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"COMMUNITY LIVING" FOR EX-MENTAL PATIENTS IN NEW YORK CITY. The state of New York has been able to reduce its institutionalized patient load at the expense of neighborhoods and the ex-patients.

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HEALTH CARE IN BROOKLYN, 1890–1915. By the second decade of the 20th century, hospitals were turned from charity institutions for all—regardless of ability to pay, with uniform care services—into money-conscious corporations seeking to attract a better class of patient.

Pathologies of Place and Disorders of Mind

When is a mental health problem not a mental health problem? For thousands of ex-mental patients, re-entry into life outside the asylum walls means endless rounds of defeat and demoralization. Prolonged periods of hospitalization often weaken the capacity for social interaction, damage the ability to deal with independent living, and leave many ex-patients extremely wary of offers of help. Add to this whatever abiding disabilities and/or residual peculiarities (or "symptoms") that may persist despite the most powerful pharmacological agents, and it is easy to see why—under the best of conditions—ex-patients find it difficult to manage the newly bestowed freedom that comes with release.

For vast numbers of ex-patients, however, "under the best of conditions" is never realized in practice, further complicating the question of ex-patients' ability to handle "freedom." To exercise
deliberation and choice presumes there is something to consider and choose—a presumption wildly at odds with the everyday situation of most ex-patients.

The courts have directed—humanely, many feel—that the "least restrictive" treatment alternatives be employed for ex-patients. But for many ex-patients, this is experienced as a new form of societal rejection. This is less due to the fact that some people are callous and uncaring than it is to the fact that the material necessities of a decent livelihood prove terribly difficult to procure. In this respect, the ex-patient's plight parallels that of other unproductive populations at the margins of polite society.

In the pages that follow, we examine one of the basic material necessities—housing. The facts suggest that present circumstances contrive to ensure the failure of "community living" for ex-mental patients because New York remains a house divided against itself—with one bureaucracy handling strictly "mental health" problems, and a myriad of others handling housing, food, emergency assistance, etc. For many of New York's ex-patients, the impossibility of securing adequate housing becomes the major threat in the day-to-day struggle for peace of mind.

To Find A Home

The fact that it was the fiftieth anniversary of the Great Crash didn't change things much for Andrew. He got up early to go to mass at St. Francis Church—one of the few accessible warm spots in the city at six in the morning. The friars don't seem to mind you nodding off in the back pews, and afterwards, they give out coffee and baloney sandwiches. Last night, Andrew was lucky. He slept, as he put it, "at the Princeton Club, up on 43rd Street." He means on the sidewalk outside, where the blowers from inside the building provide an intermittent stream of warm air. He hasn't worked "for some time," has "something of a drinking problem" and has been in and out of mental hospitals.

Uptown, the commuters at the 110th Street Station haven't quite gotten used to Annie's using the place as her private urnal. Annie carries all of her worldly goods in a Lord & Taylor bag, smells profoundly bad and looks a mess. It isn't clear that this is simply evidence of a sadly disordered mind—there is too much cunning to her statement that her disheveled appearance keeps strangers away. Annie sleeps "around," on the trains when she can, and finds most of her food, it seems, by rummaging through garbage. No, she doesn't know who the President is and she'd probably have difficulty counting backwards from 100 by sevens.

These people have two things in common: they are homeless and they have some difficulty negotiating the ordinary transactions of everyday life, let alone the byzantine procedures of a welfare application. Their lot is an increasingly common one. The friars at St. Francis report a 40 percent increase in the numbers of people in their breadline compared with last year, partly due to a growing number of ex-mental patients, whose arrangements for "community living"—shaky to begin with—have simply fallen apart.

The plight of people released from mental institutions to "the community" has been well documented by the media, by local politicians responding to outraged neighborhoods, by mental health professionals and, not least of all, by ex-patients themselves. There is a curious irony here. The tales of horror that emanated from institutions just over a decade ago have followed their victims into the community. "Deinstitutionalization" has become re-institutionalization. Old walls are torn down, but new, less visible ones are erected. Someone has called it moving "from back wards to back alleys." Whatever it is called, it still adds up to ghettoizing the mentally disabled.

New York State, recognized as a national leader in mental health, offers a prototype case. Until recently, state officials were still proclaiming the loftiest of intentions in the face of obvious and recalcitrant failure as thousands of ex-patients are left to make do as best they can in subways, parks, single-room occupancy hotels (SRO), the notorious adult homes and the Men's and Women's Shelters.

Estimates of the number of mentally disabled in New York vary widely depending on one's source. One source, the Associate Commissioner of the State's Office of Mental Health, has calculated on the basis of aggregated county-by-county data that there are 79,900 chronically mentally ill people in "the community" in New York State, 47,000 of which reside in New York City (1).

Legacy of Deinstitutionalization

The origins of deinstitutionalization can be traced to three developments: the synthesis of powerful "anti-psychotic" drugs in the early 1950s (2); a growing recognition by the public and professionals that institutional treatment was less than therapeutic for most and harmful for many (3); and, finally, the efforts of state and local governments to cut costs (4). The relevance of this last factor is especially important when one notes that costs of inpatient care were rising simultaneously with pressure to renovate the deteriorating insti-
Vital Signs

The medical malpractice insurance crisis . . . again

The belief that crises can be solved without changing underlying causes is one of the great and transparent fallacies of liberal and conservative thought. It is like the inventor of the gattling gun thinking his invention would make war so horrible that humans would cease forever to wage it. More recently, liberals and conservatives thought the crisis in medical malpractice insurance had been solved by limiting the patient's right to sue and by setting up some inhouse or cooperative insurance companies, often owned by the client hospitals or doctors.

These cooperatives, incidently, should not be interpreted as collective action in the socialist mold. Rather, these "bed-pan mutuals" are cases of the attempt by monopoly capital to drop losing propositions into the public lap—"lemon socialism." But their efforts were short circuited by physicians and hospitals which want to keep the public out of "their" business at all costs.

And these costs may be higher than they imagined. For once again, malpractice insurance rates are on their way up. Recently, Aetna Life and Casualty Co. raised premiums charged to Connecticut doctors by 24.5 percent; International Telephone and Telegraph subsidiary Hartford Insurance Group hit Colorado doctors with a 20 percent hike; and St. Paul Fire and Marine Insurance Co. boosted rates in 20 of the 30 states in which it insures nearly 44,000 physicians.

Discussions of the reasons for
the rate hikes sound like an old phonograph record: more claims; greater severity of claims; claims staying open for more than a year (40 per cent of losses paid by the Hartford Group are from accidents prior to 1977); expanded concepts of liability; a fading of the defensive medicine practiced after the last crisis; more sophisticated lawyers; and generous juries. Mostly, doctors and lawyers blame each other. Just as in the medical encounter, the patient is the silent legal partner. No one raises the possibility that there are too many malpractice suits because there is too much malpractice.

And as in 1974-1975, victim blaming is running rampant. Says Business Week: "Publicity about high jury verdicts—such as the $7.6 million recently awarded to an 18-year-old California girl who became a quadriplegic when an overdose of radiation damaged her spinal cord—'whets the appetites of plaintiffs,'" according to Donald J. Fager, consultant for the New York State doctors' mutual. (Editor's note: such awards are almost always lowered substantially on appeal.) Indeed, one can see patients climbing all over each other to be first in line to become a quadriplegic so they too may be awarded multimillion dollar jury verdicts and get their pictures in the paper.

—George Lowery


THE OLD SHELL GAME

In an ironic twist, the leading free-market advocates on the 4 Health and Environment Subcom-

mittee of the House Commerce Committee are moving quickly to deprive consumers of the very information which would make meaningful choice between competing providers possible. The Subcommittee has passed a "compromise" bill which will keep consumers from getting quality of care information about individual physicians or hospitals. The information is collected by Professional Standards Review Organizations (PSROs). PSROs are funded and regulated by the federal government, and their decisions can deny Medicaid or Medicare reimbursement for medical treatment. Although they are strictly controlled by local physicians, the PSROs collect information and deny payment in the name of the federal government. Arguing that this relationship made them subject to the Freedom of Information Act (FOIA), Ralph Nader's Public Citizen Health Research Group has sued to force disclosure of PSRO data.

After initial court decisions favored the consumer group, conservative Congressmen sought to exempt PSROs from FOIA. In December the Health Subcommittee passed a "compromise" bill which would prevent
the release of any data under FOIA until six months after a final court decision—ample time for Congress to change the law and protect physician secrecy.

This development is especially troubling in light of increasing pressures for hospital closures and regionalization. Health Systems Agencies (HSAs) will be forced to decide which hospitals should be closed without being able to compare the quality of care at the institutions. It will be equally impossible to quickly estimate the racial composition of a hospital’s patients if the HSAs, and HEW’s Office of Civil Rights, are denied the demographic profiles of each hospital’s patients which the PSROs compile.

Because of this, the Health Subcommittee is urging HEW to rapidly make hospital-specific data available to the planning agencies. Yet HCFA is resisting PSRO disclosure of hospital-specific data. In this effort they are getting extra help from a very well-placed source. It seems that HEW General Counsel Jody Bernstein’s husband is a physician who has claimed that disclosure of PSRO data will prevent doctors from talking to their patients. Both the planning agencies and the civil rights advocates face a tough road ahead. The battle for the data may well be the first real test of whether or not HEW Secretary Patricia Harris will place a commitment to civil rights above private professional prerogatives.

—Mark Kleiman

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Pathologies of Place

Continued from Page 2

tutions in order to comply with more stringent accredit­
cation criteria. Unionization of state employees also increased the public expense of psychi­
iatric hospitalization, despite efforts by unions to compromise on some issues and to de­
develop deinstitutionalization strategies of their own. Most notably, the State’s burden could be
shifted to federally financed entitlement systems (i.e., SSI and Welfare) and to local programs
when patients were discharged into “the community” (5).

The numbers involved were staggering. The
nationwide state hospitals census which had in­
creased steadily since asylums were first con­
structed in the early nineteenth century, reaching
a peak of 559,000 in 1955, began to drop
precipitously from 1961–1970. Combining
stricter admission criteria with rapid discharge
policies, New York State was able to reduce its in­
patient population from 85,000 in 1965 to 25,000
to date (6). The State’s Five-Year Plan for Mental
Health (1979–1983) projects that this population
will drop to 18,000 by 1983.

