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22 Vital Signs

New Orleans Heals

The article that follows presents a case study of the New Orleans medical empire, an empire situated in the heart of the city, based on three medical giants—Tulane, Louisiana State University and Charity Hospital—and fed by the development of a public funding agency. This case study illustrates that even in this era of economic recession, health care continues to be an important growth industry and that the growth and consolidation of medical facilities characteristic of what we have called medical empires still has currency, not only on the East and West Coasts, but in large cities throughout the country.

What is of particular interest in the New Orleans case is the fact that health care plays such a clearly crucial, although publicly unacknowledged, role in the economy of the city and region. This fact no doubt helps explain the convergence of banking, financial
and medical forces, among others, to publicly underwrite the expansion of this complex. We would also surmise from the experience of other localities that the prominent role of doctors in New Orleans medical politics represents an attempt to resist the eclipse of the power of doctors that so often accompanies the growth and consolidation of medical empires.

Medical education is one of the largest industries in New Orleans, but it is also an elusive creature whose true size and impact is difficult to measure.

Curiously enough, the Chamber of Commerce—which can tell us that the port is New Orleans' number one industry and that tourism is number two—can assign no rank either to health care in general or to its controlling core of medical education in particular. But from other statistical sources, the following rough outline of industry emerges:

- In 1970, there were 4,335 physicians in Louisiana—119 per 100,000 population, and 1,246 dentists—35 per 100,000 population. These per-capita rankings are higher than for all other Southern states except Texas and Florida. The Orleans Parish Medical Society estimates there are 1,350 doctors in New Orleans and that the metro area contains one-third of the doctors in the state. Most of these metro area physicians hold some sort of full-time or part-time faculty appointment to a bewildering maze of educational institutions or their affiliated training hospitals, all centering in and around New Orleans.

- Louisiana had 146 hospitals in 1971, serving 639,000 patients. Some 30 of these hospitals are located in New Orleans, and their 9,000 beds rank them up there with the tourist industry's hotel-room count. Grande dame of the pack is Charity, the state's principal teaching hospital. Founded in 1737, the oldest hospital in continuous operation in the United States, Charity is also said by its public relations office to be the largest single-site hospital in the country—weighing in with 1,700 beds, one-fifth of the local total.

- The twin crown jewels of Louisiana's Medical-Education Complex are the medical schools at Tulane and Louisiana State University (LSU), which together have graduated over 15,000 physicians into practice. Louisiana had the first medical school in the United States outside the original 13 colonies (in 1834), and its successor, now doing business as the Tulane Medical Center, boasts the sixth largest medical alumni association in the country.

In 1968, the State Legislature's Act 112 established an unprecedented instrument for aiding this Complex in overcoming a variety of internal and external threats to its already considerable power—the so-called Health Education Authority of Louisiana (HEAL). HEAL is an unusual state agency answerable only to the Governor. Its board, appointed by him, is dominated by representatives from the boards of Tulane, LSU and Charity Hospital.

HEAL has development rights on, and a carefully devised Master plan for, 25 blocks of choice downtown New Orleans real estate nestled between the Superdome, the financial district, the Civic Center and the Canal Street shopping area—offering local physicians, real estate developers and bankers their best chance to date for evening the score of civic competition with the med-ed complex at Houston, New Orleans' South Coast arch-rival.

The folks at HEAL have hatched—right there in the shadows of Louisiana's other major beat-Houston entry, the Superdome—a multimillion dollar scheme which, even if it doesn't succeed in improving the quality of health care in Louisiana, will at least enable Louisiana's highest-income professional group to meet and bask together in a sprawling, multiblock downtown Xanadu of regionally unprecedented glitter, glory, greed and gall—a Xanadu made possible by taxpayers and a heavily mortgaged Tulane.

This is their story, not always a pretty story, to be sure, but a story upon which the lives of Louisianans—or at least their future health care—may ultimately hinge.

Profile of the Complex

Three production centers have long dominated the health-care-training industry in Louisiana:

- The Tulane Medical Center, a traditional New Orleans upper-crust linchpin, and an institution that, until only recently, has dominated a Louisiana medical establishment said by at least one high-ranking state health authority to be "the most conservative in all the United States";

- The LSU Medical Center, an insurgent group established by Governor Huey P. Long in 1930 specifically for the purpose of
HEAL's Big Three

CHARITY: Charity's School of Nursing and Allied Health, in operation since 1894, had 425 nursing students and 225 "allied health" students last year—including one- or two-year programs in such specialties as x-ray, medical, EEG and operating room technology, plus programs for anesthesia, inhalation therapy and nurses' aides.

TULANE: The Tulane Medical Center, re-organized in 1969 with its own board of governors headed by New York coffee magnate Jack R. Aron, runs a School of Medicine with 593 students and a School of Public Health and Tropical Medicine with 301 students, plus federally subsidized research centers for primates on 500 acres in Covington and 500 acres for other biomedical research on Helbert Center in Belle Chasse, plus an international research center in Cali, Colombia, and a university health services clinic on its Uptown campus. Over 2,000 people work and study at the Tulane Medical Center, and until recently many of them held joint appointments to the staff of the now-bankrupted Family Health Foundation, founded by Tulane's ambitious birth control pioneer Dr. Joseph Beasley. The School of Public Health and Tropical Medicine is particularly valuable to the medical-education complex because it trains hospital administrators.

LSU: The LSU Medical Center has 1,934 students in six schools, and with the exception of the Medical School in Shreveport (225 students) and the School of Dentistry on Florida Avenue (482), they mostly work and study in downtown New Orleans. The School of Medicine, with 610 students, has overcome Tulane's enrollment and could grow to double its size by 1980. The School of Nursing with 343 students, and the School of Allied Health Professions with 204 students, however, are expected to grow even faster. The LSU Medical Center has 1,200 full-time or part-time faculty members, over 1,000 of whom live in metro New Orleans.

School of Nursing at Flint-Goodrich Hospital and miscellaneous other nursing or technology programs at a dozen other area hospitals—few are wholly independent of Big Three involvement and interference, especially now with the advent of HEAL to help finance and pull off whatever coups its three oft-squabbling partners can be persuaded to agree on. HEAL is, in business parlance, a "trust"—a state-subsidized trust, yet—whose creation signals the coming of a dramatic alteration in power relationships across the rest of the state's health-care industry.

Tulane, for example, trains its residents at the local Veterans Administration and US Public Health Service hospitals and at Touro, Baptist, Eye-Ear-Nose-and-Throat and Ochsner in New Orleans, plus public mental health institutions across the state; while LSU maintains residencies at Hotel Dieu, Lakeside Hospital for Women, Ochsner, Baptist and the VA in New Orleans, plus all other Charity Hospitals across the state—all in all an administrative spider web of considerable proportions, even without the added clout of the powerful new HEAL trust.

If this were any other major private industry, anti-trust lawyers long ago would have been bussed in to break it up—but these monopolists, let us remember, are doctors—businessmen possessed of both an aura and a lobby few other capitalist practitioners can equal.

**Legitimizing HEAL**

Where has this monopoly decided to consolidate its new power first?

On medical students and trainees, which are the source of its basic power and on which the Complex bases the rest of its program of institutional control, including controls on where they come from and where they’ll go when they finish their training.

Increasing the state’s supply of medical students certainly sounds like an action in the public interest, hence the public explanation for the creation of HEAL’s government-sanctioned trust among the three largest medical personnel training institutions in the state. But the issue of student raw material is far more subtle than that and is far more intimately linked to two other, far more noteworthy self-serving interests of the Louisiana Med-Ed Complex—the aforementioned competition from the well-financed mavericks in Houston (a threat certain to make New Orleans’ banking and real estate interests salivate at the thought of all that local land and money changing hands) and the looming threat of increased federal interference through national health insurance (organized medicine’s traditional rallying point for unified political action). Tighten up your control of the situation, and you can effectively block out the Houston rivals, the feds and the possibility of an independent Louisiana medical power base that might ally itself with either of them in an economic and political war with the Med-Ed Complex for control of Louisiana medicine.

