Bellevue and Boston City Hospitals face very different situations—so a superficial reading of the two case studies presented in this issue would lead one to believe. Bellevue is about to be reincarnated in a classy new facility; Boston City is about to be reduced in size by half. At second glance, however, the similarities of the two situations are striking. However different the details, it is clear that the changes taking place at both nominally public institutions largely reflect the plans and priorities of the private institutions—New York University Medical Center at Bellevue and Boston University Medical Center at Boston City—on which they are dependent for medical resources.

The public system emerges as public in name and legal status only—in effect it has become an adjunct of the private system, partly performing functions the private sector prefers not to perform in its own facilities, partly providing a setting in which the private sector may carry out its own pet projects at public expense. In both cases this development is being aided and abetted by those public servants whose nominal responsibility is to protect and further the interests of the public hospital's constituency.

All of this is essentially nothing new, but rather represents particular manifestations of a trend that began with the use of medical schools and voluntary hospitals, via some form of affiliation arrangement, as the source of physicians for public hospitals. In some areas this trend has reached its logical conclusion in the complete demise of the public system by way of outright transfer of a public hospital to private ownership and control (see BULLETIN, April, 1973). In other places, such as Boston and New York, the privatization of the public sector has taken less blatant forms, which nonetheless represent a continued erosion of its ability to stand on its own feet, much less set its own priorities.

Many concerned about the plight of public hospitals are considering the strategy being pursued by the administration at Bellevue—a broadening and consequent economic integration of the Hospital's constituency. At the hands of those responding to felt public needs, this strategy may well hold hope for strengthening the public system. At the hands of those private interests shaping the future of Bellevue, however, the much-heralded transformation of the character of the Hospital becomes a facade for the furtherance of the particularized interests of an elite private medical center whose correspondence with public need is coincidental at best. The public system may appear to be strengthened but, in fact, it has become less than public in the process.

The privatization of the public sector has been almost overshadowed in Boston by concurrent cutbacks at BCH—a fiscal crunch, in part facilitating that institution's takeover by Boston University. The cutbacks set off the beginning of a struggle to strengthen the public sector's constituency.
The article describing the happenings in Boston, representing the perspective of some people close to the situation, points out the failure of that struggle and sets forth a number of reasons for that failure, such as the rapidity of critical events and the lack of preparedness for meeting them. We would add other, we think more fundamental, reasons for the failure of the anti-cutback coalition to effect a reversal of the plans of the Mayor and of Boston University. Those activists most concerned with stopping the cuts, the Better Breaks Group, were transient young hospital employees organized across departmental lines. Given who they were, they inevitably lacked a long-term, solidly organized base either with hospital workers generally or in a particular section of the hospital. Given that lack, it is not surprising that they failed to consolidate an effective anti-cutback force.

The Boston City activists might also have better addressed themselves to what in the long run will be an even more serious development at Boston City Hospital—its takeover by Boston University—rather than get caught up in the urgency of the budget crisis. Indeed, in the future BU can be expected to be an ally in the struggle for adequate resources—except that BU will be fighting not for patient and community priorities, but for the furtherance of its own interests.

No one has yet developed a strategy capable of dealing with the colonial relationship of the private sector to public hospitals and the death rattle of the latter being heard across the country. All too often, in fact, the more subtle and complex manifestations of the public sector’s death by strangulation are completely ignored by activists dealing with sexier issues or reacting to the crisis of the moment. It is clear at least that the struggle to revive the vitality of public hospitals cannot be a defensive one nor can it be mounted quickly or easily. To have any hope of success, such a struggle must be a long-term operation conducted by hospital personnel who are critical to the functioning of the institution, building up their strength unit by unit, department by department. In such a fashion it may be possible to begin to correct the current distortion of the institutional balance of power and shift control to those responsive to the interests of the public.

BELLEVUE HOSPITAL:
GROWING UP ABSURD

On November 15 the City of New York will proudly dedicate the new Bellevue Hospital. The speeches at the dedication ceremony will predictably dwell on Bellevue’s glorious past and project an even more glorious future in its magnificent new facility. This article considers what the speechmakers will predictably fail to acknowledge, namely, the role of private health institutions, at Bellevue as much as elsewhere, in shaping public hospitals to fit their own needs. In other cities this phenomenon has led to the closing, leasing or contracting of public hospitals; in New York a more sophisticated accommodation of the public sector to the private is being shaped. Here a new public hospital has been designed to serve essentially as an annex to an elite private medical center, serving its needs primarily and the public need only coincidentally.

Setting the Stage

Around the world, people know about Bellevue, even if they mistakenly think it’s only a psychiatric hospital. It’s historic—dating back to 1736 and probably the nation’s first public hospital. It’s big—with 1,622 beds, it’s the fourth largest hospital in the country. Its emergency services are frantic—their 102,000 annual patient visits include the most critical of emergencies and form the basis of the legend that “If you sit in Bellevue emergency for a few
nights you will see everything there is to see in this world." It's where people come who have nowhere else to go.

And of course it's rundown—elevators don't work, water pipes break, plaster falls. Its decrepitude in fact has become part of what is advertised as a glorious tradition; according to the New York Times, "The Bellevue mystique persists and tradition survives in spite of, perhaps partly because of, the challenge that lies in providing decent patient care in the face of extraordinary difficulties." No matter how the patients feel who have suffered the results of staff shortages and broken equipment, the professional view of Bellevue has been (quoting the reminiscences of a former department chairman) that "exemplary medical care without amenities can be given to people under the most dreadful circumstances of a physical plant, providing that the people tendering this care are willing to make do and willing to allow their enthusiasm for giving good care to overcome many difficulties." Dr. William A. Nolen of The Making of a Surgeon fame goes so far as to write: "I'd hate to see the old place changed. I won't deny it's a wreck, if you want to look at it that way, but it's a wreck I love. If they clean her up, Bellevue will never be the same."

Sorry, Dr. Nolen, they are cleaning her up, replacing her, in fact, with a new 21-story building squeezed between the East River and the old hospital's 14-building sprawl. Although it has yet to admit any patients, the new Bellevue Hospital has already inspired official rhetoric that borders on the grandiose. Not only will the new building have "a remarkable effect on improving the logistics of providing quality medical care," it will "represent the changing of the concept of the functioning of our hospital from that of one that is presently capable of only serving the sick poor into a true community hospital capable of serving all who would want our help on a regular basis."

Being against a "true community hospital" is a bit like being against motherhood and mom's apple pie. In this case, however, the ingredients may well prove hazardous to the public health: There is the New York University Medical Center, a prestigious medical school-hospital-research complex that has a way of dominating the shape and flavor of the Bellevue product. There is the New York City Health and Hospitals Corporation (HHC), the so-called public benefit corporation that nominally runs the City's municipal hospital system, which intrudes itself here and there in ways that embitter NYU without appreciably improving the quality of the result for its consumers. And there is the Bellevue administration, nominally under the control of the HHC, which attempts to establish an independent role but usually comes off smelling suspiciously like NYU. There is also a Community Board to the Hospital, which would like to add a dose of public accountability to the ingredients, but which is still struggling to get inside the kitchen. Although the mix, at least on the surface, is in a state of constant flux, the form it ultimately takes may well prove indigestible, if not inaccessible, to those who have traditionally turned to Bellevue for their medical sustenance.

Introducing the New York University Medical Center

Bellevue exists in the shadow, literal and figurative, of its neighbor to the immediate north, the New York University Medical Center, which includes NYU Medical School, University Hospital (UH), and assorted institutes of research. For over a century NYU Medical School has based its teaching program on the large and
In some departments the term means a formal affiliation contract between the New York University Medical Center and New York City's Health and Hospitals Corporation (HHC), the agency that operates the municipal hospitals; in other departments the term implies a gentlemen's agreement of many decades' standing whereby NYU provides medical staff without either the payment or the nominal public control that a formal contract involves.

The Department of Medicine, for example, is not covered by the partial affiliation contract because Dr. Saul Farber, the department chairman, has always been unwilling to accept money and the possibility of control from anyone but NYU. Similarly with surgery—"We need the money," Dr. Frank Spencer, its chairman, admits; the problem with a contract is that the "superb physicians" on the NYU staff have preferred to donate a portion of their valuable time to Bellevue rather than get paid and have to put up with such harassments as signing in and out. The point seems to be that if labor is charity, the recipient can't complain if it's provided at the convenience and for purposes that serve the benefactor. On the other hand, Spencer notes, the lack of the City money that would accompany a contract means that the department can't afford the number of physicians he feels it needs to conduct a top-notch teaching program; thus it would be nice to have a contract if only it would leave NYU physicians free to determine how and where to spend their time.

Some of the departments that the affiliation contract covers—namely, intermediate care, home care, and the chest service—are also services that rank low on the hierarchy of academic importance. (The intermediate care service, for one, has no internship or residency program.) The official explanation is that the City's contract offer was accepted for these services because running them represented an additional burden that NYU assumed with the departure from Bellevue of Columbia and Cornell, a burden it wasn't prepared to take on without financial support. One suspects that the lack of academic interest in such programs also has something to do with NYU's willingness here to submit to a formal affiliation arrangement.