The declining census obscures the fact that State
readmission rates for former mental patients climb­
ed markedly, reaching 65 percent of all admis­
sions in 1974 (7). The readmission rates indicate

For many of New York’s ex-mental
patients, the impossibility of securing
adequate housing becomes the major
threat in the day-to-day struggle for
peace of mind

that many have failed to “make it” in the community
and can even pass the heightened admission
barriers to reside “inside,” albeit for shorter average stays. The rates would be multiplied many
times if they included all those who seek admission or are brought for admission by police, family or
others, but are refused. Manhattan State Hospital,
for example, currently refuses to hospitalize 40
percent of those referred from Bellevue Municipal
Hospital (7b).

New York City is estimated currently to hold 40
percent of the State’s population and 57 percent of

the State hospital inpatient population (8). Of the
estimated 47,000 chronically mentally disabled
people living outside hospitals in the City, at least
5200 are (conservatively) estimated to be
homeless, surviving as best they can on the streets
(8b). In the face of cutbacks and threatened closing,
municipal hospitals provide the bulk of the City’s
emergency mental health services and short­
term inpatient treatments. The few aftercare
facilities and the services of the City’s Department
of Social Services are swamped by referrals
following discharge from the hospitals. One of the

Robberies and assaults in SROs are
common, most never reported. Ex­
patients—among the more defenseless
of the city’s population—are easy prey

key problems they face along with their newly
discharged clients is that no one has planned for
the basic problem of a place to stay—a home.

Few Choices

The search for housing theoretically begins
while an individual is still an inpatient, as part of
“discharge planning.” This is widely recognized to
be “a joke,” according to one member of the Quality
of Care Commission for the State’s mental health
system. Discharge planning, in most cases,
amounts to giving the soon-to-be ex-patient the ad­
dress of the Department of Social Services and a
subway token to get there (9).

It be a mistake, however, to ascribe the place­
ment of ex-patients in substandard housing solely
to administrative bungling, neglect or corruption.
Horror stories, of course, abound, but simple
greed does not adequately account for the ubiqui­
ty of the problems. Even the most humane intent is
shipwrecked on one brute fact: decent, low­
income housing alternatives do not exist (see Box).

Dangerous, filthy and relatively expensive cells
exist in SROs and PPHAs (private proprietary
homes for adults). Cots in dormitories or wire­
ceilinged cubicles can be had at the Bowery’s
flophouses. There is space for up to 200 on the
concrete floor of the “big room” at the Men’s
Shelter. But even these options do not meet the de­
mand. Many are turned away daily even from
these because they are “undesirable”—that is,
even less desirable than the people who are accepted—or because there is, in fact, no spare room, cot or floorspace.

During the summer months, parks are resorted to—even preferred—to the other choices. The winter months are more forbidding. These "surplus people" are warned to "keep circulating." There are few refuges: even passing time in 24-hour coffee shops requires money and reasonable behavior as well as a presentable appearance.

SROs

The "SRO phenomenon" as it has been called—characterized as "the conspicuous clustering of deviant single people in specific buildings" (10)—had its origins in the housing shortage produced by the wartime migration of workers and servicemen in the 1940s. Landlords suddenly found it profitable to convert tenements into single-room hotels. The postwar economic boom attracted families as well, who huddled in cramped quarters while breadwinners attempted to gain some measure of financial security. Many of them failed to do so, and an uneasy alliance grew between the City's Department of Welfare and the more marginal SROs. Migrant families were joined by ex-inmates, discharged patients and homeless convalescents. Conditions deteriorated to the point that a 1960 law forbade rentals to tenants with children. The resulting outflow of poor families was quickly countered by an inflow of single men, mostly from the Bowery.

Urban renewal efforts in the '60s had their peculiar effects as well. As whole blocks of "unrenewable" hotels were reduced to rubble, their populations were displaced elsewhere. Middle-class neighborhoods were invaded, the new residents offending sensibilities and depressing real-estate values. Charges of "spreading urban blight" were heard with increasing frequency. These were intensified when, in the late 60s, an old figure, the ex-mental patient, began to accumulate in harrowing numbers. Public outrage mounted as "proper" neighborhoods read their demise in the appearance of local clusters of ex-patients.

SRO residents, typically paying around $150/month, live in tiny rooms and usually share bathroom and kitchen facilities at the end of an open hall. Some officials talk as though it were planned that way. According to the National Executive Board on SROs:

...kitchens and private bathrooms are often not considered necessary by many older people who have never had them. Heat, security and cleanliness are much more important to the quality of life of tenants than room size or even private bathrooms (11).

Such a proposition reveals a great deal about the bureaucratic mentality that often does the "planning" for the ex-patient population. It ignores the reality that SRO tenants rarely have heat, security or clean quarters. It is not apparent why ex-patients should be forced to trade one "necessity" for another in any event. Nor do the stated "preferences" square at all with our own experience in talking with tenants. (We are quite curious about the origins of these and similar "judgements" about ex-patients).

For better or worse, the National Executive
Several forces have exacerbated conditions for SRO residents. New York City's J-51 program grants tax abatements to developers who convert SROs into middle and upper class residential housing. This has led to the closing of several SROs and dislocation of tenants; some SROs have been emptied over the weekend.

Board does not set standards for SROs. The present reality is that SRO tenants exist at the mercy of individual SRO landlords, who consider heat, security, cleanliness, room size and private bathrooms as secondary to collecting maximum rent and maintaining high occupancy rates. The resulting conditions typically resemble those described by one reporter in a recent article:

The halls and stairways are dimly lit, unswept, littered with debris and fallen plaster. Throughout the halls, there's the stink of toilets overflowing with paper, feces and urine. Some of the toilets haven't worked in months. Electrical wires are exposed where plaster has been knocked out of the walls. Doors to the rooms have been broken, patched with boards. Locks have been gouged.

One hotel on the Upper West Side was cited for over 250 violations of the City Health Code and its owner fined $37,500; it remains in operation while the case is in litigation. Robberies and assaults are common, most never reported. Ex-patients—among the more defenseless of the city's population—are easy prey.

Estimates of former psychiatric patients in SROs are difficult to obtain. Many SRO residents are justifiably hesitant about admitting psychiatric histories for fear of being rehospitalized. Estimates of ex-patients in SROs range from ten to twenty thousand. The greatest concentrations in Manhattan are currently on the Upper West Side and in the Murray Hill area.

The New York City Department of Social Services has provided on-site assistance to SRO tenants for several years, including hot lunch programs as well as recreational and rehabilitation programs staffed by case workers, part-time physicians and nurses. A new "Community Support Services" program has augmented their staff. Both are admirable efforts and both help, despite a context which presents staggering obstacles to the ordinary notion of "service."

Given such obstacles, it is remarkable what some dedicated workers have managed to accomplish in certain SROs with the most meager of resources. The Aberdeen Hotel on 32nd Street is one such example. For nine years, Al Pettis and his small staff have worked to transform this hovel. Today, one stumbles across elements of genuine community at the Aberdeen: tenants are offered support, companionship, assistance in managing money and dealing with the demands of SRO management and activities—all despite their own shaky mental status and the deteriorating physical structure of the hotel.

The great majority of SROs have no such programs. In the past, managers occasionally agreed to such programs in hopes of getting more referrals and hence a higher occupancy rate. Now empty units are scarce, and the rooms in which programs operate could be rented out.

Several forces have exacerbated conditions for SRO residents. The City's J-51 program grants general tax abatements (which total approximately $40 million annually) to developers who convert SROs into middle/upper class residential housing—clearly the more profitable real estate holding. This has led to the closing of several SROs and dislocation of residents. Harrassment of tenants by owners eager to empty their buildings for conversion has included the use of dogs and sawed-off shotguns at early morning hours; some SROs have been emptied over a weekend. Tenants, especially disabled ones, rarely exercise their legal rights to prevent such harassment.

In addition to the number of SROs that have closed, others have raised their prices above the designated lower-priced hotel level. In March 1978, there were 23 percent fewer lower-priced hotels than in January 1975. Waiting lists for vacancies are growing as hotels report near-capacity occupancy.

Predictably, the cheap drama and outrageous characters that are everyday fare in SROs has recently occasioned exploitation of a new sort. CBS is preparing a pilot script for a serial situation comedy based on one SRO and its inhabitants. The SRO situation has its comic aspects, to be sure, but to reduce it to personal idiosyncrasy and confusion is to misread both the scale and the insigence of the suffering involved. One wonders what SRO residents themselves will feel, watching the dirty particulars of their lives parodied on the television set wired near the ceiling of a small bleak room lined with chairs.
The Context of the Housing Problem

Decent low-cost housing is increasingly hard to come by in New York City. In recent years, housing stock has declined and the quality of what remains on the market has deteriorated. At the same time rents have been increasing and incomes shrinking. The resulting hardship falls on many households, but is especially acute for low-income households and the single elderly, as the following excerpts from Peter Marcuse's recent study, Rental Housing in the City of New York: Supply and Conditions 1975-1978 (January 1979), make clear.

Level of Rents

No matter how one examines the data on renter household incomes for New York City in the aggregate, having adequate income for the necessities of life in New York City appears to be a problem for an increasing number of renter households. (p. 27)...
The long-term trend of the rent income ratio has been up. After a relatively stable period between 1950 and 1960, it began a slow trend upward starting in 1960, with a possible partial and temporary decline between 1968 and 1970, but a sharp increase between 1970 and 1975, and a continuing increase between 1975 and 1978. ... Both changes in rents and changes in incomes contribute to this pattern. Median rents increased by 23.8 percent in the last three years alone, while median income has been substantially stagnant—rising seven percent—and the cost of living rose 19.8 percent. Thus, at the same time as rent is taking a higher portion of income, the cost of commodities other than rent has also gone up faster than incomes (although not as fast as rents, at the median) (p. 197f.). ... For the first time in the City's recent history, more than half (57 percent) of all tenants are paying more than 25 percent of their gross incomes for rents and utilities. The median gross rent-income ratio in 1978 was 28.3 percent; in 1975, it was 24.7 percent; 10 years ago it was 21.0 percent (p. 8).

