staff. Affiliations are also extending the influence
of the Center. Manhattan Eye, Ear, and Throat Hospital has
recently affiliated with the Center, as has the Burke Re-
habilitation center at White Plains, N.Y. A number of other
prominent clinical and research hospitals have long been a
part of the Cornell Empire. The Westchester Division of New
York Hospital (350 beds) and Payne Whitney Clinic form the
psychiatric facilities. The Lying-in Hospital, well known wom-
nies is the Rockefeller family-dominated Sloan Kettering
empire, bears prime responsibility for the narrow-minded and
exclusionary outlook of the entire Center. Reform of the
medical school curriculum was begun a few years ago but
has bogged down in a mire of general recalcitrance and buck-
passing among the faculty. The student body is still primarily
a reflection of Cornell's white upper class power structure,
although admission policies are slowly changing. For instance,
Jewish students, excluded by a rigid quota system until about
five years ago, now supposedly have equal access to Cornell's
waspish halls. Blacks and browns will have to wait until a new
student-sponsored recruitment policy gets underway.

With the resignation of Dean John Dietrick, who had warned
medical schools in 1953 against "building up large empires
which serve as welfare and semicharitable institutions," Cornell
may have a chance to look down from its towers. Students
have gained two seats on the selection committee for the new
dean, and student pressure may well determine whether
Cornell breaks out of its exclusive shell.

NEW YORK MEDICAL COLLEGE EMPIRE

New York Medical College may be the first local medical
school to run away from its imperial holdings. Presently
clining to the green edge of Central Park at 106th Street (a
safe distance from the dark interior of East Harlem), NY
Medical College looks forward to an early retirement in
suburban Westchester County. When it pulls out within the
next few years it will leave behind its immediate property:
a nine-story college building, the 10-story Cohen research
building and the 400-bed Flower and Fifth Avenue Hospital,
plus its affiliates: 1000-bed Metropolitan Hospital and 1800-
bed Bird S. Coler chronic care hospital, both Municipal.

Like the many small, white-run furniture stores and phar-
macies in East Harlem, New York Medical College will be
leaving a good deal when it moves out to a more congenial
neighborhood. Before the affiliation with Metropolitan, New
York Medical College was on the verge of bankruptcy. With the
affiliation, it gained guaranteed staff salaries plus access to
one of the city's fastest pools of human pathology for teaching
material. Flower Hospital creams off the paying patients and
the "interesting" cases, leaving the routine hepatitis, drug
overdose, VD, etc., cases for the long wards at Metropolitan.
According to house staff who have worked at Met, the care is
not bad in the Dept. of Medicine, sloppy in many other de-
partments, and "atrocity" in surgery.

Under the medical leadership of the Medical College, Met-
ropolitan has developed no significant community outreach or
preventive medicine programs. Asthma and addiction—among
the leading local health problems—are virtually ignored by
Metropolitan, white mental health—which is eligible for heavy
federal support—is a major New York Medical College "com-
munity" program. As if to compensate for its generally low
level of community performance, New York Medical College
three years ago set up an office of its Community Relations
Department in an East Harlem storefront. Community people
employed in this outpost assembled the East Harlem Health
Council, which, allied with the Metropolitan medical board,
took action to protest the threatened budget cuts last spring.

As a medical school, New York Medical College is not
among the academically elite (Cornell, Columbia and NYU) or
intellectually innovative. There is no course in community
medicine and students are given hardly any elective time.
According to an ex-student, the atmosphere is oppressive,
with frequent tests and occasional criticisms of dress and hair
styles. In spite of this academic backwardness, the Medical
College boasts impressive tie-ins to New York City's voluntary
hospital establishment. Dean Frederick Eagle [see "NYC," Page 7], an ex-Einstein man, is chairman of the Associated Medical Schools of NY and chairman of the Regional Advisory Group of NY Metropolitan Regional Medical Program [see July/August BULLETIN]. Faculty-woman Jane C. Wright sits on two New York Metropolitan RMP committees.