Pathology and radiology, on the other hand, are both covered by the affiliation contract and are both academically important. Apparently these service chiefs decided it was simply impossible to equip and staff what they considered a modern, adequate department without an infusion of funds, whatever its source. This has not, however, meant that Bellevue physicians in these services must sever all ties with NYU. In radiology, for example, NYU guarantees to Bellevue the full-time equivalent of 11 physicians; the department, however, is perceived
alternatives, there may be usable space for this purpose in the new Bellevue, of which more later.)

At the concrete level of physicians—teachers, researchers, and clinicians—Bellevue and NYU virtually merge. NYU is the entry point for physicians who work at Bellevue. With minor exceptions, every attending physician at Bellevue is a faculty member of the Medical School and an attending at UH. Conversely, acquiring those NYU credentials requires undertaking an obligation to do “service” at Bellevue. In most cases, the chairman of the Medical School’s academic departments, in addition to becoming chiefs of the corresponding service at UH, also become the corresponding chiefs of service at Bellevue. (At the very least, the Medical School department chairman designates the Bellevue chief of service and himself is granted a nonvoting seat on Bellevue’s Medical Board.) It is frequently, and proudly, said that the medical staff is the “connecting tissue” that binds the two institutions together.

The Politics of Affiliation

Into this long-existing milieu came during the 1960’s the drive of the City’s then Department of Hospitals to place the municipal hospitals under an affiliation sys-

To Be or Not To Be?

as one department for both Bellevue and NYU’s University Hospital (UH), with physicians shuttling back and forth as the need arises. (The physicians receive a full-time salary in the form of an NYU check, partly representing affiliation funds, partly NYU funds.) The theory is that this arrangement gives Bellevue the advantage of a super-specialist whose specialized talents aren’t needed on a full-time basis. The relationship between bookkeeping and reality under such an arrangement, however, remains an open question.

In pathology, the affiliation gives NYU a double advantage. The pathology service at UH doesn’t include neuropathology, pediatric pathology, or obstetrical-gynecological pathology; these are “unified services” that are located at Bellevue. These pathology procedures, in other words, are done for UH patients as well as Bellevue patients by pathologists whose salaries are paid by the HHC through the affiliation contract. If there’s a flow of money from NYU to Bellevue to pay for the procedures done for UH patients, no one—including NYU’s affiliation administrator, who says it’s “not an affiliation matter”—seems to know about it.

Pediatrics by a stroke of luck found a way to be both prosperous and unaffiliated, at least for a while. The service used to suffer from a lack of staff and facilities sufficient to do more than run a disjointed, emergency-type program. When Congress legislated the Children and Youth (C&Y) program in 1966, NYU was quick to jump at the opportunity to obtain relatively unfettered federal money. With a million and a half annual federal dollars coming directly to NYU, Dr. Saul Krugman, the department chairman, developed a showpiece comprehensive-care department, with its own labs, its own pharmacy, and the Hospital’s only computerized medical records system. (Krugman, we might note in passing, is one of NYU’s star researchers, famous—or infamous—in particular for studying hepatitis by injecting live hepatitis virus into retarded children at the Willowbrook State School.) Regrettably, federal money got tight a few years ago and the amount of the C&Y grant was no longer sufficient to cover the department’s needs; to make up the deficit, Krugman took his physicians off the C&Y budget and negotiated an affiliation agreement to cover their salaries. As in radiology, most of the doctors are on full-time salary but spend part of their time at NYU, mostly doing research. Krugman doesn’t agonize over whether their time actually spent at Bellevue corresponds to that part of their salary paid by the HHC; after all, he reasons, Bellevue “is where the action is” and consequently where doctors prefer to be anyway. He is proud to point out that his own office as department chairman is not at NYU but at Bellevue—where it immediately impresses the observer as a lushly carpeted, walnut-panelled, air-conditioned oasis in a desert of bleakness.
tem, whereby various voluntary hospitals and medical schools contractually agreed to provide medical staff to municipal hospitals in exchange for a lump-sum payment (see BULLETINS, December, 1971 and May, 1972). NYU was offered an affiliation contract around 1966, at a time when Columbia and Cornell, who had had relatively small pieces of the action at Bellevue, were being asked to devote their efforts to other City hospitals. Many of the prima donnas of the NYU medical hierarchy—the chairmen, for example, of such key departments as medicine and surgery—declined to rise to the bait. Freedom, it seems, is still in some circles more important than cash—freedom, that is, from any semblance of public accountability, such as an affiliation contract might impose. There was also for these department chairmen the critical question of control; the affiliation contract requires that the affiliate designate a full-time chief of service for each department of the affiliated municipal hospital. The Chairman of the Medical School's Department of Medicine, for example, who also, of course, is chief of the medicine service at University Hospital, obviously wouldn't qualify and just as obviously would have to give up his power to run the show at Bellevue.

These considerations persuaded many department chairmen that NYU should decline the City's kind offer of payment for what, after all, they had an academic incentive to do for free. Other department chairmen felt the need for an infusion of funds to be sufficiently pressing to outweigh the attendant disadvantages. The upshot was a compromise in the form of a partial affiliation contract covering only certain specified services (see box, Page 4). When NYU's senior faculty subsequently resolved their differences in favor of a total affiliation, they discovered it was too late—the City had run out of affiliation money and was no longer offering a full contract.

This is not to say that NYU has necessarily been starving. In the unaffiliated departments, it developed a clever money-making mechanism known as the Professional Services Fund, into which third-party payments for physicians' services performed at Bellevue are channelled via a power of attorney extracted from all attending physicians. Physicians in departments subject to the affiliation contract are obligated to channel the third-party payments attached to their services to the City. Until the federal bureaucrats administering Medicare got wind of it, the certification by NYU that Dr. Jones actually performed, say, a surgical procedure at Bellevue was handled at the top of the NYU bureaucracy without much concern for whether Dr. Jones was around that day. Regrettably the feds were inspired by a scandal in Chicago to do some auditing, which in NYU's case led them to the discovery that one Dr. Jones had been in Switzerland when he was reported by NYU to have been in the operating room. Apparently the Professional Services Fund has been somewhat less profitable ever since.

The same considerations that made many NYU figures wary of the affiliation mechanism also made them uneasy about the legislation enacted in 1969 creating the Health and Hospitals Corporation. If the HHC lived up to its press releases, it might get actively involved in the running of what NYU faculty saw as their operation at Bellevue. The legislation also had a provision mandating the creation of a community advisory board to each municipal hospital, something that NYU feared might get in its hair. Having failed to ward off the HHC's creation, many at NYU now bemoan the fact that a feature of the legislation permitting the creation of subsidiary corporations to the HHC, one for each City hospital, has never been implemented. Their line is couched in terms of the benefits of decentralization, but one suspects their motivation relates to the possibility of a subsidiary corporation, if controlled by NYU, becoming a mechanism for diluting the HHC's control over the goings-on at Bellevue.

Bellevue's buildings include about 48,000 square feet of research lab space used by NYU researchers. The maintenance costs of these labs are paid for by Bellevue.
Our Labs, Your Electric Bills

Some of the goings-on at Bellevue, which neither Bellevue administration nor the HHC has very much to say about, relate to research. (NYU’s research operation is not trivial. Its 1972 research budget was in the neighborhood of $60 million, mostly representing lab research.) Bellevue’s buildings include about 48,000 square feet of research lab space, used by NYU researchers paid by research grants coming to NYU, on research that Bellevue’s administration knows little or nothing about. The maintenance costs of these labs—including electricity for the air-conditioning that is present in the labs but absent in the wards—are paid for by Bellevue, since the HHC has never gotten around to figuring out what a square foot of such space costs to heat, light, and electrify.

Bellevue’s role in NYU’s research operation has been limited to being accommodating. In one case, for example, NYU sought a federal grant to renovate unused ward space at Bellevue for use as lab space. When the National Institutes of Health said it wouldn’t give NYU money to renovate real estate it didn’t own, Bellevue’s administration obligingly solved the problem by giving NYU a long-term lease for the space at a nominal rent.

Innovating with Outpatients

Before extricating ourselves from the intricacies of the Bellevue-NYU relationship, we should pass by the Outpatient Department, where we find the beginnings of an arrangement that may have interesting implications for the future of that relationship. The traditional, and still predominant, setup in the clinics is direct payment by the HHC of clinic attendings, assigned by NYU to fulfill their service obligation there. Their rate of pay—$13.30 an hour for two-hour sessions—is viewed around NYU as extortionately low and only possible as the price of a faculty appointment and admitting privileges at University Hospital. Reportedly the session physicians typically come late and leave early, with the bulk of medical care being provided by the house staff.

A departure from this arrangement was established two years ago with the creation within the Outpatient Department of a medical group practice, known as the Comprehensive Care Unit. The unit is staffed by 18 physicians representing different subspecialties of internal medicine, who are salaried at the rate of $10,000 a year for 10 hours of work per week, six at

THE NEW BELLEVUE:
A DREAM DEFERRED

1940 Plans drawn up for a new Bellevue Hospital.
1946 More plans drawn up for a new Bellevue Hospital.
1957 Mayor Wagner pledges $85,000 grant for yet another plan for a new Bellevue; initial studies project a 32-floor, 2,300-bed building at an estimated cost of $60 million, to open in 1961.
1963 Mayor Wagner breaks ground for a new Bellevue, promises completion in five years.
1964 Excavation begins; total cost now estimated at $88 million.
1966 Construction begins. Plans now call for a 24-floor, 1,886-bed hospital, estimated to cost $88.7 million.
1969 Original construction contract expires, construction comes to a halt. City’s Board of Estimate appropriates additional $22 million for construction, without public hearing.

