a mid-May meeting in Vancouver, B.C. with members of the US anti-War movement, representatives of the Provisional Revolutionary Government (PRG) called on the US Government to honor the Paris Peace Treaty, in particular Article 21 in which the United States agreed to “contribute to healing the wounds of war and to postwar reconstruction throughout Indochina.”

BULLETIN readers may also wish to contribute personally to reconstruction in the health care field. Contact Medical Aid for Vietnam, 61A Winthrop Street, Cambridge, Mass. 02138.

BACH MAI HOSPITAL FUND
On May 11 a celebration of the end of the war in Southeast Asia was held in New York City’s Central Park and attended by 50,000 people. The Bach Mai Hospital Fund now has available a 45-minute half-
inch sound and color videotape of the day’s events, show-
ing Congresswomen Bella Abzug and Elizabeth Holtzman, David Dellinger, Richie Havens, Phil Ochs, Peter Yarrow
and many others. The tape may be rented for a charge of $15.

The tape is perfect for public meetings, private fund rais-
ing events and distribution on local cable (and, if possible, commercial) television. All funds raised will be used to re-
build Bach Mai Hospital and to redevelop Vietnam. The tape may be ordered from the Bach Mai Hospital Fund, 777 United Nations Plaza, 11th Floor, New York, N.Y. 10017.

The Fund will also usually be able to provide a speaker should one be desired.

FROM HEALTH/PAC’S WEST COAST OFFICE

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The Dismantling of California’s County Hospitals

—What are the national trends that spell doom for public hospitals?

—How have these forces caused the closure or private takeover of 40% of California’s hospitals?

—Why does Medicaid fail to insure decent health care for low-income people?

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1 The Mental Health Con Game: REPRESSION AS REFORM. The shrinkage of state mental hospitals is more about fiscal politics than patient care.

9 Sterilization Guidelines: STERILE DEBATE. Draft guidelines for tubal ligations in New York City’s municipal hospitals raise a storm in the bureaucracy.

26 Media Scan: Medical Nemesis: The Expropriation of Health. by Ivan Illich.

30 Vital Signs

The Mental Health Con Game:

REGRESSION AS REFORM. Living in a welfare hotel gets to you. The place is unbelievable. You can’t even call it an existence. But the worst thing is just being alone, just being ignored completely.” The person speaking was a 31-year-old unmar-
ried man who had been discharges some months earlier from a New York State mental hospital. He went on to explain that he had admitted himself to the psychiatric unit of Bellevue Hospital (a New York City municipal institution) four times in two months since his discharge “because I just couldn’t stand not
having others I could reach out to. I preferred the hospital to my SRO (single-room occupancy)
room.” (1)

That person is one of many unwitting vic-
tims of a system that might be called the com-
munity mental health con game. As with all con games, this one is marked by a sharp dis-
junction between the promises held out to the victim and the reality of the con artist’s in-
tentions—the con artists in this instance being state politicians and those professionals and
bureaucrats who do their bidding. The reality of their intentions involves containing and
reducing costs, shedding responsibilities and reaping the mental health care deliv-
ery system to conform to the structure of the health care system in general, with its predomi-
nance of the voluntary sector and its empha-
sis on treatment of clinically interesting acute conditions and corresponding neglect of chronic conditions. The promise held out to the victim—shaped by the politician’s need to maintain the legitimacy of the state and borrowed from the rhetoric of progressive mental health professionals—is, in the words of former New York governor Nelson Rocke-
feller, that “a mental patient’s well-being and his chance for recovery are better served if he can
be treated at home while maintaining ties as family and community.” (2)

What follows is intended neither as an at-
tack on the community mental health system nor a defense of state mental institutions, however modernized physically or therapeu-
tically. On its own terms, the community mental health system is a failure, and its critique of institu-
tionalisation represents a humanitarian vision that has proved unacceptable to professionals and laypersons to work toward the reinte-
gration of the mentally disabled into a society that historically has preferred to relegating them to the dehumanising environment of a
warehouse.

What follows is intended as an examina-
tion, using the State of New York as a case history, of the fraudulent use of that theory as an ugly reality. At the policy making level that reality involves the operation of a set of economic and political motivations hav-
ing nothing to do with a concern for the heal-
ing of the psychologically wounded; at the human level, it involves forcing those whom the coping mechanisms have been found to be faulty out of a mental hospital and into the
revolving door. Large numbers of those dis-
charged, rather than following a trajectory leading from institutionalization to more-or-
less successful recovery with the outside world, are getting caught in a bind along the way
and being propelled back into an institution. (Some clinicians would say that the revolving
door can be a good thing in that multiple brief hospitalizations over an extended period may be preferable from the patient’s point of view to a single extended period of hospitalization. These clinicians assume that the hypothetical patient is receiving treat-
ment while outside the institution but is sub-
ject to occasional acute episodes that require hospitalization. Such a pattern undoubtedly has theoretical validity but, as what follows will demonstrate, also bears no resemblance to the facts of life for many patients dis-
charged from state hospitals.)

Introducing the Magic Potion
The year 1955 has been used as a refer-
ce point because it was in that year that chemistry replaced applied physics as the
major treatment modality in New York’s state mental hospitals, as well as in those around the
country. The straitjacket and the padded cell gave way to the tranquilizer, which, hav-
ing been tested in the New York state mental hospital system, was administered to 20,000 of its patients in 1955. That same year marked the turning of the tide; the total patient popula-
tion, which had been steadily increasing (it increased by 2,500 in 1950), began to reverse course (declining by 500 in 1956). (Notably, the equally steady increase in the patient population of all state and local government mental hospitals declined by 7,500 in 1956.)

More importantly, the existence of tranquiliz-

ing drugs made possible psychiatric proce-
dures that had previously been unthinkable, as the unmanageable became manageable and the undiscardable thus became per-
fectly discardable.

Table 1
DISCHARGES AND DISCHARGE RATES* NEW YORK STATE MENTAL HOSPITALS
Selected Fiscal Years, 1955-1973

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Discharges</th>
<th>Discharge Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1955</td>
<td>9,554</td>
<td>27.7</td>
</tr>
<tr>
<td>1958</td>
<td>13,356</td>
<td>20.2</td>
</tr>
<tr>
<td>1960</td>
<td>16,819</td>
<td>20.3</td>
</tr>
<tr>
<td>1963</td>
<td>19,951</td>
<td>14.4</td>
</tr>
<tr>
<td>1966</td>
<td>23,674</td>
<td>13.8</td>
</tr>
<tr>
<td>1969</td>
<td>28,778</td>
<td>13.1</td>
</tr>
<tr>
<td>1972</td>
<td>33,768</td>
<td>11.9</td>
</tr>
<tr>
<td>1975</td>
<td>36,007</td>
<td>10.9</td>
</tr>
<tr>
<td>1978</td>
<td>34,476</td>
<td>8.6</td>
</tr>
<tr>
<td>1981</td>
<td>35,011</td>
<td>4.7</td>
</tr>
</tbody>
</table>

*Discharges are those admitted to New York State mental hospitals who were patients in the hospital on the anniversary date of dis-
charge or who were patients on the anniversary date of admis-
sion, or who were on the anniversary date of admission. (Admis-
sion or discharge rates are the sum of admissions and discharges divided by the average number of patients on the hospital’s in-
patient service for the fiscal year.)

Table 2
READMISION NUMBER AND AS PERCENT OF ALL DISCHARGES* NEW YORK STATE MENTAL HOSPITALS
Selected Fiscal Years, 1955-1974

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Number of Readmissions</th>
<th>Readmissions as Percent of All Discharges</th>
</tr>
</thead>
<tbody>
<tr>
<td>1955</td>
<td>5,835</td>
<td>27.1</td>
</tr>
<tr>
<td>1958</td>
<td>8,752</td>
<td>20.3</td>
</tr>
<tr>
<td>1960</td>
<td>10,225</td>
<td>20.3</td>
</tr>
<tr>
<td>1963</td>
<td>15,301</td>
<td>20.0</td>
</tr>
<tr>
<td>1966</td>
<td>16,921</td>
<td>20.7</td>
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<tr>
<td>1969</td>
<td>15,467</td>
<td>20.2</td>
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<tr>
<td>1972</td>
<td>15,467</td>
<td>20.2</td>
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<tr>
<td>1975</td>
<td>15,467</td>
<td>20.2</td>
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<tr>
<td>1978</td>
<td>15,467</td>
<td>20.2</td>
</tr>
<tr>
<td>1981</td>
<td>15,467</td>
<td>20.2</td>
</tr>
</tbody>
</table>

*Readmissions are those admitted to New York State mental hospitals who were patients in the hospital on the anniversary date of admis-
sion or discharge, or who were patients on the anniversary date of admission. (Admis-
sion or discharge rates are the sum of admissions and discharges divided by the average number of patients on the hospital’s in-
patient service for the fiscal year.)
By 1965 drug therapy was being administered to over two-thirds of the patients in the New York State mental hospital system and about $4 million was being spent annually on the purchase of tranquillizing drugs. In its 1970 annual report, the State Department of Mental Hygiene (SDMH) waxed ecstatic over the dramatic reduction in the state's role in its development: "The results of Department drug therapy research have contributed to the release of thousands of inmates and have made hospitalization unnecessary for thou-

sand of others who could be treated effectively as outpatients. The estimated $30 mil-

lion annual saving this has effected is out-

weighed by the social values resulting from thousands of persons staying in, or being re-

turned to, productive lives in the commu-

nity."

