Editorial: INSTITUTIONAL ORGANIZING

A movement for radical change in the health system has grown to significant proportions in the last few years. Its primary goal has been fairly clear—the total restructuring of the health system in the interest of people, not profit or hierarchy. But how to achieve that goal has not been so clear.

The focus has often been the dramatic or episodic. Many health activists have set up “alternate institutions” like free clinics or neighborhood health centers. But there has been a growing recognition that meaningful change must be fashioned at the heart of the health system. Health institutions—hospitals, medical schools and centers—represent the primary concentration of power and wealth in the system. More and more they are responsible for the delivery of inadequate health services to large segments of communities throughout the nation. Finally, they are accessible and vulnerable to the organizing efforts of workers and community groups.

The concept of institutional organizing follows from the knowledge that the needs and interests of institutions and those who control them differ from the needs and interests of the workers who run the institutions and the communities which receive their services. The result most often is neglect or exploitation of the latter groups.

The health movement is young and many strategies remain untried or half-tried. The three-year struggle to improve patient care and work conditions at Lincoln Hospital in the Bronx allows us to glimpse one of the first thin threads of a sustained struggle to achieve worker-community control within a health institution.

Initially many at Lincoln felt that control of the hospital on behalf of the community was the key goal. Time and practice have shown, however, that the workers at the hospital are in fact pivotal. Their actions have made the greatest inroads and have had the most continuity. This arises in part out of the differences in the relation of workers and community residents to a hospital. Workers are at the hospital every day. A major part of their lives is spent there. Far more than outsiders, they know how it actually runs. Community people visit the hospital infrequently and when they do, it is often under conditions of great personal stress—the worst condition for focusing attention on the institution. Furthermore, workers at the hospital are concentrated in one place and are relatively accessible to each other. Thus it has happened at Lincoln that the slogan of “community-worker control” has to some degree shifted toward “worker control,” even as those involved have attempted to develop creative tactics to unite workers and patients.

Lincoln today is just beginning to be a different place in which to work or to be sick. Workers have succeeded in driving a very small wedge, allowing them to begin to control parts of their work environment. A wide and creative range of tactics has come to hand, some eruptive and some painstakingly slow. One hallmark is that workers have been extremely careful to safeguard patient welfare. Rather, when the crunch has come, ironically it has been those in positions of power who deserted the patients.
But if significant gains have been made, the Lincoln struggle raises some critical questions for any group intending to engage in institutional organizing. First, who is the constituency for such political work? It is obvious that hospital workers are not homogeneous. It is already clear at Lincoln that white male professionals cannot lead the majority of hospital workers who are non-professional, often poor, third world and women. Instead it appears that they can only lead those like themselves, supporting other hospital workers, but leaving the leadership to the workers own choosing. What the final relationship will be, however, between the professionals and non-professionals is still unanswered.

Beyond the gray areas involving leadership and constituency, there are other unanswered questions: What should be the target of the organizing? Should it be the public hospital itself or the affiliated, and often controlling, medical school? Are demands to be placed upon city and county officials or upon hospital administrators, medical school deans, and chiefs of departments?

Finally, while it seems true that the role of workers in effecting a radical restructuring of health services has been underestimated in the past, the relationship between worker and community demands is far from settled. What happens in the event of conflicts between the two? Which receives priority?

This Bulletin does not pretend to answer all of these questions. Some of the problems have yet to be confronted at Lincoln Hospital. Other struggles are in progress in other hospitals. As more experience is gained, hopefully, the lingering questions will be answered.

In the meantime, the gains won so far at Lincoln are impressive. And among the more impressive have been the changes in outlook which have taken place for those who have been involved in these struggles. These changes have amounted to nothing less than a fundamental redefinition of themselves, their needs, and their place in society. These changes will not easily be reversed.

400,000 Puerto Rican and black people live in New York's South Bronx, is one of the nation's worst ghettos. Survival in this community is a daily struggle. Unemployment is severe. 80 percent of all housing is deteriorating. Transportation is poor; schools, overcrowded. In health, the picture remains just as bleak. The infant mortality rate is 90 per 1000 live births—twice the national average. Heroin overdose is the leading cause of death among adolescents and young adults; tuberculosis in the South Bronx runs three times the national rates. Major health needs are met by one municipal hospital: Lincoln.

Although Lincoln Hospital is located in an inaccessible and desolate corner of the South Bronx, it is very much a part of that community. Its neighbors are warehouses and a bread factory. The hospital sits on a hill of broken glass, slag, and rubble, overlooking the Bruckner Expressway. Trash and litter accumulate in the hallways. Rats and mice scamper across the wards. Last winter the lead levels on the walls of the pediatric wards were found to be higher than lead levels in the homes of the children who were being hospitalized for lead poisoning. The corridors are lined with patients who wait for hours to see doctors. Staff shortages are severe in all job categories. Broken equipment is stockpiled in closets because the money for repairs has vanished in recent City economy moves.

As the South Bronx's only public hospital, Lincoln is straining at the seams. It has 346 beds—one tenth the number of New York's King's County Hospital. Its size pales in comparison with other public hospitals serving similar needs—like Chicago's Cook County.

Lincoln's range of services is woefully inadequate, Neurosurgical and preventive
dental programs have never existed. Home care and elective surgery have been cut in the budget squeeze. The excessive use of Lincoln's emergency room indicates both the dimension of need in the community and the inadequacy of the hospital's response. Although known throughout the Bronx as the "butcher shop," tiny Lincoln logs more emergency visits than any other New York hospital. It is the fourth busiest emergency facility in the nation!

It is within this setting that over the last three years various institutions and groups have been engaged in an ongoing struggle, occasionally breaking into open skirmishes, to alter the control and thus the conditions for both workers and patients at Lincoln. During that time the issues, tactics and groups have changed; but there has been a groping development toward the vision of community-worker control. This article focuses on the more active, confrontational forces rather than on all the groups involved. A brief sketch of these groups (those in power and those challenging it) is followed by a historical overview of the events at Lincoln and a discussion of the issues of community-worker control and the role of white professionals.

THE ACTORS

The Powers That Be

Albert Einstein College of Medicine—Einstein, a private medical school, controls almost all the hospital resources in the Bronx, including Lincoln. 5135 of the 9969 acute and long term beds in the Bronx are directly controlled by or affiliated to Einstein.

