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On a Foundation Wide in Scope: the History of Mount Sinai Hospital, Milwaukee, Wisconsin 1903-1987

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ON A FOUNDATION, WIDE IN SCOPE: THE HISTORY OF MOUNT

SINAI HOSPITAL 1903-1987

by

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ABSTRACT

ON A FOUNDATION, WIDE IN SCOPE: THE HISTORY OF MOUNT
SINAI HOSPITAL: 1903-1987

by

Michele M.E. Radi

The University of Wisconsin-Milwaukee, 2016
Under the Supervision of Professor Amanda I. Seligman, Ph.D.

This research studies the history of Mount Sinai Hospital in Milwaukee, Wisconsin, a

private, nonsectarian Jewish hospital. It was supported by the Jewish residents in

Milwaukee through their philanthropic efforts for eighty-three years. In 1987, the hospital

merged with a Christian hospital, but in 1992, hospital administrators announced that the

establishment of operational practices designed to maintain the Jewish identity of the

current hospital. I sought to answer the question of why a Jewish identity mattered to the

new hospital after the merger. This research reveals that the Jewish identity of Mount

came from the strong Jewish support in the early years, not from a large Jewish

strict religious practices, or a majority of Jewish patients. I argue that the hospital

represented a sense of collective action between two conflicted groups within the Jewish

population of Milwaukee. These groups were divided along socioeconomic class and

ethnic differences. The hospital provided a communal place for all Jewish residents to

perform acts of charity, including fundraising and volunteer work. I argue the relationship

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between the Jewish population and the hospital was symbiotic, in that the hospital provided opportunities for Jewish doctors to establish practices and also provided economic opportunities and gave the Jewish population an icon for their charity efforts. I argue that the hospital historically treated more Gentiles than Jewish patients, but was a Jewish hospital by way of the Jewish collective action and support. I argue that the collective action of Milwaukee Jewish residents gave Mount Sinai a Jewish identity. However, changes in funding options for indigent care decreased the Jewish presence at Mount Sinai. It decreased as the need for fundraising for direct patient care decreased. After the creation of Medicaid and the expansion of Medicare, the direct financial support and the volunteer hours donated to Mount Sinai by Jewish residents decreased. As more affluent members of the Milwaukee Jewish population moved away, the Jewish participation at Mount Sinai diminished. I argue that the announcement about establishing a Jewish identity at the former Mount Sinai in 1992 represented an attempt to preserve the history of the traditional Jewish presence at the and to remind the residents of Milwaukee of the contributions of the Jewish people.

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Dedicated to the Jewish people of Milwaukee,

Past, Present, and Future

and

to Rabbi Victor Caro z'l,

who dreamed of this hospital, but did not live long enough to see it bloom

Also, to my grandma and Aunt Barbara, who

dreamed of better things for me

and did not live to see any of this happen

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INTRODUCTION

In a September 2, 1988 article, the *Wisconsin Jewish Chronicle* reported changes at the former Jewish hospital in Milwaukee, Wisconsin. Mount Sinai Hospital merged with Good Samaritan Medical Center ten months prior. The new facility, Sinai Samaritan, remained at the former Mount Sinai Medical Center site, at 12th Street and Highland Avenue, in downtown Milwaukee. The post-merger plans included the expansion of Sinai Samaritan's Jewish linkages. To that end, the hospital erected a menorah in the hospital lobby during Hanukkah in lieu of Christmas decorations and closed clinics on major Jewish holidays. Sinai Samaritan President Albert L. Greene noted that "We have said all along that we have intended to maintain Jewish tradition at the Sinai campus." At the same time, the article noted that the Board planned to remove the iconic Star of David from the front of the hospital. Sinai Samaritan donated the Star to the Karl Jewish Community Center Campus.[1] This commitment to "maintain" Jewish traditions at Sinai Samaritan Medical Center in 1988 came at a time when much of the Milwaukee Jewish population lived outside of the city, taking their synagogues and the Jewish Community Center with them. At the time of this announcement, the majority of Sinai Samaritan patients were not Jewish. The removal of the Star when hospital administrators announced the preservation of Jewish identity for the former Jewish Mount Sinai Hospital after it merged with a Christian hospital seemed incongruous and contradictory. Why did the commitment to Jewish traditions matter after a merger with a Christian hospital? Why

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[1] Newspaper clipping, "Changes for Sinai Samaritan," *Wisconsin Jewish Chronicle*, September 2, 1988, Box 1, Folder 7, Mount Sinai Collection, Jewish Museum Milwaukee Archives, Milwaukee, Wisconsin (hereafter cited as JMM Archives).

remove an iconic part of the building that signified a Jewish identity? I sought an answer to those questions.

The existing literature of the history of the Milwaukee Jewish community did not provide a great deal of specific information about Mount Sinai Hospital. Historians Louis J. Swichkow and Lloyd P. Gartner published their seminal work, *The History of the Jews in Milwaukee,* in 1963. It described the history of the Milwaukee Jewish population in great detail, but only mentioned Mount Sinai Hospital on twelve pages. The information included about Mount Sinai did not offer any insight as to why the Jewish people of Milwaukee would want to keep a Jewish identity at Mount Sinai when many Jewish residents lived outside Milwaukee. In fact, their research noted that Mount Sinai Hospital was a nonsectarian hospital from the start. It consistently treated more Gentile than Jewish patients.[2] The discussion of the hospital in this important work does not delve deeply enough to answer the question of identity. It described the history of the hospital in terms of dates–when the hospital opened, when the hospital relocated to its current location–and pictures of the different structures.[3] The question about the importance of expanding Jewish identity at Mount Sinai remained unanswered. Historian John Gurda grounded his 2009 book *One People, Many Paths: A History of Jewish Milwaukee* in Swichkow and Gartner's work.[4] He included information about an additional forty-five years of Milwaukee Jewish history. His work mentioned Mount Sinai Hospital a total of fifteen times, but only three references added to the overall history of Mount Sinai. Both of these sources contain a great deal of historical information about the Jewish people of

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[2] Louis J. Swichkow and Lloyd P. Gartner, *The History of the Jews of Milwaukee* (Philadelphia, PA: The Jewish Publication Society of America, 1963), 201.
[3] Swichkow and Gartner, *The History of the Jews of Milwaukee*, 97.
[4] John Gurda, *One People, Many Paths: A History of Jewish Milwaukee* (Milwaukee, WI: Jewish Museum Milwaukee, 2009), 48.

Milwaukee, but the history of their hospital is limited to significant changes at the hospital. Both works discuss the history of the hospital building. These books place the history of Mount Sinai Hospital in the context of the Milwaukee Jewish community. The dozen or so mentions of the hospital come tangentially to the overall history Milwaukee Jewish community.

Swichkow and Gartner and Gurda detail a contentious history within the Milwaukee Jewish community. East Side and West Side Jewish groups did not form a cohesive community in Milwaukee. Conflict within the Milwaukee Jewish population stemmed from differences in ethnicity, class and religious observance. Yet, members of both the East and West Side Jewish population supported Mount Sinai's nonsectarian mission for eighty-three years and sought to preserve a Jewish identify after a merger. In order to answer the question of why Jewish identity mattered for a nonsectarian hospital in Milwaukee, I decided to focus on the history of the hospital as it relates to the Jewish population in Milwaukee. That is, instead of inserting the history of the hospital in the larger Jewish history, I used the history of Mount Sinai Hospital in order to study the Jewish contributions to the hospital and the history of the Milwaukee Jewish population. I believe that this allowed me to use the work of Swichkow and Gartner and Gurda about the Jewish community as a foundation for describing their contributions to the hospital. The change in perspective revealed additional information about Milwaukee's Jewish population.

SELF, IDENTITY, AND COLLECTIVE ACTION

It is important to be clear about terminology and meaning; specifically, identity, community, and population. For the purpose of this research, the term Jewish identity denotes the social, behavioral, and individual understanding of what defines "being Jewish." Jewish community refers to the collective activity of the Jewish population in Milwaukee in support of Mount Sinai and other charitable entities. I argue that a combined Jewish community effort, first by the East Side Jewish population, sustained this hospital through most of its years of operation as a nonsectarian institution. Members of the West Side Jewish population also contributed to the hospital. The support from the two Jewish populations contributed to the Jewish identity of Mount Sinai, a sense of ownership and assumed responsibility that made it their hospital. The term Jewish population describes East and West Side Jewish groups living in Milwaukee. Identity describes the socially constructed reality, using ethnicity, and norm behaviors and beliefs of Jewish individuals to describe and quantify what makes them Jewish. Jewish community collective action signifies the efforts of Jewish groups and individuals in Milwaukee, and population refers to the geographical location of the different groups. The term Milwaukee Jewish identity is defined as the combined collective action of the Jewish community, the social characteristics of the Jewish population in Milwaukee, and their relationship with the city.

The literature pertaining to Jewish identity falls into two broad categories: the creation of a Jewish self-identity, and the understanding of a collective Jewish identity. The two categories overlap in that the literature of both Jewish self-identity and the collective identity state the creation of each involves a process of using a set of criteria to

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establish an understanding of what makes an individual or a collective "Jewish." The Jewishness of individuals is measured using the answers to a selected set of questions about personal practices and beliefs, collective Jewish identity is measured by the actions of a Jewish population in a specific location.

The concept of self is the foundation for both individual and collective Jewish identity. Sociologist H.S. Himmelfarb used the terms Jewish identity and Jewish identification to emphasize the role of self in the matter of identity building. He believed that Jewish identity is "one's sense of self with regard to being Jewish," as part of the overall self-concept. Jewish identification, on the other hand, was defined as "the process of thinking and acting in a manner that indicates involvement with and attachment to Jewish life."[5] Individuals accepted "Jewish" behavioral and social expectations that they identified as "Jewish." This formed a sense of Jewish identification, defined by Himmelfarb as an integral aspect of creating a Jewish identity. This "self-identification" simplified the process of creating a working definition of Jewish identity.[6]

Sociologists Peter L. Berger and Thomas Luckmann described identity as that which is "formed by social processes. Once crystallized it is maintained, modified, or even reshaped by social relations. The social processes involved in both the formation and the maintenance of identity are determined by social structure."[7] That is, in order to answer the question as to why a Jewish identity mattered for Mount Sinai after a merger with a Christian hospital, the term Milwaukee Jewish identity must be defined. I argue that the relationship with the hospital sustained and maintained a sense of an individual's Jewish

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[5] H.S. Himmelfarb, "Research on American Jewish Identity and Identification: Progress, Pitfalls, and Prospects," in Understanding *American Jewry*, ed. Marshall Sklare (New Brunswick, NJ: Transaction Publishers, 1982), 56-57.
[6] H.S. Himmelfarb, "Research on American Jewish Identity and Identification,", 56.
[7] Peter Berger and Thomas Luckman, *The Social Construction of Reality: A Treatise in the Sociology of Knowledge* (New York: Random House, 1966), 173.

identity through Mount Sinai Hospital by way of their collective actions.

Collective action stems from a sense of group identity. Scholars have defined collective Jewish identity in the context of measuring the strength of an individual's attachment to predetermined attributes and participation in their communities for Jewish causes and concerns. The literature revealed that one of the more common goals of the process of assessing an individual's Jewishness was creating a scale that measured how "good" a Jew the individual was using the scale of any number of statements and questions, rather than the individual's understanding of being a good Jewish person. These scales also used questions about Jewish collective action in charitable and religious groups to measure the strength of the attachment and commitment to Jewish collective or group identity. The various lists of rating one's Jewishness included many of the same items including religious traditions, participation in Jewish organizations, and Jewish education. Sociologist Ralph Segalman noted that the use of scales is problematic in that the definition of who is a "good Jew" depends heavily on the interests of those creating the list of desirable Jewish attributes. Scales have used facial features, dialect, manner of dress, and ethnicity to determine whether a respondent was, in fact, a good Jew. Other scales measured religiosity, political affiliation and created lists of various beliefs and behaviors which were considered essential traits for an individual to have in order to be considered Jewish.[8] Those lists are influenced by the author and any sponsoring groups or interests, resulting in a list of carefully selected parameters that often measure a specific aspect of Jewish identity, namely religious, cultural, social, organizational, or in some cases, a combination of these and any other theme or themes each author selects to

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[8] Ralph Segalman, "Self Hatred Among Jews: A Test of the Lewinian Hypothesis of Marginality of Jewish Leadership," (PhD diss., New York University, 1966), 93.

measure identity.[9] Segalman explained that one weakness of using scales of any kind to measure Jewish identity is the assumption that a single scale, no matter how exhaustive, could in fact definitively measure an individual or collective sense of Jewishness.[10] Sociologist Simon N. Herman rejected the notion that Jewish identity could be measured. He believed that such studies measured an individual's sense of Jewish identification, and not a comprehensive sense of Jewish identity. The scale score of any individual in a research project highlights "the process by which an individual comes to see himself a part of the Jewish group. . .But very few of them are studies of Jewish identity, of what being Jewish means, of what kind of Jew and what kind of Jewishness develop[sic] in the majority culture."[11] Like Himmelfarb, he advocated for research that does more than attempt to measure an arbitrary strength or weakness of individual identity. His research defined Jewish identity using two distinct contexts: either a pattern of attributes characterizing the Jewish group, or the relationship between the Jewish individual and the Jewish group and the "reflection in him of its attributes."[12] In the case of Milwaukee's Jewish population, a sense of identity came from the hospital, Mount Sinai represented the contribution of the Jewish population to the city.

Research on community collective action contributes to the creation of group identity by studying the participation of Jewish people in specific social institutions or activities. Sociologists Marshall Sklare and Joseph Greenblum evaluated the Jewishness of "Lakeview," Illinois by measuring participation at synagogues, Jewish day schools, and

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[9]   Ralph Segalman, "Self Hatred Among Jews," 92.
[10] Segalman, "Self Hatred Among Jews,", 98.
[11] Simon N. Herman, *Jewish Identity: A Social Psychological Perspective* (Beverly Hills, CA: Sage Publications 1977), 28.
[12] Herman, *Jewish Identity*, 30.

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support for the state of Israel.[13] Sociologist Herbert J. Gans measured suburban

Jewishness using the availability and knowledge of Jewish food, and creation and

membership in formal and informal Jewish organizations as criteria for Jewishness.[14]

Using predetermined scales or lists of characteristics limits, and in some cases, excludes

members of the population studied. What of the Jewish families not sending their children

to a Jewish day school? How can one account for the Jewish members of a community

that do not attend services?

The answer to the research question about the Jewish identity of an institution comes

from an understanding of the Jewish identity of the population that created it. The

complexity involved in the formation of individual and group identity definitions noted

above is important when considering the task at hand, that is, how to measure the Jewish

identity of a hospital. Mount Sinai Hospital was the collective achievement of the

Milwaukee Jewish population. The answer to any questions about the Jewish identity of

Mount Sinai Hospital have to come from the history of the Milwaukee Jewish population

and an understanding of their Jewish identity. They established the hospital and supported

its mission.

I viewed the existing literature on the history of Milwaukee Jewish population as a

guide. The definition of Milwaukee Jewish identity for this dissertation started with the

history of original Jewish immigrants and an understanding of what made an individual

Jewish. Philosopher Michael Krausz noted two specific considerations about the

construction of Jewish identity, descent and assent. He defines Jewish descent as the

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[13] Marshall Sklare and Joseph Greenblum, "The Friendship Pattern of the Lakeville Jew," in *American Jews; A Reader*, ed. Marshall Sklare (New York: Behrman Inc. Publishers, 1983), 176-78.

[14] Herbert J. Gans, "The Origin of a Jewish Community in the Suburbs," in *American Jews; A Reader*, ed. Marshall Sklare (New York: Behrman Inc. Publishers, 1983), 158-64.

means of ascribing a status upon an individual as Jewish, either by birth, born to a Jewish mother, or conversion regardless of any beliefs or religious practices. Descent makes an individual inherently Jewish, but does not describe what being Jewish is in practice. Assent is the means to characterize an individual as Jewish based on the acceptance of Jewish identity by an individual.[15] Assent is the social and behavioral aspects that reveal the lived Jewish life. These traits are integral to the creation of a definition of Jewish identity. Krausz believed that the search for a definition of Jewish identity can only be understood in terms of an individual or collective understanding and acceptance of "constellation" of traits, beliefs, practices and features that exist over time.[16] It was assent, rather than descent, that defined Jewishness. Because of the various experiences of Jewish communities, Krausz posited that there is no single historically correct Jewish identity discourse. There is no definitive scale, list, or history as to what ultimately defines Jewishness and Jewish identity.[17] Psychologists Perry London and Allissa Hirshfeld described scales as incomplete in the understanding of Jewish identity in that, "So, we cannot know from them what bearing Jewish background has on aspects of personal identity that are not consciously Jewish but may have been profoundly influenced by being Jewish, albeit unconnected to the Jewish community."[18]

   The concept of a Milwaukee Jewish identity then, requires an understanding of the history of the city's Jewish immigrants. This dissertation examines the "constellation" created by the founding members of the Jewish population and carried on by Jewish residents in Milwaukee today. I constructed three core traits of Milwaukee Jewish identity

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[15] Michael Krausz, "On Being Jewish," in *Jewish Identity*, ed. David Theo Goldberg and Michael Krausz (Philadelphia, PA: Temple University Press, 1993), 268.
[16] Michael Krausz, "On Being Jewish,", 272
[17] Michael Krausz, "On Being Jewish,", 273.
[18] Perry London and Allissa Hirshfeld, "The Psychology of Identity Formation" in *Jewish Identity in America*, ed. David M. Gordis and Yoav Ben-Horin (Los Angeles, CA: Wilstein Institute, 1991), 46-47.

using the literature of the history of the city of Milwaukee, namely Swichkow and Gartner. Jewish immigrants in Milwaukee are assumed to be Jewish by descent. However, they differed in religious practice and ethnic customs. They arrived in Milwaukee from different European regions. Their differences led to conflict between the two groups. That conflict is one of the defining features of Milwaukee Jewish identity. It should be noted that this definition of Milwaukee Jewish identity is limited in that Swichkow and Gartner's work is almost exclusively from the perspective of the original immigrant population arriving from Western Europe in the nineteenth century. However, the conflict between the two groups is also a defining feature of Milwaukee Jewish identity. Social stratification is an integral part of Milwaukee Jewish history. The East Side Jewish population established themselves in business and in the professional class. The West Side Jewish population settled on the West Side and was initially poor. The differences between the two led to social distance between them. East Side and West Side did not socialize. They did not live together and they did not pray together. This early segregation had a profound effect on Milwaukee Jewish identity. To be from the East Side was desirable; it was not advantageous to claim a West Side status. These statuses were so strong that they remain a part of Milwaukee Jewish identity in the twenty-first century.[19]

The creation of the hospital also represented the second and third attribute of Milwaukee Jewish identity-philanthropy and sense of commitment to the city of Milwaukee represented by the support for the health care for the indigent. I argue that at the time of announcement of a continuing Jewish identity at Sinai Samaritan, the goal was to an attempt to preserve Jewish history, or heritage rather than identity. That is, the hospital represented their historic support of the hospital as Milwaukee Jews for

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[19] Pat and Joan Kerns, Interview by author, Mequon, Wisconsin, May 24, 2011.

themselves and their fellow citizens.

MILWAUKEE JEWISH IDENTITY: THREE HISTORIC TRAITS

I have identified three core components of Milwaukee Jewish identity; ethnic origin, defined as either East and West Side Jewish population, philanthropy, defined as collective action in charity work, and a sense of commitment to the city by way of maintaining Mount Sinai Hospital for eighty-four years even after many Jewish residents moved away. These three traits form the foundation for a sense of what constitutes a sense of Milwaukee Jewish identity. These traits are not meant to impart any sense of being a "good" Milwaukee Jew based on any predetermined scale. Instead, they are an attempt to describe the traits that Jewish residents of Milwaukee socially constructed and maintained to express and define their Jewish identity. I used data from interviews with members of the Milwaukee community, both Jewish and Gentile. This allowed for a more diverse understanding of Milwaukee Jewish identity; Himmelfarb noted that many Jewish identity research projects often excluded Gentiles. The inclusion of the perspectives of Gentile nurses in particular provides insight about how they viewed the Jewish contributions to Milwaukee through the work at Mount Sinai.[20] Interviews with members of the Milwaukee Jewish population revealed that of these three components, the East and West side labels were both ascribed on those born in the city[21]and achieved by those who moved to the city.[22] Current members of the Jewish community in Milwaukee applied these statuses to new community members. In the 1970s and 1980s, new immigrants from

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[20] H.S. Himmelfarb, "Research on American Jewish Identity and Identification,", 66-67.
[21] Dr. Harry Kanin, Interview by author, Milwaukee, Wisconsin, July 14, 2011.
[22] Pat and Joan Kerns, Interview by author, Mequon, Wisconsin, May 24, 2011; Dr. David Amadari, Interview by author, Milwaukee, Wisconsin, July 14, 2011.

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Soviet Russia were called Russian Jews and West Side Jews by some of those interviewed.[23]

The Milwaukee Jewish population originated from distinct regional groups; Western and Central Europe, commonly referred to as German, and Eastern European, which in Milwaukee refers to Russian. Cultural differences between the two resulted in a segregated Jewish population. The first wave Western Jews arrived first, and formed a social identity among themselves. The second wave arrived and found that some of their cultural practices and religious traditions did not fit with the socially constructed Jewish identity in Milwaukee.

Like other urban areas, these cultural and religious differences between Milwaukee's Jewish populations divided the group. The issue of nomenclature for the two immigrant waves is important. There were two large waves of Jewish immigration to the United States in the nineteenth century; one started in 1848, the second in 1888. For this research, I refer to the groups as first and second wave immigrant groups. The history of the first wave of Jewish immigration to America is linked with Milwaukee's Germanic immigration. Jewish and non-Jewish immigrants from the Germanic regions in Western and Central Europe arrived together and established a neighborhood on the East Side of the Milwaukee River.[24] The economic opportunities available to Jewish immigrants in Milwaukee made Mount Sinai possible. The wave of Jews arriving in the recently established city the late 1840s and early 1850s joined a familiar Germanic culture.[25] The first wave of immigrants to arrive in Milwaukee left Europe after supporting a failed

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[23] Pat and Joan Kerns, Interview by author, Mequon, Wisconsin, May 24, 2011.
[24] Bayrd Still, *Milwaukee: The History of a City* (Madison, Wisconsin: The State Historical Society of Wisconsin, 1948), 112.
[25] Swichkow and Gartner, *The History of the Jews of Milwaukee*, 110.

revolution in Europe.[26] The immigrants who settled in the German neighborhoods of Milwaukee were from Germanic regions that had failed to unify a German nation and secure civil rights in the revolution. The histories of the Jewish and non-Jewish German immigration are so connected in much of the scholarship that the initial wave of immigration in the 1800s is colloquially known as the "German" wave of "Jewish" immigrants.

The first wave Germanic Jewish immigrants in Milwaukee are identified here as East Side Jewish immigrants. This label continues to be salient in Milwaukee as a means of tracing family history and country of origin. In interviews, members of the Milwaukee Jewish community used these terms to describe their family histories as well as members of the current Jewish community.[27] Many of the East Side Jewish immigrants were secular in their education and eventually adopted American Reform Judaism once in Milwaukee. Sociologist Calvin Goldscheider argued that in the case of these first wave immigrants, "Their socioeconomic background, social mobility, and prior exposure to secularization resulted in rapid integration in American society."[28] These immigrants were from urban areas and sought to acculturate in their countries of origin. The accepted the social norms and mores of the dominant culture, and many practiced a less traditional form of Judaism. They did not want to live apart from their Gentile neighbors: they wanted to live as European Jews, not as Jewish Europeans. To assume Jewish immigrants in Milwaukee wanted to assimilate is erroneous, despite living in Germanic neighborhoods, they did not intermarry, nor did they stop identifying themselves as Jews.

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[26] Dr. Harry Kanin, Interview by author, Milwaukee, Wisconsin, July 14, 2011.
[27] Pat and Joan Kerns, Interview by author, Mequon, Wisconsin, May 24, 2011.
[28] Calvin Goldscheider, "Demography of Jewish Americans: Research Findings, Issues, and Challenges," in Understanding *American Jewry*, ed. Marshall Sklare (Brandeis University: Transaction Publishers, 1982), 9.