(We should disclaim here any intention of evaluating the uses and misuse of psycho-

drugs by SDMH in the treatment of its charges. The possible functions of such drugs range from the benign function of making possible the treatment of a person the cru-

estness of whose condition makes him unaccept-

able otherwise, to the malignant function of making the social reality that has literally driven a person crazy. For our present pur-

pose the significance of drugs is simply the fact that their introduction on a large scale was a necessary precondition to the plans and policies that followed.)

effect of drugs, it might be noted, was not limited to the patients but extended to the economics of the state hospital system and the role of patients in that economy. In its budget for fiscal 1967, for example, SDMH requested $1 million for the purpose of beginning to hire paid employees to replace patients who had worked in the laundries of state hospitals. Since inception of the drug therapy pro-

gram, there is no accumulation of patients who will remain in the institutions for the re-

mainder of their lives. The influence of drugs makes it practically impossible for patients to work during their hospital stay. Further-

more, it has been determined that laundry work has no significant vocational rehabilita-

tive value.

Coping a Veneer

Psychotrophic drugs provided the opportu-

nity while the community mental health orien-

tation provided the ideological cover for a

ploy of forces, at the highest levels of state

government, that had nothing to do with the needs of the mentally ill for treatment, care

and support. The result was a policy of dis-

closing existing and attracting admission to the state hospital system huge numbers of peo-

ple whose successful functioning outside a mental hospital required ongoing treatment

programs and/or more-or-less structured liv-

ing situations at a time when neither were available anywhere in anything resembling

adequate numbers.

While from the point of view of a would-be

patient or a concerned outsider such a policy seems potentially nonsensical, from the

point of view of the state and of the state's mental health professionals in its service that policy was eminently rational. When the public appearance of the discharge policy eventually created re-

quired that it be defended, its defense, in the

words of Dr. Robert A. M. McKinley, SDMH Dep-

uty Commissioner for Mental Health, was:

"We want to provide programs for ex-pat-

ients, but many of their problems are due to

housing, not mental health—and we don't want to get involved in the housing busi-

ness."

Prior to the 1960's, of course, SDMH had

been in the housing business—providing little more than shelter for society's reject, whom

their families and communities had dumped on the state hospital system. During the first

half of the 1960's the state government devised a scenario for reversing the human tide, for
deflecting the homeless and rejected back to a condition of homelessness and rejection.

Not only had it become therapeutically pos-

sible—thanks to psychotropic drugs—to do more than simply discharge mental patients

in state hospitals, it was becoming politically untenable not to do so. The ever-present

threat of exposure of the state hospital as snake

pit, abetted by the pressures mounted by mental health professionals and civil liber-


tions, not to mention the felt need of the Rockefeller Administration to present a pro-

gressive image, all created an imperative that moves me in the direction of trans-

forming the state hospitals from purely cus-

todial institutions into something resembling modern treatment facilities.

Again this backdrop there emerged two motivating considerations, both of which can be traced through the statements of policy and administrative action demonstrating from state policy-makers from 1962 onward: First, the cost of the state to treating the mentally ill can be kept within manageable limits, both by reducing the population for which the state is responsible and simultaneously by transferring the existing state costs to both local and federal levels of government. Second, the mental health care system, which hitherto had been more akin to a welfare system than a medical system, must be transformed into something more closely resembling the mainstream health care system, a process that involves either rejecting or ejecting those patients who do not conform to the conditions of living psychiatric treatment and simultaneous-

ly channeling funds for the provision of such treatment from the public to the private sec-

tor. The two motivations, however concep-
dually distinct, were mutually reinforcing. The projected overhaul of the mental health care system, given its byproduct of drastically reducing the number of people for whose sustenance and care the state accepted re-

sponsibility, was consistent with the cost-con-

straining strategy, given the political necessity

that those for whom the state did accept re-

ponsibility be given something more expen-
sive than purely custodial care. Before a curtain concealing an unhappily view, the pa-

tient-centered community mental health phi-

losophy became the themes of communities old and new which to conceal such less-than-patient cen-

tered machinations.

Escaping a Cost Explosion

The problem of changing the state institu-

tions from asylum to therapeutic facilities was that the elimination of their overcrowd-

ing and understaffing in accordance with evolving professional standards of adequate

space and staff with a patient population hovering around 20,000 to 25,000 per year. The

state of the system's patient population had remained stable, the annual cost of running

the system would have thereby increased by $113 million to $368 million. The actual 1972 ex-

penditures for operating the state mental

hospitals totalled $376 million, or slightly over half the latter amount. (7) That the care

provided for $20.33 a day is less than the best in psychiatric treatment is suggested by the

fact that at Bellevue Psychiatric Hospital—its-

self frequently cited as a model for the state-

quotas—$11 per day, the 1969 cost per patient day was $59.94. (8) Multiplying that amount by 50,000 patients and by 365 days a year the state would be spending a staggering hypothetical figure of $3.1 billion.

In this context the community mental health ideology becomes the ideal escape route from a potentially horrendous financial

Brand: If it is clinically preferable, as that orien-

tation espouses, to treat most mental pa-

tients most of the time in decentralized com-

munity facilities and services closely reas-

ming the mainstream health care system, a process that involves either rejecting or ejecting those patients who do not conform to the conditions of living psychiatric treatment and simulat-

ously channeling funds for the provision of such treatment from the public to the private sec-

tor—one can argue that most of the responsibility for treating the mentally ill lies not with the state at all, but with communities and their governments. The state can thus maintain its legitimacy by sharply narrowing the defini-

tion of its role and can invoke the techniques of modern medical science to validate that strategy.

Such a shift in responsibility is accom-

panied of course by a corresponding shift in dollars. When a state hospital whose cost of care is entirely a state expense be-

comes an ambulatory Medicaid patient at a psychotic clinic, the state only has to pay
ROCKY O'DEIFICE COMPLEX

The man who brought us the Albany Mall and the World Trade Center found in the field of mental health another means of leaving a permanent imprint on the State of New York and doing it as a favor for the construction-trades unions. Along with that creative bond lawyer, John Mitchell, he also found in mental health another opportunity for launching that financial wonder, the moral-obligation bond.

On January 23, 1965 Nelson Rockefeller proudly announced a $500-million construction program that was to be "the most comprehensive and extensive in the nation in the field of mental health and mental retardation." Its mental-health elements included four new 1,000-bed psychiatric hospitals, 13 new 200-bed special-care units and eight new 100-bed psychiatric hospitals, 13 re-habilitation centers to be attached to existing state hospitals and three 300-bed so-called intensive-care units, also to be attached to existing facilities. For the localities, the package included a program of financial aid and incentives for the construction of community mental-health and mental-retardation centers.

Both the construction and its financing were placed outside the structure of state agencies and control. Mental Health Facilities Improvement Fund. Everything in New York being subject to change, the Fund was renamed the Health and Mental Hygiene Facilities Improvement Corporation in 1968 and renamed the Facilities Improvement Corporation in 1973. Financing was to be accomplished via that other modern wonder, the mortgage bond, a new concept. The bond was issued by the State Housing Finance Agency and secured by payments made by or on behalf of all beneficiaries of mental-health facilities.

The granddaddy of the original construction plan did not survive the test of time. The 13 children's hospitals were completely restructured. The 13 rehabilitation centers became 11; the three intensive-care units never got built; and the four new 1,000-bed psychiatric hospitals became one 300-bed hospital, two 400-bed hospitals and one 750-bed hospital. (In terms of beds, the original total of 7,500 got scaled down to 2,892, a drop of 61 percent.) There were the usual cost overruns (the South Beach Psychiatric Center on Staten Island, for example, was originally estimated to cost $25 million but actually cost closer to $100 million). The usual delays (ranging from five years from original projected completion dates) and the usual examples of shoddy construction (one children's hospital's mental retardation ward was so overcrowded it was virtually not occupied). The usual additional costs were money used to finance unnecessary construction, excessively expensive construction, high interest rates or high administrative costs was money not available for the operation of state facilities.

The usual problem of disjunction between a construction process operating independently of state appropriations and the fact that operation of the newly constructed facilities was dependent on such appropriations. The risk that disjunction creates is of course that the process is a waste of public moneys and, totally or partially unoccupied because appropriations are not available for staffing. That risk was realized in the completion of much of the new construction in the early '70s coincided with a period of budgetary austerity. SDMH explained hospitals, hospitals, hospitals, "building occupancy was considerably delayed" due to "serious cutbacks in the Department of Mental Health budgets during the early 1970's."

Meanwhile, patient care was in jeopardy at the old court-ordered admission system had been the legal basis for use of the state hospitals as a dumping ground for a former state mendicant welfare, so the new medically based admission system became the legal basis for the state hospitals to reject candidates for admission. The elderly, as we shall see, became prime candidates for being rejected.