In terms of control, one worker at Lincoln summed up Einstein's preeminence: "The guts of the hospital are in the hands of Einstein." This control is exercised through the Medical Board composed of the chiefs of the clinical services (medicine, pediatrics, radiology, etc.) at Lincoln. The chiefs of service are appointed by the medical school and receive their departmental budgets through the school. The quasi-public Health and Hospitals Corporation, which administers the municipal hospitals, gives half of Lincoln's budget ($10 million out of last year's $21.1 million) to Einstein through an affiliation contract. The division of that budget and the scramble for funds between the Lincoln departments ultimately takes place in the Einstein dean's office. Einstein's priorities at Lincoln are poignantly demonstrated by the fact that Lincoln's Einstein offices are air-conditioned, while the overcrowded stuffy patient areas are not. Einstein has held on to Lincoln for its affiliation money and because it meets the medical school's teaching and research needs. It was rumored that given all the headaches, Einstein might pull out; but the ground has been broken for a $50 bed, $120 million new Lincoln. It seems less likely now that Einstein will let Lincoln go.

The Health and Hospitals Corporation—The Corporation is responsible for determining the budgets for the City's eighteen municipal hospitals, including Lincoln. Again Lincoln gets short shrift. Several months ago, tentative budget allocations showed that Lincoln would only get a 3 percent increase in fiscal year 1972, compared to an average 10 percent at most other city hospitals.

The Corporation appoints the hospital's chief administrator. He is responsible for non-medical areas such as security, kitchens, housekeeping, maintenance and some professional units like nursing. But he must contend with a parallel administrative structure and the fact that Einstein's control over professional services determines what goes on at Lincoln.

Worker Groups

The Work Force—With the exception of the doctors, social workers and administrators, who are usually white, almost all the other workers—aides, nurses, technicians, clerks, janitors—at Lincoln are either black or Puerto Rican. Some of them live in the South Bronx community and they and their relatives use Lincoln as their hospital. Some came to work at Lincoln expressly because they wanted to be of service to their community. Lincoln's workers are divided by the traditional tracking and hierarchical separations of the health field. In addition, there are divisions created by differences in race (black vs. Puerto Rican), job level, and the different salaries workers receive for the same jobs depending on

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whether they are paid by Einstein or the Corporation.

The Unions—Due to the dual funding there are also two unions at Lincoln. Local 1199, the Drug and Hospital Workers Union represents the workers who are paid by Einstein. District Council 37, American Federation of State, County, and Municipal Employees, represents those paid by the Corporation.

The unions have limited roles at the hospital. They have fought with varying degrees of militancy on worker demands like wages, upgrading, grievances, etc. Except for tussles with the administration based on personality issues, the unions have not challenged the administration of the hospital about the quality of care it gives. On the contrary, in some instances they have functioned to discipline and police rank and file workers who were raising basic issues about patient care and working conditions.

Among the problems—
"... Specifically Lincoln suffers from a dearth of facilities—parking space, a good cafeteria."

—Antero La Cot, M.D.
Vice Pres. of the Corporation,
former administrator of Lincoln

Health Revolutionary Unity Movement
—The Health Revolutionary Unity Movement (HRUM) is a city-wide organization of black and Puerto Rican health workers. Its ten-point health program and newspaper, For the Peoples Health, demonstrate HRUM’s educational and agitational focus. HRUM’s Lincoln Hospital chapter grew out of the 1969 worker struggle at Lincoln’s community mental health center. Since then HRUM has grown and reached workers within the hospital itself.

Professionals—Pediatrics, Medicine and Psychiatry are staffed by full-time interns and residents, who are both American and foreign trained. Surgery and Obstetrics-Gynecology are staffed by interns and residents who rotate from the Bronx Municipal Hospital Center. In July, 1970, doctors for the Pediatrics Department were recruited by other interns and residents on the basis of their social commitment to radical change in the delivery of medical care. They formed a group known as the Pediatrics’ Collective. It has attracted members from the Medicine and Psychiatry Departments and is now called the Lincoln Collective.

Other professionals, such as social workers, psychologists and nurses have come to Lincoln with goals similar to those of the Collective. Several work at the satellite community mental health centers while others work in the hospital itself.

Community Groups

The Community—With the exception of the politicos in the poverty program and Model Cities, there has been little awareness or involvement of residents in health activities within the South Bronx. Clergymen in the Bronx Clergy Coalition have noted that residents have responded to meetings and rallies when they are on their own block or when they relate to a very specific need. The community’s support for change has grown, however, when the more radical political groups have attempted to reach them.

Young Lords Party—The Young Lords are a cadre organization of young Puerto Rican revolutionaries who have taken health as one of the essential arenas around which to organize. They have been active in mounting support for actions at both Lincoln Hospital and Metropolitan Hospital in East Harlem. They are closely aligned with HRUM.

Think Lincoln—In the spring of 1970, the Think Lincoln Committee was formed to do precisely what its name implies: to direct attention to Lincoln Hospital and try to improve conditions there.

The group was a coalition of white, Puerto Rican, non-professional and professional hospital workers in alliance with active community people, including some of the South Bronx street gangs.

Community Advisory Board—Lincoln has a Community Advisory Board that was created in 1967 as part of a city-wide dictum from the Department of Hospitals for some semblance of community involvement in hospital affairs. The Board members represent the usual cast of characters from poverty agencies and planning councils, "the people who join everything," according to Ralph Alvarado, vice president of the board. "No health groups were in existence at the time. None of these people are really invested in health; they have other agendas." The Community Advisory Board has met sporadically since 1967. It has endorsed HRUM actions and was active in bringing the first Puerto Rican administrator to Lincoln.
HISTORY

Over the last three years, Lincoln has become a focus for community attacks from the outside and for worker revolts from within.

The first explosion occurred in March, 1969, when black and Puerto Rican community mental health workers supported by professionals at Lincoln's community mental health center revolted against the administration's dismissal of four fellow employees. This represented the final straw for the workers who had already experienced broken promises for paraprofessional upgrading and worker participation in administering the center. In retaliation, workers had a confrontation in the administrator's office which escalated into a takeover of the center. During the takeover, the workers continued to provide patient services despite worker arrests, suspensions and the actual closing of the center.

Community residents, ranging from the Black Panthers to clergy and representatives of neighborhood social service agencies were brought in by the workers to help make center policy. In the end, the workers succeeded only in winning conventional gains in job security and pay. Because Lincoln's mental health center is physically separated from the hospital, the takeover did not affect the hospital directly. The takeover did demonstrate, however, that Lincoln was not an impenetrable institution. An atmosphere for further change had been created.