Once they arrived in Milwaukee, many were able to acculturate quickly with their fellow immigrants, greatly facilitated by the fact that many of their Gentile cohort accepted them as fellow Germans in manner and dress.[29] Several of those interviewed refer to the East Side Jewish immigrants as "assimilated" but this was not the case. It is true that those first wave Jewish immigrants that settled alongside Gentiles in German neighborhoods were almost indistinguishable from their neighbors, but the fact that they retained their Jewish sensibilities indicates that they did not fully assimilate. Sociologist Milton M. Gordon uses two hypothetical groups, the "Sylvanians" and the "Mundovians" to illustrate his concept of assimilation. The Sylvanians are citizens of the "host country" and Mundovians, new immigrants. Gordon believed that the new immigrant, in a series of stages, eventually accepted the dominant cultural practices of the host country and thus underwent both structural assimilation by accepting entering primary groups with Sylvanians, and identification assimilation, where they took on a shared sense of being Sylvanian.[30] Sklare and Greenblum argued that by taking their place in German neighborhoods and remaining almost indistinguishable from their Gentile neighbors, they were "assimilated."[31] I argue that in the case of the first wave of Milwaukee Jewish immigrants, those who settled in German neighborhoods did so without adopting different religious beliefs. Members of the East Side Jewish population settled with Gentile German residents without converting. The most salient indicator of the importance of retaining Jewish religious practices in the Milwaukee East Side Jewish population is the ongoing attempts to establish synagogues. East Side Jews lived among

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[29] Swichkow and Gartner, *The History of the Jews of Milwaukee*, 187.
[30] Milton M. Gordon, *Assimilation in American Life: The Role of Race, Religion, and National Origin* (New York: Oxford University Press, 1964), 68-71.
[31] Sklare and Greenblum. "The Friendship Pattern of the Lakeville Jew,", 176-78.

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Gentiles, but they did not convert to the dominant Christian religion; rather, they eventually created houses of worship in order to practice their Jewish faith.[32]

The three core characteristics of Milwaukee Jewish identity– the ethnic origins of the East and West Side Jewish populations– collective philanthropic action– and a commitment to the people and city of Milwaukee– are the foundation for the Jewish identity of Mount Sinai. Sociologist Calvin Goldscheider noted that in the study of the value of living in an area with strong Jewish institutions and networks, the characteristics of Jewish identity in smaller Jewish populations are largely absent from the existing literature. He stated that scholars have yet to ask whether living in areas with Jewish institutions enriches Jewish solidarity and kinship. He questions the use of traditional scales to measure Jewish identity and advocates the study of collective Jewish action on their cities.[33] I argue that Mount Sinai did have a positive impact on the lives of both groups of Milwaukee Jews. The East Side Jewish financial support, their commitment to relief work, and service to Milwaukee are all at the heart of Mount Sinai's mission. Members of the West Side Jewish population received care at the hospital. The hospital received support from both groups as the West Side Jews gained upward socioeconomic status.

The original Jewish population of Milwaukee came from Western Europe, many from regions now known as Germany. These Germanic East Side Jews established the cultural foundation for later Jewish immigrants. By virtue of being the first Jewish settlers in Milwaukee, the Germanic Jewish immigrants created a system of beliefs and behaviors that they imposed on later arrivals. I argue that this group established a basis for the city's

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[32] Swichkow and Gartner, *The History of the Jews of Milwaukee,* 179.
[33] Calvin Goldscheider, "Judaism, Community and Jewish Culture in American Life," in *Religion or Ethnicity: Jewish Identities in Evolution*, ed. Zvi Gitelman (New Jersey: Rutgers University Press, 2009), 283.

Jewish identity. The second wave of Jewish immigrants arriving in Milwaukee had little in common with the first wave.[34] Many of those interviewed referred to these immigrants as Russian Jews. In fact, however, many Jewish and Gentile immigrants came to Milwaukee at this time from all over Eastern Europe, not just Russia. They created the West Side Jewish community in the Haymarket neighborhood. However, unlike the East Side Jews, the West Side Jewish immigrants arriving in Milwaukee did not settle in a Russian neighborhood, or a Polish neighborhood with non-Jewish immigrants. They arrived after 1888 and established a Jewish Eastern European enclave because of the anti-Semitic feelings of the other Eastern European immigrants in Milwaukee. The Jews who started arriving in the late 1880s were more observant and less secular than the first wave. Many came from *shtetls* in Eastern Europe and Russia.[35]

The West Side immigrants experienced anti-Semitism from other Gentile immigrant groups. They also suffered the disdain from the East Side Jewish community. The differences between the two Jewish groups and the establishment of a sense of Jewish identity by the East Side Jews led to conflict. Interviews with members of the Milwaukee Jewish population revealed that many of them believed that the East Side Jewish population attempted to "assimilate" new arrivals.[36] The more traditional religious practices and different manner of dress of the West Side immigrants led to efforts by East Side Jews to transform the new arrivals, but assimilation did not include conversion to Christianity. East Side Jews themselves did not so much assimilate, as they did they did acculturate with Gentile Germanic immigrants in many ways, but remained Jewish, albeit American Reform. After the arrival of the West Side Jewish immigrants, the East Side

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[34] Swichkow and Gartner, *The History of the Jews of Milwaukee*, 14.
[35] Swichkow and Gartner, *The History of the Jews of Milwaukee*, 190.
[36] Dr. Harry Kanin, Interview by author, Milwaukee, Wisconsin, July 14, 2011.

Jewish residents, in fact, attempted to acculturate the new arrivals and impart a sense of Milwaukee Jewish identity upon them.[37]

The relative poverty of many of the West Side Jewish population led to the creation of another important historic characteristic of Milwaukee Jewish identity: philanthropy and relief institutions. The East Side Jewish population established the Hebrew Relief Association in order to assist the West Side Jews. In addition to charitable assistance, they also established a Settlement and offered education and lessons that sought to educate the new arrivals on the Milwaukee Jewish norms. The first wave immigrants acculturated, and created an American Jewish culture. They then, in turn attempted to teach second wave immigrants their cultural understandings to the next wave. Historian Jonathan Sarna uses the term "Cult of Synthesis" to describe the attempts of first wave Jewish immigrants to impart American Jewish values and norms to the second wave. This term is defined as an understanding of "the belief that Judaism and Americanism reinforce one another, the two traditions converging in a common path."[38] He notes that the cult of synthesis "reflects an ongoing effort on the part of American Jews to interweave their 'Judaism' with their 'Americanism' in an attempt to fashion for themselves some unified, 'synthetic' whole. Anyone even remotely connected with American Jewish life is familiar with this theme, which has elsewhere been described as a central tenet of American Jewish 'civil religion."[39] Synthesis defines the actions of the East Side Jews more accurately than the term assimilation and is more akin to acculturation; the new immigrants were expected to embrace Milwaukee Jewish identity traits, created largely

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[37] Swichkow and Gartner, *The History of the Jews of Milwaukee*, 121.
[38] Jonathan D. Sarna, "The Cult of Synthesis in American Jewish Culture," *Jewish Social Studies Ethnic Studies, First Series, American Jewish History and Culture in the Twentieth Century,* 5, No. 1/2 (Autumn, 1998 - Winter, 1999): 53-55.
[39] Sarna, "The Cult of Synthesis in American Jewish Culture," 53.

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by the first wave. Sarna's use of synthesis defines the process of acculturating Eastern European Jews in that they should adopt the dominant American Jewish population's behaviors and religious observances in the areas that they settled. They did not have stop being Jewish; they should become American Jews.

The East Side Jewish population had expectations of the new immigrants, and they had the social resources to enforce those expectations. They possessed considerable social and economic advantages. Sociologist Pierre Bourdieu used the term "creating cultural capital" to describe the process by which individuals form preferences for cultural practices and activities, including religion. He identified primary social groups like family and schools as agents of socialization, especially for children. Those that practice the preferred cultural activities are more likely to gain social acceptance.[40] Cultural capital could and often did lead to the creation of social capital. Sociologist Robert D. Putnam defined the core idea of social capital as the benefits of connections among and between individual members and the advantageous effects that can occur. Individuals form connections in their own self-interest and can result in "public good" through the actions of "well connected" people."[41] The status of East Side Jew could be achieved through adopting the socially acceptable norms and behaviors, which included the socially acceptable religions practice. Both Jay Larkey and Pat Kerns were born to Russian parents. Both were raised in the Reform tradition, and both identify themselves as East Side Jews. Each used their cultural capital to achieve upward social mobility.[42]

The second trait, the collective act of philanthropy, also frames the relationship

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[40] Pierre Bourdieu, "Cultural Reproduction and Social Reproduction," in *Power and Ideology in Education* (New York: Oxford University Press, 1977).
[41] Robert D. Putnam, *Bowling Alone: The Collapse and Revival of American Community* (New York: Simon & Schuster, 2000), 20-21.
[42] Pat and Joan Kerns, Interview by author, Mequon, Wisconsin, May 24, 2011; Dr. Jay Larkey, Interview by author, Milwaukee, Wisconsin, August 14, 2011.

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between Milwaukee Jewish identity and Mount Sinai Hospital's Jewish identity. The hospital was a direct response of the relief efforts in the Milwaukee East Side Jewish community to increased Jewish immigration from Eastern Europe. The more affluent East Side Jewish men contributed their money and time to create Mount Sinai. That historic contribution remains an important part of Jewish identity for members of the Milwaukee community.[43]

Tzedakah is often translated as "charity," but is more accurately defined as an act of "loving kindness."[44] The concept of loving kindness includes specifics act on the part of individuals and groups designed to assist the poor. Donating money, volunteering and visiting those in need are all examples of *tzedakah.*[45] The collective action to create a hospital defined the Milwaukee Jewish community and Mount Sinai embodied their commitment to those in need. Rabbi Joseph Telushkin cites Deuteronomy 15:7-8: "If however, there is a needy person among you. . .do not harden your heart and shut your hand against your needy kinsman."[46] This commandment led to the earliest philanthropic efforts on the part first wave Jewish immigrants. Many first wave Jewish immigrants adopted Reform Jewish practices and many had embraced Reform Jewish practices in their countries of origin.[47]. The later immigrants arrived from Eastern Europe and did not share those practices. This led to the creation of two distinct Jewish groups in Milwaukee. The East Side Jewish population adopted American Reform Jewish practices and lived on the east side of the Milwaukee River. The West Side Jewish group retained religious practices from Eastern Europe and settled on the west side of the river.

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[43] Pat and Joan Kerns, Interview by author, Mequon, Wisconsin, May 24, 2011.
[44] Joseph Telushkin, *Jewish Wisdom: Ethical, Spiritual, and Historical Lessons from the Great Works and Thinkers* (New York: William Morrow and Company 1994), 11.
[45] Telushkin, *Jewish Wisdom*, 24.
[46] Telushkin, *Jewish Wisdom,* 11.
[47] Goldscheider, "Demography of Jewish Americans: Research Findings, Issues, and Challenges," 9.

The first wave Jewish immigrant population accepted the responsibility to establish and sustain operations of Mount Sinai Hospital for the poor Jewish immigrants who arrived starting in 1888.[48] That responsibility and the commitment to Mount Sinai Hospital represented an important trait for Jewish identity for Milwaukee's East Side Jews. In contrast to the community's struggles in establishing multiple synagogues that met their religious needs, Mount Sinai Hospital thrived because it was the only Jewish hospital in the area and received the full support of the Jewish community, through their collective actions on its behalf. Their dedication to Mount Sinai was an expression of their acceptance of the Jewish commandment of *tzedakah*, one more salient than specific religious observance at any one synagogue. Members of the West Side Jewish population eventually joined the East Side Jewish population in supporting the hospital. Sociologist Harold Polsky noted that by the 1950s, Jews from both sides of the Milwaukee River contributed to Mount Sinai. The historically impoverished "Russian" Jews from the West Side embraced the importance of philanthropy and assumed one of the most important traits of Milwaukee Jewish identity.[49]

A third core trait of Milwaukee identity is the historic Jewish commitment to the city of Milwaukee as a whole. The hospital offered care for Jewish and Gentile patients. The nonsectarian mission of Mount Sinai represented the sense of gratitude for the perceived acceptance the first wave Jewish immigrants felt in Milwaukee. They shared cultural and ethnic traits and spoke the same language as Milwaukee's non-Jewish Germans.[50] The fact that the Jewish population in Milwaukee was so similar to the non-Jewish

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[48] Dr. Harry Kanin, Interview by author, Milwaukee, Wisconsin, July 14, 2011.
[49] Howard W. Polsky, "The Great Defense: A Study of Jewish Orthodoxy in Milwaukee" (PhD diss., University of Wisconsin, 1956), 38.
[50] Dr. Harry Kanin, Interview by author, Milwaukee, Wisconsin, July 14, 2011.

immigrants arriving with them had a profound effect on the mission of Mount Sinai. At a time where urban hospitals were usually established as either nonsectarian or religious, Mount Sinai was created with the distinct dual mission of serving not only the Jewish community of Milwaukee, but all in need in Milwaukee. Mount Sinai Hospital in New York and Beth Israel eventually developed nonsectarian missions, but Mount Sinai Hospital Milwaukee was founded with one.[51] This dual identity was one reason that Mount Sinai was able to serve the City of Milwaukee for over eighty years and why hospital leaders decided to keep Mount Sinai downtown in the face of Jewish community outmigration. The founders of the hospital developed a strong commitment to the city of Milwaukee, not only to the Jewish residents. That commitment strengthened the relationship between the Jewish community and the city of Milwaukee.[52] Pat Kerns, the owner of a successful flooring company in Milwaukee, was a Board Member at Mount Sinai. He related his understanding of the history of the hospital in terms of Jewish philanthropy and gratitude on the part of the Jewish population for Milwaukee. He believed that the hospital began as a response to the needs of indigent Jewish immigrants in Milwaukee. The reason Mount Sinai leadership agreed to the 1987 merger that kept the hospital in downtown was, in part, a formal recognition of the gratitude felt by the Jewish people for the city of Milwaukee and its acceptance of the first wave Jewish immigrants.[53]

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[51] Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century* (New York: Basic Books 1989), 20.
[52] Pat and Joan Kerns, Interview by author, Mequon, Wisconsin, May 24, 2011.
[53] Pat and Joan Kerns, Interview by author, Mequon, Wisconsin, May 24, 2001.

THE FOUNDING OF MOUNT SINAI HOSPITAL

Mount Sinai Hospital opened on June 7, 1903. Members of the Milwaukee community, Jewish and non-Jewish, listened to speeches and accolades from some of Milwaukee's most prestigious citizens. Local newspapers reported the event, as the hospital was declared open to treat those in need of care, no matter what religion, race, or creed.[54] Hospitals in American cities in the early twentieth century were transforming both their services and their public image, and Mount Sinai reflected these changes. These hospitals replaced the county almshouses, which housed rather than treated the indigent sick– often in deplorable conditions. Hospitals of the early twentieth century were designed as modern institutions of scientific healing.[55] Other cities in the United States opened hospitals that were larger and served more patients than Mount Sinai. Specifically, these larger urban hospitals served more Jewish patients. New York,[56]Newark,[57]Boston,[58] and Chicago[59] had large Jewish populations and with the exception of Michael Reese Hospital in Chicago, were private Jewish hospitals.[60] There were hospitals in Milwaukee established by other religious groups, yet Mount Sinai was distinctive in that it was founded to be simultaneously nonsectarian and Jewish. Mount Sinai Hospital served the greater Milwaukee community and was dedicated to the nonsectarian principle of treating all in need.

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[54] Newspaper Clipping, "Jews Dedicate Hospital," *Milwaukee Sentinel*, June 4, 1903, Box 51, Folder 1, Sinai Samaritan Medical Center Records, Milwaukee Mss Collection 108, University of Wisconsin-Milwaukee Libraries, Archives Department (hereafter cited as Sinai Samaritan Collection).

[55] Rosemary Stevens, *In Sickness and in Wealth*, 17.

[56] Arthur H. Aufses, Jr., and Barbara J. Niss, *This House of Noble Deeds: The Mount Sinai Hospital, 1852-2002* (New York: New York Press, 2002), 6.

[57] Alan M. Krause and Deborah A. Krause, *Covenant of Care: Newark Beth Israel and the Jewish Hospital in America* (New Brunswick, NJ: Rutgers University Press, 2007).

[58] Arthur J. Linenthal, *First a Dream: The History of Boston's Jewish Hospitals 1896 to 1928* (Boston: Beth Israel Hospital, 1999).

[59] Sarah Gordon, ed., *All Our Lives: A Centennial History of Michael Reese Hospital and Medical Center* (Chicago: Michael Reese Hospital and Medical Center, 1981).

[60] Gordon, *All Our Lives*, 42.

The hospital cared for the large Jewish and Gentile immigrant population that arrived in Milwaukee beginning in the late 1800s and early 1900s. The hospital's Jewish identity originates not from any specific practice or formal religious tradition. The hospital was Jewish because of the support of the Milwaukee Jewish population. It also contributed to the establishment of the Jewish medical profession in Milwaukee. The hospital also served the latent function of providing a place for Jewish men to practice medicine. Jewish doctors in Milwaukee had no place to establish their practices. Despite the relative acceptance of Jewish businesses, Milwaukee hospitals did not allow Jewish doctors on staff. Mount Sinai Hospital created opportunities for the Jewish members of the Milwaukee community. The doctors of Mount Sinai described the history of the hospital in terms of what the Jewish hospital offered them, namely the opportunity to achieve upward social and economic success. In 1903, Christian hospitals in Milwaukee were not open to Jewish doctors. Mount Sinai Hospital served as a means for the establishment of the Milwaukee Jewish medical profession.[61] The doctors established their livelihoods because of the availability of a Jewish hospital at a time when antisemitism prevented them from practicing elsewhere in Milwaukee.[62] Being a board member conferred a positive social status on those who contributed time and money for fundraising.[63] Jewish businessmen were able to serve on the hospital board and achieve the status of leaders at their hospital.[64]

The decision to be both a Jewish and nonsectarian hospital guided and challenged the Milwaukee Jewish community through decades of medical and social changes. As early

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[61] Swichkow and Gartner, *The History of the Jews of Milwaukee*, 209.
[62] Dr. Jay Larkey, Interview by author, Milwaukee, Wisconsin, August 14, 2011.
[63] Dr. Harry Kanin, Interview by author, Milwaukee, Wisconsin, July 14, 2001.
[64] Pat and Joan Kerns, Interview by author, Mequon, Wisconsin, May 24, 2001.

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as 1904, hospital leaders noted that Mount Sinai was serving more Gentiles than Jews. The nonsectarian mission of the hospital encouraged non-Jewish patients to seek care at Mount Sinai, and they did use the hospital. Yet, the number of Jewish patients was consistently lower than the number of non-Jewish patients.[65] Mount Sinai treated more non-Jewish patients than Jewish throughout its history. However, members of the collective Jewish community provided leadership at Mount Sinai. It was Jewish because of that participation. From 1903 through the 1960s, the Jewish Board members of Mount Sinai, Jewish doctors, and volunteers staffed and funded the hospital to aid Milwaukee's growing population.

For the majority of Mount Sinai's history, fundraising by the Jewish community covered the costs of caring for the poor in Milwaukee. Support for Mount Sinai Hospital was an important aspect for two of the three attributes of Milwaukee Jewish identity. The philanthropic efforts of the Jewish collective community enabled Mount Sinai to treat the poor in Milwaukee, regardless of their religious affiliation. Despite the long term support of the Jewish population, the hospital merged in 1987. The relationship between the Jewish community and Mount Sinai changed beginning in the 1970s.

The literature offers various theories as to why long standing private religious hospitals closed, relocated, or merged. Many immigrant groups established hospitals in American cities. Catholic, Protestant, and Jewish hospitals served patients for decades. Historian Rosemary Stevens glossed over the loss of community funding and focused on a larger discussion of insurance plans and health care costs.[66] I believe that the decrease in support from their communities starting in the late 1970s and early 1980s was

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[65] The Rosenfeld Study, Box 1 Folder 5, Mount Sinai Hospital Collection, JMM Archives.
[66] Stevens, *In Sickness and in Wealth*, 310.

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significant to private urban community hospitals. Why did so many private religious hospitals close or merge with other hospitals? Some scholars attribute the closing to changes within the communities themselves. Many sociologists contributed to the large body of literature on the concept of community. Some of the earliest works came from Tonnies, Durkheim, Marx, and Weber. Each offered views on the effects of industrialization on community groups and its members. Tonnies used the terms *gemeinschaft* and *gesellschaft* to describe communities before and after the industrial age. *Gemeinschaft* defined pre-industrial community life as a way of life consisting of close community ties between individuals living in close proximity and including the importance of religion and religious unity between community members.[67] *Gesellschaft*, seen after the establishment of an industrial economy and larger urban environments, represented a distance between community members in their personal lives. The rise of industry brought individuals together for the shared purpose of earning a living and weakened the more personal relationships through social and physical distance within the community.[68]

Durkheim's concepts of mechanical and organic solidarity and the theory of a community's "conscious collective" also examined the effects of industrialization on community members. Mechanical solidarity described the close ties between members of a community as a "collective consciousness" which facilitated the cooperation of individuals toward accepted goals. These goals, adopted by the community members, served as a means of creating a sense of all for one and one for all within small communal

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[67] Rick Tillman, "Ferdinand Tonnies, Thorstein Veblen and Karl Marx: From Community to Society and Back?," *European Journal of the History of Economic Thought* 11, no. 4 (Winter, 2004): 585-86.
[68] Tillman, "Ferdinand Tonnies, Thorstein Veblen and Karl Marx," 584-85.

spaces.[69] Organic solidarity represented the less personal, more individual community model. He argued that as community members industrialized, the struggle to earn and maintain livelihood led to an increase in social interactions based not on religious observance or shared kinship, but on economic necessity. Wage earning increased. The interactions between tradespeople, artists, and other community small businesses and their customers decreased as more people sold their labor and their time.[70]

Sociologist Karl Marx studied the impact of capitalism on communities. He noted the inequality between two broad groups: the bourgeoisie and the proletariat. The bourgeoisie, those in possession of the means of production in an industrialized economy, affected community ties through the exploitation of proletariat labor. He argued that capitalism divided the members of the working class into separate groups, often competing for the same goals, namely wages. This was what he called divide and conquer. Marx believed that social distance between community members was not an effect of capitalism, it was a specific goal of the ruling class.[71]

Sociologist Max Weber introduced the term socioeconomic status (SES) into the discussion of community. He described SES as a social position within an agreed upon hierarchy, beginning with wealth and economic gain. He argued that those with more wealth achieved higher social statuses based on their assets. They lived in neighborhoods with high SES. This created distance within communities. Wealth afforded individuals both material gain and social capital. The lower SES did not live with those in the upper echelons: economic disparity changed the community relationships.[72]

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[69] Emile Durkheim, *The Division of Labor in Society*, trans. George Simpson (Glencoe, IL: Free Press, 1947).
[70] Durkheim, *The Division of Labor in Society*.
[71] Tillman, "Ferdinand Tonnies, Thorstein Veblen and Karl Marx," 586-88.
[72] Max Weber, *Economy and Society, An Outline of Interpretative Sociology*, trans. Guenther Roth and Claus Wittich (Cambridge, MA: Harvard Press, 1954), 157.

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While the theories noted above illustrate the changes between members of a community with the creation of an industrialized economy, Jewish collective action in support of Mount Sinai continued even after many of the more affluent members of the Jewish population moved from the city. The history of the collective actions of the Jewish community in Milwaukee in the creation of Mount Sinai Hospital revealed the importance of both high SES and wealth in establishing the hospital. The more affluent members of the Milwaukee community, Jewish and non-Jewish, listened to speeches and accolades from some of Milwaukee's most prestigious citizens at the June 1903 dedication ceremony. The fact that Mount Sinai received support and acknowledgment from the Gentile population is a testament to the success of the first wave Jewish immigrants in Milwaukee. The theories above do not fully explain the decrease in the Jewish collective action at Mount Sinai.

By the 1960s, many Jewish families had moved away from Milwaukee. However, these families, especially the doctors and their wives, continued to support the hospital. Jewish doctors admitted their patients to Mount Sinai. I argue that the creation of government insurance programs, more so than changes brought on by industrialization, changed the way hospitals provided care for the poor and changed the relationship between collective communities and their established hospitals. Immigrants founded community hospitals in urban areas. One crucial event in the history of Mount Sinai was the War on Poverty, established by the Lyndon Baines Johnson administration in 1965. Over the course of the War on Poverty, new in health care programs, health care payment options, and even the attitudes about care for the indigent in the United States transformed the way urban hospitals did business. Mount Sinai's actions and reactions in

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the wake of funding changes reveal how hospitals treating a large number of poor patients began to lose large amounts of money. The support for hospitals through donations and volunteer hours diminished. In 1965, Medicaid, or Title 19, provided money for the care of poor patients at many private religious hospitals, including Mount Sinai. At first, Medicaid provided full reimbursement for patient care. In 1982, the Medicaid program underwent a series of changes, including the decrease of reimbursements to hospitals for patient care. The hospitals had to absorb the costs. This created financial difficulties for many hospitals around the United States, including Mount Sinai. Community fundraising efforts continued after 1965, but the money was redirected to other Jewish institutions in new Jewish residential areas. The Ladies Auxiliary continued to raise money for Mount Sinai, but the funds were used for medical libraries, redecorating projects, and other improvements instead of costs of patient care.[73] In an attempt to compete with other area hospitals, Mount Sinai expanded their facilities, medical research, and specialties, and established a teaching program with University of Wisconsin-Madison. These changes were insufficient to stop the losses, however, leading to the 1987 merger with Good Samaritan Medical Center. Good Samaritan was created after a 1982 merger between Deaconess Hospital and Lutheran Hospital (also known as Passavant Hospital).[74]

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[73] Marilyn Kahn, Interview by author, Milwaukee, Wisconsin, June 6, 2011.