Availability of Low-Income Housing and its Quality

Faced with virtually no vacancies within their price range among standard units, it is no wonder that many low income households are forced to accept dilapidated units even of rentals that are little savings to them over what other households pay for standard units. There are, after all, 11,100 vacant dilapidated units for rent in New York City. These units are not considered "available for rent" for purposes of measuring the availability of adequate housing, since dilapidated units are not by definition adequate, but that does not necessarily mean that they are not on the market. When a household, particularly a low income household, goes out to seek an empty apartment within its means in the City of New York, it will find that 16 percent of all vacant units for rent, and undoubtedly far greater proportions of units for rent within its price range, are dilapidated. It is these low income households that will end up in dilapidated units, whether or not they save money by doing so. It is thus understandable that rent-income ratios will be almost as high in dilapidated units as in standard ones; those forced to live in dilapidated units in the first place have too little choice to bargain (p. 212).

Single-Person Households

The continuing increase in single persons living alone is one of the major phenomena on the New York housing scene. Since 1965, the number of renter households of each size decreased with the exception of the number of single-person households. Single-person households went from 26.9 percent of all renter households in 1965 to 33.7 percent in 1975, and in 1978 accounted for 37.2 percent of all renter households. In Manhattan, over 50 percent of all households today are single persons (p. 21). ... Singles have a lower median income than renters as a whole. In part this is because of the greater percent of singles who are age 65 or older, the majority of whom are likely to be on fixed incomes (p. 49).
The 'problem' is the nettlesome presence of these individuals—the mentally disabled, discharged into the community, have become visible. Most solutions all have the effect of removing objects from the public's eye.

**Private Proprietary Homes for Adults**

Another substantial number of discharged psychiatric patients, approximately 6,650, reside in the State's notorious private proprietary homes for adults (PPHAs), with the greatest concentration in the NYC metropolitan area. An investigative report by the Deputy Attorney General (March, 1979) exposed the pervasiveness of:

- unhealthy, unsanitary, and unsafe living conditions,
- poor nutrition,
- failure to provide even minimal services and recreational programs,
- deficiencies relating to medical care and the administration of medication,
- and numerous violations of local buildings, fire and safety codes.

The questionable circumstances around a number of deaths of PPHA residents, combined with numerous suicides, underscore the extreme precariousness of such living conditions. During one month in 1977, one PPHA witnessed:

- an attempted rape by an incoherent resident walking around naked,
- a knife-point demand for $5.00,
- four fights or assaults in the course of a day by one resident,
- five other assaults, including one with a broken bottle and one with an iron pipe...two suicide attempts...and missing residents.

Adult home residents are entitled to $444 per month through supplemental security income payments, of which all but an $18 to $38 personal allowance goes to the adult home. The minimal income of the adult home industry in the State has been estimated at $8.4 million monthly.

**The Shelters**

The Men's Shelter located on the Bowery provides meals, showers, clothing and medical care to approximately 10,000 men annually. The State Department of Social Services licenses and funds 50 percent of the Shelter's operating costs; the City matches this amount. A study in 1976, based on 1,235 men provided with sleeping accommodations on a given night, found that 30 percent of them had previous psychiatric hospitalization(s) (19). Estimates based on interviews with clients placed the percentage of significant, overt mental illness in that same group at nearly 50 percent or over 600 men on that single night.

Again reflecting the underlying housing and related problems, the supervisor of the Shelter's psychiatric unit notes that this is not simply due to failure to plan:

Most of the men don't come directly from the State hospital...usually community plans are made for them, but they fall apart...either they are thrown out of their SRO, their welfare stopped or they never followed through with referrals to a clinic.

The Shelter serves three meals a day to about 1,500 men and dispenses 800 lodging vouchers redeemable in one of the Bowery lodging (flop) houses under contract with the Men's Shelter. The liquor store on a nearby corner has a steady clientele. During the winter, 1,200 men seek lodging each night. When the Shelter exhausts its supply of vouchers, the remaining men sleep on a concrete floor in the shelter's "big room." Once the "big room" is filled to capacity, men are turned back into the street. In the fall of 1979, upwards of 200 were turned away every night.

The official spokesperson for Human Resources Administration (HRA), the agency that operates the Shelter, has denied (in an affidavit) that any men are turned away from the big room. Providers in nearby service programs, men living on the Shelter's vouchers, and "off the record" information from HRA functionaries all argue otherwise. It is unknown how many men are never counted as being turned away because they know their vouchers have long since been exhausted.

The lodging houses—dirty, unhealthy and dangerous—offer dormitory space for approximately 100 men sleeping in a single room or in separate five by seven foot cubicles with a small
cot and wire ceilings—cubicles which would not meet federal regulations for prison cells. The State Department of Social Services says it is considering denying its license and withdrawing support unless conditions are ameliorated. Without replacement, such action would, in fact, exacerbate the situation. Meanwhile, a recent city report concluded that the Shelter "resembles nothing so much as a 19th century asylum" (21).

The surrounding neighborhoods are justifiably outraged when their streets are turned into running sewers because a shelter has only two toilets for the 500 men who eat there . . .

outraged when their streets are turned into running sewers because the Shelter supplies only two toilets for the 1,500 men who live there. They are equally upset when men wander the streets aimlessly all day because the flophouses they sleep in throw them out at 7–8 in the morning and will not allow them back in until late afternoon. Neither of these concerns is an automatic byproduct of the disabilities of the ex-inmate or wino, but reflect the structured neglect that characterizes provisions for their living arrangements.

The City-run equivalent for homeless women is also located on the Lower East Side, and has 77 beds. Competition to get in is fierce. During one four-month period, 407 women were turned away. Many are rejected because they refuse to be questioned, to take showers, or to undergo the mandatory physical and psychiatric examinations.

**Proposed Solutions**

Surveying recently proposed solutions to the severe housing shortage facing disabled, dependent people in New York City results in some uncertainty as to which is worse: the problem or the proposed solutions. Neither seriously meets the needs of mentally disabled adults. The "problem" recently has been the nettlesome presence of such individuals: the mentally disabled, discharged into the community, have become visible. The "solutions," it will be noted, all have the effect of removing objects from the public's eye.

**The “Country Retreat” Alternative**

Camp LaGuardia, a 1,000 bed facility operated by the NYS Department of Social Services in upstate New York, claims to restore men's health through "fresh air, nutritious food, proper rest and work training" (22). Its regimen has reminded more than one observer of the workhouses of the 19th century. Men from the Shelter are encouraged to go there and stay indefinitely.

**The Island Alternative**

Two islands, Wards and North Brothers, are also being considered for the surplus Shelter population. On Wards Island, the State Office of Mental Health owns a vacant building which was formerly part of Manhattan Psychiatric Center. The State has been reluctant to give the Island to the City for the purpose of housing surplus population from the Shelter, and it is simultaneously being considered for four other undesirable and dependent populations.

Should the Island be designated for the excess Shelter population, men would go there on a voluntary basis, although their only alternative may be freezing to death, adding a particular urgency to such "voluntarism." North Brothers Island, owned by the City, lies in the waters off the South Bronx. Its remaining buildings were formerly used for tuberculosis treatment. One minor problem with this site is that there is currently no access to the island. (One wonders whether the City has contemplated restoring the 15th-century "ship of fools"—perhaps converting one of the Circle Liners to carry the more disorderly of the mad on soothing tours around Manhattan.)

**The Winter Storage Alternative**

Rows of cots in State armories have been considered as emergency measures for the homeless this winter. A high proportion of persons needing these emergency provisions would, again, be discharged ex-mental patients. The program was conceived to operate for only the five coldest months, putting the men back on the streets in the Spring.

**The Back-to-the Asylum Alternative**

Others, less concerned with cosmetic surgery, have rediscovered the mad-house in its classical...
Residents of SROs and Shelters generally do not demand essential services for fear of being rehospitalized, indicating that although community living may be difficult, even treacherous, the institution is worse.

form. A National Institute of Mental Health (NIMH) study re-affirms that "custody and asylum" are permanent institutional needs in any society (25). The New York State Mental Health Subcommittee on Community Aftercare concluded that:

The Department Office of Mental Health must seek to locate those discharged patients who are not ‘making it’ in the facilities where they presently reside, and it must urge their return to the state hospital for further care, with the understanding that they will be returned to the community in more appropriate accommodations when that is feasible (26).

Now that inpatient costs of treating a patient in a psychiatric hospital have risen to $30,000 per year, it is unlikely that the State will reinstitutionalize many, however, at least not within the same highly regulated structures. More likely, old institutional forms will be tinkered with to create less costly structures. As for re-release at some future date once “feasible” accommodations have been arranged, given the past history of neglect and abuse, ex-patients wisely suspect these to be paper promises.

**The Conversion Alternative**

Perhaps inevitably, the State Office of Mental Health has proposed to convert those buildings on the grounds of mental institutions that can no longer meet federal and State regulations for newly accredited “domiciliary care facilities” (DCFs). These facilities would be occupied by residents transferred from the inpatient buildings across the paths, in-patients now in substandard housing in the community, and a third, peculiarly undefined category, “the new chronics.” Among the stated advantages of such facilities would be improved staffing ratios for inpatients, heading toward the mandated JCAH (Joint Commission on Accreditation of Hospitals) levels, and the removal of these buildings from the hospital classification, thus exempting them from the JCAH survey altogether and its more stringent treatment, health and safety criteria.

Reimbursement to State hospitals from third party payers is currently linked to a facility’s compliance with the standards of JCAH, an agency which apparently had "traditionally been sympathetic to the financial plight of state hospitals and consequently had not required rigid compliance to all life safety codes, staffing ratios, patient requirements, etc” (23). More recently, under pressure from legislative authorities, the JCAH is strictly enforcing standards for state institutions.

Residents of DCFs would be guaranteed none of the rights (i.e., right to treatment, right to minimum wage remuneration for labor performed and rights around the process of commitment and discharge) that have been won by patients’ activists in recent years. These rights have been legally limited, for the most part, to inpatient settings. The conversion of state hospital buildings to DCFs, it is suggested, would require “modest cost and staffing levels.” Unquestionably, it would mean a large increase in resident capacity (24). The ominous feature in all of this, of course, is that residents will be as isolated from the community as are inpatients and yet legally and statistically would be considered as residing in a “community-based” structure.

To criticize the forms community care has taken—or the remedies currently under discussion—is not to conclude that institutional care is the alternative. Recent, somewhat glib arguments that the mental hospital has a new role to play in advocating for the mentally disabled, or that the mental hospital is a necessary and supportive part of “the community,” strain the credulity of those familiar with the recent history of such institutions. While the names of public institutions for the mentally disabled have changed from lunatic asylums and "farms for the insane" to state hospitals, and most recently to mental health institutes or psychiatric centers, conditions for individuals inside remain generally deplorable. And, according to a 1978 survey of inhabitants of State hospitals, 28 percent of the current inpatient population are capable of being discharged, but remain "backlogged" for lack of community placements (27).