Nov.
1973 Scheduled dedication of new hospital and opening of clinics. Building at opening to have 21 floors, 1,083 beds, with top four floors lacking interior construction. Cost to date: $142 million.

scheduled clinics and four reserved for unscheduled patient visits. For a small number of clinic patients—2,200 out of a total Outpatient Department census of about 40,000—this means being assigned a primary physician who will see the patient at every visit and who is even accessible, via telephone answering service, any time of the day or night. If the patient is admitted to the hospital, the comprehensive care physician follows along to the extent of writing an initial note on the chart and discussing the patient’s care with the house staff.
Organizationally, the Comprehensive Care Unit brings the clinics into a middle-class pattern of providing ambulatory care that may set the stage for bringing the middle class into the clinics. Fiscally, the unit is innovative in creating salaried positions for ambulatory-care physicians. (Their checks are signed by the HHC, although their selection remains the responsibility of NYU.) Most of these doctors spend the other three-fourths of their time on NYU salary, teaching and/or doing research, their comprehensive care salaries in effect permitting NYU to pay them less than it would otherwise have to.

It should not be supposed that the Bellevue-NYU relationship, and NYU's multiple uses of what Bellevue has to offer it, have settled down to a permanent pattern. The about-to-be-opened new Bellevue Hospital overlooks a new neighborhood that portends a whole new set of rules for this very old game.

"Low-cost housing's loss was luxury housing's gain."
—Esther Rand
Met. Council on Housing

"Raising Social Standards"
What was once a not very pretty, but stable, "ethnic" working class neighborhood—with light industries, tenement housing, and institutions and shops which spanned several generations—has now become one of the most glamorous spots for the white upper middle class to live in New York City. Low-rise has given way to high-rise, street culture has been bulldozed out; empty plazas, fancy lighting fixtures and underground garages provide a serene, placid and expensive environment for the Medical Center and the new Bellevue—the "campus," as NYU officials fondly refer to their paved, superblocked turf.

Nowadays, it would seem crass for an eminent institution like NYU to appear to be involved in slum clearance, urban renewal, etc. And so it seems that NYU's neighborhood has somehow magically transformed itself, while NYU has busied itself with educational and scientific matters. (NYU has been so successful in promoting this hands-off image that a member of the local planning board characterized NYU's role as "low profile," even though the planning board meets at NYU and its public relations are handled by the Medical Center's PR man.)

But back in 1945, when the Medical Center published its major planning document, and again in 1950 when it republished it, institutions were more candid about their interests in renewal and clearance. The Mission of a Medical School welcomed clearance projects which "would help to stabilize the local neighborhood and raise the economic and social standards of the section."

In fact, more than just welcoming it, NYU at first got directly involved. The Medical School attempted to sponsor the Kips Bay housing development project, right across the street from its new campus. The school was unable to produce the necessary financing and sold the project to William Zeckendorf, real estate robber baron, who opened Kips Bay. While the complex (which finally opened in 1963) is architecturally outstanding, the apartments are not available at the promised middle-level rentals.

Then in 1954 NYU in conjunction with the Bellevue administration succeeded in getting the Bellevue South Urban Renewal Project under way. This massive seven-block clearance project had been twice defeated by community uproar. The Medical Center claimed that the neighborhood was seriously dilapidated and that staff housing was desperately needed to overcome staff shortages at its institutions. Neighborhood residents, organized on the theme "Remember Kips Bay," presented an alternate plan calling for low-income housing to be built on platforms in the East River. It was dismissed as unfeasible. In all nearly 2,200 families paying average rents of $55 monthly were moved out. Many of the residents were, in fact, staff at the Medical Center, but they were lower echelon workers of lower social status—perhaps not desirable neighbors. Now the new housing is becoming too expensive for the Medical Center's house staff and nurses. Although half of the new housing units were to be reserved for Bellevue staff, at present only 180 units out of a total of 1,185 are occupied by staff. The last building in the renewal area to open has rents starting at $275 for a studio apartment.

"Low-cost housing's loss was luxury housing's gain," according to Esther Rand of the Metropolitan Council on Housing. This fall Waterside becomes ready for occupancy. This subsidized luxury complex was built on platforms in the East
River (quite feasible), and its rents start at $300 for an efficiency apartment.

**Lowering the Patient Load**

While its immediate environs have been undergoing a transformation, Bellevue’s burden as a healer of the poor has been becoming appreciably lighter. Its total bed complement has gone down from 2,818 in 1960 to 2,479 in 1965 to 1,622 in 1972, a decline of 43 percent in 12 years; its average daily census has dropped from 2,144 in 1960 to 2,000 in 1965 to 1,229 in 1972, a 45 percent decline. The trend in outpatient visits has been down for a while and then somewhat up again—from 425,445 in 1965 down 41 percent to 252,706 in 1969, then up to 274,325 in 1970, 310,498 in 1971, and 318,324 in 1972, a total recovery of 26 percent.

No one seems to have developed a firm analysis to explain the decline in Bellevue’s usage, a trend that to varying extents it shares with others of the City’s municipal hospitals. In part, the decline undoubtedly reflects the dramatic changes in the character of Bellevue’s immediate surroundings. In part, it may (since 1966) reflect the ability of Medicaid and Medicare patients, repelled by the deterioration of Bellevue’s physical plant, to gain admission to many voluntary hospitals. To a small degree, the inflexibility of Bellevue’s 26-bed, sex-segregated open wards may have led to low occupancy rates that could have been higher had it been possible to shuffle bed assignments. And within the past year, the opening of the new municipal Gouverneur Hospital on the Lower East Side may have drawn patients away from Bellevue who would formerly have gone there. Whatever the reasons and whatever the extent to which they reflect forces beyond Bellevue’s control, this alleviation of responsibility conveniently makes it easier for Bellevue to think about assuming a new role.

**Enter the New Bellevue**

Bellevue’s administration is advertising the newness of its new hospital in terms that go beyond its air-conditioned rooms and high-speed elevators. According to Bellevue’s 1972 Annual Report: “This building will represent a radical departure from both the philosophy and logistics of care in the existing plant. Its opening presents a unique opportunity to change the concept of Bellevue as only a hospital for the sick poor to Bellevue as a true community hospital with a primary dedication, still, to those without sufficient funds to carry the expenses of their medical care.” Given the demographic changes that have made Bellevue’s immediate community into a middle-class neighborhood, that reference to “a true community hospital” sounds like it means a middle-class hospital—something, perhaps, like an annex of University Hospital.

The first step in the annexation would be through the further development of the group practice arrangement now established at Bellevue’s Comprehensive Care Unit, described earlier. The Bellevue Comprehensive Plan, an elegantly produced document prepared by the consulting firm of Westermann-Miller Associates (after extensive consultation with the folks at NYU), cites the possibility of using outpatient space at the new hospital to expand the group practice method of organization “to make complete patient care services available to the mixed income population within Bellevue environs. . . . It would permit private physician services to those who both wished and could afford them, but the program itself would not be economically discriminatory.”

Bernard Weinstein, Bellevue’s Executive Director, describes the plan concretely: The Comprehensive Care Unit would be expanded into a number of group practices staffed by physicians receiving a base salary from the HHC, which they would be permitted to supplement with fees from patients. He fails to mention that experience with similar arrangements else-

"If normal Bellevue patients do not fill the beds, other members of the public will need education to use the beds effectively."

—Dr. Frank Spencer
Chairman, Dept. of Surgery
NYU Medical School
where suggests that the care of the group practice patients will suffer from their having to compete with fee-paying patients. (For a critique of New York's Health Insurance Plan from this point of view, see BULLETIN, October, 1972.) Or that in the NYU-Bellevue setting, the physician in question may well be a researcher rather than a private practitioner when he's not working at Bellevue, in which event his Bellevue patients may suffer from competition with what he regards as his primary career.

Patient admissions, continues the official scenario, would be arranged through the comprehensive care units, presumably with the referring physician relating to his patient like the current unit's physicians do, performing a liaison function vis-a-vis the ward physicians, who actually carry out the patient care. This projected arrangement is not radically different at the inpatient end from what is beginning to happen in the private sector, at University Hospital, for example. There one of the two floors occupied by the medicine service has been designated a teaching service, in which medical students do clerkships and patient care is the ultimate responsibility of ward attendings and house staff, although the advice of the patient's private physician may well be listened to.

As to NYU's reaction to the question of moving the middle class into the new Bellevue, Dr. Frank Spencer, the chairman of surgery, notes University Hospital's long waiting lists for elective surgery and goes on to observe that what motivates middle-class elective surgery patients to wait several weeks for a bed at UH rather than use a Bellevue bed is the wretchedness of Bellevue's physical facilities rather than the mystique of the private doctor-patient relationship. "Our main concern at the new Bellevue is that it be fully utilized. With its superb facilities and the shortage of hospital beds in Manhattan, it should be fully used. If normal Bellevue patients do not fill the beds, other members of the public will need education to use the beds effectively."

