1 Trustees:

THE CAPITAL CONNECTION. With the declining importance of private money in hospital finances, the role of trustees is changing. It's no longer who you are, but who you know.

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BORN AGAIN? An update on prospects for NHI under Carter pictures a conflicted Congress led by an ambivalent new administration.

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Trustees

Conventional wisdom attributes trustees' involvement in nonprofit hospitals to altruism, while the radical approach has been to assume that they are really profiting through deals hidden from public view. In truth neither of these views is sufficient to understand the role of private nonprofit hospital trustees.

The following article explores several questions concerning hospital trustees: Who
are they? How are they chosen? To what degree do they wield power in the hospital? What’s in it for them? In seeking answers to these questions, we analyzed the boards of San Francisco’s eight private, nonprofit hospitals and interviewed thirty hospital trustees and administrators. Although our conclusions are specific to San Francisco, we consider them applicable to many cities in the country and perhaps to the nation as a whole.

Trustees are those legally responsible for a hospital fulfilling its corporate charter. As such they have legal authority over everything that goes on in the hospital. Simply because they have legal authority, however, does not necessarily mean they have power. Most students of nonprofit hospital policymaking conclude that trustees exercise little power in the hospital and that power rests largely with doctors and the administration. (1) Our study of San Francisco hospital trustees does not differ significantly from these findings. Until very recently, nonprofit hospital policymaking has rarely been the province of trustees.

Historically hospital trustees were not supposed to run their hospitals, report several San Francisco board members. Hospitals were workplaces for private doctors; yet doctors lacked sufficient capital to build and operate them. Thus, doctors approached wealthy businessmen to donate funds and, incidentally, to occupy a place on the hospital board. Trusteeship and philanthropy went hand in hand. In the words of Joseph Sloss, former President of Mt. Zion Hospital, “The board meeting ended with everyone getting out their checkbooks.”

Growth of the health industry is slowly changing the relation of the trustee to the hospital. No longer can individual philanthropists give sufficient sums to construct and operate hospitals. Capital investment now relies on loans, and hospital operation is tied to private and government insurance. These changes have been slow to reflect themselves in the day-to-day functioning of most hospital trustees, but the changes are on their way.

**The Outer Circle:**
**Political and Economic Role**

One unmistakable feature of current hospital boards of trustees is that most of their members do little. As the president of one board put it, “If the ground opened up and swallowed the board, the hospital would go on; but if it happened to the administrator, the hospital wouldn’t last three days.”

As a rule, hospital boards meet as a whole once a month, usually for lunch. In addition, the members serve on various committees—building, nominating, etc.—which meet when necessary. The most important committee is the executive committee, which makes decisions for the entire board should anything arise between monthly meetings. For most of the board members, the time spent in meetings is the bulk of the time they spend on hospital matters.

If most trustees simply rubber-stamp the decisions of their administrator or board officers, why do they serve on hospital boards? It appears that trustees do use their power in society to help the hospital implement its policies. Essentially, they continue to perform their philanthropic function, but in new ways that are more appropriate to the current economic era.

In the economic realm, trustees can assist the hospital by donating or raising money for hospital expansion. This function was more important in the past than it is at present. Wealthy citizens used to be invited onto hospital boards solely in the hope that they would make contributions. Several San Francisco trustees denied the importance of personal wealth today, saying that the day of the “letterhead trustee” has passed. “The patron-type of trustee is disappearing.”

Private philanthropy accounted for two-
thirds of the funds for voluntary hospital construction in the 1920s, and 40 percent as late as the mid-1960s. By 1969 charitable donations were only 19 percent of the funds for construction, and by 1973 they had fallen to 13 percent. While in dollar amounts charity to medicine continues to rise, private philanthropy makes little dent in a national health bill that runs to $118 billion a year. Moreover, insofar as philanthropy is important, hospitals increasingly hire professional fundraisers to perform functions previously carried out by board members.

The trustee who neither gives nor solicits funds on a personal basis may help to raise money for the hospital in another way—by using his or her organizational connections. Trustees obtain contributions from companies in which they are executives or from foundations and charities with which they are connected.

With personal philanthropy declining in significance, the main source of capital for hospital improvements is now the nation’s money market: loans and the sale of hospital bonds through banks and insurance companies. Well-connected trustees are helpful in these matters. For example, one San Francisco hospital, while both in debt and short of cash, was pressured for more financial information by its loan officer at Wells Fargo Bank. The situation was delicate: if the hospital could not satisfy the bank, it might lose its line of credit and go under. Three trustees were “able to go to the head of the bank, Dick Cooley,” because “three of us knew him in an informal way, on a first name basis.” Saving the hospital’s bank credit is worth far more than any private donor could give.

In addition to their economic support, trustees provide the political muscle that has become increasingly important for a hospital’s survival. There are important government monies to be had, particularly federal construction subsidies and research grants. Also there is the matter of good relations with public regulatory agencies, ranging from comprehensive health planning boards to city planning and building commissions. Political connections can be as important as monetary contributions.

Political efforts of trustees in some cases focus directly on matters of health—serving on health planning agencies, city planning boards, etc. In other cases, trustees are valuable for generalized political influence. Jack Hume, former Governor Ronald Reagan’s campaign finance manager, for example, would simply call the Governor whenever his hospital had a problem. This kind of influence can be very helpful, for example, in obtaining a state loan guarantee.

The importance of outside forces, especially government agencies, is increasingly recognized by trustees. As one put it, “Now we’re unable to make any decision without looking outside. Nine out of ten items [on the agenda] have to do with outside.” Board members admit that political lobbying for the hospital is one of their functions. Seeking public support, or neutralizing public displeasure, can be as important as fundraising. Often it brings dollars, but even when it does not, it allows hospitals to operate with less interference.

NOTICE

We welcome Keith Bendis as our new illustrator.
And we give our best wishes to Bill Plympton in his new endeavors as a nationally syndicated political cartoonist.
The trustees' role in lining up economic and political support explains why many hospital boards are so large. As one trustee commented, his board did not need so many members—more, in fact, than those who direct the fortunes of General Motors—just to run the hospital. One study finds that the size of a hospital board relates to the nature of its tasks: if it seeks to raise private monies and build public support it must be large; if it aids in managing the hospital it can be smaller. (2)

The Inner Circle: Policy Making

While the role of most trustees is limited to helping the hospital implement its policies through their economic or political support, a few active trustees—the "inner circle" of each hospital board—do more: they play a role in policy formation.

- Administration: A key decision for the board of trustees is the hiring and firing of the chief administrator. The board does not even hire the rest of the administrative staff: "I serve at his [the administrator's] pleasure, not the board's," said an administrative assistant at St. Francis. The board president of another hospital declared that the administrator has "the right to have his own staff under him." He viewed it as an aspect of "letting him do his job."

Trustees occasionally fire administrators, but we found them reluctant to discuss their reasons. Some, of course, are obvious, as in instances where an administrator is alcoholic or runs off with the funds. Only a few trustees mentioned poor financial management as the basis for firing the administrator. Among these few, however, were former board presidents. One said, "The first thing a
board would notice is fiscal incompetence," while the other explained that trustees take notice "when you're losing your ass financially." An authoritative study of commercial corporations, moreover, cites financial problems as the reason a board fires its chief executive. Thus it seems likely that poor financial management is the single most important reason for firing an administrator.

This is borne out by our study of San Francisco hospitals. The two hospitals which have had financial difficulty for many years, French (a for-profit hospital) and St. Joseph's, have each hired and fired several administrators in a space of a few years, finally contracting with professional hospital management corporations to administer the hospitals. The president of another hospital board reported that an administrator there had made financial errors and was asked to leave.

Mt. Zion Hospital recently dismissed its administrator, due not only to financial difficulties, but to morale problems among the staff. Key to the trustees was the discovery that some important administrative assistants were leaving the hospital for other jobs. The administrator lacked the confidence of the medical staff, as well as that of some trustees. It was said he "ruled by fear," and the president even wondered if her own office was bugged. The Mt. Zion case, however, is exceptional; in general, the board takes financial success as the basic indicator of the administrator's ability.

* Staffing: With the exception of hiring and firing the chief administrator, even the most active board members have little or no interest in staffing policy. This is left to the administrator. Mt. Zion Hospital, for example, is cutting back staffing on its floors and has markedly increased the number of registry nurses, while St. Luke's introduced a new acuity system which increases the workload per nurse or aide; in these and other cases, hospital trustees know little about either staffing patterns or staff cutbacks, other than their impact on hospital finances.

Other staffing issues involve wages, fringe benefits and union contracts for hospital employees. In some parts of the country, trustees enter directly into negotiations with unions on behalf of the hospital, but in San Francisco hospitals belong to a bargaining unit which relies on the efforts of a hired negotiator. The board is involved, said one trustee, only in terms of dollars—"only in terms of when we'll take a strike."

* Services: The next level of policy making concerns which services the hospital will offer. Here the initiative is held by the medical staff and administration. Boards of trustees ask if a service will pay for itself, and if so tend to rubberstamp the decisions of professionals. In crisis situations, however, trustees may become actively involved in service decisions. Financial difficulties at St. Luke's, for instance, have caused the board to consider closing the outpatient clinic. The board found the clinic to be losing $20,000 per month. After three subcommittee meetings, the board set a target date of six months in which to reduce the deficit to $10,000 per month. Although this may simply be taken as a financial decision of a hospital swimming in red ink, it is, more importantly, a policy decision vitally affecting those low income patients who will be hit by the cutback. Mt. Zion also has a large outpatient department, and its financial problems have led one trustee to predict the need for Mt. Zion to "cut down on free and part-pay patients," adding that "clinic care will be the first to go." Another said, "Some perfectly wonderful programs will go down the tubes."

* Survival: Finally the highest level of policy involves the basic decision of whether or not to keep the hospital open and on what basis. In the past this question arose only rarely, but today the oversupply of hospitals and their financial problems make it an ongoing question. This level of policy is made by the board of trustees, particularly by the inner circle. Questions of survival, merger, and federation are corporate matters and are resolved at the trustee level.

**At the Center: Doctors**

Historically, doctors, not trustees, are key to the production of hospital services. Trustees have provided buildings, equipment and, most importantly, the trained workpower of hospital employees; but none of those factors can be put into motion without the legally licensed skill of the physician. Doctors have increased their...
National Health Insurance

While optimism about National Health Insurance (NHI) may be running high as a result of the recent elections—with many predicting it is an issue whose time has come—action on NHI may not be forthcoming for some time, if at all.

On the optimistic side, Jimmy Carter, a Democrat, won the Presidential election and overwhelmingly Democratic majorities in the House (289-142) and Senate (62 to 38) will overcome one important obstacle in the last Congress—President Ford’s threat to veto any new spending programs, including NHI. Rep. Bob Eckhardt (D-Tx.), Chairman of the Democratic Study Group, noted that during Ford’s term an NHI plan could not be enacted “even with the Democratic majority in Congress, as long as we have a President of the opposite party.”