Things remained quiet for a year with the exception of a brief flurry of activity from Lincoln's Community Advisory Board. In February, 1970, the City's Hospital Department tried to select a new administrator for Lincoln, without community consultation. The Community Advisory Board responded in outrage and formed its own search committee for a third world administrator. Ultimately the City was forced to choose one of the Board's candidates—a Puerto Rican gynecologist, Dr. Antero LaCot.

In the spring of 1970 the Think Lincoln Committee came into being. It initiated a complaint table in the emergency room where patients and workers registered grievances about hospital conditions. These grievances were embodied in seven demands which were presented to Dr. LaCot. These demands included immediate construction of a new Lincoln Hospital; door-to-door preventive health services; a day care center; and total community-worker control of all services.

Knowing that the administration would not act on most of the other demands, HRUM, Think Lincoln and the Young Lords also tried to bring the hospital to the community. For the next several months weekly mobile street clinics were set up to do preventive screening for lead poisoning, anemia, tuberculosis; to educate the community residents about these diseases; and to place responsibility for health problems at Lincoln's door.

When by July 14, 1970, the administration had not responded to the demands, about 100 members of Think Lincoln, the Young Lords, and HRUM occupied the old Nurses Residence adjacent to the hospital. This building now houses some mental health services, personnel offices and

LINCOLN HIGHLIGHTS

March 1969
Mental Health staff takeover of mental health center.
February 1970
Community Advisory Board begins search for a new administrator.
June 1970
Budget cuts for municipal hospitals announced. Think-Lincoln is formed. Complaint table is installed. Seven demands are pressed.
July 14, 1970
Occupation of Administration building by Think-Lincoln, HRUM and Young Lords.
July 17, 1970
Death of Carmen Rodriquez in the Obstetrics and Gynecology Department.
July 20, 1970
Four new demands presented including the resignation of the head of Obstetrics Department.
August 1970
Injunction taken out by the administration which forbade further organizing activity at Lincoln.
November 1970
Takeover of Administration building by HRUM, Young Lords and addicts to set up a methadone detoxification program.
November-December 1970
Culmination of power struggle in Pediatrics Department. Einhorn leaves and Helen Rodriguez is installed as head of the Department.
June 1971
City Budget cuts for hospitals announced. Billing action begins and continues to the present.
October 1971
Psychiatry Department work stoppage.
administrative offices. As in 1969, there was no disruption of patient care. The occupiers, threatened by police attack, left the same day after two of the seven demands were granted: that there would be no cutbacks in services and that a preventive health screening clinic would be established.

Three days later the death of a patient due to gross malpractice during a therapeutic abortion rekindled the sense of life and death urgency among the insurgent forces. They called for the immediate resignation of the head of the Obstetrics Department. Shortly thereafter the resignation was forthcoming. However, an injunction was taken out by the hospital which prevented community groups from entering the hospital and which forbade worker meetings.

"The takeovers didn't lead to immediate programs. Since the takeovers, the administration has been fearful of our power. They knew we could produce."
—An HRUM spokesman

Several months later, in November, 1970, community activity surfaced again, this time in the form of a takeover of a floor of the administration building (scene of the July 14 action). A group of addicts supported by Think Lincoln, the Young Lords and HRUM wanted to institute a methadone detoxification unit. Despite fifteen arrests and initial harrassment from the hospital administration, the detoxification program has grown and thrived. The program is entirely run and staffed by community residents.

Independent of this activity but during the same period, an internal struggle was being waged in the Lincoln Pediatrics Department. The Pediatrics' Collective was committed to setting up a community pediatrics program that embodied the goals and strategies of community-worker control. The Collective had actively supported the Think Lincoln summer actions to the chagrin of the department's foreign housestaff and the department director, Dr. Einhorn. A five-month struggle ensued over the department's relationship to the community. During this time the foreign housestaff resigned because of the turmoil at the hospital. Finally the Collective demanded Einhorn's resignation because of his growing inability to administer the department and his resistance to community-worker control. The affair, which was played up in the press, ended with Einhorn's replacement by a Puerto Rican—Dr. Helen Rodriguez-Trias.

Under Dr. Rodriguez-Trias' direction, Lincoln's Pediatric Department has charted new directions. Faced with a department torn apart by antagonism, she established a basis for unity. Through department wide meetings, including nurses aides, clerks, nurses and housestaff, problems confronting the Pediatric service were discussed. A diverse group of attending physicians were recruited to fill the vacancies left by the staff which departed with Einhorn. The Department challenged the hospital administrator, the medical board and Einstein over funds. And the process of recruiting Puerto Rican doctors was begun, with a view toward making Lincoln a third world training center.

1971 began without visible agitation in or around Lincoln. By June, 1971, however, the action began again—this time around threatened budget cuts. The clerks in the Pediatrics Outpatient Department, supported by the doctors, led the protest. Without the fanfare of a sit-in, takeover or strike, they stopped submitting Medicaid billing forms, holding them until the issue of budget cuts is negotiated. The Pediatric clerks now hold approximately $750,000 in Medicaid forms.

The history of Lincoln's struggle for emancipation goes much deeper than these surface events. It goes to the heart of defining community-worker control and the role of the white professional in the third world community.

COMMUNITY-WORKER CONTROL

The underlying theme of all the struggles at Lincoln has been community-worker control. These words have come to mean an attempt to change the nature of the health care at Lincoln by: 1) challenging those who control and set priorities for the hospital; 2) altering the way in which daily work is determined and organized, and; 3) affecting the way workers relate to one another and to patients.

Beneath the community-worker control slogan is the issue of power. Will men who work for Einstein and the Corporation, but never use Lincoln, determine its priorities, budget, quality of care and work relations—or will these things be determined by the people of the South Bronx.
who use the hospital and the workers who staff it?

The issue of community-worker control has developed at Lincoln with more emphasis on worker than community. The community residents’ relationship to the hospital is episodic; people only come when they are ill. Furthermore Lincoln is only one of a number of oppressive institutions that they must deal with each day. Thus like their visits to the hospital, the community residents’ role at Lincoln has also been episodic.

Community residents have made demands on the hospital for services and have joined with worker groups to improve care; but not on a sustained basis. For example, the South Bronx Senior Citizens Council demanded a geriatric clinic in the Medicine Department to serve the special needs of its members. South Bronx residents were part of the Think Lincoln Committee. In Pediatrics, the parents themselves are not ill and they make frequent visits to the hospital. Thus, a tighter, more substantial, relationship between worker and community forces has developed into new organizational forms like a Pediatric Parents Association (see page 16.)