[74] Ellen D. Langill, *A Tradition of Caring: The History of Milwaukee's Three Primary Service Hospitals–Lutheran, Mount Sinai, and Evangelical Deaconess* (Milwaukee, WI: Sinai-Samaritan Hospitals History Committee, 1999), 9-16.

Demographic changes in the Jewish population and the development of new government insurance programs for the care of the poor created distance between the hospital and Jewish community support. The Jewish community moved out of downtown Milwaukee starting in the 1950s and began to establish Jewish organizations in the suburbs. As Krausz noted, the concept of identity evolves, and it did in Milwaukee.[75] The Milwaukee Jewish population established themselves in the city. The more affluent Jewish population moved out of downtown Milwaukee starting in the 1950s and began to establish Jewish organizations in suburbs. Social changes, namely the decrease in discrimination in light of the Civil Rights Act of 1965, created new opportunities at Milwaukee hospitals. Jewish doctors obtained privileges to practice and their patients followed them. The symbiotic relationship between Jewish doctors and patients and their hospital became less vital, but did not end.[76]

The East Side Jews moved to the suburbs, while Mount Sinai remained downtown. The relocation of the East Side population altered two of the three core traits of the original Milwaukee Jewish identity. The collective efforts to the city were replaced by the need to establish and sustain suburban Jewish institutions in their new neighborhoods. Philanthropic collective action continued, but in support of institutions outside the city limits. The historic East Side and West Side Jewish identities should have weakened as Jews moved out of the city, but they did not. The historical divide between the two groups remained, still defined by location, between those who remained in Milwaukee, and those

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[75] Krausz, "On Being Jewish," 268.
[76] Dr. David Amrani, Interview by author, Milwaukee, Wisconsin, July 14, 2011.

that moved out.[77] Suburban Jewish populations invested a great deal of time and money in their local Jewish entities. Synagogues, Jewish day schools, and neighborhoods grew outside of the city. Jewish doctors began practicing at other Milwaukee hospitals, and their patients followed them. The racial composition of the neighborhood surrounding Mount Sinai changed as well.[78]

Some interview subjects reported perceptions that the location of Mount Sinai was unsafe, which may have kept some patients and even long-time volunteers from outlying areas away. The downtown location, just north of the area sometimes called the "inner city," contributed to the belief that Mount Sinai was a hospital for the indigent.[79] Many Interviewees reported that the decrease in the Jewish involvement and support facilitated the merger with Good Samaritan. That merger was considered a painful loss by members of the community.[80] However, by this time, the hospital had merged. The result of the merger was that, as one doctor summed it up, "The only thing Jewish about Mount Sinai now is its history."[81]

POLICY, FUNDING CHANGES, AND DEFICIT

One of the main reasons for the loss of Jewish sponsorship and the decreased participation stemmed from the changes in the American hospital system: specifically, how it financed indigent care. Mount Sinai did treat a large number of patients using Medicaid and Medicare. Decreased reimbursement changes to those programs created an

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[77] Pat and Joan Kerns, Interview by author, Mequon, Wisconsin, May 24, 2011.
[78] Marilyn Kahn, Interview by author, Milwaukee, Wisconsin, June 6, 2011.
[79] Dr. Paul Jacobs, Phone Interview by author, November 2, 2011.
[80] Dr. David Amrani, Interview by author, Milwaukee, Wisconsin, July 14, 2011.
[81] Dr. Harry Kanin, Interview by author, Milwaukee, Wisconsin, July 14, 2011.

increasing financial burden at the facility.[82] Changes in funding for indigent care resulted in loss of revenue for many hospitals. The creation and expansion of Medicaid and Medicare in 1965 began to replace fund raising in funding medical care for the poor. The Milwaukee Jewish population believed that these new programs would provide for those in need of care. It was a misguided belief. Funding cuts to both programs beginning in the 1970s led to a fiscal crisis. Both programs fell short in covering the cost of care and led to financial problems at many hospitals, including Mount Sinai. By the time hospitals felt the full effects of policy change, the support of their founding communities had all but ended.

Historian Charles Rosenberg stated that, "Policy is a familiar term. But like many indispensable words, it is not easily defined." In one sense Rosenberg believed that policy is descriptive of practice in the public sector but also notes that "policy" has a variety of meanings: it may imply a sense of responsibility for the planning and strategic unity between goals and outcome. Policy should plan for the possibility of conflict, negotiation, and compromise in policy changes.[83]

Rosenberg believed that some types of policy had the potential for consequences, labeled "cumulative" in that each decision and its significance interact over time to define a new yet historically structured reality, one that is usually unintended and can be missed by those who did not plot the policy steps completely. He wrote, "The system moves through visible decision points, elaborated by subsequent administrative practice–with that specific experience along with other relevant variables shaping the next visible shift

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[82] Dr. Jay Larkey, Interview by author, Milwaukee, Wisconsin, August 17, 2011.
[83] Charles E. Rosenberg, "Anticipated Consequences: Historians, History, and Health Policy," *History and Health Policy in the United States: Putting the Past Back In*, ed. Rosemary Stevens, Charles E. Rosenberg, and Lawton R. Burns (New Brunswick, New Jersey: Rutgers University Press, 2006), 13.

in public policy."[84] The changes in health care policy and procedure for the indigent at Mount Sinai illustrated the cumulative effect. The shift in policy, from a community based and funded support system for private religious hospitals to a governmental program, vulnerable to changes in political support, left hospitals struggling to provide care with less money. By placing the responsibility for charity care with the government, funding became vulnerable to the political positions and attitudes over time. Changes in the political climate translated into changes in the social program. Historian Jonathan Engel discussed the political changes since the creation of Medicaid in the context of his belief that the government's responsibility to provide charity care is considered permanent by the majority of citizens. While the debate about how much to spend and who deserves coverage continues, he argues that no serious attempt to return to collective community funding for health care.[85] His conclusion was that Medicaid, although flawed, has been successful. At the time of its creation, the data about health care utilization among the urban poor was dire. Prenatal care, dental care, well child care, and many other medical services were anomalies for the poor American population prior to the 1960s. The rates of service to the poor in these low income areas were very low, until the poor were able to pay for the care that wealthier Americans were buying for themselves using Medicaid. This program, Engel argued, worked as it was designed to, although not perfectly.[86]

Others supported Engels in his conclusions about the new programs, but issued a warning about the future. At a medical conference held in Philadelphia in 1981, David

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[84] Rosenberg, "Anticipated Consequences," 20.
[85] Jonathan Engel, *Poor People's Medicine: Medicaid and American Charity Care since 1965* (Durham: Duke University Press, 2006), 245-46.
[86] David E. Rogers, Robert J. Blundon, and Thomas W. Molony, "Who Needs Medicaid?," *New England Journal of Medicine* 307, no.1 (1982): 245.

Rogers, Robert Blindon, and Thomas W. Moloney presented an article they had written for the *New England Journal of Medicine* examining the effectiveness of the Medicaid program. Their findings showed that while Medicaid was working as intended, and that the poor were being helped, "A worsening national economic situation has led the public to place a much lower priority on the provision of health services particularly tax supported services to our low income citizens." In short, the popular opinion was changing and the program was up against the growing economic worries of the public. The call to safeguard tax dollars from waste was affecting the support for a successful program.[87] They warned that the issue of cost should not be ignored; they feared the development of a conventional wisdom framing tax dollars spent for the poor to get care as a "waste." Medicaid, they argue, was at risk, due to the relative ignorance of the general public about the assistance program. They were correct. Medicaid costs drew criticism while being associated with the negative attitudes about social welfare programs. The public believed that along with cash, food stamps, and housing assistance, Medicaid was just another example of wasteful government spending.[88]

Contrary to this emerging conventional wisdom of wasted tax dollars on a broken program, the authors noted that Medicare benefits were serving exactly the population it was supposed to: the elderly, the disabled, the mentally ill, and poor children. In fact, the program was costing so much because it was doing exactly what is was designed to do, provide health care for those in need. Nursing homes were receiving half of their funding from the Medicare program. Teaching hospitals, which served a large urban poor

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[87] Rogers, Blundon, and Molony, "Who Needs Medicaid?," 247.
[88] Rogers, Blundon, and Molony, "Who Needs Medicaid?," 246.

population, received 10% of their funding from Medicaid.[89]

Changes in health care also affected hospitals. Medical advances, the creation and expansion of specific specialties and the creation of health care networks increased the cost of medical care. Prior to the July 30, 1965 signing of the Title 19 Act, also known as Medicaid, the Jewish community supported Mount Sinai and assumed responsibility for the hospital and supported its operations with time and money. The community sustained operations even during the Great Depression and World War II, when money and resources were limited.[90] The national recession of the early 1980s revealed the decreased financial contributions to from the Jewish collective to Mount Sinai Hospital. While volunteer opportunities remained through the 1980s, the fundraising events that had supported hospital renovations, innovations, and patient care for decades decreased dramatically. Contributions decreased as private donations were erroneously considered obsolete in the wake of Medicare and Medicaid by the Jewish community.[91] Hospital administrators understood the fiscal ramifications of changes in Medicaid and Medicare reimbursement, but the community at large did not donate funds as they once had.[92] The hospital began to struggle when funding for Medicaid and Medicare were cut at the start of Ronald Reagan's first term as president in 1981. The majority of the patients treated at Mount Sinai were using those programs. Mount Sinai served a large number of patients who could not pay for their care at all, or who had their services reimbursed at rates lower than the actual costs.[93]

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[89] Rogers, Blundon, and Molony, "Who Needs Medicaid?," 245.
[90] Langill, *A Tradition of Caring*).
[91] Ruth Traxler, *The Golden Land, 150 Years of Jewish Life in Milwaukee* (Milwaukee Wisconsin: Sesquicentennial Celebration, 1994), 66.
[92] Traxler, *The Golden Land*, 66.
[93] Walter I. Trattner, *From Poor Law to Welfare State: A History of Social Welfare in America* (New York: The Free Press, 1994), 365.

Before the new government programs, the Jewish people in Milwaukee held events like a charity ball and an annual Donation Day or some other funding drive to offset fiscal losses. By the 1980s, the historic fundraising on the part of the Jewish community had essentially ended. There are two strong explanations for the lack of fundraising for Mount Sinai. First, the donations stopped because the work was deemed no longer necessary in light of the government programs. The belief that the government programs paid for the care the donations used to cover may have undermined the drives.[94] In addition, an overall decrease in female volunteers at the hospital explains why fundraising ended. Jewish women in the 1980s did not replace the aging volunteers from the 1950s and 1960s. Fundraising efforts abated because there were simply not enough volunteers to continue.[95]

The hospital faced closure in the early 1980s until a merger with another hospital, Good Samaritan, was approved in 1987. Two Milwaukee hospitals, Passavant and Deaconess, merged to create Good Samaritan Medical Center. They, like Mount Sinai, relied on community donations for operations. Financial support for the two also declined. The creation of a regional medical center necessitated a merger under new regulations established by changes in the Medicaid program. The merger attenuated decades of financial support and volunteerism. It also severed the community relationship between members of the Jewish community and the city of Milwaukee, a relationship that had lasted thirty years after many of the Jewish families started moving beyond Milwaukee's borders. The creation of government insurance programs changed the way hospitals provided care for the poor. Immigrants founded community hospitals in urban areas. The

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[94] Traxler, *The Golden Land*, 66.
[95] Marilyn Kahn, Interview by author, Milwaukee, Wisconsin, June 6, 2011.

communities supported hospitals through donations and volunteer hours. In 1965, Medicaid, or Title XIX, provided funds for the care of poor patients at many private religious hospitals, including Mount Sinai. At first, Medicaid provided full reimbursement for patient care. In 1982, the Medicaid program underwent a series of changes, including the decrease of reimbursements to hospitals for patient care. This, combined with the end of patient care fundraising, and almost bankrupted many hospitals, including Mount Sinai. After the creation of Sinai Samaritan, Jewish leaders announced plans to preserve a "Jewish identity" at the new facility. However, what was actually preserved was a symbol of the core traits of Milwaukee Jewish identity; East and West Side Jewish history, philanthropy, and service to the city.

ORGANIZATION AND CHAPTER OUTLINE

Chapter One of this dissertation discusses the history of the city of Milwaukee and Jewish immigration. It examines the history of the first wave Jewish population, the foundation of Milwaukee Jewish identity, and their relationship with other Milwaukee immigrant groups, including the relatively small West Side Jewish population that settled outside of the Germanic neighborhoods. The chapter examines upward social mobility experienced by the founders of Mount Sinai and the planning stages of creating the hospitals and those organizations and individuals who were instrumental in bringing the hospital into being. I include a discussion of the early years of operation, including the dedication of the hospital and the board members and volunteers who served. The foundation for Jewish commitment to Milwaukee is discussed. In Milwaukee, many first wave Jewish immigrants obtained civil rights, something denied to them in their countries

of origin. The 1848 European Revolutions failed to secure basic rights of suffrage and freedom from punitive taxes for Jewish men.[96] This chapter describes the early interactions between the East Side and West Side populations in Milwaukee and the contentious attempts to establish Jewish houses of worship. The differences in ethnic and religious traditions and the actions of the first wave Jewish immigrants toward compelling second wave immigrants to adopt an American civil religion led to the creation of several synagogues in Milwaukee. The struggle to establish religious traditions and congregations cemented the animosity between East and West Side Jewish populations. The increased SES of West Side Jews did not automatically remove the stigma of being from the West Side. Increased SES, due in part to the business opportunities in Milwaukee, made philanthropy possible. This chapter explains the history behind the three main traits of Milwaukee Jewish identity.

Chapter Two details the arrival of the second wave Jewish population, mainly Eastern European. This chapter explains how charitable efforts in Milwaukee grew in response to the large number of Jewish immigrants, most of them very poor. Mount Sinai Hospital and other Jewish organization began during the late 1890s and early 1920s. This chapter illustrates the early interactions between East and West Side Jewish populations through the charitable efforts created. The history of philanthropy, a Milwaukee identity trait, is an integral part of this chapter. The hospital board members and noteworthy supporters of the hospital also led relief associations. The important events during these years, namely the establishment of the annual Donation Days in 1904 show the strength of Jewish contributions to the new hospital.

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[96] Hanni M. Holzman, "The German Forty-Eighters and the Socialists in Milwaukee: A Social Psychological Study of Assimilation" (MA thesis, University of Wisconsin, 1948), 5.

Chapter Three discusses the creation and expansion of Mount Sinai's Dispensary. The literature pertaining to the dispensaries at Mount Sinai New York, Beth Israel in Newark, Beth Israel in Boston, Mount Sinai-Chicago, and Michael Reese-Chicago reveal the differences and the similarities of urban hospital dispensaries. The contribution of the Ladies Auxiliary and the establishment of community ties with other hospitals at the Mount Sinai Dispensary created and sustained community health services and training for doctors and nurses. Mount Sinai's leadership attempted to weather the fiscal difficulties associated with a worldwide economic downturn by creating a membership program for the hospital. The program ended due to the objection of the doctors in Milwaukee.

Fundraising efforts lagged during this time. The decrease in fundraising activity for the hospital in the Jewish community concerned leaders at Mount Sinai. Chapter Four takes up the complex merger negotiations between The Passavant and Deaconess, two Christian hospitals in Milwaukee. The history of the merger is significant. The two hospitals considered merger in order to remain open. The financial problems related to changes in both the American hospital system, namely the increase in costs of care, and in how care for indigent patients, specifically the creation of Medicaid and Medicare, stretched hospital resources. The new government funding programs replaced the historic community fundraising at many urban hospitals, including those in Milwaukee.

The creation of government resources for urban hospitals led to massive renovations at many Milwaukee hospitals and also spurred the idea of a regional medical center. Local political leaders and groups, namely the GMC, utilized these resources in order to build the center. The merger was the result of the political efforts of Milwaukee County civic groups to that end. Local leaders parlayed their knowledge of federal and state

regulations to gain funding for the project. They also secured state approval for construction by facilitating the merger between Passavant and Deaconess. Their plans hinged on that merger. Good Samaritan Medical Center, the hospital that Mount Sinai merged with in 1987, opened after a merger between The Passavant and Deaconess. The protracted process revealed the difficulties associated with the merger process in the early 1980s. The leadership at the merging hospitals were at odds with the new medical center leaders and a great deal of acrimony delayed the final merger decision.

The creation of the Regional Medical Center in Wauwatosa, Wisconsin occurred during the merger of The Passavant and Deaconess. The teaching hospital and a medical college located in Wauwatosa competed with Milwaukee hospitals at a time when the city's hospitals needed more patients. The Milwaukee County Hospital moved to the grounds of the medical center, leaving Mount Sinai to treat more indigent patients. The limitations associated with new government regulation on hospital construction and pricing after the creation of the Medicaid program left Mount Sinai with few options after the creation of Good Samaritan.

Chapter Five details the efforts of leaders at Mount Sinai Medical Center to remain open after deficits in patient care reimbursements and debt caused by the 1972 expansion. Between 1974 and 1979, hospital leaders experimented with the idea making Mount Sinai more religiously Jewish as a marketing strategy. The Executive Vice President behind the initiative, Raymond Alexander, left Mount Sinai abruptly in 1976, and the initiative was tabled. The Regional Medical Complex in Wauwatosa ended plans for establishing Mount Sinai as a teaching hospital, so in 1976 leaders established a teaching partnership with the University of Wisconsin-Madison. The program was both a blessing and a burden. A

blessing in that it allowed Mount Sinai Medical Center to remain in downtown Milwaukee and a burden in that the university doctors resulted in conflict between Jewish doctors at the hospital and university doctors. This weakened the relationship between the hospital and the local doctors.

This chapter also describes the circumstances that led to the creation of the suburban Milwaukee Jewish population. Jewish families moved to the suburbs, and many of their institutions moved with them. These new suburban organizations benefited from the time, effort and funds donated by Jewish families. Mount Sinai did not receive the time, money and attention it had once enjoyed, but the Jewish population continued to support the hospital, but not to the extent it had in the past. The charity balls continued into the early 1980s, but the money was redirected from patient care to additions and departments at Mount Sinai. Hospital board members continued to serve, despite moving away from the city. The Suburban Jewish population did not completely sever their relationship with Milwaukee, Mount Sinai remained their responsibility.

Chapter Six describes the severe financial shortfalls at Mount Sinai and the merger decision. One of the most profound changes came in the aftermath of the PL 93-641, federal legislation passed in 1974 as part of the Hill-Burton Act. This legislation gave the U.S. government the power to set reimbursements on the medical care of Medicaid patients through state agencies. The legislation led to Rate Review Boards and state control over hospitals in matters of construction and charges for patient care. Hospitals did not collect the total cost of care from these programs. Secondly, in 1982, federal regulations on Medicare patients automatically disallowed two percent of the total cost of care, leaving the care provider responsible for the balance. And finally, the creation of

Diagnostic Related Groups (DRGs) and standardized medical coding in the health care industry lowered the amount of reimbursement for Medicare patients further. The combination of reimbursement deficits and the remodeling debt was unsustainable. The 1987 merger of Mount Sinai and Good Samaritan took far less time that the Passavant/Deaconess agreement. By 1987, Mount Sinai's leaders sought to keep the hospital open, even if it meant merging with another religious hospital. Hospital leaders realized that the location of Mount Sinai made it an integral facility for many of Milwaukee's poor patients. The goal was to remain open, not to remain Jewish, and to that end, Sinai Samaritan replaced Mount Sinai and Good Samaritan in 1988.[97]

The conclusion examines the Milwaukee Jewish community today, and efforts to establish a sense of identity. The Milwaukee Jewish Federation held a Jewish Summit in 2011. The two-day event, held at the Milwaukee Public Museum, sought to bring Jewish groups and individuals from the state of Wisconsin together in order to set goals for the future of the Jewish population. Accommodations were made to foster the contribution and participation of all branches of Judaism, Shabbos and kashrut observance in particular, to maximize community input. I include the idea of revisiting the history of the Jewish contributions in creating community health care initiatives in Milwaukee. The history of the 1935 Dispensary provides an example of how cooperation between organizations and agencies, Jewish and Gentile, provided health care for a growing number of indigent patients during The Depression. The Affordable Care Act did not result in universal health care. The issue of coverage and care for those without is a possible avenue for the efforts of the Milwaukee Jewish Federation to encourage Jewish collective community action.

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[97] Pat and Joan Kerns, Interview by author, Mequon, Wisconsin, May 24, 2011.

SOURCES AND METHODOLOGY

Archival resources from the Jewish Museum Milwaukee and Golda Meir Library at the University of Wisconsin-Milwaukee are crucial to understanding this history. The Sinai Samaritan Collection and the Jewish Social Services collection provided details about the Jewish hospital and Jewish charity efforts in Milwaukee. These two archives contain newspaper articles, meeting minutes, and reports. Newspapers in Milwaukee provide a context for the actions of the hospital. The *Milwaukee Journal, The Milwaukee Sentinel,* and *The Wisconsin Jewish Chronicle* published many articles about Mount Sinai during its eighty-four year history. The Sinai Samaritan Collection at the Golda Meir Library at the University of Wisconsin-Milwaukee provided a great deal of data about the relationship between the Jewish population and the city of Milwaukee. Newspaper clippings, hospital reports and memos, press releases, and a variety of pamphlets illustrated the relationship between the decisions made by Mount Sinai's leaders. They acted to continue the hospital's contribution to the people of Milwaukee, the merger was their last act toward continuing the mission of Mount Sinai. The Mount Sinai Collection and the archival resources from the Jewish Museum Milwaukee and Golda Meir Library at the University of Wisconsin-Milwaukee provided a great deal of information about the historic relationship between Mount Sinai Hospital and the Jewish community of Milwaukee. In particular, this collection includes documents about the attempt to establish Mount Sinai as a Jewish hospital, led by Raymond Alexander, between 1971-1976.

A special note about the *Wisconsin Jewish Chronicle* belongs here. This publication provided a means to examine the attitudes and positions held by some members of the

Jewish community in Milwaukee. During the years of Mount Sinai's operation, this paper's editors were some of Mount Sinai's most vocal supporters. Established in 1921, the newspaper's very first editorial stated that it was not interested in solving anything; it was created to report on the lives and experiences within the Jewish community in Wisconsin. *The Chronicle* remains in publication and continues to provide information to the Jewish community of Wisconsin.[98] It reported many of the high and low points of the history of Mount Sinai and the efforts to continue on as a Jewish hospital. The Jewish Museum Milwaukee Archives holds every edition of the newspaper.

In addition to the oral histories, the dissertation of sociologist Howard Polsky, *The Great Defense: A Study of Jewish Orthodoxy in Milwaukee*, provided information about characteristics of the West Side Jewish population in Milwaukee. Polsky provides a voice for the West Side Jewish population. Swichkow and Gartner provided a great deal of history about the East Side Jewish experience. Polsky picks up the history of the more Orthodox West Side Jewish immigrants.[99] The addition of the West Side narrative augments the history of the Jewish immigrant experience in Milwaukee.

The sources listed above were very helpful in providing a great deal of historical data for this research. However, oral histories provided by the members of the Milwaukee Jewish community, former employees of the hospital, and volunteers offered a contextual component to the archive holdings. The voices of the respondents enhance the existing archival information. The experiences of those who were kind enough to participate in this study reveal the interactions and reactions that elaborated upon the facts reported in

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[98] Newspaper clipping, editorial, September 28, 1951, *Wisconsin Jewish Chronicle*, Box 1, Folder 10, Mount Sinai Collection, Jewish Museum Milwaukee.
[99] Howard W. Polsky, "The Great Defense: A Study of Jewish Orthodoxy in Milwaukee" (PhD diss., University of Wisconsin, 1956).

newspaper articles. In addition, these histories included information not reported elsewhere. They relate the history of community interaction and activism from their perspective. The voices of the community complement the archival holdings and allow for the community members to elaborate on the printed history.