New York Medical College's history is the story of a long exodus northward. Founded in 1860 at 20th Street and Third Avenue, it moved in 1890 to 63rd and York, powered by funds from Roswell P. Flower (hence Flower Hospital) and John D. Rockefeller. In 1935 it pushed on to its present site, which was then a large Irish and Italian neighborhood, and within a few years will vanish to Westchester. What will happen to Metropolitan and Coler is still unclear. Possibly New York Medical College will try to maintain the affiliations, with staff commuting from Westchester. More likely, the fledgling Mt. Sinai Empire, whose "manifest destiny" definitely includes Metropolitan, will move in to fill the vacuum left by the fleeing New York Medical College.

DOWNSTATE EMPIRE

The Downstate medical complex, which covers most of Brooklyn and reaches into Queens, is less tightly integrated than most of New York City's empires. There are several degrees of connection to Downstate, and the hospitals included in the empire connect with other empires as well.

At the hub of the empire is the Downstate Medical Center College of Medicine of the State University of New York. 2700-bed Kings County, the largest Municipal hospital in Brooklyn, is located in the Downstate medical center and run by Downstate Medical College. Its outpatient department serves ghetto communities; its psychiatric department is the Bellevue of Brooklyn. In short, Kings County is very much connected to everything that goes on in Brooklyn. Yet with all this on its doorstep, Downstate has chosen to retreat into the sanctuary of medical academe. In 1966 the University completed its 350-bed University Hospital, which, according to the medical school's catalog, "serves as the nucleus of the clinical teaching program, providing a concentrated experience in medical care under the model conditions that can be met only in a university-controlled hospital." Since Downstate is directly responsible for Kings County as well as the university hospital, the meaning of that claim is clear: interesting cases, University—routine case, Kings County.

Of the remaining hospitals in the Downstate orbit, Long Island College Hospital (LICH) has the deepest historical ties to the heart of the empire. Third and fourth year Downstate students do clinical work there, and high level LICH staff hold faculty and/or administrative appointments at Downstate. The original medical school teaching hospital in Brooklyn, LICH is now engaged in transforming itself from a "general hospital to a regional total care medical center" and is expanding its own relationships with other hospitals to become a strong second-level hospital center. LICH now has cooperative programs with Beekman Downtown Hospital, Congress Nursing Home, St. Charles Hospital, St. John's Episcopal Hospital, Staten Island Hospital, Victory Memorial Hospital, the VA hospital in Brooklyn, Brooklyn-Cumberland, and Methodist Hospital-Prospect Heights. LICH also runs the budget-troubled, OEO-funded Red Hook Health Center. Eight other hospitals at the same level of integration with Downstate as LICH are:

- Brooklyn-Cumberland Medical Center, in which Brooklyn (voluntary) runs Cumberland (Municipal).
- Brooklyn VA, a federal institution.
- Jewish Chronic Disease Hospital, a voluntary with attached research institute, affiliated with the Federation of Jewish Philanthropies.
- Jewish Hospital and Medical Center of Brooklyn, Brooklyn's largest voluntary hospital (632 beds), also affiliated with the Federation of Jewish Philanthropies.
- Long Island Jewish, voluntary, affiliated with the Federation of Jewish Philanthropies, located in Queens. Most of the directors of service have faculty status at Downstate, and one is an Assistant Dean of the College of Medicine.
- Maimonides, voluntary, 568 beds, affiliated with the Metropolitan Jewish Geriatric Center. Many staff hold faculty appointments at Downstate, one is an Assistant Dean, the Executive Vice President is chairman of Downstate's Hospital Administration program.
- Methodist Hospital of Brooklyn, voluntary, 471 beds. Clinical directors hold faculty rank at Downstate, one is an Assistant Dean.

At the next level of integration into the empire are the Municipal hospitals run by voluntaries affiliated with Downstate, the neighborhood health centers and community mental health centers run by the various hospitals. For example, Maimonides runs Coney Island Hospital under the City's affiliation program. It also has a community mental health center [see, BULLETIN May 1969].