In contrast, the non-professional and professional workers are at Lincoln every day; it is a focus and a definition for their lives. From this base changes at Lincoln have come. This is not to say that the community has taken a disinterested role. However, over the course of the last three years, sustained political activity has come from workers. The relationship between the community and workers is clearly illustrated in the development of the Health Revolutionary Unity Movement.

HRUM: A Strategy for Creating Space

Since 1969, HRUM has taken on the task of building political awareness and consciousness among the black and Puerto Rican workers at Lincoln. HRUM is the thread of continuity which has woven in and out of Lincoln over the last three years.

It was the mental health unit takeover, during which workers provided services under their own direction, that created the vision of a new way to perform hospital jobs. The process of taking control was a turning point in the consciousness of some of the participants. It was during this period that a growing connection was made between the demands of workers and the needs of patients.

The link between community and worker was forged when HRUM members united with the Think Lincoln Committee in the Spring of 1970 to press the seven demands and to establish a community-worker complaint table. The grievances submitted were not just documented. Doctors taking extended lunch breaks were confronted and told to return to their clinics. When complaints were made about poor garbage removal in the hallways, the garbage was collected and dumped in the Administrator’s office. The garbage removal schedule improved the very next day.

These actions and their emphasis on the community meant that HRUM found itself doing less and less day to day organizing among the workers. Their militant actions and rhetoric ran the risk of alienating some of the hospital workers. Some workers saw the community demand for more service simply presenting more work for them. Although most of the non-professional workers at Lincoln are third world, there is an inherent antagonism between the users and providers of service. Einstein and the Corporation can take advantage of this conflict and translate community demands into threats to workers by refusing to increase either the number of workers or their pay.

Many workers also felt threatened by the issues raised and the groups with which HRUM was aligning itself. In keeping with the direction of the Young Lords Party and the Black Panthers, HRUM began to address itself to health issues that are of concern to what they called the “lumpen-proletariate,” i.e. the street people, high school drop-outs, addicts, etc. For example, in the fall of 1970, HRUM joined in the occupation of the sixth floor of the Administration Building to set up a detoxification program for the addicts. However, since the addicts line up for the Detox Program right next to the nurses’ lockers, many of the nurses saw HRUM’s community service as a threat to their safety and needs.

“Our goal is self-determination, and the way to that is community-worker control.”

—Daniel Argote, HRUM member
HRUM was forced to reevaluate its strategy. It has now moved back to worker organizing within the hospital. According to Kathy Larkin, an HRUM spokeswoman, their day-to-day energies are spent in talking to workers. “We lay out what the problems are, challenge them to see the issues. We point out that the division among the workers and the community is not their fault. We try to show them why this happens.” In line with this strategy, HRUM recently showed a film of the 1969 mental health takeover to emphasize that the issues and conditions that led to the action are still relevant to Lincoln and that workers can organize to change these conditions. About 250 workers showed up to see the film.

HRUM’s new posture is also reflected in its attitude toward the unions. The heroin detoxication program is one of several positive programs that have emerged from the last few years of ferment in and around Lincoln Hospital. The program was initiated by three third world political organizations. It is run with a strong element of worker control. And instead of offering group therapy, it provides PE (Political Education) for the estimated 5,000 addicts who have gone through its methadone withdrawal cycles.

The idea for the Lincoln Detox Program came from the work of the Young Lords and Black Panther Parties and the Health Revolutionary Unity Movement (HRUM). These groups, along with ex-addicts, had been trying to organize addicts in the fall of 1970. In the South Bronx in order to do any organizing in the community, one must confront the problem of drugs. Addiction (and its companions, crime and police) is one of the worst of the “people’s ills”: it controls significant portions of everyone’s life in that community.

The addicts, according to the political analysis of these groups, can be seen as a potentially ‘revolutionary’ group. According to an early participant in the Detox Program, “Addicts are a lumpen class—they don’t produce anything but crime . . . Addicts have a keen sense of hardship and they must stay away from the police.” The intent of the organizing effort was to bring political consciousness to their keen sense of hardship and explain why “both groups [addicts and organizers] are fighting the cops.”

Because there were no facilities in the South Bronx for detoxifying addicts and because of their strong political objections to both methadone maintenance and therapeutic community drug programs, the three political groups and some unaffiliated ex-addicts started meeting with hospital officials to pursue the idea of a detoxification program at Lincoln. Lincoln had been planning to institute a small drug program for some time; funds were anticipated from the City’s Addiction Services Agency (ASA). After some fruitless meetings and no anticipation of action on Lincoln’s part, the doctors’ “on-call” rooms on the Administration Building’s sixth floor were seized on November 10, 1970.

When an impromptu detox program was set up during the takeover, the hospital quickly moved in to break up the action. Fifteen people were arrested and negotiations with the hospital started. After only several days of meetings, the groups won the use of Lincoln’s anticipated ASA funds; the use of the old Nurses’ Auditorium in the Administration Building for the Detox Program; and a little office space in the Psychiatry Department.

The Program got underway immediately with 25 addicts, four counselors and volunteers from the community and the hospital medical staff. In fact, during the five months that elapsed before funds actually came through, the Program was run by the activist group entirely on volunteer labor; individual doctors from the Psychiatry and Pediatrics Department also contributed their time. Lincoln Hospital itself made no effort to locate staff or reimburse the workers for their labors.

Since then the Detox Program has provided 30 ten-day withdrawal cycles with approximately 200 addicts in each cycle. The staff now consists of a director, 12 counselors, 39 other clerical and medical workers, and anywhere from 5 to 30 volunteers per cycle. 90 per cent of the staff are ex-addicts many of whom came through the Detox Program themselves. The Program does not
HRUM have always been at odds. The Union's position at Lincoln was typified by their refusal to support the workers' action during the mental health takeover. In denying 1199 support, the Union's Vice President commented: "If the workers want to challenge who should be management, who should control the center, that is their own affair." HRUM has been critical of the Union's role of policing the workers and keeping the lid on conflict with the hospital administration.

However, the unions play a crucial role by providing workers with certain protections, grievance machinery and negotiated wages and benefits. It was clear to HRUM members that these protections could not be ignored or regarded as unreal.