It might be noted in this connection that the operating room capacity of the new Bellevue, according to the Westermann-Miller plan, is sufficient to double the number of surgical procedures currently performed at the old Bellevue, assuming a low average of three procedures per room per day. Spencer is an open-heart surgery specialist and projects an increase in the number of coronary bypass operations that will be done at Bellevue in its new facility. "Economically, we'd love to use the new Bellevue for open-heart surgery," says Dr. Ivan Bennett, Jr., NYU's Dean and Director. The procedure is inordinately expensive and involves a loss of several thousand dollars per operation. Obligingly enough, Bellevue included in its discretionary budget for the 1973-74 fiscal year a $1.1 million item for an expanded cardiac surgery program. Some observers note that the capacity of the new Bellevue for open-heart surgery far exceeds the needs of Bellevue's traditional clientele.

The objective conditions that make the new Bellevue an attractive object from NYU's perspective are summarized in the Westermann-Miller plan: "The opening of the new Hospital will generate new opportunities for the Bellevue-NYU relationship to develop. The new Hospital, with its image radically improved from what has historically been associated with Bellevue, represents a potential expansion of private practice beds for NYU faculty, a powerful inducement to continued NYU participation, especially in the light of NYU's limited bed capacity. The new Hospital will also provide more and better facilities for clinical training programs."

"Economically, we'd love to use the new Bellevue for open-heart surgery."

—Dr. Ivan Bennett, Jr.
Dean, NYU Medical School
Director, NYU Medical Center

Exit the Planning Committee

As a companion concept to the new Bellevue as community hospital, Bellevue's administration sometimes bandies about the concept of sharing of services, more grandly known as "medicine under one roof." The trial balloon for the idea was floated by Manhattan Borough President Percy Sutton in an address at NYU Medical School's 1972 commencement. Herald ing "a magnificent opportunity... to establish the pilot project of a huge ultra-high quality medical complex where equal
medical services could be provided to rich, middle class, and poor alike in the same, well-equipped facility,” Sutton put forth a vision of “the University Hospital, the Veterans Administration Hospital (VA), and Bellevue Hospital all operated as a single institution within a unified health concept. Each hospital would house specialty services and each would serve all three of the populations which are currently served separately.”

Precisely what’s been going on by way of planning and negotiation toward the implementation of shared services is shrouded in mystery. It used to be that the participants at least admitted the existence of something called a Planning Committee; Bellevue’s 1971 Annual Report announced that “For over a year a group composed of the Dean of the NYU Medical School, the administrators of the three hospitals [Bellevue, University, and the Manhattan VA Hospital, located just south of Bellevue] and the chairmen of all clinical departments have been meeting weekly” to discuss how the institutions involved might share staff and facilities in the years ahead. By the 1972 Annual Report the existence of such a planning group was no longer mentioned, and sharing of services had been reduced to “a concept that is under development.”

What happened, the participants will admit if pressed, is that the Planning Committee stopped meeting as such during the summer of 1972. Why? “The summer came,” says Weinstein. “There was nothing to talk about,” says Bennett. The real reason, says the proverbial informed source, is that someone started making noises to the effect that maybe the Planning Committee’s representation should be enlarged; maybe the Medical Board and even outside groups should be allowed in on the act. Presto chango, there is no longer a Planning Committee, but there is a suspiciously similar group of men who have lunch together with some regularity at a location safely off hospital grounds.

One Roof or One Linear Accelerator?

In a sense, sharing of services is nothing new. We have already noted (see box, Page 4) the sharing of pathology services—Bellevue does it free of charge for University Hospital’s patients. Bellevue’s ophthalmology service also does testing for University, and Bellevue’s pediatric intensive care unit is sophisticated enough for University to send over an occasional premature infant in distress. The VA Hospital sometimes gets into the act; it does a sophisticated gastroenterologic procedure that isn’t done at the two other hospitals.

As far as anyone on the outside can tell, what’s going on by way of planning to expand such arrangements bears little relationship to the grandness of the “medicine-under-one-roof” concept but is bogged down in such particulars as how to administer radiation therapy to the combined clientele of Bellevue and University Hospitals. NYU has beefed up its radiation therapy capacity with a new linear accelerator—it is, after all, vying for designation as a national cancer center—while Bellevue has cancelled its orders for equipment for the radiation therapy suite in the new building. The two parties have initiated negotiations over the logistics and cost of getting radiation therapy to Bellevue’s patients at University Hospital, which reportedly have reached an impasse over what Bellevue regards as an exorbitant price. Note that sharing of services seems to mean that a service done at Bellevue for University Hospital patients is free, but not the reverse.

In any event, the tentative plan is for Bellevue to maintain one cobalt unit (as opposed to its original plan for two of them plus a linear accelerator) to treat patients who can’t safely be transported between the two hospitals. This raises the interesting question of why these patients couldn’t be admitted directly to University Hospital. After all, NYU seems to plan to admit elective surgery patients who might otherwise wait for a UH bed directly to Bellevue. It may be that Bellevue is reluctant to give up radiation therapy altogether, or it may be that NYU is more willing to share the
City's hospital with its patients than to share its hospital with the City's patients.

**The Managers Vs. the Medical Patriarchs**

Despite the interdependence of Bellevue and NYU, the long-range outlook for collaboration between the municipal hospital and the elite private medical center is that the going may, more than occasionally, get rough. NYU clearly needs Bellevue for teaching material, lab space, income, and for the possibility it offers for an expansion of NYU's brand of medicine to NYU's brand of patients. On the other hand, NYU is clearly unhappy about the fact that dealing with Bellevue brings it into contact, and conflict, with the Health and Hospitals Corporation. NYU's physicians are clearly unhappy at the prospect of any outside entity calling them to account.

"The Corporation doesn't understand physicians," says Dean Bennett. "No one trusts the HHC, and no one would say anything that suggests a dependency relationship on the HHC," says Dr. Albert Keegan, director of radiology at Bellevue. (That last remark may explain the fact that NYU has drawn up a contingency plan for use in the event it loses Bellevue as its teaching hospital.) More positively, NYU spokesmen are quick to attack the Corporation as an aloof, overcentralized bureaucracy, preoccupied with balancing its budget and failing to account for the uniqueness of particular institutions.

However strongly one may criticize the HHC for its bureaucratic bumbling (see BULLETIN, December, 1971), it is clear that NYU would find fault with any public agency that attempted to exercise an overview of its operation—thus its oft-repeated complaint that the affiliation contract doesn't provide enough flexibility for it to run things as it thinks best. It is also clear that whatever the extent of its interest in ensuring that public funds aren't squandered, the HHC has virtually no interest in getting middle-class patients into its hospital. More positively, NYU spokesmen are quick to attack the Corporation as an aloof, overcentralized bureaucracy, preoccupied with balancing its budget and failing to account for the uniqueness of particular institutions.

At the level of NYU's physicians, however, there is irritation bordering on bitter-
most need Bellevue is, however, problematic at best.

A to-date relatively minor element in this matrix of forces is the Bellevue Community Board, formed under mandate of the legislation creating the Health and Hospitals Corporation. Although that legislation was effective in 1970, it was followed by such an excruciatingly long and complex planning and selection process that it was not until this May, some three years later, that the formation of the Board was completed. While it has taken forceful positions in reaction to issues (such as the prison ward location question) that others have brought to its attention, the Board has not been able either to integrate itself into the on-going decision-making process of the Hospital or to develop a mechanism for discovering policies potentially detrimental to its constituency while their development is still in the early stages. This failing, of course, was intentional. First the legislators gave the community boards minimal powers and no resources. Later the Bellevue administration and the HHC rebuffed months of efforts on the Bellevue Board’s part to establish its right to an independent budget for the purpose of hiring its own staff. More fundamentally, no one on the scene is willing to share more than trivial, stale information, or more than trivial, last-minute decision-making functions, with what is perceived as an arrogant bunch of uninitiated outsiders.

What About the Patients?

The disturbing, and unanswered, question about the new Bellevue is whether putting middle-class patients in means pushing poor patients out. The number of beds in the new hospital totals a maximum of 1,063, down from the current bed complement of the general hospital of 1,134. (Bellevue’s 488-bed psychiatric hospital is not being replaced.) At the rate of Bellevue’s 1970 utilization, the average occupancy rate of the new building would be 87.1 percent, but predictions are rampant that utilization will increase, and the waiting list for admission to University Hospital has been known to go as high as 700.

Probably the prime candidates to be pushed out are the transfer patients. In 1971, about 3,000 patients were transferred to Bellevue, many from other municipal hospitals that either had no beds or lacked adequate facilities for their treatment. (In the municipal system, Bellevue is “paired” with Harlem, Cumberland, and Lincoln hospitals for the purpose of accepting their transfers.) Then there are the patients (including some of the transfers, but more than just transfers) who don’t live in Manhattan—these run somewhere between 20 and 30 percent of Bellevue’s inpatients and about 30 percent of its outpatients. Does becoming a “true community hospital” mean shutting them out?

These speculations might be dismissed as raving paranoia if the rhetoric about the new Bellevue were coupled with some concrete planning to guarantee the availability of beds to Bellevue’s traditional constituencies. No one seems to know, however, precisely how the admissions system will work. And while much is said about the two-class system of health care being eliminated within the walls of the new Bellevue, nothing is said about the possibility of the new Bellevue creating a two-class system within the municipal system itself—with the middle-class community around Bellevue using its classier facilities while the poor of the Lower East Side and elsewhere are relegated to other municipalities of inferior quality.

