FUNDING MEDICAL EDUCATION: A HIDDEN AGENDA

All the hullaballoo over National Health Insurance has overshadowed Congress' most significant 1971 health legislation: the Health Professions Educational Assistance (HPEA) Amendments. These relatively unheard of amendments to the 1963 HPEA Act will authorize an unprecedented $3.5 billion for medical education over the next three years. They will make medical education No. 2 in terms of federal health expenditures, surpassed only by Medicare and Medicaid.

Yet, for all the promised money in the HPEA legislation, there will be little impact on the nation's health manpower crisis. The nation suffers a critical shortage of not only doctors, but of other health workers also. Dr. Roger Egeberg, former Assistant Secretary for Health in the Department of Health, Education and Welfare, stated last year: "The United States now needs about 50,000 more physicians, a couple of hundred thousand more nurses, and almost 150,000 more technicians." But the shortages are not merely numerical. Using the distribution of doctors as the most extreme example, there are severe ethnic, geographic and class imbalances as well. For doctors alone, less than two percent are Black, even though Blacks make up more than 12 percent of the nation's population.

In addition to racial and numerical shortages there exists a maldistribution of health personnel. Recently New York's Senator Javits said: "Despite the glut of doctors on Park Avenue, there are parts of the state with only one doctor for 15,000 people."

HPEA Amendments

In response to this crisis, Congress has offered the HPEA amendments, recently given the inappropriate title, "the Comprehensive Health Manpower Training Act of 1971." HPEA deals with only parts of the crisis. It covers schools of medicine, osteopathy, dentistry, optometry, pharmacy, podiatry and veterinary medicine. Support for nursing comes under the Nurse Training Amendments (see box on p. 3), which amounts to at most, one-fourth of the support for the other health professions represented in HPEA. Other health workers, such as occupational therapists, radiology technicians, etc. are covered under a third piece of legislation, the Allied Health Manpower Act of 1970. But the lion's share of the money is going primarily for the training of doctors.

The most obvious departure from past legislation in the 1971 HPEA Amendments is the huge boost in the level of federal funding for health professional schools: for medical school alone, the HPEA authorization is at least three times larger than last year's appropriations. But more significantly, the 1971 HPEA Amendments fix the pattern of federal aid to medical education—a pattern that favors direct institutional support over and above student assistance.

Institutional Support

Institutional support means federal money sent directly to the administration of a school. In contrast, student assistance routes federal loans or scholarships through the student to the institution. Under the 1971 HPEA Amendments, there are four categories of institutional support: (1) Capitation grants, $234 million; (2) Special Project Grants, $118 million; (3) Construction Grants, $225 million; and (4)
Assistance for schools in financial distress, $20 million. Each year, from 1972 on, these grants are slated to increase.

The major financial incentives within the amendments are directed at increasing student enrollment and shortening from four to three years, the time it takes to graduate. Thus, capitation grants going directly to the schools are calculated on the basis of the following formula: for M.O.D. schools (medicine, osteopathy, dentistry), $2,500 for every enrolled student plus $4,000 for each graduate completing school in four years or $6,000 for each graduate completing school in three years. These capitation grants have one condition—increased student enrollment. This "mandatory enrollment increase" must equal 5 percent per year for schools with freshmen classes of 100 or over; 10 percent per year for schools with freshmen classes below 100. In addition, the amendments authorize "bonus capitation support" for schools which increase their enrollment by 5 percent over and above the "mandatory enrollment increase." Despite all this, the most optimistic projection under these incentives is that it will take at least eleven years just to make up today's deficit of physicians.

Capitation grants are not linked to increased minority enrollment or increased women's enrollment. These areas are left to special project grants. While special project grants have been authorized $116 million less than capitation grants, they are supposed to provide an incentive for changing enrollment patterns with regard to race and sex, as well as for providing curriculum reform. Schools must devise grant applications dealing with special programs—for training in family medicine; for developing interdisciplinary training among HPEA schools and schools of nursing and public health; for encouraging minority enrollment; for experimental teaching; etc. All these critical tasks are secondary to boosting enrollment.

Student Non-Support

The most striking problem with the 1971 HPEA amendments is the paucity of support offered directly to students through student assistance programs: loans will be limited to $50 million for fiscal year 1972 and it is estimated that scholarship aid will not amount to more than $12 million. This means that the HPEA amendments authorize 10 times more money for institutional support than they do for student support. If these loans were to go to medical students alone (actually they are intended to cover all HPEA students including dentistry and pharmacy), then only 35 percent of all medical students enrolled in medical school today would be able to get the maximum loan of $3,500. Likewise, less than 8 percent of all medical students would be able to get maximum scholarship grants under the limited funds authorized.