Interestingly enough, after 1965 (the new law became effective January 1 of that year) the number of state-hospital patients "becoming chronic" (staying over two years in the hospital) began to decline (11) and the discharges--both the absolute number and the discharge rate--started to decline. (See Table 1 and graph page 19.)

The plot began to thicken when SDMH in June, 1964 issued a statement of mental plans. Arguing in favor of a reduction in the number, the character of the state hospitals' patient population, that document called for "conversion of our institutions from custodial care to active treatment facilities." Coupled with "a careful medical screening" to effect a lower threshold for receipt of care.
Sterilization Guidelines

"We took on the medical establishment and I think we're going to win," said a member of the New York City Health and Hospitals Corporation (HHC) Advisory Committee on Sterilization. "But," she added, "this is only the beginning." Since November, 1974, the Committee—composed of representatives of women's groups, hospital community boards, health and community groups, and HHC staff—has been developing guidelines for female sterilization (tubal ligation) practices for the largest municipal hospital system in the world.

The bitter battle waged by the Committee for the adoption of its guidelines has been confined primarily to the bureaucratic corridors of the HHC. The Committee has locked horns with many of the chiefs of service in obstetrics and gynecology at the municipal hospitals and their affiliates. Preliminary drafts of the guidelines have been subject to near sabotage by some of the senior staff of the HHC. The issue has created waves outside the bureaucracy as well. The Committee's work has been attacked both privately and publicly by most of the powers that be in the family planning/population control establishment.

The widespread interest and resistance to guidelines relating to a medical procedure with rather limited application is explicable because the New York City system, with its 13,289 beds and nearly-billion-dollar budget, often sets the pace for the rest of the country. If sterilization abuse is effectively curtailed here, the result would probably be fewer sterilizations elsewhere. If the principle of informed consent is integrated into the policy of this system, other hospitals may be forced to follow suit. It operating policy can be shaped by nonmedical, nonbureaucratic people in this one area, what stops the extension of such influence into other areas of hospital practice?

Most of the fears of the guidelines' foes, however, will prove groundless if the Committee's work really batters up inside the HHC bureaucracy. The probable adoption of the document by HHC's Board of Directors is only the first step, albeit an important one. Only if the principles of public control and the federal government's thinly disguised

rate of hospitalization" and to exclude from state hospitals those patients, primarily the elderly, "who need long-term nursing care with a minimum of medical care." (12) The rationale for seeking increased staffing of the state hospitals was provided by the observation that active treatment programs would require "a major build-up of staff in contrast to present staff ratios, which have changed little since the days of custodial care." (13)

The theoretical basis for a shift in responsibility from the state to the local level was established in a redefinition of continuity of care. "As we approach a system in which early care is provided in community facilities and services, continuity of care must be viewed as maintaining continuity with those rather than with the state hospitals." (14) Perhaps to facilitate such a shift in roles and attendant responsibilities, SDMH also in 1964, in the course of a reorganization of its central office, created a Division of Community Facilities.

The next major enunciation of state mental health policy emerged in July, 1965 in the form of a new and improved master plan, this one fueled by a two-year, $290,000 federal planning grant, which made possible the creation of a State Planning Committee on Mental Disorders, ten regional planning committees, 14 task forces and a new Division of Mental Health Resources and Policy Planning within SDMH.

In the view of the State Planning Committee, as enunciated in the master plan, the role of the state was in part to assume responsibility for "[n]eeds which cannot be met or are not met by voluntary or private efforts." (15) One such need was housing for hospitalization for periods of longer than 30 days, whereas the state hospitals were to provide "intensive inpatient treatment and care of persons with mental disorders who require such care for longer duration." (16) The conversion of state hospitals to "active treatment centers" would mean "a corresponding shift of primary responsibility for providing continuity of patient services to local government." (17) "Responsibility for arranging and providing sheltered living, temporary or permanent, for those with mental disorders who do not have the financial means to provide their own shelter should be carried by public social welfare departments," and (18) "there should be a planned and orderly transfer to [local] community mental health boards and departments of mental health of responsibility for aftercare of patients released from State hospitals." (18) The state thus established, according to the new directive, of acute inpatient care for moderately long periods, the responsibility for treatment and maintenance of the mentally ill lay with local welfare and mental health agencies.

If this scenario for a transformation and shrinkage of the state's role in the care of the mentally ill made sense as a cost-containing strategy, it made equal sense that it be carried out irrespective of the adequacy of local resources to provide the needs of those for whom the state had assumed responsibility. If the state itself set up community-based programs on anything more than a token scale, it was contravening its own interest in reducing responsibilities and costs. If it waited for localities to create such programs in adequate numbers, it was at the mercy of forces largely beyond its control. In the words of SDMH Deputy Director for Mental Health Planning Kenneth Skrivack, "If we waited for all the necessary programs to develop before discharging, nothing would happen; there'd be no felt need. By discharging, we're pushing the total system—society at a whole." (19) Discharged patients, in other words, were only of concern to the state as pawns in a game plan against the localities.

Professionalizing the System

The cost-containing strategy, as we have seen, was closely linked to the thrust of reshaping the state hospital system into something less like a welfare system and more like a medical care system. This thrust in (Continued on page 16)
accountability and informed consent, which underlie the guidelines, are used as a catalytic impetus of users of the system will the effort have any lasting impact.

The Issue: From Backwater to Mainstream

Sterilization abuse used to be found in the dark recesses of American society, most notably in mental hospitals and prisons where compulsory sterilization, particularly of men, was common practice. But political and social pressures pushed sterilization, especially of low-income women, from the backwaters to the mainstream of the health system. Two events in 1969 marked the turning point.

In one, the Nixon proclaimed population policy a matter of government concern and appointed John D. Rockefeller III chairman of the Commission to Study Population and the American Future. The new policy as forecast by Nisa was articulated by the Commission re-versed the long-standing government opposition to population control. Arguing that population growth was no longer synonymous with manifest destiny, the Commission wrote: “We have concluded that no substantial benefits would result from continued growth of the nation’s population.”

At the same time, the American College of Obstetricians and Gynecologists (ACOG) dropped its age/parity formula for female sterilization. This long-advocated rule of thumb for sterilization was limited to women whose ages times her number of living births equals 190. While not legally binding, most hospitals adopted the formula as policy. Thus simple arithmetic ruled admissions for sterilization. The age/parity formula obviously reflected the social mores of a society largely opposed to sterilization. Its moral opened the floodgates, and abuses soon followed. (See BULLETIN, January/February, 1973.)

Changing policy on sterilization gave the green light to doctors training in obstetrics and gynecology. Tubal ligation, a relatively new operation, became known as the procedure used by first-year residents to “crock the tuba” (make a surgical incision). Or if sterilization was accomplished without major abdominal surgery (i.e., by laparoscopy), the pre-operation gave doctors a chance to fool around with pieces of complicated medical instruments. In either case, tubal

ligations provided young doctors with an opportunity to combine their need for surgical material with practicing social and political values. And best of all, the government paid. HEW has indicated its preference for sterilization by picking up 75 percent of the tab for Medicaid patients. The usual federal contribution to Medicaid reimbursements is much less, ranging from 50 percent in most states to 83 percent in Mississippi.

ACOG’s open-ended policy, combined with the federal government’s thinly disguised cheerleading, were integrated into hospital policy. Metropolitan Hospital, a New York City municipal institution with a predominantly Puerto Rican and Black patient population, adopted the following policy in 1973:

The operation for surgical sterilization may be suggested by the physician for medical or social reasons or requested by the patient for personal reasons. The operation is not to be considered for contraceptive purposes.

Predictably, then, the 1970s has seen an enormous upswing in the number of sterilizations. According to the Association for Voluntary Sterilization, there was a three-fold increase in the number of sterilizations performed on women between 1970 and 1974, from 192,000 to 548,000. Local surveys report similar increases. (1)

Putting the Lid On

HEW and other sterilization advocates skipped merrily along stopped this practice has a $1 million damage suit filed on behalf of 14 Alabama black girls sterilized in Alabama under the auspices of a federally funded family planning program. Recognizing the fact that the operation on the 12- and 14-year-old Black girls was obtained from their illiterate mother by having her mark "X" on a consent form. The suit argues that neither the mother understood what she was agreeing to. After reviewing the evidence in this case and others like it, US District Judge Gesell found that there was "uncontroverted evidence in the record, ... that an indefinite number of poor people have been improperly coerced into accepting a sterilization under the threat that various federally supported welfare benefits would be withdrawn unless they submitted to irreversible sterilization."

Judge Gesell ordered HEW to promulgate new regulations to specify the circumstances under which sterilization may be performed and that are required for effective informed consent. The guidelines subsequently issued by HEW provide minimal protection and concern patients and medical institutions minimal protection and concern patients and medical institutions. The guidelines amount to the issuance of a regulation, including a description of the discomforts and and of the benefits to be expected; an explanation of alternative methods of family planning and a statement that sterilization is considered permanent on an offer to answer questions and an instruction that an individual may withdraw consent at any time without the loss of any benefit. In addition, the HEW guidelines required that a 72-hour waiting period be established between giving of consent and performance of the surgery.