Accordingly, as the first element of this strategy, a “manpower needs” study has been commissioned—not so much to determine what Louisiana’s citizens need as to determine what Louisiana’s Med-Ed Complex needs. Two of the study’s specific objectives are (1) to demonstrate a need for more physicians, hence more training facilities, hence physical expansion of the Complex (the fight with Houston), and (2) to figure out how to keep more of the Complex’s graduates in Louisiana, tied in by professional and financial connections to the Complex for reinforcement of its powerful political ranks (the fight

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**Will the Tulane Med School**

Maybe yes, maybe no. Students doing their annual “evaluation” last year discovered that their findings had been exactly duplicated by the three previous such reports—meaning, therefore, no change. Except maybe for the worse. Several departments remain without a chairperson; the big names are dropping off—surgeon Theodore Drapanas in the Eastern/Kennedy plane crash; nutrition pioneer Grace Goldsmith of old age; the Medical Department’s world-renowned George Burch was kicked upstairs to an emeritus professorship and next door to Charity; the former Medical School Dean is said, by students, to have been reassuring them “everything is okay” while they knew of his job-shopping in Houston en route eventually to Oklahoma. The current head of the Orleans Parish Medical Society sums it up: “Tulane still has prestige, it just doesn’t have any money.”
with the feds and, not coincidentally, with physicians independent of the Complex).

This manpower study, set up and partially funded by the ultraconservative Regional Medical Program (RMP), has accidently discovered, however, to its considerable dismay, that some 40 percent of all LSU graduates ultimately leave the State of Louisiana, mostly for California or Florida.

"We're an exporting state," worries LSU Medical School Associate Dean R. W. Sappenfield, a participant in the RMP study, who notes that rival Tulane, as a "regional" school, has an even higher export rate. "If the students did their premed elsewhere, or came from outside, most of them will leave. If they do all of their training here, however, 80 percent of them will end up staying. Half of those who leave do so within a year of graduation." Within a year of graduation is during their residency period, that program of specialty apprenticeship in which young unestablished doctors supply scut labor to a select number of community hospitals controlled by older, more established doctors.

And so we arrive at monopoly objective number two—tighter Complex control over the hospital sector of the health-care industry in order to control more perfectly the environment in which an increased number of residents can be induced to stay in Louisiana. Specifically, the HEAL Master Plan calls for keeping 75 percent of LSU's graduates and 25 percent of Tulane's at home.

The process works like this: Should the resident find his residency contacts sufficiently rewarding, he is likely to stay around that hospital and join the medical staff there as it grows wealthier from the labor of yet more residents being funneled its way by the medical schools. Or else he might join up with a band of other physicians or ex-classmates to directly own a proprietary (i.e., money-making) hospital or clinic in the vicinity and maintain a lucrative staff membership at both institutions.

Better yet, if he's really good at playing this game, the enterprising young resident will end up one day on the faculty back at the Complex where all of these elaborate professional—which is largely to say, financial—arrangements and connections began. A casual perusal of the 1975 catalogue for the School of Medicine at the Tulane Medical Center, for example, reveals that an astonishing 698 faculty members (of 1,071) are graduates of schools in the Complex, 573 of them claiming Tulane as their alma mater. The 1975 catalogue for the School of Medicine at the LSU Medical Center lists 608 faculty members (of 1,084) who hail from schools in the Complex, 465 claiming LSU as their alma mater. Even without counting unduplicated facilities at the other five health schools downtown, that adds up to almost one-third of all the doctors in Louisiana sucking, as it were, at the tit of Mother Complex.

In the few short years since HEAL was formed in 1968, this group has already managed to suck to the tune of $100 million (not counting the Family Health Foundation debacle, other ongoing direct government grants or all the millions of dollars in planning money administered by the RMP to maintain tight control over all the federal cash to come). And there are well-devised operations already underway to increase both the number of suckers and the size of the tit, the specific details of which we'll get to in a minute.

But one last word about that ever-precious raw material, the ultimate source of all this power, the life-blood of the interlocked health-training and health-delivery system—the medical student. Twenty years after the US Su-
preme Court’s school desegregation decision of 1954, Dean Silas E. O’Quinn says there is only one full-time faculty member at LSU’s Medical School who is Black, Dr. Albert J. Bocage—and his PhD just happens to be from the Medical Center’s Graduate School. Moreover, LSU says it has only 22 Black students out of its total of 610, a meager figure somewhat further diminished by the revelation that nine of the 22, almost half, are in this year’s freshman class. Over at Tulane, the public relations office boldly insists that it keeps no such records on the number of minority students, even though their own in-house publication “What You Should Know About Tulane Medical Center” boasts a total of 34 Black students out of a total of 593 for 1974.

Women have fared only slightly better than Blacks—85 at Tulane and 104 at LSU, 40 of whom also are in this year’s freshman class.

Largely in anticipation of revenue from the Legislature’s recently enacted block grants for state students in private institutions, half of Tulane’s 1975 freshman class comes from Louisiana, and a substantial number of them are sons and grandsons of Complex-trained physicians. The only non-Louisiana students admitted to LSU, according to one well-placed source there, are sons of LSU-trained doctors who live out of state.

The result of all this consistent pattern of incest in admissions, residency training and faculty appointments—the manpower material base for the entire Complex enterprise—is an almost all-white, almost all-male elite club of some of Louisiana’s wealthiest men, for whom Mother Complex is a vital revolving door, an “old boy” network that would make even the CIA or the State Department blush.

Once we disabuse ourselves of the notion that Louisiana’s Medical-Education Complex—with its medical schools, hospitals and physicians—serve the power of anyone other than themselves in these arrangements, then we can begin to see the seven-year planning strategy of HEAL from an entirely new perspective.

The Real Story

The primary schemer behind HEAL is local notable Darwin Fenner—a blue-blooded New Orleans financier and retired partner in Wall Street’s Merrill Lynch, Pierce, Fenner and Smith colossus of the same name. No less a personage than Jefferson Davis died in the Fenner family’s former Garden District home, and ex-Rex social doyen Fenner chaired the Board of Administrators of the Tulane Educational Fund until he got his white-gloved hands on HEAL.

Of course, Fenner didn’t go out and do HEAL all by himself, his critics will assert. But, then, they will also concede that HEAL would not bear the marks of its current complexion or direction without him. Fenner’s

The only non-Louisiana students admitted to LSU, according to one well-placed source, are sons of LSU-trained doctors who live out of state.

(Continued on page 16)
The Emergence of Hospital Nursing

One of the conventional myths of our time is the belief that from the development of technology flows the division of labor. Another common belief about technology is that its introduction is labor-saving, enabling fewer people to produce more. The history of nursing during the first three decades of this century, however, flies in the face of both assertions. Nursing technology neither explains the division of labor among bedside workers nor reduces their number.

The introduction of hospital technology—from complicated intensive care units to the modern hospital bed—has not only not reduced the size of the nursing workforce, but has been accompanied by a tremendous increase in the number of nursing workers caring for each patient. Along with this numerical growth has come the creation of new groups of nursing workers, the redistribution of tasks among different kinds of workers, and the imposition of a supervisory hierarchy. In today's hospital there are aides, orderlies, Licensed Practical Nurses (LPN's), staff Registered Nurses (RN's), supervising RN's and various nursing specialists. Paradoxically, it seems, the more technology developed for the bedside, the more and more varied people the hospital has to hire.

The apparent paradox is usually explained in terms of the technology itself—that the complexities of work mandate the division and specialization of the workforce. The problem with that explanation, however, is that the division of nursing work predates the significant development of hospital technology. Rather than stemming from technology development, the nursing hierarchy reflects the historic emergence of the hospital as the primary site for medical care. The creation of the hierarchy has its origins in the attempt of the hospital as an institution to control its labor force. The imperative lies at the heart of the transformation of the nursing workforce during the 20th Century.