It is all too apparent, that health science students will have to continue to work part-time jobs, marry and be supported by their spouses, be descended from wealthy families or seek commercial loans to get through their education. This is particularly true with the acceleration of private medical school tuitions (from $1,005 in 1958 to $2,270 in 1970) and the constantly rising cost of living. In 1968, the average medical student had annual expenses, including tuition, totalling $4,394. Considering inflation this figure is probably over $5,000 this year. In 1968, students paid for their education and living expenses in the following ways: 29 percent from spouse's income; 25 percent from family gifts; 24 percent from student's own earnings or savings; 12 percent from loans outside the family; 3 percent from grants or scholarships; and 6 percent from all other sources. The present HPEA amendments will do little to change this pattern of student dependency on family and spouse. It is likely that low income students will continue to shy away from medicine for lack of financial resources, perpetuating the present skewed distribution of medical students from the middle and upper income brackets.

While student hardship and perpetuation of financial barriers to education for low income students will continue, the federal government will be pouring more
than $1 billion per year into health science schools and each medical school will be getting approximately $6,000 per student in institutional support through capitation and special projects grants. Evidence from medical schools, concerning their present state of financing, suggests there is another agenda—financial solvency of the nation's medical education institutions—lurking behind the manpower trappings of the HPEA amendments.

Medical School Financing

Over the last two years, over 61 of the nation's 101 medical schools have been awarded special grants by the federal government on the basis of some "condition of financial distress." Medical school expenditures have gone up twice as fast in the past decade as expenditures in higher education generally, yet the number of students in medical school has increased at only half the rate of students in other fields. The cost crisis in medical education has deep roots that penetrate back to the turn of the century.

In 1906 the number of American medical schools peaked at 162. By 1915 only 96 medical schools remained. The Carnegie Foundation's Flexner report on American medical schools, published in 1910 was largely responsible for the decrease. This was the first foray into medical education by the Carnegie Foundation, noted for its interest in all types of education. Abraham Flexner was employed by the Carnegie Foundation and commissioned by the American Medical Association's Committee on Medical Education to study and recommend reforms for the American system of medical education. Flexner visited every medical school in the United States and he classified the variety of medical schools into three types: "the clinical type, which derives more or less directly from the apprentice system; the university-type which emphasizes the ideals of scientific development; and the proprietary type, the educational policies of which may be assumed to be modified by commercial considerations." 

The Nurse Training Act

Along with the Health Professions Educational Assistance Amendments, Congress passed the Nurse Training Act of 1971. The doctors' amendments are separated from the nurses', not out of Congressional chauvinism, but to provide political visibility for the nurses. The amount of Congressional authorization is another matter. The nurses were funded at one-fourth the level of the doctors. Of course, nursing education is much less expensive than medical education; but, the total number of nursing students (164,545) is more than three times the number of medical students.

The Nurse Training Act is a mini-HPEA. All the categories are essentially the same, only the authorized amounts are smaller. The distinction between institutional support and student assistance is maintained. For fiscal year 1972 there are four categories of institutional support: (1) Capitation grants, $78 million; (2) Special Project grants, $20 million; (3) Construction grants, $35 million; (4) Assistance for schools in financial distress, $15 million. The Capitation grants are calculated on a formula which gives each school $250 per fulltime enrolled student, plus $500 for each graduate or $900 for each graduate in a nursing specialty. To be eligible for capitation support, each nursing school must increase its freshman class enrollment by 5 percent. Bonus capitation support is available for any school that increases its freshman class enrollment by 10 percent. This amounts to $100 per student in the first year class.

Student assistance, as in the HPEA amendments, is much smaller than institutional support. Congress has authorized $25 million in loans, $20 million in traineeships for graduate nurse training and an unspecified amount of scholarship aid. All of these authorizations must first be appropriated by Congress and second made available by the President through the Department of Health, Education and Welfare. These processes are still off in the future.
Millions for Less

How will the HPEA amendments effect the average medical student? The very early experience at New York's Albert Einstein College of Medicine (AECOM) suggests some of the problems. This year AECOM received a $12 million five-year grant under the special project provisions of the 1968 HPEA amendments. The grant will make AECOM one of the first medical schools to experiment with a three-year medical education program.

School started at the unusually early date of August 2nd. Although the total length of schooling (approximately 32 months) will be the same for three year and four year graduates, the pre-clinical years have been condensed from the usual 16-18 months to 13 months. The result is that students have exams every three weeks. In anatomy, time ran out at the ankle, and students had to reschedule time to study the foot. Last year neurobiology was taught in 6 weeks' this year it will be taught in four. As one student commented, "Everyone is anxious and strung out. The competition is worse than ever."

One of the major consequences of this streamlined form of medical education is the elimination of summer vacations. "There are three weeks off next August," points out one student, "but they're just before National Boards in September." Fortunately, students in the three year program can switch anytime to the four year one. It is still to early to tell how many will take this option.

The three-year curriculum may not benefit the student. But it sure does help AECOM. For a school that has real trouble in meeting its payroll, the $2.4 million first installment of the grant was a godsend.
been alleviated by the small increases in medical school income derived from "faculty practice." Although Medicare and Medicaid boosted income in the faculty practice sector (because poor patients now could pay for doctor care), this was a mere pittance in terms of the medical schools' need. By 1968, it accounted for no more than 7 percent of the medical schools' income. (This source of income is reflected in "teaching hospital" and "medical service fund" income, see Chart I.)