Mount Sinai was a Milwaukee nonsectarian Jewish hospital, founded and strongly supported by the Jewish population, for the city of Milwaukee Jewish and Gentile alike. It served as a symbol of the Jewish value of *Tzedakah*, operated from a sense of benevolence, and a source of community pride in its growth as an innovative and respected hospital. For decades, the men and women of the Jewish community raised large sums of money through a variety of donation drives, gala events and community wide fund raising; served on the Hospital board; and advocated for the hospital through their business ventures and contacts. The history of the Jewish contribution to Milwaukee begins with the arrival of the first wave East Side Jewish population.

CHAPTER 1 THE JEWISH POPULATION IN MILWAUKEE

This chapter analyzes the creation and relationship between the two separate Jewish populations in Milwaukee leading up to the creation of Mount Sinai Hospital in 1903. The distinction between them contributed to the creation of the East Side vs. West Side populations. The two groups were split along ethnic, socioeconomic, and religious differences. However, the differences between the two did not prevent the creation of Mount Sinai; rather, they inspired it.

Milwaukee was a city poised for growth in the 1850s. Jewish immigrants on the East Side of the Milwaukee River established businesses and lived among the non-Jewish Germanic immigrants. Historian Kathleen Neils Conzen noted that Milwaukee attracted both farmers and artisans, lured by the stories of a great deal of economic opportunity for those willing to work hard.[1] Some of the more prosperous members of this Jewish community established Mount Sinai Hospital. Initially, a small West Side Jewish population, those that arrived with the East Side Jews in the 1840s and 1850s, were less likely to embrace a more American style of Jewish worship and did not settle with the others. They created their own congregations apart from the other group. After the arrival of the Eastern European immigrants, starting in the late 1880s, the new West Side immigrants created one of the largest Jewish neighborhoods in Milwaukee. This chapter describes the foundation of the first core characteristic of Milwaukee Jewish identity: namely the significance of which side of the Milwaukee River on which immigrants settled.

A discussion detailing the foundation for the strong commitment of the Jewish

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[11] Kathleen Neils Conzen, *Immigrant Milwaukee: 1838-1860: Accommodation and Community in a Frontier City* (Cambridge, MA: Harvard University Press, 1976), 29-32.

population to the city of Milwaukee is also included. The demographic characteristics of Milwaukee, a large Germanic population chief among them, and civil rights offered to certain immigrants in Milwaukee at the time of the arrival of the East Side Jewish population fostered a sense of belonging and gratitude within the East Side Jewish population. The first wave of Jewish immigrants capitalized on economic opportunities and civic freedoms in Milwaukee and founded the East Side Jewish population. The success in business ventures created social and cultural capital for members of the East Side Jewish population. The increase in SES in the German Jewish immigrant population was very important for Mount Sinai.

Many of these immigrants gained rights and freedoms not available to them in Western Europe. The failure of the 1848 revolution did result in a great deal of German migration to many American cities, Milwaukee included. Historians Louis J. Swichkow and Louis P. Gartner noted that in Milwaukee, support for those involved in the 1848 revolution in Germany attracted immigrants. They stated, "Another factor [explaining the large number of German immigrants in Milwaukee] was the publicized sympathy of Milwaukee's German community for the revolutionary movement in Germany. This attracted 'Forty-eighters' to Milwaukee in great numbers."[2] John Gurda explained, "The famed Forty-Eighters, [sic] many of them well-educated and all of them decidedly liberal, suffered exile for their assault on the established order, and Milwaukee became one of their American strongholds."[3] The founding members of the East Side Jewish population arrived with their Gentile counterparts after the revolution. They settled in Milwaukee

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[2] Louis J. Swichkow and Louis P. Gartner, *The History of the Jews in Milwaukee* (Philadelphia, PA: The Jewish Publication Society of America, 1963), 10.
[3] John Gurda, *One People, Many Paths: A History of Jewish Milwaukee* (Milwaukee, WI: Jewish Museum Milwaukee, 2009), 6.

and joined the German community. They established many successful businesses in Milwaukee because they shared many cultural traits with Gentiles in the city. German Jewish businesses grew rapidly, and many East Side Jews experienced a great deal of upward economic and social mobility. Swichkow and Gartner noted that "Jews actively participated in Milwaukee's commercial life and contributed heavily to the early commercial and industrial development of the city. They were represented among the grain dealers and were pioneer Great Lakes shippers. As elsewhere on the Western frontier, Jewish peddlers and merchants were prominent, while Jewish manufacturers clothed most of Milwaukee and its outlying districts."[4] Both Bourdieu and Goldscheider described this experience as the means to both create social and cultural capital, which gave a sense of agency to this population to create acceptable cultural standards for anyone wishing to achieve upward social mobility and higher SES.[5] The fact that they arrived first and many enjoyed economic success also established the East Side population as the creators of certain norms and acceptable traits within the Jewish population. Sociologist Hanni M. Holzman wrote that by virtue of being in Milwaukee first, "They could set up their own society where they made the rules."[6] Holzman posited that in Milwaukee, East Side Jews found what they had hoped to create in their countries of origin: freedom to live among Gentiles and equal rights.[7] She noted that as many in the East Side population attained wealth and high social status, these traits were included to a growing list of certain qualifications that led to acceptance in the German Jewish

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[4] Swichkow and Gartner, *The History of the Jews of Milwaukee*, 12.

[5] Pierre Bourdieu, "Cultural Reproduction and Social Reproduction," in *Power and Ideology in Education* (New York: Oxford University Press, 1977); Calvin Goldscheider, "Demography of Jewish American: Research Findings, Issues, and Challenges," in *Understanding American Jewry*, ed. Marshall Sklare (Brandeis University: Transaction Publishers, 1982), 9.

[6] Hanni M. Holzman, "The German Forty-Eighters and the Socialists in Milwaukee: A Social Psychological Study of Assimilation" (MA thesis, University of Wisconsin, 1948), 13.

[7] Holzman, "The German Forty-Eighters and the Socialists in Milwaukee," 9.

community as an East Sider.[8]

However, what Holzman calls "assimilation" is in fact something quite different. The German Jewish East Side population was not assimilating so much as they were both acculturating and creating the social norms and mores for their own subculture. The Cult of Synthesis, as described by Sarna, best illustrates the early history of Milwaukee's Jewish population. Affluent East Side Jews synthesized Americanism and Jewish identity in the context of the city of Milwaukee and created the earliest cultural understandings about being a Milwaukee Jew.[9] They could acculturate, in part because many of the Gentile Germans living in Milwaukee at the time they arrived supported the 1848 Revolutions taking place in Europe. They were likeminded in the matters of suffrage and civil rights.[10] However, they did not intermarry in Milwaukee in large numbers or feel the need to change their names.[11] They focused a great deal of time and effort creating a Jewish subculture that allowed them to define and create and later, enforce rules about being Jewish in Milwaukee, particularly East Side Milwaukee Jewish status.[12]

Economic opportunities allowed the East Side Jews to create Mount Sinai Hospital, not just for Jewish patients, but for all those in need.[13] The nonsectarian mission of Mount Sinai Hospital signified, in part, a commitment to the city on the part of the first Jewish immigrants. This commitment represents the second of the three aspects of Milwaukee Jewish identity, contributions to the city of Milwaukee. Max Landauer, the first president of Mount Sinai Hospital and successful East Side Jewish dry goods

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8 Holzman, "The German Forty-Eighters and the Socialists in Milwaukee," 13.
9 Jonathan D. Sarna, "The Cult of Synthesis in American Jewish Culture,*" Jewish Social Studies American Jewish History and Culture in the Twentieth Century,* 5, No. 1/2 (Autumn, 1998 - Winter, 1999).
10 Holzman, "The German Forty-Eighters and the Socialists in Milwaukee 32.
11 Swichkow and Gartner, *The History of the Jews of Milwaukee*, 63-64.
12 Holzman, "The German Forty-Eighters and the Socialists in Milwaukee,", 32.
13 Pat and Joan Kerns, Interview by author, Mequon, Wisconsin, May 24, 2011.

businessman, dedicated the hospital in June, 1903, saying, "The urgent necessity of a free hospital for the poor and suffering of our city came to us in a practical way as members of the Hebrew Relief Association."[14] The commitment to treat all in need in Milwaukee at Mount Sinai emanated from a sense of gratitude on the part of the East Side Jews. It was an acknowledgment of the rights and opportunities Milwaukee offered to them upon arrival. The decades of fundraising efforts and donations of money and volunteer hours on the part of the Jewish community continued after many Jewish residents moved from Milwaukee. The 1987 merger kept the hospital in the city as a sectarian hospital in order to continue the mission of caring for the poor in Milwaukee.[15]

The third facet of Milwaukee Jewish identity, the history of philanthropy, is grounded in the arrival of the West Side Jews. Milwaukee Jewish philanthropy must include the discussion of early Jewish religious practices in Milwaukee. The question of how best to describe the religious differences between the first and second wave Jewish immigrants is complicated. The sheer number of arrivals challenged relief organizations as well. The Jewish relief efforts available in Milwaukee at the turn of the twentieth century grew as more Jews from Eastern Europe arrived. The large number of Eastern European immigrants in Milwaukee spurred the growth of relief organizations in Milwaukee. The creation of relief programs and Mount Sinai Hospital in the early twentieth century was as much about acculturating to the accepted synthesis of Jewish and American practices as they were about assistance.

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[14] Max Landauer, quoted in newspaper clipping, "Jews Dedicate Hospital," *Milwaukee Sentinel*, June 8, 1903, Box 51, Folder 1, Sinai Samaritan Collection, Golda Meir Library Archives Department, University of Wisconsin-Milwaukee, Milwaukee, Wisconsin (hereafter cited as Sinai Samaritan Collection).
[15] Pat and Joan Kerns, Interview by author, Mequon, Wisconsin, May 24, 2011.

AMERICAN JUDAISM: CONGREGATIONS AND CONFLICTS

In 1654, the first group of Jewish immigrants arrived in America. They established themselves in New Amsterdam, now New York.[16] Two large immigrant waves, the first starting in the late 1840s and the second, in the 1880s, established the foundation for the Milwaukee Jewish population. I use the terms first and second wave Jewish immigrants to describe immigration to Milwaukee during those two periods. The first wave refers to the 1840 immigrant members of the Jewish population, the second to those who arrived in the 1880s. Religious practices between these first and second wave Jewish immigrants were very different in Europe. Those differences created divisions between them after they arrived in America. The literature revels that these divisions were not primarily about religious observance: many of the issues that led to discord between the groups centered on ethnicity and class. These differences often manifested themselves in religious terms. The early use of the term "Orthodoxy" in some sources used for this research took on various social meanings, some quite pejorative. At the time of the meeting of first and second wave Jewish immigrants in American cities, in the late 1800s and early 1900s, the term Orthodox tended to describe immigrants from the smaller cities of Central and Eastern Europe and the less secularized. That is, the term often reflected where that person was from and any secular education they had before arriving in America. There were social implications stemming from that particular status. In this sense, historian Jeffrey S. Gutrock found that the term Orthodox became synonymous with Yiddish speaking immigrants with little formal education outside of the synagogue. Members of American Reform congregations believed that secular education and acculturated religious practice increased the likelihood of social and economic upward

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[16] Hasia R. Diner, *A New Promised Land: A History of Jews in America* (New York: Oxford Press, 2000), 3.

mobility.[17] Historian Avaham Barkai believed that the earlier the arrival in America, the more likely the Jewish immigrant would eventually practice a form of Reform Judaism.[18] This form of Jewish practice differed from that of those arriving from Eastern Europe. When large numbers of Eastern European Jews began arriving between 1880 and 1914, Barkai noted that American Jewish communities acted to acculturate the new arrivals if possible, "The now urgent aim was to wean the newcomers, or at least their children from their alien ways."[19] He stated that there was a fear among those in the first wave Jewish population that the Eastern European Jewish arrivals threatened their social status and achievements in their communities.[20] The first wave Jewish American feared the loss of their hard earned social and cultural capital. That fear influenced relief efforts for the new arrivals.

Barkai noted that these new immigrants did not quickly adopt the trappings of American Jewish life, "The new immigrants did not share the German's passion for rapid Americanization. They gathered in ethnic neighborhoods and tried to benefit from what America had to offer without relinquishing their traditions."[21] However, Gurock found that for many of the immigrants in the second wave, the decline in traditional observance began well before they actually considered leaving Europe. Many Jews living in Eastern Europe worked on the Sabbath, despite social pressure against such actions.[22] He observed that for some second wave Jewish immigrants, their desire to look and act like

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[17] Jeffrey S. Gurock, *Orthodox Jews in America* (Bloomington, Indiana: Indiana University Press, 2009), 51.
[18] Avraham Barkai, *Branching Out: German-Jewish Immigration to the United States, 1820-1914* (New York: Holmes & Meier, 1994), 204.
[19] Barkai, *Branching Out,* 204-05.
[20] Barkai, *Branching Out,* 205.
[21] Barkai, *Branching Out,* 205.
[22] Gurock, *Orthodox Jews in America*, 95.

other Americans led to their decision to change their dress and appearance.[23] Men shaved

their beards and *payes*, married women removed their head coverings, sometimes

throwing them overboard as their ship docked at Ellis Island.[24]

Historian Eli Faber wrote that the earliest Jewish immigrants realized their freedom to

follow whatever religious traditions they wish, indeed, they were free to create their own.

This applied to both Reform and Orthodox practices. In America, no central Rabbinical

court or leader dictated the religious traditions, as they did in Europe,

> Moreover, it was the complete lack of need for a universal Jewish community that
> undermined all claims to hegemony. The authority of the autonomous *kehillah*
> (community) of Europe arose from its function as intermediary between the
> Jewish population and the government and from its responsibility to provide for
> the welfare of a population burdened with civil disabilities. In the tolerant
> atmosphere of English North America, in contrast, the Jewish population was
> neither required nor ever instructed to provide an official entity to represent it and
> to which all Jews must consequently be subordinated. The Jewish colonist was
> free to associate voluntarily with the Jewish community or not, whatever its
> pretensions to universal authority may have been.[25]

This situation also limited the amount of power any single congregation could expect

to hold in a given city. This freedom reduced the amount of control any religious leader

could expect over his congregation.[26] In New York, there were congregations founded by

Dutch, Bohemian, English, German immigrants by the 1850s. They opened when

immigrants could not or would not join the Sephardic and Ashkenazic congregations

established by America's earliest Jewish immigrants.[27] In Boston, two congregations

developed in the South and North End neighborhoods, the more affluent original

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[23] Gurock, *Orthodox Jews in America*, 96.
[24] Gurock, *Orthodox Jews in America*, 96-97. *Payes* are the distinctive hair styles worn by men who followed the traditional practice of not shaving certain areas on their heads.
[25] Eli Farber, "The Formative Era of American Jewish History," *American Jewish History* 81, no.1 (Autumn 1993):17.
[26] Gurock, *Orthodox Jews in America*, 55.
[27] Gurock, *Orthodox Jews in America*, 51.

synagogue in the North, and the more "traditional" congregation in the South.[28] In Fort Worth, Texas, the relocation of the more traditional orthodox *shul*, Ahavath Sholom to the center of the city to attract new members inspired the creation of a Reform congregation, Beth-El.[29] In Chicago, an Orthodox *shul* was established by a former peddler turned successful businessman, Abraham Kohn, in order to provide kosher meat for his elderly mother, who refused to eat anything *trafe* .[30]

The term Orthodox is used by sociologist Howard W. Polsky, in his dissertation about Milwaukee, to describe the traditional mostly Eastern European Orthodox religious observance of Judaism.[31] That specific type of Judaism was not a large part of the early Jewish immigrant experience in Milwaukee. Gurock noted that "Amidst the multitude of immigrants who made partial peace with Jewish tradition as they strove to adjust and succeed in America, there was a coterie of deeply devoted Jews who rigorously kept the commandments."[32] There were more traditional European Jewish immigrants in the second wave of the late 1800s, but they did not settle in Milwaukee.

Scholars have noted that the Jewish immigrants arriving between 1880 and 1920 were possibly less likely to remain Orthodox in America. Historian Eli Faber noted that many European Orthodox Jews heeded the warnings of their rabbis about the dangers to Orthodox traditions in the *Trafe Medina* (unclean country) of America. The more Orthodox Europeans likely remained in Europe.[33] Historian Jonathan Sarna remarked that "All Jews, to be sure, did not join the leftward swing [to Reform Judaism]. Every major Jewish

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[28] Meaghan Dwyer-Ryan, Susan L. Porter, and Lisa Fagin Davis, *Becoming American: Temple Israel of Boston* (Lebanon, NH, Brandeis University Press, 2009), 6-8.
[29] Hollace Ava Weiner, "Whistling "Dixie" while Humming 'Ha-Tikvah': Acculturation among Orthodox Jews in Fort Worth," *American Jewish History* 93, no.2 (June 2007): 223.
[30] Gurock, *Orthodox Jews in America*, 68. *Trafe* refers to non-Kosher, in this case food, primarily meat.
[31] Howard W. Polsky, "The Great Defense: A Study of Jewish Orthodoxy in Milwaukee" (PhD diss., University of Wisconsin, 1956), 7.
[32] Gurock, *Orthodox Jews in America,* 106.
[33] Farber, "The Formative Era of American Jewish History," 15.

community continued to maintain one or more traditional congregations."[34] The Jews that arrived in Milwaukee and labeled Orthodox by Polsky did not retain many of their religious customs once settled. The histories of Congregation B'ne Jeshurun on the West Side and Emanu-El on the East Side of the Milwaukee River, illustrate the relatively brief period of time some immigrants of the first wave Jewish population practiced a more traditional form of Judaism. Swichkow and Gartner explained that "Although B'ne Jeshurun had left Orthodoxy by the later 1860s, its brand of Reform Judaism was very halting. As the sole congregation, it was an arena for contests between traditionalists and proponents of completely Reform belief and practice."[35] The Reform minded Milwaukee Jews broke from the congregation and formed the Reform synagogue Emanu-El.[36] Gurock mentioned B'ne Jeshurun, describing it as a congregation that had "surrendered" to more American Reform Jewish practices by the late 1850s. The influence of Rabbi Isaac Wise, proponent of the American Reform Movement, spurred changes at what was once considered Milwaukee's Orthodox synagogue. Wise viewed the adoption of mixed seating [men and women sitting together] and music played on Shabbos as indications that the dissenters had seen the advantages of adopting "modern" views on the issue of Jewish rituals.[37] Gurock noted that by 1870, almost all Americanized congregations had turned away from European Orthodoxy.[38] The arrival of the second wave Jewish immigrants challenged these newly established religious traditions of first wave immigrants in American cities. By the time the second wave arrived, many members of Milwaukee's Jewish population achieved upward social and economic mobility. This was

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[34] Jonathan D. Sarna, *American Judaism: A History* (New Haven, CT: Yale University Press, 2004), 129.
[35] Swichkow and Gartner, *The History of the Jews of Milwaukee*, 50.
[36] Swichkow and Gartner, *The History of the Jews of Milwaukee*, 51.
[37] Gurock, *Orthodox Jews in America*, 79.
[38] Gurock, *Orthodox Jews in America*, 83.

made possible by the favorable economic climate for Jews in the city and the religious freedom to define their Judaism.

A CITY OF OPPORTUNITY

In 1839, the two original settlements, Juneautown and Kilbourntown, after a series of conflicts between founders Solomon Juneau and Byron Kilbourn over political decisions, together formed the Town of Milwaukee.[39] Until 1840, white migrants from New York State or New England, known as Yankee-Yorkers, represented the majority in Milwaukee.[40] Historian Bayrd Still described a demographic shift Milwaukee at this time: "In the middle forties, Teutonia began to challenge Yankee-dom and European migration."[41] A large number of Germanic immigrants arrived in Milwaukee. These immigrants began to "transform the tone of what had been predominantly a Yankee-Yorker village; by 1843 a Germanic influence that was to reach its peak by the end of the century had already begun to make itself felt."[42] The new immigrants from Germanic regions of Europe arrived in Milwaukee and established a large ethnic enclave in Milwaukee.[43] Historian Bayrd Still noted, "By 1843 it was evident that the increasingly numerous German-Americans were going to assume a positive role in developing village culture."[44] The result of this immigrant wave was the creation of one of the largest Germanic settlements in America. The influence of the immigrants on the city's landscape and the association between Milwaukee and German immigrants resulted

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[39] John Gurda, *The Making of Milwaukee* (Milwaukee, WI: Milwaukee County Historical Society, 2006), 39.
[40] Bayrd Still, *Milwaukee: The History of a City* (Madison, Wisconsin: The State Historical Society of Wisconsin, 1948), 72.
[41] Still, *Milwaukee,* 72.
[42] Still, *Milwaukee,* 72.
[43] Still, *Milwaukee,* 128.
[44] Still, *Milwaukee,* 75.

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in the nickname *Deutsche Athens* (German Athens) for the city, signifying a city in America where German culture met American democracy and freedom.[45]

The fact that a large number of Germanic immigrants settled in Milwaukee was not happenstance. An outreach program established by both the town of Milwaukee and the State of Wisconsin advertised the industrial and agricultural opportunities in Wisconsin in order to draw immigrants. Bayrd Still recorded that pamphlets and circulars written in German to attract immigrant workers were distributed in many European countries.[46] Still noted that the outreach to Germanic immigrants was so successful that, "As a result, in many parts of Germany more was known about the Badger State than about an outlying Prussian province."[47] Milwaukee's German immigrants wrote to relatives in Europe about the opportunities in Milwaukee and urged them to emigrate. Still reported the results of the outreach in term of increased immigrant numbers: "The earliest German immigrants began to arrive in 1835, and the remainder of the decade saw scattering arrivals, among them a party of German carpenters, who had come at the solicitation of Juneau; Matthias Stein, whom Juneau induced to stay; and Louis Trayser, whom the shipbuilder George Barber persuaded to build an inn for his workers: 'Zur Deutschen Little Tavern.'[48] However, Still concluded that during this time, a "push/pull" dynamic brought more immigrants to America. The failed revolutions in Europe and the expanding economic opportunities in America increased the number of immigrants. Still found that in the North Central sections of the United States the number of arrivals totaled 280,000 by 1850.[49] Immigration numbers rose in Milwaukee. Still that between 200 and 300

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45 Gurda, *The Making of Milwaukee,* 39.
46 Still, *Milwaukee,* 114.
47 Still, *Milwaukee,* 113.
48 Still, *Milwaukee,* 72-73.
49 Still, *Milwaukee,* 73.

German immigrants were arriving weekly in the 1840s; and soon young Germans from Chicago were visiting Milwaukee to find themselves brides.[50] In the summers of 1843 and 1844, the numbers grew to 1,000 to 1400.[51] The city of Milwaukee and the state of Wisconsin encouraged German immigration after the European Revolutions in 1848.[52] Many European Jews immigrated to Milwaukee in order to escape the severe restrictive laws passed after the revolution ended. Milwaukee offered civic freedoms and the outreach efforts of the region brought the founding members of what became the East Side Jewish residents to Milwaukee.

REVOLUTION AND RELOCATION

The European Revolutions of 1848 began when revolutionaries deposed French King Louis-Philippe in Paris on February 25, 1848. Revolts in Vienna quickly followed the Paris unrest. Historian Eton Amos notes that "It had started in Paris and Vienna, and from there it was now leaping with remarkable speed to the main German cities. Across Europe, the declared aim of the rebels was to put an end to despotism and to the inequalities under the law."[53] In May of 1848, a revolution nicknamed a "spring of nations" sought, among other goals, civil rights for Jews in some European regions. Initially, some governments granted suffrage rights for Jewish men. Some leaders passed new edicts which lifted restrictions on Jewish students at universities, in order to avoid losing political power. The Jewish male population held equal rights for a brief time. However, leaders rescinded the rights granted during 1848 revolution after the revolution

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[50] Still, Milwaukee, 73.
[51] Still, *Milwaukee,* 73.
[52] Still, *Milwaukee,* 114.
[53] Amos Elon, *The Pity of It All: A History of Jews in Germany,* 1743-1933 (Metropolitan Books: New York, 2002), 152.

ended. By December 1848, the revolutions ended and the new Jewish suffrage rights were revoked. Jewish government participation ended, and new edicts limited their opportunities even more than before the revolution.[54] These losses increased Jewish emigration.

