Editorial: 
PUBLIC MEDICAL SCHOOL

The downhill slide of New York City's 18 municipal hospitals reached crisis proportions in the early '60's. The City, always willing to cut back municipal services to relieve itself of the headache of providing health care, turned for relief to the private hospitals and medical schools. It signed a series of affiliation contracts with the private hospitals, which agreed to staff the municipals in return for a slice of the City's already hard-pressed hospital budget. While this made city hospitals almost totally dependent on the voluntary teaching hospitals, it did not relieve the crisis of the municipals.

Unfortunately, the interests of the new staff lay not in providing quality health care for those who use the municipal hospitals, but in pursuing their teaching and research careers. Nor did the City provide the money to improve facilities or raise the wages of non-affiliated, non-professional staff. As a result the municipals were further undermined relative to the voluntaries, the upshot was that the voluntaries now had even more money, staff positions and power to shape the direction of health care for the entire city.

The establishment of a new medical school in New York City could serve as a catalyst to reverse this tide and move a long way toward relieving the crisis of the municipal hospitals. Properly developed, the medical school would be public, oriented toward the training of third world students, and incorporated into the municipal hospital system.

This was part of Health-PAC's recommendation for a Public Health Sciences College, presented at affiliation hearings of the Health and Hospitals Corporation in February, 1972. It is also similar to the proposal for a Medical School of the City University of New York (MSCUNY), advocated by Dr. William Stahl, Chief of Surgery at Bellevue Hospital.

To reflect the priorities of urban New York City, with greater emphasis on training community practitioners and studying urban medical problems, such as pollution, lead poisoning and drug addiction, a new medical school must be public. The incorporation of the municipal hospital system with the medical school could go a long way toward enhancing the hospitals' prestige, opening up challenging new teaching and research possibilities, and making it easier to attract talented and dedicated staff to the municipal hospital system. It could also introduce a permanent new source of staff for the municipals, namely, the medical students who have trained there. Affiliation with a school such as CUNY, with its free tuition and open enrollment at the undergraduate level, offers an opportunity for the medical school to reflect the racial and ethnic composition of New York City.

The major weakness of the MSCUNY proposal in its present form is one of constituency. Advocates of this proposal have so far directed most of their efforts to recruiting the support of prominent individuals such as Robert Wagner, former New York Mayor and chairman of the Citizens Commission on the Future of CUNY. Possibly they can in this way succeed in establishing a medical school, but the nature of the individuals recruited and their ties to the present medical and political establishments will inevitably result in the reshaping of this proposal and the removal of its more promising features.

What is badly needed now is the organization of solid grassroots support for such a medical school proposal in the community, at the 18 municipal hospitals and at the community and senior colleges of CUNY. Only in this way can the progressive intent of the proposal be maintained and enlarged upon. The possibilities for establishing the medical school are real, but the time for organizing is short.
Medical schools are experiencing their own baby boom. Never before in this century have so many new medical schools been opened. Of the existing 103 medical schools, 15 have been born since 1965 and 12 more are in development stages, to be opened by 1975 (see chart).

The gestation and birth of a new medical school is a long and arduous process. It is also an important process to understand—because of the issues it raises and the political forces it involves.

Whereas medical schools of yesterday were built where medical need, university prestige and financial resources dictated, today's new medical schools grow up in a more complex environment. The issues of racial composition, new jobs and job mobility for health workers, community service and public accountability confront "new school" planners from the beginning. And these issues evoke new political forces. No longer is the decision to build a new medical school left only to the medical establishment and its philanthropic allies. Now business and industry, politicians and government, even labor unions and community groups are involved.

Nowhere is this more true than in New York City. Any new medical school for New York City will have to be born from new political forces and raised on new issues. In part, this is due to the fact that New York City already has seven medical schools and a well-entrenched private medical establishment, which will most likely oppose plans for new schools. For this reason, many observers doubt that there will be a new medical school in New York City in the foreseeable future.

But evidence suggests the contrary: there will be a new medical school in New York City and soon, perhaps as soon as 1975. Consider the following:

- In the last year, proposals for a new medical school for New York City have surfaced from many different quarters. This BULLETIN explores just four such proposals: the Queens Medical School; the Harlem Medical School; the Community Medical School; and the Medical School of the City University of New York (MSCUNY). Each proposal has a different emphasis and each represents a blend of new and old political forces. Together, the proposals indicate a groundswell of interest in a new medical school for the City.

- There is space for an additional medical school in New York City. With New York Medical College leaving the City for the Westchester suburbs, there is a "vacuum" that begs to be filled. This space may be defined statistically: compared to Boston or Philadelphia, which have less than 700,000 people per medical school, New York's 1.3 million people per medical school is high. In particular, the Borough of Queens, with a population of over two million people, the fastest growing borough in the City, does not have even one medical school. Or, it may be defined racially: New York City has the largest population of Blacks and Puerto Ricans in the country, yet it has no third world medical school. However it is defined, New York City still has room for another medical school.

- Also, money is available to start medical schools. The Comprehensive Health Manpower Training Act of 1971 gives each new medical school $10,000 per student expected to be enrolled in the first year, one year before the school opens; $7,500 per student in the first year, $5,000 in the second year and $2,500 per student in the third year of the school's operation. In addition, construction loan guarantees and interest subsidies are available on a priority basis for new medical schools.

- Besides money to start schools, there is an increasing amount of money available to finance their operation. Though many medical schools are presently in financial trouble, that problem arises from the shifting base of medical school financing. In 1947, 43 percent of the operating budget of the nation's medical schools came from state and local governments and philanthropy. By 1968, these sources accounted for only 18 percent of operating costs, while the federal government had assumed 40 percent of these costs, mostly in the form of research subsidies. With the passage of the Comprehensive Health Manpower Act of 1971, the federal government is shifting from support of med-
ical education through research to direct payments to medical schools on the basis of the number of students they enroll (see Health-PAC BULLETIN, November, 1971).

The climate for starting new medical schools is extremely favorable. After long neglect, many people are clamoring for an end to the doctor shortage. Even the conservative AMA, which historically has promoted “zero-doctor-growth” by limiting the number of entrants and graduates from American medical schools, asserts that “medical manpower [is] . . . the most important problem in the health field.” It supports the effort to double medical school enrollment in first year classes to 15,000 by 1975. It is estimated that almost 40 percent of this increase will be in new medical schools.

More than just increased numbers of doctors is involved. New medical schools mean larger budgets and more prestige for the universities with which they are affiliated. They also ease expansion into manpower training programs for allied health professionals. And, they can give a community’s sagging economy a real shot in the arm. In the words of one new medical school proposal: “The large operating budget of a medical center is primarily spent on thousands of personnel, who in turn spend their money locally in the purchase and maintenance of homes, clothes, groceries, amusements and all that can materially influence the local economy. Medicine is ‘big business’ . . . in the current fiscal year the aggregate national dollar commitment to medical research is about $2.5 billion . . . Any school of medicine is in a position to channel large funds annually into its community’s economy.” Like military bases, medical schools have become keenly sought after prizes, with even better prospects for growth and stability.

The Next is the Last

If there is lots of evidence pointing to a new medical school for New York City, then it is also likely that that next school will be New York City’s last new medical school for decades. With stabilization of the City’s population and the growth of the suburbs, the demand for additional medical schools will shift outside the city line. Already, the sprouting of Stonybrook on Long Island and the New Jersey Medical College in Newark are testimonials to this future direction of growth.

In addition, though there is no federal government regulatory agency for medical schools, their accreditation is becoming more rigorous. The recently renamed Joint Liaison Committee on Undergraduate Medical Education [comprised of six representatives each from the AMA’s Council on Medical Education and the Association of American Medical Colleges (AAMC), and one representative each from the federal government and the ‘public’] has started this process. It has enunciated principles for accreditation, including affiliation with a university; demonstration of adequate financial capacity; and appointment of competent faculty, including the clinical attending staff of a general hospital. The Carnegie Commission Report on Medical Education (see BULLETIN, November, 1971) suggests limiting the number of new medical schools to nine for the entire country. It seems likely that stricter principles, based on the distribution of present medical schools, will undoubtedly be considered in the future. As the national process consolidates, New York City’s prospects for new medical schools will decline.

If New York’s next is New York’s last medical school, then there’s lots at stake in its creation. It is important to establish criteria for measuring and evaluating existing and future proposals. The following list of questions provides a foundation for establishing such criteria:

Will it be public or private? Although all medical schools rely on public financing, this does not guarantee public control or accountability. Even an affiliation to a public university, such as Mt. Sinai’s affiliation to the City University of New York

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(CUNY) does not guarantee public control. While CUNY pays Mt. Sinai $300,000 in salaries to professors each year and has agreed to pay for Mt. Sinai’s new basic science building, Mt. Sinai is still run by a private, self-perpetuating board that responds to public need as it pleases.

But public control and accountability is an elusive concept. It does not mean just state-financed medical schools, like Downstate, which reflect the prevailing priorities within all medical schools. Rather, it means completely new priorities in curriculum, research, and health care delivery. For instance, will New York City’s next medical school place a priority on training community practitioners or will it continue the traditional emphasis on producing highly-trained specialists and researchers? Will it emphasize research into the particular health problems of urban areas, such as lead poisoning, pollution, and health care delivery to ghettos? Will it be a crucible for developing team practice, different relationships between professionals and their co-workers, pre-paid group practice, etc.?