Enter the Committee

The Advisory Committee on Sterilization was put together by several women on the Health and Hospitals Corporation staff. The chairperson, Elia Arrigo, Special Assistant to the HHC President, was joined by the following members: Vice-President for Quality Control and the head of the Family Planning and Assurance, had worked on the sterilization issue for five years as a staff member of the New York Urban Coalition. Now on the inside in a position of some responsibility, she and likewise headed members felt that the issuance of the HEW guidelines presented a propitious moment. They thought the HEW guidelines, and feared that unless a more informed and community-based approach were given, the HHC would merely send-off one federal regulation to its 13 hospitals. The Advisory Committee was given a mandate from the President of the

HHC, Dr. John Holloway, to draft guidelines that were legally adequate and more importantly, responsive to the needs of patients using the public hospitals.

The Committee's informed guess (because reliable data did not exist) was that most New York City hospitals were probably sterilizing women in compliance with the federal regulations. This estimate was confirmed in large part by subsequently published surveys of sterilization practices in large teaching hospitals. Results of the surveys showed that:

- Two municipal hospitals (Bellevue and Elmhurst) and one affiliated hospital (Beth Israel) complied with neither the waiting period nor the consent guidelines of the HEW regulations.
- The largest municipal hospital (King's County) admitted that it had not observed the mandated 72-hour waiting period.
- Harlem Hospital and three of the systems' centers (Methodist and Presbyterian) failed to advise patients that they would lose no benefits if they refused to be sterilized.

Most of the early meetings of the Committee were devoted to defining priorities, identifying the areas of hospital practice with the greatest potential for abuse and evaluating the specific portions of the HEW regulations. Female sterilization presents unique opportunities for abuse because women can be subjected to coercive pressures merely by virtue of the fact that they must choose to hospital for childbirth or abortion. The Committee's concern was with the operation on the postpartum and post-abortal women.

Generally, the guidelines and consent form developed by the Committee elaborate on specific items in the federal guidelines. The key concern underlying all of the provisions is to assure that women have access to all relevant information and to that women have ample opportunity to consider their decisions free from an atmosphere of pressure and coercion. The major points of the guidelines are:

1. Sterilization should be discussed as a birth control method similar to the discussion with alternative methods and in the context of a general discussion of contraception. Numerous surveys have shown that women who need to be sterilized are highest when the decision is initiated by a doctor. (3) This provision bans only

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The Health and Hospitals Corporation has adopted the following set of guidelines for the performance of a female elective sterilization operation. Several major considerations have determined the nature of certain items. Primarily, the guidelines attempt to insure that a consent form will be signed only after the woman has indicated a complete understanding of the procedure to be performed, its complications, and its aftereffects. To help her in understanding this, she will receive an informational session, which will include discussion of all methods of birth control, and the advantages and disadvantages of each; she will also receive information about the permanence of sterilization and the circumstances of regret which may accompany the operation under certain circumstances. She will be informed, as required by Federal regulations, that her consent may be withdrawn at any time prior to the operation without threat of loss of health services or other benefits. She will also reaffirm her understanding of the sterilization operation and its implications by a second written consent, given just prior to the performance of the procedure.

No woman will be subjected to any kind of pressure by any employee of the Health and Hospitals Corporation or by any member of the municipal hospital staff, medical or otherwise. If, after careful consideration of all other methods of contraception, a patient elects to be sterilized, compliance with the following guidelines is required in order to discharge the hospital's legal and ethical obligation to a competent adult woman requesting the procedure.

Patients eligible for sterilization in Corporation facilities must be at least 21 years of age and mentally competent.

Patients requesting sterilization will not be denied sterilization because of their marital status, the number of children, or age, as long as they are 21 years old and legally competent, unless the procedure is medically contraindicated.

Sterilization is to be discussed by hospital staff only in conjunction with alternative birth control methods and in the context of a general discussion on this subject.

(4) Initial consent may not be elicited from a patient during admission or hospitalization for childbirth or abortion or other medical treatment, except in emergencies; the time of giving these times will be presumed involuntary.

(5) Information for consent for sterilization requires that the patient understand the risks and benefits of sterilization, as well as the risks and benefits of all alternative, reversible methods of contraception. In order to meet the requirements of informed consent, every patient must receive an informational session by a non-physician counselor in addition to any information she may have received from a doctor or a medical student.

(6) At the time that a patient requests information about sterilization, she should be given an informational packet and an appointment for an informational session. She will be encouraged to bring to the session a friend or family member who can serve as her witness.

(7) Written informed consent for sterilization must be obtained from each patient. The Health and Hospitals Corporation requires that the attached consent form be used. This form must be presented orally in the presence of a witness. If the woman has brought a witness of her own choosing, the hospital will provide a witness who is neither the counselor nor a physician.

(8) All consent forms and informational materials must be available in at least Spanish, French, Chinese, Yiddish and English. If the counselor does not speak these languages or the primary language of the patient and the witness cannot serve as an interpreter, the hospital must provide an interpreter. Where an interpreter is not available, the patient should be referred to another municipal hospital where such an interpreter counselor is available.

(9) Sterilization may not be performed sooner than thirty (30) days following the giving of initial informed consent by the patient, except as described in (10) below. The hospital treating the patient must offer and encourage the use of other methods of birth control during the waiting period.

(10) A woman may choose to waive the normal thirty (30) day waiting period under the circumstances listed below. However, in each case she must first be informed of the normal waiting period, the reasons for it, and she must be given the full informational session.

(a) Interval Sterilization (not associated with pregnancy). The woman must sign the consent form in the presence of the witness present, indicating in her own words her reasons for wanting to abort the waiting period. In no case may the sterilization be performed in fewer than 72 hours, as prescribed by federal law.

(b) Early Delivery. A woman who has completed the appropriate forms and informational session and who signs the required consent form thirty (30) days prior to her anticipated delivery date may be sterilized in less than thirty (30) days if she delivers prior to her anticipated date. If a woman appears for delivery at a municipal hospital other than the one in which she has completed the appropriate forms and informational session, the receiving hospital shall contact, by telephone, the hospital at which the forms and procedures were completed for verification of same. This must be noted in the record, with the name and title of the person providing the information, the date that the consent form was signed, and the anticipated delivery date. If the consent form was signed thirty (30) days prior to the anticipated delivery date, this will be sufficient to enable the receiving hospital to perform the sterilization operation. Telephone verification may not be ignored.

(11) The procedure for telephone verification as outlined in (10)b above must be followed in the case of a woman presenting herself for a full-term delivery at a hospital other than that at which she has completed the appropriate forms and procedures. The information thereby obtained must be noted in the record. If the patient presents a duplicate copy of the initial consent, duly signed, witnessed and received in the hospital thirty (30) days prior to the delivery date, telephone verification may be waived.

(12) All sterilizations, whether pursuant to a waiver, performed after the normal waiting period, or based upon medical indication, must be reported to the Office of Quality Assurance on a monthly basis.

(13) As required by New York State regulations, all women must sign a statement reaffirming their request and consent to sterilization upon admission to the hospital.

(14) There is no legal basis in New York which requires that a married individual must be joined by the spouse at the time of the sterilization as a prerequisite to the performance of a sterilization procedure.

(15) Assurance must be given to every patient, orally and in writing, in the form of the following legend, boldly printed at the top of all consent forms and all informational materials. The legend should read: "IF YOU DECIDE YOU DO NOT WANT TO BE STERILIZED, YOU WILL NOT LOSE ANY BENEFITS OR MEDICAL SERVICES. YOU CAN CHANGE YOUR MIND AT ANY TIME PRIOR TO THE OPERATION." Medical services cannot be delayed or withheld while a woman is considering sterilization.

(These guidelines apply only to legally competent adults. Federal regulations have declared a moratorium on sterilization of individuals under the age of 21 or legally incapable of consenting by reason of incompetence.)
The Rejection

The response to the draft guidelines and recommendations was far from encouraging. The official advocates of family planning and sterilization—Planned Parenthood, the Association for Voluntary Sterilization and the Maternal and Infant Care Project of the City Health Department—and the gynecological establishment opposed them. The former feared any regulation that might result in fewer sterilizations of low-income women and the latter was threatened by the Advisory Committee's attempt to curtail its prerogatives. Women's groups, hospital community advisory councils, and community organizations were generally enthusiastic supporters.

The most vehement criticism of the draft centered on the 30-day wait, the limitation of sterilization to patient request and consent form, which stipulated risks and benefits. Additionally, many were outraged that policy in an area that they considered the province of doctors was being formulated by a group of predominantly nonmedical people.

The opening shot in the campaign to defeat the guidelines was fired by Dr. Ira Lubell, Executive Director of the Association for Voluntary Sterilization (AVS). In an article he wrote in the New York Post, Lubell lambasted the draft. According to the article, "The AVS opposes the guidelines in their present form, fearing they will make sterilization totally unavailable for many poor women."

Following up on his public attack, Lubell organized his allies among gynecologists to alert them to what he called "inexcusably dodgy" documents. Shortly after Lubell began his campaign, the HHC was bombarded with missives from gynecologists, chiefs of service, medical boards, Planned Parenthood and the American College of Obstetricians and Gynecologists. Even the New York State Bar Association got into the act. Assistant Secretary for Family Planning Dr. Louis Hellman made known his intention to accept a suit charging denial of services if the guidelines went into effect.