A new way had to be found for federal funding of medical schools. The groundwork was laid by the 1963 Health Professions Education Act (HPEA), which provided construction grants for educational facilities and loans for medical students. In 1965, this Act was expanded over the opposition of the American Medical Association to include federal funds for the actual operation of medical schools and student scholarships. The deans through their organization, the Association of American Medical Colleges (AAMC) consistently pushed for federal government funding.

By 1968, the handwriting was on the wall. Uneasily the AMA switched sides and joined the AAMC in pushing for expansion of the HPEA Act. The result was gratifying: institutional support for medical schools rose from $25.5 million in 1968 to $76 million in 1971. But even this was grossly inadequate.

Carnegie Foundation to the Rescue

In October, 1970, just before HPEA legislation came up for renewal, the Carnegie Foundation for the Advancement of Teaching released a report entitled: "Higher Education and the Nation's Health: Policies for Medical and Dental Education." This is perhaps the most significant report on medical education since the Flexner Report. Like the Flexner Report it talks about different types of medical schools that are called models.

There is the "Flexner model," which is based on research, but which the report says "leads to expensive duplication and can lead to some loss in quality." In addition, the report points to two new models: "(1) the health delivery model, where the medical school, in addition to training, does research in health care delivery, advises local hospitals and health authorities, works with community colleges and comprehensive colleges on training of allied health personnel, carries on continuing education for health personnel, and generally orients itself to external service; and (2) the integrated science model, where most or all of the basic science (and social science) instruction is carried on within the main campus (or other general campuses) and not duplicated in the medical school, which provides mainly clinical instruction."

The Carnegie Report is not primarily concerned with models. Rather, its major emphasis is on financing medical education, cutting costs, rationalizing and streamlining the medical education process. Though many words are devoted to curriculum change and increasing minority student enrollment in medical schools, suggestions for reforms in these areas are

### Sources of Medical School Income

<table>
<thead>
<tr>
<th>Source</th>
<th>1947-48 (in millions of dollars)</th>
<th>1959-60 (in millions of dollars)</th>
<th>1967-68 (in millions of dollars)</th>
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<tr>
<td>Sponsored Research</td>
<td>$17.1 (24%)</td>
<td>$134.4 (38%)</td>
<td>$473.3 (43%)</td>
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<td>Federal</td>
<td>8.0 (11%)</td>
<td>92.2 (26%)</td>
<td>369.6 (36%)</td>
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<tr>
<td>Non-Federal</td>
<td>9.1 (13%)</td>
<td>42.2 (26%)</td>
<td>83.7 (8%)</td>
</tr>
<tr>
<td>State and Local Governments</td>
<td>25.0 (34%)</td>
<td>60.9 (17%)</td>
<td>159.4 (15%)</td>
</tr>
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<td>Training Grants</td>
<td>6.8 (10%)</td>
<td>21.4 (6%)</td>
<td>93.7 (9%)</td>
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<td>Overhead (from contracts &amp; grants)</td>
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<td>16.2 (5%)</td>
<td>82.5 (8%)</td>
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<tr>
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<td>17.0 (5%)</td>
<td>53.3 (5%)</td>
</tr>
<tr>
<td>Tuition and Fees</td>
<td>12.1 (17%)</td>
<td>25.8 (7%)</td>
<td>48.3 (4%)</td>
</tr>
<tr>
<td>Medical Service Funds</td>
<td></td>
<td>10.9 (3%)</td>
<td>48.0 (4%)</td>
</tr>
<tr>
<td>Others (includes RMP, CMHC, etc.)</td>
<td>4.7 (6%)</td>
<td>12.7 (4%)</td>
<td>44.0 (4%)</td>
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<tr>
<td>Teaching Hospitals</td>
<td></td>
<td>17.5 (5%)</td>
<td>36.7 (3%)</td>
</tr>
<tr>
<td>Endowment (unrestricted)</td>
<td>6.7 (9%)</td>
<td>18.7 (5%)</td>
<td>28.6 (3%)</td>
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<tr>
<td>Misc. University Income &amp; Reserves</td>
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<td>18.0 (5%)</td>
<td>27.9 (3%)</td>
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<tr>
<td>TOTAL</td>
<td>$72.5</td>
<td>$353.5</td>
<td>$1,095.7</td>
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</table>

perfurctory and relatively insignificant (e.g., the creation of an educational opportunity bank, improving curriculum by tying more closely together basic science and clinical instruction). The real reforms appear to be directed at cutting medical education costs—such as, reducing from four to three years the time it takes to get an M.D. degree, or combining science work on campus and in the medical school, thus reducing the duplication, or reducing the ratio of faculty to students; and rationalizing medical school financing by for example, increasing federal financial support for medical education, while not decreasing state support, and holding federal research expenditures steady as a percentage of the Gross National Product.