With which university will it affiliate? For accreditation, all new medical schools must be affiliated with a university. The choice of which university and what type of affiliation is critical. If a new medical school affiliates with a private university, then it will adopt that school’s policy with regard to admissions and priorities. But if a new medical school affiliates with the City University of New York (CUNY), then it is possible that CUNY’s principles of free tuition and open enrollment will be applied to medical students. This would make such a new medical school the only medical school in the country with open access for students.

But mere affiliation is not a sufficient measure of a new medical school’s intentions, as the Mt. Sinai–CUNY relationship has shown. Mt. Sinai’s tuition is $2,400 and its enrollment of blacks has never exceeded 4 percent. Needless to say, Mt. Sinai’s teaching and research priorities appear to be as little affected by the CUNY affiliation as their admissions and tuition policies.

Will it deal with the crisis in New York City’s municipal hospital system? Any new medical school must define its relationship to the City’s 18 municipal hospitals. Will it relate to only one municipal

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* excludes 12 schools in development
hospital, or will it attempt to deal with some of the major systemic problems of the entire municipal hospital system?

One major dilemma for the New York City municipal hospitals is attracting top-quality full-time professionals while keeping them accountable to the public. Up to the early 1960's, the city hospitals had difficulty attracting full-time professional staff. Salaries could not compete with private institutions; the prestige of full-time work.

in the city system was low; and the working conditions were usually inferior to those in comparable private hospitals. Without top quality full-time staff, interns and residents flocked to the greener pastures of the private sector.

Then came the Affiliation Program. Each city hospital was linked to a private medical school or voluntary hospital. Affiliations seemed to solve many of these problems: they allowed the offering of competitive salaries and provided the prestige of a medical school or large medical center affiliation. But the cost of affiliations was great. Not only in fiscal terms (millions of dollars was spent for the private affiliate rather than the city hospital), but also in terms of accountability. Since the full-time professional staff of the city hospital was employed by the private affiliate, the professional staff was accountable to the private institution rather than the city. This resulted in lopsided teaching and research emphases within city hospitals, rather than the development of basic patient care programs, such as satellite out-patient clinics, family practice training programs, etc. As medical schools extracted more and more of their "teaching material" from city hospitals, the municipal system sank deeper and deeper into second class status.

In the early 1970's, after the advent of the Health and Hospitals Corporation—primarily a managerial reform—plans for closing, selling or leasing up to eight of the 18 municipal hospitals were discovered. While the private hospital system continues to expand, the city system was...
Queens Medical School Proposal

In a city of seven medical schools, the Borough of Queens has none. Its leaders feel deprived. After all, they save, Brooklyn has Downstate, the Bronx has Einstein, and Manhattan is overrun with medical schools. Playing second fiddle to Manhattan is one thing, but Brooklyn and the Bronx too?

It's more than borough chauvinism that has brought together Queens politicians, urban renewal entrepreneurs, the borough medical establishment and veterans groups. It's been the careful organizing of the County Medical Society and the political and economic promise of a new medical school for the borough.

Four years ago, the Ad Hoc Committee of the Queens County Medical Society, concerned with bringing a new medical school to Queens, decided to seek support outside the medical society. Since County Medical Society committees cannot have non-doctor members, the ad hoc committee was forced to establish a new group: the Queens Medical and Health Program. Subsequently, the Presidents of York College and St. John's University, borough politicians, and representatives from nursing, dentistry and veterans groups were recruited to the committee. The Queens Medical and Health Program gradually transformed itself into the official arm of the Regional Medical Program (RMP) in Queens, while maintaining its original goal—a new medical school for Queens. The group has built a powerful lobby around the notion of a medical school based on the existing hospital facilities in the borough and affiliated to one of its universities. Its major opposition seems to come from small hospitals that fear the loss of autonomy under a new medical school.

Financial Transfusion

One of the major benefits of a new medical school for the borough is economic. In one of the several reports produced by the Queens Medical and Health Program, this is stated explicitly: “In terms of economic assets, any community with a medical school is fortunate . . . a university medical center can have an annual operating budget of $25 million, and more. Employees can number from 6,000 to 10,000 and students in various categories can easily exceed 2,000. A medical center that has earned a reputation for leadership in medical education is a magnet for scientists . . . and patients. All these visitors can make a substantial contribution to a community's 'economic health’.”

Besides the direct transfusion of dollars and jobs, a new medical school has indirect fallout: it can expedite urban renewal plans. The South Jamaica Redevelopment Corporation has seen this potential, and is presently lobbying to have the new school located in Central Queens in the middle of Jamaica's black ghetto.

Several arguments have been advanced to support this plan. First, there are two universities in Jamaica, CUNY's York College and St. John's University (a private, Catholic school), either of which could provide the necessary academic affiliation for the new medical school. Recently created York College has available land, a construction budget approved by Governor Rockefeller and a College President, Milton Bassin, who would welcome a medical school which might catapult his college's prestige beyond the eight other senior colleges in CUNY's system. Second, Queens Hospital Center, the borough's largest hospital, is also located in Jamaica. It offers a 1,155-bed municipal hospital facility, which would be an excellent teaching base for a new medical school, not to mention its $15.2 million affiliation contract which would prime the new school's money pump.

Of course, the bulk of the Queens private medical establishment, including the Queens County Medical Society favor a new school. After trudging off to Cornell or Mt. Sinai in Manhattan for years, just to maintain a teaching hospital connection.

“We have all the necessary elements working on the City, State and Federal levels to make the long sought-after dream of a medical school and VA hospital for Queens a reality in 1973. After all, why should a borough of two million residents, larger than 19 states, have neither a medical school nor a VA hospital?”

—Donald Manes, Queens Borough President
tion, many Queens doctors look to the new medical school as a necessary and more convenient link to competence and prestige. The most energetic of these doctors have been instrumental in forming the Queens Medical and Health Program, one of the primary groups lobbying for a new medical school in the borough. There is some disagreement among the doctors. Some of those affiliated with Long Island Jewish Hospital, the empire-builder of Long Island, would like to see the new school based at their hospital rather than in Jamaica. Most doctors, however, appear to favor the more centrally-located Jamaica site.

Veterans March

Even veterans groups are mobilizing for a new medical school. For years, leaders of the borough's 325,000 veterans have tried unsuccessfully to get a VA hospital for Queens, so the borough's vets will not have to travel to Manhattan, Brooklyn and the Bronx for their care. One major stumbling block is the Veterans' Administration guideline which requires that all new VA Hospitals be built within five miles of a medical school. The new Queens Medical School is the linchpin in the vets plan for a new hospital. But the vets may also be crucial to the new school plans. Presently, there is legislation before Congress that would authorize $15 million for the construction of five new medical schools around VA hospitals.

The politicians aren't trailing too far behind their constituency. In February, 1972 a bill was introduced in Albany to enable the State Dormitory Authority to allocate funds specifically for a medical school at Queens Hospital Center. The bill passed the State legislature, but was vetoed by Governor Rockefeller for what borough leaders call a technicality, the failure to submit a master plan to the Board of Regents, a requirement of the State Education Law.

In June, within a week after the Rockefeller veto, Queens Borough President Donald Manes announced that the Borough Improvement Board, which he chairs, has allocated $35,000 to draw up plans for a Queens Medical School. Presently, a Borough Medical School Planning Committee is preparing a plan to submit to the Board of Regents in time for the 1973 legislative session, when the bill is certain to be resubmitted.

The Queens proposal has substantial roots within the Queens medical, economic and political establishment. Whether this is sufficient to bring about a new medical school in the borough is yet to be seen.

Harlem Medical School Proposal

In April, 1972 the New York Post announced that Knickerbocker Hospital, the City College of New York (CCNY) and Montefiore Hospital plan to open a new medical school in New York City, called the Harlem Medical School. Though the story was premature, the plans have been long in the making. It is this long history of careful preparation, designed to give Blacks a more significant role in at least one medical institution, that makes the Harlem Medical School a major contender in the race to become New York's newest medical school.

Harlem Doctors

Black doctors have historically been excluded from most hospitals. Often, they were denied admitting privileges and forced into second-rate proprietary hospitals to perform surgery. This held true even in Harlem, the capital of Black America, where for years there was not one major voluntary hospital to which Black physicians could admit their patients.

As a result, Harlem's Black doctors had to depend on public municipal hospitals: Metropolitan, in east Harlem; Harlem Hospital, in central Harlem; and Sydenham Hospital in west Harlem. During the '50s, the old and decrepit 207-bed Sydenham Hospital was, in effect, turned over to Black physicians, as an institution where they were permitted to control staffing and hence admitting privileges. But in the '60s, Black doctors were denied the grand prize. When the brand-new Harlem Hospital was opened, it was affiliated to Columbia College of Physicians and Surgeons. Columbia appoints the staff of the hospital, and therefore Columbia controls admitting privileges. For this, its garners $20 million per year from the city. Today, community-based Black physicians have less to say about what happens at Harlem Hospital than they did ten years ago, before the affiliation contracts.