The earliest hospital workers were recruited from the ranks of the poorest down and outers. A 1913 survey of New York hospitals noted, for example, that "in the absence of other institutions where the periodic and semi-
"The division of labor in society is characteristic of all known societies; the division of labor in the workshop is the special product of capitalist society. The social division of labor divides society among occupations, each adequate to a branch of production; the detailed division of labor destroys occupations... and renders the worker inadequate to carry through any complete production process.... While the social division of labor subdivides society, the detailed division of labor subdivides humans...."

Harry Braverman
Labor and Monopoly Capital

respectiveable drunks can live and work, they can, to the best advantage to themselves and to the City, be supported as workers in the City's hospitals." (1) With few skills, little or no salary and high turnover, such workers constituted no threat to the prerogatives of doctors or administrators. Beginning in the 1870's a second group of nursing workers—student nurses—took their place. They were rendered subservient by virtue of their temporary, student status. The incorporation of to use hospitals in great numbers. They were in a position to "bad mouth" the institution and upset the applecart of hospital growth. The graduate nurse had been trained as a semi-autonomous practitioner whose allegiance was first to her profession, the physician and her patient, not to the institution. To defang this potential wolf at the door, hospital administrators adopted some of the management techniques developed earlier in the century in other industries and employed previously in hospitals to assert management authority in areas other than patient care.

The reason for these management devices, dubbed "scientific" by Frederick Taylor, their messianic advocate at the turn of the century, was to divest workers of control of production processes so that productivity could be controlled by management. The central concepts of scientific management—the separation of the conception from the execution of work, the subdivision of tasks, the precalculation of tasks and the creation of supervisors—were introduced simultaneously with new labor-saving technologies. Taylor argued that they inevitably went together. An unruly workforce could be harnessed to a machine only with the exercise of management. The resulting detailed division of labor and the denigration of skilled artisans were made to seem part of the cost of industrialization. Management changes appeared necessary to mechanization.

Since in the case of patient care hospital administrators did not have machines to hide behind, the application of scientific management techniques to nurses could not be tied to changes in the production processes. Instead, these pure and simple assertions of authority were said to be integral to good medical care. Scientific medicine provided the ideological cover for scientific management and medical technology the rationalizing agent. Because the organization of nurses' work was external to the content of the work, management could succeed only if nurses themselves accepted the authority of the hospital and its definition of their status.

Student Nurses: Indentured Servants

At the turn of the century the administration and division of labor in hospitals was relatively simple. A board of trustees or administrators made the major decisions. A superintendent or steward was selected as the chief administrator, responsible mainly for

graduate nurses (RN's) into hospitals during the 1920's and 1930's, however, presented hospital administration with an entirely new set of problems.

Graduate nurses posed a potential threat to the control of the hospital by its administrators, and, more importantly, a threat to the prestige of the institution. Nurses' work brought them in close contact with patients, especially the middle-class and upper-class patients who in that period were beginning
financial and maintenance functions. A separate women's board was deemed necessary to oversee the personnel and the care. A board of physicians who donated their services comprised the medical staff.

The most numerous hospital employees were the nurses. Prior to 1873, when the first nurse training schools began, nursing was primarily taught on the job by the more experienced to the neophytes. The women drawn into nursing were either paupers "recruited" from the city's asylums and prisons or poor, often immigrant, women drawn from the community. Middle-class women, interested in nursing for personal or humanitarian reasons, were chosen as head nurses and supervisors. Thus from the very beginning there was a class division in nursing and a lack of upward mobility for poor women; middle-class status being a requirement for supervisory positions. (2)

Work was organized and controlled by the head nurse on each ward. Nurses were responsible for almost everything: cleaning, laundering (especially of bandages), food preparation, serving and patient care. In some of the larger, better endowed hospitals, ward maids were used for the heavier cleaning and laundering. At Massachusetts General Hospital, for example, nurses slept in small rooms between the patient wards. Such rooms were used during the day for conferences and minor operations. (3) Night watchers were responsible for the patients after dark.

Nursing schools attached to the hospitals grew rapidly and this development changed the nursing workforce. The untrained attendant slowly evolved into a nursing student. Even in 1920, however, untrained nurses outnumbered the trained nurses three to two. (4)

Student nurses rapidly became the key nursing employees in the hospitals. They were, however, unpaid except for being given room and board and some spending money. Graduate nurses were used only in the supervisory positions. The hospital administrators quickly realized that the nursing students were not only cheaper but as employees were preferable to either untrained attendants or graduate nurses for several reasons.

First, students could be trained into the exact routine of the hospital and would not bring the knowledge of different routines from other hospitals with them. Second, since training lasted for three years, the students became a relatively permanent workforce who could be depended upon to stay longer than other employees. Finally, management could exert more discipline and control over students than it could over employees who didn't see the work as something to be endured until graduation and might quit. Lavinia Dock, one of the early leaders of American nursing, put it succinctly: "Discipline and strict subordination of the school makes it possible for the hospital to exact from [the nursing student] an amount of work it would be quite impossible to exact from women over whom it had no special hold . . ." (5)

Since the nursing students were pushed onto the wards with almost no training and were expected to do everything, strict supervision of these unskilled women was necessary if any degree of quality care was to be obtained. Nursing leaders rightly believed that good supervision would help with the on-the-job training of the nursing students. The system was not flawless, however, as the following comments from an Iowa physician make clear: "We are entirely too careless in the operating rooms, and too many pupil nurses are put into operating rooms who are too stupid ever to learn operating technic, too many who are too careless, and who have not been long enough in the school to have acquired the proper mental attitude toward the profession of nursing." (6)

Since the hospital was also a school, control over the nurses was sanctioned by the ideology of in loco parentis as well. Adherence to such strict control over work meant that the hospitals could admit virtually any warm body to the nursing school knowing that the supervision and teaching of strict routines would largely make up for the deficit in knowledge and training. Consequently, the public often viewed the hospital nursing school as "... a sort of respectable reform
Graduate Nurses: Autonomous Professionals

For the graduate nurse conditions of labor were quite different. After graduation, most nurses left the hospital to become private duty and home nurses. As such they were hired and worked individually. Hiring took place either by word of mouth or through registries established in the major cities by the nursing alumnæ associations, commercial businesses and the hospitals. For a small fee, nurses could register, give their prices and their preferences for work.

In private duty nursing, the only real supervision was that given by doctors, and this was at best haphazard and uneven. Nurses were still expected to kowtow and cover for the physicians and their mistakes. Dr. William L. Richardson, for example, told the graduating class at the Boston Training School for Nurses on June 18, 1886 to “always be loyal to the physician.” He warned them not to be “tempted” to impress the doctor with their knowledge because “what error can be more stupid?” (8)

Graduate nurses occasionally worked in hospitals, mostly as private duty or special nurses for the paying patients in their private rooms. Hospitals usually kept registries, mostly of their own graduates, but patients could obtain private duty nurses anywhere they pleased. The presence of the private duty nurse was a constant problem for both the nursing supervisors and the hospital administrators. She was independent of the rules, discipline and supervision of the hospital and its nursing hierarchy. Often her patients were not considered to be “that sick” and the fact that she worked less diligently than the other nurses was deeply resented.

Moreover, she was not responsible for anything but the care of her one patient. Because she was usually older than the students and out of school, she often used older or different techniques, a practice which clearly disturbed nursing supervisors bent on teaching the students their own particular way of doing things. (10)

Hospital administrators were even more concerned about the behavior of private duty nurses who could tell their patients about failings in the hospitals. Since their patients were usually well-to-do people in the community, the hospitals could ill afford to have their problems or limitations revealed to them. (11) Where they could, hospitals retaliated against these nurses, limiting their registry lists and using these as blacklists to keep out particularly troublesome nurses. Nurses frequently complained about discrimination on the part of the hospitals. (12)

Upgrading Quality, Increasing Divisions

The outbreak of World War I and the flu pandemic of 1918 were critical events which helped shape personnel relations within the hospitals. Both made the hospitals more acutely aware of shortages, the cost of labor turnover, and the need for better trained workers. (13) Problems of quality and the division of labor intensified in the 1920's. The hospitals' concern for efficiency became linked to their desire to upgrade their workers and the increasing realization that they were not attracting the right kind of employee.