The Senate version of the 1971 HPEA Amendments sponsored by Senator Kennedy used the Carnegie recommendations down to the specific dollar amounts. Although the House version was considerably more conservative than the Senate’s, the trends established by the 1971 HPEA Amendments are apparent and consistent with the Carnegie Report: first, they increase federal support for medical education three times over 1971 appropriations; second, they favor institutional support far above student support; third, they emphasize increased enrollment and shortening of medical education (“streamlining”) above increased minority enrollment and substantive curriculum reform.

**Impact of HPEA Amendments**

The obvious impact on medical schools of the HPEA amendments will be to shift financing from federal research support towards general institutional support. But the ramifications of this shift are not so obvious. Changes in the source of medical school income will be reflected in changes within the internal power structure of the schools.

In the recent past, the dominance of research money within the medical school has fostered the development of departmental and individual researcher autonomy. In fact, some individual big-name researchers have been so independent that they can move whole research staffs numbering 15-20 people and expensive research equipment from one institution to another. Within medical schools, departmental heads have developed baronies of their own, from which they vie with each other for teaching time, laboratory space and power on the executive faculty. In contrast, the deans and central administration of the medical school are often quite weak. They have no financial base from which to wield power and end up mediating the differences between autonomous departmental forces.

The HPEA amendments will change this distribution of power. Capitation and special project grants will go directly to the deans and administrators, who will parcel money out to support faculty for teaching and even research purposes. Power will shift from the departmental heads and autonomous researchers to the dean’s office. With this consolidation of power within the school’s central bureaucracy, the anachronistic baronial power structure based in separate departments will fade away. Medical schools will step into 20th Century forms of corporate management and control.

William N. Hubbard, Jr., M.D., former dean of the Medical School at the University of Michigan, Ann Arbor, now Vice President and General Manager, Pharmaceutical Division, The Upjohn Company, was aware of the corporatization of the medical school, when he said: “Maximization of budget size with minimal loss of institutional independence is the academic [i.e., medical school] equivalent of the profit motive in the business sector of our economy.” He also anticipated the importance of the HPEA amendments in providing medical schools with a new source of income not tied to research or faculty practice: “An institutional grant program for physician education which does not compete with the power of income generation from service and research sources will not change significantly the mix of efforts of the faculty.” In other words, give the institution (the dean) the money and the faculty will follow the institution’s (the dean’s) priorities.

This is the hidden agenda of the HPEA amendments—a realignment of medical school power structure and priorities. Likewise, it is one of the unstated purposes of the Carnegie Foundation Report. This comes as no surprise, however. A glance at the advisory committee on medical education to the Carnegie Commission on Higher Education gives ample explanation. Of the eight members of the advisory committee, three are medical school deans, one is head of a department of psychiatry, another is director of a university affiliated research institute, the classic dean’s man, such as chairman of the department of medicine or biochemistry, is absent. However, there is a systems-man—the former director of health planning for the University of California, presently corporate planner for the Kaiser Foundation Health Plan. This is certainly a dean’s team if there ever was one.

What’s wrong with these shifts of pow-
er? It is about time that medical schools left the middle ages. Certainly, medical education needs to be supported in and of itself not through research grants. Teaching must have high priority, if doctors are to be trained well, rather than being a by-product of research and faculty practice. But it is not clear that such new priorities will emerge with the new sources of funding. The shift of power from departmental heads to deans is a shift within the same group of people who have run medical schools in the past. In fact, the corporatization and centralization of the medical school, signals a step away from increased faculty, student and community control of the institution. Now, medical schools will be capable of pursuing institutional priorities directed at "empire building" unfettered by departmental resistance and financial constraints.

Research for this article was done by Stanley Padilla and Oliver Fein. (Stanley Padilla is a fourth-year medical student at the University of New Mexico and was a summer intern at Health-PAC.)

**ATTICA:**

**MURDER BY OMISSION**

The State moves in mysterious ways, its wonders to perform. Many times its performance assumes a brutal clarity, and one is left without wonder, only rage. Such was Attica—September 13, 1971.

It would be a mistake, however, to believe that the appalling disregard for human life exhibited by Governor Rockefeller on that day was an isolated phenomenon involving only a single unresponsive political figure. To the prisoners of Attica, the bullets fired by Rockefeller’s troops were simply tangible evidence of the less blatant homicidal policies governing their lives daily.

Among those issues leading the prisoners to rebel was health care. One inmate stated to his lawyer, “Within this prison for years our blacks, latinos, and poor whites have been denied medical attention. We have gone to the Prison Hospital when we got sick, and the racist doctors refused to treat us. As a consequence, eight inmates died within just four months in 1971.” Thus two demands of the Attica Prisoners’ Manifesto of September 8 attacked the inadequate prison health care system.

1. “We demand a change in medical staff, and medical policy and procedure. The Attica Prison Hospital is totally inadequate, understaffed, and prejudiced in the treatment of inmates. Numerous ‘mistakes’ are made; improper and erroneous medication is given by untrained personnel.