HRUM is not trying to build an alterna-

**CLEARING THEIR HEADS**

compile statistics on the number of addicts who remain drug-free after detoxification, but staff members assume that their success rate is comparable to other more conventional drug rehabilitation programs.

The Program still operates out of the Nurses Auditorium, which is seen as one of its greatest handicaps. There is no quiet or space for confidential conversation. Counselors sit at long tables down the center; addicts sit in rows of folding chairs on either side. Medical histories are taken and tests given at the foot of the stage. Methadone is dispensed from trays of carefully watched cups up on the stage itself. If the South Bronx is in a state of siege, and drugs are part of the battle, then the Nurses Auditorium can only remind one of makeshift hospital scenes in war movies.

Although the Young Lords, Black Panthers, and HRUM have pulled out of the Detox Program "because of their own political priorities" the philosophy of those groups continues to guide the therapeutic and administrative aspects of the program.

During its first year of operation each department (like medical aides) elected its department head and these department heads met together to make programmatic decisions. A short time ago however this system was overturned by the employees. Workers within each department ("having had PE") now elect one representative for every five workers. These representatives sit on the Disciplinary and Grievance Committee, and this body makes all decisions for the program. This committee's meetings are supplemented by General Meetings of addicts, volunteers, and workers every two weeks.

The Detox Program does not want to be seen as simply the place that dispenses methadone or maintains addicts on it. For that reason, it has established rules about the frequency that an addict may come in for the ten day withdrawal cycles. (An addict must wait 30 days for a second cycle and ten months for a third). That is also why the Detox Program has instituted PE (Political Education).

The Detox Program does not dispute the value of providing support for detoxified addicts. Support, however, comes in terms of survival needs for life in the South Bronx, rather than in terms of establishing an alternate and distinct "supportive environment" or "therapeutic community." The Program gets many eligible addicts onto the welfare rolls; helps locate housing, arranges for medical treatment within the hospital. It also works closely with the Spirit of Logos, an organization of ex-addicts who attempt to organize other addicts around the economic and political causes of their addiction.

PE at the Detox Program is offered to both addicts and workers in the program. PE sessions, in small groups, occur in corners of the Auditorium during the afternoons. PE sessions focus on "conditions in the community ... we are out to deal with the contradictions and problems of that class of people." All addicts are asked to participate, but there is no coercion involved, and one-third attend at most. It is obvious that the Detox Program staff view addiction as an affliction which arises out of socioeconomic conditions, rather than individual neuroses. Therefore, the Program emphasizes PE, rather than the personal encounter-type therapy of other programs.

—Constance Bloomfield
HRUM organizers tell workers what the unions' limitations are and they advocate support for radical caucuses within the unions. In keeping with this new approach, an HRUM member agreed to speak at a DC 37 budget cut rally and HRUM met with Local 1199 representatives to try and win their support for rallies following the Attica Prison rebellion.

HRUM is also moving closer to other rank-and-file organizations. HRUM helped sponsor a conference in early December with the Federation of Puerto Rican Workers. It is also considering working closely with the Black Workers' Congress (a group that grew out of black worker organizing in the Detroit auto plants).

HRUM continues to maintain unity despite its racial and sexual divisions. In recognition that 75 percent of hospital workers are women, HRUM's leadership is female. While racial differences have divided workers at Lincoln for many years, HRUM has been able to unite black and Puerto Rican workers in its organization.

Making Day-to-Day Changes

Worker-community actions obviously challenge the authority and control of both the Health and Hospitals Corporation and the Albert Einstein College of Medicine over day-to-day affairs at Lincoln. The spectacular tactics (like takeovers) and less well-known rebellions (like the billing action) have made small dents in the control these institutions hold. But a clear, defined long-range strategy for shaking these institutions has yet to be devised. The activists are, however, clearly aware that the more basic changes made in the work process and work relationships are essential to building for more concentrated assaults.

The Psychiatry Department: Changing Job Roles

The Psychiatry Department uses a progressive team work approach. Within the teams there is no functional difference between social workers, psychiatrists or mental health workers. However, the clerical workers have not been included in the breakdown of job distinctions.

This fall a Manpower Career Development Administration (MCDA) program for training community people to become mental health workers was introduced into the department. The clerical workers were again excluded despite earlier promises of upgrading.

Many of the clericals had been stuck in the same dead-end positions for years. Angry at being once again excluded and at the lack of support from Local 1199, they organized a workers' committee and called a work stoppage. They were supported by housestaff and other professionals who not only agreed with their demands but had grievances of their own.

The administration backed down, and 1199 stepped in to negotiate the settlement. The clerical workers won inclusion in the training program, but as a result, community trainees were dropped by MCDA without guarantees that their training will be continued. Unfortunately this presents a classic case of the division between the community and workers, exacerbated by a tight money situation.

The key element in the incident was the unity of the clerical workers with the doctors and other professionals over basic work issues. "We knew," said one activist, "that just asking and being polite wasn't enough. We knew how other issues have been won at Lincoln and we decided to take action for our demands."

An End to Doctor-Dominated Clinics

One of the most exciting changes at Lincoln has taken place in the Pediatrics Department. Here some decision-making within the various services (outpatient, wards, etc.) has been taken over by a committee drawn from all levels of the health hierarchy.

The worker committee in the Pediatric Outpatient Department Clinic is the most developed. It is divided into two groups: a general clinic group of all workers and doctors; and an elected steering committee with clerk, nurse and doctor representatives. The steering committee deals with the ongoing running of the clinic and such issues as the processing of charts; how innovations can be made to allow for more patient privacy; and the more difficult issue of doctor attitudes and work practices. General meetings are used to acquaint the entire staff with different aspects of pediatric care. One week the public health nurse spoke about her function; at another time, workers and doctors went to see a public health child care facility.

"We're more together as a unit. We're not underlings to anyone. No one is holding us back."

—Tony Cruz, pediatric outpatient clerk.
Billing Action: No Green for Red

Budget cutting has always been an issue at Lincoln. Each cut is normally accompanied by a flurry of protest from department heads and occasionally from the unions, and then things settle back into the usual desperate situation. Recently different tactics have been used. The July, 1970, Administration Building take-over was, in part, inspired by the cutbacks. 1971 was the year of the "billing action."

During a meeting in the Pediatrics Outpatient Department in early June, the upcoming budget cuts were discussed. Members of the department sent a letter to the administration demanding an end to the cutbacks and threatening action. When no word was forthcoming, they took action.