It is frequently observed that those who live in SROs, the Shelters and on the streets do not contact or respond to available services for fear of being rehospitalized, indicating that although community living may be inhospitable, even treacherous, the institution is worse. James Prevost, current State Commissioner of Mental Health, reflects some official awareness of this last point. In an in-
**WASHINGTON**

**BLUE BOARDS OF HAPPINESS**

Physician control of Blue Shield boards and reimbursement committees is like money in the bank according to a recent report of the Federal Trade Commission. A detailed econometric study by the FTC found that Blue Shield boards controlled by local medical societies reimburse physicians at a rate at least 16 percent higher than more independent boards do. Even when factors which could affect the charges for medical services are taken into account, the FTC found that physician domination of Blue Shield boards costs US consumers an additional $500 million annually—equal to the entire annual budget of New York City's Health and Hospitals Corporation.

The national study is a significant boost to growing local efforts to turn control of these key insurers over to the premium paying public. In 1978 the Pennsylvania legislature passed a law requiring that Blue Cross, the largest single insurer of inpatient services, turn its board over to a majority of subscriber representatives. Similar legislation in Michigan is being enthusiastically supported by the United Auto Workers. In the most promising legal development, Ohio's Assistant Attorney General Charles Weller forced the Ohio State Medical Association to agree to turn over Blue Shield of Ohio to a board of subscriber representatives. The settlement terms prohibit the medical association from having any representatives on the Blue Shield board or rate-setting committees. The Ohio Attorney General has recently announced a similar victory against a provider-controlled dental insurance program.

The ground-breaking FTC report was the first shot in an effort to promulgate a legally binding FTC rule limiting physician control of Blue Shield boards because of the stifling effect it has on competition.

In addition to its work on Blue Shield, the FTC has taken the lead in exposing the "Medigap" insurance industry. "Medigap" policies are sold to elderly citizens, ostensibly to cover the gaps in Medicare coverage. Because many of the policies overlap with Medicare, unreasonably exclude common conditions, and have unrealistically low payment levels, they are often nearly useless to the tens of millions of seniors who purchase them. High pressure tactics used by many insurance agents add to the problem.

The FTC has also drawn blood with its report on cancer insurance. Cancer insurance already grosses several hundred million dollars per year. It was given a big boost after the Three Mile Island nuclear disaster last year. Agents for the leading cancer insurance companies reported great success selling their policies door-to-door in the Harrisburg area and in other communities with nearby nuclear plants. Although most commercial insurers pay out in benefits 80-90 percent of what they take in, the cancer insurers pay out less than half their take as benefits. The rest goes for lavish commissions and profits. Most policies have so many exclusions that they pay for less than one-fifth of the actual cost of cancer treatment for those individuals who do get cancer.

**The Agony and the FTC**

Such activism does not go unnoticed—or unavenged. The insurance industry, the American Medical Association and the American Dental Association are all taking leading roles in a major corporate attack on the FTC's authority. It is virtually certain that the FTC will be stripped of its ability to even investigate any insurance matters.

An amendment, sponsored by Senator McClure (R-ID), would prevent the FTC from studying or regulating the conduct of any "state regulated professions." In theory, doctors, lawyers and dentists are already regulated by state licensing boards which control their conduct and protect consumers. This theory ignores the reality that professionals dominate on state licensing bodies and use them to protect and advance professional prerogatives. Only California, New York and Maryland have experimented by placing a significant number of non-professional public members on licensing boards. The McClure amendment is opposed by a wide range of labor and consumer groups. Despite this concerted defense of the FTC, the amendment has a 50-50 chance of passing.

The attack from the health industry is only one part of an even bleaker picture. Other amendments would void FTC activities in the areas of children's television advertising, funeral homes, large agricultural combines and mobile homes. Although consumer groups have mounted a last minute defense, it may be too little and too late. This drives home an important lesson for regulators.
COMMUNITY CLINICS IN SEATTLE: A SYSTEM THAT WORKS

Over the past decade, Seattle has developed a network of community-based primary care clinics which today seem to be thriving. What are some of the reasons that the Seattle experience has succeeded where others have not?

By many of the traditional measures, there is certainly no lack of health care in the Seattle-King County area. The ratio of physicians to the general population is higher than all but a few places in the country. There is a large medical school (University of Washington) reputed to be among the finest. One of the oldest HMOs in the nation—Group Health Cooperative of Puget Sound—presently has nearly a quarter-million local enrollees out of some 1.2–1.4 million residents in the greater Seattle area.

In the face of this apparent bounty, however, a large segment of Seattle's population lacks access to routine health care: the uninsured "medically indigent," including the working poor, members of the city's ethnic minorities, and a variety of marginal people with alternative lifestyles who find existing primary care services inaccessible and/or unacceptable.

In response to this need, a variety of community controlled clinics were formed in Seattle in the late 1960s with funding from a variety of sources, including Model Cities' and Office of Economic Opportunity (OEO) grants. These have developed into some 20 medical and five dental facilities that today provide 70,000 patient contacts yearly and wield significant political power.

Seattle has traditionally been a city of neighborhoods. Built on multiple hills, the geography of the area promotes the sense of neighborhood, with political "clubs" and Community Councils that have played an active role in local politics for many years. According to Linda Doupe, President of the Central Seattle Community Council Federation, these organizations often represent widely disparate views. The issues they raise and the stands they take are sometimes exclusionary and elitist, at other times radically idealistic. As in most cities, they nearly always focus on issues close to home: schools, parks, health, safety and preservation of life style. Their role in stabilizing and strengthening neighborhoods is undeniable.

In the late '60s several factors accentuated the need for additional health care in Seattle's neighborhoods. Two of the major factors were significant cutbacks in the county hospital clinic system and a prolonged economic recession precipitated by massive layoffs at the Boeing Company, one of the city's major employers.

The clinics that were developed reflect the diversity of the communities they serve: the inner city elderly, "skid rowers," Blacks, Chicanos, Native Americans, Asians, women, street people, youth, residents in a number of low-income housing projects and "garden communities." Such diversity means the clinics are unique in a real sense, and each reflects varying individual needs and life styles.

The clinics share commonly stated goals: providing continuous, quality primary care, patient service in a humanistic fashion, affordable prices and an emphasis on preventive care. All have community boards which actively participate in planning, implementation, maintenance and evaluation of the clinic's programs.

Innovative organization has been one key to continued growth and stability. Some clinics are run as collectives (in 1980!) without hierarchy or salary differences.

Innovative use of local and federal resources has strengthened the positions of all parties, involved, including government agencies

Others are molded along more traditional lines.

All of the clinics utilize some variation of a multidisciplinary team of medical providers, social service personnel, patient advocates and outreach workers and volunteers. Most direct medical care is provided by mid-level practitioners. Some clinics offer alternatives to traditional Western medicine.

Central to the vitality of the community clinic network has been the role of Seattle's US Public Health Service (USPHS) Hospital. In the early 1970s, the USPHS Hospital system nationally
In a bold move to both provide needed care and strengthen its community ties, the Public Health Service Hospital negotiated agreements of affiliation with each of the various clinics. The clinics agreed to provide care for low income patients and the hospital agreed to provide secondary and ancillary services.

was under severe political pressure from the Nixon administration and was in serious danger of being disbanded. In a bold move to both provide desperately needed care and strengthen its community ties, the hospital negotiated agreements of affiliation with each of the various clinics. Under this agreement, the clinics agreed to provide primary care for low-income patients as well as all PHS beneficiaries (federal employees and other original users of the old USPHS Hospital system). The hospital agreed to provide secondary and ancillary services including laboratory, x-ray, specialty consultations and inpatient admissions.

The consequences have been extremely favorable for all involved. The clinics gained a powerful political ally as well as a high quality backup resource. The hospital gained a substantial increase in both inpatient and outpatient volume plus new support from the community. Today, federal officials proudly speak of the Seattle experience as a model for governmental involvement in local health care.

National Health Service Corps personnel have been utilized since the early phases of development of the Seattle clinics. The Seattle Indian Health Board—one clinic in the system—got approval for the use of NHSC personnel as early as 1972. Subsequently, several of the larger clinics formed two consortia, each of which developed its own umbrella community board and administration, while member clinics maintained their own individual boards and administrative structure. By 1976, Health Manpower Shortage Area (HMSA) designation for many of the clinic catchments was accomplished. Shared NHSC personnel were assigned to the consortia beginning in July, 1977. The USPHS Hospital Director functions as project officer for this unique project, and additional administrative personnel and a clinical coordinator were added at the hospital to facilitate the project.

More recently, added funding has been obtained from the Urban Health Initiative (UHI) program and additional personnel have been assigned to several innovative projects. A cooperative effort between the Seattle-King County Jail and two community clinics was begun in 1979, the first of its kind in the country. In another cooperative venture, Planned Parenthood and two clinics have joined forces in a program to address the problems of teenage and other high-risk pregnancies by providing enhanced prenatal and maternity services.

The Seattle network has also enjoyed strong political support. At a national level, Senator Warren Magnuson has been an instrumental supporter. Both city and county governments have lent much needed financial support, making health care a major priority. Mayor Royer's primary advisor on health issues gained nearly 10 years experience working within the community clinic system.

For 1980, over $1 million of Seattle's Community Development Block Grant revenues have been allotted by the city to help the clinics provide service to their medically indigent patients. Several clinics already obtain grants from the King County general fund. The Seattle-King County Health Department has also been closely involved in both planning and monitoring clinic programs as well as providing some ancillary lab and x-ray services, immunizations and screening. Other agencies, such as the HSA, have become active supporters in the development of this network.

The model developed in Seattle bears close study. Innovative utilization of local and federal resources has strengthened the positions of all parties involved, including governmental agencies. Agency cooperation has generally been good. Perhaps most central to the success of the whole system has been its roots in well established communities and strong local commitment to health services for the entire Seattle population. Finally, the utilization of diverse resources including the NHSC, UHI, the USPHS Hospital, the local Health Department and other local governmental agencies has created a broad financial and political base which strongly favors the continued success of the project.