In the Downstate Empire, nearly everyone builds. Downstate itself is deeply involved in planning for expansion and renovation at Kings County. Many of the component hospitals are engaged in multi-million dollar expansion programs, usually increasing the number of beds, sometimes expanding particular programs or services. For example, Long Island College Hospital has acquired land along Hicks Street for a 500-bed extended care facility as the first step of a projected new medical center. Metropolitan Jewish Geriatric is building at Maimonides. And the Jewish Hospital and Medical Center plans a new facility to expand its HEW-founded program of comprehensive child care.

Downstate's far-flung empire has so far enjoyed relative immunity from student/worker/community insurgency, but the currents are beginning.

NYU AND BETH ISRAEL EMPIRES

The two medical empires on the Lower East Side—one that's made it, and one that's on the make—are drawing battlelines in the hope of winning patients, beds, students and prestige.

NYU-Bellevue is a medical empire that has made it. Included in its dominion is the medical school of New York University, the Bellevue Nursing School now affiliated with Hunter College, a large private voluntary hospital (University Medical Center), two large public hospitals (Bellevue and the Veterans Administration Hospital), and various ancillary hospitals such as the Institute for Rehabilitation Medicine and Bellevue Psychiatric. NYU has made it as a world-renowned teaching and research center in medicine, garnering over $20 million of federal grants. It has been more concerned with consolidating its power within its own domain than reaching out into new arenas. For instance:

- Much energy has been expended over the last few years in expanding coverage at Bellevue to take up those medical services dropped by Columbia and Cornell, as they pulled out of their affiliations with Bellevue.
- Dean Lewis Thomas of NYU Medical School was one of

(Continued Page 14)
the main architects and supporters of the law to turn all City hospitals over to a quasi-public authority, the Health and Hospitals Corporation [see "NYC Demonstration," Page 7].

Dean Thomas was particularly interested in decentralizing the corporation, which would free Bellevue from the City's grip after two years and permit NYU complete control over Bellevue.

NYU has competed with other Lower East Side hospitals within HHPC (Health and Hospital Planning Council) for the expansion of private and teaching/research beds in NYU's University Hospital.

The result of this internal focus has been an outright isolationist policy toward the Lower East Side community. The first overt manifestation of this attitude came in 1967, when NYU abruptly withdrew its support from the NENA Comprehensive Health Services, setting back the effort for governmental funding by at least one year. Even now, at Bellevue a debate rages between the surgeons who want nothing more than a better public relations campaign to lure more patients to their clinics and the pediatricians who recognize the need for a major change in the pattern of delivery system. But medical isolationism has not spelled real estate isolationism. NYU has fostered, if not planned, the shift from low-income tenements to high-rent luxury apartments that is presently sweeping the area between 1st and 2nd Avenues and 23rd and 34th Streets.

But there are nascent insurgent forces developing within the community, among the hospital workers, and among the medical students, interns and residents. For example, last Spring, when house officers began to publish their opinions about the inadequacies at Bellevue in their own publication entitled "The Needle," the editors were called before a special medical board meeting and reprimanded for the tone and content of the publication. But the interest and demand among hospital staff was great enough to support continued Needle (ing) (i.e., four additional issues). Within the Medical School, it was largely the interest and the efforts of the students that resulted in a community medicine course for first year medical students.

Beth Israel (BI) Medical Center is a medical empire on the make. From its beginnings as a small private hospital, Beth Israel has expanded to include a School of Nursing, a center for the study and treatment of addiction—the Bernstein Institute—and (according to the maps published by BI) a public hospital—the new Gouverneur Hospital. Beth Israel still has a small-town style, with few fulltime, salaried staff as directors of even such major departments as internal medicine. This will be rectified, however, when department heads share appointments on the faculty at the Mt. Sinai School of Medicine. With Dr. Ray Trussell (former City Hospitals Commissioner) as medical center director and with the Mt. Sinai affiliation, continued expansion is guaranteed. Indeed, while construction of the new Science Building and staff apartments continues, Beth Israel has completed plans for a 250-bed extended care facility in its own backyard.