This new concern for quality in the workforce was closely related to the change in the nature of patients using the hospital. As the hospitals expanded and the scientific and sanitary basis for care improved, more middle and upper class patients came to the hospital. By the 1920's hospital journals began to express concern about the middle class patient. By 1931, the income from private, paying patients was the most important source of hospital income.

Because of the difference in the kind of patient hospitals served and their importance to hospital income, administrators began increasingly to worry about the quality of the workforce and the impressions they made on the patients. Thus during the 1920's and 1930's the hospital managers moved both to downgrade the scope of authority of their workers through increasing the division of labor and to upgrade their quality through
better selection and standardization of training and through the provision of better ancillary benefits. In direct patient care areas, in particular, nursing, the changes were made in training and the types of workers.

Administrators quickly learned they could not rely upon moral exhortation or fancy lounge areas to gain increased work from their labor force. Slowly, principles of scientific management began to slip into the hospitals. (14) Charles Mayo heralded this approach when he told the Catholic Hospital Association in 1916: "...the directing [of the hospital] fails generally through lack of organization and division of labor. A Taylor system of management would accomplish much without lessening the efficiency." (15)

**Taylorism Strikes**

The new administrators' first line of attack was upon the stratum in the hospital which would be equivalent to lower middle management or foremen in industry: the head nurses and matrons in charge of the housekeeping departments. As administrators tried to chart lines of authority and make concrete rules about procedures, these "foremen" quickly sensed a threat to their authority. They clearly understood that the development of bureaucratic rules and the clear demarcation of authority would limit their control over their work.

Henry Hurd, one of the editors of The Modern Hospital, editorialized that matrons and nurses sometimes had "the impulse" or an "overwhelming desire" to organize or super-

"...the directing [of the hospital] fails generally through lack of organization and division of labor. A Taylor system of management would accomplish much without lessening the efficiency."

Charles Mayo, 1916

vise the work in departments that were not their own. He was particularly concerned that these women did not want to give up the power of purchasing to a central authority. "The result of all this," he pointed out, "is a confusion of duty, a mingling of responsibilities, and a loss of efficiency, costly to the institution, all of which are most unwise." Such plans led to increased departmental dependence on centralized planning and control of the administrators. (16)

The nurses and matrons realized this and fought as best they could. Counseling and cajoling on the part of the administrators did not always result in cooperation. When department heads refused to give up their broader decision-making powers, The Modern Hospital counseled firings, and letters to the journals made it clear that dismissals were common. (17) At the same time the administrators moved to increase the division of labor. The extent to which this division of labor and increasing substitution of lower skilled workers occurred varied depending upon both the hospital's size and funding source. (18) Regardless of the speed of substitution, however, increasing division of labor in the direct patient care areas resulted from the convergence and delicate balance of professional pressures and scientific management principles. The establishment of nurse's aides illustrates this tension.

**The New Nurse: Aides**

During the shortages of the First World War and the flu pandemic many hospitals introduced nurse's aide programs. Toward the end of the 1910's the expansion of these programs and other quick nursing courses produced an oversupply rather than a shortage of nurses. (19) With funding from the Rockefeller Foundation a commission was established in 1918 to study nursing and nursing education. (20) When the report, known as the Goldmark Report after its principle investigator, Josephine Goldmark, was issued in 1922, it established two principles which were to become more generally accepted in subsequent years: 1) subsidiary grades of nurses serving patients with mild cases and serving as nurses' assistants in the hospitals should be licensed, and 2) such workers should be trained in the hospitals, apart from regular nursing students. The report also recommended that nurses increasingly be trained in universities and transformed into hospital foremen. (21)
The Goldmark report was not greeted with hosannas from the physicians and administrators. They were unwilling to give up the cheaper nursing students or to upgrade to any higher professional status the "uppie nurses." (22) Other doctors, notably Charles Mayo of the Mayo Clinic, went as far as to accuse the nursing profession of being the most "autocratic closed shop" in the country and to suggest that professional nurses could be done away with completely and "100,000 country girls could be trained as subnurses." (23)

While numerous hospitals began setting up training programs for aides in the 1920's and 1930's, widespread use of aides did not occur until the shortages of World War II. Most training programs attempted to follow the dictates of the Goldmark Report, limiting the training of aides and constantly reminding them "... they are not and will not be nurses." (24)

The attempt to develop a subsidiary nursing worker who was cheaper but could provide quality care caught the hospitals in a contradiction which they have yet to resolve. If aides were to be given less responsibility and pay than the nurses, then their duties had to be different and more narrowly circumscribed. Yet because they were going to be handling sick patients, not machine parts, they had to be taught to understand basic procedures and to cope with many different kinds of emergencies. It is therefore understandable that they would want to improve their skills and to grow into more responsible positions. Yet the credentialing barrier established by the nursing profession in its quest for status and control prevented this happening through a job ladder in the hospital. (25)

A report on a nurse's aide program from Cleveland City Hospital makes this point candidly from the perspective of the administration: "... There is keen resentment on the part of several students because they feel that there is too much class distinction in the hospital. Probably it is inevitable that in so large a group a few would lose perspective regarding their place. On the other hand, perhaps, we, in our enthusiasm for the experiment, painted too glowing a picture of the joys of domestic work on our wards. After all, there is not much glamour to cleaning and bed making, even if they are an expression of devotion. Undoubtedly the continuance of their interest will be one of our perplexing situations..." (26)

Hospitals met this dilemma in several ways. First, the training programs emphasized again and again the limited role of the aide. She had to be socialized "... to continue to try and perfect herself in the skills that her assignments permit rather than to forge ahead to new accomplishment." (27) Second, nurses were shifted to paperwork and supervisory tasks and nurse's aides and practical or vocational nurses were left to do much of the direct patient care. (28) Since neither of these solutions really solved the "perplexing situation" for the hospitals, the aides responded in classic ways—shirking greater responsibilities, fighting with other workers, or quitting. (29)

"There is keen resentment on the part of several students because they feel that there is too much class distinction in the hospital."

Report of nurses aides program at Cleveland City Hospital, 1938

Thus by the 1920's, turnover in hospitals relying heavily on aides first surfaced as a major issue. This dilemma was and continues to be unsolved by the hospital management. On the one hand, high turnover controlled the resentment of the workers, allowed the hospitals to continue to pay low wages and yet keep an unskilled workforce. On the other hand, such high turnover meant that new workers had to be constantly taught the routines and integrated into the hospitals, making the workforce less efficient—the goal the administrators were trying so hard to achieve.

Learning to Play on a Team: RN's Incorporated into the Hospital

Most of the hospitals in the 1920's and 1930's were, however, more concerned about the nature of their nursing staff than they were with the question of aides. Long debates ensued during these years over who the worker should be, how she should be trained and who should control her work. Decisions
about the kind of nursing worker necessary were based in part upon attempts to determine a nurse’s productivity and how many patients she could care for in an hour. How to “scientifically” ascertain this number was and still is a question which is extremely difficult to answer.

A survey of nurses in the New York City hospitals in 1913, concluded: “... no recognized standards of the numbers of nurses that should be employed to a given number of beds and admissions existed.” (30) The problem was based in part on the fact that, while the hospitals could regularize the number of beds they had, the occupancy rate of those beds always was variable. It was difficult for hospitals to know their staffing needs from day to day.

Hospitals did try nevertheless to measure the number of nurses they might need at any given time on different services. In 1921 Elizabeth Greener, Superintendent of Nurses at New York’s Mt. Sinai Hospital, undertook the first time and motion study to determine the nurse-patient ratio. (31) A similar study was done of pediatric nursing in Cleveland in 1927. (32) A study done at Bellevue in 1930 became the first major attempt to examine both the administration of nursing within the hospital and the supervision of nursing students. (33) The time sheets and stop watches of scientific managers were brought into hospitals in an attempt to measure both the quantity and the quality of nursing care.