2. We demand periodical check-ups on all prisoners and sufficient licensed practitioners available 24 hours a day.”

What had been the mechanism for delivery of health care prior to the rebellion? Primary medical care at Attica was delivered by two state-employed doctors, one full-time and one part-time. Responsibility for further consultative care had been informally assumed by faculty of the University of Buffalo (UB) Medical School, 40 miles away. As described by Dr. LeRoy Pesch, Dean of the School of Medicine, “The Medical School of the State University of New York at Buffalo and Erie County’s Meyer Memorial Hospital (a teaching affiliate of the medical school) have been deeply involved in meeting the medical needs of the Attica facility for the past five years.” Aside from elective surgical procedures performed by Meyer Hospital house staff at the prison, the University’s ‘deep involvement’ was limited to epidemiological studies using the inmates, and to the provision of Buffalo physicians in emergency situations.

Limited though it was, the historical connection between Attica and the University of Buffalo made the latter institution the logical one to respond to the medical crisis created by the state troopers on Monday, September 13. On the afternoon after the shootings, the University of Buffalo and Meyer Hospital sent only 14 doctors and medical students out to Attica to treat the estimated 400 wounded men. In addition, an emergency call for upstate physicians was being circulated. It seemed therefore quite reason-
able to the fifteen nurses and doctors who came from New York City Monday evening to offer assistance to the University of Buffalo in treating the wounded prisoners. This offer of aid even seemed reasonable to Federal Judge Curtin, who signed a court injunction Monday night to allow this medical team immediate access to the prison. But a short time after receiving the court order the fifteen doctors and nurses were unconditionally denied entry at the gates of Attica.

Rule Not Reason

It was clear that reason was not the rule. As they waited outside Attica all Monday night and Tuesday morning, reports of the medical situation inside the prison were communicated to the members of the medical team. From these reports it became clear that medical responsibility was being abdicated in deference to the political priorities of the state prison authorities.

According to W. G. Schenk, Director of Surgery at UB and Meyer, fifty prisoners had, on Monday afternoon the 13th, been judged so critically wounded as to require transfer to Meyer. Within a short time, Meyer Hospital had marshalled emergency personnel and equipment in order to receive the fifty men. Only eight men arrived; Warden Mancusi had refused to allow any other men to be transferred from the prison. Rather than challenging the warden’s “medical judgment”, Dr. Schenk remained silent. As a result, the UB doctors were forced that day to perform twenty-five operations, including three abdominal laparotomies, in the small prison operating room, often operating on two men at the same time. By 11 PM Monday night, their surgical marathon completed, all the UB doctors were ordered out of the prison by the warden. The nurse-inmates were returned to their cells and the one remaining prison doctor announced he was going to bed. One UB doctor shrugging his shoulders, referred to the post-operative patients, “Well, they’re young and strong; I guess they’ll be all right with no care.” To the New York City medical team waiting outside the prison gates, it appeared that Dr. Schenk had shirked medical responsibility in accepting both the restriction on transfer of pre-surgical patients and the abandonment of the twenty-five post-operative patients. Monday night, Dr. Evans Calkins, Director of Medicine at UB Medical School, stated by telephone to one of the New York City doctors that “medical malpractice” was being performed at Attica; by Tuesday morning he joined Dr. Schenk in silence because Warden Mancusi had requested a pledge of ‘security’.

The most telling indictment of the UB Medical Center’s commitment to health care at Attica came from Dean Pesch. In spite of assurances on Monday night that he was anxious to facilitate the medical team’s entry into Attica, Tuesday afternoon he stated publicly that medical care inside the prison was adequate and therefore there was no need for the New York group to enter the prison. The justification for his change in position consisted of an explanation of the delicacy of his status at the medical school as a proponent of a black student admission program in the face of a staunchly right-wing county and state legislature, which supplied the school’s, and the program’s, funding. While the goal of the black student admission program at Buffalo is 25 percent, Pesch has only managed to increase black admissions from 6 percent in 1969 to 8.8 percent in 1971.

Medical Responsibility

The medical institution’s lack of commitment to Attica soon became more than insensitivity; it progressed to medical irresponsibility. Descriptions of troopers’ clubbing injured and delirious inmates in order to quiet them, leaked out. Two house staff doctors from Meyer who told the press of guards’ brutality were denied re-entry. According to reports from within the prison, mutilations and castrations were performed in the prison infirmary on the bodies of men killed the day of the attack. No one knows how many men, deprived of immediate physical exams to establish the presence or absence of injuries, were subsequently beaten and had their injuries ascribed to September 13. Members of the negotiating committee reported that three of the men ‘found dead’ were seen alive after the official onslaught had ended. However, independent doctors were still not getting in. The commitment of Dean Pesch and UB is perhaps best described by a third-year medical student at Buffalo Medical School who arrived at Attica on September 13 soon after the shooting stopped:

“When I arrived I was told to evaluate this one inmate who had gunshot wounds to both legs with obvious open fractures. The inmate was delirious, moaning in pain. I heard two guards tell the inmate to shut up. When he did not comply, they began to beat the wounded man over the head with clubs and gun butts. I stopped them; in disbelief I told them to leave the man alone. I then waited for over one hour until my attending physician returned. I told him about what had happened and asked him about transferring the man to our hospital in Buffalo. He
immediately to expand its present surgical program at Attica to include general medical care.