Perforce, Beth Israel has more contact with the community of the Lower East Side than NYU-Bellevue, because of its management of a satellite ambulatory facility, the Gouverneur Health Services (NYU-Bellevue gave up on satellites when it turned away NENA). The consequences have been that Beth Israel presently has to deal with the articulate and powerful Lower East Side Neighborhood Health Council-South (LESNHC-S), the OEO-sanctioned community health council to the Gouverneur Health Services. For several years, the

LESNHC-S had focussed most of its grievances on the services offered at the health center. Over the last year, however, LESNHC-S realized that the health problems of the Lower East Side and the problems of Gouverneur itself should be laid at the doorstep of Beth Israel. For instance, an evaluation report done by researchers at Gouverneur indicated that physicians there had difficulty admitting patients to Beth Israel, because residents in the emergency room at BI insisted on screening all transfers, selecting some and sending others to Bellevue. This clearly affected care at Gouverneur. As the report stated: "some physicians developed such a defeatist attitude toward admissions that they just don't even try to refer their non-critical cases." In Spring 1969, LESNHC-S presented Beth Israel with a series of demands ranging from improved handling of transfers, and increased enrollment of black and Puerto Ricans within the nursing school, to community representation on the Beth Israel Board of Trustees. These demands, presented with a health council member's horror story of a nine hour wait in the Beth Israel emergency room, prompted some action within the Beth Israel establishment. The Committee on Ambulatory Medicine met and decided to hire a fulltime director and to improve doctor coverage of the emergency room. Of course, little progress has been made on the other demands.

The real showdown between Beth Israel and the community is likely to come over the extent of health service offered by the new Gouverneur Hospital. This has been an issue since the Health and Hospital Planning Council [see July/August BULLETIN] wanted to turn the new Gouverneur into a chronic disease hospital. The present plans call for four floors of ambulatory medicine, three floors of acute pediatric and adult medicine, and two floors for rehabilitation and chronic care. Note the absence of surgery and obstetrics, which are presently slated to take place at Beth Israel.

Presently, this issue is moot, as Beth Israel and LESNHC-S forces unite to accelerate construction on a building that has been seven years in construction. The community wants and needs a new hospital. Beth Israel, despite Dr. Trussell's historical opposition, wants the new beds and teaching patients. Besides, with a whole hospital rather than just an ambulatory facility, BI probably calculates that LESNHC-S will be out of its depth, unable to gain effective leverage over anything as "complex" as a hospital. Thus Beth Israel tacitly supported the group of community activists who took over the street in front of the new Hospital, with the slogan "No Hospital, No Street." For three days the community people camped on the street, raised their own barricades and demanded a commitment from the City to speed up construction. When the demonstration was over, a completion date of June, 1971, was guaranteed—six months later than announced last year.

There is real community motion around health on the Lower East Side. How this will affect the development of the isolationist NYU-Bellevue and the expansionist Beth Israel medical empires will be the drama of the next few years. If teaching patients begin to "dry-up" at NYU-Bellevue, as seems to be happening within the obstetrics and to a lesser extent within the surgery departments, this empire may be forced to abandon its isolationist policy. NYU should lose still more patients when NENA Comprehensive Health Services opens in September, 1969. The response of Beth Israel to these dynamics should be to listen more attentively to the community . . . but who knows?

[EDITOR'S NOTE: The Medical Empire stories were prepared cooperatively by the staff and other contributors.]
House Staff CIR-cus: Who Runs the Show

ON SEPTEMBER 30TH THE PRESENT CONTRACT for the Committee of Interns and Residents (CIR) expires. This time, CIR may not do as well as it has in previous negotiations. In a year of budgetary belt tightening, which has cut back laboratory services and threatened to completely eliminate outpatient and emergency services at many of the major municipal hospitals, CIR is asking for a $5,000 pay hike, so that interns will start at $14,000 and 6th year residents will end up with $21,500. To some observers it looks as if CIR is going the route of the AMA.

The Committee of Interns and Residents (CIR) was formed 15 years ago as the collective bargaining representative for house officers in the New York City Municipal hospitals. Since that time, it has also been recognized in a number of voluntary hospitals. Up until 1968, CIR gains were minuscule. But last year, two things happened to the organization. First, a $5,000 pay hike for interns and residents was won, making New York's Municipal hospital house staff among the best paid in the nation.