—William Shaw

(William Shaw is a physician who works at the Pioneer Square Neighborhood Health Station, one of the clinics in Seattle's system.)
OSHA ACT AXED

Recently in this column we discussed OSHA’s failure to stem the growing rate of lost-time injuries among US manufacturing workers (see Health/PAC BULLETIN, Vol. 11, No. 2, pp. 19-20). I suggested that to improve its record OSHA will have to expand the scope of its safety standards to cover a great many more unsafe situations than it now does. “If OSHA can’t or won’t do this, it can expect grave political problems, since its business and political enemies will surely make the general public aware of the agency’s failures.”

Well, in just a few short months this has happened—with a vengeance! Citing OSHA’s inability to stem the lost-time injury rate—industry’s lost-time injury rate, it should be added—Senator Richard Schweiker (R-PA), a chief spokesman for the Senate’s raving rightwing, but by prominent Democrats as well. Among the Democrats are Senator Harrison Williams (D-NJ), co-author of the original OSHA Act and previously OSHA’s strongest, most consistent defender in the Senate, Senator Alan Cranston (D-CA), Assistant Democratic Majority Leader in the Senate and one of President Carter’s closest Senatorial allies, and Senator Frank Church (D-ID), chairman of the powerful Senate Foreign Relations Committee.

A Bad Taste All Around

The bill itself is a much more comprehensive rewrite of the OSHA Act than other OSHA amendments in the past. It would exempt an estimated 94 percent of all US businesses and industries from OSHA inspections, based on the companies’ fatality and lost-time injury records for the previous year as determined primarily from worker’s compensation reports. It would also eliminate or lower fines for OSHA violations from firms that establish “advisory” labor-management safety committees and regular safety and health consultation programs.

Senator Williams couched his support for the amendment as “one method” to “effectively tar-
OSHA has been a thorn in industry's side for many years and industry is using OSHA's real failures in the safety field as a smokescreen to accomplish their long-term goal—to kill the agency outright if during the previous year the company did not report one or more injuries each involving at least two lost workdays.

OSHA could only enter the firm one injury, even a fatality, and still be exempt from inspection. In such cases:

- An incident occurs involving a fatality or the hospitalization of two or more employees,
- An imminent danger of a serious nature occurs in the workplace (presumably reported by some one inside, since the OSHA inspector is initially barred from entering),
- A worker reports a suspected violation to OSHA and after the employer is notified of the complaint OSHA has not been given "satisfactory assurances that appropriate action, if any, has been taken," or
- OSHA wishes to conduct a health hazard investigation. (The proposed amendment, by the way, does not specify how to distinguish a safety from a health investigation—how's that for creating a legal wrangle that will keep inspectors out of the workplace while lawyers on all sides are busy at hearings and in the courts?)

Then to keep the legal kettle boiling further—and the inspectors stewing on the outside of the plants—the bill stipulates that "where distinctly separate activities are performed at a single physical location, each activity shall be treated as a separate workplace"! Think of the license that this provision alone will give employers—for example, if two welders were killed or injured on the job in the previous year, the company can try to keep the OSHA inspector out of the machinists' work area, etc.

And if the OSHA inspector is entitled to enter the plant based on any of the above specifications and if further the company has an "advisory" safety committee and a hazard consultation program, then the company cannot be fined for any serious violations found, even if it has caused a worker's death.

Finally to assure that the bill gives the employer an even break (!), it also allows employers yet another escape hatch from OSHA investigation. If the company had no fatalities caused by occupational injuries during the previous year and the rate of lost-time injuries in the plant is below the national average of four lost-time injuries per hundred full-time workers in that year (the specific rate limits for plants of various size are given in the bill), the firm is also exempt from the inspections.

The First of the Worst

What are the quintessentially worst features of this bill, among the many candidates in its two short pages?

- With exemptions from inspection based on weak, poorly administered state worker's compensation laws, the bill encourages employer manipulation and deception on worker comp reports. (For example, in a number of states like Rhode Island, injured workers are encouraged to file for compensation under the relatively more generous state medical disability laws than under the state comp laws. Since the disability laws use state funds to compensate for any disabling injury or illness, no matter what its cause, this system keeps employer comp insurance rates down and leaves occupational incidents unreported or under-reported. Similar problems abound in other states).
- The bill largely removes workers' greatest power under OSHA, the threat to call in OSHA if a company does not improve health and safety conditions in the plant. Typically OSHA inspections in any given plant are infrequent and inadequate, but the threat of one, with the attendant uncertainty faced by management, is a powerful weapon in workers' hands.
- Finally the bill makes the OSHA Act the antithesis of a preventive health measure. Only after workers are killed or maimed could OSHA enter most plants—and then perhaps as much as a year after if the incidents occur early in the year of the firm's exemption. The public health concepts embodied in this bill represent the most advanced thinking of the Nineteenth Century applied to the problems of the Twentieth!

As for setting priorities for OSHA inspections, which the bill purports to do, it is one thing for Congress to set OSHA inspection priorities, it is quite another to eliminate OSHA's right to inspect most workplaces, as this bill does.

The New York Committee for Occupational Safety and Health (P.O. Box 3285, Grand Central Station, NY, NY 10017) is coordinating activity against this measure, as are other COSH groups and labor unions around the country.

—David Kotelchuck
Marianne Doshi, Elizabeth Leggett, Carole Baya, and Rosalie Tarpening are just four of the most recent victims of the struggle for humane, safe childbirth. As birth rates declined during the 1960s the practice of obstetric medicine became less profitable, simply because there were fewer patients to receive this care. And as existing standard obstetric practice has come under fire from a number of different fronts, because of its dehumanizing obsession with technology, its high costs, and its less than laudable infant mortality statistics, more and more women turn to the only real alternative: homebirth. And as the popularity of homebirth increases, the medical community becomes more threatened—and more vicious.

California legislators introduced legislation in 1977 to legalize lay midwifery and give it autonomy from the medical profession (see "Lay Midwifery: The Old Becomes the New?", Health/PAC BULLETIN, no. 79, November/December 1977). By September 1978, when the bill became law, there was no mention of midwives at all. The bill had become an authorization for any government agency to apply to sponsor a pilot project for "training innovative health care personnel." The change in emphasis is attributed to the California Medical Association's (CMA) strong opposition. This organized opposition to midwifery extended to the delivery of medical care itself, as clearly evidenced by the case of Marianne Doshi, a lay midwife from San Luis Obispo, charged with second degree murder and practicing medicine without a license.

After an apparently uneventful labor, the baby of a couple Doshi attended at a home delivery exhibited breathing difficulties at birth. Doshi administered mouth-to-mouth resuscitation until the local fire-men arrived and mechanically induced breathing. The infant and her mother were taken to Sierra Vista Hospital, where the mother was refused admission because she had no attending obstetrician. Numerous sources report that this was the result of an agreement among local county obstetricians to refuse prenatal consultation and care for women planning to deliver at home. The baby was subsequently flown 200 miles to Mt. Zion Hospital in San Francisco, where she died five days later. The parents filed no charges against Doshi. Doshi was arrested and charged, however, by the County of San Luis Obispo.

Doshi was cleared of both charges on October 20, 1978, by San Luis Obispo Superior Court Judge Richard Kirkpatrick. In his ruling Kirkpatrick defended the right of parents to deliver children at home and called for better communication between the medical community, the educational community, midwives and parents seeking alternative childbirths. John N. Miller, Chairman of the California chapter of the American College of Obstetricians and Gynecologists, commented after the hearing, "The difficulty I find with the judge's decision is that these people are totally unlicensed. They are just a group of people, some with no qualifications, whose only experience in some cases is having watched five or six people give birth. They have no comprehension of the complications that can arise in childbirth." Yet the very bill which would have established licensure criteria (education, apprenticeship, etc.) was the very bill decimated by the CMA, Miller himself and numerous other medical groups and individuals.

Midwifery itself is not the issue. Midwifery is a growing specialization in the nursing profession. What is at issue is who becomes a midwife, where the midwife attends births, and how much autonomy the midwife has.

The nursing profession has recognized both the criticisms of modern obstetric practice and the demands of women to have more wholistic, supportive prenatal and delivery care, and created a midwifery specialty, certified by the American College of Nurse Midwives. Certified nurse midwives do much to alleviate a number of the recent criticisms, but they have not been able to solve all of them. By state regulation, and professional choice, most nurse midwives confine their practice to hospitals or birthing centers. Thus the demand for home birth attendants is largely ignored by the obstetrical profession and certified nurse midwives. Nurse midwives bring with them a medical bias towards birth, at least more so than lay midwives. Nurse midwives are trained to see themselves as "apprentices" of obstetricians, having the same relation to 19
them that physician assistants have to family practitioners.

In Tennessee, where The Farm is known for its safety record of midwife-attended out-of-hospital deliveries, Elizabeth Leggett, RN, had her nursing license revoked by the Tennessee Board of Nursing for practicing midwifery without certification. Tennessee has no laws regulating lay midwives, and lay midwifery is specifically exempt from the state's medical practice act. The charges? "Unprofessional conduct, performing functions she is not prepared to handle, and being unfit or incompetent to handle foreseeable consequences." At issue here was the fact that Leggett was an RN, since, "If she weren't a nurse, the board would have no case, because Tennessee law does not regulate midwives," according to Elizabeth Hocker, RN, executive director of the Tennessee Board of Nursing.

Doctors in Tennessee are no more receptive to homebirths than are doctors in California. The Childbirth Information Association has "been looking for over three years for a doctor to help us set up a safe home delivery service for women who want it." One such doctor was found, but was allegedly threatened with loss of hospital privileges unless he withdrew his assistance. President of the Tennessee Medical Association, John B. Dorian, feels that anything is better than the home delivery. "The specialty of gynecology actually got its start from the repair of home deliveries," commented Dr. Terry DeWitt, a "local obstetrician" who refuses prenatal care to any woman anticipating home delivery.

The attacks keep coming. In St. Augustine, Florida, Carolle Baya, a birth attendant and home birth educator, was charged with practicing midwifery and medicine without a license. Although there had been no bad outcomes or parent complaints concerning Baya's birth attendances, the charges were initiated by Dr. Anthony Mussalem, one of the two practicing obstetricians in her community. Dr. Mussalem's complaints led to Baya's termination as a Lamaze instructor for the County School Board and to the (aforementioned) charges from the State Attorney's Office, as well as an attempted injunction to "temporarily and permanently enjoinder home birth" until she was granted a midwifery license. The attempted injunction would have been the ultimate catch-22—licensure is contingent upon attendance of a specified number of births! Baya had been pursuing licensure as a midwife for over a year prior to the levying of charges against her.