Knickerbocker—The First Step to a Medical School

In the early '60s, when Knickerbocker Hospital, a 228-bed voluntary hospital located in west Harlem, was threatened with extinction, several Black physicians under the leadership of Dr. Arthur Logan "seized the time." They convinced the hospital to rescind its apartheid policy of excluding Black physicians from attending and staff positions. They had a vision—a private, voluntary medical center with Blacks in control—the first step toward a Harlem Medical School.
But it's a long way from a hospital on the verge of collapse to the establishment of a Harlem Medical School. Knickerbocker was dying because of its apartheid policies, which dated back to the time when the Upper West Side was a fashionable community, and when J.P. Morgan, Andrew Carnegie, Ogden Mills and John Markle served on Knickerbocker's Board. In the meantime, the neighborhood around the hospital became Black and Puerto Rican. While the census of white patients in hospital dropped, white doctors still held admitting privileges. Increasingly, the hospital had to rely on emergency room admissions to fill its beds. Though the hospital brags that "among the 78 voluntary hospitals in New York City, Knickerbocker has the largest ambulance district," everyone knows that without these patients, the hospital would fold.

Then came the Medicaid cut-backs. First, patients previously eligible for Medicaid were taken off the rolls and forced to use city hospitals. Then, the state froze reimbursement rates to the hospitals. Marginal hospitals, like Knickerbocker, that depended for approximately 80 percent of their income on Medicaid, were caught in a financial squeeze.

In spite of the adverse conditions, several more Black physicians were attracted to the Knickerbocker staff, and in 1969 plans for the new hospital were released to the public. Proposed were the following: a 500-bed teaching hospital, with an additional 200-300 bed extended care unit and a mental health unit of 50 beds; a medical office building adjacent to the hospital's clinics (to provide Black private practitioners with their own modern offices); and "an industrial complex of shared facilities such as a laundry, food service, pharmaceutical and medical supplies, maintenance services, housekeeping and general stores", designed to support the medical center.

Two barriers could have blocked the expansion plans: the Health and Hospitals Planning Council, whose approval is required for any hospital construction, and the lack of construction funds.

In 1971, the Health and Hospitals Planning Council not only approved Knickerbocker's plans, but they also designated it as first priority for State funds for the replacement of obsolete voluntary hospital beds in New York City. Shortly thereafter, the state notified Knickerbocker that $35 million had been allocated for construction of the new hospital. Dr. Arthur Logan, one of the principle architects of the Knickerbocker plan, had done his homework well. No doubt his ties to both the Kennedys and the Rockefellers stood him in good stead.

The Second Step to a Medical School

Knickerbocker's 1969 planning report states that the new teaching hospital will be "affiliated with an undergraduate medical school, a graduate teaching and research center and a school of nursing." Though Dr. Logan considered Columbia and Mt. Sinai, he clearly preferred greater independence than these established centers would provide.

When Dr. Robert Marshak was appointed President of the City College of New York (CCNY), the oldest and largest senior college in the City University of New York (CUNY), Dr. Logan saw his opportunity. CCNY is located just across the street from Knickerbocker. In fact, its South Campus, which is closest to Knickerbocker, has space for a new health sciences building. Dr. Marshak is interested in building an "urban-grant" university, that would receive federal support to serve crisis-ridden metropolitan communities. Health training, including a medical school, is one of the basic components of this model.

As Dr. Logan sees it, CUNY would provide the first two years of basic science medical school training, while Knickerbocker would be the site of the last two years of clinical training. This vision is shared by Dr. Marshak who stated that he saw "a four year school ... in associ-
Knickerbocker can survive the next three years until construction gets under way. The hospital is constantly on the verge of financial collapse. The threat of more Medicaid cuts, the loss of accreditation for the new medical school, and the present lack of clinical faculty that would assure accreditation for the new medical school, Montefiore Medical Center, across the Harlem River in the North Bronx, seemed to fit the bill. It is well-stocked with excellent clinical faculty and its position within the Albert Einstein School of Medicine has been uncertain. Traditionally, Montefiore has been seen as the “west campus” of Einstein. However, it has been regarded as second-class to the “east campus”. Montefiore has always wanted at least equal status in policy-making and teaching at Einstein. But it hasn’t gotten it. Thus, rumors abound that Montefiore will bolt from Einstein and form its own medical school.

Montefiore seemed ripe, both politically and technically, to be the missing link in the Harlem Medical School. But here the plan is stalemated. According to Dr. Logan, after some initial nibbles Montefiore has postponed a decision until October. Some observers speculate that Dr. Martin Cherkasky, executive director of Montefiore, is using the threat of Montefiore’s involvement in a new medical school to gain leverage within Albert Einstein. Other observers point out that Montefiore, with the opening of the new North Central Bronx Hospital (a city-built 400-bed hospital connected by tunnels to Montefiore and dependent on it for radiology, surgery, etc.), will become the regional medical center in the Bronx. In this position, they say, Montefiore’s destiny clearly lies within the Bronx and Einstein, rather than in Harlem.

Back at Knickerbocker, things are just barely holding together. The hospital is constantly on the verge of financial collapse. The threat of more Medicaid cutbacks or the loss of accreditation undermines any sense of stability. “The problem now,” says Dr. Logan, “is whether Knickerbocker can survive the next three years until construction gets under way.

It is rumored that Dr. Marshak and Logan might receive a planning grant of $250,000 from the Johnson Foundation to investigate the feasibility of a new medical school at CCNY. The details of the grant are still sketchy. But it suggests, together with the rebirth of Knickerbocker Hospital, that plans for a Harlem Medical School are indeed serious.

**Montefiore—The Third Step to a Medical School**

The missing link, however, is Knickerbocker’s present lack of clinical faculty. The task was to find some established repository of clinical faculty that would assure accreditation for the new medical school.

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**Under the Negotiating Table**

While Leon Davis, President of Local 1199 of the Drug and Hospital Workers Union, is claiming complete victory in the settlement of union disputes with the New York City Health and Hospitals Corporation, Local 1199 members are becoming confused about who won what and if they won anything at all.

The dispute has a complicated history which revolves around the affiliation of private medical centers with public municipal hospitals. The 4,000 affiliate-employees whose workplaces are municipal hospitals belong to Local 1199, while public employees in the same hospitals belong to the larger District Council 37 of the State, County and Municipal Employees Union. Several years ago, when the Health and Hospitals Corporation was created to administer the 18 municipal hospitals, DC 37’s support for the idea was gained by the City’s promise to transfer the 1199 workers to DC 37 and thereby end dual unionism in the municipal hospitals. In keeping with this agreement, 1,900 clerical workers belonging to Local 1199 were sent notices this summer that they would be transferred to the City payroll and to District Council 37 representation.

For several weeks up until the July 5th settlement, the newspapers were filled with strike threats, charges of union “raiding”, and statements and counter-statements emanating from all parties. Attention was focused on the possibility that those better-paid Local 1199 workers would be frozen at their present salaries until the lesser-paid DC 37 workers caught up to them.

Now that the dust is starting to settle, a lot of unanswered questions are starting to be raised. While the 1,900 clerical workers are being transferred to the City payroll, it is not known whether they have lost future wage boosts. Scuttlebutt around the Local 1199 office says that the clerical workers were sold down the river—the rationalization for the sell-out being that “they weren’t really hospital workers”. As for the “real hospital workers”, the 2,100 technicians and others who have yet to be transferred to the City, “Well, they’re not telling us what’s going to happen.”

While up to 4,000 individual workers may be in trouble, it appears that the union itself may come out even. According to high-ups Local 1199 will get to represent all the workers at the forthcoming North Central Bronx Hospital (a municipal hospital which is being built at the behest of and next door to Montefiore), a private medical center in the Bronx.
Community Medical School Proposal

What could bring together such politically disparate groups as Einstein faculty and students, labor representatives from 1199, insurgents from the Lincoln Hospital Collective, other Lincoln Hospital full-time staff, and a Vice President of the Health and Hospitals Corporation? Ordinarily, nothing. But, in Spring, 1972 these groups and individuals sat down together to map out plans for a Community Medical School in the South Bronx.

The impetus for the Community Medical School came from a Provisional Committee consisting of a small group of Black and white Einstein faculty members and third world students who enlisted support of the other groups. They felt an entirely new kind of medical school was necessary to correct the faults in the present system, which they listed as:

- Lagging enrollment of third world students. For instance, at Einstein the percentage of Blacks and Puerto Ricans in the first year class has decreased from 12.5 percent in 1969 to 7 percent in 1971.
- Rigid hierarchy that prevents hospital workers, many of them Black and Puerto Rican, from becoming trained as MDs, by insisting on full-time student status in medical school and by denying credit for any previous related health experience.
- Declining number of primary practicing physicians in ghetto areas, from 4,500 in 1959 to 2,100 in April, 1972. Meanwhile, the total number of physicians in New York City has risen from 16,700 to 23,500 during the same period.

As one solution to these problems, the Provisional Committee proposed a hospital-based medical school, providing both basic science education as well as a "deep ongoing relationship to the day-to-day life experience of the community being served."—a Community Medical School. They saw this new type of medical school differing from the traditional Flexner model which is research oriented. It would be similar to the new health care delivery model proposed in the Carnegie Commission Report (see November, 1971 BULLETIN), but would go beyond it. For instance, students would be drawn from the community on an open-admissions basis and would be encouraged to remain in the community after completing their training. They would learn and work at community facilities throughout their entire period of training.