Wisconsin's liberal suffrage rights encouraged foreign immigrants by giving them the right to vote after one year's residence.[55] The right of suffrage was established in 1847 for immigrants who were "one-year residents, including white males, twenty-one years of age, who had declared their intention to become citizens."[56] The outreach efforts of civic and business interests in Milwaukee and the state of Wisconsin to German settlers in the 1850s and 1860s, combined with the failed revolutionary movement in Europe in the late 1840s drew many "Forty-eighters" to Milwaukee. Still explained, "The impact of the Forty-eighters on the developing urban society was chiefly significant for the cultural and intellectual ferment which they stirred up in the already cohesive German community."[57] The first wave immigrants created debating societies, lodges, schools, and newspapers in addition to their businesses. They created an intellectual subculture in Milwaukee, but they were held in beer gardens than in European style salons, a reflection of the acceptance of Milwaukee German cultural practice.[58]

The early East Side Jewish community was part of that immigration population. They settled in neighborhoods with other like-minded Gentiles, many of whom supported the 1848 revolutions.[59] The fact that the city of Milwaukee had a large Germanic influence at the time the first wave Jewish immigrants arrived is noteworthy. The fact that some first

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[54] Elon, *The Pity of It All,* 153.
[55] Still, *Milwaukee,* 78.
[56] Still, *Milwaukee,* 78.
[57] Still, *Milwaukee,* 115.
[58] Still, *Milwaukee,* 115.
[59] Holzman, "The German Forty-Eighters and the Socialists in Milwaukee," 7-8.

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wave Jewish immigrants spoke German and considered themselves assimilated Jews in Europe made their experience in Milwaukee vastly different from that of the second wave. The first wave Jewish immigrants were able to establish their homes and themselves in Milwaukee's Germanic neighborhoods because they shared common cultural traits with Germanic Gentiles. This allowed them to join the community and facilitated their entrance into German neighborhoods. Swichkow and Gartner noted that, "These Jews came during the heyday of German immigration to the United States between 1845 and 1857."[60] They cited the restrictions placed upon Jews in German and a depression in 1850, coupled with reprisals from the failed 1848 revolution as explanation for the increase in German immigration to America.[61]

The East Side Jews settled in a neighborhood established by the 1840 immigrants that Still described as "German town" which was a "self-contained and self-conscious community centered in the Second, Sixth, and Nineteen wards" founded in cultural and civic solidarity.[62] The East Side Jews lived among the Second Ward's non-Jewish population. The neighborhood grew and eventually included areas in the Second, Sixth, and Ninth wards, where German-style houses, German signs, and the German people made their homes and businesses and political parties.[63] Milwaukee Germans created associations, lodges, clubs, as well as beer halls and taverns in the city. They established businesses, places of worship, and schools. Still notes that immigrants born in German regions made up one third of Milwaukee's population by 1870 and concluded, "As a result, the coordinate German society within the developing city was in many ways the

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[60] Swichkow and Gartner, *The History of the Jews of Milwaukee*, 11.
[61] Swichkow and Gartner, *The History of the Jews of Milwaukee*, 11.
[62] Still, *Milwaukee,* 112.
[63] Swichkow and Gartner, *The History of the Jews of Milwaukee,* 12.

most distinctive feature of mid-century Milwaukee."[64]

The Milwaukee East Side Jewish community arrived at a time when the city wanted immigrants. The large number of arrivals from Germanic regions after 1848, both Jewish and Gentile, spoke German in their homes and places of worship and business concerns.[65] The East Side Jewish population established themselves in business ventures due in great part, to the characteristics of Milwaukee described previously and three fortuitous factors in Milwaukee after 1848. First, they arrived in Milwaukee with a large, culturally-similar non-Jewish cohort. Second, many Jewish immigrants acculturated themselves in Milwaukee by learning English. Finally, Milwaukee did not restrict their civil rights and provided them with the opportunities denied in their countries of origin. Harry Kanin described the situation as "a perfect storm" for the East Side Jewish immigrants. Milwaukee was a city open to secular and educated immigrants. Kanin explained, "They came together with other Germans and were able to succeed."[66] The civic freedoms for Jewish immigrants in Milwaukee afforded them the opportunities to build successful businesses and establish professional practices. The economic opportunities in Milwaukee in the later 1840s facilitated the growth of the Jewish upper class.

BUSINESS OPPORTUNITIES

The East Side Jews synthesized their Jewish practices so thoroughly that they were almost indistinguishable from non-Jewish immigrants in their work, habits, language and enterprises. They joined the earlier German immigrants in their established neighborhoods. Indeed, they were often identified most readily with the German community as a whole.

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[64] Still, *Milwaukee,* 112.
[65] Still, *Milwaukee,* 71.
[66] Dr. Harry Kanin, Interview by author, Milwaukee, Wisconsin, July 14, 2011.

Swichkow and Gartner noted that the Wisconsin State Census of 1855, which listed residents by wards, showed that most Jews lived alongside Gentiles in the Second Ward.[67]

Many of the East Side Jewish immigrants started their own businesses. Sociologist Hanni M. Holzman noted that many of these first wave Jews were from the European middle class, hoping to secure permanent civil rights and the freedom to establish businesses without government restrictions.[68] Historian John Gurda noted that in Milwaukee, "Jews showed an unmistakable preference for independent business. In a sample of eighteen immigrants who came to Milwaukee between 1845 and 1850 and lived in the city for at least five years, all eighteen were operating their own businesses in 1855, selling groceries, clothing, dry goods, liquor, tin ware, and even ice, often in association with relatives."[69] The historic European restrictions on Jewish economic activity explain the prevalence of Milwaukee Jewish businesses. Gurda noted, "The Jewish predisposition to business was the product not of genetics but of history. After experiencing the capriciousness and often the viciousness of their host societies for hundreds of years— the Spanish Inquisition and the English and French expulsion decrees come to mind— Europe's Jews had learned self-reliance the hard way."[70] Jewish families established businesses which offered jobs to new arrivals. Children grew up in the family enterprises. They staffed clerking positions in stores and piecework in clothing factories. Their economic success was a source of community pride. Jewish businesses in the dry goods, grocery, clothing and textiles flourished in Milwaukee.[71] The success of Jewish businesses was such that Swichkow and Gartner noted, "of the 196 businesses exceeding $200,000 in 1894, eighteen

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[67] Swichkow and Gartner, *The History of the Jews of Milwaukee,* 12.
[68] Holzman, "The German Forty-Eighters and the Socialists in Milwaukee," 5-6.
[69] Gurda, *One People, Many Paths,* 9.
[70] Gurda, *One People, Many Paths,* 9-10.
[71] Swichkow and Gartner, *The History of the Jews of Milwaukee*, 99.

of them were Jewish. Four of the 62 in the $200,000 were Jewish. Six of the 50 in the $300,000 bracket− Landaur, Smith-Mendel Scheftels, G. Patek, H.S Mack and National Knitting Company− were the property of Jews. The Gimbel Brothers and Henry Stern, were the only Jewish businesses among the 25 with net worth over $400,000 and the Pereles Brothers and J.E Friend belonged among the 25 enterprises in the $500,000 group."[72] These businesses included clothing and textile factories, dry goods and groceries, and retail shops. Sons of immigrant founders continued the family tradition of business ownership.[73] By 1895, most clothing factories in Milwaukee were Jewish-owned. In addition, Jewish families opened department stores and groceries and dry goods stores throughout the city. Gimbel's Department Stores in particular grew rapidly in Milwaukee and spread into other cities in Wisconsin. Swichkow and Gartner noted, "Local merchants could hardly keep pace the seven Gimbel brothers who advertised their wares."[74] Henry Friend and David Adler were among those local merchants, each of them successful. Adler's corporation employed 800 by the 1890s and had sales in excess of one hundred thousand dollars. It employed many Jewish workers for manufacturing and sales positions.[75] Julius Lando was a jeweler as well as a merchant in the optical trade. He was joined by his brother, Max, an optician, and established an eye-wear business in Milwaukee.[76]

Jewish men also held elected public offices in Milwaukee. Baruch Weil was elected as a Democratic State Senator in 1853. He remained in office until 1857. Jewish Aldermen held office in Wards 1, 2, 4, 6, 8 and 9, Lewis Mack, Isaac Neustadtl, Louis Rindskopf,

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[72] Swichkow and Gartner, *The History of the Jews of Milwaukee,* 108.
[73] Swichkow and Gartner, *The History of the Jews of Milwaukee,* 109.
[74] Swichkow and Gartner, *The History of the Jews of Milwaukee,* 99.
[75] Swichkow and Gartner, *The History of the Jews of Milwaukee,* 95.
[76] Swichkow and Gartner, *The History of the Jews of Milwaukee,* 101.

Fred Adler, Bernard Leidersdorf and M. Heiman respectively.[77] Leopold Hammel, a founding member of the Mount Sinai Hospital Board, was elected as District Attorney in 1892. The Jewish contribution to Milwaukee politics increased in the twentieth century.[78]

The Jewish professional class in Milwaukee did not grow as quickly as the business class. The position of lawyer was one of the few professional careers open to Jews. One of the first professionals was Nathan Pereles, a lawyer in the investment business.[79] Jewish doctors in particular struggled to establish practices in Milwaukee. There were few Jewish doctors educated in the United States by 1880, only two Jewish doctors practicing in Milwaukee, Dr. Louis Adler and Dr. Jacob Mendel, were both educated in Europe. The lack of opportunities for Jewish doctors in Milwaukee was a problem.[80] Jewish doctors were barred from practicing medicine at existing hospitals in Milwaukee. Milwaukee's Jewish doctors needed a hospital to establish medical practices. However, despite the large number of Jewish businesses, Milwaukee Jewish institutions, namely synagogues, took longer to establish. The Jewish population in Milwaukee created charitable organizations in the late 1880s that led to the creation of Mount Sinai Hospital. In addition, Milwaukee Jews established several congregations, each representing the cultural differences within the Jewish population.

Jewish businesses grew quickly, but the establishment of formal Jewish religious practices and institutions in Milwaukee proved difficult. This process took more time. Before any synagogue was built, Milwaukee's Jewish community purchased a burial ground, Imanu-Al Cemetery, which indicated an intent to establish a community.[81]

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[77] Swichkow and Gartner, *The History of the Jews of Milwaukee*, 505.
[78] Swichkow and Gartner, *The History of the Jews of Milwaukee*, 107.
[79] Swichkow and Gartner, *The History of the Jews of Milwaukee*, 109.
[80] Swichkow and Gartner, *The History of the Jews of Milwaukee,* 110.
[81] Swichkow and Gartner, *The History of the Jews of Milwaukee,* 34.

Historian Hasia Diner noted,

> Nearly all of the congregations that served the nearly American Jews began as informal groups. It took time for the Jews to decide that they were staying in America and needed permanent institutions. This decision often took place when the Jews of a community realized that they needed a cemetery. While all that was required to conduct Jewish prayer services was a space and a *minyan* (ten men to pray together), a Jewish cemetery signified the desire to stay.[82]

Jewish burials were recorded in Milwaukee as early as 1848. Swichkow and Gartner explained that, "While land was probably not purchased before 1854, arrangements must already have existed in 1848 for the ultimate acquisition of that land."[83] The Jewish residents of Milwaukee had a communal burial ground but did not have a synagogue.

The early Jewish services were informal. The first communal Jewish service recorded in Milwaukee was on Yom Kippur in 1847. It was held in a room in Isaac Neustadtl's home.[84] The Imanu-Al Cemetery Association spurred the creation of the first Milwaukee Congregation, Imanu-Al, in 1849. However, no building was built or purchased; the congregation initially met in a room over the grocery of Nathan Pereles.[85]

There were differences between members of the first wave Jewish immigrants in matters of religious observance. Diner noted that these differences are often obscured by the overly broad strokes applied to first wave Jewish immigration. There were distinct differences in cultural understandings and religious traditions within the first wave Jewish cohort. These differences resulted in conflict when building congregations.[86] The contention over established religious observance in Milwaukee stemming from those differences was such that Milwaukee's Jewish community eventually supported several

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[82] Hasia R. Diner, *A New Promised Land: A History of Jews in America* (New York: Oxford Press, 2000), 12.
[83] Swichkow and Gartner, *The History of the Jews of Milwaukee,* 34.
[84] Swichkow and Gartner, *The History of the Jews of Milwaukee,* 33; Gurda, *One People, Many Paths,* 12.
[85] Swichkow and Gartner, *The History of the Jews of Milwaukee,* 34.
[86] Hasia Diner, *The Jews of the United States: 1654 to 2000* (University of California Press, 2004), 80.

congregations to meet the religious needs of the relatively small Jewish community.

BUILDING JEWISH CONGREGATIONS IN MILWAUKEE

The process of creating Jewish congregations in America was often quite contentious.
The social, economic, and religious differences, often along ethnic lines, made any broad
consensus about Jewish practice and prayer almost impossible. Nomenclature was a matter
of great concern. The difference between establishing a "temple" as opposed to a "shul"
signified an ethnic, and often, socioeconomic divide. The term temple denoted a
congregation that was predominantly German Jewish, and usually more affluent. Shuls
were created by more traditionally practicing Jewish immigrants.[87] In contrast to Europe,
American cities, including Milwaukee did not have civil restrictions preventing Jews from
creating synagogues. The city of Milwaukee was accepting of religious diversity.
Swichkow and Gartner noted that, "Religious diversity marked Milwaukee from its earliest
years. During its village era, about twelve different church organizations were born."[88]

The lack of religious oversight by a central religious figure or governing body in
Milwaukee led to the creation of a number of synagogues before the second wave West
Side Jewish immigrants arrived. Small congregations, split primarily by ethnic differences,
sprang up in Milwaukee, starting in the 1850s. In fact, the sheer number of individual
congregations came as a surprise to Jewish visitors. Rabbi Isaac Mayer Wise, a major
leader in the American Reform movement, noted that in 1856, 200 families supported three
congregations. He hoped to unify the Milwaukee Jewish population by establishing a

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[87] Weiner, "Whistling "Dixie" while Humming 'Ha-Tikvah,'" 226.
[88] Swichkow and Gartner, *The History of the Jews of Milwaukee,* 32.

single Reform congregation.[89] The first wave Jewish population in Milwaukee established small congregations before 1880. Some sought to Americanize Jewish practice and others incorporated rituals based on their ethnic practices. Most did not last long.

By the time the West Side Jewish immigrants arrived in Milwaukee there were two main synagogues in Milwaukee. Emanu-El was considered more American in its services and B'ne Jeshurun retained some European practices. Neither practiced Judaism in the ways of the second wave West Side Jewish immigrants. Sociologist Howard W. Polsky noted that

> Rarely has the dialectic of religious change manifested such clear-cut lines as in the German Jewish community of Milwaukee in the years stretching from 1847-1927. At first there were only Orthodox synagogues. The usual splits and combinations took place until in 1860 there emerged a united synagogue with modern tendencies. When the next split took place (the antithesis) in 1869, a complete break was made with the Orthodox ritual by a small dissident group.[90]

The "usual splits" refers to the differences within and between synagogues in Milwaukee. These occurred when members left congregations in protest of any changes they did not support. In the case of Milwaukee, the "small dissident group" described by Polsky eventually broke from B'ne Jeshurun and formed the East Side "Reform Congregation Emanu-El," which eventually became the largest and wealthiest synagogue in Milwaukee.[91]

As the Milwaukee Jewish population increased, the small, informal congregation meetings in rooms above stores could no longer accommodate worshipers. Some Jewish individuals began to plan for a facility of their own to conduct services. However, the East

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[89] Swichkow and Gartner, *The History of the Jews of Milwaukee,* 37-38.
[90] Polsky, "The Great Defense: A Study of Jewish Orthodoxy in Milwaukee," 74.
[91] Swichkow and Gartner, *The History of the Jews of Milwaukee,* 51.

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Side Jewish population as a whole did not quickly build a single central synagogue. Swichkow and Gartner remarked that, "A few of the 'most spirited,' Jewish citizens believed that the time had arrived to erect a synagogue. They subscribed a sum to buy a site, hoping that Jews elsewhere in the city would also come to their aid. However, more cautions members preferred to renovate an existing building for several hundred dollars. A contemporary criticized the 'nonchalance' which retarded the progress of this pioneer congregation, and the absence of 'the vital spark' to enliven and enlarge it."[92]

The delay in building a formal synagogue in Milwaukee is noteworthy in that in Europe, the synagogue was integral to Jewish life. Polsky writes,

The synagogue was the gathering place for all extended family celebrations. After the religious service marking the *bris*, (circumcision rite) and engagement, wedding, a *bar mizyah*, [sic] a graduation, and so on, the people of the *shtetl* would gather in the hall, usually in the back of the synagogue. There they performed the blessings over food, and consumed the *gefillte* [sic] fish, chaleh [sic], sponge cake and wine and whiskey, sang songs, and conversed. The synagogue was the chief dispenser of honors in the community. Individuals of high status sat against the Eastern Wall of the synagogue. They would be called up to the Torah reading at preferred times. Such persons would be called upon to utter special prayers during the major holidays, and would assume the important offices in the synagogue and the various associations connected with it.[93]

Historian Ewa Morawska observed that in the Eastern European *shtetls*, the *shul* was central to the whole community.[94] The diversity within the Jewish immigrant population led to a great deal of contention and many *shuls*. Sarna noted that in large Jewish urban population centers, those Jews that did not wish to worship at any of the available congregations formed one to their liking.[95] Gurock noted that the many early American *shuls*, established from the 1850s and into the next century, represented a place where some

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[92] Swichkow and Gartner, *The History of the Jews of Milwaukee,* 34.
[93] Polsky, "The Great Defense: A Study of Jewish Orthodoxy in Milwaukee," 53.
[94] Ewa Morawska, *Insecure Prosperity: Small-Town Jews in Industrial America, 1890-1940* (Princeton, NJ: Princeton University Press, 1996), 19.
[95] Sarna, *American Judaism,* 59.

European immigrants found spiritual and social sustenance upon arrival to cities with diverse religious traditions. He called them "Landsmanshaft synagogues" and described them as "small storefront congregations" that incorporated familiar rituals and practices along ethnic lines.[96] The term Landsmanshaft, as defined by Sarna, refers to the organizations and associations formed by immigrants from the same area. He noted that the goal of these Landsmanshaft groups was to unite the Jewish population based on shared ethnic ties.[97] The Landsmanshaft *shuls* sought to do the same. These congregations served the needs of Jewish immigrants in American cities, including those in Milwaukee. They prayed as they had in Europe, and in doing so, recalled the traditions of their country of origin. In these early congregations, immigrants from all over Central and Eastern Europe established social ties that extended to life outside the *shul*.[98]

Neighborhoods provided the foundation for many of these smaller congregations.[99] They also, inadvertently, linked the traditional European prayers and rituals with a lower SES. By 1920, the descendants of the first Eastern European Jews established religious practices different from their fathers. Gurock remarked that, by this time, the early Landsmanshaft congregations had given way to more Americanized institutions. He identified a specific type of synagogue, the Proto-American Synagogue of the 1890s, using Kehal Adath Jeshurun on New York's Lower East Side as an example of the rapid change in some immigrant congregations. He considered such institutions as "halfway houses" in the history of American Jewish synagogues. They represented the holding place for American Jews at a time of increased upheaval cause, in part by differences in religious

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[96] Gurock, *Orthodox Jews in America*, 104.
[97] Sarna, *American Judaism*, 165.
[98] Gurock, *Orthodox Jews in America*, 104.
[99] Jeffrey S. Gurock, "A Stage in the Emergence of the Americanized Synagogue among Eastern European Jews: 1890-1910," *Journal of American Ethnic History,* 9, no. 2 (Spring 1990): 7.

traditions between first and second wave Jewish populations. These halfway houses of worship sustained their Jewish congregations as they made the transition from Eastern European traditional worship to a form of Judaism that reflected the acceptance of American social behaviors.[100] Services included sections held in English, conducted by rabbis that, more often than not, had been trained in America, "There, while sitting still during services and participating, they could taste the world of their parent's religious past through familiar hymns and the unchanged basic prayers without doing violence to their growing identities as Americans."[101] Members of these types of congregations concerned themselves with public perceptions of their services as well as the content of the services. Proper behavior was strictly enforced; worshipers were to remain quiet in order to avoid giving the wrong impression to any Christians that may have passed by during services.[102]

This was certainly true in Milwaukee synagogues. Creating any synagogue was a complicated process. Before any decision was made to create *a* synagogue, the first step was to decide what *kind* of Judaism would be practiced. That decision took a bit of time. The attempt to create a synagogue in Milwaukee in the late 1840s revealed that while it is true that many of the immigrants in this wave, Jews and Gentile alike, did share many aspects of German culture, some Jews in this wave that were more traditionally religious and less secular that the "Reform" Jews associated with the East Side immigrant wave.[103] Historian Hasia Diner writes, "Complications emerge as historians look more closely at who migrated and why [in the first wave]. Many of the 'German' Jews who left for America before 1880 came from Polish provinces like Silesia and Posen, which had been

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[100] Gurock, "A Stage in the Emergence of the Americanized Synagogue among Eastern European Jews," 7.
[101] Gurock, "A Stage in the Emergence of the Americanized Synagogue among Eastern European Jews," 8.
[102] Gurock, "A Stage in the Emergence of the Americanized Synagogue among Eastern European Jews," 12.
[103] Pat and Joan Kerns, Interview by author, Mequon, Wisconsin, May 24, 2011.

annexed by Prussia and later incorporated into Germany. On paper, these Jews seemed to be German, and indeed many described themselves that way. But the term does little to convey their poverty, their religious traditionalism, and the kinds of Jewish communities they left behind. Even their language [Yiddish] linked them to the later group of immigrants."[104] That was certainly a factor in the difficulty between Jewish immigrants in Milwaukee in the 1840s and 1850s. The differences between members in the first wave of Jewish immigrants became evident when the Jewish community tried to establish a synagogue.

There was a more religiously traditional segment in the first wave Jewish population in Milwaukee. They arrived with Jews who identified themselves as Reform and made their religious observance part of their Jewish identity. In response, the more traditional members of the Jewish population created a number of small congregations along ethnic lines. However, they were not as traditional in religious observance as the second wave Jewish immigrants. The most observant Jewish people in Milwaukee before 1888 were still not as traditional as the second wave immigrants.[105] What is significant about this difference within the first wave is that the differences in observance within the first wave disappeared rapidly. Himmelfarb described this process as self-identifying, a means of accepting and practicing social behaviors.[106] The more traditional Jews arriving in the first wave adopted cultural practices of the more Reform Jews as part of their identity at a faster pace than the later arrivals.

Establishing a congregation was a complex process, prone to conflict between

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[104] Diner, *The Jews of the United States,* 80.
[105] Swichkow and Gartner, *The History of the Jews of Milwaukee,* 168.
[106] H.S. Himmelfarb, "Research on American Jewish Identity and Identification: Progress, Pitfalls, and Prospects," in *Understanding American Jewry*, ed. Marshall Sklare (New Brunswick, NJ: Transaction Publishers, 1982), 56-57.

founding members. One of the more important and potentiality contentious decisions to be made was what kind of *Minhag,* or regional religious customs, to use for services in the new congregation in Milwaukee. It was an important decision. Swichkow and Gartner explained that, "The adoption of a particular *Minhag* implied the predominance of immigrants from that European region, and thus was a matter of pride for each group."[107] It is because of these distinct ethnic differences within the first wave Milwaukee Jewish population that the *Minhag* decision was difficult. Some members "insisted on the Polish *Minhag*, and organized Ahabath Emuno (Love of the Faith) in January, 1854, for 'the promotion of a love and knowledge of our religion.'"[108] These Jews were part of the German immigration wave but ethnically Polish, thus considered different from the Germanic Reform Jews; often the term Orthodox signified those differences. They were distinct in matters of dress and many of the men wore beards, unlike the members of the Reform Jewish congregation. Ahabath Emuno lost some congregants after adopting the Polish *Minhag*; advocates of the German *Minhag* seceded and formed a third religious group, Anshe Emeth (Men of Truth) in 1855.[109]

According to Swichkow and Gartner, the East Side Jews felt the use of the Polish *Minhag* showed these first wave Jews to be "stabile [*sic*] Orthodox Jews. . .all they wish for is to repeat the same *Piutim* (liturgical poems) in the same order exactly, as their fathers did. The criticism itself hints at the Reform tendencies not far beneath the surface."[110] Members of East Side Jewish community adopted Reform Judaism that was in fact, brought to America from Europe. Diner noted, "In Berlin, Hamburg, and other German

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[107] Swichkow and Gartner, *The History of the Jews of Milwaukee,* 34.
[108] Swichkow and Gartner, *The History of the Jews of Milwaukee,* 34.
[109] Swichkow and Gartner, *The History of the Jews of Milwaukee,* 35.
[110] Swichkow and Gartner, *The History of the Jews of Milwaukee,* 35.

cities, beginning in the second decade of the nineteenth century, groups of laypeople and a growing number of university-educated rabbis launched reforms that would in time become the Reform Movement. This movement, aided by the relative freedoms from rabbinical restrictions in America, meant that religious reform from strict Orthodoxy to a less observant form of Judaism was not only possible, but in some cases, preferable."[111] Reform Judaism was the religious tradition of the East Side Jewish community. They established Congregation Imanu-Al in 1850. The effect of these religious ethnic differences was that by 1856, 200 Jewish families were supporting three Milwaukee synagogues.[112] The East Side Jewish community solidified their commitment to Reform Judaism with the assistance of Rabbi Isaac Mayer Wise, a strong advocate of the Reform Judaism Movement in America.[113] In the 1880s, Milwaukee's East Side Jewish practices were more Reform than European traditional, but a few small congregations continued to serve the more traditional members in the city.