In the meantime, it is clear that Weinstein and NYU are willing to woo the middle class at the expense of Bellevue’s least-favored constituency, namely prisoners. In arguing against placement of Bellevue’s prison health service on the 18th floor of the new building (as opposed to a site outside the new building), Weinstein has written that “The placement of a prison unit and the traffic to and from it in the guts of the new Bellevue would be a crippling blow to the philosophy [read “image”] that we are trying to develop from which this institution would never recover.” Westermann-Miller take up the theme: “Prison beds in the new Hospital might jeopardize the attitude toward Bellevue from its community of users . . . prison services would induce a coercive atmosphere that would adversely color the image Bellevue as an institution would like to project.”

But after all, it’s not Bellevue’s image that’s being polished, it’s NYU’s. When Bellevue was a wreck, no one worried about who came; now that it’s all shiny and nice, the hope seems to be that only (or at least mostly) people of a similar description will fill its beds.

—Louise Lander, Constance Bloomfield, and Jonathan Morley. (Louise Lander, as well as being a Health/PAC staff member, is a member of the Bellevue Community Board. Jon Morley was a Health/PAC summer intern and is a fourth-year student at NYU Medical School.)
Horror and degradation have tainted Bellevue Hospital throughout its history, being renewed every generation with new tales of woe. Bellevue suffers from a dual inheritance—the general unwillingness of the population and municipal government to adequately fund a hospital for the poor and the tradition by which patients cannot secure their own doctors but are cared for by physicians working for medical schools.

Bellevue Hospital's great-granddaddy—actually a six-bed infirmary—was built in New Amsterdam in 1736. The infirmary was part of the Workhouse and House of Corrections, an almshouse for the poor and forsaken. The building stood on the site of the present Municipal Building in downtown New York. The inmates had to work hard for their keep. Some provided nursing care for the sick while others worked at spinning wheels and looms. For the uncooperative, the unruly and the demented, there was a whipping post and an iron cage in the cellar.

The first teaching at Bellevue started in 1787 when Dr. Nicholas Romayne established a private medical school there. A colleague, Dr. David Hosack, pronounced it good with the now-familiar refrain: "Under their united care, this infirmary was rendered a profitable school of medicine and surgery, while the sick received the benefits of physicians distinguished for their abilities and education."

The almshouse buildings were relocated to Chambers Street in 1796, but soon were "in a ruinous condition." A new almshouse was built in 1816 on part of the Kip's Bay Farm overlooking the then-beautiful East River. The almshouse adjoined an intermittently used Fever Hospital, later renamed Bellevue. Both were located on Bellevue's present site.

During the early 1800's the Hospital was run by the Superintendent and the resident physician, who became known for their greed and disregard of the patients' welfare. During the 1830's and 1840's public criticism of the almshouse and the Hospital was frequently voiced—and ignored. In 1836 an investigating commission reported that the "condition of Bellevue Hospital was such as to excite feelings of the most poignant sympathy for its neglected inmates." Others noted that "the same apparel and the same bedding had been alternatively used by the sick and dying, the convalescent, and those in health." They believed that the "totally inadequate number of medical officers," as well as the inadequate laundry and inadequate housekeeping, were responsible.

The Hospital was reorganized, a Medical Board established, and the functions of the almshouse and the Hospital were clearly distinguished. The almshouse was sent to Blackwell's Island while the Hospital moved from the crumbling Fever Hospital to the vacated almshouse.

A new wing of the Hospital opened, and Bellevue acquired a surgical amphitheater for teaching in 1856 and a pathology building in 1857. The Medical Board members prepared to open a new medical school—launched in 1861 as Bellevue Hospital College of Medicine.

In the early 1870's one upper-class woman heard from an intern who conducted her on a tour: "You've only seen the outside. It would take weeks for you to learn all the horrors of this place, but you must be very careful not to be seen with me or to quote me. It might cost me my position here." This woman represented a group of women who took a prolonged interest in Bellevue, got their upper-class manners revised, worked as advocates for patients and finally established the first school of nursing in the country at Bellevue in 1873. As guardians of the poor and politically powerless, they emphasized that "constant vigilance is necessary on our part to sustain the present improvements, for if the authorities of the Hospital see that our labors are relaxed, they will immediately return to the former regimen."

Priorities were confused, then as now. The City was pressured into providing chairs for Bellevue's female employees, who were housed in the cellar. Yet it provided a decent room with a private bath overlooking the East River for each intern, and in 1890 the Commissioners of Corrections and Charities appropriated $25,000 for a new amphitheater attached to the Columbia Division at Bellevue. In spite of investments in its teaching program, the (Continued on Page 24)
TWO HOSPITALS

Up From The Graveyard

When the New York University School of Medicine (NYU) was founded in 1842, the state of the medical arts was primitive. For example, human dissection, necessary for advancing knowledge in pathology and anatomy, was socially unacceptable—and illegal. To conduct their early research and teaching, some of NYU’s most respectable founders resorted to grave robbing, body snatching and cadaver smuggling. In one of the more bizarre and macabre claims to fame ever, NYU boasted in its first catalogue of its easy access to the bodies of the poor and unclaimed in Potter’s Field: “No city in the Union furnishes the same supply of the material for the study of practical Anatomy, as the City of New York. Indeed, it is a fact of notoriety, that a considerable part of the supply required in the dissecting-rooms of Philadelphia [home of the more prestigious medical school] has heretofore been obtained in New York.”

While all things change, everything remains the same. Despite the remarkable transformation of medical practice and education since those early days, NYU is still characterized by two traits which marked it at its inception. One, its reputation and appeal have always been based more on its ready supply of bodies, both living and dead, from which to learn and teach, than on the skills or reputation of its faculty. Secondly, NYU has always been engaged in fierce and occasionally ungentlemanly competition for control of teaching and research resources (patients, laboratories, and staff), sometimes losing, but more recently winning over its fellow medical schools.

Back in the 1840’s, medical education was as crude as the practice of Physic and Surgery itself. Instruction was based on a fee-for-teaching tutorial and apprenticeship system, with individual physicians teaching their private students at the bedside of their charity patients. Fees were high and it was a profitable enterprise. The more distinguished teaching-doctors associated with universities, in the European tradition, and their students were awarded the university degree, upon completion of several lecture courses and success in examinations. The universities had little to do with the policies and administration of the medical schools. (There was so little association that in some cases, such as Columbia Medical College, predecessor of Physicians and Surgeons, the faculty actually purchased the diplomas from the parent school, to distribute to their students.)

NYU Medical College was founded such a fashion by Valentine Mott, surgeon, in collaboration with five other doctors, including John Revere, Paul’s youngest son. Mott originally taught at Columbia, which collapsed in a dispute over control of the medical college’s profits. He then started a short-lived medical college in association with Rutgers University. When he approached NYU about fostering a medical school, the University Council was agreeable—although disappointed that the doctors, for economic reasons, would only operate the customary two-year school. While a four-year curriculum would have produced better-trained physicians and furth ered “the Cause of Medical Science” it also “would prove fatal to the hopes and prospects of the Faculty.”

Bellevue Hospital had been used for teaching since 1787. Mott and his colleagues conducted their teaching there. It was clear, even in the early 1840’s, that Bellevue offered remarkable educational resources. The New York Society of Medicine, among others, pressed to make the hospital more accessible to students: “It is a crying shame that such a wide field for clinical instruction should be actually lost to the City, to science, and to the world merely to subserve paltry party political purposes; to give to some favorite a monopoly of private teaching in that great establishment.”

Five years after the NYU Medical College was founded, control of Bellevue was established in a Medical Board, one important member of which was Valentine Mott. Bellevue became a full-fledged teaching hospital and, according to NYU’s published history, The First 125 Years, “the cause of medical education in New York was greatly advanced.” Bellevue’s patients were shared between NYU and Columbia’s resurrected school, Physicians and Surgeons.
They were joined in 1861 by the Bellevue Hospital Medical College, a new institution organized by the Medical Board and hospital staff. The new school reflected the increasing importance of the clinical basis for instruction in medicine. Bellevue Hospital Medical College quickly outpaced NYU in quality and reputation. In 1884, the Bellevue College received the Carnegie laboratories from philanthropist Andrew Carnegie and the new school became a leader in pathological research. By 1897, NYU's fortunes as a proprietary school had fallen so low that their graduates ranked at the bottom of all other doctors licensed by the State.

When the Council of the parent university moved in to clean up and control the school, it found dissident faculty which wanted to remain in charge. In the resulting power struggle the issue of control became even more compelling when philanthropist Oliver Payne indicated that he would donate a modern research lab to the school. When the dust settled, the University controlled the college. However, half the faculty and students had left, taking with them the Payne research laboratory grant and a number of sympathizers from the Bellevue Hospital Medical College. With Payne's assistance, they promptly founded Cornell University Medical School several blocks away.

Most fortunately for NYU, Bellevue Hospital Medical College was in financial difficulty at the time. Their difficulties were aggravated by a fire which destroyed some of their buildings. Happily, NYU invited them to merge, gaining the Carnegie labs and a number of new buildings not destroyed in the conflagration. Later, NYU acquired the Cornell buildings when that institution moved uptown. Shortly thereafter, its name changed from the University and Bellevue Hospital Medical College to the New York University College of Medicine.