To get the process rolling, the Provisional Committee mandated Dr. Cyril Moore, a Black faculty member at Einstein who chaired the Committee, to submit a letter of intent to the National Institutes of Health for funds to plan such a Community Medical School. The letter, dated June 23, 1972, spoke in very general terms of the need "for a new type of community-based medical school" and mentioned the new Lincoln Hospital as a possible site. But the money that was available from NIH was for starting Area Health Education Centers for paraprofessional training rather than for starting new medical schools.

Ironically, another letter of intent was sent to the same office of NIH on the same day from Dr. Ernst R. Jaffe, acting Dean of Einstein. Jaffe's letter, in contrast to Moore's, specified Lincoln as one of three proposed sites for Area Health Education Centers. Einstein was "invited" by NIH to submit a proposal for this year; the Community Medical School group was not. It is almost certain that Einstein will receive funds.

However, the reality is that the Provisional Committee is hindered by much more than their lack of planning money. Besides being unfamiliar with the steps necessary to set up a new medical school, those who form this loose coalition have very different goals.

The Black students and faculty from Einstein and some of the full-time staff from Lincoln are interested mainly in opening a medical school for third world students. This was evident from the beginning, with their focus on the racism, both cultural and academic, that they face in white-dominated, traditional schools. The new Drew Medical School in Watts

Medical schools, trying to maintain a traditional model, find it difficult to accept and work with students from poor communities; they find their programs for 'minority group' students emerge as a burden justified by 'social duty.'

—Cyril Moore, Ph.D. Letter of Intent to N.I.H.
most closely approximates their model. It is a Black controlled school with a community emphasis, but a fairly traditional organization.

The union members on the Committee have a similar goal, but with different emphases. They too would like the new medical school to be traditional in terms of credentials, accreditation and legitimacy, but they envision a slightly different student body. They would like the medical school to admit union-affiliated hospital workers, regardless of ethnic background. They would insist that the curriculum of the new school credit hospital workers for their experience. Through their training fund, the union has been able to provide some measure of mobility for a few of their workers at the lower levels of the medical hierarchy; getting union members admitted to a medical school would be a crowning achievement.

The various insurgent groups at Lincoln Hospital itself have very different views of what a community medical school would be and how it would function. They are primarily interested in changing the way health care is delivered. Therefore, some are not as interested in credentialism as they are in providing medical training for hospital workers and other community people. They want to break down the rigid categories of the medical hierarchy rather than merely opening them up to poor and third world people.

Although initially the Provisional Committee was adamant about not having any ties, formal or informal, to Einstein, Einstein's anticipated federal grant has changed matters drastically. Now, some members of the Committee are a good deal less committed to their initial position of aloofness. They have begun to realize that planning a new medical school requires more than an idealistic philosophy and a curriculum committee. It is a political process.

Recently, a meeting was held between Community Medical School advocates and Assistant Dean William Glasser, also acting chairman of the Community Health Department at Einstein. Glasser agreed to include a request for some planning money for the Community Medical School group in Einstein’s proposal for federal funds. According to Dr. Cyril Moore, Provisional Committee chairman, the Committee would accept money “only to provide investigatory help, and for an office and a secretary at Lincoln. We don’t want Einstein too involved.” The future of the Community Medical School is completely uncertain—but its early association with Einstein does not bode well for its independence.

Proposal for a Medical School of the City University of New York

What is it the would accomplish the following goals:

- Development of a full-time high quality physician staff for all of New York City’s municipal hospitals.
- A large increase in medical school graduates (perhaps as many as 300 per year).
- Financial and educational accessibility to medical school for Black, Puerto Rican and poor white populations.
- An increase in the number of physicians practicing in all New York City’s communities; especially among the poor.
- Part-time study in medical education, so that health workers may advance, even to become MDs?

For Dr. William Stahl, Chief of Surgery at Bellevue Hospital, there is only one answer: a Medical School of the City University of New York (MSCUNY).

Dr. Stahl’s proposal is as much a plan for the total reconstruction of the New York City hospital system as it is a plan for just another medical school. Although forces powerful enough to deliver such a plan are not lined up yet, the general outline of a Medical School of the City University of New York is a challenging and imaginative proposal that requires serious consideration.

What is MSCUNY?

A Medical School of the City University of New York would probably be the nation’s largest medical school. Its pre-clinical faculty, which would teach the basic science courses of the first two years of the standard medical school curriculum, would be drawn from existing faculty within the City University of New York’s nine senior colleges and selected community colleges. They would continue to teach in their respective institutions. Already, a host of pre-clinical courses are taught in the City University from anatomy, biochemistry and physiology to histology and microbiology. These courses might require some reorganization and coordination, but the basic rubric for the first two years of medical school is present at this time.

The clinical faculty would consist of the full time staff of all 18 municipal hospitals. They would teach much of the clinically-related science, such as pharmacology, pathology and physical diagnosis. In addition, they would offer the basic
clinical clerkships in pediatrics, medicine, surgery, obstetrics and gynecology through all 18 hospitals, with 15,187 beds presently within the city hospital system.

The magic of this proposal is that a large number of the elements necessary for its success already exist. Without the creation of massive new buildings, the human resources in terms of faculty are basically present. The precedent for free tuition to all New York City residents has been established by the City University of New York at the undergraduate level. Access to the medical school for Black, Puerto Rican and poor white students is enhanced by the City University's policy of open enrollment. And the probability that these students will stay in the communities which they grew up in is increased by training in a local community municipal hospital, which has the prestige of a medical school affiliation.

A Solution to the City Hospital Crisis

What is most imaginative about the MSCUNY proposal, however, is its potential as a solution to the city hospital crisis in New York. For decades the city hospitals have had difficulty attracting top quality, full-time professional staff and well-trained interns and residents. The Affiliation Program which linked individual city hospitals to private medical schools and medical centers only partially succeeded in overcoming this problem. Today, some see the ultimate solution as selling the city hospitals to their private affiliates. By integrating private with public patients, private physicians would be attracted back to the city hospitals, they claim. But more private doctors will not solve the staffing dilemma. What is needed is full-time professional staff accountable to the public. Affiliations increased the full-time staff, but decreased their accountability to the public, by placing them in the employ of private medical schools and medical centers.

The Medical School of the City University of New York provides one potential solution to this dilemma. As a medical school, MSCUNY will be able to provide the prestige of an academic university-based setting, thereby attracting top-quality professionals to the system. As a public medical school, it will regain control of hiring and firing its professional staff and thereby be able to demand some degree of public accountability from its staff. Of course, competitive salaries will need to be continued, but the affiliation program and the City University of New York both have excellent records in this regard. The novelty of such a "decentralized" medical school with its potential for curricular innovation both in the classroom and in the community will, as Dr. Stahl suggests, "draw capable and enthusiastic staff from the entire country."

MSCUNY and CUNY

In addition to being a solution to the City Hospital crisis, MSCUNY offers some specific advantages to the CUNY system. It provides the faculty and perhaps the financing for expanding CUNY's training program in nursing, medical technology and para-professional occupations, such as physicians assistants training. Within the framework of a health science university, health workers presently serving within the municipal hospital system would be able to go to school part-time to pick up the necessary courses and electives to complete pre-clinical medical school training. With some credit offered for on-the-job experience in their respective hospitals, these workers would be able to advance to become doctors without having to attend medical school full time.

MSCUNY has one additional advantage. All the other medical school proposals presently being considered, are designed to be affiliated with only one part of the CUNY system. For example, the Harlem Medical School would be affiliated with City College, while the Queens School would be affiliated with York College. A medical school is a big feather in a college president's cap. No doubt, any president will make demands that might stall a project excluding his school. MSCUNY obviates these problems by decentralizing its medical school to each of the senior colleges within the CUNY system. It's like giving a medical school to each of the college presidents.

Problems, Problems

But MSCUNY is faced with a myriad of problems. At present, it seems to be the least "politically entrenched" proposal. In essence, it appears to be a proposal without a constituency. Dr. Stahl has a two-pronged strategy: first, to convince CUNY of the viability of the proposal. Here his tactic is to approach a few highly-visible and influential people to support the program, such as Robert Wagner, Chairman of the Citizens' Commission on the future of CUNY. The immediate goal would be to have the President of CUNY appoint a dean for the new medical school, so that concrete plans may be undertaken soon.

Second, Dr. Stahl must win over the Health and Hospitals Corporation. So far, he has not approached the board, but has concentrated on the Lindsay appointees, like Gordon Chase. But all these machina-
tions are taking place behind closed doors.

In addition, the free tuition and open enrollment policies at CUNY will not automatically apply to a medical school. In fact, they are presently limited to the undergraduate schools, where many critics claim that open enrollment is a farce—students are admitted without CUNY offering appropriate support, and many flunk out after one semester. On the graduate level, free tuition and open enrollment have never existed. MSCUNY will have to fight to win these crucial goals.