Beyond the mere fact that Carter is a Democrat, however, is the fact that he has been a strong supporter of the NHI concept and has vowed to act on it quickly. For example, Carter stated “although it’s going to take 12 months to assess specifics on tax reform and governmental reorganization,” he would not wait for “welfare reform and national health insurance. I intend to be ready to go with that the first of the year [1977]. I’ll do as much as I can before the inauguration.”

As evidence of Carter’s intention to move quickly, he developed a panel of health advisors with a mandate to write an NHI plan ready to be introduced in January. Panel members include former Social Security Commissioner Robert Ball, currently with the National Academy of Sciences’ Institute of Medicine, and former HEW health insurance expert Ruth Hanft, a Dartmouth College professor.

Although Carter has countered Republican charges that he would be a “big spender” by stating “there will be no programs implemented under my Administration unless we can be sure that the costs of those programs are compatible with my goal of having a balanced budget before the end of that term,” NHI was specifically cited as an exception to that rule. “There is one possible major program that may cause a deviation from that [federal spending ceiling]. If we take large amounts of presently private income that goes into the health system and administer the health program through federal expenditures, that might cause an increase of maybe one or two percentage points. But, that would be the only exception... I think this is one element of increased federal spending that would be completely acceptable to the American people.”

Also on the positive side is the Democratic platform’s call for “a comprehensive National Health Insurance system with universal mandatory coverage... financed by a combination of employer/employee shared payroll taxes and general tax revenues.”

This means, of course, that there should be more than a minimal degree of compatibility between the majority in the Congress and the White House on the NHI issue.

Carter’s commitment to a plan similar to that in the Democratic platform is strengthened by the fact that his NHI stand was a key to winning the support of organized labor so essential to his campaign. On Labor Day, for example, Lane Kirkland, AFL-CIO Secretary-Treasurer, commented, “the choice between a Carter or Ford Administration is a decision for or against National Health Insurance,” and indicated the renewed commitment of organized labor to its passage.

In sum, Carter believes “we need a national health program. I mean to do it. Nobody’s ever done it. It’s been talked about by very fine Presidents since as early as Harry Truman.” Furthermore, the heavily Democratic Congress, which has had President Ford as an excuse for inaction on NHI, will now have no partisan reason for not fulfilling the Democratic platform provisions pertaining to NHI.

A Hard Road

Nonetheless, this is not the first time the cards have seemed stacked for NHI enactment. Although the change of party in the executive branch makes political prognostication particularly difficult this time around, it is probably safe to project that the road to NHI enactment will not be easy.

One immediate question is posed by
Carter's lack of specifics concerning the precise nature of the plan he favors. Although he has a large debt to organized labor, which strongly backs the Health Security Act, he carefully avoided outright endorsement of the act throughout his campaign. Instead, he supported its major features—comprehensive, universal coverage financed by a combination of payroll taxes and general revenues.

Also, throughout his campaign Carter repeatedly backed away from immediate, full-scale implementation, indicating that NHI would be phased in "as rapidly as 7
revenues permit." He even clouded the issue of government financing and administration: "There are several ways it could be paid for—employer-employee contributions, increase in the general tax level. Of course the question that still has to be addressed is how much of the program would still be financed through, or administered by, the private insurance sector. These questions will have to be answered later on." The phasing, according to Presidential advisor Peter Bourne, will be by "service increments, not population increments." Among the top service priorities are coverage for catastrophic and emergency care. Maternal and child health are also high priority items, although they are directed at specific population groups.

In addition to the question of Carter's position, there were a number of factors in the 94th Congress that clouded enactment of an NHI Plan. With the economy still in trouble, and virtually no hope for quick recovery, Congressional liberals who favor publicly financing NHI faced serious questions about the nature of additional taxes.

One proposed source of financing—payroll taxes—is by nature regressive. Moreover, many observers believe that payroll-based Social Security taxes must already be increased just to cover projected deficits in the Social Security trust funds.

The other favorite—use of general revenues—has serious drawbacks as well. Given the severe federal, state and local budgetary problems, initiation of a major new spending program such as NHI would probably mean cutting current programs. More important, the use of general revenues may later jeopardize NHI itself. Many states, for example, in response to tight budgets, have instituted reductions in Medicaid coverage. The warning is clear: health programs may fare poorly if forced to compete with other priorities—especially during hard economic times.

Private financing of NHI, on the other hand, is anathema to many of its strongest advocates. Organized labor, for instance, worked to block NHI plans that relied on private rather than public financing and administration. Many liberals prefer to see NHI enactment postponed rather than accept a privately financed and administered plan, fearing such a plan would preclude passage of a publicly financed and administered measure when the economy improves.

Another major obstacle to Congressional action is concern about current delivery programs, especially Medicare and Medicaid. The cost overruns of both programs have been monumental. Coupled with worries about trust deficits mentioned above, they are causing second thoughts vis-a-vis NHI among many Congressional liberals.

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Attempts to impose cost and quality controls under Medicare and Medicaid have met little success to date, creating skepticism about such controls under NHI. With the recent, widespread publicity spotlighting Medicaid and Medicare abuses, Congressional NHI advocates are understandably nervous about turning administration of such a major program over to a bureaucracy already racked with problems.

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No Real Plan

Perhaps the greatest obstacle in the path of NHI enactment, however, is the lack of agreement among proponents of various NHI plans. While there is general agreement on the desirability of NHI, there is no consensus concerning the fundamental principles that it should embody, nor is there agreement on such basic issues as financing, administration, scope of benefits and limits of coverage.

Many analysts felt that a compromise NHI plan was in the offing when Senator Kennedy (D-Mass., and Chairman, Health Subcommittee, Senate Labor and Public Welfare Committee), a prime Senate sponsor of the Health Security Act, and Representative Mills (D-Ark., and former Chairman, House Ways and Means Committee) introduced the Comprehensive National Health Insurance Act (S. 3286/H.R. 13870). Almost immediately after introducing the measure
early in the second session of the 93rd Congress (1974), Mills held extensive NHI hearings and began mark-up sessions. Hopes for quick NHI action were doused, however, when absolutely no agreement could be reached among Committee members on issues of financing and administration and Mills suddenly cancelled the mark-up sessions. There is little reason to believe that agreement within Committees—or within Congress as a whole—is any closer than it was when Mills was forced to halt action.

Contributing to the lack of Congressional consensus is the scarcity of hard data available, reducing proponents of various NHI positions to arguing primarily on the basis of personal opinion. No one really knows, at this point, the facts about such areas as: costs of providing specific services; potential impacts of services (e.g., home health care) on costs and utilization of others (e.g., inpatient hospital and extended care); impacts of increased or decreased utilization on the per-unit costs of a service; and, potential impacts of various forms of cost sharing, such as deductibles, coinsurance and copayments, on utilization and costs.

Much existing information is contradictory. For example, a General Accounting Office (GAO) study differs with other recent studies on whether claims processing costs for Medicare are higher under the Social Security Administration, Blue Cross-Blue Shield, or commercial insurance companies.

There have been virtually no studies of the impact of various plans on the actual health status of individuals to be covered, the availability or accessibility of services, or the health status of the general population. Indeed, workable measures of the quality of care that are acceptable to the health community have never been developed.

Jurisdictional Disputes

As if the above obstacles were not enough, Congressional action has also been forestalled by battles concerning Committee jurisdiction over NHI legislation.

In the House, the Health Subcommittee of the Ways and Means Committee, chaired by Rep. Rostenkowski (D-Ill.), vies for jurisdiction with the Health Subcommittee of the Interstate and Foreign Commerce Committee, chaired by Rep. Rogers (D-Fla.). Both Subcommittees have proceeded independently on the NHI issue with duplicative hearings.

In the Senate, the dispute is between the Health Subcommittee of the Labor and Public Welfare Committee, chaired by Sen. Kennedy (D-Mass.), and the Senate Finance Committee, chaired by Sen. Long (D-La.).

Attempts to resolve the dispute in the House by the Democratic Study Group’s Health Task Force, chaired by Rep. Eckhardt (D-Tx.), have failed, as have direct attempts by Rogers and Rostenkowski. Eckhardt has suggested an ad hoc House Committee, including members from Interstate and Foreign Commerce and Ways and Means, to break the jurisdictional deadlock. Eckhardt feels that Rostenkowski’s Subcommittee is “too parochial about its Committee jurisdiction,” while Rogers’ Subcommittee is used to “narrow guidelines.”

While there is general agreement on the desirability of NHI, there is no consensus concerning the fundamental principles that it should embody.

On the Senate side, both Committees claiming NHI jurisdiction held NHI hearings prior to the 94th Congress. During that Congress, the disputes never reached the magnitude of those in the House since the Senate remained relatively dormant on the NHI issue while waiting for the House to act. When and if it becomes apparent that the House will send an NHI bill to the Senate, or Senate NHI activity increases, the jurisdictional disputes in the Senate are likely to equal or exceed the proportions reached in the House.

Quick and full implementation of NHI in the early period of the Carter Administration, then, seems unlikely. Rather Carter and the Congress are more likely to view Medicare/Medicaid as NHI laboratories and focus on major reforms of these troubled programs. One could foresee, for example,
considerable experimentation with benefits, cost sharing provisions, payment and administrative mechanisms, and so forth under Medicare/Medicaid in order to generate a data base for use in development of an NHI plan. Certainly Carter and the Congress will make a concerted effort to reduce Medicare/Medicaid program abuses in order to reassure the Congressional liberals—many of whom are becoming skeptical—concerning the government’s ability to administer an NHI plan.

The Administration and Congress can also be expected to continue reform and development of programs such as Professional Standards Review Organizations, health planning, health manpower and Health Maintenance Organizations—viewed by many health analysts as necessary components of NHI if costs and quality are to be controlled and availability and accessibility are to be guaranteed.

Carter himself has indicated that "National Health Insurance will not be enough. Reform of the delivery system must accompany financing reform. For example, there must be greater emphasis in our health care system on preventive care. Our purpose must be to promote health, not just to provide health care as such. We must emphasize the early detection and prevention of the cripplers and killers of our people, as we did in a major three-year program when I was Governor of Georgia."

Carter has also indicated that the preventive approach must go beyond biomedical research and physical examinations to such initiatives as adequate family income, a clean environment, occupational health and safety, and better educational programs regarding safety, nutrition and self-care, "all of which reduce the need for much more expensive hospital treatment." What policy impact this broad statement will have remains to be seen.

Perhaps the likeliest course in the short run is suggested by a plan such as that of Sen. Javits (R-N.Y., and member, Health Subcommittee, Senate Labor and Public Welfare Committee) to improve the Medicare program and to provide coverage for mothers and children. This type of "mini-NHI" plan has been mentioned by Carter as a possible first step in implementing a full-scale NHI program and might be acceptable to proponents of more comprehensive plans such as Health Security. This would be especially true were a "mini-NHI" plan to include such basic mechanisms as public financing and administration, permitting eventual expansion to comprehensive benefits covering the entire population.

The 95th Congress seems likely to take some action towards NHI. The nature of that action, however, is likely to be more limited than many observers have projected.