In 1929, NYU commissioned a Plan of Development to be drawn up for the Medical College. The timing was unfortunate and the plan was short-circuited by the Depression and War. However, the plan was not short-sighted; it defined NYU's interests plainly and laid out its assumptions for later growth. NYU's reputation lay at Bellevue's feet. In fact, a survey of alumni and medical leaders confirmed that NYU's best asset was the hospital, not the faculty, laboratories or classrooms. Acknowledging that "a great hospital, rather than classrooms, forms the best basis for the study of disease," the planners estimated that "Should any university decide to provide for its own medical school a clinical plant equal to that of Bellevue [which NYU had for free], the cost would be from $30,000,000 to $40,000,000." The plan advocated that Columbia and Cornell be encouraged to give up their teaching programs at Bellevue, so that NYU could take over all the services.

The Plan also recommended that a University-Bellevue Medical Center be established which would include a private hospital so that students would have "contact with classes of people not represented among Bellevue patients" and so that the college would be helped in "obtain[ing] and hold[ing] a high type of clinical teachers who are in practice." The Plan also recommended that the school close its Charity Clinic, since students had access to poor patients at Bellevue and thus the Clinic was a needless school expense.

In 1945 another far-sighted planning document was prepared, this time with a more grandiose title, The Mission of a Medical School. The plan was euphoric about the post-war possibilities of medical education and practice. It contained a number of very progressive elements. It proposed sweeping reforms of medical school curriculum, most of which were never enacted. It was convinced that some form of insured prepaid group practice for the middle class was "imminent" and recommended that University Hospital be designed for eventual conversion into a faculty group practice. This too has not come to pass, although the idea is being rejuvenated in a new form (see Page 9). In fact, the only significant parts of this plan that were ever to see the light of day dealt with the construction of a new campus and hospital for NYU and a new neighborhood for the school and Bellevue. These plans were rationalized by and coordinated with similar plans for NYU's greatest asset, Bellevue: "To make full use of the teaching and research possibilities that will be available in the new Bellevue, the University also must provide for the future."

NYU's future has been well provided for. Over the last twenty-five years, it has built a totally new campus; it has kept its 630-bed University Hospital running at capacity; and it has seen its environs transformed from a working class immigrant neighborhood into a high-rise high-cost residential district.
AS THE NATION GOES,
SO GOES BOSTON

- January 3, 1973: Boston Mayor Kevin White announces, "We will cut the City Hospital budget by more than 20 percent, make the hospital self-supporting within five years."
- February 3: The Mayor announces a Health and Hospitals Department budget of $56 million, $12 million less than the amount required to keep services at the present level.
- February 7: Boston City Hospital's Trustees vote to cut down the Hospital from 850 to 500 beds.
- February 21: The Trustees vote to turn over all medical services at Boston City Hospital to Boston University Medical Center.
- April: Boston University announces a plan for Boston City Hospital to exclude all services but the most basic—medical, surgical, children's, and maternity; the result is described as "a community ... hospital focused on the provision of high-quality family care."
- September 7: Health and Hospitals Commissioner Leon White (no relation to the Mayor) announces the elimination of 400 more workers' jobs at Boston City Hospital, bringing the total jobs cut this year to 1,000.

It's the Only One We've Got

Boston City Hospital (BCH) is the only public acute care hospital in the City. In 1968 (the last year for which figures are available) it treated a whopping 27.4 percent of all patients treated at Boston hospitals who were Boston residents. The percentage is higher for areas where Boston's Black, Puerto Rican, and working-class white population is concentrated.

BCH is also Boston's major emergency hospital for victims of gunshot and stab wounds and other traumatic injuries. It is the main center for mass hospitalizations arising from serious fires or auto accidents. Any alcoholic who is picked up and in need of medical care will most likely end up there. So will low-income people, no matter what the emergency and no matter where they come from; last year 45 percent of the ambulances arriving at BCH came from outside its official ambulance district.

BCH has been the only hospital in the area where the three major medical schools—Harvard, Tufts, and Boston University (BU)—have co-existed. For most of this century, each of the three has run its own medical and surgical services at BCH while dividing the other services among them. However inefficient, this system has allowed the Hospital to maintain the large staff necessary to care for Boston's poor. (Five years ago the City offered the then 850-bed Hospital to whichever medical school would take it. None accepted the offer. It is only now, when the Hospital has been cut back to 500 beds, that it has become feasible for one medical school to assume full responsibility for its staffing.)

"Some of you people may have to die."

Like mayors of most cities, Boston's Kevin White has felt himself pressed for funds for a number of years. One of his favorite ways of saving money has been to cut down BCH. In 1971 he froze jobs at the Hospital; in 1972 he made an unsuccessful attempt to cut the City's contribution to the hospital's budget by almost one-fourth. In January, 1973 he singled out the Health and Hospitals Department budget (of which 80 percent is spent at BCH) for a huge cut. In doing so, he played a numbers game—referring to the Department's $62-million budget while talking about the high cost of health care to Boston's taxpayers. The Mayor conveniently ignored the fact that the Department last year brought $47 million into the City's general funds. Thus the net cost to the City of running an 850-bed acute care hospital, two chronic care facilities, a number of neigh-
borhood health centers, and innumerable public health services was really only $15 million ($62 million less $47 million), not a bad price for a city of 640,000 people.

The cutback at BCH has been couched by the Mayor and his allies in terms of a presumed bed surplus in the private hospitals, and the elimination of second-class care by farming-out BCH patients to those hospitals. On one occasion, however, the Mayor let slip the true significance of the major surgery being performed on BCH. On February 4, after his press conference announcing the budget cuts, 50 angry BCH workers and patients stormed the Mayor's office. A Black woman told her story, the story of thousands of people—her child has a congenital disease, she cannot afford to go to Children's Hospital, BCH has saved her child's life for years. Mayor White listened and then actually said to her: "Some of you people may have to die." Then he went on to talk about the tight straits the City is in, especially with the cutbacks in federal spending, the need to provide relief for taxpayers, and the need for all of us to pull in our belts. He didn't mention, as he looked out over Boston harbor from his office, that some people's belts were already past the last hole.

The Research Centers Don't Want Them

Mayor White does not make his health care decisions alone. Boston's three medical empires wield tremendous power in determining health policy in the City. One result of the existence of the three competing complexes and the numerous hospitals they control is what is commonly referred to as over-bedding, a ratio of hospital beds to residents that is far higher than the national average. The gross figures, however, do not speak to the critical question of who has access to those beds. As a medical research center, Boston fills many of its hospital beds with patients from across the country and the world. This fact casts doubt on Mayor White's frequent statements that the City's bed surplus makes it safe to cut Boston City Hospital by 300 beds; whether the City has the power to force the medical schools to take these patients has never been established.

"The academic medical centers are referral centers," says Dr. Steven Saltzman, President of the BCH House Officers Association. "They take care of patients with different exotic diseases because enough people come in from all over the world to justify those services. There's no way for Commissioner Leon White to change that.

If he tries to make those into community hospitals, the specialists will leave, but that won't happen because all those people are a lot more powerful than he is. You can't expect a specialist to call a patient from Atlanta who's scheduled for complicated heart surgery and tell him not to come because they have an alcoholic with pneumonia filling his bed."

Poor patients are seen as a burden by private hospitals. Their diseases are boringly similar—complications of years of alcoholism, heart disease, results of inadequate diet, poor housing, unsafe working conditions, and almost no preventive care.

"Some of you people may have to die."

—Mayor Kevin White
Feb. 4, 1973

They take up beds for longer than the elective surgery patients that hospitals and doctors make money on, because they come in far sicker than the person who has a private physician, who can afford convalescence after illnesses, and who is taken care of in old age.

Unlike BCH, which treats all comers regardless of ability to pay, private hospitals employ a number of devices to restrict access to their facilities. They keep their emergency rooms small and close them at 9 PM; charge a fee before letting patients enter a clinic; ask extensive questions about health insurance and ability to pay even before diagnosing the patient's condition; require patients to sign forms—usually illegal—agreeing to have their property and paycheck attached to cover their bills. There is no evidence that these practices are about to be abandoned, especially with the tightening of spending by Medicaid, Medicare, and Blue Cross.

Empires in the Wings

The actual size of these medical empires is always shifting, particularly since the federal government made lavish money available for hospital construction and research in the mid-sixties. Dominant among these three is Harvard, whose medical school controls about ten major teaching hospitals in greater Boston, most inside the city limits. Harvard's primary orientation is to maintain and enlarge its medical complex as an international center of medical specialties—most of the patients in Harvard
hospitals don’t live in Boston.

Harvard’s resources—in money, people, prestige, and power—allow it to outlast or buy off most of its potential critics. This is not to say that Harvard is invulnerable. When it wanted to expand facilities near its major geographical area of concentration, which includes four teaching hospitals and its medical school, pressure from the Mission Hill community stopped it. The medical school, in true Harvard fashion, soon had a solution—an end run. While continuing to exert pressure on its own local community, Harvard took over administrative control of Cambridge City Hospital, a few miles away.

Harvard’s move into Cambridge City Hospital may explain its willingness to lose its share of BCH, since both institutions are primarily hospitals for the poor. (Harvard controlled less than 250 beds at BCH and acquired 217 at Cambridge City.) Harvard also had a major research operation going at BCH at the prestigious Thorndike Memorial Laboratories, operated within the Hospital premises but completely controlled by the medical school; it was no problem, however, to move the labs to another part of the empire, namely Beth Israel Hospital, another of Harvard’s teaching hospitals.