Florida's 1931 statutes regarding midwifery were declared unconstitutional by Judge Richard O. Watson in a six page opinion, October 10, 1979. The opinion applies only to the Baya case, unless, after appeal by the State and the Department of Health and Rehabilitation Services (HRS), the decision is upheld in the Florida Supreme Court. As of December 1979, no appeal had been filed.

HRS, however, proposed new regulations for midwives while the decision was being awaited. Among other provisions, the legislation would require a physician to "certify" a patient as suitable for lay midwife delivery and to forbid lay midwives to attend a woman having her first baby. It is expected that this legislation will be introduced in 1980.

The most recent case to come to our attention, and the most serious known charge to date, is that of Rosalie Tarpening. Tarpening is a licensed physical therapist who first assisted at a friend's home delivery some 10 years ago in Madera (Monterey County), California. Since then, Tarpening assisted over 350 home births, with an infant mortality rate of 2.7/1,000 live births. The rates for the county were so high (23.9/1,000), that a trial program recruiting nurse midwives was initiated, lowering the rates to 10.2/1000. Tarpening's rates compare most favorably with the county statistics cited above. Until November 28, 1979, Tarpening had no problems in any of her assistances. On that date, Tarpening assisted in what was to become a still birth. Although the family had no complaints, the District Attorney, after learning of Tarpening's presence at the home, charged her with first degree murder and practicing medicine without a license. The preliminary hearing is scheduled for February 28, 1980.

The struggles for the legitimization of lay midwifery cited here are part of a much larger struggle in obstetrics, and health care in general, today. Financial factors lend credibility to the cries of women for nonhospital-based deliveries, since the latter are obviously less costly. Traditionally, childbirth has been woman's domain. The development of forceps and anesthetic technology allowed the male medical profession to dominate childbirth here in the United States. As the women's health movement grows stronger, this dominance is challenged. The cases cited here are just the beginning of a long, protracted struggle for the control of a human birth experience—and for the control by women of their own bodies.

—Marilynn Norinsky

(Editor's note: For further information, see The Federal Monitor, volumes 1 and 2.)
Pathologies of Place

Continued from Page 12

house memorandum responding to the suggestion that "patients" in SROs (the state vacillates between calling them "patients" and "ex-patients") would be better kept in institutions, he wrote:

...Hard though, that it may be to believe, however, many of the individuals living in those facilities are there by choice and state a preference for remaining rather than returning to the hospital. If these individuals are prisoners, they are prisoners of poverty not of the mental health system. Were SSI benefits adequate. Were jobs really available. Were low income housing sufficient. Most of these individuals could live quite capably in community settings. While they may be living in circumstances far less than ideal, many of them prefer those circumstances to a hospital environment (28).

Ironically, however, Prevost's remarks neglect a more commonly stated prerequisite for successful community survival—readily available and sufficient mental health services. Whether intentional or not, the omission is a rather telling one because the "more services" mentality is a deeply ingrained and widely proclaimed one, receiving its latest and most illustrious endorsement from the President's Commission on Mental Health (29).

What the mentally disabled need, however, is less often more services than it is a more decent life. One ex-patient has described his situation as follows:

I realize you got to have a place to live when you leave the hospital, and (patients) take what they can find. . . . (But in an SRO) you're still isolated and by yourself. Most of all, you aren't living in a place that you chose for yourself. It was simply arranged for you. . . . Many of us with just a little help, could live with each other in a real apartment of our own (30).

It is sometimes objected that these are "social"—not "therapeutic"—needs, thus the concern, properly, of the welfare—not the mental health—system. But it has long been recognized that pathologies of place compound disorders of the mind. One study under way in Pittsburgh indicates that among ex-patients living in the community, the severity of roaches in the home is a better predictor of re-hospitalization than the severity of symptoms in the sensorium (31).

Service bureaucracies are inherently ingrown, overweight and firmly entrenched. In a period of fiscal cutbacks, their de facto priority has become their own survival. In "the field" (or "front-lines"), mental health workers tiptoe daily round the edge of despair: demoralization is rampant, caseloads are huge and efforts at finding decent housing for their charges are futile when there is none to be had. The "helpfulness" of such professions becomes a cruel joke to practitioner and ex-patient alike. Meanwhile, public disgust scales new heights in outrage over the eyesore of the sidewalk psychotic. Even reconstructed liberals, survivors of all the failures of the Great Society, are overheard muttering, "I don't care what you do with them, just get them off my street."

It would be wishful thinking to encourage ex-patients to "hold out" till the next turn of prosperity arrives. Nor is there any real hope in shuttling them off to some well-ordered oblivion.

The City, for its part, might be taken as seriously concerned if it were to propose legislation reversing the I-51 "gentrification" program, thus providing incentives for upgrading low-income housing. The result might then be shelter which respected the privacy and dignity of even the unwashed and deranged—in short, providing both short-term refuges and long-term possibilities for setting up housekeeping on one's own or with others. However, in the words of one City administrator we interviewed, "this is still a landlord's town." So long as that remains the case, articles like this can go on restating the problems that result.

Fluctuations in the real estate market and cost-cutting by State and City governments facing fis-
cal crises force the mentally disabled to live in expensive, unsafe, substandard housing, and on the streets. Many of their routine fears and unusual behaviors are best understood as reactions to conditions none of us could truly be asked to tolerate. Shelter is, after all, a fundamental human need; it is not a mental health service to be given and withheld on the basis of one's mental status. Nor does it require mental health expertise to know that security and stability of environment promotes stability of mind.

—Ellen Baxter and Kim Hopper

( Ellen Baxter and Kim Hopper work at the Community Service Society of New York on a research project examining the quality of life for mentally disabled adults in the 'community' of New York City.)

References


7. Ibid.


13b. Not to be alone and isolated, to have regular and varied social contacts with others (be they family, friends or other tenants) has been shown to reduce re-hospitalization rates among ex-patients living in a similarly serviced hotel. See Cohen, C. and J. Sokolovsky, "Schizophrenia and social networks: ex-patients in the inner city," Schizophrenia Bulletin 4:546-560, 1978.


17. Ibid.

18. Ibid.


24. Ibid.


Business at the Bedside

Jewish Hospital of Brooklyn has been in end-stage financial condition for the past few years. The reasons for its chronic financial plight, however, are subject to dispute. On the one hand, various officials maintain that its condition is the result of severe administrative mismanagement and improper business practice. On the other hand, its trustees and administrators claim that their institution is insolvent because it has been meeting the special needs of a very poor and underserved community and has not been adequately reimbursed. Ironically, as the following article will illustrate, it was the trustees of this very institution who, in the early years of this century, were in the forefront of a battle to instill management ideals and modern business practices into what were, until that time, charitable institutions. By now Jewish Hospital's trustees have probably learned that their founders' view that the hospital is "no different from any other large, commercial enterprise" is probably wrong.

Institutional survival and the survival of patients need not automatically conflict. But, historically at least, there has been uneasy coexistence between an institution's financial needs and the needs of the patient. This article looks into the early history of the introduction of business methods and notions of efficiency into what were once charity hospitals. The effects of an early crisis in hospital finance on the administration, organization and patient population are studied. Now, as many administrators once again turn to business to lend us advice regarding hospital management techniques, it is especially important to review earlier experiences and learn from them.

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Most of us recognize that patients are assigned space in the hospital in accordance with special medical needs. But it is also true that patients are assigned beds according to ability to pay, insurance coverage, and source of referral. Private and semiprivate rooms and small wards are as much a characteristic of contemporary hospitals as are the medical, surgical, and specialty services (1).

The separation of patients according to economic class and other social factors has a long history. In nineteenth-century America, for instance, wealthier clients generally received care at home or in private doctors' offices; working-class and indigent patients often received care through the out-patient department of hospitals, local dispensaries, workers' associations (lodges) or the charity hospital. While distinctions in service for the rich and the poor have always existed in the American health system as a whole, the incorporation of differing services within the hospital is a relatively recent phenomenon.

Before the turn of the century most non-municipal institutions were charitable in nature and served a primarily working-class population. In that sense, the nineteenth-century hospital was a "one-class" facility. While separate institutions existed for women, blacks and distinct immigrant groups, internally they were organized in a relatively uniform way. Patients were housed in wards with few distinctions based upon the patient's ability to pay (2). Services were provided at the expense of philanthropists and hospital trustees. As Morris Vogel has illustrated, the nineteenth-century facility served primarily social, rather than medical needs for working class and/or destitute persons (3).

By the early 1900s a change occurred in the organization of hospital services in charity institutions. During that period the more modern voluntary hospital system arose. This development entailed a dramatic reorganization of the physical space and administrative hierarchy of the hospital. First, the development of class-specific services was a prominent feature of the physical restructuring of the facilities. As trustees sought private patients and their fees, private and semi-private rooms and wards began to displace public and charity wards. Second, as trustees sought to make their institutions more amenable to paying patients, private physicians were admitted to the institutions in the hope that they would bring their patients with them. Ironically, the authority of lay trustees declined as physicians began to exert greater control over the day-to-day services provided their private patients. Third, the care of the charity patient, originally the function of these facilities, was increasingly seen as an inconvenience. In New York the municipal and later the state governments were called upon to bear a larger portion of the financial responsibilities for poor patients in voluntary institutions. This article will examine some of the economic pressures that forced trustees in Brooklyn's Progressive Era hospitals to abandon their older, traditional functions as stewards to the poor and to allow their facilities to undergo profound, and at times disruptive, change.

The decline in the charity functions of philanthropic institutions resulted in part from the severe economic crisis that affected many facilities in the wake of the depression of the 1890s. This depression hit Brooklyn's institutions during a period when costs for health care were rapidly rising. In general, institutions in need of money turned to the paying patient as the most likely source. The provision of hospital care ceased to be an act of charity and became a commodity to be bought and sold by those who could afford it.

The move away from charity to pay services, was rationalized as part of the larger Progressive Era movements toward order, efficiency and bureaucracy. However, the hospitals of the period also exemplify changes that do not fit neatly into any historiographic package. The application of business principles to charity hospitals had a different result: other reform movements led to greater emphasis on corporate responsibility, while changes in hospital finance placed the burden on individuals.

**Deficits and Demand**

In the early years of the twentieth century a prominent Brooklyn businessman, Abraham Abraham, became deeply involved in the formation of the Jewish Hospital of Brooklyn. This hospital, Abraham stated, would avoid some of the chronic problems that plagued many of the city's charitable institutions; it would be so organized that it would "not run in debt." Abraham, owner of Abraham and Straus, the city's largest department store, noted that a hospital was not very
different from other large enterprises. He believed that "charitable institutions, however laudable and worthy, should be conducted on sound business principles" (4).