The Reaction

General Counsel, avoided meeting with representatives of the Committee although they were drafting a document that would have legal standing and thus came under his jurisdiction. It was reported to the Committee that Lubell and Kalkines and others were privately asserting the opinion that the Committee's report would be watered down to meet with their approval. Nancy Beards, a Committee member and a lawyer with the Center for Constitutional Rights, substituted for Kalkines and provided the Committee with legal counsel.

Lubell began organizing the opposition. The Committee had begun to address the issues. They were attempting to outwit its foes through bureaucratic maneuvering. This had seemed a sensible course since the Committee had been organized at the initiative of people inside the HHC and not in response to pressure from patients or community groups. There were at first no easily available outside groups to call upon.

After the attacks on the draft began, the Committee found it impossible to get out of the hole it had dug itself into. To abandon its previous strategy would have meant beginning all over again and creating a movement where none existed—a slow and arduous task. Instead, the Committee, now on the defense, accelerated its efforts to win the support of every conceivable administrative and decision-making structure within the vast and Byzantine HHC. As one Committee member, "I've never seen anything in here with as much participation. Unfortunately, except for osteopathic Committee members, virtually all of the participants were officially affiliated with the corporation."

Having locked itself into doing battle bureaucratically, the Committee had no choice but to negotiate its critics. As a matter of strategy the Committee decided that if it could neutralize the opposition of the chiefs of OB-GYN, the other anti-guideline groups and individualism would be undermined. Thus it began a series of meetings with a committee of the chiefs. The first few sessions were filled with anger, name-calling and insults directed from the chiefs toward representatives of the Committee. The chiefs refused to address the issues and instead upon venting their anger at spokespersons for the Committee, repeatedly cutting them off and referring to them as "dairies."

After several meetings, dubbed "group therapy" by one Committee member, the doctors began to address the issues. They were hard pressed to present convincing counterarguments that would not expose them to charges of exploitation and coercive practices. They fell back to conjuring up outrageous situations where the procedures set forth in the guidelines simply would not work. They spent considerable time, for example, worrying about the woman who might sign a consent form 30 days before her delivery date and then have her baby prematurely or the woman who might consent to a postpartum tubal ligation while in prenatal care at one hospital and then have her baby at another. The assembled chiefs wondered how the consent could then be transferred from one hospital to another. The Committee was happy to reply that a telephone was the appropriate instrument. swords. Instead of the special circumstances were accommodated in the draft document with appropriate clauses.

Much of the disagreement with the Committee evaporated over the course of the meetings. However, the one change upon which both the chiefs and George Kalkines insisted was a clause that would allow women to receive the 30-day waiting period. The Committee requested a special committee allowing the exception but felt compelled by the threat of a lawsuit brought by HHC and/or AVS. With the exception clause, which the Committee believed was the key to the HHC's continued support of the guidelines, the Committee feared that the HHC was denying services to anyone who decided on their own to have an abortion.

The guidelines, which went through 12 drafts during the nearly three months of negotiations. But aside from language and style, both of which were subject to compromise, the exception clause, the substance of the final document closely resembles the first. The one unresolved issue is the prohibition against approaching women scheduled for abortion. The chiefs insisted that abortion was an appropriate time to solicit consent to sterilization. They argued that otherwise a woman would be subjected to two separate procedures with the attendant risks to her health. The Committee remained adamant that the stress of the situation made this a potentially unethical practice.

The Board of Directors of the HHC will decide whether they will accept the chiefs' recommendation or the Committee's. On all other issues, the Sterilization Advisory Committee and the chiefs of service have written a joint statement urging the Board's adoption of the guidelines. With that kind of backing it is extremely likely that the Board will enact the guidelines into policy at their next meeting.

A Good Beginning?

The Board's acceptance of the guidelines will be a hollow victory if the struggle remains as it is now in the confines of the bureaucratic structure. One explanation of the apparent collapse of the opposition of the chiefs of service is that they believe that whatever is the written policy of the Corpora- tion, in the final analysis they, and not some outside group, will be in control of their departments. In keeping with the confines of the HHC, the Committee replicated the existing decision-making process, substituting different primates for the same old monkeys. Despite the ensuing battle it was the Committee members who decided the fate of the guidelines.

The Board's acceptance of the guidelines will be a hollow victory if the struggle remains within the confines of the bureaucracy. After all, the rights of patients against the encroachment of the medical system. But there was a certain quality of noblesse oblige to the entire process and it is not at all clear who will be the final victors. Without informed, aggressive patients the battle will have been fought, but the chiefs, after the furor dies down, will reassert their authority in less conspicuous ways.
The error can be remedied in part if the Committee follows through with its expressed intention of organizing a series of workshops on the guidelines. If these workshops can expand the process outside the committee rooms, then a major step will have been taken. On the other hand, few people become involved with the issue; then the work of the Committee will remain at best a case of a few with good intentions making policy for the uninformed many. Some instances of overt abuse may be curtailed, but the system will remain unchallenged and essentially unchallenged.

**Collapse of the House of Cards**

As had previously been agreed, Dr. Norman Herzog, representing the OBGYN chiefs, and Eta Street, chairman of the Committee, made a joint statement before the July meeting of the Medical and Professional Affairs Committee. As expected, the Board committee unanimously endorsed the guidelines. The only surprising aspect of the meeting was that the Board committee, with only one dissenting vote, eliminated the exception clause. The Board Committee members were elated by the Board committee’s action. Less than a week later, however, Dr. Herzog forwarded a letter to him from Dr. Myron Gordon, Chief of OBGYN at Metropolitan Hospital, Chairman of District II of the American College of Obstetricians and Gynecologists and a member of the chiefs’ negotiating committee. Gordon strongly objected to the final draft. “The tone of distrust and dismissal of the physician’s role was objectionable in the original document still exists in this one. . . . the proposal would have been scrapped and a totally new and useful document drawn up.”

The next day Dr. Herzog informed Ms. Armstrong that the deal was off. No joint presentation will be offered to the OBGYN Board of Directors. Rather, as Gordon urged, the chiefs will ask the Board to either table the question until they can come up with their own regulations or to adopt the HEC guidelines.

The Advisory Committee is outraged. At this writing, however, it has not decided what its response will be. Having been led down the primrose path by the August report, it is not clear whether the Committee will now take an independent turn. From the start the Committee has consistently demanded principles be dictated by its weakness. Its bureaucratic victories sustained it while its critics took pot shots at the draft. Now it faces an opposition well organized and united. Whether it can keep its house of cards from toppling remains to be seen.

Barbara Caness

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**Mental Health**

(Continued from page 16)

The care provided by both state and voluntary mental health services would concentrate on treatment of acute, as opposed to chronic, conditions.

The core of both acute and chronic mental health is the state mental health system, which is incidentally the same as the state hospital system. The state hospitals are the primary providers of both acute and chronic care. The state hospitals are funded by the state government and are managed by state agencies. The state hospitals are responsible for providing care to all residents of the state who meet the criteria for admission. The state hospitals are staffed by licensed mental health professionals, including psychiatrists, psychologists, social workers, and nurses.

The care provided by both state and voluntary mental health services would concentrate on treatment of acute, as opposed to chronic, conditions. This means that the state hospitals would focus on providing care to people who are experiencing a mental health crisis, such as a psychiatric emergency or a suicide attempt. The state hospitals would provide short-term care, typically for a few days or weeks, to help people stabilize and recover from their crisis.

The voluntary mental health services, on the other hand, would focus on providing care to people who are experiencing a chronic mental health condition, such as schizophrenia or major depression. The voluntary mental health services would provide long-term care, typically for several years or longer, to help people manage their condition and improve their quality of life.

The state hospitals and voluntary mental health services would work closely together to ensure that people are transitioned smoothly from acute care to chronic care. This would involve coordinating care across different settings, such as between the state hospital and a community mental health center.

The state hospitals and voluntary mental health services would also work together to ensure that people have access to the services they need. This would involve ensuring that people have insurance coverage for mental health services and that they have access to transportation to get to their appointments.

The state hospitals and voluntary mental health services would also work together to ensure that people are treated with respect and dignity. This would involve ensuring that people are treated by providers who are culturally competent and who are trained in the latest evidence-based practices.

The state hospitals and voluntary mental health services would also work together to ensure that people have access to support services, such as housing and employment, to help them stabilize and recover from their mental health condition.

The state hospitals and voluntary mental health services would also work together to ensure that people have access to research opportunities, such as clinical trials and other types of research studies, to help advance the field of mental health care.

The state hospitals and voluntary mental health services would also work together to ensure that people have access to education and training opportunities, such as internships and residencies, to help train the next generation of mental health professionals.

The state hospitals and voluntary mental health services would also work together to ensure that people have access to advocacy and support opportunities, such as self-help groups and peer support networks, to help people advocate for themselves and their loved ones.

The state hospitals and voluntary mental health services would also work together to ensure that people have access to policy and system change opportunities, such as state legislative advocacy and other types of policy and system change efforts, to help advance the field of mental health care.
provide state aid to localities for construction (as opposed to operation) of such centers, whether their operation would be under the auspices of local government or the voluntary sector. (28) The 1965 Legislature duly enacted the appropriate legislation, making available state funds to finance one-third of the cost of constructing such facilities.)