— Jeffrey A. Prussin

(The author is a private consultant on health care organization, delivery and financing based in Kensington, Maryland. He is also editor-in-chief of "HMO and Health Service Report" and "Washington Information: National Health Insurance.")
Trustees

(Continued from page 5.)

power by avoiding the status of salaried hospital employees. Rather, they gain staff privileges at several hospitals. Thus, they can pick and choose hospitals in which they exercise their skills, thereby determining the number of services a particular hospital produces and consequently the revenue it receives. Thus it is the doctors, not the trustees, who have a fundamental economic stranglehold over the hospital.

Physicians' power is not absolute; they are dependent on access to the facilities and hospital employees for a considerable portion of their income. The present overexpansion of hospital facilities, however, enhances their power. And their ability to leave one hospital for another virtually guarantees them the additional facilities, equipment or personnel they desire. The economics of nonprofit hospitals, then, vests major power in the physician, and, until recently, the trustees as legal owners have not challenged this arrangement.

Why Become A Trustee: Profit

While trustees generally attribute their motives to community service, critics, noting the preponderance of businessmen, have looked for other motives, usually monetary. This study, however, found that most trustees do not join hospital boards for personal monetary gain.

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<td>Trustees' Occupations</td>
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<td>Businessmen, Bankers, Financiers, Lawyers</td>
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<td><strong>Hospital</strong></td>
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<td><strong>St. Francis</strong></td>
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<td><strong>Pacific Medical Center</strong></td>
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<td><strong>Mt. Zion</strong></td>
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<td><strong>St. Luke's</strong></td>
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<td><strong>Children's</strong></td>
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<td><strong>Ralph K. Davies</strong></td>
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<td><strong>St. Joseph's</strong></td>
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<td><strong>(5 wives)</strong></td>
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<td><strong>St. Mary's</strong></td>
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<td><strong>(28 wives)</strong></td>
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The hospital boards included in this study are those of the major private, nonprofit hospitals in San Francisco. The University of California Hospitals, though governed by the big-business-dominated Board of Regents, was omitted because it is technically public. The Kaiser Foundation Hospital, also governed by a board of corporate executives, was left out because it is one component of a prepaid group practice and thus is an entirely different entity from the typical nonprofit hospital. French Hospital has been considered a for-profit institution by the State of California. The few remaining small nonprofit hospitals are insignificant in number of admissions and are not likely to survive as independent entities. Board rather than the governing board (which is composed of seven nuns) because the hospital is planning to secularize its board, presumably elevating CAB members to trusteeship soon.

The trustees were counted in 1975, but due to frequent changes on hospital boards, including changes in numbers of trustees, the listed numbers may not be exact.

In the chart, the occupations of the husbands of female trustees are placed in parentheses in addition to their listings as "female civic leaders."

Information on the occupations and connections of trustees was gathered from Who's Who, Poor's Register of Corporations, Directors and Executives, Dun and Bradstreet's directories, and similar compilations on businessmen.
In recent years, various private hospital trustees have been accused of conflict of interest. In 1972, a six-part Washington Post series on the Washington Hospital Center reported that ten out of the 38 hospital trustees had been involved in conflicts of interest. A similar case involved five trustees of Sibley Memorial Hospital, also in Washington, D.C. In Altoona, Pennsylvania, ten hospital trustees were accused by Insurance Commissioner Herbert Denenberg of conflicts of interest involving banks. An Oklahoma authority issued bonds which benefited both the hospitals and the banks with which the authority members were associated. In Brooklyn, a local builder sitting on a hospital board landed a construction job, and in San Mateo, California, Frank Burrows, the owner of a construction company, turned up with a $30 million contract to rebuild Mills Memorial Hospital of which he is a trustee.

In its popular definition, a conflict of interest occurs when a person with a position of public trust, usually a government official, uses his or her position for personal financial gain. Hospital trustees are subject to scrutiny for conflicts of interest because nonprofit hospitals are tax-exempt and trusteeship therefore involves an element of public trust.

A conflict of interest can take place on two levels: self-dealing and outright "ripoffs." Self-dealing occurs when a hospital does business with a company affiliated with one of its board members. Self-dealing always benefits the trustee who obtains the hospital's business, since the business might otherwise have gone to a competitor. But simple self-dealing need not hurt the hospital, and might actually benefit it, as in the cases of a relatively low construction bid or a lower than average interest rate on a bank loan. Such simple self-dealing has no prejudicial moral connotations, but it could represent an explanation for trustees joining hospital boards.

Unethical conflicts of interest occur when trustees' companies benefit at the expense of the hospital. From the legal standpoint, even a major ripoff may be legal as long as the hospital trustee abstains from voting on any matter that affects his business firm. Since members of the board are often friends, they can scratch each others' backs without legal consequences.

How important are conflicts of interest, however? In particular, how accurate is the seemingly radical notion that the actions of hospital board members are based solely on a desire to make a financial gain out of their association with the hospital? This is also an important question because the unspoken assumption behind the muckraking journalism exposing conflicts of interest is that who serves on the hospital board is unimportant so long as no one makes a buck from it.

Cases of self-dealing occur to a limited extent in San Francisco hospitals. The insurance business of Ralph K. Davies Medical Center is handled by the firm of one of its trustees. The stock portfolio of Children's Hospital is managed by the firm of the husband of a hospital board member. These cases are by no means sufficient in number or in financial significance, however, to explain the motivations of San Francisco trustees in general and our study must conclude that making money is not the principal reason why San Francisco businessmen join hospital boards. The vast majority of trustees simply do not appear to be doing business in the hospital boardroom.

Moreover, it is a false conception of capitalism to think that windfall ripoffs form the basis of the system: big corporations make their money in the ordinary, day-to-day operations of their businesses. Big businessmen whose time is money would profit more by staying away from hospital board meetings than by attending them. Except for those corporations selling hospital products or services, there are few financial benefits to be gained from trusteeship. So for every instance of monkey-business, there are many trustees who receive no money from the hospital and who, in fact, contribute money to it. In San Francisco, conflict of interest is a permanent side show, but not the main arena.

(Continued on page 14.)
Trustees: It's Who You Know

Hospital boards are self-perpetuating. Board members select their successors or reselect themselves through a relatively simple procedure. Internal nominating committees propose new candidates, take suggestions from the entire board and screen prospective members. Most boards stagger the terms of trustees so there is continuity over the years. They limit how long a trustee can serve on the board. Recycling of trustees is common, however. The only exceptions to complete self-selection occur in religious hospitals where the church plays a role.

When asked what qualifications are sought in a new board member, the President of Pacific Medical Center said "demonstrated community responsibility, and in the men, particularly the men, someone who has some sense of financial responsibility." The President of St. Luke's looked for candidates who can give "good sound financial advice, well-recognized in the community," while another trustee from that hospital looks for "younger men with business experience, people who know people in the community."

While these qualifications do not exclude working people from hospital boards, the argument that board members should have expertise in, for example, banking, investment, law, real estate, construction or insurance effectively accomplishes this.

Yet the expertise of most trustees is largely irrelevant to their functioning on the board. A small number can point to considerable board use of their expertise, but for the great majority, this is not true. Many trustees admit they are unable to understand the hospital's finances. A trustee with 20 years service remarked how glad he was to have a recent business school graduate on the board, who could explain things that board members would otherwise have missed. It appears that the majority of trustees look only at the bottom line of the balance sheet. For anything more complex, they rely on the expert advice of administrators, consultants or the very few board members who do understand what is going on.

Even those with relevant expertise do not feel it applies to the major problems facing hospitals. Most trustees, for example, point to government regulations and late third-party payments as the major problems and freely admit they can do nothing about these matters.

One trustee stated the case accurately when he said, "It's not what I know but who I know" that explains why he was put on the board. A second agreed, "Who you know is pretty important." Even those who denied the importance of "who I know" talked about how their contacts with wealthy friends are systematically used in fundraising. The most realistic comment came from a trustee who said that what you know cannot be separated from who know, since anyone who gets to be important knows important people.

Who you know seems to the avenue onto hospital boards. "As it happened, I knew 80 percent of them already," said a trustee from St. Luke's. "We're all best friends," said a woman from Children's, mentioning that her neighbor was also a director. Another trustee at St. Luke's "knows everybody on the Children's board and quite a few at Pacific Medical Center and Mt. Zion's" and sees them socially. A Ralph K. Davies trustee mentioned his friends on the boards of St. Francis and PMC. Even a man chosen specifically because he is a banker "happened to know" members of the board he joined.

The significance of this mode of selection is that by choosing their friends, trustees select people whom reflect their own class credentials. With this assurance, new members can be taken onto the board easily.
Why Become A Trustee: Prestige

A key to understanding the motivation of hospital trustees is the recognition that, for most, hospital trusteeship is not a big deal. While hospital workers put in 40 hours and more a week, most trustees devote closer to five hours a month to their hospitals. Trustees are chosen from the class which is thoroughly accustomed to running things. Some are directors of as many as a dozen large corporations. They are used to making decisions that affect thousands of people and have little trouble doing so in yet one more arena.

The primary motivation of most trustees is prestige. As one doctor who is an ex-officio member of his hospital board put it, they're there for "points in society." While most trustees deny that they themselves joined for prestige reasons, they made it clear that everyone thinks of the position as an honor. A director of Children's Hospital recognized that board membership is "highly considered" in WASP social circles; a trustee from Mt. Zion said the hospital "has been the most prestigious of the agencies in the Jewish community," and another trustee claimed that board membership at St. Mary's is most important in Catholic circles. Finding board members has not been difficult for hospitals precisely because of the prestige which goes with being a trustee. Becoming a hospital trustee is often more like joining an exclusive social club than making a major political or business commitment.

The prestige motivation applies to the few active trustees as well as to the bulk of inactive ones. In addition, the active inner circle enjoy the challenge of guiding a large and complex operation. "I got intrigued," said one, and became "concerned with making something work." Another long-time active trustee knew nothing about hospitals to begin with, but was caught up

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Total Board Membership</th>
<th>Percent in Social Register</th>
<th>Pacific Union Members</th>
<th>Burlingame Country</th>
<th>Bohemian Club</th>
</tr>
</thead>
<tbody>
<tr>
<td>St. Luke's</td>
<td>14</td>
<td>86%</td>
<td>8</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Ralph K. Davies</td>
<td>10</td>
<td>40%</td>
<td>4</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Children's</td>
<td>26</td>
<td>77%</td>
<td>10</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>St. Francis</td>
<td>17</td>
<td>35%</td>
<td>5</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Pacific Medical Center</td>
<td>27</td>
<td>30%</td>
<td>3</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Total in Secular Protestant hospitals</td>
<td>94</td>
<td>53%</td>
<td>11</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>Mt. Zion</td>
<td>31</td>
<td>3%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>St. Mary's</td>
<td>32</td>
<td>19%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>St. Joseph's</td>
<td>14</td>
<td>0%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total in Jewish &amp; Catholic hospitals</td>
<td>77</td>
<td>9%</td>
<td>11</td>
<td>3</td>
<td>10</td>
</tr>
</tbody>
</table>

Information was drawn from Social Register of San Francisco, 1975, Who's Who, and similar compilations on businessmen.
with trusteeship and "wanted to see the hospital succeed."