The 1932 report of a study conducted by the National League of Nursing Education had important implications for the changes in nursing in the 1930’s. The study documented the variability in both patient census and nursing load which made it necessary to shift nurses from one service to another. When these nurses were students, however, their education and ultimately the quality of nursing care suffered. The researchers concluded that nursing students could not provide enough quality care and that “a supplementary general duty graduate nursing staff... [was] essential.” (34) The study also found that one-third of the nurses’ time was spent in “extratreatment activities or non-nursing duties.” This finding laid the basis for further consideration of the introduction of ward clerks and nurse’s aides to take over these functions.

The move toward the employment of graduate nurses was encouraged by the work of
yet another major nursing study which issued several reports between 1928 and 1934. (35) The first report urged the closing of some nursing schools and the upgrading of training in those that remained. The national nursing groups began to reconsider their focus on private duty and to look increasingly at the hospital as a place to work.

It was not time and motion studies or the actions of the American Nurses' Association, however, which determined the gradual introduction of the graduate nurse to the hospital. (36) The expansion of nursing in the early 1920's had led to an oversupply; by 1928 the depression had already begun in nursing. (37) The plight of private duty nurses became even more acute as the Depression wore on and patients began to cut back on use of their services. The American Nurses' Association moved exceedingly slowly in assisting their members through pressure for shorter hours or relief. (38) By 1932, the national nursing groups reluctantly drafted an appeal letter to the trustees of American hospitals asking them to remember nurses in their hour of need and to begin to employ graduate nurses. The letter also noted that the dilemma for nursing was not just the result of the Depression but was due "... to a weakness of a system of accepting students primarily as workers in the hospital. . . ." (39)

Hospitals were at first reluctant to employ more graduate nurses. A 1927 questionnaire sent to five hundred supervisors questioning them on which type of worker they preferred showed that 76 percent wanted students; only 24 percent wanted graduate nurses. (40) The nursing supervisors were fearful of employing women used to working independently because "... they find even kindly direction irksome," as one nursing supervisor explained. (41)

Hospitals had been convinced by economics and by earlier demands of the nursing profession to use trained nursing students. They now seemed reluctant to give up their free labor in exchange for the graduate nurse, even if the Depression made her cheaper and more available. The 1928 nursing report remarked: "It is an extraordinary thing, but it seems to be a fact that hospitals regard the suggestion that they pay for their own nursing service as unreasonable . . . the student nurse is seen as an inalienable right. . . ." (42)

As the Depression wore on, however, more and more small hospitals were forced to close their nursing schools. The number of schools dropped from 1,885 in 1929 to 1,311 in 1940. Studies began to appear in the journals to show that nursing students were not cheaper because of their high maintenance and supervision costs. (43) By 1934 a new study of nursing superintendents concluded that their position on the use of graduate nurses had shifted positively. (44)

Some hospitals at first experimented with a form of private group nursing, which allowed a group of private duty nurses to care for several private patients at once. The nursing associations, finally coming to understand that this meant allowing the graduate nurse to become the general floor duty nurse, attacked the group nursing plans as "... merely another attempt on the part of the hospital to saddle the patient with nursing costs the hospital itself should meet, if this is not merely one more attempt to bolster up an inadequate nursing service." (45)

By the end of the 1930's it became clear that graduate nurses could provide better quality nursing service, could function as supervisors for auxiliary personnel, and, if they were not cheaper than students, neither were they that much more expensive. The hospital nurse became more common than private duty or public health nurse by 1937 and the number of graduate nurses within hospitals climbed from 4,000 in 1929 to 28,000 in 1937. (46)

**From Soloist to Second Violin**

Scientific medicine created the need and provided the cover for scientific management. Having made the hospital the center of the health system, scientific medicine necessitated a skilled as well as a controlled labor force; more than this, hospitals needed employees who were socially acceptable to paying patients upon whom they were becoming increasingly dependent. Poor men and women from almshouses were neither skilled nor acceptable. Students, although socially
compatible, were expensive to maintain and inadequate to the tasks. While graduate nurses met the two former objections, they presented a threat to the institutional integrity of the hospital. Scientific management techniques thus became important in the integration of RN’s into the hospital setting.

This was achieved in two ways. First, RN’s were separated from their source of power—the paying patient. A new level of workers, aides, was introduced to take over many of the traditional nursing chores. Aides could be employed in nursing without risk to the administration. They had no collective memory of control over patient care, and were more easily contained because of differences in training, class and race from graduate nurses. Additionally, they were cheaper to employ.

**Advancement in nursing consisted of climbing up the hospital hierarchy and meant implicit acceptance of the institution’s terms.**

Second, nurses were further removed from the bedside by being made supervisors. This served two purposes: it made clear to the aides that there was more to nursing than bedside care, and it seemingly elevated the RN by making her someone else’s boss. Once incorporated into the administration of the hospital, nurses quickly gained a stake in its smooth functioning. Advancement in nursing consisted of climbing up the hospital hierarchy and meant implicit acceptance of the institution’s terms.

In the face of institutionalization, however, nurses were not merely passive recipients of bureaucratic whims. Often they saw the dangers inherent in their situation. Unfortunately, their response was inadequate to meet the challenge and ironically played into the hands of the very forces they needed to combat. Imitating the earlier, successful thrust of doctors for professional status, nurses called upon their own unique abilities to cope with the nursing demands of scientific medicine, inadvertently conferring their stamp of approval on the ideology of high technology medicine. Thus, the more professional the nurse, the further removed she became from the patients and the more vulnerable she became to administrator’s control. Like the insect in the spider’s web, the more the nurses fought, the more entwined they became.

Prior to World War II, the transformation of nursing from direct patient care to a variety of specialized roles, including administration, was accomplished with few changes in technology. Rather it was effected by the division of nursing into subsections with the imposition of a multi-leveled hierarchy. For graduate nurses, it meant an end to the possibility of being autonomous practitioners who set their own work rules and controlled their own time. Unlike doctors, nurses became employees of institutions and were dependent upon and subject to those institutions’ needs.

RN journals today are filled with articles about the threat to the existence of nursing coming from technicians below and doctors’ assistants above. This pincer-like grip on the nursing profession is most frequently attributed to the technological proliferation within some aspects of nursing care and the complexity of hospital administration. Thus on the one hand, nurses are being replaced by lesser paid, lesser skilled people operating machines, and on the other, by clerical workers and computers. Their response is to either recite the catalog of nurses’ skills or to insist upon some mystical healing quality inherent in the nurse’s touch. But, as the history of nursing demonstrates, the extinction of the profession, if it happens, will result from the increasing division of labor mystified and speeded up by high technology medicine. It can only be resisted and reversed through a critique of scientific medicine and scientific management. They go hand-in-hand.

—Susan Reverby

*(Susan Reverby is a Health/PAC associate. This article was adapted from a longer work in progress on the history of the hospital labor force. Barbara Caress was the editor.)*

**References**

no taxes need be paid on its earnings by its purchasers. Its earnings are hovering around 7 percent annually, all of it tax-free.

HEAL has already issued $40 million worth of these bonds and is currently getting ready to act on a request from the Ochsner Foundation Hospital that it issue $60 million more. An interesting clue to who really stands to profit—all of HEAL's bonds are of the $5,000 denomination, which makes them particularly attractive to institutions like banks and to seekers of tax shelters, like wealthy Louisiana doctors.

HEAL, a cynical might conclude, is not functioning just as a facilitator of increased low-wage laborpower or as a source of financing for new buildings and new gadgets for a monopoly on the move—it is also a guaranteed safe investment haven for the beneficiaries of all the rest of its wholly publicly-financed largesse, an instrument for permitting Louisiana's wealthiest professional class and their wealthy confreres to divert even more of their surplus income away from the public's treasury.