REFORM JUDAISM IN MILWAUKEE

Rabbi Isaac Mayer Wise was a strong proponent of the Reform Movement. He was raised in a European Jewish environment in his native Bohemia. Once in America, "he quickly fell in step with the American zeitgeist, one that saw the creation of hundreds of new denominations and that asserted the right of Americans to create the religious practices they wanted."[114] The absence of any central rabbinical authority in America facilitated his movement to create an American Reform Jewish tradition. Rabbis in America acted as

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[111] Diner, *The Jews of the United States,* 120.
[112] Swichkow and Gartner, *The History of the Jews of Milwaukee,* 37.
[113] Swichkow and Gartner, *The History of the Jews of Milwaukee*, 120.
[114] Diner, *The Jews of the United States,* 121.

representatives of Jewish congregations, not authority figures. They did not have authority to make binding unilateral decisions. They lacked the power conferred upon them in Europe. Rabbis in Europe were appointed as leaders and acted as emissaries between Jewish populations and government officials. American rabbis did not have that authority.[115] Wise advocated for the Reform movement in America, but he did not have the resources to establish Reform as the accepted form of Judaism for any population.

Wise's actions at his first congregation, Beth El in Albany, New York, revealed his interpretation of and vision for American Reformed Judaism. He added music to the service, something forbidden in Orthodox Judaism. The music was performed by a mixed male-female choir at a time when men and women did not even sit together. When his lay board fired him in 1850, he and a group of his followers in Albany founded a Reform congregation, Anshe Emeth, the first in America to do away with sex-segregated seating.[116]

The East Side Jewish population in Milwaukee adopted Reform Judaism as a means of Jewish observance that allowed them to define their Jewish practice, without looking or acting very differently from Gentile Germans.[117] Until the immigration wave of the 1880s began, Reform Judaism represented a form of Jewish religious observance that acculturated Jews adopted as part of a larger Gentile European immigrant group.[118] It became part of Milwaukee's East Side Jewish identity through the adoption of American Reform Jewish rituals.[119] Their particular form of Jewish practice allowed them to maintain their social status and social capital while remaining Jewish, effectively synthesizing their American and Jewish traits.

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[115] Farber, "The Formative Era of American Jewish History," 21.
[116] Diner, *The Jews of the United States,* 121.
[117] Robert M. Seltzer, "American Jews & Their Judaism," *Commentary* 97 (1994): 99.
[118] Seltzer, "American Jews & Their Judaism," 98.
[119] Marshall Sklare, *America's Jews* (New York: Random House, 1971).

The support of Rabbi Wise profoundly affected the Milwaukee Jewish Reform movement. According to Sociologist Howard J. Polsky, Wise believed that more Orthodox Jewish rituals and traditions brought to America from Europe stymied American Jews.[120] Wise told one audience, "As severely as I have attacked the impertinence and wickedness of Atheism, I have also rebuked the benumbed and senseless conservatism which not only gives birth to atheism, but also tears into fractions the house of Israel."[121] Polsky believed Wise inspired the Reform movement in Milwaukee: "His appearance [in 1856] was Milwaukee Jewry's first contact with the forthright, persuasive exponent of Reform Judaism, and it left an effect."[122] However, Goldscheider noted that the likelihood of widespread acceptance of Reform practices by the more traditional members of the first wave was high, especially in areas where Jewish populations achieved upward social mobility.[123]

Swichkow and Gartner believed that Milwaukee Jewish orthodoxy almost disappeared between the 1860s and 1880s. They note that only Anshe Emes continued to incorporate European traditional rituals. Polsky believes that the history of orthodoxy in Milwaukee during that same time period is missing. He noted that

> Before 1859, when the German-Jewish population could not
> have numbered more than several hundred families, three
> separate Orthodox congregations had been started. Each of
> them began in a home, and subsequently moved either to a
> building convertible to a synagogue or to a new structure. In
> 1859 the three combined and the. Members conducted services
> in a new synagogue on Fifth Street between Wells and Cedar
> Avenues, near the heart of the business section. This united
> synagogue, now known as B 'ne-Jeshurun, was the only Jewish
> congregation in the city and its membership in 1860 numbered

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[120] Polsky, "The Great Defense: A Study of Jewish Orthodoxy in Milwaukee," 58.
[121] Swichkow and Gartner, *The History of the Jews of Milwaukee,* 38.
[122] Swichkow and Gartner, *The History of the Jews of Milwaukee,* 39.
[123] Goldscheider, "Demography of Jewish American," 9.

close to one hundred families. The community, comprising
different national groups -- German, Austrian, Bohemian,
Hungarian -- was united religiously. The basis of religious
organization was Orthodox. Prayers were said in Hebrew, led
by the traditional cantor, the chazan. Meetings of the shul were
conducted in German. A definite bow was made to
Americanization with the stipulation that at least one sermon a
month was to be rendered in English.[124]

Swichkow and Gartner emphasized the influence of Wise and the Reform Movement as

having "played a central role in the making of Judaism in Milwaukee. His dynamic

presence, personal ties with dominant persons in the community, frequent visits, and his

calls for congregational unity in Milwaukee. . .were largely responsible for the emergence

of a moderate reformed type of Judaism in the city."[125] Polsky's opinion about Rabbi

Wise's influence on the Milwaukee Reform Jewish movement is noteworthy in that he

viewed the establishment of Reform Judaism from the perspective of Orthodox Judaism.

He noted that affluent East Side Reform minded Jewish congregants let their social and

economic resources overshadow any sense of European traditionalism:

As the synagogue grew in numbers, the possibility for dissident
opinion regarding the ritual of the synagogue was enhanced. Dr.
Isaac M. Wise, the vitriolic and tireless organizer of the Reform
movement, began to influence many German Jews in
Milwaukee. A dissident group grew to thirty-five members.
Unable to influence the others or to reach a compromise in
ritual and philosophy, the group withdrew to form a separate
congregation. This new congregation was the Reform Temple
Emanu-El. Aided by the sum of $4,250 received from
B 'ne-Jeshurun, a building campaign was begun and a temple
was constructed on Broadway and Martin streets, east of the
river and in the heart of the downtown district.[126]

 However, Gurock noted another possible explanation for the decrease in traditional

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[124] Polsky, "The Great Defense: A Study of Jewish Orthodoxy in Milwaukee," 70-71.
[125] Swichkow and Gartner, *The History of the Jews of Milwaukee,* 41.
[126] Polsky, "The Great Defense: A Study of Jewish Orthodoxy in Milwaukee," 71.

European observance before the arrival of the second wave immigrants: change in social status. He theorized that the greatest challenge to traditional observance was economic success.[127] Many American Jews gathered a great deal of cultural capital and reaped the social benefits, not least of which was the higher SES. As members of the Jewish population rose toward a middle class status, many were determined to fit it as much as possible. This included where and when they worshiped. In America, many formerly traditional Jews worked on the Sabbath and prayed in buildings that resembled any local church. "In the new world, Jews labored on holy days to both survive and advance."[128]

By the time the second wave of Jewish immigrants arrived, the more "Orthodox" synagogue in Milwaukee, B'ne Jeshurun, had installed an organ for services, something the Eastern European Jews had not had in their congregations in Europe.[129] However, it is considered by many in the Milwaukee Jewish population to represent one of Milwaukee's original Orthodox synagogues.

B'NE JESHURUN

Swichkow and Gartner noted that "Although B'ne Jeshurun had left Orthodoxy far behind by the later 1860s, its brand of Reform Judaism was very halting."[130] The East Side Jewish population claimed Emanu'El as their Reform synagogue, leaving B'ne Jeshurun as an option for Jewish worship that was a bit behind the times compared to Emanu'El.[131] The Orthodox label in Milwaukee signified, most of all, a reluctance to completely Americanize worship. Unlike traditional Orthodox synagogues in Chicago, Fort Worth and

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[127] Gurock, *Orthodox Jews in America,* 97.
[128] Gurock, *Orthodox Jews in America*, 98.
[129] Swichkow and Gartner, *The History of the Jews of Milwaukee,* 172.
[130] Swichkow and Gartner, *The History of the Jews of Milwaukee,* 50.
[131] Swichkow and Gartner, *The History of the Jews of Milwaukee,* 187.

New York, the congregants at B'ne Jeshurun slowly adopted new practices, and eventually

assumed a more Reform Jewish tradition. Emanu-El began holding services in English,

B'ne Jeshurun continued to use German.[132] Polsky stated that,

> The German Jews rapidly shed customs and traditions which differentiated them
> from fellow Americans and quickly absorbed American values and forms into
> their lives and institutions. They showed much energy in fraternal, communal and
> philanthropic organizations. A well-organized German-Jewish community was
> already in existence at the beginning of the mass immigration of East European,
> Yiddish speaking Jews.[133]

Gurock noted that by 1870, almost all American congregations had adopted less

Orthodox practices. The second wave Jewish immigrants became a Jewish religious

majority in cities that had no existing shuls in which they felt comfortable and welcome to

worship.[134] In the 1880s, Milwaukee's Jewish community was a predominantly Reform

community, albeit with two distinct forms. Swichkow and Gartner wrote that, "Emanu-El

promptly made it clear that it stood for Reform Jewish practice and ritual. A few members

who found it difficult to break entirely with traditional practices, and held their own early

Sabbath service before regular worship, or who worshiped with covered heads during the

regular service, were discountanced. Emanu-El decided to permit but one Reform service

on Saturday morning, and prescribed uncovered heads during worship."[135] B'ne Jeshurun

continued to serve the less affluent, less acculturated Jews left behind after the split, but

even those services were much more Reform than Orthodox.[136]

The second wave Jewish immigrants arrived in Milwaukee and quickly realized their

religious practices were very different from the established Jewish community. The large

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[132] Swichkow and Gartner, *The History of the Jews of Milwaukee,* 187
[133] Polsky, "The Great Defense: A Study of Jewish Orthodoxy in Milwaukee," 67.
[134] Gurock, *Orthodox Jews in America*, 83.
[135] Swichkow and Gartner, *The History of the Jews of Milwaukee,* 51.
[136] Swichkow and Gartner, *The History of the Jews of Milwaukee,* 50.

number of Jews arriving in Milwaukee in the second wave found their religious traditions were not acceptable to many of the Jews already in Milwaukee. In 1880 the number of Jews in Milwaukee was estimated to be about 2,000; in 1920 it was estimated at 20,000. The German-Jewish community in Milwaukee established relief agencies to assist the new immigrants. At the same time, many Milwaukee Jews separated themselves from their poor unacculturated Orthodox Yiddish-speaking co-religionists.[137] The second wave immigrants arrived from Russia, Romania, Hungary and Poland, but are often labeled the Russian Jewish immigrant wave. Russian Jews in Milwaukee, as in other cities across America during this period, initially established neighborhoods with all the elements of the social organization they were familiar with in Europe.[138] They settled together in some of the poorest areas of the city and established a neighborhood apart from the East Side Jews.

THE WEST SIDE JEWS ARRIVE IN MILWAUKEE

Residential segregation is an important part of Milwaukee Jewish history. When the Russian Jewish immigrants arrived in Milwaukee, the established Jewish residents did not welcome them into their neighborhoods; the original West Side Jewish population moved from their neighborhoods, as did the East Side Jewish residents. One of the most distinctive aspects of the Milwaukee Jewish population is the residential migrations of the East Side and West Side communities. Polsky wrote,

> One of the most interesting phenomena of the Jewish
> population was that entire Jewish neighborhoods seemed to
> move together. Discrimination from without, traditional norms
> and social structure brought over from Europe, and economic

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[137] Swichkow and Gartner, *The History of the Jews of Milwaukee,* 121

[138] Polsky, "The Great Defense: A Study of Jewish Orthodoxy in Milwaukee," 139.

factors account for the geographical distribution of Milwaukee Jewry. One of the thorniest problems confronting Orthodoxy was that its institutions, amounting to considerable capital investments, lagged behind the newer neighborhoods into which Jews moved. The area of original settlement of the German Jews and the Russian Jews was dictated by economic considerations. For the penniless arrivals, work-place, synagogue and meeting hall were all within walking distance of their places of residence. The German-Jews settled in the downtown area and built their first synagogues there. When the Russian Jews arrived during the 80s and 90s, the German Jews separated themselves from their co-religionists by moving East and North. Up to the 1940s, the Northeast section of Milwaukee was identified by both Russian and German Jews as the more or less exclusive area of residence of the latter.[139]

Many of the West Side Jews were Eastern European and poor, and were usually described as "Russian" Jews. The true composition of this immigrant wave has been obscured by the label, much like the first wave and the German label. Historian Hasia Diner wrote, "Emigration from the East should not be viewed either merely as a desperate flight from terror or as a wholesale transfer of Jews and their communities from places of peril to a place of safety."[140] Jews from Central and Eastern Europe did experience violence, punitive taxation and exclusion from civic life in their countries of origin. That harsh treatment shaped political consciousness in this particular Jewish immigrant wave. Many of the Jews of this group were Marxist socialists, and that political consciousness had an impact on the places they settled.[141] In the history of Milwaukee's Jewish population, the poor, more traditional European immigrants comprised the largest group of West Side Jews.

After decades of acceptance into the German population, the East Side Jews of

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[139] Polsky, "The Great Defense: A Study of Jewish Orthodoxy in Milwaukee," 64.
[140] Diner, *The Jews of the United States,* 89.
[141] Diner, *The Jews of the United States,* 90.

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Milwaukee viewed the large number of Jewish immigrants as very different from themselves and almost unrecognizable.[142] Swichkow and Gartner described the opinion of East Side Jews, "Reform Jews thought of the immigrants' worship as uncouth and out of touch with the needs of modern society."[143] Harry Kanin described some of the cultural differences in terms of class and religion. He noted that the West Side Jews could not afford to live with the wealthier East Side Jews when they arrived in Milwaukee. The two groups did not socialize because of the cultural differences between them. East Side Jews considered the West Side Jews as uncultured and too different from themselves. These feelings prevented them from socializing with the new immigrants. Kanin described the situation as, "The East Side Jewish people were more secular and less religious. They had secular education. The Russians were less secular. They had Talmudic educations, studied the Torah, they were not secular."[144] Kanin described other differences between the two Jewish groups, "The East Side Jews were well off, and the Russians were poor. They were very different. When an East Side household served a meal, the table was set with place settings and serving dishes and sat at table. The West Side Jewish meal was such that the diners took plates and served themselves. When one had tea at an East Side home, the service was more formal; sugar was served in a dish to add to the cup. The West Side tea service had sugar cubes, which one could place between their teeth to sweeten the tea as they drank it."[145] The differences in customs were framed as which was proper and which was not. The East Side Jewish population considered their customs proper etiquette and avoided social interaction with the West Side Jews. The socialized in their own

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[142] Gurda, *One People, Many Paths,* 41.
[143] Swichkow and Gartner, *The History of the Jews of Milwaukee,* 170-71.
[144] Dr. Harry Kanin, Interview by author, Milwaukee, Wisconsin, July 14, 2011.
[145] Dr. Harry Kanin, Interview by author, Milwaukee, Wisconsin, July 14, 2011.

neighborhoods and did not often venture to the West Side.[146]

The ethnic differences between the two Jewish populations created a social distance that defined the relationship between them. East Side Jews avoided the new arrivals. Their disdain derived from sense that new immigrants reflected negatively on them. The West Side Jews were not the first Jewish immigrants, but they were by far the most distinctive in that they stood out from the East Side Jewish population. Their socioeconomic status, language, and cultural practices prevented them from settling on the East Side among the established Jewish population. Nor did they settle with their fellow immigrants from their countries of origin. Instead, they carved out an enclave on the West Side.

Gentile immigrants from Poland and Russia arrived in Milwaukee in the late 1800s and early 1900s, but the Jews within their number did not settle with them. The West Side Jews spoke Yiddish, not German. They were from Eastern Europe, not the Western regions. They did not possess the knowledge of the cultural practices of the East Side Jewish community and could not join the earlier Milwaukee Jewish immigrants. The Gentile Russians and Poles brought anti-Semitic attitudes over from Europe. Their hostility toward Jews prevented the West Side Jews from establishing Russian or Polish neighborhoods.[147] The West Side Jews established their own Jewish neighborhood in Milwaukee because there was no other option available to them. They represented a Jewish population in Milwaukee: distinctive from both the East Side Jews and the non-Jewish immigrants with whom they arrived. Their arrival created a concentrated Jewish community on the West Side of the Milwaukee River, to the blocks around the Haymarket at Fifth and Vliet

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[146] Dr. Harry Kanin, Interview by author, Milwaukee, Wisconsin, July 14, 2011.
[147] Gurda, *One People, Many Paths,* 45.

Streets.[148]

The West Side Jewish neighborhood was one of the poorest in Milwaukee. The increased number of immigrants and growing poverty necessitated the growth of Jewish relief and philanthropy in Milwaukee as a direct response to the needs of the new immigrants. Jewish relief organizations in the 1880s were small and unorganized. They rapidly grew and expanded to meet the increased requests for assistance.

WEST SIDE JEWISH IMMIGRATION AND CHARITABLE ASSISTANCE

The first group of Russian immigrants that arrived in Milwaukee was small and included skilled laborers and other able-bodied people. The Milwaukee Jewish community received word that the immigrants were on their way and had time to gather resources to assist them. In October of 1881, Milwaukee's Jewish leaders were told to expect small number of Russian immigrants. The Montreal Committee, located in Canada, worked with European organizations, including the Alliance Israelite Universelle, that assisted immigrants in relocating.[149] Montreal received immigrants from England and sent them to American cities, usually by way of New York. The Emigrant Relief Association of New York worked to help new arrivals settle in American cities.[150] The local Jewish community raised funds and found shelter for the new arrivals. There was no recorded opposition to providing the aid and the community waited to welcome them. Ten immigrants arrived, ranging in age from 20-25. The literature described as them "able bodied" skilled tradesman, and they were quickly given assistance.[151] The insistence on able bodied status

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[148] Gurda, *One People, Many Paths,* 46.
[149] Swichkow and Gartner, *The History of the Jews of Milwaukee,* 71.
[150] Swichkow and Gartner, *The History of the Jews of Milwaukee,* 76.
[151] Swichkow and Gartner, *The History of the Jews of Milwaukee,* 72.

reflected the reluctance on the part of American Jews to encourage the desire for charity. European leaders did not want Russian Jews settling in their cities in great numbers. Many of the immigrants sent to American cities were not young, skilled, and able to work, despite promises from immigration organization in Europe.[152]

However, as poorer, unskilled immigrants arrived, a distinct decrease in contributions for relief efforts on the part of the East Side Jewish community led to an appeal from the Emigrant Relief Association of New York on June 1, 1882. More Jewish immigrants were on their way to Milwaukee and they needed assistance. The Association needed funds from Jews and non-Jews alike to meet the needs of the growing number of poor immigrants. The effort was successful as Christians donated $400 within a few weeks, and Jewish organizations donated an additional $300. The immediate relief crisis was resolved.

A larger challenge for Jewish relief workers loomed. Like many of the American Jewish communities of the late nineteenth century, Milwaukee's Jews did not realize just how many immigrants would arrive in this second wave. Sociologist Marshall Sklare noted that, "In fact, the new immigrants swamped the older element. The 400,000 Jews in the United States in 1888 were joined by 334,338 more by 1896. Thus the ratio of net migration to initial population after a mere decade was an astonishing 83 percent."[153]

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[152] Swichkow and Gartner, *The History of the Jews of Milwaukee,* 71.
[153] Sklare, *America's Jews*, 8.

By 1898, two settlements of Russian and Polish Jews lived in downtown Milwaukee. At least 2,000 lived in these areas which the *Milwaukee Sentinel* defined as a "jewry [sic], or ghetto," in an article linking Jewish religious observance with poverty and uncleanliness:

> These people do not look like desirable acquisitions when they first arrive, but it is safe to say that the younger generation of them will turn out some valued citizens. . .The racial desire for self-betterment is not snuffed out by the filthy environment into which their poverty forces them. . .As a rule the Russian Jew is more orthodox than the American Jew. This is attested by the number of 'kosher' butcher shops to be found in the Milwaukee ghetto. . .Whatever of bad air and lack of soap may pertain to the average kosher shop, one thing is certain, the meat exposed for sale did not come from a diseased animal or from one not slaughtered according to Mosaic law. . .The members of the Milwaukee's ghetto are not all robust people, yet they maintain fair health in spite of their decidedly unsanitary mode of living. . .It is well worth the trouble to walk along Sixth Street between Vliet and Cherry on a warm summer evening before the daylight has entirely vanished. Then may be seen a ghetto in full bloom for the sidewalks fairly swarm.[154]

Relief efforts for the poor Jewish newcomers initially lagged because high number of immigrants and the scant amount of resources available. There was also the matter of the disdain for them on the part of the East Side Jewish community leaders. The East Side Jewish population designed relief assistance to compel the new arrivals to adopt appropriate cultural norms. The new immigrants settled in their neighborhoods and tried to take advantage of the opportunities available in Milwaukee.[155]

Many of the West Side Jews quickly realized that their employment opportunities were limited. Sociologists Sidney Goldstein and Calvin Goldscheider observed that for many of these immigrants, their efforts to achieve a higher SES was limited because of their overall

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[154] Swichkow and Gartner, *The History of the Jews of Milwaukee,* 90.
[155] Barkai, *Branching Out*, 205.

lack of secular education, "In particular, Jews came to recognize that the amount of formal secular education an individual receives is a major determinant of the occupations open to him, the income he will eventually receive, and the opportunities he will have to realize desired values and to enhance life chances."[156] In their hometowns of Eastern Europe, many Jewish men aspired to gain extensive religious knowledge, the accepted cultural capital in their old life. The cultural practices in their countries of origin and their pursuit of religious education did not have as much value as part of Jewish life in Milwaukee.[157] Religious observance and hours spent in study were not valued by the East Side Jewish leaders. New immigrants that insisted on keeping the Sabbath and who suffered from a lack of employment did not receive much sympathy from those in charge of charity relief programs. Jews who practiced strict religious observance were identified as "Talmudic Jews." Relief organizations viewed religious study and more traditional Jewish practices as laziness and sloth.[158] Relief assistance included attempts to Americanize the new immigrants. Rabbi Moses from Congregation Emanu-El felt so strongly about the need to educate the new immigrant that he announced in July 1882,

> It will be necessary to establish a free school for the children where, after returning from public school, they will receive their Hebrew and religious instruction under the direction of the two local rabbis. . .also it will be necessary to form a woman's society whose duty it will be to visit the families and activate society. . .and civilize those families so they do not succumb in isolation, lest left to themselves, they perpetuate their semi Asiatic existence. We believe we are not mistaken in maintaining that through such civilizing efforts, we shall be averting from ourselves a potential danger which threatens us all.[159]

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[156] Sidney Goldstein and Calvin Goldscheider, *Jewish Americans: Three Generations in a Jewish Community* (Englewood Cliffs, New Jersey: Prentice-Hall, 1968), 63.
[157] Swichkow and Gartner, *The History of the Jews of Milwaukee,* 82.
[158] Swichkow and Gartner, *The History of the Jews of Milwaukee,* 82.
[159] Swichkow and Gartner, *The History of the Jews of Milwaukee,* 84.

Rabbi Moses viewed the new immigrants as a threat to the East Side population due to their unfamiliar habits and poverty. Sociologist Erving Goffman wrote that in society, prestige stems from the favorable judgment and "a status may be ranked on a scale of prestige according to the amount of social value placed upon it."[160] There was no prestige associated with religious study.