Active women trustees have somewhat different but related motivations for their involvement. One very active female board member noted three reasons: the desire to keep busy, noblesse oblige, and the enjoyment in having a position of power. She commented that she was "born with a silver spoon and I'd like to put back as much as I can." But more than anything else, "I love the business. I like to run it, and get a kick out of it." For upper class women, hospital trusteeship is one personal solution to the problem of discrimination in the business world.

**For upper class women, hospital trusteeship is one personal solution to the problem of discrimination in the business world.**

Bankers: The Exception

San Francisco’s hospitals provide one major exception to the thesis that hospital trustees by and large do not profit from their hospital board membership. The exception is bankers. Although a small percentage of San Francisco hospital trustees are bankers, this group is of particular importance because of the hospitals’ growing dependence on banks.

As charitable donations have decreased in importance in financing hospital construction, commercial money-markets have become central. In San Francisco, every nonprofit hospital carries a significant long-term debt:

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Debt</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pacific Medical Center</td>
<td>$16 million</td>
</tr>
<tr>
<td>St. Luke’s</td>
<td>8 million</td>
</tr>
<tr>
<td>Children’s</td>
<td>6 million</td>
</tr>
<tr>
<td>Mt. Zion</td>
<td>5 million</td>
</tr>
<tr>
<td>St. Francis</td>
<td>5 million</td>
</tr>
<tr>
<td>Ralph K. Davies</td>
<td>6 million</td>
</tr>
<tr>
<td>St. Mary’s</td>
<td>24 million</td>
</tr>
<tr>
<td>St. Joseph’s</td>
<td>1 million</td>
</tr>
</tbody>
</table>

In fact, banks have provided a great deal of the financing that has enabled hospitals to overexpand and overequip themselves. Loans to hospitals are good business: hospitals rarely default and the loans are often guaranteed by the state government.

Current financial problems of hospitals, often created by bank-financed overbuilding, have strengthened the financial hold of banks over hospitals. Hospitals, unable to meet their capital needs from patient revenue, turn to banks for credit. Banks hold mortgages on long-term multimillion dollar hospital construction loans and help hospitals deal with accounts receivable (bills owed the hospital) by granting short-term loans of several hundred thousand dollars. Hospitals increasingly lease rather than purchase new equipment. Such leasing is often done through a bank or its subsidiary, increasing the banks’ exercise of power over hospital affairs. When a bank makes multiple loans to a hospital, it often imposes certain conditions: that the hospital not take other loans, lease or buy equipment, or pledge its accounts receivable, for example, without bank review and permission.

The cumulative effect of large long-term loans, short-term loans, and leasing agreements has been to dramatically increase the dependence of hospitals on banks. Growing out of this dependence is a particularly significant change in bank-hospital relations: the locking-in of a hospital to one bank. Whereas years ago a hospital might have had accounts in several banks, today most San Francisco hospitals have one primary bank.

For at least two hospitals, consolidation of the accounts was a condition for big construction loans. One trustee summarized the phenomenon as "We're locked into Wells Fargo," while another more euphemistically described the bank’s conditions as a "fairly comprehensive agreement." The same kind of locking-in was required by the Bank of America for a large construction loan to another hospital. The president of the board at yet another told how that hospital had "established a policy of two banks, one for endowment service" and one commercial. The commercial account is at the bank which granted the hospital its long-term loan. The consolidation of bank accounts stands in sharp contrast to the conditions of the 1960s when hospitals had accounts scattered in many banks.
How do banker-trustees participate in the locking-in of a hospital to a bank? Bankers, as our study and every other study of hospital trustees shows, are found on the boards of almost every nonprofit hospital. Bankers have been board members for many years. Nonetheless, the enormous growth of hospital borrowing for capital development gives credence to the notion that bankers, as representatives of their banks, have more than personal prestige and community service in their hearts when they serve as hospital trustees.

Years ago a friendly banker on a hospital board could perhaps help the hospital by getting a percent off the interest on a loan. Those days are long gone, however. Hospitals today are treated by banks just like any other business customer. "The days of who I know are over," said the president of one hospital, adding that it is more important to "be known to run a good outfit." At present it is economics, not personal contacts, that are in command in the relationships between banks and hospitals.

Generally then, banker-trustees appear to give neither the hospitals nor their banks special treatment. The cases of huge, interest-free accounts are, in all likelihood, exceptions. The importance of bankers sitting on hospital boards is more to get the hospital’s business rather than to arrange special terms for the bank.

Wells Fargo has a long-standing financial relationship with Mt. Zion Hospital: the bank holds the hospital’s commercial accounts, makes loans, and has had a bank director on the hospital’s board for years. A director of Wells Fargo sits on the board of another hospital which received a multimillion Wells Fargo loan. Kenneth Larkin, Senior Vice-President of the Bank of America, serves on the Citizen’s Advisory Board of St. Mary’s Hospital, which has received $30 million in loans from the bank. St. Francis Hospital received a loan from the Bank of America, and Anthony Clausen, President of the Bank, served on the hospital board, while Roland Pierotti, who was with the Bank of America for 20 years, serves as an honorary trustee. Mr. Pierotti is currently a consultant for the Bank of California, where St. Francis recently opened a $1,750,000 line of credit. In all these cases, there is no evidence that the hospitals were particularly "ripped-off" by the banks, but there is obvious self-dealing taking place.

Although direct proof is lacking, our supposition is that bankers who serve on hospital boards are the means by which banks obtain a hospital’s business. Once a hospital is locked into a bank, however, the trustee takes on lesser significance. At the point of heavy hospital indebtedness, banks exert direct economic pressure that no longer requires an interlocking directorate.

Hospital leaders understand the power of banks over heavily indebted hospitals: "Wells Fargo practically owns us," said one trustee, while a doctor said of another hospital, "That’s a hospital run by the Bank of America." Trustees generally feel that banks follow their client hospital’s finances closely. "They get all of our financial reports" and "are very concerned with cash flow," said one. Another said the bank doesn’t directly interfere but wants to know "what steps we’re taking to conserve assets."

Only one trustee (regarded as extremely knowledgeable by trustees from several hospitals) was willing to state the obvious: "As hospitals develop bigger and bigger mortgages, bankers have more to say." Hospitals themselves will have to "cut the cloth to fit the pattern, the economic pattern," he explained, and as a result, "some perfectly wonderful programs will go down the tubes. The quality of health care will suffer."

Another trustee was almost as clear in explaining why banks do not need to make direct suggestions to hospitals. To get permanent financing, the hospitals must show good cash flow, and to show good cash flow, hospitals must cut free and part-pay medical services and must keep up occupancy. He concluded that banks do not have...
to tell the hospitals what to do since the trustees and administrators know what is necessary to insure bank financing. And, without doubt, hospitals are cutting free, part-pay and unprofitable clinic services.

Just as banks fueled the overexpansion of hospital facilities with loans, some trustees believe that banks have the power to put a stop to further hospital construction. Said one, "The banks will force it." Whether the pattern of bank control over hospitals will encourage further expansion, a stop to expansion, or actual contraction of unprofitable services (such as out-patient clinics) is difficult to predict. What is clear is that debt service [interest payments] is taking an ever larger share of the hospital budget, that more service policies will have to be approved by banks, and that banks will be ever more important in the life (and death) of hospitals. The banker-trustee symbolizes this relationship, but it should be understood that it is the economic power of banks, rather than the individual banker on the hospital board, which dictates the dependence of hospitals on banks.

Who Are the Trustees: Class

Since the trustees' main function is to provide political and economic support for the hospital, and not to run it, it should come as no surprise that hospital trustees, in the simplest terms, are wealthy. A 1965 study in Hospital Management found the average trustee is "a businessman either owning his own business, or is a professional manager of a corporation." (10) "Hospital boards are dominated by business executives, members of the legal and accounting professions, and spokesmen for medicine and hospitals... Hospital boards are not representative of nor do they reflect the composition of the community generally," concluded a 1971 study of hospital trustees in the Detroit area.(11) A 1973 study, "Occupations of Boston Hospital Board Members," found
that "Regardless of hospital size, businessmen occupy most board seats. Financiers and lawyers rank second or third, depending on board size."(12) "Who Governs Long Island Hospitals?" a 1972 study of 27 hospital boards, found that "corporate business not only is the largest single occupational category, but that combined with the related occupations of banking (both investment and commercial), retail business, stock brokerage and real estate and insurance, over half of the 467 board members whose occupations we were able to determine were drawn from the world of business."(13) Cleveland's hospitals are similarly controlled by corporate aristocrats.(14)

The great polarity dividing modern capitalist society is that between capitalist and workers—those who own and control the means of production versus those who own no facilities and work for someone else in order to live. Between these two great classes are the petty-bourgeoisie, who may be divided into the "old" and the "new." The old petty-bourgeoisie are small businessmen, independent doctors and lawyers and other self-employed persons. The new petty-bourgeoisie are managers, supervisors, engineers, financial agents, corporate lawyers and other salaried professionals, who are usually employed by large corporations or institutions. As a class, the old petty-bourgeoisie has a several hundred year history, while the new petty-bourgeoisie is a creation of modern monopoly capitalism, little more than 75 years old.

Key elements in determining class position are a person’s relationship to the means of production, control of the process of work—whether it is self-controlled or determined by others—the amount of remuneration received and whether income is an exchange of wages for labor or a share in the surplus produced by society.

The working class owns no facilities, does not control its own work, receives little income and that as wages in exchange for labor. The old petty-bourgeoisie own small businesses, control their own work and perhaps that of a few others and receive income from the business profits. The new petty-bourgeoisie possess specialized skills, control their own work within spheres delineated from above, have delegated authority over the work of others, and receive remuneration beyond that of wages, i.e., a share of the surplus. Capitalists own the means of production, control the work of millions of others and take considerable wealth from the surplus produced by others.

It should be noted that while each class in society pursues its own interests, the new petty-bourgeoisie is particularly tied to the capitalist class and generally increases its power and income by increasing the profits of the corporations they serve.

Investigating the individual trustees, we translate these occupational categories into class terms as follows (including unemployed women in the class of their husbands):

- Capitalist: 32%
- New Petty Bourgeois 33%
- Old Petty Bourgeois 25%
- Working Class 0%
- Unknown 9%

In other words, the capitalist and petty-bourgeois classes completely fill the hospital boards in San Francisco; the working class, comprising between 80 and 85 percent of the population, is completely unrepresented. (From the above tabulation, it might seem that the petty-bourgeois control hospital boards; many of these, however, are stockbrokers and corporate lawyers, members of the new petty-bourgeoisie, whose allegiance is with the capitalist class.)

Source: Many of the above ideas were drawn from Harry Braverman, Labor and Monopoly Capital, Chapter 18, Monthly Review Press, New York, 1974.
Our investigation of trustees at San Francisco’s major voluntary hospitals confirmed these findings on trustee occupations. We want to enlarge this understanding, however. For hospitals trustees are not simply businessmen and lawyers, but members of particular classes in society. In sociological terms, hospital trustees tend to have important business and professional occupations, high social standing, come from the same families in succeeding generations, know each other socially, and take leading positions in other aspects of cultural and political life. More scientifically, trustees are members of the capitalist and petty-bourgeois classes.