Finally, the MSCUNY has to deal with the problem of money for running a medical school. Dr. Stahl points out that the average medical school budget is $20-25 million per year. The city already pays medical schools and private medical centers $160 million to provide professional staff for the municipal hospitals. If this staff were appointed and on the payroll of MSCUNY, then this $160 million would go to MSCUNY. If approximately 10 percent of each affiliation contract goes for overhead rather than direct services, a transfer of the affiliations to MSCUNY should "free-up" approximately $16 million for MSCUNY administrative and overhead expenses.

Realities

It is clear that the MSCUNY proposal pushes right up against the major establishment forces in New York City's private medical system. MSCUNY implies the phasing out of the present affiliations: Einstein out of Jacobi and Lincoln; Columbia out of Harlem; New York Medical College out of Metropolitan; NYU out of Bellevue; Downstate out of Kings County; Long Island Jewish out of Queens Medical Center; etc. A school like NYU would be hard pressed for a place to teach medical students if it didn't have Bellevue. Without Jacobi, Einstein would probably go bankrupt. Downstate could never staff its State University Hospital with interns and residents without rotating them from Kings County. It seems patently obvious that any proposal which forbodes such sweeping changes must have more than "behind-closed-doors" support. MSCUNY has the potential for widespread popular support, but this must be developed.

Unfortunately, this is not Dr. Stahl's present approach. Whether he will change in the future is not certain. If past experience is any indication, the prospects are gloomy. Dr. Stahl was closely associated with NYU's former dean, Dr. Lewis Thomas. Undoubtedly, he was involved with Dr. Thomas in the "behind-closed-doors" discussions and politicking that resulted in the present Health and Hospitals Corporation failure (see December, 1971 BULLETIN). MSCUNY needs a broader constituency than Dr. Stahl appears willing to bring to it.

Four Questions

In conclusion, let us turn back to the four questions that each proposal was to answer:

- Will it be public or private? Of the four proposals presented, only the MSCUNY one calls forthrightly for public control and accountability. The Community Medical School implies some form of public or community control, while both the Harlem and Queens Medical Schools look like they will be run by private boards.

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Medical School Boxscore

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<th>Characteristics of Each Proposal</th>
<th>Proposals for New Medical Schools in New York City</th>
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With which university will it affiliate? All four proposals seek some relationship with the City University of New York (CUNY), but in most cases this is limited to one of the nine senior colleges. The only proposal that deals with all of CUNY is the MSCUNY proposal. Harlem would relate to CCNY; Queens would relate most likely to York College. The Community Medical School is just beginning to explore a CUNY relationship.

Will it deal with the crisis in the New York City municipal hospital system? The Harlem Medical School appears to be completely independent of the municipal hospital system, except that the opening of a new Knickerbocker Hospital will mean the closing of Sydenham and probable transfer of its $7 million budget to the new hospital. The Queens Medical School and the Community Medical School apparently are relating only to one of the 18 municipal hospitals—Queens Medical Center in the case of the former; Lincoln Hospital in the case of the latter. Again, the only proposal that deals with entire municipal hospital system, is the MSCUNY proposal. Thus, MSCUNY is the only proposal that holds the promise of dealing with the affiliation system and the erosion of public accountability within the municipal hospitals.

Will it be third world oriented? Though none of the proposals explicitly states that it will be a Black or Puerto Rican medical school, the Harlem and Community Medical Schools imply that this will be their emphasis. Likewise, the MSCUNY proposal sees itself as encouraging third world admissions. The Queens proposal makes no pretense in this direction.

Which proposal will most likely become New York’s next medical school? Politically, the Harlem and Queens proposals appear to have evolved through more sophisticated political processes. They both have a defined constituency, in contrast to the amorphous constituency that relates to the Community Medical School and the non-existent constituency around the MSCUNY proposal. Conceptually, MSCUNY is miles ahead of the others. However ideas are not the same as political power, and political power is ultimately what makes the decision. So, the eventual outcome is quite uncertain. But one thing is certain: New York City will have a new medical school soon.

—Oliver Fein, A. Sandra Abramson, Michael Gordon. Michael Gordon is currently a medical student at Univ. of Penna. He was a Health-PAC student intern this summer.

Public Utility Hospitals?

An impressive battle is underway in Ann Arbor, Michigan for public control of the City’s major provider of medical care. St. Joseph’s Mercy Hospital, a Catholic voluntary, is being sued by the Medical Committee for Human Rights (MCHR) for attempting to move from Ann Arbor to Superior Township ten miles away, thus depriving the City’s residents (and particularly the poor who can’t afford to travel to the new planned site) of needed medical services. The suit charges that the State Health Department, the Southeast Michigan Comprehensive Health Planning Council and six other public agencies—all apparently powerless to forestall the move—have failed to insure comprehensive health services, reasonable medical fees and rates, and to control hospital costs. Instead, the plaintiffs maintain that the hospital is informally controlled by Blue Cross and Blue Shield, both private corporations.

To bring the hospital under public control, the MCHR suit requests that the court establish precedent by declaring St. Joseph’s Mercy Hospital a public utility, subject to regulation by the State Public Service Commission. MCHR would then force public hearings on St. Joe’s relocation plans, its exorbitant rates (second highest in the state for a hospital of comparable size), and its services.

To Show Mercy

The MCHR suit is part of a campaign to publicize the arcane actions of Ann Arbor’s health institutions and the need for community control of health services. The campaign has drawn the support of an interesting array of local groups such as: the Welfare Rights Organization, Student American Medical Association, Free People’s Clinic, the Human Rights Party, the Women’s Health Collective, United Health Workers Union, and the Black Economic Development League. Several city councilmen have also endorsed the hearings and support the suit.

Knowing the capriciousness of the courts, MCHR and other co-sponsors are not counting on a favorable decision. Even if the hospital is declared a utility, they are not placing their faith in the State to adequately perform its regulatory functions. Plans are in the offing for various groups involved to incorporate as an authority themselves to police the quality of care, control costs, approve expansion plans, etc. of local health institutions.
The Health Insurance Plan of Greater New York (HIP), one of the oldest prepaid group practices in the country and second in size only to the West Coast-based Kaiser-Permanente, is on the skids. Indeed, HIP's immediate crisis, which has been building for some years, has brought it to the brink of bankruptcy.

HIP's problems are of concern not only to its 750,000 New York subscribers, nearly half of whom are New York City municipal employees, but to national health planners as well. Rapidly evolving events at HIP are being watched closely by the Department of Health, Education and Welfare, Blue Cross and the staff of Health Maintenance Organization booster Paul Ellwood. Undoubtedly Ellwood and Blue Cross see HIP's crisis as an opportunity to convert the Plan to the single largest HMO in the country with Blue Cross at its helm. As a result, Blue Cross, its eyes glued to the national health insurance horizon, is moving in to pick up the pieces of the broken HIP.

Congenital Defects

HIP's current crisis has been a long time coming but could have been predicted. In fact, the seeds of the Plan's present difficulties were planted at its conception.

In 1943, New York's Mayor, Fiorello LaGuardia, appointed a committee to devise a prepayment plan to provide comprehensive care for city employees and for employees of private industry. Notably excluded were the unemployed poor. Then as now, the gaps in private health insurance were so great that a single illness could leave a worker destitute. The committee rapidly split into three camps: one camp, led by representatives of the County Medical Society, favored a fee-for-service indemnity plan with limited coverage; a second camp held out for a state or national system of compulsory health insurance; while a third took a middle-of-the-road position, that prepaid group practice was the answer.

The Mayor steered toward the middle-of-the-road; and between 1944 and 1946 legislation was introduced and passed within the State Legislature to legalize prepaid group practice. Meanwhile, liberal private "health movers" went to work. For start-up expenses, David M. Heyman of the New York Foundation and Mary Lasker raised $855,000 in loans from the Rockefeller Foundation, the New York Foundation and the Albert and Mary Lasker Foundation.

By March 1, 1947 twenty-two medical groups located in various parts of the city had been organized and the plan opened for enrollment. From the beginning, however, HIP had two major deficiencies: its inability to recruit adequate numbers of full-time doctors and its lack of ownership of hospitals.

The 22 medical groups (there are now 30 groups) were set up independently, similar to present-day franchises. The medical group centers were, by and large, owned and operated by private partnerships of doctors, each of which signed a contract with central HIP to deliver a specified set of services to subscribers. The medical group received a fixed amount per year for each enrollee (prepayment per capita) regardless of the amount of medical service utilized by the subscriber. In the contract ending July, 1971 this amounted to an annual fee of $45 to $61 per enrollee, depending on the services offered by the group.

The medical groups grew up as dual practices for most HIP doctors—part-time HIP practice and part-time private practice, with the latter usually being favored. Central HIP lent its prestigious name and recruited patients for the local groups. Meanwhile, as the local doctors concentrated on building their more lucrative private practices, they increasingly shortchanged their HIP patients. The doctors' private practices served as insurance against any attempt by central HIP to force the medical groups to live up to the contract. If central HIP demanded higher quality service, the doctors could always pack their black bags, take their medical center out of HIP, and devote themselves to full-time private practice.

The leeway shown the doctors may have been necessary in the beginning of
HIP because doctors were understandably reluctant to pledge a full-commitment to an untested new experiment in medical care delivery. However, this arrangement institutionalized the power of part-time doctors and once established it became very difficult to subsequently reverse. Eventually, HIP's survival depended upon increasing the number of full-time doctors from whom accountability could be demanded. This task, however, still awaits accomplishment.