Boston’s other two medical empires are considerably smaller. Tufts controls well under 1,000 beds and does not have the money necessary to attract large numbers of researchers, who contribute to a medical empire’s prestige and bring in needed federal money. About four years ago, Tufts faced the prospect either of building up its Department of Medicine at BCH or pulling out entirely, but couldn’t make a firm decision one way or the other. As a result of the lack of support from Tufts, the Department was never able to find someone willing to be its chairman. Thus when Tufts got the chance this past Winter finally to rid itself of this albatross, it did so quite willingly, although it went through the motions of submitting a proposal for taking over BCH on its own.

Like Tufts, the Boston University Medical Center is comparatively small. Geographically limited to Boston’s South End (although it provides medical staff to several suburban hospitals), BU includes the medical school and the 350-bed University Hospital. Gaining total control of BCH (where it had formerly controlled about half the beds) meant increasing its bed capacity by a couple hundred beds with very little added expense.

**BU Expands**

BU launched an expansion program in 1965. Since then it has built or bought four new buildings going $14 million into debt in the process. Most of this money has gone for research and teaching space and private physicians’ offices. Hence two of its new buildings are the Evans Memorial Research Building and the Doctors’ Office Building. Almost no funds have gone to build up outpatient facilities for so-called “clinic patients,” a euphemism for the poor.

Recently federal health research cutbacks have forced the BU ship off course. BU has been compelled to change its compass reading and is now coming on as doctor for the surrounding Black and Third World communities. Reflecting its location in such a community, BU has engaged in

"The academic medical centers are referral centers.... You can’t expect a specialist to call a patient from Atlanta who’s scheduled for complicated heart surgery and tell him not to come because they have an alcoholic with pneumonia filling his bed."

—Dr. Steven Saltzman, President
BCH House Officers Association
the past in token measures such as running one of the City’s few methadone detoxification clinics and serving a mental health catchment area that includes most of the South End, North Dorchester, and Roxbury—the largest concentration of Third World people in Boston.

Spurred on by federal funds for a new residency program and a $5 million seed grant from the Robert Wood Johnson Foundation (as in Johnson & Johnson), BU has proudly announced that Primary Care Delivery (PCD) is now its “central theme.” PCD has become the rationale for eliminating specialty services from BCH under BU’s auspices and limiting the Hospital’s services to medicine, surgery, pediatrics, and obstetrics.

The PCD proposal is carefully couched in terms of commitment to the community: “The success of a pattern of health care for a community depends upon the involvement of a knowledgeable and representative community in every step of the planning and implementation.” Despite the rhetoric, the community was never consulted in the initial plans for the proposal, nor have concrete guidelines been articulated for the involvement of medical students or the inclusion of patients. The substantive emphasis of the proposal is on the training of physicians, not the delivery of community-oriented health care or the training of community residents to serve primary health care roles. Dr. Joel Alpert, BU’s head of pediatrics and a prime mover of PCD, has stated that “The doctor is the foundation of the health network.”

Given its emphasis on physician training, the program is caught in a contradiction between its rhetoric of providing “continuity of service” and its projected practice of rotating physicians-in-training through a community. Given its character as a pilot research project in health care delivery, PCD is precluded from providing a general solution for health care delivery problems. Patient care will be provided, but only to those whom BU defines as part of the pilot project.

**The Plot Thickens**

Both the PCD program and the complementary construction programs of BU and BCH fit in very nicely with BU’s assumption of total control at BCH, a fact that suggests something was in the works long before that takeover was officially decided on in February. BU cites its assumption of responsibility for professional services at BCH as one of the critical developments inspiring it to make the PCD proposal. BU’s plans for constructing a new hospital next door to BCH, to replace University Hospital, were publicly discarded last December. Shortly after the original announcement, a newspaper report quoted an anonymous “highly placed BU official” who hinted at the real reason. He suggested that a new UH hospital might not be needed since “BU Medical School’s role at Boston City Hospital might expand if one or even both of the other medical schools that utilize BCH for teaching and research were persuaded to reduce or phase out their participation.”

Further evidence of a well thought out strategy on the part of BU was its omission of a new outpatient building, despite the fact that the outpatient services at University Hospital are in the oldest and most crowded part of that institution. Interestingly enough, the City is currently constructing a new outpatient building for BCH, a facility that has become a central factor in BU’s PCD proposal, which emphasizes “educational settings which focus on the ambulatory instead of the hospitalized patient.”

BCH’s new outpatient building was originally one part of a plan developed in the late 1960’s for a completely new $91-million hospital with 1,000 acute and 300 chronic care beds. Of the rest of the plan, only ancillary facilities have to date been built—a new 28-story, 112-unit apartment complex for doctors (including a swimming pool, gymnasium, and squash courts) and a new nursing school and rooms for 300 student nurses. With the cut in BCH’s beds and a concomitant 20 percent cut in its house officers this year, the apartment building is larger than needed by BCH but presumably will come in handy for the house staff at University Hospital.

There are other factors that suggest that the BU takeover at BCH fits in nicely with
its own plans and priorities: A few years ago University Hospital closed up its maternity and pediatrics facilities, while BU renovated those services at BCH that it was then operating. Until this past July, University Hospital did not even have an emergency room, whereas BCH has one of the largest in the city.

All of this is evidence that the decision to let BU run the medical services at BCH was not made in a week by the Board of Trustees, as they would have us believe. The Trustees' request for proposals to be submitted by all three medical schools was made a week before the decision was announced, and in retrospect was merely a formality. The urgency of winning control for BU is highlighted by the Harvard proposal, which would have closed down those services—pediatrics and maternity—most urgently needed by BU. (Harvard already controls hospitals specializing in those areas.) The City may well have found BU to be the most pliable of these dubious allies precisely because it was the most needy. Or perhaps the prospect of trying to get concessions from Harvard drove the Mayor and his political advisers into the waiting arms of BU. Either way, the decision saves BU millions of dollars in construction money and gives it control of a very large medical complex.

But Will It Work?

One critical question is unresolved at this point: Can the health needs of Boston’s poor communities be met with BCH as a 500-bed institution? The situation looks grim.

During the winter months, BCH normally has a census of over 600 patients. Since the plans call for a 500-bed hospital this means that about 100 BCH patients will have to be sent elsewhere. But a majority of BCH admissions are on the danger list and cannot be transferred out. What is more, if other patients are transferred, and the number of danger-list patients at BCH rises, greater burdens will be put on its already overworked staff and the result will be inferior care. (Already the number of staff—but not the number of patients—has been cut in pediatrics and obstetrics.)

The bright young men who set policy for the Department of Health and Hospitals confidently state that there are plenty of empty beds in the private hospitals that can be used to absorb the overflow, and that more efficient management of BCH will work wonders. But their crude numbers games ignore certain realities: On the busy days of the week (Monday to Wednesday) the private hospitals are quite full; in any event, the statistics are all averages, which do not truly describe the health needs of the people of Boston. Their plan to cut down the average length of stay at BCH ignores the fact that BCH patients tend to stay longer because they have nowhere else to go.

The transfer of patients not on the danger list is also problematic. The document spelling out the transfer procedures states that “there is little reason to be concerned that BCH transfers will systematically bump a private hospital’s elective patients.” This revealing statement, meant to assuage the nerves of money-conscious private hospitals, serves to clarify the real inflexibility in the system: They’ll only take our patients if it pleases them.

Evidence from BU’s University Hospital reinforces this observation. Under a formal arrangement, UH has agreed to take the first three non-danger list admissions to BCH every morning. However, since the agreement has gone into effect, UH has often not taken three admissions and has sometimes taken none. After all, as an unnamed UH administrator put it: “As a private, non-profit, voluntary hospital, we cannot just swing open the doors like a drop-in health center, treating anyone who comes in.”

—UH administrator

Evidence from the State Senate’s Social Welfare Committee suggests...
that these hospitals have already begun to resist the influx of the poor. "We have documented cases," says a legislative aide, "in which the private hospitals have taken people into their emergency wards and then sent them after the initial work-up to Boston City if they can't pay."

Peter Bent Brigham Hospital (a Harvard institution) came out shortly after the BCH cutback was announced with a new outpatient form by which the patient signed away all rights and agreed to pay his bill by any means necessary. The form, which was probably illegal, was withdrawn after worker and community pressure was exerted. Its introduction, however, is hardly an indication of the willingness to "pick up the slack" that the Mayor's men have imputed to the private sector.

As of late September, 1973, BCH had not yet been fully cut back to 500 beds. At its present capacity of 550, the Hospital has been full on several occasions during the summer, traditionally its slackest period. Voluntary hospitals have also been full; UH, for example, peaked at a bed census of 110 percent of capacity. The winter thus promises to be a bitter one. BCH will almost certainly overflow, and the private hospitals will almost certainly either not have any beds available or not be willing to use them for BCH's unattractive constituency.

How Did It Happen?

One would have expected a variety of groups to mount a campaign of opposition to the budget cuts and the consequent undermining of Boston City Hospital, groups such as health professionals, hospital workers' unions, community activists, and activist health workers. And some of these groups did protest. Unfortunately, the opposition failed. Lessons, however, can be learned from the failure.