Through their class positions, trustees are better able to provide the broad-based support hospitals need. Moreover, trustees from the capitalist class direct hospitals’ activities according to the logic of capitalist development and not for the well-being of the communities they serve. By describing the class relationship of the trustees, one can better understand the circumstances (defined by the needs of capital) in which the trustees act to intervene in the hospital’s affairs. (See box.)

Trustees serving on boards of San Francisco’s eight major nonprofit private hospitals number 171 (see Table 1 for occupations). Of these, 91 are businessmen, bankers, financiers and lawyers; 33 are doctors, professionals, religious leaders and educators; 43 are female “civic leaders” (no occupations); and four are unknown.

Hospitals are only one respect in which these members of the capitalist classes run society. Many of them hold important places in political life and in cultural and charitable activities. Many play a similar role in education. Their university trusteeships include Stanford, the University of Chicago, the University of California, University of San Francisco, Stanford Research Institute, the Hoover Institute, Pepperdine and many more. Hospital trustees also serve as directors of private charitable fundations, large and small. The most important of these include the Newhouse, Rosenberg and San Francisco Foundations.

Trustees also play an important role in local politics, serving on public commissions overseeing public utilities, the airport, police and crime, recreation and parks, the municipal railway and others. One is a former mayor of San Francisco, another the wife of a former mayor, a third a former mayor of a posh suburb. One served on the Board of Supervisors, another is the City Assessor. Needless to say, many are active behind the scenes, as donors or in party politics.

A final indicator of class position is the large number of San Francisco hospital trustees who are listed in the Social Register. Many are also members of the three leading Bay Area clubs: the Pacific Union, Bohemian and Burlingame Country Clubs (see Table 2). (The Bohemian Club has a national membership, with 1,100 members and a waiting list of several years.)

Who Are the Trustees: Race

One particular consequence of the class composition of hospital trustees is racial exclusion. Whereas about half the population of the city of San Francisco is non-white, only seven private, nonprofit hospital trustees, or four percent, are non-white—four blacks, two Latinos, and one Asian. The two hospitals with the most minority members are Mt. Zion and St. Mary’s. These hospitals have relatively fewer members of the national, ruling business class and more trustees who run local businesses. With the exception of Children’s, the secular and Protestant hospitals have held firm on the color line.

All of the trustees interviewed were aware of the massive under-representation of non-white peoples, and knew it was a basis for criticism. Given the attitudes expressed by board members, and the paucity of non-white capitalists, it is likely that hospital boards will change very little in this regard.

The seven non-white trustees include: two lawyers, two accountants, a businessman’s wife, and two educators. The addition of a few additional petty-bourgeois members...
does nothing to change the class composition of hospital boards, while in racial terms the action of the boards is mere tokenism.

**The Trustees' Impact**

Hospital boards of trustees now find themselves in a difficult position. Regardless of their power within nonprofit hospitals, they are legally responsible for the behavior of the private sector—behavior that has been twisted into a sorry excuse for health care. Private hospitals have over-expanded their bed capacities such that one-fourth of hospital beds are empty on the average day. In addition, at least 30 percent of days spent in the hospital are unnecessary. Unused and unnecessary units abound in cancer radiation, cardiac surgery, coronary angiography and other specialty areas. Emergency rooms have proliferated, sometimes literally across the street from one another. This overproduction of hospital services enormously inflates the cost of hospital care—bedding and overhospitalization alone add $8 billion each year to the public’s hospital bill. While private beds lie empty, the 25 million low income Americans without Medicare, Medicaid or private insurance are often denied hospitalization due to their inability to pay. Finally, private hospital involvement in badly needed comprehensive ambulatory and preventive services has been minimal.

The overexpansion crisis is now hitting not only consumers, but also the hospitals themselves. With empty beds costing two-thirds as much to maintain as full ones yet bringing in no revenue, private, nonprofit hospitals have painted themselves into a tight financial corner. Many are deeply in debt to banks, and some have discontinued community-oriented (often money-losing) services, such as outpatient clinics. Yet the overbuilding continues, with each hospital investing in the most modern facilities and equipment in order to attract more doctors and thereby more patients.

Is the sorry state of the private hospital industry the fault of the hospital trustees? Fundamentally, the driving force behind unnecessary hospital expansion is the medical staff. Hospitals compete for doctors, who are needed to admit patients, and this competition takes place by building the most modern facilities and purchasing the latest equipment. Trustees can take partial credit for participating in this competition—competition which has produced the crisis of overbedding and duplicated facilities. And the trustees know it. "If you haven't got doctors, you haven't got patients, and if you haven't got facilities, you haven't got anything," was the way a Ralph K. Davies trustee put it.

A long-time trustee spoke about hospital competition at some length: "Individual hospitals, in the vacuum of their own boardrooms, have made decisions independent of the effect on other hospitals and regardless of the needs of the city’s people." This trustee confirmed that doctors never had to lobby hard to get financing for their latest projects. In short, while trustees did not initiate hospital overexpansion, their connections facilitated it and they did nothing to stop it. They have acted privately, on behalf of the interests of their own individual hospitals and its doctors, with no concern for the overall health needs of the community.

Have the class interests of trustees been served by their performance on hospital boards? Has capitalism gained by the...
overexpansion initiated by doctors and rubberstamped by trustees? Here the answers are mixed.

Health-care services and products (physician care, insurance, drugs, supplies, equipment, facilities, etc.) are commodities that are sold for profit, benefiting those companies and individuals that provide and supply health care. Hospitals buy and resell many of these products, and they help create the demand for many insurance and physician services. In this way, the overexpansion of hospitals leads to increased sales and profits for a sector of the economy.

On the other hand, someone has to pay for the $118 billion (in 1975) in health services and products. Most of these billions come out of the pockets of working people—in health insurance premiums, medical bills and taxes. But the working class does not pay the entire health care bill. Unionization has forced many large corporations to contribute to the insurance premiums of their employees, and business sees a growing portion of the taxes it pays flowing to government health programs such as Medicare and Medicaid. With skyrocketing hospital costs—significantly abetted by hospital overexpansion—accounting for much of the increasing health care costs to business, a conflict is set up between capitalists as businessmen and capitalists as hospital trustees.

Predictions and Trends

The scenario created by overexpansion of hospitals, the resultant health-care cost inflation, and the consequent unhappiness of corporate leaders with the medical profession can be expected to play itself out within the nonprofit hospital. Two kinds changes can be expected to reduce medical staff power vis-a-vis administration and trustees: (1) consolidation or centralization of the power of the board and the administration; and (2) toward merger or federation in most big cities where there is an overabundance of hospital facilities.

• Consolidation of Authority Within the Hospital: In the past, nonprofit hospitals have been run by medical staffs. Administrations have acted at the beck and call of the physicians, and trustees have done the rubberstamping. With the financial difficulties resulting from overexpansion, administrators have increasingly denied doctors' requests for equipment and facilities in order to protect the financial integrity of the institution. In order to consolidate this power over the medical staff, there is a trend to merge the traditional tripartite division of powers of hospital board-administration-medical staff.

One step in this direction is elevating the administrator to board membership. The Macy Report on "The Governance of Voluntary Teaching Hospitals in New York City" suggests that "It would seem logical for these institutions to follow the common practice of corporate boards of directors to include 'inside management' on their boards." Already this has begun at three San Francisco hospitals—St. Francis, Pacific Medical Center, and Ralph K. Davies—where the chief administrator has a corporate title and is a member of the board.

Another technique for consolidating trustees and administration involves a few trustees taking a more active role in administration. Board presidents have offices at Mt. Zion and Children's Hospitals, and put in a regular work week, thereby closely joining the board and the administration. The two hospital presidents functioning as unpaid administrators are both women, again reflecting the differing amounts of time which upper-class women and men give to their hospitals. This also suggests that raising up the chief administrator to the trustee level may be a more viable long-term solution for consolidating power.

Centralizing power helps create a clear chain of command in dealing with recalcitrant doctors. A number of administrators and trustees commented on the need for
clearer lines of authority, preventing individual doctors from going over the head of the administrator to deal directly with the board. To aid in this process of rationalizing the in-house chain of command, a small number of doctors are being coopted to join the administration and the board, thereby splitting the medical staff into corporate-oriented vs. private practice-oriented physicians.

A related trend to tighten up private-hospital corporate structures may be the shrinking in size of hospital boards. At Ralph K. Davies, for example, the board had 23 members in 1967; it has only ten today. The presidents of two other San Francisco hospitals expect board size to be cut; one would like to pare it down to about ten members. This trend is possible since the external fundraising aspect of trusteeship, which requires large boards, is diminishing in importance while the need is growing to run a tight corporate ship that can control the doctors.

• Federation: Perhaps the most important developments in private, nonprofit hospital governance will be an increased number of hospital federations, cutting down the number of autonomous hospitals and reducing the competition between hospitals. Hospitals have already begun to federate, most notably in Hartford, Connecticut,(19) and efforts to federate major voluntary hospitals are underway in such big cities as Chicago and Detroit. A similar but more drastic process is the actual merger of hospitals, still an unusual event but one that is taking place with increasing frequency.(20)

In San Francisco, four of the leading hospitals—Children's, Mt. Zion, St. Luke's and PMC—are moving toward federation. The process is slow and difficult, and is being negotiated at the level of board president and chief administrator.

Federation begins with the sharing of such services as laundries and computers, extends to joint planning about which hospitals will have which facilities and equipment, and could reach its culmination when the medical staffs have privileges at all (or none) of the federated hospitals.

This last aspect is most important and most likely to meet physician resistance. The power of specialists to get from their hospital whatever equipment, beds and personnel they desire is based on their ability to choose where they wish to hospitalize patients. If all hospitals in a city have one medical staff and decide jointly which specialists admit patients to which hospitals, the doctors' power is undercut.

A major motivation for federation is the fear of government regulation and desire to preserve private control over hospitals. Even though federation is the opposite of competition, one trustee supported the concept because "I'm a great believer in private enterprise." Another agreed with the notion that, "We're doing it now so they [the government] won't do it to us later."

The trustees are right. Whether from within, for survival reasons, or from without, responding to governmental pressure against massive waste, hospitals will be forced from their present competitive stage to that of a more regulated monopoly. Ironically, voluntary changes initiated by trustees through the federation process will not differ ultimately from compulsory regulation by the government. So whether federation, public regulation or status quo, little shift in health care priorities can be expected. Big machines, specialty units and surgery will continue to dominate at the expense of needed primary and preventive care. And any cost savings that might conceivably flow from a more rational hospital system will stay within the hospitals themselves rather than benefit the patients.

At this critical juncture, the thrust of hospital trustee actions is to strengthen their own hospitals and to preserve private control and profit in medicine.

—David Landau
References


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**SOCIAL AMNESIA:**
(Boston, Beacon Press, 1975).

This is an intensely political and polemical book directed against contemporary psychology and the society that sustains and profits from its production. As a critique of contemporary, largely American psychological practice and an assessment of the social structure that supports it, it is devastating. Comprehensive in scope, political in intent, it is also narrowly focused.