HIP's second major deficiency was that it owned and operated no hospitals. This completely undercut the economic incentives of a prepaid group practice. By offering preventive care and other measures, it has been demonstrated that prepaid group practice reduces hospitalization for its members by about one-third. In a prepaid group practice like Kaiser, which owns its own hospitals, the savings from this reduced hospitalization are returned either as "profit" for the plan or reduced premiums for subscribers.

However, HIP only covers doctor's office visits, outpatient laboratory tests, preventive check-ups, etc. Each HIP subscriber must have hospitalization insurance as well, and for most this is Blue Cross. So, in the case of HIP, the money saved from its subscribers' decreased utilization of hospital services was not poured back into the plan or given to subscribers. Rather, Blue Cross ended up the winner, because it had to pay less hospital bills for each HIP subscriber.

For decades HIP struggled along with its congenital disabilities. Throughout the forties and fifties it grew in spite of intense opposition from medical societies whose paranoid fears equated prepaid group practice with socialized medicine. Presently, it consists of 30 medical groups and approximately 750,000 subscribers.

**Consumer Rumblings**

By the 1960's, however, HIP's built-in liabilities began to catch up with it. Subscribers began to complain that medical service was not up to snuff. HIP users experienced long waits for appointments and off-the-cuff impersonal treatment when they finally got to see a doctor. Many HIP doctors, two-thirds of whom were in private practice, used HIP as a soft financial cushion to pad their private practice incomes. Often, in fact, the doctors give preferential treatment to their private patients, seeing them first at HIP facilities. Even some of the HIP doctors recognized HIP's inadequacies. Doctor Robert Rosengarten, medical director of the Jamaica HIP group, admits that his facilities were "inadequate," "crowded," "run down," and "gave limited services."

"I think that early in this (HIP's) development it was recognized that certain deficiencies were present in the plan, but there was no alternative at that point in the mid-forties but to begin with a less perfect design."

---James Brindle,
Ex-President, HIP.

At first, poor service merely discouraged new subscribers from joining HIP. However, as the problems worsened, long-time HIP subscribers began to leave. According to Ed Gluckman, a consumer representative on the HIP Board, "HIP's 1972 enrollment, discounting Medicaid patients, is back to the 1962 level." But HIP's Medicaid enrollees cannot so easily be discounted. In fact, without them, HIP would have been bankrupt long ago.

**Fleecing Medicaid**

HIP's first drop in enrollment occurred early in 1966. Only six months later, HIP enrolled its first Medicaid subscribers. Since then Medicaid has provided the transfusion—both in enrollees and dollars—that kept HIP alive. Indeed, HIP's relationship to Medicaid has been nothing short of scandalous. It is estimated that HIP "profits" over $2 million a year on its Medicaid enrollees, while it looses approximately $1 million on its regular subscribers.

Medicaid is a money-maker for HIP because Medicaid subscribers, whose annual premiums are actually higher than those of regular subscribers, use only one-third as many services. In 1969, Medicaid subscribers received only 1.3 services per person, compared with 4.3 services per person used by regular subscribers. For some groups, the rates are considerably worse. The Yorkville Medical Group, for example, gave only .66 services per Medicaid subscriber (under age 65) compared to 4.07 services per non-Medicaid subscriber.

Lack of utilization of HIP by Medicaid subscribers is not because they are healthier. On the contrary, most Medicaid subscribers probably need more medical services than the average HIP member.
One explanation for the poor utilization by Medicaid enrollees is that many of them don’t even know what HIP means. During 1968-69, HIP conducted a door-to-door enrollment campaign, during which, it is alleged, it signed up Medicaid enrollees without fully explaining what the HIP program was all about. Naturally, many Medicaid enrollees continued to use their local city hospital for medical care. But, when the City put a stop to these enrollment tactics, HIP still noticed that Medicaid enrollees didn’t come for services. Other explanations were sought.

In some medical groups, the barriers to increased utilization are clearly formidable. For example, the Bedford-Williamsburg Center was judged undersized by HIP’s own guidelines, prior to Medicaid, when its enrollment was only 10,000. Without additional space, it clearly cannot serve the added Medicaid enrollees, who boosted enrollment to 27,000. Other groups maintained their customary 9-5 weekday hours, forcing Medicaid enrollees to use emergency wards during the off hours. Strict adherence to appointment schedules also ward off the crisis-oriented Medicaid subscriber. Whatever the reason, it appears that HIP never intended to serve Medicaid patients. Rather, HIP used Medicaid merely to stave off impending financial crisis.

Revolution-Come-Lately

At best, however, Medicaid could only provide a temporary respite from HIP’s impending doom. Though Medicaid brought in millions of dollars, much of it went to satisfy the incessant demands of the medical groups. What was left over was sunk into meeting HIP’s already-bloated central office budget. Even after creaming Medicaid, HIP could barely meet expenses. There was certainly no money left over to deal with consumer dissatisfaction by upgrading medical service. So HIP subscribers continued to drift away.

In 1971, HIP tried to counter subscriber demoralization by creating Consumer Councils. Predictably, HIP doctors opposed the move; but, after its customary foot-dragging, Central HIP acceded to subscribers’ demands and initiated Consumer Councils at each HIP center. By this time, however, many subscribers had no interest in a “consumer movement” around HIP. They wanted out, and they voted with their feet.

Under pressure from dissatisfied consumers, and, more importantly, irate labor leaders, HIP officials belatedly admitted in 1971 that “the time had arrived to deal with long-standing, vexing problems.” HIP President Brindle proposed a sweeping reorganization, misnamed the “regionalization plan,” to overcome HIP’s two major deficiencies: its part-time doctors and its lack of hospitals.

In essence, the plan sought to consolidate HIP medical groups by merging them with those groups which were already substantially manned by full-time doctors. To prevent the doctors who shied away from a full-time group practice commitment from leaving the Plan, Brindle sought to remove their major asset: the medical facilities which they owned. The demand that the doctors sell their facilities to central HIP was bound to raise the ire of the doctors.

Tense negotiations began between Central HIP and the local medical groups. Almost immediately one affiliate, the Astoria Medical Group, rejected full-time HIP practice and bolted HIP. Other HIP groups, ostensibly at least, agreed to consolidate. Though half of the regionalization plan
was to be implemented by August 1972, thus far only two such plans have transpired involving groups on Staten Island and Queens. While this covers nearly one-quarter of HIP's subscribers, conservative doctor groups have hardly given up their fight to preserve their part-time relationship to HIP.

Brindle's second objective, the acquisition of hospitals which "will become the focal point of full-time medical group practice" and which will achieve "an integrated system of ambulatory and inpatient care ..." has fared no better. For the moment, HIP operates only a single hospital, LaGuardia Hospital in Queens. This 220-bed facility serves the new regionalized LaGuardia Medical Group.

The problem with Brindle's scheme is that the purchase of hospitals and the higher salaries which must be paid to full-time doctors, not to mention other elements of Brindle's reorganization plan, such as the expansion of multiphasic screening and centralized laboratories, cost money and lots of it. But money is precisely what HIP doesn't have. In fact, at its present spending rate, without any improvement of services, HIP is losing money on its non-Medicaid subscribers.

Lowering the Boom

To pull off its reorganization plan, HIP requested a 36 percent rate increase from the New York State Insurance Department. In May, the Department approved a 29 percent hike, sufficient, according to sources close to HIP, to insure implementation of the plan. But, even before the Insurance Department's ruling, testimony offered at the rate increase public hearings provided a harbinger of bad tidings.

Speaking for the half of HIP doctor groups organized in the conservative Medical Group Council, Dr. Martin Gold expressed the fear that the new plan would lead to dire consequences. "... If the doctors can't stand working under circumstances where they're told they must come in, actually, about 41 hours a week ... [the] whole darned plan is going down the drain. ..."

The testimony of Harry I. Bronstein, City Personnel Director, was even more ominous. Bronstein, the City's representative, had the ultimate power to decide whether the City would go along with a rate increase for the 300,000 City employees and their families who comprise nearly half of HIP's members. His comments left little doubt about the City's decision. If the rate increase were granted, he said, it "may require the City to examine other possible alternatives for its employees ... at a cost which is fair and equitable to the taxpayers of the City."

By mid-August, Bronstein acted. He rejected the Insurance Department's approved 29 percent rate increase, and declared that the best the City could offer HIP was 15 percent. And, in so doing, Bronstein shot down the reorganization plans in one fell swoop. To make matters worse, HIP's creditor, the Chase-Manhattan Bank, declared that it was refusing HIP any further credit. The combination punch of Bronstein and Chase-Manhattan did more than throw HIP's reorganization plan into a tailspin. It knocked President Brindle right out of the ring. On August 14, Brindle and HIP's Executive Vice President, Martin Cohen, handed in their resignations.

Nobody mourned for Brindle and Cohen. For years they had been accused of mismanaging HIP. Allegations of the misappropriation of money were widespread. Critics blamed HIP's enormous overhead costs of 14 percent of its total budget (as compared to 3 percent for Kaiser) on Brindle's and Cohen's ineptitude. Furthermore, Brindle's reorganization plan had won little favor with HIP doctors. But none of this completely ex-
plans why the City suddenly turned on Brindle, guaranteeing his ouster.