The majority of professionals at BCH are doctors—house staff and attendings—and nurses. The attendings, the senior permanent staff in the hospital, never publicly opposed the changes; this was hardly surprising in light of the fact that their primary allegiance was to the medical schools.

In theory at least the residents and interns might have been another story. Their four-year-old union, the House Officers Association (HOA), has 300 dues-paying members. But it has never been able to build a solid organization with more than token participation by the membership.

The HOA did express concern about the cutbacks and a desire to work with "the community." But the gap between its young, white, male, professional, suburb-dwelling members and the real community of the Hospital was so great that the sentiment never got beyond words.

Ultimately the worm turned and the house staff paid for its aloofness. The first cut at BCH eliminated 70 house officers' positions. By then it was no wonder that other workers felt, "We have nothing at stake when house officers are cut."

If the house staff failed to win the race, the nurses barely got to the starting line. They did have a number of meetings of their organization, the Massachusetts Nursing Association (MNA). The Association, however, never really developed any resistance. This wasn't surprising, since the leadership of the MNA was mostly non-hospital based and could hardly empathize with the plight of their sisters at BCH.

Furthermore, in an interesting conflict of interest, the president of the Association this year is also the City's head nursing administrator.

Most non-professional Hospital employees are divided into two major unions. About 1,800 blue-collar employees belong to Local 1489 of the American Federation of State, County, and Municipal Employees (AFSCME), and about 1,200 white-collar workers are members of Local 285 of the Service Employees International Union (SEIU). The history of both unions hardly inspired confidence that they would forthrightly stand up either for their membership or the cause of good patient care. Local 285 has not held a meeting in the Hospital for a year and, in violation of state law, has not reported its income for seven years. Nor is Local 1489 much more democratic; when a young activist tried running for shop steward, union officials failed to show up for the election and thus prevented its ever being held.

In fact, the leadership of both unions seemed to be protecting both the Mayor and the older, long-term workers, a vast majority of them white. Despite great talk of militancy on the part of the leaders of Local 1489, they never once took a stand against the cuts, even though hundreds of their members' jobs were at stake.

As to patient care concerns, the union has never raised quality of care as a union demand. Its business agent, in fact, once answered a question about cuts in jobs and services with the remark, "Forget the patients." Thus although a movement within the union against the cutbacks could have provided the authority to command the at-
ention of the vast majority of hospital workers, it clearly wasn’t in the cards for 1973.

The community as a force against the cutbacks was initially handicapped by the fact that the Hospital serves many diverse communities—mostly Black Roxbury, the racially mixed South End and North Dorchester, and mostly white South Boston. Few community groupings have real spokespeople; all have politicians and social agencies claiming to speak for them. Their disunity, combined with more than a little demagoguery, did not bode well for creating a strong community voice to oppose the Mayor’s chicanery.

There were a couple of community meetings, greeted with small attendance and with even fewer people who were willing to do any real work on the issue. Interruptions by sectarian left groups made things even worse. These internal weaknesses were intensified by the lack of any link between consumers and workers and by everyone’s being unprepared for the suddenness of the cuts and the massive-ness of the problem.

Linking consumers and workers would have been difficult at best, given the divisions of race and class that existed. The Hospital’s political groupings and leaders were mostly white, in contrast to the mostly Black and Third World community. Many white workers and white patients had once lived in neighborhoods since “taken over” by Black and Spanish-speaking people. Class contradictions were interwoven: The hospital hierarchy was topped by those who see themselves primarily as professionals, unwilling to grant others the ability to make intelligent decisions in a field as “specialized” as health.

Much of the scant eight-week period from the first announcement to the final blow was lost in waiting for the official community representative, the Board of Trustees of Health and Hospitals, to furnish leadership. This body, mostly Black and Spanish-speaking, all appointed by the Mayor, spent weeks issuing rhetoric about opposing the cuts, while quietly arranging behind the scenes to carry out the reductions. A widespread willingness to let the Trustees carry the ball was reinforced by the fact that previous threats of cutbacks had proved to be false alarms and the fact that the quality of care at BCH had been such a frequent target of criticism that it was a little embarrassing to take a position defending the Hospital.

The final locus of opposition to the cutbacks was a group of activist hospital workers known as the Better Breaks Group (BBG). Composed primarily of young, white, transient, educated employees in their first year at the Hospital, the BBG had been meeting for only about three months (with attendance ranging from half a dozen to about 50) when the crisis broke. It lacked solid political unity, organizational form, and real connections with the majority of workers.

To deal with the budget crisis, several BBG members organized an Ad Hoc Committee to Save the Hospital. It got off to an encouraging start—organizing, on 12 hours’ notice, a demonstration of 50 people at the Mayor’s office, followed by a mass meeting attended by 200 people, who agreed on a demonstration and petition drive and an effort to reach out into the community.

Then things started falling apart. The number of people willing to work turned out to be pitifully few, and the most disciplined of them were affiliated with the Progressive Labor Party. This group pushed through decisions and set up agendas and speakers’ lists that many people in the Ad Hoc Committee thought were exclusive and sectarian. They called for a citywide strike without being able to back up the call with any substance. The second mass meeting, which started out with 150 in attendance, quickly broke down into factional bickering among the National Caucus of Labor Committees, the Communist Party, and the Progressive Labor Party. Within half an hour, two-thirds of the audience had departed.

Overall, however, the failure of the anti-cutback coalition cannot be blamed simply on factionalism.

Those who actively organized against the cuts were afflicted by the same lack of contact with most workers and patients that affected the sectarian groups. Also things happened fast—for too fast for them to act intelligently. The overriding sense was that of being overwhelmed by the Mayor, the Trustees, the administration, the medical empires at play.

One big lesson from the struggle this year is that an organization cannot be built overnight and in a time of crisis. The groundwork must be laid before. The object of organizing at BCH must be to fight to keep it in the hands of the City, where there is the possibility of exercising some control over the course it takes. A City-run BCH could be a base from which an organized constituency of health workers and
consumers could experiment, create models, demand more city-run health services and more privately-run community health services. Hopefully, the losses suffered this year can be used as lessons on how better to fight and win victories in the coming years of struggle over the future of public health care in Boston.

—Jeff Blum, Jerry Feuer, Kate Mulhern and Joan Tighe. (The authors of this article worked at Boston City Hospital and were members of the Better Breaks Group.)

HOSPITAL POSITIONS

Detroit General: Two years ago Wayne State University medical students organized the Norman Bethune Collective “to change health care in Detroit, to change the quality of our professional lives, and to help make social change in this country. More people are needed by the Collective. Those interested should write Howard Beckman, 741 Seward (Apt. 202), Detroit, Mich. 48202 or call (313) 875-0261.

Lincoln Hospital: Lincoln Hospital is the only public hospital in the South Bronx and logs more emergency visits than any other New York hospital. For the last three years the Lincoln Collective has fought for improved patient care with Third World community and worker groups. Now refocusing its efforts on particular departments such as Pediatrics and Medicine, the Collective seeks to recruit new staff. Those interested should contact Mike Steinberg, Box 62, Lincoln Hospital, 333 Southern Blvd., Bronx N.Y. 10454.

Cook County: Cook County Hospital, the largest hospital in the country, is the only hospital in Chicago serving poor people. It has responsibility for prisoners, is developing a growing outreach program and is developing new approaches to the use of paraprofessionals. Those interested in staff positions there should contact Quentin Young, M.D., Chief, Dept. of Medicine, Cook County Hospital, 720 S. Wolcott, Chicago, Ill. 60612.

Bellevue (Continued from Page 14) Hospital failed to function adequately. Dr. Carlisle, the first historian of Bellevue, stated in 1893 that “Bellevue Hospital, with its yearly census of over 16,000 patients, has a maternity ward of six beds. This ward is not only inadequate in size, but it possesses inadequate means of caring for patients. It has not proper room for the segregation of patients nor has it means for ventilating the building after modern methods and has no room for the disinfection of clothing.”

Even with such statements being made by eminent physicians and recorded in print, no action was taken until a decade later when newspaper exposés and a murder trial related to the psychiatric service appeared. One writer of Bellevue’s history assessed the situation this way: “Bellevue as a surgical and medical experimental center using as material the human wreckage of the city was one thing. As a hospital it was a disgrace, even by the city hospital standards of the day.” In 1902 another wave of reform hit Bellevue. Control of the Hospital was transferred from the Commissioners of Charities and Corrections to a new Board of Hospitals, with Dr. Brannan, a man committed to building a new Bellevue Hospital, at its head. Beginning with the general medical pavilions in 1908 and finishing with the psychiatric building in 1933, the Hospital was built anew. McKim, Meade, and White, the most famous architectural firm in the country at the turn of the century, designed the new Hospital which is the decrepit Bellevue of today. But even with this new start and many people’s commitments to the goals of patient care, the facilities and faculties were again overwhelmed by widespread deterioration of the buildings, services and medical care coordination, and by the overcrowding with the advent of new groups of poor peoples.

The situation became almost intolerable, but doctors, administrators, and City government applied themselves to quieting the discontent, until in 1957 Dr. Dickinson Richards, director of the Columbia Division at Bellevue, summoned attention to the neglected institution. He asserted that the City had "shamefully neglected" Bellevue and that there were "neither the physical facilities nor the personnel to permit adequate care." The next day his statement was endorsed by other prominent heads of departments in the Hospital. The City promised to plan for the new Hospital, which finally nears completion.