HEAL's Master Plan, issued on March 1, 1973, estimates that $240 million in Complex expansion money by 1980 will come from direct state or federal government grants to pay for specific kinds of educational build-

New Orleans

(Continued from page 6)
nings, notably in the basic sciences. This anticipated public investment considerably enhances the value of the $100 million-plus in HEAL-organized bond issues being floated to private investors—a $240 million taxpayer investment which, in fact, in some instances is going to be used as partial collateral for the privately held bonds!

Dr. Albert Dent, a special consultant to HEAL, sits in its offices at the Civic Center's State Office Building overlooking the Super-
dome and the HEAL financial garden spread out before it, and grimaces at this analysis of HEAL's underlying purpose and modus operandi. His partner in this particular interview is Joe Wall, a health planner on the HEAL staff, who merely listens uncomfortably. Dr. Dent, who is retired from the presidency of predominantly Black Dillard University and who headed its Flint-Goodrich Hospital prior to that appointment, tactfully concedes, "I can understand your concern." However, as a former member of the City Planning Commission and as the newly chosen Black representative to the controversial Board of Liquidation, City Debt—the city's own bond-issuing agency—Dent has been, as they say, around, and he knows all too well how the money game in this town is actually played.

A sizeable proportion of the 8,500 workers and 3,700 outpatients coming to the Med-Ed Complex every day are Black, and an expanding Med-Ed Complex can only increase the number of Black jobs, Black students and Black patients receiving medical care. Dr. Dent reasons, regardless of who else may happen to be getting a piece of the pie. Wall fetches a copy of HEAL's feasibility study for an eventual public day-care center for children of students and staff within the complex—a project of no immediate apparent financial value to either bankers or bond-buying doctors—in an attempt to demonstrate that HEAL is not totally their captive. But the $100 mil-
lion in bonds (read $7 million in annual tax-free income for someone) involved in this one-third billion dollar scheme—the equal of two Superdomes—says otherwise.

**HEAL’s Bond Projects**

Consider, for example, the first facility HEAL ever built: a $3.2-million parking garage for 847 cars. The garage was designed by government-financed architecture’s less-than-dynamic New Orleans duo of August Perez and Mathes-Bergman, and it was built by Landis Construction Company, who do most of the city’s public buildings. Half its auto spaces are reserved for the Complex and the rest have been handed over to ITT Consumer Services, whose Airport Parking Corporation of America (APCOA) already owns a sizeable piece of the public parking action in New Orleans at Moisant and the French Market. The state owns the land. HEAL owns the garage, and ITT owns all the profits after its $117,000 annual rent. This is a considerable potential profit when you realize that a nearby hotel has subleased several spaces and that the parking spaces are only two blocks away from the Superdome.

What conceivable connection is there between the commercial parking business and medical education? “The people at Houston Medical Center,” Wall offers by way of explanation, “advised us to build something, anything, as quickly as possible so that we could get the agency off the ground.” An increase in parking facilities was a top priority that all three HEAL partners could early and easily agree upon. Dent and Wall nod in agreement, pointing out once again that unusual clause of the trust agreement—the HEAL trust can embark on no project without unanimous agreement from the three-headed body which propels it forward, as fast as deals can be made. That the new garage is closest to Tulane goes unmentioned, as does also the Master Plan’s call for eventual erection of 8,500 parking spaces—ultimately amounting to $30 million dollars worth of concrete and steel dumped into storage facilities for private automobiles.

But the parking garage is only the beginning of our $100-million HEAL story to date. Tulane was first in line for the next handout also, this time $37.5 million for construction of a university teaching hospital, an ambulatory care facility (meaning a walk-in clinic) and parking garage number two, all of which are nearing completion in chocolate-brown brick across Tulane Avenue from Tulane’s Medical School headquarters.

In theory, Tulane can improve the quality of its education by having its faculty hospitalized all of their private patients in a facility across the street from the faculty and student body. (Any overflow, of course, could be diverted to a cooperative community hospital.) In theory, these 300 additional beds will not detract from Tulane’s commitment to the 312,000 indigent people in Charity Hospital’s service area who have no other source of major medical care—a whopping 34 percent of the metro area population. In theory, Tulane can even make money on the deal, by charging service fees only partially remitted to the participating doctors, in the form of increased “faculty salaries,” with the university’s cut going to pay off its mounting debts. So in theory, Tulane can’t lose.

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**Beast of Beasley**

The Family Health Foundation (FHF), Louisiana’s pioneering effort at providing family planning services to poor people, was a political controversy from the days it opened its first clinic. In heavily Roman Catholic South Louisiana, the Catholic Church and ultraconservative Catholic physicians did everything they could to block the program and create trouble for it. The apparent empire-building ambitions of its founders, however, combined with clearly illegal manipulation of federal funds, gave FHF opponents all the ammunition they needed.

The troubles started with Sherman Copelin, the young Black political genius who rose through the ranks of the city’s antipoverty program to head the Model Cities agency of New Orleans’ Mayor Moon Landrieu. FHF needed Model Cities contracts to expand its birth control clinics into full-scale primary care delivery facilities in three low-income New Orleans neighborhoods—contracts that practically doubled the size of FHF’s multimillion dollar operation within a period of six months. Copelin began receiving a $1,000 a month fee from FHF while on the City Hall payroll, and testified before a local grand
In practice, however, these theories may not turn out to be the case—and that question is a particularly favored issue among surgeons. The July, 1970 issue of Surgery—a prestigious journal whose editorial board is headed by local surgeon Alton Ochsner (and a copy of which was thoughtfully provided at our interview with surgeon Claude C. Craighead, president of the Orleans Parish Medical Society)—shreds what it claims to be nine of the 10 myths surrounding university hospitals. In a survey of medical schools with “geographic full-time” (GFT) faculty—the men who can free-lance on the side—and “strict full-time faculty” (SFT)—the ones who have to practice in their university hospital only—Surgery discovered that only 24 percent of SFT faculties are “satisfied,” versus 72 percent of the GFT faculties. The reason can be adduced from the title of the article reporting these findings, “Economic Motivation in Academic Medicine.” GFT faculties make more

money, get more grants, tend to attract older and more experienced practitioners and have more time for medical society politics, among other things, Surgery contends.

HEAL, however, vigorously supports Tulane’s SFT university hospital proposal in its 1973 Master Plan. HEAL even goes on to muster alarm at the proliferation of hospital beds in other areas of the city that are duplicating investments in expensive equipment—and competing beds. HEAL wants the hospital beds to increase only at Complex headquarters and not among doctors and hospitals that are not under Complex control, and who, in fact, often resist some of the Complex-originating controls that accompany such things as residency programs.

Fee-paying hospital beds will be increased by this plan, that is. Because national health insurance will presumably let everyone take their business anywhere at government expense, the leaders of the Med-Ed Complex

jury that he received his first payment in a restaurant men’s room from an FHF consultant. Ultimately Copelin and his close friend Don Hubbard—who left City Hall to join the FHF staff—were to receive $100,000 for their services, money which they used to set up a private consulting firm and start up Superdome Services, Inc., a Black capitalism janitorial firm at the city’s domed stadium.

Ultimately, the federal government accused FHF founder Dr. Joseph Beasley and comptroller Oscar E. Kramer of defrauding the government of $770,000, by using dummy orders for modular, prefabricated health clinics that were never delivered as one of many fundraising schemes. A laundering operation involving Tulane University and a Texas-based nonprofit foundation was also exposed in the course of the federal investigation (leading to the naming of Tulane Medical Center chancellor and former US Surgeon General Dr. John Walsh as an indicted co-conspirator in the case). All this was added to even more lurid media coverage of previous disclosures: FHF-owned jet airplanes (with free flights to Las Vegas for Louisiana’s Governor Edwin Edwards), an apartment at the Watergate complex in Washington, ties to the CIA-front Agency for International Development in birth control clinics in South America, etc. Much of the seed money for starting these ventures and adventures came from the Rockefeller family and Ford foundations in the form of unrestricted grants, which Beasley and company utilized in a spectacularly unrestricted manner.