Undoubtedly, part of the reason for the City's refusal to pay the full rate increase was its desire to put the reins on its galloping budget. But it's doubtful that the center of HIP policy making.

Whether Michelson will be satisfied with the controlling of HIP is uncertain. The $60 million a year HIP is small fish and there are much bigger fish in HIP's troubled sea. This became evident when

"My group, the former Jamaica Group, was, just like the other groups with representatives here, inadequate, crowded, had run down facilities; we gave limited services; we had old equipment, but we were very successful. We maintained successfully for twenty years the status quo system, with very little change in the delivery of services.

And we divided sufficient profits at the end of the year to keep the physician partners on a part-time basis. True, we had to underpay our employees, and the contract physicians, who didn't stay very long. When they asked for a salary increase we let them go."

—Dr. Robert Rosengarten, Medical Director of Jamaica H.I.P.

City would have rejected so decisively an attempt to modernize New York City's only major prepaid group practice plan without significant prodding from other important political interest groups. Sifting through the rubble of Brindle's demise the heavy hand of organized labor can be seen not far beneath the surface.

Labor's visible figure in HIP affairs is William Michelson. A devotee of the "power school of politics," Michelson was a key member of the HIP team which negotiated and accepted the 15 percent rate increase the City finally granted HIP. Michelson, President of the United Store Workers' Union, and Board member of the Health and Hospitals Corporation (which operates all of New York City's municipal hospitals), now heads a five man committee temporarily running HIP.

Michelson expressed no regrets about Brindle's resignation. Indeed, he has openly boasted about his opposition to Brindle for the past two years. Michelson's opponents go a step further and suggest that he engineered the crisis with the City to force Brindle's resignation. Michelson denies being the hatchet man, but, in any event, the upshot of Brindle's resignation has been to place him at the it was revealed that Michelson invited Blue Cross and Group Health Insurance (GHI) to make formal proposals to rescue HIP from its present misery.

The Vultures Descend

According to HIP insiders, GHI's proposal amounted to nothing less than a total takeover. Blue Cross, on the other hand, proposed to set up a new corporation, jointly controlled by itself and HIP, into which Blue Cross would pour millions of dollars to purchase HIP's medical groups' facilities and eventually hospitals. Blue Cross has sweetened its bid by suggesting that perhaps Blue Cross/HIP could offer package insurance deals to industrial firms, like New York Telephone.

Both GHI and Blue Cross have assured the City that they could pare costs and provide the current level of HIP services well within a budget consistent with the City's approved 15 percent rate increase. Looking more closely at the interests of GHI and Blue Cross, it becomes clear that their real plans have little to do with preserving HIP or its subscribers' medical services or even ultimately the City's budget.
GHI has been described as a hybrid, or, less charitably, as a "bastard," medical insurance company. While it ostensibly offers its one and a half million New York City subscribers prepaid doctor services, it does not, like HIP, assure that health care is comprehensive or is delivered by medical groups. Most GHI-affiliated doctors are in private, solo, fee-for-service practice. Like HIP, GHI does not cover hospitalization.

Despite these deficiencies, GHI is attractive for several reasons. For patients its big selling point is that it offers a wider choice of doctors than HIP. And for both its patients, many of whom are low-salaried workers, and several major labor unions who use the plan for their members, GHI has another cardinal virtue: it's cheaper than most other plans. The reason it's cheaper, however, is that it offers fewer benefits. Since it reimburses its doctors a mere four dollars for an office visit, GHI doctors regularly bill patients for the balance of their fees. Hence patients wind up having to pay out pocket.

A takeover of HIP would eliminate its major competitor and would push GHI closer to the big leagues in the medical insurance industry. GHI participating doctors would be delighted at the prospect of some 750,000 HIP patients being driven into their private offices.

Blue Cross' interest in HIP derives from no less self-aggrandizing motives. But, befitting the reigning king of the health insurance world, Blue Cross' vision is more majestic. Blue Cross sees the acquisition of HIP as a stepping stone to becoming the sole fiscal intermediary for any future national health insurance plan. Already the major contender for this role, Blue Cross is nonetheless saddled with one major handicap: it has had little experience with Health Maintenance Organizations (HMO's) [see BULLETIN, November, 1970], a component of every national health insurance proposal on the legislative table. However, were it to succeed in placing HIP in its hip-pocket, Blue Cross would overnight have the nation's second largest prepaid group practice, thus partially fulfilling Blue Cross President McNerney's boast that, "Our goal is to have 80 operative HMO's by the end of 1973. . . ." For Blue Cross, it would mean the best of all possible worlds. With its proposed 50-50 shared ownership of HIP medical centers and future hospitals, it would mean that Blue Cross would exercise control, much as HIP doctors now do, of the entire HIP operation.

Back at HIP

It is already clear that Michelson will not be the uncontested arbiter of HIP's fate. Already opposition is building on the HIP Board of Directors. The 30-member self-perpetuating HIP Board must set some kind of record for its lack of representativeness regarding HIP subscribers. It consists of seven labor representatives, six doctors, two consumer representatives (only recently added), and the rest a hodgepodge of health and welfare professionals and political appointees. The coalition which is developing against Michelson, like the entirety of the HIP Board, is made up of people who share only one point in common: they represent no HIP subscribers. Appropriately, it is led by another "loner," Werner Kramarsky.

Kramarsky is a business consultant by trade and a man on the political make. Among other clients, he consults for various voluntary hospitals, including Methodist in Brooklyn. During the first Lindsay Administration, he was the Mayor's right-hand man on health matters. He is also the son-in-law of Dorothy Schiff, owner of the New York Post, a matter of some importance at City Hall. Kramarsky is generally thought to represent the views of the voluntary hospitals and consequently he is sympathetic to a greater role in HIP affairs for Blue Cross, historically a handmaiden to the voluntary hospitals.

The outcome of Kramarsky's zealous campaign against Michelson isn't clear. Michelson doesn't seem worried; "Who," he asks, "does Kramarsky represent?" The question is self-answering.

At the moment William Michelson is the man to watch at HIP. The question is, can he be the kingpin between HIP, GHI and Blue Cross and use it as springboard to project himself as the national labor expert on health care policy?

The chances are this question will not

"I guess the city's labor guys got scared to death about the city's finances and thought the money would come out of their pockets next year."

—William Michelson, H.I.P. Interim Executive Committeeman
"The City has always endeavored to obtain the best health insurance program for the money available. We are now confronted with a situation which challenges this concept. This rate increase request may require the City to examine other possible alternatives to insure equal quality medical care for its employees and their families at a cost which is fair and equitable to the taxpayers of the City."

—Harry Bronstein,
City Personnel Director,
Testimony at State Insurance Commission
Hearings on HIP Rate Increase

be immediately decided. Michelson claims that a reexamination of HIP's balance sheets reveals that it will wind up in the black this year. Michelson's agenda is to cut administrative costs by eliminating dead wood, of which there is a forest-full at HIP.

He speaks vaguely about his desire to employ full-time doctors at HIP. But the conservative doctors who oppose a move would seem to have little to worry about. For now at least, it's clear that movement in this direction is stalled.

More intriguing is Michelson's notion of how HIP might obtain hospitals. He suggests that the City might make a deal allowing HIP to acquire municipal hospitals like Van Etten which are sitting empty." Just six months ago Health-PAC released a series of confidential memos from the City's Health Service Administration suggesting just such a plan (see BULLETIN, May, 1972). Michelson's membership on the Board of the Health and Hospitals Corporation might yet come in handy. For the moment, however, hospital acquisition also seems relatively distant.

While Michelson promises no cutbacks of services, other HIP employees and consumers are less optimistic. Stringent belt-tightening may abate the crisis but HIP's prognosis as an independent, prepaid group practice is still very much in doubt. When all is said and done, Michelson's plan will simply bring HIP's wheel of misfortune right back to where it started: few full time doctors and no hospital-based services.

**Powers Behind The Scenes**

Whatever course of action Michelson elects to pursue, it is certain that he will act on behalf of representatives of organized labor who have an interest in HIP's direction. Indeed, without a unified labor position on HIP policy, Michelson, whose own union has few HIP subscribers, would be left out in the cold. Ultimately, Michelson owes his power within HIP to the support of other union leaders whose members do belong to HIP.

Prominent among labor " heavies" who are close to Michelson is Victor Gottbaum, President of District Council 37, which represents municipal employees, many of whom are HIP enrollees. DC 37 is represented on the HIP Board by one of its Vice Presidents, Lillian Roberts.

Another pivotal figure in the Michelson "power bloc" is Jack Bigel. Now the head of a multi-million dollar-a-year consulting firm, Program Planners, Inc., Bigel has his roots in the trade union movement. Bigel's firm, observers within HIP allege, does consulting work for many unions whose members belong to HIP, as well as for GHI. Program Planners, Inc. is located in the GHI-owned building and Bigel is reportedly buddy-buddy with Jim King, GHI's Senior Vice President.