Thus the total picture falls into place: The state's role in the provision of mental health services was to shrink while it became more medical and less custodial. Local governments were to bear the burden of sheltering and caring for those kept out of or discharged from the state's "acute treatment centers," while medical schools, voluntary hospitals and voluntary mental health agencies were to become the beneficiaries of affiliations and funding mechanisms for the provision of such services as they cared to provide.

One piece of the game plan was already in place when the Planning Committee's report was published in July, 1965. In January, the Governor had announced with great fanfare a major new construction program, to be financed outside the normal appropriations process, which projected construction of four new mental hospitals of 1,000 beds each, 13 new children's psychiatric units of 200 beds each, 12 patient rehabilitation centers and three 300-bed intensive-care units. (See box page 6.) In line with the Planning Committee's recommendations, the new Capital District Psychiatric Center in Albany, for example, was built contiguous to the Albany Medical College-Albany Medical Center.

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The new hospital's garage to the Medical Center, along with the heating of the Medical Center by the new hospital's power plant.

Raising the Drawbridge

The next major landmark on the road to a new, improved mental health care system was less public and less pretentious, but no less significant, than a master plan or a major construction program. It was known to the bureaucrats as 88-27, that being the number attached to a memorandum dated June 19, 1968 to all state hospital directors from SDMH Deputy Commissioner for Mental Health John Cuming, M.D.

The memo applied to would-be patients among the elderly, classifying that population into six categories, of which those in one (reversible psychiatric illness) would be routinely granted admission, those in three (serious physical disability with minor mental disorder, physical disease of which mental symptoms were the direct result and socio-economic need) would be routinely denied admission and those in the remaining two (reversible psychiatric illness complicated by serious physical infirmity and irreversible mental disorder) would be considered on an individual basis. (Although the memo on its face applied only to geriatric patients, several hospital directors took it as a clue to shut off the flow of admissions of "chronics" of all ages.)

Although the selective-admissions policy was initiated without advance warning to the localities, something like it had clearly been in the offing for some time. The 1962 master plan had called for increased use of nursing homes for "aged persons with mild mental symptoms." (30) A 1964 report of SDMH's Office of Planning and Procedures had urged that "good nursing homes and related facilities can meet the needs of most aged persons, including those with mental disorders," and had noted that "[a]ny decrease in the number of geriatric patients admitted to State hospitals would result in a considerable saving to the State. A 50% reduction would save an estimated $5.1 million annually." (31) The 1965 master plan had spoken of state hospitals being "overused and misused as a resource for the aged" and had cited "the need for adequate domiciliary provision for older people." (32)

Expected or unexpected, the new admission policy was effective. The number of ad-

RESIDENT PATIENTS, ADMISSIONS, DISCHARGES AND DEATHS*
New York State Mental Hospitals Fiscal Years 1955-1974

[Graph showing data]

*Data on deaths not available prior to 1960.

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missions to state hospitals of those age 65 and over was 8.3% in fiscal 1968 (ending March 31, 1968); in fiscal 1969 geriatric admissions dropped to 6.044 and by fiscal 1972 they num-
bered only 607. (32) MDH reported that screening
tests had "evaluated the needs" of over
5,000 elderly that year and that, "More than
one half were found not to need state hospital
inpatient care and were referred to more
appropriate services." (33)

Those "more appropriate services," how-
ever, turned out to be elusive. A March, 1971 study
carried out by SDMH's Mental Health Research Unit
of the fate of 385 elderly per-
sions refusal admission at four screening sites
around the state concluded that "somewhere
very few (2-7%) one of every three were
judged to be receiving care that was either
inappropriate or inadequate." (34)

Opening the Floodgates

The geriatrics admission policy was reduc-
ing the number and changing the quality of
admissions to state hospitals. The other fac-
tors in the equation that equalled a declin-
ing and more medically interesting patient
population were discharging new admissions after
a decreasing length of stay and also stepping up
the number of so-called "chronics,"
whose patients who had been in an institu-
tion, for years.

While never the subject of an appropri-
tely numbered directive, a policy of stepped-up
discharging began to appear around 1968 both
within and outside of the system. With
the system SDMH's 1965 budget request in-
directly addressing system policy by char-
acterizing the increased appropriations as
being provided "the initial impetus which will enable the Department to greatly acceler-
ate the trend of a decreasing hospital pop-
ulation." (35)

Officially but more directly, a carrot-
and-stick strategy was employed by the cen-
cal office of SDMH to overcome the natural
reluctance of hospital directors to reduce the size of their respective domains. Comparative
rankings of individual hospitals' relative dis-
charge ratios were circulated among directors
for the purpose of inspiring competition
among them. Budgetary allocations among
state hospitals were based solely on in-
patient census, were modified to reward
the establishment of new treatment programs
aimed at accelerating discharge. Some re-
calcitrant hospital directors were able enough to
be eased out by forced retirement. Within
the hospitals, the policy of unitification—cre-
developed self-contained admission units
within the larger hospital—became a means of cre-
ating competition for high discharge rates
among unit directors. The objectives of unit-
ification had been officially described by the
Department as "to provide better services to
patients and hopefully, to reduce the average
period of hospitalization. Other benefits which
might be realized from full implementation
of this program would be a reduction in the
number of beds required and eventually few-
er facilities." (36)

Outside the system, welfare workers began
to complain that discharged mental patients
were comprising an increasing and increas-
ingly diverse "mixed bag." At the Central
Islip and Pilgrim State Hospitals on Long Island,
where many New York City residents ended up being hospitalized, were known
to effect discharge by driving buses loaded with
former patients to a welfare center in the City.

Residents of Manhattan's Upper West Side (where a number of so-called welfare
hotels and SRO's were) and of Long Beach in Long Island (where a number of proprietary
boarding houses were a big business) began
to complain of the hospital's inability to manage
the new influx of patients who had recently
been discharged from the state hospital.

The system to find its place among the
"chronics" frustrated by the mental health
services for patients who had been in the
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former patients to a welfare center in the City.
Neglecting the Neediest

The official rationale for kicking out and keeping out of the state hospitals large numbers of patients and potential patients was that their care would more appropriately be provided in a community setting and that the state, through its program of aid to localities for community mental health services, would subsidize that community-based care. Like resources for mental health generally, resources from the state to the localities had their ups and downs—state aid for operation of community mental health services (including services for the mentally retarded) went up from $28 million in 1966 to $53 million in 1971, then down to $56 million in 1972. The fate of the hypothesized network of community mental health centers was down all the way—from a recommendation for 150 in the 1965 master plan to a projection of 112 in SDMH’s 1967 annual report to an actuality in 1972 of 23 in operation, five under construction and seven in the conceptual stage.

Large amounts of state aid to localities was and is doled out to voluntary agencies (the New York City Department of Mental Health and Mental Retardation Services was administering over 100 contracts with voluntary agencies in 1971). The preferred patient population of such providers, however, is not the type of patient who is a potential candidate for, or a discharged patient from, a state mental institution. A 1973 report of the Legislative Commission on Expenditure Review, for example, found that only 17.2 percent of admissions to community mental health facilities in fiscal 1972 were considered severely ill, as opposed to 30 percent considered not ill, slightly ill or mildly ill and 52.8 percent considered moderately ill. The Commission concluded: “By approval and continued funding of facilities not treating the severely ill, both the State and local governmental units are endorsing priority service to those who are not the population in most desperate need of treatment.” (italics in the original.)

In a written reply to the Commission’s report, the Acting SDMH Commissioner, alluding to “the alleged failure of the community programs to serve institutional discharges,” argued that “This statement is valid, but not an accurate statement of the facts. In the community there is a still considerable unmet need for services to the community. It is natural and appropriate for agencies to deal with visible needs first. It is also a more efficient use of available resources to try to prevent institutionalization rather than to only remedy the effects of it.”

The possibility of a disjunction between the state hospital’s admissions and discharge policy and the availability of community services to those affected by it is actually built into the structure of SDMH, in which the state hospitals are administered by the Division of Mental Health, and state aid to localities is doled out by a separate Division of Local Services. That fact has made it possible for state aid to stall in the pipeline toward those voluntary providers with little taste for treating difficult cases, a situation that observers in and out of the Department confirm.

Falling Between the Cracks

It is impossible precisely to survey the fate of patients discharged from the state hospital system, whether they are patients who get caught in the revolving door of multiple hospitalizations or patients who are not hospitalized but who spend most of the rest of their lives sleeping in bed in a welfare hotel or the television set in a boarding home. The simple fact is that no one, in or out of SDMH, has been able to keep track of the discharges (“dumped,” some would say) from the state hospitals. There have, however, been enough scattered studies conducted and case histories reported to suggest the dimension and style of the dust-bin to which many discharged patients have been relegated. SDMH itself has occasionally admitted, for example, that of all the released from its care during the fiscal 1972 budget, nearly 56 percent of all admissions, admitted that “The need for improved community services for the mentally ill is strongly suggested by these figures.”