In the course of his rise to power, Beasley became dean of Tulane’s School of Public Health and Tropical Medicine and put many of his fellow faculty members on the FHF payroll in an attempt to help out Tulane’s desperate finances. There also was a scheme to have Tulane and FHF set up clinics in the proposed Pontchartrain New Town in New Orleans East (since cancelled by the federal government), which would have guaranteed Tulane paying customers for its new university hospital downtown. But those days are over with now. FHF was declared bankrupt and taken over by the Louisiana Health and Human Resources Administration (LHHRA), headed by one-time Beasley arch-rival Dr. Charles Mary, who had started tangling with Beasley while he was still head of Charity Hospital. LHHRA and the remnants of Beasley’s old empire are now headed by Dr. William H. Stewart, formerly the head of the LSU Medical School.
have also grown to fear that they may lose the patients they teach over to those institutions not under Complex control. Hence, HEAL proposes 300 beds for Tulane, 400 beds for a similar new facility for LSU (which, in the meantime, is negotiating for control over surplus beds at financially beleagured and recently expanded Hotel Dieu, just outside HEAL district boundaries), and also 1,200 new beds for Charity. With 1,200 new beds in a new wing on Gravier Street, Charity can then remodel some of its existing wards into private (fee-paying) and partial fee-paying facilities to compete for middle and upper-middle income patients whose private health insurance now takes them to Baptist or Touro or some other hospital.

Not only would it have more beds, but the Med-Ed Complex already has all the newest and fanciest gadgets and the best-trained manpower the community hospitals cannot compete for, and so, past some as-yet-undetermined future point in this strategy, the Complex will be able to exert more control over medical and administrative policy at community hospitals.

There was considerable bickering within the Tulane faculty, however, before this plan of action could be agreed upon. Some faculty members, it seems, face a net loss of income under the new set-up. Despite threats of mass walk-outs, Tulane Medical School Dean James T. Hamlin III says only four faculty members actually resigned. Students contend that most of the threat-makers have merely adopted a wait-see attitude.

Friends of Tulane had better hope the whole plan works. The university pledged all its assets to back up the $37.5 million bond issue, which requires repayment of $1.2 million cash annually from 1982 to 2009. That may not be quite as alarming a task in practice as it looks on paper, however, considering that Tulane is also seeking a multimillion-dollar federal block grant to build a new medical education building on the site of the current Trailways bus station, add five floors to its existing complex and remodel its lower floors into more fee-generating clinic space. In the event of a default, these new assets could likely be sold off to LSU or the state to pay off the bonds without damaging any of Tulane’s other real estate or academic holdings, like its medical library collection.

Some of the community hospitals, however, have begun to fight back against this consolidation scheme—which is where the story of HEAL’s next $60 million comes in. The 356-bed Ochsner Foundation Hospital in Jefferson Parish—sort of a Mayo Clinic-South and the home base for some of the most intransigent reactionaries in Louisiana medicine—wants $60 million in HEAL-sponsored tax-free bonds to double the size of its current facilities. Why a fat, elite preserve like Ochsner needs such a public subsidy is being explained in terms of support for its prestigious residency program.

Now bear in mind that a residency at Ochsner is probably the best that any medical student who elects to remain in the South can do. And also bear in mind that Tulane and LSU must share their residency privileges there—an arrangement which, until the arrival of HEAL, had always kept the Ochsner staff from being too overpowered by downtown academics.

At the very least, Ochsner is just flexing its considerable muscle to make sure that not all of the local action will be confined to downtown. And given the fact that four Ochsners are listed in the Tulane catalogue’s faculty and that founder Ochsner and a large number of his staff are all Tulane alumni, it may well be that the Tulane faction of the HEAL trust has once again succeeded in bolstering its flanks in its ongoing battle with the insurgents at LSU.

Those insurgents have been hiding their time, however, watching all of this with growing amusement, because they see themselves playing a long-term waiting game that is inevitably guaranteed to succeed. Tulane has won all of the plays it still has left to make, growing as fast and far as it will, in all likelihood, be able to do. LSU, by patiently tagging along, has obtained 11 blocks of expansion room in the northern sector of the HEAL development district, while Tulane is boxed in on four blocks immediately adjacent to the Civic Center. In the next major move on the
boards, LSU could end up symbolically dominating the whole HEAL ball game, depending on the outcome of some delicate negotiations going on now over HEAL's proposal for a joint library-learning resources center.

**The Final Move?**

Tulane's medical library contains 124,000 volumes, safely above the minimum 100,000 a regulation medical school should have. Rival LSU has 103,000 volumes, but many of them are split with the Dental School. Charity Hospital's library is a vile joke.

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**LSU could end up symbolically dominating the whole HEAL ball game.**

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Tulane's annual medical library budget of $226,500 ranks it 21st of 23 Southern medical school libraries. LSU spends $314,525 annually, but $141,536 of it goes to the Dental School, depositing it at the bottom of the ranks.

Some 42 percent of Tulane's holdings were acquired before the LSU school was founded, and only 15 percent of its collection is duplicated at LSU. So LSU has shrewdly decided to buy only books that Tulane doesn't have. Tulane participants in the joint library feasibility study bitterly denounce the proposal for shared facilities; because of territorial imperative "the stronger one will dominate." Or, "If HEAL runs it, I will resign right now. Look at the difficulty in running Charity Hospital." Or, "Tulane would lose its identity and be swallowed up or lost," all direct quotes from the sizzling text of a July 15, 1975, HEAL-financed feasibility study marked "confidential and intended solely for the information and benefit of the immediate recipient hereof."

An obvious bone of contention would be where to build this new center. And what to call it. Attorney Harry McCall, the Captain of Comus, the most prestigious secret Mardi Gras social organization in New Orleans, acting this time in his capacity as counsel to Tulane, avers that the wills governing certain of Tulane's books and library resources stipulate they could be donated only if the new facility is named after Dr. Rudolph Matas (a Tulane graduate who was also president of the Orleans Parish Medical Society in the 1890's) a concession to Tulane that LSU would probably grant.

In that event, there are three possible sites for the new facility: across Tulane Avenue from Charity, built into the front facade of Charity over what now makes up an art deco reflecting pool and court, or in a parking lot behind Charity's maintenance building and the VA Hospital. All sites are equidistant from the two institutions, thus letting LSU "win" without Tulane appearing to "lose."

HEAL also proposes that commercial space be made available for possible lease to the various area medical societies (Orleans Parish Medical Society currently has its offices at Tulane) and to organizations like the American Heart Association. This consolidation of health-affiliated institutions into the Complex would be aided by constructing new headquarters for the Louisiana Hospital Television Network, with its bank of videotapes that Louisiana physicians (at participating, Complex-allied hospitals) can refer to whenever their memories grow dim. Along with several additional rooms full of the latest multimedia equipment, the new Rudolph Matas library would become the literal brain and command center of the Louisiana Med-Ed Complex.

And in a Faculty Club, also proposed by HEAL's consultants, a posh dining facility likely to be located on the rooftop overlooking the empire its construction will symbolically crown, the faculties of both schools can come toast each other in the company of other personages from around the state who "have contributed to the development and growth of the health sciences."

If you can't beat them, Tulane will one day soon come to discover—and may have already, long ago—you might as well join them. Or at least, finally, step aside gracefully and let them in.

—Bill Rushton

*Bill Rushton is a graduate of the Tulane School of Architecture and worked as an advocate planner for the War on Poverty before assuming his present position as architectural critic and managing editor of the Courier, a New Orleans weekly. This article is adapted from a piece appearing in the August 28, 1975 edition of the Courier.*
Vital Signs

CONFIDENTIALLY SPEAKING

Have you ever wondered what people have always wanted to know about their health, but were afraid to ask their doctors? An experimental dial-a-tape program conducted by Boston City Hospital and offering 189 taped health messages found the most frequently-asked questions concern marijuana (asked by parents rather than by users), when to see a psychiatrist and how to stop smoking. Circulars listing the tapes, which cover a wide range of illnesses and health information, are distributed at health centers, hospitals, libraries and neighborhood government centers. In its first two months, the program received 35,000 calls. Additional tapes on the "top ten" include: "I'm Just Tired, Doctor," "Masturbation," "Vasectomy," "Fears of the After-40 Man," "Baldness and Falling Hair," "Diaphragms, Foam and Condom" and "Am I Really Pregnant?" (Boston Globe, March 18, 1975.)