Abraham's concern for the development of "business principles" in charity institutions was spurred by a mounting crisis in hospital financing. During the depression years of the 1890s, many of Brooklyn's charity institutions had found their costs rising at the very time that their incomes from philanthropy were shrinking. As economic conditions worsened, working-class patients increasingly demanded hospital service. Ever larger numbers of patients found themselves in need of the traditional services that hospitals provided—shelter and food (5). As demand increased, so too did the costs of running the facilities. At Brooklyn Hospital, for instance, hospital utilization nearly doubled during the depression years, growing from just over 1,200 patients in 1895 to nearly 2,300 by 1899 (6). At Brooklyn Maternity Hospital the secretary noted a similar dramatic increase. "When the necessity for relief is great, the greater will the demand be upon all charitable institutions for that relief" (7). Others noted that the "times have been hard... but it is hard to turn away appeals for aid [from patients]" (8). Even in relatively good times, the use of the hospital by those who needed non-medical services and aid was common. "The coming of Spring always brings remarkable recoveries to some of our most stubborn cases," sarcastically noted one hospital surgeon (9).

At the very time that patient demand was rising, hospital trustees were faced with another challenge to the financial security of their institutions: costs for medical supplies were growing. As bacteriological practices began to be felt in terms of higher standards of general cleanliness, sterile surroundings, and aseptic surgery, a slow growth in costs for medical supplies and maintenance resulted (10). During the period, for instance, the use of rubber gloves, sterile bandages, supplies and equipment became a standard part of hospital expense. At Brooklyn Hospital the average cost for a day of care rose from $.89 in 1890 to $2.78 by 1915 (11).

These two factors, rising patient demand and increasing costs for medical supplies, had a significant impact upon many hospitals. But the ultimate crisis in finance was a result of the fact that philanthropists could no longer make donations large enough to rescue the hospitals from their plight. In the earlier years of the nineteenth century philanthropists could be counted on to cover deficits that were chronic features in most nineteenth-century charity facilities. Many hospitals, in fact, used small but manageable deficits as part of their appeals for funds. A deficit was seen as an indication of the worth of the institution, just as modest want was seen as proof of the worthiness of one of the hospital's inmates. Philanthropists were more willing to give to an institution that had a small end-of-the-year deficit.

The depression forced philanthropists to reassess this long-standing practice. Hospital deficits were now growing larger every year. Furthermore, the trustees and philanthropists themselves were feeling the pinch of this long and severe depression. They were less willing and able to part with their money than they had been in the past.

In sum, charity was proving an inadequate means of supporting the hospitals. Trustees and managers alike remarked that there was a "ten-

By the early years of the 20th century, it had become apparent that a few wealthy benefactors and local subscription drives were an inadequate means of financing the city's private hospitals
marked, "we have not been able to meet our expenses" (13). The president of one of Brooklyn's oldest specialty facilities summed up the crisis that plagued many institutions during the depression years: "Not only are the demands upon the hospital greater and the expenses consistently increasing, but the sources of revenue from individual subscription are diminishing" (14).

The economic crunch that hit Brooklyn's hospitals served as a warning to the trustees of some institutions and as a death blow to others. During the 1890s, for instance, no fewer than five of Brooklyn's largest hospitals closed their doors. One trustee noted that Memorial Hospital "had an uphill and hopeless struggle... Disaster after disaster overtook them until burdened with debt, [it]... had to succumb" (15). When the Williamsburg Hospital in a large working-class neighborhood closed in the early 1900s, the trustees were deeply in debt and could not gather the necessary funds. Homeopathic Hospital struggled through the depression and was taken over by the city, $70,000 in debt (16). By 1899 one of the prominent hospitals reported that it owed $27,000 to various banks and that a substantial portion of its endowment had been spent (17).

By the early years of the twentieth century, the general crisis in hospital finance had become so widely recognized that a "Conference on Hospital Needs and Hospital Finances" was called for by administrators and the Charity Organization Society. In the announcement for the meeting the sponsors noted that "heavy annual deficits are the rule rather than the exception" in most of the city's hospitals (18).

In New York and Brooklyn alike, trustees and superintendents recognized that the charity system was breaking down. A few wealthy benefactors and local annual subscription drives were an inadequate means of financing the city's private institutions (19). Hospital administrators and trustees were faced with the necessity of finding alternative sources of financial support. As Mr. Abraham pointed out in his own inimicable way, "In reading over the reports of [Brooklyn's] charitable institutions they all ring... the one leit

Increasingly, hospitals began to look for paying patients, seeing their traditional 'charity' role as an unmitigating financial burden

motif and the one refrain: appeal upon appeal to the public to help pay off large mortgages and other indebtedness" (20). A new means of financing charitable institutions was clearly needed. During the early 1900s, in the wake of a severe depression, trustees in many facilities began to look toward pay patients as a new source of income and as a means of forestalling the collapse of their facilities.

Giving 'Em the Business

The traditional financial bases of most Brooklyn hospitals had been the benevolence of wealthy trustees, patrons, church-goers and other private individuals. They participated in hospital work for many reasons: partly from a sense of noblesse oblige, in order to gain or maintain recognition as community leaders or because of their interest in social control and cultural hegemony. The objects of their benevolence had uniformly been the poor and working class of the city.

But by the early 1900s it was clear that there were good economic reasons for reluctant trustees to abandon their uniform objective of servicing the poor (21). Scientific medicine was changing the character of the old charity facilities, wealthier patients seemed ready to utilize the hospital and poorer persons were a severe drain on the resources of many facilities. Hospital income could be increased significantly if, first, patients could be convinced to pay for their care and, second, if a greater number of wealthier clients could be attracted to the facility. Most trustees still maintained that charity was the proper justification for the hospital. But, increasingly, "free" or "charity" patients were seen as a growing burden to financially pressed trustees (22).

Some trustees felt that the number of poor persons admitted should be limited, while others
felt that more extreme measures were necessary. Some actually refused care to those who could not pay. Especially during the depression, trustees learned that limiting the number of working-class patients who needed "free" care was the only means open to them to cut costs. "Early last winter, it became apparent that something must be done to procure immediate pecuniary relief," one hospital president remarked. "A cruel fact stared us in the face. . . . We had been rolling up a debt. . . . After careful study, our advisors decided that . . . we should limit the number of inmates" (23). At a small Williamsburg facilities, trustees reluctantly observed that there was a "limit to our resources" (24).

During bad times it was clear that no facility could accommodate everyone. But this practice of excluding poorer patients was carried on past the immediate depression years and became an axiom of hospital administration during the early twentieth century. At the Brooklyn Hospital, for instance, the trustees began to see the paying patient as an important source of income and the free patient as an increasingly expendable burden. "Further space in the wards must be prepared for the [pay] service if we wish to further increase our income from this source," the vice-president of the board of trustees declared in 1899 (25). By 1902 the trustee "decided to shut out part of the charity patients [in order to] keep expenditures down." The hospital, the president remarked, had previously "attempted to do more charity work than it could afford" (26). In 1892 only 12 percent of this hospital's income came directly from the patient. By 1905 nearly 45 percent was derived from patient payments (27).

Although changes in hospital organization and administration had begun earlier in the nineteenth century, the depression of the 1890s greatly accelerated them. Specifically, the deficits made the businessmann's cry for efficiency, bureaucracy and business practices more convincing to hospital boards. The deficits also undermined the charity orientation of many trustees. Furthermore, the crisis led to the hospitals' new dependence on physicians who claimed they could supply them with a new class of patients who could pay for care. This meant that new amenities and services would have to be provided in order to attract doctors and their patients. Advanced technology services that were of interest to practitioners were introduced. Private rooms, wards, doctoring and nursing had to be provided for wealthier clients. In quick succession hospital boards voted to expand their visiting and attending staffs. Brooklyn Hospital increased the number of associated physicians from fewer than a dozen in 1890 to nearly sixty by 1915. At Methodist the number rose from about fifteen to fifty-five during the same period (28).

The introduction of private physicians into the charity hospital had a profound and long-lasting effect on the organization of these facilities. First, trustees had traditionally seen the hospital as their private responsibility and the arrival of large numbers of physicians meant a new challenge to their authority as benefactors and stewards to the poor. Second, the physicians had a substantial impact on the underlying purpose of these institutions. Hospitals became more clearly defined as places for medical treatment rather than shelters for the poor and homeless.

While doctors changed the tone of the wards, businessmen on the boards changed the tenor of board meetings. Like Abraham Abraham at the Jewish Hospital, businessmen gained a new importance at other institutions as well. The president of the board at the small Bushwick Hospital announced that H.C. Bohack, who had recently opened a chain of food stores, had joined the board. As the president saw it, "the business interests of the hospital could not more effectively be safeguarded" than by directly involving such men. At Brooklyn Hospital, Charles Pratt became president of the board. Pratt, whose family had founded the oil refineries in Greenpoint and who managed John D. Rockefeller's East Coast refineries, made substantial changes at this institution as well (29).

The direct effects of the involvement of all of these individuals was ambiguous. But they certainly did bring a business point of view to challenge the norms of the hospital boards. Managers and trustees, who ascribed to older paternalist ideologies, found themselves hard put to defend their roles as financial stewards when they themselves had no solution to the chronic financial crises. Older ideals began to be played down and newer business ones placed in their stead. Some trustees were often put in a quandary, denying that the facility had changed into a business. The president of one hospital cried out that his facility was "a work of mercy. . . not a business" (30). Another declared in 1907 that "we are not in hospital work to make money" (31).

At the end of the Progressive Era one prominent surgeon commented on a paper about a Brooklyn hospital published in the Bulletin of the Taylor Society, the society dedicated to scientific management. The paper sought to apply principles of scientific management to the organization of the hospital. In commenting on the paper,
Ernest Codman, a Boston surgeon concerned with the rationalization of the hospital, observed that “charitable hospitals have become businesses and are . . . wolves in sheep’s clothing” (32). Clearly the older charitable impetus for hospital work was waning as the financial cruch hit many facilities. Charity clients were a burden. As one trustee pointed out, “Additional income must be had, and that can come only from pay patients” (33).