Jacoby's principal concern is with the theory and praxis of individual and social liberation. He thus analyzes not only the state of current psychology but political thought and the poverty of its practice, particularly on the left. The basis of his argument, however, is to be found in the history of psychoanalysis and the increasing triumph of therapy over psychoanalytic theory.

If the tension between theory and practice is nearly universal in the history of social action, the particular historical experience of psychoanalytic theory and practice is considerably more parochial. The exploitation of contradictions within psychoanalytic theory, which is the foundation of Jacoby's interpretation, is part of the recent intellectual history of western capitalist society. In the broader context of struggle for liberation—a problem of physical and political survival for the majority of mankind—neither the revival of Freudian theory, nor the imperfections of therapy assume extraordinary importance. This must be borne in mind precisely because Jacoby is concerned with the general problems of human and social liberation.

**Revisionism**

Jacoby's contention is that in psychoanalysis, as in Marxism, revisionism has led to a decline of theory and to the emergence of empiricist and pragmatic tendencies that undermine their revolutionary thrusts as conceptual systems. With consideration being given to the differences between psychoanalysis and Marxism, this nevertheless leads Jacoby into the debate on revisionism in Marxism, and incidentally, to his own reformulation of its terms. It also accounts for his emphasis on the urgent need for revival of critical theory in both domains. His case is made with great aplomb and with a wealth of examples impossible to ignore. Yet one is left with the question—particularly in the case of psychoanalytic thought—of what role he would assign to theory, and what place he would leave for therapy.

So insistent is Jacoby on the need to restore theory and to subvert the triumphant advances of a positivism allied with the dismantling of theory, that it is incumbent on readers to ask for a clarification of the intended function of theory and the nature of its praxis. The almost total, though perhaps unintended, disjuncture between theory and therapy in Jacoby's discussion of psychoanalysis constitutes one of the book's principal weaknesses.

It should be apparent from even this brief comment that Social Amnesia is no ordinary
criticism of contemporary psychology. It is, in part, a critique of the deformations imposed on psychoanalytic theory by "conformist psychology;" it is also a critique grounded in an analysis of the social relations of capitalist society. It seeks not only an exposition of the conformism inherent in contemporary psychological practice, but the causal relations between the transformation of psychoanalytic theory and the social formations of capitalism.

The course of this critique includes a reminder that depth psychology, contrary to its current style, "by its own logic, turns into sociology and history." (p. 79) Jacoby's attempt, then, is to uncover the materialist foundations of psychoanalytic theory and to forge a more effective alliance between them and Marxist social theory. Analogies with the Frankfurt School are appropriate, since Jacoby endorses a methodology that can reflect "the logic of society and the logic of the psyche." Indeed, his concern is to establish a "relationship between psychology and a social theory...." (p. xxii) because "the pursuit of these issues is an integral part of the theory and praxis of liberation: social and human transformation." (p. xxii)

The emphasis is primarily, though not exclusively, on developments within psychology and psychoanalysis. Jacoby devotes considerable space to a discussion of orthodoxy in Marxism, noting parallels with psychoanalytic thought and pursuing the prospects of a "negative psychoanalysis" in alliance with Marxism.

The conception of a "negative psychoanalysis" is basic to Jacoby's view of the individual in the era of "synchronized capitalism." It also contrasts with the prevailing image of the individual in writings by many radical therapists and in the theorizing by some members of the left. Jacoby sharply criticizes the left's subjectivist tendencies, which he sees manifested both in pseudo-politics and in therapy. He accuses both kinds of activists—radical therapists may be called such—of a myopia which prevents them from grasping that "the cult of subjectivity is a direct response to its eclipse," (p. 105) and not a sign of its imminent rebirth.

The image of the left that emerges from Jacoby's analysis is a harsh one. Its empty sloganeering, its specious rhetoric, its mindless discoveries of what has already been discovered—whether in theory or in political action—constitute elements of precisely the condition Jacoby is concerned with, "social amnesia." It should be pointed out in passing that the chapter in which Jacoby elaborates on the condition of the left, "The Politics of Subjectivity," was published on several occasions prior to its incorporation in this text. Since it was not revised when integrated into the present work, there is no reference to the self-criticism of the left that has since appeared in print, nor any discussion of the US left developments since its first publication in 1971.

**Social Amnesia**

Jacoby sees the situation of the left as not significantly different from that of the psychological establishment. Both have fallen prey to "social amnesia," a process of increasing mindlessness that "takes its toll in the inability to think." (p. 4) Although he distinguishes the content of left politics and radical therapy from that of the psychological or psychoanalytic establishments, all are seen as victims of a "memory driven out of mind by the social and economic dynamic of this society." (p. 4)

To explain this condition, Jacoby begins with the Marxist concept of reification which "refers to an illusion that is objectively manufactured by society. This social illusion works to preserve the status quo by presenting the human and social relationships of society as natural—and unchangeable—relations between things." (p. 4) What is omitted or forgotten is the psychological dimension; fundamentally, then, social amnesia is this "forgetting and repression of the human and social activity that makes and can remake society." (p. 4)

To succumb to this state is equivalent to forgetting history in favor of the current rationalizations of the ruling class. It implies a readiness to abdicate in the search and struggle for the truth of the past, and to acquiesce in the distorted representations of
present social realities. Such a society, in losing its memory, turns apologetic and conformist. Yet in practice, the past is never totally forgotten; it surfaces in mutilated forms and as dogmatic, partial resurrections of an undisclosed whole.

The process of social amnesia is not innocent, nor are its effects simply alleviated. The society that produces it acts in accordance with its own needs and conditions. To halt the process of amnesia, then, requires a restructuring of society. Short of that, the trend toward instant change and gratification, a surface phenomenon, proceeds apace with evident repercussions. Culture is pre-packaged and offered in the same concentrated formulas as the latest food fad. Mindlessness is not an unseemly accusation in this situation; it merely describes what those who resist already know.

To halt the process of amnesia requires a restructuring of society.

Turning to conditions within psychology, and particularly its popular expressions, Jacoby finds abundant examples of precisely this kind of production. It is not difficult to test the validity of his interpretation by simply glancing at the appropriate section of almost any bookstore. Condensed therapy, promised at a fraction of the price, offers rewards to those who succeed in deciphering the proper code of success. As astonishing as the promises of health and happiness are the numbers of paths offered to achieve them. This may be only one of the many glaring examples of the malaise that a capitalist society produces and a consumer society profits from, but it is a real form of malaise nonetheless.

Not all examples of pop psychology are either melodramatic or banal; some are frankly, if inadvertently, comic. One might cite, for example, a recent promo for Psychology Today, a journal which in some ways illustrates Jacoby’s general propositions about the fate of psychology. A recent New York Times advertisement for the journal features a model couple, Robin and Joe, who share with us their expectations and concerns. (2) Like their four and a half million counterparts, they are people who “believe in living their dreams today, not tomorrow.” They seem to have the means to do so, and though this may or may not be true of their fellow readers, we are told that the way they “feel about life is an example of the new values many young adults share today.” These are familiar and expensive values of bourgeois society—tennis in exotic places, if the whim decrees; theater and concerts at the appropriate spots. Robin and Joe are interested in success, in competition—without strain, if possible—and in self actualization theories that will help them achieve their potential. And why not? These are precisely the goals their society presents as ideal.

It is hardly astonishing that the review of Social Amnesia in Psychology Today should have dismissed Jacoby’s assault on conformist psychology as so much ideological prattle. His analysis is as fundamentally irrelevant to readers of Psychology Today as are many of Freud’s theories. Jacoby’s reviewer, Ernest van den Haag, finds nothing to regret in this situation. The renunciation of Freud’s meta-psychological theories is perfectly justifiable, he argues, since these “have proved to be untestable.” (3) This, of course, omits the story of how this position evolved along with the current, nearly exclusive concentration on problems of therapy within psychology. The pragmatism of Psychology Today, its how-to-do and how-to-be approach, are as representative of the condition Jacoby decries as Van den Haag’s review. Rather than isolated cases reflecting individual views, they suggest a deep trend in contemporary psychology, systematically shunting theory aside in favor of more immediately practical considerations.

What becomes important in this context are the broad and very real problems identified with adjustment, whether in sexual, social or occupational terms. In the reliably limited frame of reference of modern therapy, authenticity, identity and potential are the call words for a promise of pseudo-liberation whose dimensions are known. Whether or not one belittles the goals or the problems which this psychology identifies as critical is not Jacoby’s question. They are legitimate to those who express them.

Meanwhile, there is no real attempt to relate these problems to larger social issues, outside of which they lose anything but their specifically personal meaning. This is not a trivial consideration; Jacoby
identifies it as a by-product of contemporary psychology’s renunciation of theory. There are many approaches to the question of contextual analysis for what psychology singles out as proper subject of concern; the nature of this contextual analysis is crucial and is not merely the relating of an individual to a social predicament. In this very domain the difference between contemporary psychology and psychoanalytic theory emerges vividly. The contrast moves Jacoby, in fact, to uncover the history of confrontation between the movement to reform therapy and psychoanalytic theory.

**Critique vs. Cure**

Jacoby’s interpretation of the impact of revisionism, which forms the crux of his wide ranging argument, is based on Herbert Marcuse’s “Critique of Neo-Freudian Revisionism,” which first appeared in 1955 in the Epilogue to *Eros and Civilization*. (4) What Jacoby suggests, in keeping with Marcuse’s thesis, is that it was the work of the neo-Freudians, especially Fromm, Horney, Thompson and Sullivan, and the post-Freudians (whom Marcuse did not discuss), especially Maslow, Allport and Rogers, that resulted in the transformation of psychoanalytic theory into the more acceptable formulations of contemporary psychology.

Jacoby’s relation to Marcuse, as reflected in *Social Amnesia* and *Eros* as well as two of Marcuse’s later works, is not easy to unravel. On the one hand there is a virtual identity of views and a candid recapitulation of Marcuse’s position, as stated in *Eros*, in Jacoby’s text. On the other hand, it is a mistake to see Jacoby’s effort as merely an updating of Marcuse’s critique. Despite complete accord on the role of revisionism in psychoanalytic theory and therapy, there are important differences in the discourse on the New Left and particularly on what Marcuse terms the “new sensibility.” In an extended discussion of the meaning of Freudian theory in *Eros*, Marcuse associates this new individualism with emerging biological needs and consequent, if as yet elusive, prospects for psychic and political liberation. But it is in *An Essay on Liberation* (5) and *Counter-Revolution and Revolt* (6) that these concepts are developed, sources which Jacoby does not mention.