Other such findings, explicit and implicit, include the following:

• A 1973 report on community mental health services by the Legislative Commission on Expenditure Review concluded that “The lack of day hospital and rehabilitation services and inadequate use of existing follow-up for those in the community is contributing to a high return rate of patients to state mental hospitals.”

• A 1972 study conducted by staff of Meyer-Manhattan State Hospital of 168 patients admitted to the hospital during a three-month period found that of the 168, 100 were readmissions. Of those 100, the staff found that 84 patients might not have needed to be rehospitalized, had new or augmented services existed, or had the already existing services provided better follow-up care.

• A March 1971 report by the New York City Department of Social Services (DSS) of discharged state hospital patients living in so-called private proprietary homes for adults (which were receiving from DSS about $50 per month for residents on public assistance) found that “The discharges need continuity of after-care, which is not provided by the staff in the proprietary homes. Local after-care facilities are frequently involved in the increased population of discharges. The discharges, as a group, tend to congregate in the lobby of one or another large area and store blankly at one another, making no attempt to socialize or participate; the net result is an atmosphere of a vast wasteland.”

• Another 1971 City DSS study, this one of 65 persons discharged from state hospitals who were clients at two welfare centers, found that 38 of them were living in so-called welfare hotels. That fact inspired the comment that “The housing of many discharged in Manhattan hotels lumped together with junkies and alcoholics—putting them on restaurant allowances and providing no social service and no group facilities of any kind is pretty clearly destructive to any stability they might attain, whether on or off prescribed drugs. These individuals require a protected or sheltered environment and are simply not getting it.” (The remaining 27 persons in the sample, four were in furnished rooms, four in apartments, two in foster homes and 17 were living with relatives.)

• In March 1975 a Suffolk County (Long Island) jury convicted the two owners of a chain of boarding houses in that county and in upstate New York of 12 counts of kidnap-
ping, imprisonment and mistreating former state hospital patients. The trial included tes-
timony by several former patients that the
couple had chained them, beaten them and fed
and clothed them inadequately, while re-
ceiving regular payments for their care from the
County DSS. The couple had also forcibly
transported up to 40 former patients from their
boarding houses in Suffolk County to one in
an isolated upstate region so that they might
house more former patients in the Suffolk County
chain. (48) Suffolk County is the site of three
of the largest mental hospitals in the
New York State system. Central Islip, Pilgrim
and Kings Park State Hospitals; the conver-
sion of old resort hotels to boarding houses for
discharged mental patients has become a big
business in the area.)

A 1977 report of the Community
Council of Greater New York cited an SDMH study
discharged patients that found that only
23 percent had returned to their own homes, the
remaining going to single room occupa-
cy hotels (38 percent), nursing homes (11 per-
cent) and unknown places of residence (38 percent).
The report estimated that 8,600 dis-
charged mental patients in New York City
were in need of "community residential care"
(i.e., halfway houses, group apartments and the
like); it further found that only four of
officially designated halfway houses and a few
of group apartments in the City and that
foster homes, nursing homes and proprietary
homes did not provide rehabilitation services.
The report concluded: "Assuming that suffi-
cient group apartments were available as a
second stage of residential care and the
number of (first stage) halfway houses was
doubled and the average length of stay in
halfway houses was four months, it would
still take 4½ years to serve only the current
identified population of 8,600 in need (which
does not include persons living with families
or the number of persons who become in
need during the interim.)" (49) (Italics in the
original.)

The Double Bind

The last few years have seen changes in
detail but not in essentials. Budgets have gone
up and down (the movement currently is
down), with sharp cuts in education and
services being a prime victim of the budget-makers' ax; and commissioners have come and
gone (Dr. Lawrence C. Kohl, former Presi-
dent of the American Psychiatric Associa-
tion, is the cream of the voluntary establish-
ment crop, coming from a post as Director of
Psychiatry of 'Cushing' Hospital and Chief of
the Medical Center and Chairman of the Psychi-
atria Department at Columbia University School
of Physicians only to be replaced by the new
one). The new one is in turn being replaced by the
new one. The new one is in turn being
replaced by the new one. And so it continues
to draw a salary as a tenured professor.
For the victims of the community mental
health game, however, the deception re-
mains the same.

Those who used to find a home, however
dismal, in the state hospital system have for
the last decade increasingly found them-
securing the worst of all possible
worlds. Many are no longer able to
for entrance into "acute treatment centers" and
find themselves instead in such horrific
manifestations of the profit motive as pro-
nitary nursing homes and houses for adults.

Those who get into the system are in the
realm of modernized treatment appreciably less
than the promise and in any event find them-
selves sharply shuttled out into such equally
horrible manifestations of the profit motive as
SRO's and boarding houses. They may
find a facility that will replenish their medi-
cation, but many find that to be only the form
of "treatment" available to them. In desper-
ation, they may also end up at Bellevue or pay a
return visit to a state hospital, where in either
event after a short period the revolving door
will turn again. They probably haven't heard
the Rockefeller homily that "[a] mental pat-
tient's well-being and his chance for recovery
are best served if he can be treated at home
while maintaining ties with family and com-
munity," and perhaps that's just as well.

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Much of our culture today reminds us to beware of doctors and to stay out of the hospital if at all possible.

do cure bacterial pneumonia. Realizing that antibiotics are overprescribed, isn’t there some way to make decisions about using them?

More important, the notions of social and structural intro-
genesis lead to a popular crit-
ique of medicine as social control without placing this controlling function within the broader needs and goals of so-
ciety as a whole. For example, it is easy to see how housewives and mothers are caught up in an endless cycle of visits to doctors—to gynecol-
ologists, ob/gyns, pediatrici-
s, internists and so on. For many women, particularly in subur-
ban neighborhoods, these vis-
is constitute an important emo-
tional and sexually laden event. Surely many doctors prey on the isolation and frustra-
tion of housewives. They of-
ter them the little pill and the pot on the shoulder that keeps them going. Yet eliminating the role of the doctor in the suburbs, without eliminating or radically changing the so-
cial construction of the suburbs and of women’s lives in them, will merely create a situation in which existing dependency needs are shifted onto another potentially controlling institu-
tion.

Ironically the medical estab-
ishment itself is now question-
ing the current role of many of the doctors that now treat these women. In the emerging high-technology medical sys-
tem, there is an increasing strain to develop a system of paraprofessionals who would deal with the “personal com-
munication” needs of patients by enabling doctors to spend their time more profitably in the huge hospitals and with the new sophisticated machinery. In the future, women may no
longer get "ripped off" by doctors, but unless their dependen-
cies are altered, they will likely be even more ripped off by a system of pseudo-specialists whose distance from the real power and knowledge of medicine only increases medi-
cal mystification.

This trend can already be seen, in fact, in the growth of the "natural" vitamin industry and other sorts of self-cure. What is happening is that the social control component is passing from the center of the medical establishment to new industries, without, however, a genuine alteration in people's state of dependence.

One of Illitch's most intriguing questions is the issue of pain. But as the sense of truth is drawn into a black-and-white picture that confuses and misleads us in seeking any solution to the problem, Illitch compares how preindustrial and traditional rural and feudal societies handle pain and sickness. He quite rightly reminds us that "Traditional culture derives its hygienic function precisely from its ability to equip the individual to make pain tolerable, sickness understandable and the lifelong encounter with death meaningful." In contrast to modern society, where the question asked about pain and illness is what, traditional culture focuses the question on why. "Why must I/ought I/can I suffer?" The universe is moral one and, although this may have repressive implications for particular individuals, its richness and内容 do not lie in the fact that pain and suffer-
ing are always viewed and treated as absolutely natural but are thus given personal and social meaning. Most tra-
tional health care was a process for sleeping, eating, loving, working, playing, dreaming, singing and suffering.

In contrast, "Medical civili-
tization tends to turn pain into a technical problem and there-
by to deprive suffering of its inherent personal meaning." Questions of why are rele-
gated to such symbols as pain is something to be immediately eradicated; it "gives rise to a snowballing demand on the part of anesthetics consumers for artificially induced insensi-
tibility, unawerness, and even unconsciousness."

Again, Illitch's description calls up our anger about such technological deprivations as surround anesthetics for childbirth. Certainly he is right that women ought to be able to ex-
perience the pain and excite-
ment of childbirth—if they want to. But should they not also be able to allow some kind of pain-killing if they want? Or to focus on a kind of pain where joy is not so intimately related, what about the pain of a per-
son dying from cancer? Or the more mundane pain of a tooth-
ache or broken bone?

I myself worked for awhile in a state hospital, where men-
tal patients were slowly pushed into a society of rationality, to put into "normal" behavior. For several years after, I was very much recom-
manded that anyone and everyone and every-where stay away from psych-
opharmacologic drugs—at whatever the cost. More recently, how-
ever, I have come to feel that in the context of the social rela-
tions were greatly altered, such drugs could be benefi-
cial to those who are suffering from the social stress of the crowd. Illitch's under-
standing of these drugs as a form of social control that makes us prefer the wilfully deep despair of insanity to the dropped insensitivity is that common on most mental wards.

Illitch understands that the medical focus on pain is a sign that the profession is con-
cerned with symptoms, not people. But this observation is common to the social at large, not merely to the medi-
cal Establishment.