The Medicaid forms that the city uses to collect its Medicaid reimbursements began to "disappear." To date, the forms, worth almost $750,000 dollars, have not found their way to the Health and Hospitals Corporation's coffers. Participants say that the forms are being held for ransom until the budget cuts are restored. This action, while dramatic, has no negative effect on patient care.

The administrators responded at first by threatening to press criminal charges. The DC 37 union representative refused to back his members up and even threatened them with job loss. However, the workers have been supported by HRUM and by Lincoln's Community Advisory Board.

It is clear now that both Einstein and the Corporation are keeping the lid on the case. Observers say the Corporation is willing to lose the money; it is a drop in the bucket and is a danger to them only if similar actions spread to other departments and hospitals.

Because of the legal implications, worker fears of firings, the lack of union support, and lack of publicity, the action has not spread. Unless workers in other hospitals feel sufficient support from fellow workers and doctors, Lincoln's billing action will remain an isolated harassment.

Similar groups in the Pediatric Emergency Room and on the wards have met sporadically. But the clinic committee is the most developed. It grew out of opposition to the arbitrary practices of the clinic Director. Workers, as well as doctors, wanted to have the meetings and pushed to continue them in the face of harassment, mainly from the nursing hierarchy. When the more vocal nurses started to attend, they organized other nurses and clerical workers to attend and participate. The committee has been supported by parents of pediatric patients, although the parents do not attend meetings.

This committee has changed the role that different level workers have historically played, or more accurately not played, in hospital decision-making. More importantly, it has changed the way people relate to one another, has offered the possibility of an honest exchange of ideas and experience and has provided a forum for political unity and action.

These changes have affected on-the-job relationships between workers and patients; this ultimately affects patient care. The changing attitudes and roles of pediatric clerks demonstrates the potential of day-to-day internal changes.

The clerks in the out-patient department and emergency room are the first and last representatives of the hospital to see patients. They are responsible for checking patients in, making appointments, directing patients to other services and generally explaining hospital procedures. They are, as one clerk put it, "the foot soldiers in the hospital."

Lacking an atmosphere of change, clerks turn their frustration over their rigidly defined roles into apathy and even misdirected hostility toward one another and toward patients. Their anger at the doctors and their supervisors is usually more subtle and covert. In most departments, clerks do not go out of their way to redirect wandering and confused patients. Their usual comment is "that's not my job."

The contrast in the Pediatrics Department is striking. First of all, worker opinions are respected—clerks are not intimidated by higher-echelon workers. "The biggest change," says Gladys Aponte, an out-patient department clerk, "is the creation of an atmosphere for struggle. We're not afraid any more to tell doctors when they're doing something wrong. We won't lose our job . . . we're not afraid to initiate actions, to do something."

In Pediatrics, worker anger toward the doctors is more openly expressed than in the usual hospital situation. In one instance, a doctor was called to the steering committee and confronted about his behavior and attitudes toward both workers
and patients. The community has noticed the change. When queried by visiting nurses about what they thought had changed at Lincoln over the last three years, patient's families invariably answered: pediatrics.

The Medicine Department is now beginning to make similar changes. It has adopted a team approach in its clinic, and team members, including doctors, nurses, social workers, etc., meet after each session to discuss medical and administrative problems encountered there.

One outgrowth of the struggle for community-worker control is a changed perception, among workers, of their own dignity, worth and ability. Small victories have provided these "new workers" with a vision of different power and work relationships. At Lincoln, this process has created an atmosphere which is encouraging workers to seek control over more areas of their work lives.

Accountability to Whom?

Traditionally doctors are held accountable only to each other, to chiefs of service, or to administrators. At Lincoln this concept of accountability has been challenged.

Patients and the community demanded accountability in the Obstetrics-Gynecology Department following the death on July 17, 1970, of Carmen Rodriguez during a therapeutic abortion. A doctor who knew her from another program, saw the chart and felt that proper care had not been given. Doctors have faced this situation many times before; if they act at all it is to call a clinical conference of the other doctors to discuss the case. Instead the information was given to the Think Lincoln complaint table. A "people's clinical conference" was called to discuss the case. Using a "medical Nuremberg" principle, it was determined that the head of the department is responsible for the actions of his staff. Since Dr. J. J. Smith, the chief of the department, refused to take this responsibility or to accede to the community demand for better services, he was forced to resign.

"The patients want service. If you can't give them that, you can't give them anything else."

—A Lincoln doctor

WHITE PROFESSIONALS

Each year hundreds of white middle class medical students receive their clinical training in municipal hospitals servicing third world communities. Students are trained to view the patients they treat as "teaching material" and the hospital workers below them as doctor's "handmaidens." For those 20 percent of students who pursue their internships and residencies in public hospitals, the same socialization process continues. To those few, who choose to resist these pressures and to serve their patients, the task is literally impossible, especially if faced alone. The overwhelming demands placed on interns and residents and their inability to alter priorities within the hospital, mitigates against most individual attempts at change. Furthermore, young doctors run the risk of unwittingly falling into a missionary or mercenary role.

In order to deal with some of these problems, a group of interns and residents at Lincoln (and some that rotated through Lincoln from the Bronx Municipal Hospital Center) drew up a proposal for a Lincoln community pediatrics program in fall, 1969: "By concentrating a significant number of people with a socially conscious orientation in one hospital and work situation a critical mass of people may be created which will be able to change rather than merely adapt to and attempt to survive in a difficult work situation."

During the winter and spring of 1970, thirty-two interns and residents and a few nurses were recruited by the group to work in this new, but relatively undefined program. While the recruitment efforts were neither helped nor hampered by Einstein, they were endorsed by Dr. Arnold Einhorn, Director of Pediatrics at Lincoln. For Einhorn, it was the first time in decades that an American-trained pediatric staff would come to Lincoln, thus enhancing the prestige of his program.

The Collective's Program

The Collective's program goals were derived from the experience of some of the housestaff in the Student Health Organization summer ghetto projects. According to two of the original doctors, Fitzhugh Mullan and Charlotte Fein, the Pediatric Collective had two goals:

■ Commitment to provide continuity of care to a colonized community. The clinical program reflected this commitment by stressing the development of "primary rather than sub-specialty physicians" and through offering a community elective for experience outside the hospital.