Second, a significant section of CIR leadership and grassroots began to work on patient care problems confronting their institutions. It was this group that was disappointed at how easily patient care demands were dropped after salary gains had been won in the fall of 1968.

It was this patient advocate group that marshalled pediatric house staff at Jacobi Hospital in winter, 1969, to pass out leaflets to their patients urging them not to pay the exorbitant fees resulting from Medicaid cutbacks. Publicity surrounding this action forced Hospitals' Commissioner Terenzio to issue a sliding fee schedule for all municipal hospitals. Again, the patient advocates within CIR called a forum entitled “New York City, a Health Disaster” in spring, 1969, which attracted patient advocates from all over the city to testify to the atrocities within their institutions and to develop strategies for changing those institutions.

But the new forces representing patient care issues did not win control of the organization. The old guard leadership and the lawyers (Murray Gordon and Michael Horowitz) who had helped found CIR continued to make the decisions. The results are new contract proposals with the same old priorities: salaries first and patient care last.

The demand letter sent to the City by CIR in July, 1969, contains fifteen points, all of which fall into one of four major categories: (1) the salary demands, which are fairly straightforward; (2) non-salary, monetary demands (the “union” fund); (3) non-salary, non-monetary demands (vacations, police protection, stenographic services and parking); (4) patient care demands.

The non-salary, “fringe benefit” demands could be seen as a short of safety margin, thrown in in case the CIR wage package is turned down at the bargaining table. However, in any union, building up the union funds always has the political effect of strengthening the central bureaucracy, which in the case of CIR, means the lawyers who now run the organization. Already the present CIR House Staff Benefits Plan (which is used to buy life insurance for CIR members) produces an $11,000 rake-off for the CIR’s lawyers and fund administrators. One of CIR’s demands is to increase the Benefits Plan from $110/house officer to $200/house officer per year, paid by the license fee.

City. Another demand calls for an annuity fund with City contributions on behalf of house officers ranging from $275 to $425 per year, and a third calls for a $500 transportation allowance for travel to professional conferences. Clearly these benefits will have only a marginal economic impact on the house officers themselves. The real “benefit” which will accrue from these slush funds is to CIR’s lawyer-managers, who will be able to use the funds as investment capital.

The one patient care demand is weak and obviously of low priority. It consists of a demand to assign one Registered Professional Nurse per nursing unit, per tour of duty, at each municipal hospital and the assignment of a Licensed Practical Nurses and Nurses Aides “in appropriate ratio” to registered nurses. A joint committee of CIR and the Department of Hospitals will be established to determine the ratios.

Already a large group of CIR members and leaders have raised questions about these demands. They would like to strengthen the patient care demands by stipulating that the municipal system must hire enough nurses and subprofessionals to match the staffing pattern of the best voluntary affiliated hospitals. The contract should not pass the buck to some non-existent committee but should stipulate the facts as they are. For instance, within the voluntaries there are 60-70 registered nurses per 100 beds compared to the municipalities ratio of 23 registered nurses per 100 beds. This patient advocate group, which is growing in CIR, would like to make these patient care demands the primary goal of the contract negotiations. They plan to present their proposals to the next CIR meeting, and, if unsuccessful, to take their case to other interns and residents through a petition.

—Oliver Fein, M.D.

The Profit Seekers

The legitimacy of the American Medical Association (AMA) was challenged by a militant group of 200 medical professionals, students and consumers who disrupted the AMA's 118th annual convention in New York City on July 13.

A spokesman for the groups, including the Student Health Organization, the Medical Committee for Human Rights, and the Movement for a Democratic Society, said the AMA is really the “American Murder Association.” By seizing the microphone and denouncing the “profit-making motives” of organized medicine, Dr. Richard Kunnes, a 28-year-old New York psychiatrist, opened up a dialogue with many people around the country who feel oppressed by the health system. Among the congratulatory letters and telegrams he received was the following from Tulsa, Oklahoma:

“I read with interest your effort to influence the thinking of the doctors at the AMA convention and was strongly reminded of a statement made by Pastor Niemoeller after the close of World War II:

'In Germany, the Nazis came for the Communists and I did not speak up because I was not a Communist, then they came for the Jews and I did not speak up because I was not a Jew. Then they came for the Trade Unionists and I did not speak up because I was not a Trade Unionist. Then they came for the Catholics and I was a protestant so I did not speak up. Then they came for ME. By that time there was no one to speak up for anyone.'