As in his earlier analysis of education, Illitch makes a di-
rect and deadly (for the physician) connection between industrial-
ization and technology and bu-
reaucratization. Whether the bu-
reaucrat or sociologist, as countries become industrialized, the reg-
ulation of the technology for Illitch necessitates the creation of huge, unwieldy bureaucracies. Bureaucratization, in turn, is fragmented, alienated and an instrument of domina-
tion. There is no reactivity for self-activity within a bureauc-
ocracy. Whether that bureauc-
ocracy is an educational or a medi-
cal one.

Illitch connects the relation between industrialization and bureaucratisation is virtually timeless; he does not relate it to the configuration of social classes. Consequently, his historical analysis is one of how capitalist society would simply further bureaucr-
acize, and he is correct in con-
cluding some of the existing state socialist countries for their acceptance of the same model of industrial development as their presumed capital-
ist counterparts. But he does not understand how both bureaucr-
acy and industrialization in capitalist as well as state so-
cialist countries are simply the product of systems of social re-
lations that include hierarchy and domination. That both bureaucracy and industrialization have until now been based on a stratified society and a system of wage labor. This includes a sexual and re-
productive labor, payment based on presumed levels of skill and education and a ten-
dency for the working class to the Union and the Eastern Euro-
pean countries, toward domi-
nation. This pattern appears to be in the process of disinte-
gration and through ideologies of consumption.

But even accepting Illitch's belief in the necessary connec-
tion among industrialization, technologicaI domination and bureaucratisation the solution of his final point is surprising for its blatantly reformist char-
acter. Although he reiterates that "Medical neomia is but one specific aspect of the gen-
eral counter-intuitive mindset that characterizes the tech-
ological society," his solution is to focus merely on the medical establishment. In the industrial envi-
ronment, he seems to suggest as the tool, backed by "an ethical awar-
ness of the evil." Specifically Illitch would try to "recuperate personal re-
sponsibility for health care" by limiting the power of the "professional monopolies." His legislation "would not provide medical technology to profes-
sionals until those devices and means which can be handled by laymen are truly available to anyone wanting access to them. Instead of multiplying the certified specialists who can grant one of the multiple sick-notes to people who are made ill by their work and home-life, the new legislation would guaranty the right of people to drop out and or-
ganize for a less destructive way of life in which they have more control over their milieus."

Thus, in the context of a to-
tal critique of industrial so-
ciety, Illitch leaves the basic social and economic system alone. As in his earlier work, his solution is to alter one institu-
tion without any other un-
changed society.

Illitch's book comes to us in the midst of a very generalized despair about modern technol-
ogy and bureaucracy. From modern classics such as Kat-
taro Hara's The Trial of the Cat or contemporary movies such as The Towering Inferno, most of us have as part of our consci-
ousness the hopelessness that industrial society is largely out of our hands. Like Illitch, we have come to feel that the way things are, it is likely that "the alternative to extinction is com-
pulsory survival in a planned and engineered hell."

Until recently, traditional Marxism has given us little in terms of seeing our way out of technological domination. While Marx himself was often ambiguous or even equivocal about the relationship of the so-
cial relations of production to the forces of production, the tradition since him has largely focused on the forces of pro-
duction as determining. Al-
though some Marxists have looked at technology as neutral, it has become increas-
ingly clear how changing the social system would offer the human versus inherent potential of such of the giant, centralization.

But Illitch's book also comes to us in the midst of an exciting new debate on the social rela-
tions and forces of production. Books such as Bronner's Labor and Monopoly Capital and Aronowitz's False Prom-
ises, and articles such as one in the summer 1974 issue of The Review of Radical Politi-
cal Economics by Kathy Stone on the steel industry in which one by Steve Mazquin on capi-
talist management and tech-
ology have brought new,

Thus, in the context of a critical critique of industrial society, Illitch leaves the basic social and economic system alone.
Vital Signs

TRYING TO BUY SALVATION

Financially troubled Texas millionaire H. Perot made massive campaign contributions to Senators and Representatives who overrode Medicare and Medicaid bills, obtained without competitive bidding, are embargoed in controversy.

AMA LEAKS

Someone, probably an employee, had it in for the AMA when that person turned over internal AMA memos to a congressional committee, from which in turn they were recirculated to the press. The result has been another black eye for the AMA.

The memos reveal:

- A recommendation by the AMA’s chief lobbyist that the AMA make a substantial campaign contribution to the late Rep. Hale Boggs and in addition hire the Washington law firm of his son, Thomas Boggs, to assure help in thwarting tax legislation that would have cost the AMA millions of dollars. (Washington Post, June 16, 1975.)
- A lobbying effort by the AMA on behalf of the nomination of Clement Haynesworth for Supreme Court Justice under President Nixon. (New York Times, July 4, 1975.)
- The AMA’s close association with the Nixon White House and its attempt to place doctors and other sympathizers with its views in key government policy positions.

An investigation by the US Postal Service of the AMA’s political activities to determine whether the AMA could then play on its mailing list, the number of letters sent, and the number of letters sent, and the number of letters sent to doctors and others sympathetic with its views in key government policy positions.

And finally, an effort by AMA Executive Vice President James H. Sommers early this year to counteract adverse reports on a drug for diabetics that appeared in the AMA’s own journal. Following publication in the Journal of the American Medical Association of an article and editorial raising questions about the safety of oral hypoglycemics (a growing medical controversy), Dr. Sommers wrote a letter to an executive of state, county and medical specialty societies minimizing the risks and urging physicians to ignore the controversy and continue on what ever therapy their doctors had previously recommended. Sommers then wrote the Big Pharma, the largest manufacturer of oral hypoglycemics, to distribute his letter to its 1,100 drug salesmen for use in their sales talks. (New York Times, July 8, 1975.)

THE FEUD: PLAYING THE EUHUNCH

The Social Security Administration (SSA) has just published its first spot check of hospitals receiving Medicare, and of the first sample of hospitals inspected, two hospitals (8%) failed to meet federal standards. Since the report on the first 105 hospitals was issued, 50 more hospitals have been checked, and the results appear even more shocking—almost all have reported failures.

"These astonishing findings are not only shocking, but they have profound implications for the杰克sonal health system. The report indicates that the number of hospitals that fail to meet federal standards is much higher than previously believed," said John Porterfield, M.D., AMA executive director. "It also shows that the number of hospitals that fail to meet federal standards is much higher than previously believed, and that the number of hospitals that fail to meet federal standards is much higher than previously believed, and that the number of hospitals that fail to meet federal standards is much higher than previously believed, and that the number of hospitals that fail to meet federal standards is much higher than previously believed, and that the number of hospitals that fail to meet federal standards is much higher than previously believed, and that the number of hospitals that fail to meet federal standards is much higher than previously believed, and that the number of hospitals that fail to meet federal standards is much higher than previously believed, and that the number of hospitals that fail to meet federal standards is much higher than previously believed, and that the number of hospitals that fail to meet federal standards is much higher than previously believed, 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persuasion directed at its officials, its board and the Rhode Island Department of Business Regulations.

Unemployment has reached 16 percent in Rhode Island, and 85 percent of the jobless are estimated to have had Blue Cross coverage at the time they were laid off. Even under the lower rate, families must pay as much as $60 a month for coverage. (Insur. Economics, April, 1975.)

Illich
(Continued from page 29)

words, industrialization as we know it, technology as we know it, is not the only possible one. Rather it is an industrialization or technology that arises out of a system of social relations grounded in hierarchy and domination. While the sources of hierarchy and domination are different in some of the existing state socialist countries, to the extent that they are following the lines of Western technology, they are also creating and reinforcing these social relations.

Because Illich’s book does not engage in the issues of technology and social relations on the level at which this important debate is occurring, it ultimately confuses the sources of the problem it so effectively describes. More important, it will probably play quite nicely into the general trend toward self-help remedies—all of which leave the basic structure of the society and our created dependencies intact. Certainty it encourages the conservative, back-to-pre-industrial-society consciousness that is already so much a part of oppositional culture.

What medicine does need is a good critique of its technology—from kidney transplants to radiation therapy—and of its relationship to the structure of the medical profession, as well as the relationship between the profession and the people ostensibly served by it. What have the giant heart units done for medical services to people? What is the system of social relations that these units serve? What would be the preconditions for a medical technology that would provide individuals with a high level of self-management in dealing with their own bodies—their own lives?

-Carl Pope (The author is trained as an anthropologist; she has written Women and Medicine and is currently writing a book about housewives and housework.)

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HEALTH/PAC BULLETIN

1 New Orleans HEALS: A STREET CAR NAMED CONSPIRE. New Orleans big shots unite to create a medical empire out of two realms.

7 The Emergence of Hospital Nursing: HISTORY IS NOT DESTINY. The integration of RN’s as regular hospital staff created management problems in the 1920’s and 1930’s.

22 Vital Signs

New Orleans Heals

A STREET CAR NAMED CONSPIRE

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

What is of particular interest in the New Orleans case is the fact that health care players such a clearly crucial, although publicly unacknowledged, role in the economy of the city and region. This fact no doubt helps explain the convergence of banking, financial

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