**Paying Patients and Private Rooms**

The turn away from charity affected the working-class patients in two ways. First, trustees sometimes converted “free” wards into pay wards or rooms. This took away space previously available for indigent patients. Second, trustees more often began to charge working-class patients for services that were previously provided free. Different levels of services were devised for those willing to pay. Also, existing ethnic and other social distinctions functioned to convince those who could afford it not to use a “lower grade” of service. This divided different working-class groups into separate quarters and perpetuated existing divisions within this class. Moreover, the poorest of the patients, those unable to pay anything for their care, were increasingly seen as the source of the financial problems of the hospital rather than the victims of the crisis in hospital finance. The “fruitful cause for the annual deficiency in the hospitals,” remarked one hospital manager in New York, “is the large number of free patients.” If the former objects of charity did not pay for their care, then they were now defined as the problem. “If hospital patients had more honor and pride, I do not think there would be any large deficiency,” he concluded (34). Instead of seeing the poorer patients as needy and consequently deserving of care, hospital administrators viewed neediness as a moral failing of the patient.

If hospitals now charged only wealthier clients for their care while maintaining services to working-class patients, the practical effect of this reorientation toward the paying patient might not have been terribly important. This was not the case, however. In Brooklyn there was no ready and willing group of middle-class patients eager to use charity facilities long associated with the most degrading type of care; only special services and new accommodations could attract the middle class. The small, financially unstable facilities of Brooklyn could hardly afford to build additional wings and services. Consequently, space for free patients was often converted into space for pay patients and, more often than not, formerly charity patients were required to pay for their care. At Brooklyn Hospital, for instance, the number of “free” patients grew from about 1,000 to 1,600 during the depression years and immediately following but then dropped dramatically from 1,600 in 1900 to 1,200 in 1903. As noted earlier, it was 1900 when the hospital trustees announced that beds in the charity ward would be converted into pay beds in order to increase income. At the same point the number of paying patients began to grow dramatically, rising from just over 200 in 1899 to 1,400 by 1911. The number of private room patients, never a large number in any particular year, remained relatively small throughout the period. In 1895, 16.3 percent of all patient days were used for pay-ward patients. By 1905 this category had grown to 44.5 percent (35).

While the change in hospital space usage was dramatic, the change in the class of the hospital patients was not. This leads to the conclusion that the pay wards were primarily filled by the same class of patients that previously used the free hospital space. In Brooklyn Hospital, for example, white-collar workers accounted for 13 percent of the patients in 1892 and grew slowly to 21 percent by 1902. The bulk of the patients were still working class—only now they had to pay for their care. On the one hand, it was “obvious that there can be no very great increase in income from [pay patients] unless the accommodations . . . are increased at the expense of space allotted now to those [who] . . . cannot pay at all” (36). On the other hand, charging the same group of patients who had previously used the facility for free accomplished much the same thing. At Brooklyn Hospital this appeared to be what was done. The trustees periodically transformed charity wards into pay wards when income was needed (37).
The internal organization of many facilities was also greatly affected by the change from charity to pay. Hospitals throughout Brooklyn began to assign bed space to patients according to social and economic criteria rather than medical need. Within the context of the growing acceptance of patient payment as a legitimate source of hospital revenue, it became mandatory for hospital managers to make services distinctly different for the charity and paying patients in order to convince patients that, if they could afford to, they should use the paying service. The source of referral, whether the social service and business office or the private practitioner, gave some basis for differentiating between those able to pay and those who were indigent. But the offering of different services provided a surer means of selecting out patients. The right to a private physician, smaller wards or private rooms, and better food were immediately seen as prerogatives of the pay service. In contrast, charity patients were provided with care that was determined by the administration rather than by a private physician. Private patients were serviced in entirely different quarters. Some called for separate facilities for the rich and poor. The Journal of the American Medical Association pointed out that the "absolute segregation of charity patients from pay patients" was necessary if the wealthier patient was to be convinced to pay for his or her care. Those who really have no means will perform go to the genuine charity hospitals, while few of those who have any income will sink their pride so far as to enter an institution patronized by none but the destitute. . . . When the only alternative is a pay hospital where none are treated free, the deed is done. So long as rich and poor are treated under one roof, the well-to-do will not scruple at getting free treatment [since] no stigma attaches to residence in an institution where many pay their way." Separation of services along class lines was necessary to guarantee that clients would, if able, pay for their treatment (38).

The transformation of the structure and organization of the hospital preceded the introduction of wealthier clients. In many facilities private rooms and pay wards remained empty until after World War I. But in the interim many working-class patients were refused entrance, charged for services previously provided free and made to feel that the hospital was no longer concerned with their well-being. Some poorer patients were able to scrape together the necessary cash and enter the new "pay" wards. Others were forced to seek care in the growing system of public institutions. Still others were taken into the voluntary institutions only when payment from the city coffers was guaranteed.

The relationship between the charity hospitals and the city government had a long history, dating back to the 1840s. At that time the city of Brooklyn issued lump-sum payments to charity facilities so that these institutions would care for poor persons who were deemed to be proper recipients of the city's protection. But in the early 1900s this flat-grant system of payments was transformed into per capita, per diem payments schemes based upon a means test of all patients. The means test and new grant system further accelerated the administrators' plan to exclude those whose expenses were not covered (39).

It would be naive to conclude that trustees consciously reorganized hospital services along social class lines. Rather, such actions to develop class-distinct services were an outgrowth of a complex process of financial, intellectual, and social changes that had little to do with the trustees and superintendents themselves. Once patients were accepted as a reasonable source of income, the selling of health services—through private rooms, wards, private nursing, doctors and special amenities—swiftly arose. Most trustees, in fact, had little or no understanding of how profoundly their institutions would change once patients were turned to as a source of income. In fact, the trustees' own declining authority was further threatened by the very practitioners whom they needed to save the hospital. These practitioners brought with them a growing expertise and professional authority that would quickly allow them to bypass the trustee in influence (40).

The decisions of trustees to change the base of their financial support had a deleterious effect on their own position as well.
By the end of the Progressive Era the modern outlines of an internally fragmented hospital system were apparent in many of Brooklyn's facilities. Not only were physicians much more prominent, and not only were their interests reflected in an increasingly complex medical organization, but the hospital itself was now split between public and private services. In 1916 the Brooklyn Hospital distributed a brochure with an illustration of the hospital on its cover. Engraved across the roof of one of the two wings of the hospital was the word "PUBLIC." Across the roof of the other was the word "PRIVATE." Between these stood the administration building that kept two worlds of medicine far apart.

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1. See, for example, the voluminous literature on the organization of ward, room and private service within hospitals. The most widely known critique of such service differentiations comes from various Health/PAC publications. For instance, see Health/PAC's The American Health Empire (New York: Random House, 1970), and David Kotelchuck, ed. Progression Negative: Crisis in the Health Care System (New York: Vintage Books, 1976).

2. Morris Vogel, "Patrons, Practitioners, and Patients: The Voluntary Hospital in Mid-Victorian Boston," in Victorian America, ed. by Daniel W. Howe (Philadelphia: University of Pennsylvania Press, 1976), pp. 120-21: "Patients who could not, and in most cases were forbidden to, pay any fee." Other authors have also noted the organization of charity hospitals in the nineteenth century; see, for example, Charles Rosenberg, "And Heal The Sick: The Hospital and Patient in 19th Century American," Journal of Social History 10 (June 1977): 482-97.


5. Such social (i.e., non-medical) functions were an important aspect of nineteenth-century hospital care. See note 3, above, for a more extended discussion of the nineteenth-century facility.

6. See Brooklyn Hospital, Annual Reports, 1895, 1899.

7. Brooklyn Maternity Hospital, Annual Report, 1896, p. 11.

8. See Brooklyn Nursery and Infants Hospital, Annual Report, 1896, p. 15; and Methodist Hospital, Annual Report, 1896, p. 15, for similar comments.


10. An analysis of costs at a number of Brooklyn facilities indicates that general housekeeping, maintenance and other costs grew along with a slow rise in the category of "medical supplies." But patient demand was of great significance as well.

11. The statistical information in this article is drawn from the annual reports of the various institutions; see, for example, Brooklyn Hospital, Annual Reports, 1890-1915, for the above quoted material.


13. See, for example, Memorial Hospital, 10th Annual Report, 1898, p. 16; Brooklyn Eye and Ear Hospital, 13th Annual Report, 1899. In 1896 the directors noted that the "sources of revenue . . . are diminishing" (Brooklyn Hospital, Annual Report, 1895, p. 6). See also, Charity Organization Society of New York, Report, 1900: "Several of the large private hospitals are having increased difficulty in securing . . . funds [from philanthropists]."

14. Brooklyn Eye and Ear Hospital, 29th Annual Report, 1896; Methodist Hospital, Annual Report, 1894, p. 19; and other numerous contemporary statements.

15. Jewish Hospital of Brooklyn, 2nd Annual Report, 1903, p. 8. Also Memorial Hospital's Annual Reports for the previous ten years, which outline its financial collapse.

16. Jewish Hospital, 2nd Annual Report, 1903, p. 8. See also "Williamsburg Hospital Closes," New York Tribune, 16 January 1903, p. 7: "The trustees could see no way they could obtain the necessary money to continue [and] they decided to abandon the work before going further into debt." See also City Takes the Hospital," B.D. Eagle, 26 July 1900 (The Homeopathic Hospital became Cumberland Hospital); "Homeopathic Hospital to Close This Evening," B.D. Eagle, 31 March 1900; "Hosp­ital Bill Hearing To-Day," B.D. Eagle, 7 March 1900; "Anent the Homeopathes," B.D. Eagle, 6 March 1900.

17. Editorial, The Trained Nurse and Hospital Review, 29 (September 1902): 194. See also Brooklyn Hospital, Annual Report, 1899, p. 8: "Deficits of recent years [have] resulted in a floating debt of about twenty-seven thousand dollars."


19. Frederick Sturges, "What The Managers Of The Hospitals Say About Their Financial Problems," Charities 12 (January 1904): 32. Sturges continues saying that "the founders and the charter members of the great private hospitals, and their direct descendants are the ones who are now principally carrying them, and it is extra­ordinarily difficult to interest the younger generation. . . ."


21. Morris Vogel has outlined some of the demographic factors such as changes in housing patterns and in the make-up of the work force. He has also noted some internal reasons for the introduction of private patients. See notes 2 and 3 above.

22. Jewish Hospital, Annual Report, 1903, p. 11.

23. Nursery and Infants Hospital, 23rd Annual Report, p. 16.
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