As Russian Jews settled in American cities, they were increasingly associated with urban problems and conditions. Historian Eric L. Goldstein noted that "Jews, for reasons related to their distinct history and social characteristics, served as a convenient symbol for a host of social problems that were of mounting concern to the American public during those years.[161] Rabbi Moses believed that the new immigrants had to become more American in order to avoid any repercussions in the Milwaukee Jewish population as a whole. The response from the immigrants to Rabbi Moses's statement about religious observance is unknown. However, resentment toward relief organizations on the part of the poor is implied. Rabbi Moses also declared in August 1882 that "Our Russians are singing the old song of the dissatisfied. . .we doubt very much whether the majority ever had such remunerative jobs in the old country as they have managed to find here."[162]

There were attempts, in the late 1880s and early 1890s, to curtail Jewish immigration to Milwaukee. In a telegram to the Montreal Immigration Office, Louis B. Schram, secretary of the Milwaukee Russian Relief committee stated, "We demand peremptorily that you send no more Russians here. All coming from Montreal hereafter will be returned without taking from depot." He was true to his word. Milwaukee sent back a refugee with a

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[160] Erving Goffman, "Symbols of Class Status," *The British Journal of Sociology* 2, no.4 (December 1951): 295.
[161] Eric L. Goldstein, "The Unstable Other: Locating the Jew in Progressive-Era American Racial Discourse" *American Jewish History* 86, no. 4 (2001): 338.
[162] Swichkow and Gartner, *The History of the Jews of Milwaukee*, 86.

note that read, "Dear Sir, We send a man tonight who is sick and is unable to do anything for his support. Please return him to Europe and oblige. Yours respectfully, David Adler. "[163] Despite these efforts, immigrants continued to arrive, in even larger numbers. Romanian Jews arrived, as did more Russian and Polish Jews. They settled in the West Side wards. These Jews did not have the same opportunities available to the East Side Jews. The first West Side Jewish refugees found it difficult to work in many of the factories in Milwaukee because of their religious practices. Swichkow and Gartner noted that "Early Jewish immigrants from Central and later Eastern Europe used petty trade as a stepladder to retail and wholesale trade, while artisans or their sons often ended as manufacturers of that article. There was considerable anti-Semitism in employment. An observant Jew could not work on Saturday and Jewish holidays, as was required practically everywhere."[164] West Side Jews established street trades to support their families. Rags, scrap iron, and produce carts supported many Jewish families.[165] Slowly, some of the new immigrants began making their own way in Milwaukee through their street trade businesses.[166] But the wages earned from street trading and peddler carts were low. The Haymarket neighborhood, where many lived, was one of the poorest in Milwaukee.[167]

Poverty did not prevent the creation of numerous *shuls* in the neighborhood. The West Side Jewish community created several small congregations. There were differences among the West Side Jewish immigrants, much like the East Side immigrants before them. Members of the West Side Jewish community spoke Yiddish and were more traditional but did not share a common Eastern European culture. Jews from Russia, Poland, Lithuania,

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[163] Swichkow and Gartner, *The History of the Jews of Milwaukee*, 82.
[164] Swichkow and Gartner, *The History of the Jews of Milwaukee*, 160.
[165] Gurda, *One People, Many Paths*, 48.
[166] Swichkow and Gartner, *The History of the Jews of Milwaukee*, 101.
[167] Gurda, *One People, Many Paths,* 49.

Hungary, Ukraine, and Romania dressed differently, spoke different dialects of Yiddish, and also prayed differently.[168] These cultural and religious differences complicated the creation of a unified West Side Jewish Milwaukee community much as they did in the East Side Jewish experience.

WEST SIDE MILWAUKEE JEWISH

Compared to Russia, during the latter half of the 19th century Germany appeared liberated. Sarna stated that the arrival of rabbis from Europe "only heightened internal battles within the American Jewish community. Prior to 1840. . .no ordained rabbi graced an American synagogue pulpit."[169] Up until the rabbis settled in America, lay members of immigrant congregations conducted services and managed the affairs. The arrival of ordained clergy, especially Orthodox, created conflict between traditionalists and Reformist Jewish groups. Historian Adam S. Ferziger named one rabbi, Rabbi Moses Sofer, who was very much opposed to Reform Judaism. This rabbi believed Reform ideology to be the arch-enemy of "authentic Judaism."[170] Rabbi Shmuel Singer observed that "Orthodoxy was faced with one central problem from the time of its arrival in America. That issue was how to insure the religious education of its native-born children. It was because the older generation was unable to pass on their Jewish knowledge and devotion to their offspring that Orthodoxy in the past was incapable of perpetuating itself in its new home."[171] The process of obtaining cultural capital had made it difficult, if not impossible to instill traditional religious lessons and practices in the children of many of

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[168] Gurda, *One People, Many Paths,* 55.
[169] Sarna, *American Judaism*, 91.
[170] Adam S. Ferziger, "From Demonic Deviant to Drowning Brother: Reform Judaism in the Eyes of American Orthodoxy," *Jewish Social Studies: History, Culture, Society* 15, no. 3 (Spring/Summer 2009): 56.
[171] Shmuel Singer, "Orthodox Judaism and the Smaller American Community," *Tradition: A Journal of Orthodox Jewish Thought* 22, No. 1 (Spring 1986): 59.

the first wave immigrants.

Polsky described the differences between the two Jewish populations in Milwaukee: "Upon their arrival in America the German Jews rapidly shed their Orthodoxy but in America Russian Jews carried on the norms, traditions and institutions they had evolved in the *shtetl*."[172] In Milwaukee, Gurda noted that "Although the Haymarket community was insular, it was not insulated; young people in particular, absorbed the pulse of American society every time they stepped outside the neighborhood."[173] The more traditional members of the Jewish population lived in a neighborhood, not a ghetto. They interacted with the Gentiles in Milwaukee. The result was that the Haymarket neighborhood was not a *shtetl*; it was a Jewish neighborhood and open to the city at large. The freedom to come and go as they chose meant the Haymarket residents could interact with other city residents, Jews and Gentiles alike. Gurock observed that the lack of isolation facilitated the break from traditional religious practices, and the second generation of Russian Jews adopted from birth the cultural norms of the earlier arrivals.[174]

The West Side Jews also established synagogues. As more Eastern European Jews arrived in Milwaukee more shuls, most of them Landsmanshaft, opened. Almost a dozen *shuls* were established between 1882 and 1914. The issue of religious observance complicated the creation of a unified West Side Jewish religious community. Polsky noted,

> In Russia and Poland, Jews constituted a community within a community. Talmudic law was the law, the norm by which life was guided, not only intellectually, but socially. Why? The manifold restrictions in the land they were living in forced the Jewish people to turn upon themselves, and the ancient tradition with its manifold restrictions served as an inside restraint upon the Jews as they exhausted the ancient

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[172] Polsky, "The Great Defense: A Study of Jewish Orthodoxy in Milwaukee," 41.
[173] Gurda, *One People, Many Paths,* 55.
[174] Sarna, *American Judaism: A History*, 70.

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commentaries in study and the ritualistic patterns in minutest detailed practice. It was not the Mosaic law alone– but its embeddedness in the folk practice of the people which gave it enduring vitality and really maintained and shaped it.[175]

He contextualized the Milwaukee Eastern European experience in terms of a social environment that did not exist in the city. There was no large traditional population in Milwaukee. The one Orthodox congregation available to them practiced Judaism with different rituals. In addition, Milwaukee offered West Side Jewish immigrants some degree of economic, civil, and religious freedom in their daily lives not available in Europe. These freedoms allowed the West Side Jews to create livelihoods and communal organizations. Polsky noted that,

> The constant petty quarreling and personality conflicts in the early days of the Orthodox community were overlaid with old country differences. Many of the synagogues had factions within themselves and there were numerous resignations, coalitions, combinations and alliances of the various members as they changed synagogue affiliations. Beth Hamedrosh Hagodel was started when the chairman of one synagogue arose at a meeting and referred to a group in the synagogue as Russian scoundrels. This group walked out and began its own synagogue along with dissidents from the other Orthodox congregations.[176]

In Milwaukee, the West Side Jewish community created congregations and left them as they saw fit. The freedom to interact with the residents of other neighborhoods and the lack of restrictions on their religious expressions allowed the West Side Jewish residents to establish their own form of religious expression.

The increase in poor immigrants strained the existing charitable efforts in Milwaukee. They did not have the resources to assist all in need. Jewish relief organizations in

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[175] Polsky, "The Great Defense," 46.
[176] Polsky, "The Great Defense: A Study of Jewish Orthodoxy in Milwaukee," 46.

Milwaukee were small, disorganized, and also limited in resources. They could not meet the needs of the growing population of poor immigrants. The East Side Jewish community in Milwaukee believed that charity was a community responsibility, their responsibility. However, some members of the East Side community donated funds grudging and did not always respect the dignity of the poor.[177]

The belief that economic stability came from hard work guided those who dispensed aid for many relief agencies, including the ones in Milwaukee. Many individuals founded private charitable agencies in American cities to assist the poor. They helped the people who were willing to work.[178] In Milwaukee, the disjointed group of private charity organization consolidated efforts and created The Hebrew Relief Association. This organization expanded services in order to provide for the poorer immigrants.

The prevailing attitude toward poverty relief at the end of the nineteenth century emphasized the role of individual moral failings. As historian Walter Trattner explained, "Most Americans continued to believe that, since the nation offered unlimited natural resources and opportunities for success, poverty resulted from individual moral failure--idleness, intemperance, immorality, and irreligion. Such shortcomings could be countered only by bringing contrary forces to bear, 'by inculcating religion, morality, sobriety, and industry' into the poor. If malign influences could be eliminated and beneficent ones substituted, the better nature of the needy would assert itself and the problem would be solved."[179] Poverty was a result of moral deficiency and a lack of responsibility. The poor needed to remedy their own moral flaws. Once that was

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[177] Swichkow and Gartner, *The History of the Jews of Milwaukee*, 229.
[178] Kenneth L. Kusmer, "The Functions of Organized Charity during the Progressive Era: Chicago as a Case Study," *Journal of American History* 60 (1973): 326.
[179] Walter I. Trattner, *From Poor Law to Welfare State: A History of Social Welfare in America* 6th ed. (New York: The Free Press, 1994), 67.

accomplished, poverty would no longer be a problem. The role of relief work included more than funds. The indigent needed education and training to address their faults.

West Side Jews faced a difficult situation. East Side Jewish relief leaders scorned some of the tenets of their more traditional Jewish religious practices: especially those that interfered with their ability to work. At a time when conventional wisdom considered religion and morality a remedy to the moral causes of poverty, West Side Jewish immigrants committed to Jewish religious observance and scholarship received harsh criticism from the members of Hebrew Relief Association. The more traditional Jewish immigrants did not work on the Sabbath. They kept kosher, which restricted their food choices. Many of the West Side Jewish men grew up spending a great deal of their time to studying the Torah and the Talmud. The East Side Jewish population discouraged the traditional clothing and beards worn by West Side Jews.[180] Many East Side Jewish benefactors made a concentrated effort to change the religious practices of the more observant Jews, in particular observing the Sabbath and keeping Kosher. They did not consider the traditional practice of religious study as important as working for a wage. Some leaders stigmatized such behavior as lazy. Rabbi Moses of Milwaukee's Emanu-El stated that, "The Sabbath and the dietary laws form no obstacle for those among them who are decent and willing to work. And here and there emerges from among them a self-impressed 'Talmudic Jew' who would have the roasted doves that expects to fly directly into his mouth, not only Kosher-slaughtered, but also Kosher prepared."[181] Religious study, valued in the *shtetls*, became sloth, and refusing work on the Sabbath was

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[180] Swichkow and Gartner, *The History of the Jews of Milwaukee,* 86.
[181] Swichkow and Gartner, *The History of the Jews of Milwaukee,* 83.

laziness.[182] Strict religious observance marked one a "Talmudic Jew" and was a barrier and affront to the relief efforts of the less devout on their behalf. The animosity between the two Jewish populations grew as more immigrants arrived. The number of applicants for assistance overwhelmed the existing Jewish charity organizations in Milwaukee by the mid-1880s. The relationship between the poor and the affluent Jews in Milwaukee became more strained with the establishment of scientific charity, a topic taken up in the next chapter. Scientific charity, also known as the charity organization movement sought to address issues related to poverty in a rational and efficient way.[183] Swichkow and Gartner explained that "Aside from a few dozen conscientiousness ladies, charitable needs so little preoccupied the Jewish community that the Hebrew Relief Society met great difficulty in merely perpetuating itself during its first 25 years of existence."[184]

As the 20th century began, three facets of Milwaukee Jewish identity, the East and West Side divide, a foundation of civic commitment to the city, and philanthropic efforts supporting the network of Jewish charities in Milwaukee took root in the Jewish population. Jewish relief efforts grew in response to the increased poverty of the new immigrants. Jewish charity workers began to reorganize their operations and efforts to meet the needs of the increased indigent immigrant population. Swichkow and Gartner noted that "However, the 1890s were a decade of radical change. Milwaukee Jewry by then had an immigrant majority, requiring extensive services over a prolonged period to augment the immigrants' own widespread self-help. At the same time, charity in America was slowly recognizing the social problems that were generated by decades of untrammeled urban growth."[185]

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[182] Swichkow and Gartner, *The History of the Jews of Milwaukee,* 83.
[183] Trattner, *From Poor Law to Welfare State*, 92.
[184] Swichkow and Gartner, *The History of the Jews of Milwaukee*, 215.
[185] Swichkow and Gartner, *The History of the Jews of Milwaukee*, 215.

This led to the consolidation of the existing Jewish charitable efforts. The Hebrew Relief Association absorbed some of Milwaukee's other Jewish relief organizations. The efforts were part of spirit of t*zedakah*, which is part of an act of *Gemilut chesed* (loving kindness).[186] But, more often than not, the charitable hand was extended only after the relief organization investigated applicants and determined the case was valid and the applicants worthy. This harsh treatment resulted from the social divide between the groups. Swichkow and Gartner observed that the East Side Jewish relief workers felt the West Side Jews lacked a sense of gratitude for their efforts. West Side Jews may have believed that acts of loving kindness, rather than intrusive investigations, were needed.[187] The higher social status of many on the East Side, and the initial disdain they felt for the immigrants settled on the West Side of the Milwaukee River continued to affect relations within the Jewish population into the next century.

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[186] Deuteronomy 15:7-8, quoted in Rabbi Joseph Telushkin, *Jewish Wisdom* (New York: William Morrow, 1994), 11.
[187] Swichkow and Gartner, *The History of the Jews of Milwaukee*, 223.

CHAPTER 2 IMMIGRATION AND CHARITY ORGANIZATIONS

Prior to the 1880s, charity work in Milwaukee consisted of a fragmented network of charity associations in the city. After the number of immigrants from Eastern Europe increased, existing charity efforts in Milwaukee began to consolidate. This chapter describes the history of Jewish relief efforts and organizations in Milwaukee. The East Side Milwaukee Jewish population initially created assistance institutions using two different approaches to poverty relief. One being a Settlement and one founded on the principles of the scientific charity organization model, namely the Hebrew Relief Association.

Jewish women in Milwaukee contributed a great deal of support for relief work, starting with sewing circles and direct donations. The Sisterhood of Personal Service and the Milwaukee Jewish Mission, two groups that visited the poor to offer advice and educational opportunities, eventually merged and established the Jewish Settlement in Milwaukee.[1] It opened in 1900 in the West Side Jewish neighborhood to assist the local Jewish population.[2] After the creation of Mount Sinai Hospital, its Ladies Auxiliary supported the hospital for its entire history, ending only after the 1987 merger.[3]

The Settlement movement was a national relief movement, part of the larger Progressive movement. Settlements included a deliberate policy of assimilation in exchange for assistance. Workers believed that by living among the poor, they could address the core reasons for poverty. The poor neighborhoods offered practical information about the lives of the poor. The residents collected demographic information about the residents and used the data to address the needs of the neighborhoods.[4] One of the most well-known settlement houses was located in Chicago,

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[1] Louis J. Swichkow and Lloyd P. Gartner, *The History of the Jews of Milwaukee* (Philadelphia, PA: The Jewish Publication Society of America, 1963), 220.
[2] Swichkow and Gartner, *The History of the Jews of Milwaukee,* 226.
[3] Pat and Joan Kerns, Interview by author, Mequon, WI, May 24, 2011.
[4] Alice O'Connor, *Poverty Knowledge: Social Science, Social Policy, and the Poor in Twentieth Century U.S. History* (Princeton:

Hull House.[5]

The Charitable Organization Movement provided a framework for the efforts of the Hebrew Relief Association after the Russian Jewish population arrived in Milwaukee. This movement advocated the practice of "scientific charity," a philosophy of organization and rationality in relief efforts for the poor. Proponents of scientific charity believed that giving aid to "unworthy" people created dependency and a sense of entitlement for support. Sociologist Theda Skocpol noted that this was a departure from earlier relief efforts. Political corruption caused a backlash against poverty relief programs. Some reformers advocated the creation of regulatory boards to oversee relief efforts. This approach did not dispense a great deal of assistance, but did gather a great deal of information about applicants.[6] The early Jewish charitable efforts in Milwaukee used this approach. The president Interviewed applicants, conducted investigations, and dispensed aid. The large number of appeals from Milwaukee's poor Jewish immigrants overwhelmed the president and the scientific charity method of poverty relief offered a means of efficiently distribute aid.

Scientific charity emphasized coordinated relief efforts and investigation of all applicants. Upper class women, called "friendly visitors" advised the poor about the importance of hard work and sobriety.[7] This philanthropic approach was part of a national trend starting 1877, but Milwaukee did not adopt it until the late 1890s.[8] It was a direct response to the political corruption that led to widespread fraud in American relief efforts.[9] Historian Linda Gordon noted that a "historical transformation" regarding the meaning of welfare occurred during the

Princeton University Press, 2001), 31.
[5] Rivka Shpak Lissak, *Pluralism & Progressives: Hull House and the New Immigrants, 1890-1919* (Chicago: Chicago Press, 1989), 19.
[6] Theda Skocpol, *Protecting Mothers and Soldiers: The Political Origins of Social Policy in the United States,* (Cambridge, MA: Harvard Press, 1992), 95.
[7] Skocpol, *Protecting Mothers and Soldiers,* 95-96.
[8] Swichkow and Gartner, *The History of the Jews of Milwaukee,* 162.
[9] Skocpol, *Protecting Mothers and Soldiers,* 97.

Progressive Era between 1890 and 1935. She posited that during this time, concern for all mothers and children ended. Mothers were separated into categories: those that needed assistance because of circumstance, and those suffered from weakness in their character.[10]

The Settlement residents created poverty relief efforts that were different from the scientific charity workers' approaches. Walter Trattner explained the difference:

> Settlement house residents sought to improve these conditions, to promote social and economic reform so that those who had dreams about getting ahead would have the opportunity to do so. Where their predecessors had emphasized the individual and moral causes of destitution, drawing distinctions between worthy and unworthy poor, settlement house workers looked upon all the indigent alike, stressing the social and economic conditions that made and kept them poor. While charity workers were interested in dependency, settlement house residents were concerned with poverty. Whereas the philosophy of the charity organization movement led to private charity and spiritual uplift, the philosophy of the settlement house movement led to social and economic change.[11]

Volunteers were vital, "especially well-motivated people of the privileged classes who, for one reason or another, felt impelled to do something about the class divisiveness."[12] However, Trattner noted that "the settlement and charity organization movements were in many ways the very antitheses of each other. While not all social settlements were alike, most exemplified the democratic ideal in principle and in action, while the organized charities were the very opposite -- the embodiment of inequality in theory and in practice."[13] Milwaukee's East Side Jewish women established many of the early charity programs. Their motivation for doing so resembled the efforts of many other charity workers in other cities. They worked to alleviate the negative effects of poverty on families. They focused attention on improving the daily lives of the poor through

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[10] Linda Gordon, *Pitied But Not Entitled: Single Mothers and the History of Welfare 1890-1935*, (Cambridge, MA: Harvard University Press, 1998) 33.
[11] Walter I. Trattner, *From Poor Law to Welfare State: A History of Social Welfare in America* (New York: The Free Press, 1994), 166.
[12] Trattner. *From Poor Law,* 166.
[13] Trattner. *From Poor Law,* 167.

home visits and education. The women began to centralize relief efforts through cooperation between members of an historically divided Jewish population in Milwaukee.

One of the more contentious aspects of the Settlement Movement concerned the role of "assimilation" in relief work. The services provided to families included lessons in English, as well as religious classes and vocational training and homemaking. Not all scholars accept Trattner's somewhat positive view of the settlement movement in America. Historian Rivka Shpak Lissak noted that settlement movement members considered the more assimilated immigrants more worthy of assistance. Those applicants who acquiesced to Americanization efforts were more likely to receive assistance. She wrote that "Immigrants were not treated as equals and their culture was not respected. Hull Houses brought the cultural elite to the slums to work toward educating and assimilating the 'neighbors. They lead and the poor follow."[14] The settlement movement in Milwaukee adopted a model for charity relief founded in Reform Jewish practices and German cultural lessons and created its own network of programs. It first functioned as a community center, and offered a variety of services and programs. John Gurda noted that Abraham Lincoln House and the Settlement "were, in fact, the direct ancestors of today's Jewish Community Center."[15] The creation of these charitable organizations led to the creation of Mount Sinai Hospital in Milwaukee. The cost of food, housing, and other basic staples for the poor left very little for medical care. Relief workers referred poor patients to a small Dispensary, which closed between 1889 and 1892.[16] Rabbi Victor Caro of Congregation B'ne Jeshurun formed the Jewish Hospital Association 1902 to create Wisconsin's first Jewish hospital.[17] Relief agency leaders wanted to direct more resources toward hiring social workers to assist the poor. Rabbi Caro believed that the

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[14] Lissak, *Pluralism & Progressives*, 19.
[15] Gurda, *One People, Many Paths,* 72.
[16] Dr. Harry Kanin, Interview by author, Milwaukee, Wisconsin, July 14, 2011.
[17] Federated Jewish Charities continues to exist in the 21st century as the Milwaukee Jewish Federation. John Gurda, *One People, Many Paths: A History of Jewish Milwaukee* (Milwaukee, WI: Jewish Museum Milwaukee, 2009), 66.

medical needs of the poor needed urgent attention and that Jewish immigrants needed a Jewish hospital. Mount Sinai Hospital historically treated more Gentile charity patients than Jewish. They made up a large bulk of the hospital's caseload right from its founding. The history of the hospital reveals that one of the major contributors to the hospital, Abraham Slimmer, insisted that Mount Sinai adopt a nonsectarian mission. The hospital established itself as a resource for the poor of Milwaukee, whether Jewish or Gentile. The nonsectarian mission represents the commitment on the part of the Jewish population to Milwaukee. As early as 1904, hospital leaders questioned the overall lack of Jewish patients. Other American Jewish hospitals treated a far greater proportion of Jewish patients than Mount Sinai Milwaukee.

JEWISH IMMIGRATION AND CHARITY RELIEF

The arrival of a large number of indigent immigrants in the late 19th and early 20th century strained the existing resources in many American cities. Many immigrants settled in the poorer urban areas and were increasingly associated with the city's problems and concerns. Historian Eric L. Goldstein noted, "Jews, for reasons related to their distinct history and social characteristics, served as a convenient symbol for a host of social problems and that were of mounting concern to the American public during those years."[18] The fear of being associated with urban problems led to action on the part of the native Jewish population. Their main priority was to educate the new arrivals, or at the very least, their children, in the American Jewish way of life. Native Jews sought to protect the social status, prestige, and the civic achievements of the whole community by quickly helping the immigrants through a variety of social programs.[19]

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[18] Eric L. Goldstein, "The Unstable Other: Locating the Jew in Progressive-Era American Racial Discourse American Jewish History: A Review Essay" *American Jewish History* 86 4 (2001): 383-409.
[19] Avraham Barkai, *Branching Out: German- Jewish Immigration to the United States 1820-1914* (New York: Holmes and Meyer, 1994), 205.

They established organizations and groups to address the needs of new arrivals. Some programs included those intended to compel new Jewish immigrants to accept German cultural norms. Marshall Sklare noted that by the time the Eastern European Jewish immigrants arrived in America during the 1880s, many German Jews had experienced a great deal of upward social mobility, which resulted in prestigious social statuses. He commented "Geographical spread, while necessary to establish the predominance of the German Jews, would not have been sufficient [to explain the extent of German cultural influence]. It was the spectacular rise of the German Jews into the upper reaches of the middle class, and particularly into the upper class, that brought them into positions of authority."[20]

This was certainly the case in Milwaukee. There were two formal relief programs in Milwaukee when the Russian Jews arrived: The Hebrew Benevolent Society and the Hebrew Relief Society. The Hebrew Benevolent Society was a mutual aid association established in 1873 to provide members with sick and death benefits. Many of the members became self-sufficient but continued to pay their memberships fees. Surplus funds were used for poverty relief, including medical services.[21] It was a small organization and did not have a great deal of money.[22] The Hebrew Relief Association began as the Hebrew Relief Society on August 1, 1867. Members contributed five dollars a year for poor relief. A board of three trustees and officers comprised its leadership. The Society provided financial assistance to the poor for mainly coal and food. In 1880, the Hebrew Relief Society became the United Hebrew Relief Organization and in May of 1889 it was renamed the Hebrew Relief Association.[23]

The Hebrew Relief Association referred only the worthy recipients of aid to the appropriate

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[20] Marshall Sklare, *America's Jew's* (New York: Random House, 1971), 7.
[21] Swichkow and Gartner, *The History of the Jews of Milwaukee,* 221.
[22] Swichkow and Gartner, *The History of the Jews of Milwaukee,* 225.
[23] Swichkow and Gartner, *The History of the Jews of Milwaukee,* 221.