"The same type of situation seems to exist in this country now and with the same goal in mind but perhaps we will be more fortunate if you and your group are not whipped into line. I feel the first hope since I realized what was going on."
WORKSHOPS

THESE AND OTHER WORKSHOPS ORGANIZED BY HEALTH-PAC WELCOME NEW PARTICIPANTS. CALL OR WRITE THE HEALTH-PAC OFFICE.

Financing Workshop

The health financing workshop undertook the tasks of exploring the institutional structure of health financing in the US, and coming up with some models of a rational financing system. The workshop has drawn heavily on outside resource people for background information: the historic development of the present mix of public/quasi-public/private insurance, the present roles of Blue Cross, commercial carriers, Medicare, etc.

The seminar then got swept up in the fuss over the Blue Cross rate increases, and decided to do some muckraking on Blue Cross. Research was divided up into one-person packages such as: analyzing the rate increases, looking into Blue Cross' legal status, investigating the board of directors, etc. [See "New York's Cross" Page 2.]

Next on the agenda is a seminar on Medicaid, with discussion on how the cutbacks might be dealt with in NYC clinics. After that the workshop will examine the commercial insurance companies, looking at their profits, their role in shaping the delivery system, their links to other industries such as banking, drugs and hospital supplies, etc. Finally the group will try to critique the current proposals, such as the United Auto Workers' plan for a national health insurance program [see BULLETIN, June 1969].

Industrial Health Workshop

Last year only 292 more Americans died in Vietnam than died in industrial accidents. Countless other workers suffered more subtle health effects that will eventually lead to death or disability. Asbestos fibers, coal dust, noise pollution, chemical vapors, and enzymes are only some of the hazards workers face in the ordinary course of their jobs. Of course, workers are not the only people confronting these hazards—they just get them in greater concentration. Motorists in the tunnels breathe high levels of carbon monoxide; housewives using detergents may also suffer from rashes and skin irritations. The issue is breaking out all over. As of September, will be research on industrial health hazards of activity, both expected to get really off the ground in hospitals, talking with people working in health care settings, and doing basic legal research.

Women's Liberation

A number of women doctors, nurses, other health workers and consumers have participated in researching and discussing the issues related to prenatal care, childbirth and contraception. Having concluded that most such care is expensive, inhumane or nonexistent, the workshop's task has been to understand the reasons why. Part of the problem is the general deterioration of routine, general care in the US. But another problem, more specific to women, is American medicine's "sickness model" of conditions related to reproduction.

Upcoming topics include: women and mental health, women as consumers of pseudo-medical products (cosmetics, nonprescription drugs, etc.), problems of child care, and a whole range of topics related to women as health workers. The workshop intends to keep going as long as necessary to explore these issues, and aims for the publication of informational brochures as well as a position paper on women in the health system.

Letters to Editor

Dear HEALTH-PAC:

I have read carefully your well written article on the Metropolitan New York Regional Medical Program published in the HEALTH-PAC BULLETIN. The article reflects a great deal of insight into the specific problems of that specific Region, as well as a good grasp of the historical developments of the national program . . .

In the final paragraph of your article you make a fairly sweeping indictment suggesting that medical schools "elsewhere" have "failed to use RMP for anything beyond their own narrow interests" . . .

However, it is my opinion that the medical schools of this nation, along with the hospitals and professional groups, have made a major contribution to establishing effective Regional Medical Programs . . .

It would be surprising if a new concept such as Regional Medical Programs was uniformly successful in its development in all areas of this diverse country. You have commented on a single program operating in a very complex metropolitan community. I think our entire track record is somewhat better than you make it out to be.

—STANLEY W. OLSON, M.D.
Director, Regional Medical Programs Service
U.S. Public Health Service, HEW