Marcuse’s “Critique of Neo-Freudian Revisionism” developed the position that Freudian theory is inherently critical and revolutionary. This view underlies claims by both Jacoby and Marcuse that the revisionists have blunted the revolutionary edge of psychoanalysis by reforming therapy and searching for a more pacific path to individual happiness and group living. Marcuse develops his case by reviewing the history of psychoanalysis in the twentieth century:

“The collapse of the liberal era and of its promises, the spreading totalitarian trend and the efforts to counteract this trend, are reflected in the position of psychoanalysis. During the twenty years of its development prior to the First World War, psychoanalysis elaborated the concepts for the psychological critique of the most highly praised achievement of the modern era: the individual. Freud demonstrated that constraint, repression, and renunciation are the stuff from which the “free personality” is made; he recognized the “general unhappiness” of society as the unsurpassable limit of cure and normality. Psychoanalysis was a radically critical theory. Later, when Central and Eastern Europe were in revolutionary upheaval, it became clear to what extent psychoanalysis was still committed to the society whose secrets it revealed. The psychoanalytic conception of man, with its belief in the

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**Jacoby’s conviction that Freud offers an indispensable and unique critique of the individual—a prerequisite to reconstruction of social reality—justifies a return to Freudian theory that is neither blind orthodoxy nor uncritical loyalty.**

This proposition likewise motivates Jacoby to plead for an urgent rereading of Freudian thought. His conviction that Freud offers an indispensable and unique critique of the individual—a prerequisite to the reconstruction of social reality—justifies a return to Freudian theory that is neither blind orthodoxy nor uncritical loyalty.
basic unchangeability of human nature, appeared as "reactionary"; Freudian theory seemed to imply that the humanitarian ideals of socialism were humanly unattainable. Then the revisions of psychoanalysis began to gain momentum."(7)

These revisions in psychoanalytic theory came from various directions, but the circles that played the most important role in subsequent changes of Freudian theory and practice were the "cultural" and "interpersonal" schools. Emphasizing personality and its potential, the effects of environment and social conditions, adherents of these movements succeeded in "expurgating the instinctual dynamic and reducing its part in the mental life."(8)

The psyche was freed of the darkened undercurrents Freud's work brought to light. Not only was the individual once again susceptible to being "cured", he became eligible for a happiness which Freudian theories of civilization had doomed to frustration.

Along with an altered view of the individual came a parallel alteration in his or her relation to society. What appeared as inevitably conflicted relationship in Freud was now levelled to a potentially harmonious accord in the writings of the revisionists. Those concerned with the problems of society eventually came to perceive these as open to resolution through various reform measures, but the systemic relationship between the neuroses of the individual and the milieu in which he or she lived, which dominated Freud's theories, were increasingly set aside. In this manner, "the depth dimension of the conflict between the instinctual structure and the realm of consciousness, was flattened out. Psychoanalysis was reoriented on the traditional consciousness psychology of pre-Freudian texture."(9)

In comparison with the revisionist formulations, the social and critical content of Freud's theories became more apparent. This critical content was inseparable from those very elements in Freudian theory which the revisionists sought to eliminate or to weaken. By diffusing the theory of sexuality, for instance, the revisionists effectively loosened the potency of Freud's social critique. That this process results from attempts to ameliorate the therapeutic relationship, Marcuse terms an "apparent paradox."

The reformist notion of therapy, based on assumptions of the possibility of a cure, undermined Freudian notions of a therapy intrinsically limited to achieving nothing more than "everday unhappiness." Freud's concept of therapy was linked to his view of man and society: "The notion that 'civilization and its discontent' had their roots in the biological constitution of man profoundly influenced his concept of the function and goal of therapy. The personality which the individual is to develop, the potentialities which he is to realize, the happiness which he is to attain—they are regimented from the very beginning, and their content can be defined only in terms of this regimentation."(10)

To advocate an optimal program of therapy, as did the revisionists, based on recognizing the patient's claim to happiness and moral liberation, clearly violates Freud's view of what therapy could legitimately offer. It is not so much that the claims were suspect; rather, to satisfy them requires either a radical transformation of society or a redefinition of the individual's goals so that they fit in with society's existing values.

Theory vs. Therapy

Underlying the conflicting views on the potential of therapy is a profound discord on the relationship of theory and therapy, and, by definition, the totality of psychoanalysis itself. Freud had recognized the tension between theory and practice in psychoanalysis and acknowledged that therapy was restricted by his diagnosis of the repressive nature of civilization. For this reason, "The 'goal of the pleasure principle'—namely, to be happy—is not attainable," although the effort to attain it shall not and cannot be abandoned."(11)

Thus, the options of therapy were explicitly limited by Freud to a compromise, an adjustment, necessitated by what Jacoby calls "the realm of social unfreedom." His conscious admission of the limits of therapy resulting

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**By diffusing the theory of sexuality, the revisionists effectively loosened the potency of Freud's social critique.**
from instinctual structure in conflict with society’s repressive controls differed in the adjustment it imposed from that offered by the revisionists. Freed of Freud’s theoretical system, or that part of it which they rejected, the revisionist conception of therapy was limited only by what society deemed acceptable and proper.

It is interesting to recall here how psychiatrist and revolutionary, Frantz Fanon, struggled with the question of the conformism of psychiatry during his work in France, Algeria and Tunisia. In several of his books, he described the dilemma of trying to help patients adjust to the situation he found intolerable, namely, racism and colonialism. He eventually ceased practising in Algeria for political reasons; but he never abandoned the belief that psychoanalysis offers an indispensable tool for the study of racism. Fanon appears not to have made any distinction between theory and the therapists he observed in practice, both of which were seen as conformist and europocentric. That he perceived psychoanalytic theory as either having a socially critical function or as being revolutionary is doubtful.(12)

Freud, well aware of the different spheres in which theory and therapy operate, made no attempt to mitigate the contradictions between them. Quite the opposite, he was apprehensive of attempts to thoroughly assimilate theory and therapy. Particularly, as Jacoby emphasizes, "Freud was very much alive to the dangers of theory being absorbed by therapy."(13) and to some extent "anticipated and feared the neo-and post-Freudians as his succe-
sors and betrayers . . . ."(14) Freud resisted the submerging of psychoanalysis in therapy, claims Jacoby, because "he fathomed to what degree this entailed the subjugation of psychoanalysis to the given social order that it was to comprehend; reduced in this way, psychoanalysis loses its truth value."(15) Jacoby’s argument is unmistakably clear. By rendering theory largely irrelevant, therapy, in the hand of the revisionists, buried its relationship with a more disturbing truth that contained elements of a critical and revolutionary vision.

"Freud was very much alive to the danger of theory being absorbed by therapy."

—Russell Jacoby, Social Amnesia

The lesson, then, is that the tension between theory and therapy must be maintained. The implications are not so simply stated. In the introductory pages to the chapter, "Theory and Therapy I: Freud," Jacoby pays homage to the "highly complex historical relationship" involved in the tension between theory and practice. "Theory is not to be reduced to practice nor cleanly severed from it," he writes.(16) In Jacoby’s analysis of theory and therapy, however, it was in fact very nearly severed.

This observation raises a variety of problems with Jacoby’s interpretation. Not only must we determine Jacoby’s view of the practice of psychoanalytic theory; but what is to become of therapy, as well. Does psychoanalytic theory correspond directly to any therapy? If not, are we thinking in terms more appropriately considered political action when we conceive a psychoanalytic praxis? And what of the fate of therapy? To raise these questions is not to underestimate Jacoby’s task which is, of course, to revive therapy, not therapy. But if we accept the axiom that they dialectically interrelate, it is essential to question Jacoby’s treatment of therapy and its implications.

Marcuse’s discussion, by contrast, is muted by an understanding of the "fateful dilemma" in which the therapist finds himself. Although disclaiming any expertise on the issue, and, in fact, denying any intention to discuss therapy, Marcuse pictures sympathetically the therapist caught between commitment to patient and commitment to psychoanalytic theory and its social vision. The result avoids the kind of Manichean description that colors Jacoby’s text. This is less a matter of generating sympathy for the subject or the therapist, than of situating therapy within a meaningful context in such a way that it does not lose all value.

Where, after all, is the dialectical relationship between theory and therapy, when therapy appears as a soiled, compromised and compromising arm of revolutionary theory? If therapy is perceived as nothing more than theory’s dismal and distant handmaiden, while therapy remains the expression of truth, what is any real
tension between them? Under such circumstances, to speak of tension and the maintenance of contradictions between them becomes so many verbal dynamics. It certainly does not bring us any closer to restoring a reciprocal theory-therapy relationship.

**Psychotherapy vs. Praxis**

Here it may be useful to consider alternative approaches to the same problem. One involves rejecting the limited and doomed position of therapy in favor of a progressive and politically meaningful role. Some would argue that a potentially progressive therapy capable of liberating itself and its subjects from the static conformism of contemporary psychology is possible and perhaps even imminent. Those committed to this project think in terms of a radically informed therapy that is socially conscious and analytic theory revealed the free of the traditional restrictions and characteristics that mark current modes of therapy. As a project, this is to be encouraged. At the same time, the danger that such a movement may, however inadvertently, promote the psychologizing of politics must be recognized as well.

Marcuse, in *An Essay on Liberation* and *Counter-revolution and Revolt*, develops the theme, first submitted in *Eros*, that the concept of the "new sensibility" has direct implications for psychic and political liberation, and for psychoanalytic theory and therapy. Marcuse in *Eros*, and Jacoby after him, underline the inherent limitations of Freudian therapy that derive from the analysis of society and civilization explicitly offered in psychoanalytic theory. Marcuse also emphasizes that in its confrontation with the revisionist program, psycho-depth of its criticism and, "perhaps—for the first time—those of its elements that transcend the prevailing order and link the theory of repression with that of its abolition." Using the concepts "new sensibility" and "new individualism," Marcuse described a phenomenon whose importance was directly related to these conditions.

Though this is not the place to explicate Marcuse's theory, it is useful to briefly consider what the concept of "new sensibility" means in the present context. Marcuse tells us that the "new sensibility" emerged as one form of resistance against "the massive exploitative power of corporate capitalism." Its existence also held out the possibility of a radical overturning of the nature of human relationships: "Beyond the limits (and beyond the power) of repressive reason now appears the prospect for a new relation-

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**PROGNOSIS NEGATIVE: CRISIS IN THE HEALTH CARE SYSTEM**

*Edited by David Kotelchuck*

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ship between sensibility and reason, namely, the harmony between sensibility and a radical consciousness: rational faculties capable of projecting and defining the objective (material) conditions of freedom, its real limits and chances."

Involved here is nothing less than the fundamental re-definition of the personality, of individuality itself. And it was precisely the structure and definition of personality that, as Marcuse indicated in *Eros*, were at the heart of the predicament of therapy. For Marcuse, the optimal demands of the revisionist therapists were "unattainable—not because of limitations in the psychoanalytic techniques but because the established civilization itself, in its very structure denies it."

Under these circumstances, two possibilities have remained. Either definitions of personality and individuality were revised in keeping with the acceptable terms of society, in which case they would be restrictive and, invariably, conformist. Or, definitions of personality and individuality retained their veritable intent and became subversive factors, in which case "their realization would imply transgression, beyond the established form of civilization to radically new modes of 'personality' and 'individuality' incompatible with prevailing ones."(21)

It is the second prospect which the emergence of the "new sensibility" promises. And it is as a result of its double function as witness to the new individual and promoter of the circumstances that allow him or her to emerge, that this sensibility plays both a personal and a political role. It thus addresses the central concerns of psychoanalytic theory as well as the restrictive nature of therapy. By its existence and its struggle to exist, the concept of "new sensibility" points to the realization of a condition in which the parameters of therapy may be objectively altered.