Even if the contradictions inherent in Pesch's 'concerned' refusal to act had escaped the Dean, they were not missed by the student body at the University. The UB Ad Hoc Committee to Support the Attica Prisoners charged that "While the shooting at Attica stopped, the murder still goes on. We cannot rely on the same people who caused these conditions to alleviate them." In recognition of UB's medical and ethical responsibility to take the lead in assuring health care to the inmates of Attica, this campus-wide group, with the voted support of over 200 medical students, presented the following list of demands to Dean Pesch at a meeting Wednesday morning, September 15:

- "We demand that the University of Buffalo Medical School accept full responsibility for the health care of all inmates at Attica Prison.
- We demand a public statement of all medical treatments and examinations performed since the beginning of the rebellion, including a listing by name of all inmates, the treatment undertaken, their physical conditions, and their present locations.
- We demand the formation of an objective Medical Review Board, including physicians chosen by prisoners and their families.
- We demand that families of dying and injured prisoners be immediately given full visitation rights.
- We demand a full public statement detailing the relationship between the University of Buffalo and Attica State Prison."

In response to further hedging by the Dean that morning, several hundred students participated in a rally and sit-in at the Dean's office Wednesday afternoon and evening. At last on Friday, September 17, Dean Pesch tiptoed into action. Making it clear that he wasn't negotiating "in response to their [students] demands but in response to the professional demands that we provide the best medical care possible," the Dean announced a formal three-part agreement between the New York State Department of Corrections and the UB Medical Center:

- "The Buffalo Medical School proposes immediately to expand its present surgical program at Attica to include general medical care.
- The faculty of the Medical School also offer full medical consultative services to the inmates of Attica, while recognizing that legal responsibility for the inmates' medical care remains with the Department of Correction.
- The University and its Medical School further offer to institute plans to assure comprehensive care at Attica on a longer-term basis."

When this agreement was released by Dean Pesch to the press on Friday, September 17, as an "immediate and compassionate response" to the health situation at Attica, 41 men had already died.

The Aftermath

It would be at least minimally optimistic to terminate on the note of this formal and public assumption of medical responsibility by the University of Buffalo Medical School and Meyer Hospital. Unfortunately, events subsequent to the release of Dean Pesch's statement not only throw serious doubt on the sincerity of the University in adhering to the agreement but also refute the political validity of the Dean's delicate fence walking between medical principle and state pocketbook.

One week after Dean Pesch announced that the long-range prison health program would most certainly be set up with the aid of black doctors from the National Medical Association, Dr. Alyce Gullatte, President of the NMA, was refused entry into Attica. The fate of Pesch himself is a more ominous indication of the shaky future of the prison health program and of the black admission program. Having skillfully equivocated in order to protect "my position and my black student admission program," the Dean was invited to the home of Dr. Ketter, President of the University of Buffalo, on Thursday afternoon, September 30. According to Pesch, what ensued was a general discussion of problems and future projects for the Medical School. Thursday evening Pesch arrived home from his meeting only to be greeted with headlines in the Buffalo evening paper announcing his 'resignation' as Dean of the Medical School.

Dean Pesch was the fourth in a series of reportedly liberal department heads at the University of Buffalo to be resigned in such manner within that week. "I don't have to be the 'good boy' any longer," he stated to a group of students the next day. "You can publicize what really happened." He related that Ketter had charged him with lowering the standards of the medical school through the black admission program. But when asked if he planned to fight this seeming purge of liberals, the Dean replied, "No, I cannot jeopardize the black student admission program."
Several conclusions emerge from the medical crisis brought on by the Attica massacre. Despite State attempts to shroud the practices of the prison health system, non-prison employed medical participants can serve a valuable function in exposing the realities of health care inside the prisons. The involvement of the University of Buffalo with Attica, although insufficient, at least facilitated the entry of Buffalo house staff and medical students who made public otherwise unseen brutalities. Although denied entry to the prison, the New York City medical team at least by its presence highlighted the fact that the State prison authorities placed more value on internal security than the care of post-operative patients. The medical school and its affiliate hospitals can and should play a prominent role in opening the prisons to public view and accountability.

There is a danger, however, as with Attica, that the medical institutions will give political priorities precedence over medical needs. When medical ethics are manipulated to fit comfortably into political pocketbooks, one ends up with an empty bag. What is common to President Ketter's indictment of the black student admission program, to Dean Pesch's reluctance to assume responsibility for medical care at Attica, and to Governor Rockefeller's order to shoot the men inside Attica, is the commitment of powerful men to the maintenance of a blatantly racist social order. In refusing to assume a complete and conscientious responsibility for the health needs of the Attica prisoners, Dean Pesch and the University of Buffalo Medical School share, with Rockefeller, responsibility for the deaths at Attica. One does not have to kill with guns alone.—Marcia Sollek. (Marcia Sollek is a fourth-year medical student at the University of Cincinnati.)