■ The "democratization of work relations" by breaking down the traditional
Several programs have since emerged from the Collective:

Continuity Clinic—In the past, pediatric patients were frequently assigned unnecessarily to numerous sub-specialty clinics (in keeping with Einstein’s interest in specialty training and research). Now, according to a Collective newsletter for patients, “The doctor making the initial contact with the patient (in the emergency room, wards, clinics, nursery) acts as the primary physician for the children of that family on all subsequent visits.” In addition to reducing fragmentation of care, the Collective’s system has increased the opportunities for favorable relationships to develop, has led to greater utilization of services and to more efficient use of time because of familiarity with the patient’s problems.

Medical Records—The Collective has pioneered the “Weed System” for medical record keeping within the hospital. This system organizes the usually chaotic medical chart, so that medical problems are not buried in the mass of detail and forgotten. It emphasizes preventive care and facilitates continuity of care.

Community Elective—As part of their training, Pediatrics housestaff now spend one month on community work. The community elective has been plagued with many problems. At first, the Collective anticipated working in conjunction with HRUM and the Young Lords, but this never came to fruition because both groups were preoccupied with other activities at Lincoln. The housestaff have also been involved in recruiting new doctors and establishing ward and outpatient meetings. It is only recently, that the Collective has been able to get the elective out into the community as originally intended. Some housestaff have worked with community residents interested in establishing a day care center; others have responded to requests from community groups.

Relations with Community Groups

Most of the Collective’s long work day is spent in practicing medicine on the wards, in the clinics, or in the Pediatric Emergency Room. The little remaining time early in the morning or in the evening is often used for ward and collective meetings or Spanish and karate classes. The lunch hour is utilized as well for medical lectures and social medicine seminars. In addition to all this, Collective members feel a sense of responsibility to respond to demands for services from groups in the community. Thus Collective members helped staff Black Panther clinics last year, gave physical examinations to addicts in the Detox Program (see box, pp. 8-9) and lent support to the Young Lords and HRUM during the July, 1970, takeover of the Administration Building.

In the course of giving service to community groups, Collective members have emphasized the need to perform a “decolonizing role” by transferring their skills to community residents who can continue to provide service on an on-going basis. The Collective’s most recent commitment to the Community Medical Corps is an illustration of this role (see box, p. 14). The structure of work at the hospital does not allow for sustained commitment to community projects. This problem was not overcome by the community elective either. The Collective often does not realistically assess the amount of time a project will take. Several critics in the Collective have voiced their frustrations: “Most projects are well received. People think they’re great idea. The problem is getting people to follow through once the commitment is made.”

Problems with the Collective Identity

Although the Pediatrics Collective has from the start aimed toward equalizing tasks among all department personnel and improving the notoriously bad hospital work relations, their notable accomplishments have not been without blemish. The Collective has had a history of poor relations with the foreign housestaff at Lincoln. They failed to win the support of the predominantly Thai, Filipino and Indian doctors, who were already there before the Collective arrived on the scene. Nor have they related well to the new
group of foreign doctors recruited last July. One foreign doctor spoke for most of the foreign-trained staff, when he said: "The foreign doctors have felt pushed around by the white doctors. In eastern culture, our people learn not to be so aggressive. Though we are sympathetic to efforts of some of the Collective members, we also feel threatened by their aggression. Even though the Collective doesn't want to be racist, it is a white man's social club." The foreign doctors have recently formed a caucus in which they, as an independent force, will discuss their own problems and seek ways to serve the community.

The Collective has also had problems relating to the non-doctor staff. Despite their self-consciousness, some have fallen into the pitfalls of professionalism. According to one long-time Lincoln nurse, "Physicians think they can do it all and they can't do it all. They must develop respect for the people that work here. We can explain and teach about illness. We know what the environment is like."

Part of the difficulty that the housestaff has in relating to other workers derives from the hip lifestyle that many of them have adopted. The long hair and casual dress permitted doctors because of their privileged status are often options not open to other workers. Some nurses have voiced criticism of a few of the "freaky-looking" doctors' hygiene: "They don't wash their hands after seeing a patient. That's not practicing good medicine. Sometimes, they don't change their shirts.

Community Medical Corps

The Community Medical Corps (CMC) was begun in the summer of 1970 by two medical students from Albert Einstein College of Medicine. Financed through Einstein's Community Medicine Department and the New York City Health Services Administration, CMC developed a door-to-door screening program for lead poisoning. "The purpose," according to one of the CMC's student initiators, "was to develop a health care system by using outreach programs so the community can learn about health. We wanted to train para-medics from the community to help show that anyone can learn how to do these simple tests."

The first summer 110 Neighborhood Youth Corps workers divided into ten teams supervised by medical and nursing students and screened 3,000 children in several South Bronx neighborhoods in eight weeks. After the summer, seven community residents were hired to work full time on the project.

The Health Services Administration (HSA), in a maximum efficiency drive, instituted a quota system, requiring that 165 tests be done every week in order for the workers to receive their wages ($2.85 per hour for a 35 hour week, with no fringe benefits or health insurance). Outside doctors were paid a flat $13.85 per hour to draw blood from patients, regardless of the number of tests taken. At their own initiative, the workers also instituted tuberculosis and anemia testing to provide more comprehensive screening. Even with extra time for these additional tests, the workers were able to screen 12,500 children. But in order to reach their quota, most of the workers had to work up to 70 hours per week, yet they continued to get paid on a 35 hour-a-week basis.

The community workers began to challenge the doctors about their working conditions and wages. They pointed out that there was a dual system of payment: piece work for community workers and hourly wages for the doctors. The Einstein students insisted on adhering to the HSA guidelines for the program. The community workers sought to abolish the quota system and establish more worker control of the program. Finally, the Einstein students locked the community workers out of their store front office.

When the CMC workers found themselves on the streets, they approached Dr. Helen Rodriguez-Trias for help. The Department of Pediatrics at Lincoln Hospital agreed to provide physician services and back-up for the program, including training for CMC members in basic pediatric skills. A proposal for refunding CMC was then submitted to HSA, where it is presently pending.

At the same, the Einstein students have taken the remaining money allocated for the CMC program and plan to establish their own program elsewhere in the Bronx. In addition, they have gone after a grant from HSA, which will undoubtedly compete with CMC's request. And of course, the Department of Community Medicine at Einstein, conduit for the original grant, stands by declaring its "neutrality."
for weeks. Mothers complain to us that they don’t want to take their children to that kind of doctor.”