Marcuse has not, to my knowledge, applied this concept specifically to therapy, and it is useless to speculate on his intentions along this line. The implications of his discussion affect the question of therapy profoundly, however, and in this light Jacoby's silence on these themes is to be regretted.

To end this review on a note of regret, however, would be both unwarranted and misleading. It is common enough to criticize a work for what it does not do. *Social Amnesia* is not only a book that will anger and provoke, but one whose subject justifies such a response.

—Irene L. Gendzier

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(The author is Professor of History at Boston University, member of the African Studies Center and resident at the Radcliffe Institute.)
Vital Signs

Swine Flu Followup

With the Swine Flu Immunization Program pronounced dead, autopsy results are being prepared from all sides. What most analysts have missed, however, is that the real losers are those elderly and chronically ill "high risk" people who should have been exclusively targeted for the vaccine from the beginning. (See BULLETIN, November/December, 1976)

As this BULLETIN went to press, it was still unclear whether the spreading incidence of Guillain-Barre Syndrome (the progressive-paralysis disease announced as the cause for "temporarily" halting the mass vaccinations) would or would not eventually be correlated with flu vaccine. What is striking is that very few cases of the disease have occurred among the high-risk population, according to the Center for Disease Control in Atlanta. Non-high-risk people generally received vaccine for swine flu only; high-risk persons were given a combination vaccination against swine flu and other types, including the Victoria flu. At this point, there is no reason to suspect a connection between any other flu vaccine and Guillain-Barre Syndrome.

Since it is now generally agreed that no swine flu epidemic will occur this year, high-risk adults are primarily threatened by an outbreak of Victoria flu, which continues to be the most prevalent among the world's current flu strains. But, there is almost no available Victoria vaccine that has not been combined with swine flu vaccine. With swine flu vaccinations suspended, protection against Victoria is thus all but impossible.

The tragic irony at this point is that the ongoing horror story of the swine flu vaccination program will adversely affect the overall credibility of public health officials for years to come, resulting in the meantime in additional and avoidable loss of life.

AHA: Unionbusting, 1976

Editors' Note: Health/PAC recently received a prepublication copy of a document produced by the American Hospital Association (840 North Lake Shore Drive, Chicago, 60611), entitled, "Responding to a Labor Union Campaign in a Health Care Institution." Although we feel the entire document makes required reading for organizers and for health workers in general, we summarize and excerpt some highlights below. A full copy can presumably be obtained from the AHA, Department of Hospital Employee Relations and Training, at the above address.

The bulk of this document consists of six "handouts" that hospital management can use to train administrative and supervisory personnel in anti-union techniques. Designed to accompany a 16mm black-and-white sound film or videotape, Managing Responses to Unions—After the Knock, the text is divided into two broad sections. The first—Parts 1 to 4—consists of handouts, quizzes and drills to be used in conjunction with the film. These "educational aids" fea-
tured, for example, a mock conversation between hospital management and supervisory personnel around the question: "What course of action a hospital can take without violating Section 8 (unfair labor practices) of the Taft Hartley Act?"

But it is in the last section that one finds the heart of the work, the "correct answers" to all the questions posed in the drills and quizzes. It consists of Part 5, "The Hospital's Campaign to Keep the Union Out," and Part 6, "Responding to Specific Incidents." Part 5 begins by telling administrators and supervisors that:

"The administration of every hospital has an opportunity and obligation to develop its own brand of aggressive psychological warfare..." and goes on to recommend that this be done within the "restrictions of the law and the demands of honesty and sincerity." [sic]

Continuing the theme of honesty, the potential union-busting administrator is advised that, "Credibility begins with sound employee relations policies and good supervision." [emphasis ours]

The document contains an interesting, if illusory, view of class consciousness among health workers as opposed to their bosses:

"Do not appeal to the typical nonprofessional employee on the assumption that he is motivated to any great degree by the sentiment of service to humanity that might characterize board members, chief executive officers, supervisory personnel, and professional employees. The relatively high levels of employee turnover in many hospitals suggest that rank-and-file employees judge a hospital job primarily by the same criteria applicable to other jobs: current and prospective pay, hours, quality of supervision, dignity of the work, security, benefits, and so forth."

One can only speculate as to how the authors explain unionization among professional employees. In any event, administrators are given their ideological key in the succinct statement, "Few rank-and-file workers have the same views about unions, economics, or politics as persons living on higher socioeconomic levels."

Perhaps by way of endorsing the human-relations approach among other forms of ammunition, the document recommends, "Strengthen and utilize established patterns of face-to-face communication between supervisors and the employees with whom they work. Ask supervisors to increase the number of meaningful personal contacts they have with employees in their units."

Psychological warfare extends beyond the workplace in the admonition: "If you wish to use mimeographed or printed materials, consider the impact of mailing them to employees' homes, where their families could influence them."

The nuts and bolts of anti-union mobilization is described in Part 6, however, "Responding to Specific Incidents." It is in this section that hospital managements across the country are most likely to thumb eagerly in search of weapons, because it is most concrete. Organized around hypothetical incidents that might occur in the course of a unionization campaign, the section contains the following:

"Incident No. 1: Employee or Union Representative Distributes Union Handbills or Solicits Members... Actions to take, as appropriate:... take appropriate disciplinary action against any employee who is distributing union material or soliciting members on hospital property during his working time or the working time of those with whom he is in contact." Or, one might, "Prepare a full, factual repudiation of significantly erroneous statements in the materials; publicize this statement promptly to supervisors, and, at an appropriate time, to employees."

"Incident No. 2: Union Literature Appears on Bulletin Boards"

"Action to take now before the incident occurs:

"Check for the existence and consistency of application of rules for management control of bulletin board material. Take into consideration the appearance on bulletin boards of notices involving unofficial lost and found items, lodgings and transportation needed or available, meetings of professional societies, seminars, unrecognized employee groups involved in recreation and travel, and so forth.

"Actions to take as appropriate:

"1. See that union material is removed from the bulletin board, when such action is appropriate. See that this is done unobtrusively. Avoid making a public (and probably fruitless) search for the initiator.

"2. Note the allegations and promises, if any, in the literature; use this information in synthesizing a probable pattern of union demands in any future bargaining.

"3. Prepare and publicize promptly to supervisors, and..."
at an appropriate time, through normal channels, to employees, facts that repudiate significantly erroneous statements in the union literature. Do not do this in a manner that suggests that you are specifically responding to the posted material."

Then there is the case of a supervisor who doesn’t know where the bread is buttered:

"Incident No. 15: Supervisor Publicly Indicates Pro-Union Sentiments

"A supervisory employee attends a union meeting, wears a union button, walks on a picket line, makes pro-union statements, and so forth.

"Actions to take now before the incident occurs:

1. Make sure any supervisor’s job is clearly defined as supervisory and that the employee is treated as a part of the management.

2. Discuss the matter with counsel experienced in labor relations so that you understand the differences between confronting pro-union rank-and-file employees and pro-union supervisors.

"Action to avoid:

"Do not summarily discharge the supervisor. However, if this seems to be the only alternative, do not do so before discussing the situation with counsel experienced in labor relations.

"Actions to be taken, as appropriate:

1. Review all available information about the employee and his effectiveness as a supervisor. If he is a registered nurse, determine whether he is a member of local and national nursing associations and whether he is following suggestions made by these groups.

2. If the employee’s job is clearly defined as a management position, his immediate supervisor should talk to him promptly, privately, and calmly, covering the following points: (a.) What the supervisor sees as the advantages of his union membership or pro-union activities; (b.) Any details he might volunteer about the strength of the union and the issues it is stressing in its membership drive; (c.) The hospital’s position on unionization; (d.) The hospital’s decision to resist inclusion of supervisory jobs in any bargaining unit that might be set up or coverage of the supervisor’s job by any contract that might be negotiated; (e.) Past evidence of management’s treatment of the employee as a member of management, such as salary, communications, responsibility for subordinates, and, if appropriate, his professional status; (f.) His anomalous position of being a member of neither management nor the union; the conflicts involved in communication under these conditions; and the fact that, under the National Labor Relations Act, his actions might cause the hospital to be charged with committing an unfair labor practice; (g.) The fact that continued evidence of his identification with the union will lead management to question his desirability as a supervisor; (h.) A specific warning (of which a written record is kept) that if he appears on a picket line or publicly attends a union meeting, he will be discharged."

Keeping unions out of hospitals has become a common practice, particularly since the 1974 amendments to the National Labor Relations Act extended its legal protections to workers in voluntary hospitals.

Meanwhile, charging a hospital with "unfair labor practices" and depending on National Labor Relations Board (NLRB) protection is a very weak reed on which to hinge an organizing drive. According to Dollars and Sense (No. 22, Dec. 1976; available from 324 Somerville Ave., Somerville, Mass. 02143): "The median length of time between the filing of an unfair labor practice and the NLRB decision is 322 days. If the decision is appealed, or if the union has to petition the board to enforce its decision, add another year." Union organizing in hospitals is getting tougher.
If One Picture $\equiv$ 1000 Words
Then, 32 Pictures $\equiv$ 4 Health/PAC Bulletins

HEALTH/PAC BULLETIN

PRESENTS

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BY

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Dear Friend:

As it enters its ninth year of continuous operation, Health/PAC finds itself in a critical situation. One way to state it simply is that the fiscal crisis that threatens health care threatens Health/PAC as well.

For nearly a decade Health/PAC has been throwing light into the backrooms of the American health care system. It has often been the only light in the dark for the forces trying to change that system. It has often stood alone in challenging the conventional wisdom behind the costliest and most recent "reforms" proposed from within the system's walls. It has often publicized the secret plans of supposedly public officials at times when publicity was essential to increase public control. Again, more than any other organization, Health/PAC has "been there." As one of Health/PAC's friends, you know from your own experience what a uniquely enduring resource it is for those committed to progressive social change in health care services.

But we aren't resting on our accomplishments. Our plans for 1977 include:

- An expanded BULLETIN with greater emphasis on reporting rapidly changing developments in U.S. health care;
- Addition of associate staff in Washington, D.C., to monitor the emerging patterns of health policy under a new Congress and the Carter administration;
- New, regular columns in each BULLETIN on women and health, health workers, occupational and environmental health, New York City and State health policy, and Federal health policy;
- Special research reports on subjects such as company physicians, the health status of Black Americans, medical school admissions, and Carter administration health policy;

We are asking you for direct help in assuring our continued existence and in launching these new efforts. The reasons are simple. Revenues from BULLETIN subscriptions and literature sales have never equaled costs. For nine years we have actively sought and received foundation support and contributions to make up the difference. This year, these sources cannot keep up with rising costs. Clearly, the future of Health/PAC lies with its constituents. For these reasons, we are urgently asking that you join our new Health/PAC Sustainers Program in one of the following categories:

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Best wishes for a truly important New Year,

Ronda Kotelchuck for the Health/PAC Sustainers Program