GOODBYE, COLUMBUS

Throughout the country, urban neighborhoods are increasingly having to fight for their survival against the expansion of large institutions. After a year-and-a-half long battle, residents of "Bedpan Alley," a neighborhood so dubbed because it contains the largest concentration of medical institutions in New York City, are celebrating what may be an unprecedented victory in the conflict of home-vs.-institution.

Columbus Discovers 19th Street

The 200-block of East 19th Street has been a pleasant, relatively-safe block located in the midst of one of Manhattan's few remaining traditional working class neighborhoods. It is rapidly being taken over, however, as the home of Columbus Hospital and its professional staff.

Columbus Hospital is a small, voluntary Catholic institution with expanding ambitions. Next door to its present facility, Columbus has purchased land and is planning a new building to replace its present plant. To compete for upper-echelon hospital personnel, in 1968 Columbus purchased one luxury high-rise on the block (and forced its tenants out as their leases expired) and acquired options to rent apartments as they were vacated in yet another high-rise.

But its most controversial acquisition has been that of two buildings housing 48 families across the street from the hospital. The buildings were purchased surreptitiously in December, 1969, and the tenants were ordered out the following spring. Only after organizing themselves and conducting their own investigation did the tenants discover that their new landlord was Columbus Hospital and that it intended to demolish their structurally-sound, low-rent apartments to provide parking for 27 staff cars.

In order to get rid of the tenants, the hospital turned to heavy-handed tactics. First, to "manage" the buildings, it hired the Urban Relocation Company (URC), an official-sounding, private realty company notorious in New York for its expeditious, if unscrupulous, means of "convincing" tenants to leave their homes. The old building superintendent was fired and a URC superintendent moved in, along with his large German Shepherd dog which was allowed to roam the hallways unleashed. Building maintenance virtually ceased; vacant apartments were boarded up, inviting junkies and burglars; heat and hot water were cut off on numer-
ous occasions, including Christmas day, 1970; and the remaining tenants were alternately lied to, bribed, and threatened—all in clear violation of New York City's rent control and eviction regulations.

Tenants Discover Columbus

Columbus succeeded in intimidating and forcing out some of the poor and non-English speaking tenants, but as those remaining realized what was happening, they quickly organized themselves into the 19th Street Branch of the Neighborhood Save Our Homes Committee.

Action began in the summer of 1970. Four families became squatters, attempting to move into apartments which had already been vacated. Columbus Hospital moved quickly, however, arresting the squatters, their supporters, and two sympathetic tenants. It also initiated dispossession actions against the two tenants which were to drag on for months and months. That winter the Committee conducted a highly-publicized "paint-in" in the neglected buildings. This was followed shortly by a telegram written in Latin to the Pope, asking his intervention with the Rome-based Missionary Sisters of the Sacred Heart, the order which runs Columbus Hospital. (Ironically, the Missionary Sisters were founded by Mother Cabrini, the first and only American saint, whose fame rests on her devotion to homeless immigrants in New York City.)

The Committee instituted harassment proceedings against the hospital, based on violations of New York City's rent control laws; successfully fought the dispossession action against its two member, and conducted a variety of demonstrations and leaflet campaigns. But the real breakthrough came with the filing of a suit by the Committee to halt a state loan for the hospital's new addition.

"Actually there were two separate issues: the disposition of the two buildings and the larger issue of the hospital's expansion," commented one of the Committee's spokesmen. "We linked the two issues by showing that the public loan made it possible for Columbus to use its own money to buy the building and thus house 48 families in favor of 27 staff cars. We also used the suit to bring Columbus to the bargaining table regarding the two buildings."

Tenants Rock Columbus' Boat

The 19th Street Committee began to investigate and found that in 1965 Columbus had applied for the required approval of the Department Social Welfare to build a nine-story addition on the land it had acquired next door. The $8.5 million new building, which was to be privately financed, was designed to provide staff housing, a convent, a first-floor parking garage, and 118 additional hospital beds.

However, in 1969 public funds became available under the State Hospital Mortgage Loan Act. Columbus' plans suddenly blossomed and it applied for a loan to build a $44 million, sixteen-story addition. Interestingly, the new plans called for neither staff housing nor the on-site garage—needs which Columbus could presumably now meet by privately acquiring other properties in the neighborhood. The old hospital building was to be renovated for doctors' suites and for a 41-car garage, which would produce several hundred thousand dollars income each year (according to the hospital's own statements).

As the Committee probed more deeply in hopes of appealing or protesting the new loans, it discovered that Columbus had never gone back to the Department of Social Welfare to get approval for its expanded plans in spite of the fact that the project's scope had increased fivefold.

The more the Committee investigated, the more they uncovered discrepancies and contradictions in the procedure. For example, the first step in the process is to gain approval from the Health and Hospital Planning Council of Southern New York (HHPC) (previously called the Hospital Review and Planning Council).