HOSPITAL COSTS: AN OLD STORY

Hospital costs in 1974 increased at 17.5 percent, the highest rate recorded since the American Hospital Association began keeping records in 1963, the Association reports. The average cost per day nationally was $131.20 in the first six months of this year and in some major big city hospitals it approached $200. Patients are seeking less expensive forms of care, the AHA also reports. Thus hospital admissions declined 0.3 percent last year—the first such decline in ten years, while outpatient department use increased by 8.9 percent.

In the Washington, D.C. area, the cost of a day in the hospital increased from $164 to $194 in the last year, an 18.3 percent increase, according to Washington Blue Cross, which is projecting a cost of $400 a day by 1980. This is due both to inflation and to new hospital construction. Washington will have a surplus of 1,700 hospital beds by 1980, costing "hundreds of millions of dollars," according to Blue Cross.

(Medical World News, September 22, 1975; Washington Post, September 22, 1975.)

MEDICINE ON THE RUN

"The nation's first systematic study" of doctors' office practices, done for HEW by the National Opinion Research Center, provides some insights into American medical care. Findings, reported by the Washington Post, include:

■ The average American patient sees the doctor for 12 minutes during an office visit—10 minutes if he sees a general practitioner and 15 if he sees a specialist.

■ The average general practitioner sees 118 patients a week, the average medical specialist, 85. Busiest of all is the pediatrician, who sees 139 children a week on the average, not to mention their parents.

■ In most of the nation, twice as many people go to general practitioners or family doctors as to specialists. In the Northeast, however, people see specialists a third more often.

■ Doctors who practice alone rather than with others prescribe drugs 15 percent more often, but order X-rays
or lab tests much less. Specialists in internal medicine order X-rays and lab tests two to three times more often than general practitioners.

Four groups accounted for nearly half of all visits—those without illness or for routine exams (17 percent), respiratory illnesses, from colds to pneumonia (15 percent), heart and blood vessel trouble (9 percent) and nerve and sensory problems (8 percent).

(Washington Post, July 16, 1975.)

BUYING A CURE

Wanted: Surgery Department, complete with department head (only medical superstars need apply), faculty, housestaff, federal grants and special equipment. Price: Any (to be paid in salaries, tenured positions, space, staff, research opportunities). Please contact: University of Washington Medical School.

This ad might have appeared two years ago in the annals of the medical community as the University of Washington Medical School sought to cure the doldrums of its Department of Surgery. The Department had suffered a decline in residency applications and research funds, poor board exam results by its housestaff, placement of its surgery residency program on probation by accrediting authorities and loss of its chairman.

The prescription? Obvious—buy a new department, if you can. And that’s approximately what the University of Washington tried to do. In a practice that medical educators fear will become more common, Medical World News (September 22, 1975) reports that the University offered well-known Dallas trauma and burn surgeon, G. Thomas Shires, “a package deal.” Shires’ part of the package included delivery of himself and 23 staff members (22 lifted wholesale from his former department at the University of Texas Southwestern Medical School in Dallas and one brought in from Oklahoma), federal funds for a burn and trauma center and special equipment. (Never mind that this move nearly wiped out the Surgery Department at Dallas.) Precise contents of the University of Washington’s package have yet to be revealed but are known to have included salaries higher than those for comparable existing department members and an unspecified number of tenured department positions.

The cure was effective. Residency applications jumped from 120 in 1972 to 800 after the Texas team took over. Surgical services at University Hospital increased by 50 percent. The trauma unit at Harborview Medical Center, operated by the University, flowered with the addition of Shires’ burn center. And the new team is bringing considerable new federal grant money to the University.

The only problem was in the side effects. An angry staff member brought suit against the University, and seven others lodged a complaint with the State Higher Education Personnel Board concerning hiring practices. The suit was settled out of court, but a week later Dr. Shires announced he was leaving Seattle to become Chief of Surgery at Cornell University Medical Center in New York. He leaves behind him much of his team and equipment, as well as several state audits of both hiring and financial practices at the University of Washington.

PERSISTENCE

Applicants to medical school don’t give up easily, a study by a Johns Hopkins research team has found. More than a quarter of the applicants rejected in 1971 were studying in US or foreign medical schools in 1973, and nearly 40 percent of those who were still listed as “unaccepted” in 1973 were still trying to get in. Of the 2,000 students polled, less than half had abandoned plans to become doctors.

The most important factors in an applicant’s determination, the study found, were not admission test scores, socio-economic background or occupational values, but were the applicant’s sex, prior career plans and the kind of counseling and support they received after the first medical school rejection. Men were more likely than women to keep trying, as were applicants who had never considered any other career. Those who had made con-
tingency plans usually followed them after the first rejection. Finally, those most likely to reapply were those encouraged to do so by family, friends and counsellors. Only half of those who never make it into medical school take other jobs in the health field.

(New Physician August, 1975.)

THE FEDS BEAT A RETREAT

Under the tutelage of its newly appointed Secretary, David Mathews, HEW seems to be beating a hasty retreat from a growing bottle initiated under the Nixon Administration on the regulatory front. Specifically:

- HEW withdrew for revision its utilization review regulations for hospital admissions under Medicare and Medicaid shortly after losing a round to the American Medical Association, which had brought suit and received a temporary injunction against implementing the regulation.
- HEW postponed imposition of penalties mandated by 1972 legislation for states failing to meet requirements for utilization control under Medicaid.
- HEW decided not to appeal a permanent injunction barring elimination of the 8.5 percent nursing differential paid for the hospitalization of Medicare patients. Suit had been brought by the American Hospital Association.

Prior to Mathews’ dovish entry on the scene, a wave of HEW regulations, nearly all involving use of Medicare and Medicaid funds, had the health establishment sufficiently up in arms for it to file a spate of law suits. Apparently the health establishment is picking up Mathews’ signal. The Pharmaceutical Manufacturers Association, for example, is reported to have postponed going to court over regulations requiring use of generic drugs under Medicare and Medicaid pending talks with the HEW Secretary. Could this retreat have anything to do with the upcoming presidential election?

(Washington Report on Medicine and Health, September 8, 1975; Hospital Week, September 26, 1975; Washington Developments September 17, 1975.)

SCORE ONE FOR WORKERS’ HEALTH

As reported in the November/December 1974 Health/PAC BULLETIN, the current US standard for asbestos exposure in the workplace was based on the results of a single British study—a study under attack for underestimating the incidence of asbestos-caused lung disease.

Now the US Department of Labor has been sufficiently embarrassed to propose a lowering of the federal standard. Under the Occupational Safety and Health Act (OSHA), the Labor Department proposes to cut the allowed exposure by a factor of 10, from the present 5.0 fibers per cubic centimeter to a new limit of 0.5 fibers per cubic centimeter. Plans for a 1976 standard of 2.0 fibers per cubic centimeter, originally proposed by the Labor Department, have been scrapped.

(New York Times, October 5, 1975.)

A NEW PUBLICATION

Women and Health, a forthcoming bimonthly academic journal, is being produced by women from the State University of New York, College at Old Westbury, Biological Sciences Program. The inaugural issue is slated for publication in January, 1976. The journal is designed to share research and ideas on policy, structure and issues in women’s health-care delivery. It will focus on women as health workers, female physiology, the content of women’s medical care and women as health-care consumers. Subscriptions cost $10 for one year, $18 for two and $25 for three years. Make checks payable to Women and Health, Biological Sciences Programs, SUNY/College at Old Westbury, Old Westbury, N.Y. 11568.

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