Meeting Meetings, Meetings

The Collective also has its own internal problems, largely focusing around its members’ anti-authoritarianism — unwillingness to make or carry out group decisions. This is not surprising, considering the background of most of the Collective members. As medical students, many of them resisted the socialization process individually and consequently in isolation from other students. In order to face this issue and their difficulty in work relations, the Collective has turned its attention inward, through meetings.

There are bi-weekly meetings in which all Collective members discuss concrete issues and projects. At the end of these meetings a “criticism-self-criticism” session is held where members point out to each other in what ways their actions offend and ultimately oppress their co-workers.

On alternate weeks, the Collective breaks down into five small groups which discuss in more detail the problems raised in the large meetings. Collective members are urged to attend one, if not both of these sessions. In recent months, the small group meetings have become more important because the setting allows for more intimate discussion and criticism of the role of the white doctor.

In addition, some Collective members meet for breakfast at the hospital. Because they precede the rigors of a typical day’s work, these sessions are relaxed and afford the opportunity for Collective members to get to know each other personally.

Over the last six months, a new group called the Health Revolutionary Alliance (HRA) has been relating to the Collective at many of these meetings. HRA is a city-wide organization of white health workers, some of whom were early members of HRUM, but left the organization when it decided to focus entirely on a third world constituency. Some HRA members work at Lincoln and they now function to provide the Collective with a liaison to HRUM.

In the last year and a half the Collective members have wrestled among themselves to deal with criticism leveled by other staff. The results show some changes in the Collective’s view of its constituency and function. In terms of its constituency, the Collective has had a large turnover in its membership. Forty of the interns and residents who came in July 1970 spent a year at Lincoln and then moved on. A new crop came in July 1971 to take their place. This change, of course, meant that the Collective members had to spend time getting to know one another, forming new relationships with other hospital personnel, while fitting into the grueling work routine.

Still the Collective has grown to fifty members and spread to two other departments — Medicine and Psychiatry. Its members are all white, almost all male and doctors. When the Collective first started, attempts were made to recruit nurses as well. A few even joined the group.

But as in many groups of this kind which are dominated by male professionals, cries of professionalism and sexism were quickly voiced by women in the Collective. Avia Shapiro, a social worker from the Psychiatry Department said, “If you’re not a doctor, you feel out of place. You don’t feel that it’s worth it to try to change the discussion because people really don’t listen to one another when they talk. No one responds to the point of the person speaking before him. And women have consistently been ignored.” Some women doctors have also shed away from the Collective. According to Elinor Graham, a pediatric resident: “Women doctors were consistently put down. The meetings consisted of male egos jousting back and forth. They wouldn’t listen to one another. They were never concrete, only theoretical.” As a result, many women have dropped out of the Collective while continuing to work at the hospital.

Gradually the Collective has revised its assessment of its membership. It now admits that it is a group made up primarily of doctors and that it works with other kinds of personnel in the hospital to improve medical care.

The Collective has also changed its posture about its function. During the Einhorn crisis, Collective members ran the department, even though this alienated other housestaff and personnel in the process. This has changed in the last year, as the Collective has become one of several voices in the Pediatrics Department, along with foreign housestaff and workers. The development of outpatient department and ward meetings where doctors are only one of the participants and not the dominant force in decision-making is another sign of this change. These meetings are more appropriate settings than the rarefied atmosphere of a Collective meeting for challenges from workers about racism, sexism and professionalism.

White Politics

The Collective has had to face the crucial issue of the role of white professionals in a third world community. An
HRUM member has said, "Their role is to serve the people with their technical skills in a human way. We know what class they're coming from. They must understand that they are the weakest link." The response from the Collective, not unlike other white movement groups, has been the politics of guilt and the politics of adventurism. Both arise out of the Collective's inability to work out a self-conscious definition of their role. A guilt response has often resulted in the group's virtually unquestioning support of HRUM. The Collective has acted not as an autonomous unit, with a unified political perspective, that should be dealt with on its own terms. The other response is to "organize the community," which arises out of a romantic notion about the medical savior who leads other people's struggles; or the voyeuristic tendency that defines a "total politic" as "rapping with the Lords."

Some Collective members have chosen another alternative. Their primary role is to use their medical skills in a humane way in their daily work and to challenge the medical establishment, thereby creating space for community groups and workers to gain control. This requires a long term commitment to building a politically conscious staff.

One of the new steps toward this goal is the recruitment plan for the next year's house staff. A committee composed of parents from the Pediatrics Parents Association (a recently formed group of parents concerned about health care at Lincoln), HRUM members, clerks, nurses and doctors have taken on collectively the task of selecting prospective house staff. Members of the interview committee ask the prospective house staff specific questions, not only about such traditional matters as past training and professional interests, but about how they feel they will be able to function in a third world community, taking criticism from parents and workers, accepting authority from third world staff members. Those who are being interviewed on a particular day are also questioned as a group by the committee in such direct ways as presentation of a case by a parent with discussion by the group, and by skits simulating everyday hospital situations in which the group members take part and "play themselves."

THE LONG HAUL

Two themes have emerged from Lincoln's struggle for worker-community control: (1) The breaking down of hierarchies and altering the way workers and patients relate every day is critical for building a base for change; (2) The challenging of the control and priorities of an institution is both catalytic and necessary for change.

The experiences of Lincoln show the importance of political self-consciousness, as a way to define respective roles in the struggle. This self-definition is crucial if different class and racial groups are to be organized and to enter into alliances which will effect change. As one participant in the 1969 mental health takeover put it: 'We must be very clear about who is organizing whom. It is not the role of white professionals to take on the work of HRUM and the Young Lords, to go out rapping in a third world community."

Day-to-day base building is slow and its manifestations do not make front page news. The work of challenging Lincoln's administration and ultimately the powers of its affiliated medical school and the Health and Hospitals Corporation is just as difficult. As these institutions are linked into the working of the whole society, the challenges also cannot be separated from the demands for changes outside the hospital walls. Despite these obstacles, one thing is clear: Lincoln has made some steps toward emancipation.

—Susan Reveby and Marsha Handelman

Earlier Lincoln Stories

Detailed accounts of events at Lincoln are found in the following issues of the BULLETIN, available at 60¢ each:

April, 1969: Bronxmanship and Taking Care
May, 1969: Lincoln Brigade II
September, 1969: New York: Empire City and Report
September, 1970: Bronx Community Wants Control
October, 1970: Empire Roundup
December, 1970: Lincoln Detox Box
January, 1971: Pediatrics Collective