The plot thickens with the allegation that Bigel's firm also does consulting for HIP's conservative Medical Group Council. How this mutually benefits the Council and GHI can be seen in an event which occurred eight months prior to HIP's pres-
ent crisis. At that time, GHI signed contracts with eleven HIP medical groups, all of which belonged to the Medical Group Council. The contracts permitted GHI subscribers to receive care at HIP centers without enrolling in HIP. Neither HIP nor its own subscribers benefited at all from this arrangement. However, both GHI and the Medical Group Council doctors benefited. GHI was able to offer a greater variety of services to its subscribers and the doctors happily bagged the money. Bigel repeatedly refused to speak to Health-PAC about these allegations.

While the agendas of most of the key actors in HIP's current crisis—Blue Cross, GHI, individual Board members and the various doctor groups—are reasonably clear, the same cannot be said about organized labor. On the surface, at least, labor seems to have played in recent years a contradictory role in HIP's affairs. For example, while labor representatives attended Board meetings only sporadically, it is widely believed that it was labor's behind-the-scenes pressure which in part led to Brindle's reorganization plan. But after he announced the plan and the chips were down, labor made an abrupt about-face and convinced the City not to grant the rate increase which was necessary to implement it.

At the very least, labor's on-again, off-again stance toward the reorganization plan had one certain effect: Displacing Brindle left labor in the driver's seat. Unfortunately, organized labor in New York City is faced with so many concerns other than decent health care for its members that the road it charts for HIP promises to be bumpy.

Incontestably, labor leaders' primary concern right now is their members' losing battle against New York City's skyrocketing cost of living. Consequently, unions are under great pressure to secure increased wages. For unions representing municipal employees, the problem is even worse. They must confront penny-pinching City officials who claim that there is no money for higher wages in the City's empty till. To deal with the problem, some observers speculate that labor entered into a "sweetheart deal" with the City over the rate increase of HIP. In return for shortchanging HIP, labor would get a higher wage settlement when new contracts are negotiated. The problem with the "deal," however, is that union members enrolled in HIP are also shortchanged. Now that organized labor has assumed, at least for the moment, control of HIP, we may see this scenario played out over and over again. It would appear that, faced with the Hobson's choice of trading off improved health services for union members against increased wages and related settlements, labor will opt to stand-pat with HIP. If, however, HIP services continue to decline and cannot be maintained without a large infusion of money, labor could opt to dismember HIP altogether. Should it so choose, GHI and Blue Cross will leap at the opportunity to pick up the pieces.

With all the machinations, intrigues and plots, things do not bode well for HIP subscribers. Unfortunately, while individual HIP Board members, organized labor, HIP doctors, GHI and Blue Cross representatives are all scrambling for their piece of the action, hardly a consumer is to be seen. When, late in September, City employees are permitted to opt out of HIP and select an alternative insurance program, another five or ten percent will, undoubtedly, leave HIP. And so the silent exodus will continue.

—Howard Levy and Oliver Fein

Dear HIP,

I am a member of HIP and over the past half year have seen it starting to deteriorate. The medical center to which I belonged (Astoria Medical Group) suddenly broke its affiliation with HIP. In fact, it was so sudden that the HIP sent out notes in mid-April that the affiliation with the Astoria Medical Group would end July 1. As it happened, it broke its affiliation two months earlier without mentioning it to its subscribers. I found this out in early May when I had to go for a physical for the university. I was forced to go to a temporary office where I got everything but a lab test. My family transferred to the HIP center on 57th Street, and thought we'd get good service there. It took six visits to get a simple lab test which consisted of taking a blood sample and a urine specimen. The inefficiency astounded me. I couldn't make an appointment before four days, and that appointment was cancelled by mail the day before I was supposed to go. I had to wait over one and a half hours past my appointment time (I was there a half hour early) to see the doctor for ten seconds, so that she could OK my taking the lab tests. The lab, of course, was closed by that time—it was only open for three hours a day. Needless to say, I was very happy that I wasn't sick and had to get immediate medical treatment. I made many phone calls complaining about the service, and was finally told by an HIP official that they were in deep financial trouble. . . .

Signed.
Student, SUNY at Buffalo

Howard Levy and Oliver Fein
Murder on the Line

It sounds like the 1930’s, but it only happened last August. In Philadelphia, Norman Rayford, an organizer for Local 1199C of the National Union of Hospital and Nursing Home Employees, was shot and killed by a “security guard” named Daniels in the parking lot of Philadelphia Metropolitan Hospital. Workers at the hospital laundry (owned by Metropolitan and three other local hospitals) had been without a contract for a year and on strike for a month. Metropolitan had hired “security guards” known in labor circles as “goons”) to truck the hospital’s laundry to an out-of-state scab laundry. Rayford and other union activists had been following the trucks in an effort to determine where the dirty linen was being taken.

There were no witnesses to the shooting, which took place near the truck loading platform. Daniels claims that he shot in self-defense—that Rayford came at him with a knife. Union spokesmen dismiss the charge, they cite the several occasions on which Daniels had been reported for emotional instability and harassing and threatening 1199C workers. As for the knife, the forthcoming 1199 News, which memorializes Rayford, states that the knife was planted. Daniels has been allowed to go free, pending an investigation by the DA’s office. Whether or not he will be brought to trial appears to depend as much on public attention as on the results of the investigation.

Let George Do It

While Richard Nixon sweet-talks labor during the election campaign, the record of George Guenther, his Assistant Secretary of Labor for Occupational Safety and Health, continues to leave a bitter taste.

In two recent administrative decisions, Guenther has ruled that companies may refuse to pay workers for time spent accompanying federal inspectors on plant health and safety checks. Both of these rulings were made against locals of the Oil, Chemical and Atomic Workers Union (OCAW), one at the Mobil Oil Refinery in Paulsboro, New Jersey, and the other at the Stauffer Chemical plant in Le Moyne, Alabama.

These decisions, which OCAW is appealing, fly in the face of the Occupational Safety and Health Act of 1970, which specifically forbids companies to “discharge, or in any manner discriminate” against employees who exercise their rights under the Act. The law also specifically provides for an employee representative to accompany federal inspectors during inspections.

Richard Meyer, OCAW President at Mobil-Paulsboro, charged recently, “Most workers in this country are unorganized or in very small unions that don’t have the money to make up for lost wages. If workers can’t afford to take part in walk-arounds, health inspections will become an industry-government charade. They’ll be absolutely worthless.”

Hospitals Fight NLRB

Never has concern for the patient run so high among hospital administrators as when, without anyone noticing, the House of Representatives, by a vote of 285 to 95, passed a bill extending coverage of the National Labor Relations Act to employees of nonprofit hospitals. Out to testify at Senate Labor Subcommittee hearings was a panoply of hospital organizations: the American Hospital Association, eight state hospital associations, two municipal hospital associations, and two other hospital associations. So loud has been the outcry, that the bill, which was expected to sail through the Senate, has been held up for further testimony.
Columbus Hospital:  
2 Steps Forward  
1 Step Back

Tenants thought they had won a victory last summer when Columbus Hospital on Manhattan's mid-East Side was forced into a "legal" agreement with occupants of two buildings which it owned. For at least three years, the hospital has sought to demolish the 48-unit, rent-controlled building in order to build a 27-car parking lot.

But apparently the church is a law unto itself (Columbus is Church-owned), for in the year that followed Columbus proceeded to violate virtually every provision of the agreement (ceasing to evict tenants, fixing building code violations, establishing a tenant-hospital committee to decide disposition of the buildings, etc.). So last month tenants returned to court, obtaining a temporary restraining order barring Columbus from removing tenants, filing a suit for compensatory and punitive damages (to the tune of $30,000 a tenant) and reinstating the taxpayers' suit to block public financing of Columbus' new building (which the tenants had dropped previously as their part of the agreement).

The tenants are also planning a procession in honor of Mother Cabrini, founder of Columbus Hospital, and ironically, patron saint of the homeless. The procession will take place at noon on Mother Cabrini Day, November 11, in front of the hospital which is located on East 19th Street between Second and Third Avenue.

If these measures fail, the Catholic tenants say they will appeal to a higher law and legal system—that of the church—which somewhere must have a provision about not keeping your word.

The Mosquito That Kills

A gruesome P.S. on the medical-ecological devastation of the war in Vietnam (see BULLETIN, May, 1971) was reported in Le Monde on May, 17, 1972:

A "mosquito that kills" has appeared in the region on both sides of the seventeenth parallel, according to reports from Hanoi.

The new mosquito, called Falciparum, has never before been known in this region of Vietnam. A high fever, coma and then death are the symptoms which characterize most of those who are bitten. Quinine is ineffective against this disease and a new cure is being sought. According to a Soviet doctor, the "mosquito that kills" is carrying a kind of "plague."

This region, pockmarked with millions of bomb craters full of stagnant water, has been invaded by these mosquitoes and by rats and mice as well. In the combat zones where air, the land and the water have become a veritable breeding ground of disease, dead bodies have become the prey of these animals while other cadavers are unearthed by the bombs and shells.

The U.S. is responsible for the bomb craters which nurture these mosquitoes. Conspicuous by its absence is the speculation that possibly the U.S. actually introduced the mosquito.

WITCHES, MIDWIVES AND NURSES:  
A HISTORY OF WOMEN HEALERS
by Deirdre English and Barbara Ehrenreich

A 48 page illustrated pamphlet on how women lay healers were suppressed and how the male medical profession rose to dominance. A study in the origins of institutional sexism.

It may be obtained for 75¢ from HEALTH-PAC