In evaluating the application, the HHPC granted Columbus credit for "locating in an underserviced area," in spite of the fact that there are 5266 acute care hospital beds between 42nd Street and the tip of Manhattan and one-third of these are located in the six-block area which includes Columbus ("giving that area five times the national average in hospital beds"). The HHPC also credited Columbus for "consumer and community participation in the planning process," even though the Committee could not find a single community group which had been consulted or even knew about Columbus' plans.

To obtain the loan, the hospital is required to hire an accounting firm to demonstrate the financial feasibility of the project. The State requires the firm to review records given to it by the hospital. But in this case the firm stated that since the Missionary Sisters of the Sacred Heart, and not the hospital, were to provide equity for the loan, any demonstration of financial feasibility would require a financial investigation of the Missionary Sisters. Yet the State explicitly instructed the firm not to investigate the Sisters. On the basis of such discrepancies, on August 20, 1971, two 19th Street tenants and a New York State Assemblyman filed a taxpayers' suit to halt approval of the loan.
and to halt construction by Columbus Hospital.

The suit brought immediate results, due largely to its timing. It was filed two weeks in advance of the scheduled final approval of the loan by the State Housing Finance Agency. To qualify, the Committee discovered the hospital had to be free of all litigation. Not only did the suit threaten to entangle construction funds for months, but Columbus had been so certain of approval that it had already hired a contractor and construction was well under way. The hospital recognized the tenants group with dispatch and seven days later, at the hospital’s request, both sides sat down at the negotiating table.

The outcome was a legal agreement in which Columbus Hospital agreed to recognize the rights of tenants to live as long as they wished in the disputed buildings; to fire the Urban Relocation Company; to fix all violations in occupied apartments; to remove the tin on the windows of vacant apartments; to present all future expansion plans to the Community Planning Board; and to establish with tenants a committee empowered to decide the future disposition of the disputed buildings. In return, the plaintiffs agreed to discontinue the taxpayers’ suit and the Committee agreed to discontinue the harassment proceedings.

Organizers of the 19th Street Committee cite certain elements which made their victory possible. First, the neighborhood was particularly ripe for such a struggle. Many of the residents were “double-jeopardy tenants,” having been previously displaced by expansion by nearby Beth Israel Hospital. Second, it has been an “old-fashioned neighborhood” with an amiable mix of homes, stores, schools, churches and parks—“the kind of neighborhood you can feel an investment in,” commented one resident.

The 19th Street Committee provided tactics and a structure for this discontent. According to one coordinator of the Neighborhood Save Our Homes Committee, “You can’t ignore the importance of techniques that build a strong organization and keep it together.” For instance, the 19th Street Committee quickly established a subcommittee to collect and submit rent payments each month, forcing URC to deal with tenants as a single unit rather than individually. Likewise a grievance committee was established to handle all tenant complaints. Many of the actions such as the paint-in, the telegram to the Pope, and demonstrations were as important in terms of building group cohesiveness and morale as they were in applying pressure on Columbus.

“Nor can you underestimate the strategic importance of cooperation of elected officials.” A U.S. Congresswoman, a State Assemblyman and a City Councilman took roles of varying intensity in the struggle. Their participation attracted publicity to Committee actions while also boosting morale. In addition, in the midst of the heaviest tenant harassment, one official wrote letters of support to tenants, under-scoring their legal rights in the situation. “The effect was psychologically very powerful.” Finally, the assistance of elected officials and their aides was critical in terms of gaining access to government agencies, documents and official information.

The existence of a community newspaper, in this case the Gramercy Herald, was also key. “Even if the paper has limited circulation, no institution wants to see itself splashed across the front-page. Front page news in a small community newspaper is an important entrée to larger news media.” One organizer also emphasized the importance of having an aggressive, pugnacious lawyer—“one you don’t have to convince of your case before you start.” The 19th Street Committee also gained by drawing together people with an impressive collection of skills, including experience in media, promotion, research and analysis, and community organizing.

The discrepancies and contradictions on which the suit was based were primarily the responsibility of the State and not the hospital. The lesson which this may offer similar groups is that government bureaucracy is so complex that bureaucracy can often be used against itself and to the ends of insurgent groups.

The 19th Street Committee still has work to do. First of all, its victory over Columbus has not been unconditional. Columbus must still live up to its agreement and may still require friendly persuasion. The 19th Street Committee will also lend its support to other branches of the Neighborhood Save Our Homes Committee which are carrying on similar struggles with other medical institutions in the area, as well as joining with other groups organizing around broader housing issues such as rent control.

Finally, the Committee is planning a one-day seminar in the near future as an opportunity to examine the deeper issues and implications of the Columbus struggle. “Everyone came to share the concept of the right to save your own home. But there are deeper concepts which we never worked out, like: Who runs the institutions? Why do tenants get stomped on? What is ‘good’ hospital planning? What is good health care? We need to know not just what we are against, but what we are for as well.”—Ronda Kotelchuck