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relief institutions after investigating the applicants.[24] The worthy received assistance; the

slothful did not. Scientific charity organizations addressed poverty in their communities by

monitoring relief services as well as supervising the recipients. Historian Alice O'Connor

documented how upper class morals and judgments on the poor influenced poverty relief efforts.

She argued that in placing the blame for poverty on the poor, relief workers focused on allocating

help to those who met certain cultural criteria, instead of assisting those in need without regard

for their social position reified the labels of deserving and undeserving poor. These labels have

fallen away, but the ideas behind them endured.[25]

The acceptance of the validity that the labels deserving and undeserving poor continued with

the political changes in American government structures. Historian Michael B. Katz observed

that this type of assistance model solidified the acceptance of the notion that some poor people

were undeserving. That is, it sanctions the denial of aid for a segment of the poor population that

does not meet the approved criteria, no matter how deep their destitution.[26] Sociologist Herbert J.

Gans explained the power relief agencies and programs held over the poor with those labels. He

believed that the labels kept the undeserving poor from aid and also attached blame to them as

the cause of their poverty. In addition, the continued poverty in society became somewhat

acceptable because of the belief that some people did not deserve help.[27] This mindset allowed

relief workers to compel the poor to adopt acceptable norms as a condition for receiving aid. A

streamlined method of administering charitable resources and investigating applicants provided

Hebrew Relief Association leaders with the means to provide relief in good conscience by

ensuring worthiness and denying aid when necessary. The elimination of the threats of creating

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[24] Swichkow and Gartner, *The History of the Jews of Milwaukee,* 93.

[25] Connor, *Poverty Knowledge*, 285.

[26] Michael B. Katz, *In the Shadow of the Poor House: A Social History of Welfare in America* (New York: Basic Books, 1986), 71.

[27] Herbert J Gans, *The War Against the Poor: The Underclass and Antipoverty Policy* (New York: Basic Books, 1995), 6.

dependency and encouraging sloth ensured charity assisted the worthy people and rejected the undeserving. The Association sought the means to create a comprehensive and universal means of addressing poverty. Association leaders and "friendly visitors" evaluated and assessed the homes of the poor in order to make the correct decision.[28] Some of poor received assistance, but as Katz and Gans noted, denying aid to the unworthy was another important part of relief efforts.

The East Side Jewish residents created relief organizations that reflected their desire to acculturate the West Side Jews, withholding assistance from applicants not willing to comply with their goals of socialization to American ways. The end result was that the two Milwaukee Jewish populations remained segregated for much of the early twentieth century. Their efforts to acculturate the new immigrants did not include plans to welcome them into their neighborhoods.

The relative poverty of the new immigrants affected existing charity groups and spawned new ones. Relief organizations in the Jewish community in Milwaukee before the 1880s are described by historians Louis J. Swichkow and Lloyd P. Gartner as an "ad hoc affair, providing assistance to cases as they arose."[29] After the second wave, Milwaukee's East Side Jews created a large relief organization by reorganizing many of these ad hoc groups into a central charity association in response to the large Eastern European immigrant population.

On June 29, 1882, 218 Eastern European Jews arrived in Milwaukee. Historian John Gurda writes,

> When the German Jews of Milwaukee met their eastern European counterparts at the train depot in June, the event marked, on one level, a reunification of two peoples who had been separated for centuries. It did not, however, feel remotely like a family reunion. A gulf had opened between the two Ashkenazic communities in Europe, and it had grown significantly wider on the American side of the Atlantic. The eastern European refugees looked, behaved, and even smelled different from the German Jews who greeted them, and their economic circumstances could hardly have been more dissimilar.[30]

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[28] Trattner, *From Poor Law to Welfare State*, 93.
[29] Swichkow and Gartner, *The History of the Jews of Milwaukee*, 111.
[30] Gurda, *One People, Many Paths,* 40-41.

This lack of similarity between the new immigrants and the earlier arrivals created a social

distance between the two groups. First wave Jews held a marked animosity toward the new

immigrants. It was so strong that when the Hebrew Relief Association denied a charity recipient,

one possible reason noted was because the applicant was "Russian."[31] The new immigrants did not

settle in the German areas with the East Side Jews. Instead, they lived on the West Side of the

Milwaukee River and established the foundation for the West Side Jewish neighborhood. Existing

Milwaukee Jewish charities organized their efforts and solidified their mission statements to

reflect their cultural understandings about poverty relief and the poor in response to the arrival of

a relatively large immigrant population. Two entities, the *Chevra Bikur* [sic] *Cholim* (the Hebrew

Benevolent Society)[32] and the Hebrew Relief Association provided charity in the Milwaukee

Jewish community.[33] They consolidated their efforts and implemented a new system of

providing relief.

THE HEBREW BENEVOLENT SOCIETY AND HEBREW RELIEF ASSOCIATION

The relief workers were members of the higher social class in Milwaukee. They maintained

a sense of superiority implied through the actions of charity workers. Sociologist Marvin E.

Gettleman believed that the scientific charity movement was, in fact, class privilege used to

impose moral judgment to determine worth and prevent assistant to the unworthy. He described

the process as a means by which "Social programs gathered private information and sought to

protect the upper class from worthless beggars. Wanton benevolence and charity promotes the

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[31] Hebrew Relief Society Ledger, Box 1, Folder 6, Jewish Family & Children's Service, 1867-1973, Milwaukee Mss Collection 87, University of Wisconsin-Milwaukee Libraries, Archives Department, Milwaukee, Wisconsin (hereafter cited as Jewish Family Services Collection).
[32] Swichkow and Gartner, 217, the correct transliteration is Bikkur. In this source, the authors translated this as "The Hebrew Benevolent Society." Another translation is "visiting the sick."
[33] Swichkow and Gartner, *The History of the Jews of Milwaukee,* 226.

survival of the unfit."[34] The belief that the affluent understood the difference between the deserving and undeserving created a system of charity that did not respect the poor. In fact, the upper class had a moral duty to impose their moral code onto them in exchange for help.

The upper echelon in Milwaukee were firmly in charge of relief efforts. Initially, the President of the Milwaukee Hebrew Relief Association personally determined which cases received aid. He was responsible for "distinguishing between impostors who want to live without work by cunningly begging and appealing to sympathy and the really deserving who are poor by no fault of theirs."[35] Relief applicants performed a labor test in a wood yard. President Morris Miller implemented the test in 1899 as a means of "separating cheaters from the meritorious."[36] Despite these new requirements, the president soon found he could not keep pace with requests. The Association Board hired a paid agent to investigate cases in order to expedite requests.[37] A memo from a meeting in 1899 reported that, "The innovation of engaging a paid agent to assist the President in the discharge of his duty has proven a step in the right direction. Certain dependents were eliminated from our books and aid was denied to a class of dependents whose need might be supplied from private sources."[38] The Relief Association conducted routine investigations of the poor to ensure their eligibility for assistance. Leaders kept a ledger with notations about applicants that included labels such as a *schnorrer* or *goniff*.[39] These terms provided the means to describe and track those denied assistance.[40] The 1899 Annual Report of the Association stated that "Poverty is one thing, pauperism is another, a quite a different matter. The poor, says the Scripture, you shall always have with you. The poor is [sic] the result, the

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[34] Marvin E. Gettleman, "Charity and Social Classes in the United States: 1874-1900," *American Journal of Economics and Sociology* 22 (1967): 319-20.

[35] Swichkow and Gartner, *The History of the Jews of Milwaukee,* 224.

[36] Swichkow and Gartner, *The History of the Jews of Milwaukee,* 224.

[37] Esther Kovenock. "History of the Hebrew Relief Association," Box 1, Folder 2, Jewish Family Service Collection.

[38] Margaret Miller, "The History of JFC, November 6, 1957, Box 1, Folder 6, Jewish Family Service Collection.

[39] Beggar and thief, respectively.

[40] Hebrew Relief Society Ledger, Box 1, Folder 6, Jewish Family Service Collection.

product of social conditions. The pauper is of our own creation, and charity so far from fulfilling

its purpose, defeats it by creating instead of abolishing pauperism."[41] The poor received help,

the pauper received none. The paid investigator determined the difference.

   This form of relief continued until 1902. At that time a new organization, the Federated

Jewish Charities, combined the efforts of the Hebrew Relief Association and other relief

organizations, including the True Sisters, the Ladies' Relief Sewing Societies, the Widows and

Orphans Society, and the Sisterhood of Personal Service under one name. The new agency

represented a new period in Milwaukee Jewish philanthropy, as emphasis shifted from

emergency aid to systematic social service. The Hebrew Relief Association changed its name to

the Jewish Social Service Association in 1921 to signify the change in charitable perspective.[42]

Federated Jewish Charities became the Milwaukee Jewish Federation in 1956.[43] Both of these

organizations continue to serve Milwaukee in the 21st century. Howard Polsky noted that

> The Federated Jewish Charities was organized to unify fund raising in the community.
> The Hebrew Relief Association became the largest constituent member, receiving over
> one-half of the money allocated to local and national organizations. The director of the
> Federation became the superintendent of the Association. Before the Federation, the
> maximum amount raised never exceeded $1800. With unification and systematization of
> collection the Fund's totals steadily increased to more than $5,000 in 1908, $15,000 in
> 1916, and $25,000 in 1921. The Federation was largely controlled by the East Side
> Reform and Conservative German Jews.[44]

This merger gave the East Side Jewish leaders almost total control over a great deal of relief

funds. It also provided relief workers with the resources to create and sustain a Settlement House

in Milwaukee. These houses were part of a national movement designed to provide well

organized and appropriate assistance for those worthy of it.

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[41] Hebrew Relief Society Annual Report 1899, Box 1, Folder 6, Jewish Family Service Collection.
[42] Swichkow and Gartner, *The History of the Jews of Milwaukee*, 225.
[43] Gurda, *One People, Many Paths*, 256.
[44] Howard W. Polsky, "The Great Defense: A Study of Jewish Orthodoxy in Milwaukee" (PhD diss., University of Wisconsin, 1956), 83. The term "Conservative" to describe the Jewish people in 1902 probably refers to leaders at B'ne Jeshurun, the shul that was not Reform like Emmau-El and considered orthodox. Milwaukee's first official Conservative shul, Beth El, was not established until 1923. Gurda, *One People, Many Paths*, 110.

SETTLEMENT HOUSE MILWAUKEE

Prior to the 1902 merger of several charitable groups noted above, the new Milwaukee Settlement also established programs designed to assist immigrants in Milwaukee and create better living conditions in the Haymarket neighborhood, the home of the West Side Jewish immigrants.

Jewish women in American society in the late nineteenth century participated in a variety of social causes. Historian Jonathan D. Sarna wrote that "In response to the manifold crises of the day; particularly assimilation and immigration, responsibility for 'saving Judaism' came to increasingly rest upon the shoulders of women. The home, they synagogue, and philanthropic social work came increasingly to be seen as part of women's domain."[45] Historian Idana Goldberg believed that the weakening of traditional religious social structures led the philanthropic efforts of affluent Jewish Americans, with women assuming positions of social service.[46] The Settlement in Milwaukee began in 1900 with the consolidation of three different Jewish programs established by women: The Council of Jewish Women, Sisterhood of Personal Service, and Jewish Mission.[47] Upper class Milwaukee Jewish women created these groups and united in order to offer poverty relief services under the leadership of an East Side Jewish woman named Lizzie Black Kander.[48] Gurda described the relationship between members of the Milwaukee Jewish community. "There was an obvious chasm between the local German-Jewish establishment and the eastern European Newcomers, he wrote "and no one bridged that gap more enthusiastically—or more effectively—than Lizzie[Black] Kander."[49] Her visits to the poorer Jewish homes in the

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[45] Jonathan D. Sarna, "A Great Awakening: The Transformation That Shaped Twentieth-Century American Judaism," in *American Jewish Women's History: A Reader,* ed. Pamela S. Nadell (New York: New York University Press, 2003), 55.
[46] Idana Goldberg, "'Sacrifices upon the Altar of Charity': The Masculinization of Jewish Philanthropy in Mid-Nineteenth Century America," *NASHIM: A Journal of Jewish Women's Studies and Gender Issues* 20 (2010): 34.
[47] Swichkow and Gartner, *The History of the Jews of Milwaukee,* 113.
[48] Swichkow and Gartner, *The History of the Jews of Milwaukee,* 113.
[49] Gurda, *One People, Many Paths,* 67.

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Haymarket neighborhood convinced her that in order to help the indigent, material relief was not enough. She was a driving force in the Milwaukee East Side Jewish community.

Lizzie Black Kander was born on May 28, 1858 in Milwaukee. She was middle-class, German Jewish woman and a member of the Reform Congregation Emanu-El.[50] She endeavored to educate the new immigrants in the East Side way life, including Milwaukee Reform religious traditions. Trattner noted that most settlements were religious missions. Beyond their proselytizing activities, they adopted a derogatory view of ethnic traditions and assumed that their proper role was that of Americanizing the immigrant with all possible speed.[51] While the Milwaukee Settlement did not proselytize among the Gentile population, it did offer religious education for the more traditional Jewish European immigrants. Around 1907, the Milwaukee Settlement welcomed a new resident from Hull House in Chicago, "Plans for great activity at the settlement are being made, and will become effective upon the arrival of the new head resident, Miss Stella A. Loeb, who comes up from Chicago November 1 to go into residence at the settlement. Miss Loeb, who is teacher of music at the Avondale school in Chicago, has worked for eight years with Jane Addams at Hull house, teaching evening classes, and is conversant with the needs of settlement work. The settlement is now open for the cooking and sewing classes and the girls' clubs. The boys' clubs will begin next week."[52]

The Milwaukee Settlement residents sought to establish the accepted American cultural practices in the West Side Jewish immigrant population. The new immigrants received a great variety of lessons toward that goal. Settlement programs included instructions in the ways of Reform Judaism. Settlement house residents also believed that their middle-class values

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[50] Swichkow and Gartner, *The History of Jews of Milwaukee*, 219.

[51] Trattner, *From Poor Law,* 167.

[52] Newspaper Clipping, unknown publication "Use of Basement," ca. 1907, Lizzie Black Kander Papers, Milwaukee Mss Collection DN, Box 1, Folder 6, University of Wisconsin-Milwaukee Libraries, Archives Department, Milwaukee, Wisconsin (hereafter cited as Lizzie Black Kander Papers).

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improved the lives of the poor. They encouraged new immigrants to seek out volunteer work and

adopt American values.[53] While the settlement house movement may have not been democratic

and progressive in its social reform policies, Trattner believed that:

> even their most ardent critics would agree that, despite some similarities, the
> settlements were significantly different from the organized charities and that
> many were mechanisms for reform that made invaluable contributions to the
> movement for social welfare and justice in late nineteenth- and early twentieth
> century America. To the extent that settlement house residents advocated or
> practiced social control, it was because they realized (as did public health
> crusaders and others as well) that social cohesion and justice in modern society
> depended upon purposeful planning and the curtailment of some individual
> liberty.[54]

The Settlement movement in Milwaukee succeeded in that, as Trattner points out, "The

settlements, then, embodied the neighborhood ideal– the desire to create an organic community

among the people and institutions of a specific location."[55] The Settlement worked to improve

the Haymarket neighborhood, and the lives of the West Side Jewish population. Lizzie Black

Kander and her fellow volunteers created Sabbath School classes, gave instructions about

keeping a clean house, and offered English language classes.[56] There were tangible benefits

from Settlement efforts for the poor.

However, measuring the success of the Settlement efforts are a matter for debate by

historians. Historian Rivka Shpak Lissak points out that if the definition of success included the

realized goal of assimilation, then the settlement movement met that goal. She noted that

Progressive ideology included an emphasis on social reform and cultural issues. Assimilated

Americans were more worthy and less repugnant to residents.[57] She points to Jane Addams and

her work at Hull House in Chicago to illustrate the link between immigrant behavior and

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[53] Trattner. *From Poor Law,* 167.
[54] Trattner. *From Poor Law,* 168.
[55] Trattner. *From Poor Law,* 170.
[56] Swichkow and Gartner, *The History of Jews of Milwaukee*, 227.
[57] Lissak, *Pluralism & Progressives*, 17.

assistance. Lissak described Hull House as a "salon" where residents worked to bring the cultural elite to the slums to work toward educating and assimilating the "neighbors" and create a "better element" within the slum.[58] Settlement House efforts did lead to a measure of improvement in the lives of the poor. Lissak argued that these efforts were motivated, in part, by a sense of superiority on the part of the Settlement House residents. Their efforts to improve the lives of the poor were not purely altruistic. Historians Hasia Diner and Beryl Lieff Benderly remarked that "For all of the useful education they provided, for all the crucial assistance they rendered, for all the compassion they felt, many of the well-to-do helpers could not mask their condescension toward their less-favored brethren."[59] Conditional assistance, not acceptance or respect, was the legacy of the Settlement in the minds of these scholars.

In the case of Milwaukee relief efforts before the Settlement House opened, there was at least on program that appeared to instruct Jewish women in on traditional skill: Kosher cooking. Called the "only 'kosher' cooking school this side of New York," the school attempted to teach women to cook Kosher meals. The headline reads, "Only Kosher Cooking in the West: An Interesting Class of Jewish Girls are being taught to Cook by the Milwaukee Jewish Mission-- Miss Alida Pattee Is the Teacher, but She Finds it Difficult to observe the Kosher Laws."[60] The article notes that while Jews of a "higher class" may not keep Kosher, the Jews of the "lower class, especially the Russians" are "particular" about such matters.[61] However, the article goes on to describe the teacher as one who trained at the Boston Cooking School, but until coming to Milwaukee "her ideas of 'kosher' cooking were rather vague." It was noted that she made

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[58] Lissak, *Pluralism & Progressives*, 17.
[59] Hasia R. Diner and Beryl Lieff Benderly, *Her Works Praise Her: A History of Jewish Women in America from Colonial Times to the Present* (New York: Basic Books, 2002), 236.
[60] Newspaper Clipping, "Only Kosher Cooking in West," unknown publication, February 5, 1898, Box 1, Folder 6, Lizzie Black Kander Papers.
[61] Newspaper Clipping, "Only Kosher Cooking in West," unknown publication, February 5, 1898, Box 1, Folder 6, Lizzie Black Kander Papers.

mistakes in the kitchen that "horrified the children." One example cited was the incident where she accidentally placed red edged napkins, signifying a "fleischdig" [meat] meal on a "milchdig" [dairy] tea table.[62] Another example described how, when Miss. Pattee "forgets" and uses a dairy mixing spoon in a meat based soup, "there is always a small girl with large dark eyes and a wealth of coal black hair to point out the mistake."[63]

The Milwaukee Settlement initially created programs for children and met on the East Side, in the basement of Emanu El. In 1895, Kander Black led a group of volunteers in the Keep Clean Mission at Temple B'ne Jeshurun. The mission focused on hygiene; the children of immigrants were taught lessons about the importance of keeping clean and children were required to have "well-scrubbed hands and faces" at the meetings.[64] After a year of operation, the group became the Milwaukee Jewish Mission. It began offering more educational and vocational programs. It also served as a community center for Jewish residents. They added cooking, sewing and embroidery classes for girls and woodcarving and painting lessons for boys in 1898.[65]

In 1900, the Mission moved to a house called the Settlement on Fifth Street, one block away from the orthodox West Side *shul*, Beth Hamedrosh Haggodol.[66] Gurda notes that "Nearly every Haymarket resident could find something to do at The Settlement, and it quickly became a community hub much like Chicago's famed Hull House, which Jane Addams had established in 1889."[67] In her obituary, it was noted that Lizzie Black Kander was "Called the 'Jane Addams of

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[62] Newspaper Clipping, "Only Kosher Cooking in West," unknown publication, February 5, 1898, Box 1, Folder 6, Lizzie Black Kander Papers. As part of keeping a Kosher, meat and dairy products are never served together. In order to prevent incidents of trafe, rendering anything not kosher, table linens, as well as serving dishes and cooking pots and utensils were designated for meat and dairy dishes. Red linens often signified meat meals and blue, dairy.

[63] Newspaper Clipping, "Only Kosher Cooking in West," unknown publication, February 5, 1898, Box 1, Folder 6, Lizzie Black Kander Papers. The article quotes a girl saying, "At home, my mother would bury the spoon in the ground until it was purified." This practice is known as "koshering." Other methods to restore an item include using heat (boiling water or flame) and water. Some items, those made of something other than metal, cannot be reclaimed and are usually donated to charity if they are in usable shape.

[64] Swichkow and Gartner, *The History of the Jews of Milwaukee*, 226.

[65] Gurda, *One People, Many Paths,* 68.

[66] Swichkow and Gartner, *The History of the Jews of Milwaukee*, 226.

[67] Gurda, *One People, Many Paths,* 69.

Milwaukee,' Mrs. Kander was also affectionately known as the "Mother" of the Jewish Center. Through her work years ago at the Abraham Lincoln settlement house, old Jewish Center, she saw the need for other community meeting places for the foreign born, and the growth of the Milwaukee social center system is due partly to her efforts."[68]

The Settlement House offered educational programs, many centered around the kitchen and home and founded in East Side cultural norms and practices. The cooking lessons provided some of the recipes published in the *Settlement Cookbook*. Kander Black published them in 1896 as a fundraising experiment. She raised the eighteen dollars needed to publish the book through advertisements.[69] This "experiment" sold out year after year, and became nationally recognized. Proceeds from book sales provided a "substantial portion" of money used to build a new facility, named Abraham Lincoln House.[70] The money from sales supported The Settlement's programs.

Sociologist Howard W. Polsky posited an alternative perspective about the notion that the Settlement was a community hub. The opinions of the West Side Jewish community about the charitable efforts of East Side Jews are largely unknown, but Polsky believed that the West Side Jewish population saw the settlement movement in general and the Milwaukee Jewish Mission in particular as

> A group of ladies on the East Side, afforded leisure by the prosperity
> of their merchant-husbands, turned their efforts from study and the arts
> to what was called at that time 'good and welfare'. For the most part
> members of the Reform Temple Emanu-El and the Council of Jewish
> Women, these ladies decided to come to the aid of their fellow Jews. It
> is a well-known observation among minority groups that recent
> converts to an outgroup's way of life can be more enthusiastic about
> 'showing the way' to other minority members, still unacculturated,
> than natives themselves. The Reform group as a whole was to serve as
> a catalyst and harbinger of change to those Jews who arrived later on

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[68] Newspaper Clipping "Stroke Fatal to Mrs. Kander," Unknown Publication, Box 1, Folder 7, Lizzie Black Kander Papers. Papers)

[69] Swichkow and Gartner, *The History of the Jews of Milwaukee,* 226.

[70] Swichkow and Gartner, *The History of the Jews of Milwaukee,* 227. Gurda, *One People, Many Paths*, 70, notes that the book became "an American standard, selling well over a million copies in multiple editions during its first fifty years."

the American scene. This was not always done tactfully. As a result of these ladies' efforts the Milwaukee Jewish Mission was organized. It is worth recording the reaction of the immigrants. This title (Milwaukee Jewish Mission) was unfortunate and later was abandoned because of intense opposition of the immigrants themselves, who while realizing their need for assistance from their more fortunate American folk, resented the 'mission idea' applied to them.[71]

Polsky believed that West Side Jews resented the charity efforts of the East Side Jewish community. He acknowledged that differences in socioeconomic status and the limited interaction between the East and West Side Jewish communities outside of charity work explained that resentment:

Social and economic classes sought their own level. One of the most significant demonstrations of the vitality of social and economic class stratification can be found right within the Jewish community. Almost from the very beginning the poor man's rich cousins sought to isolate themselves from their less fortunate relations. Contacts on a charity basis were frequent but seldom indeed for many years did relationships mature on the basis of equality.[72]

However, historian Jonathan Sarna noted that the possibility of increased social status led to many second wave Jewish immigrants to Americanize as a means to an end, specifically, economic prosperity. He noted that as they adopted American Jewish cultural practices, they found better employment opportunities. Many curtailed their more traditional religious practices in order to take advantage of opportunities for upward mobility. Sarna allowed for the possibility that the second wave immigrants had some degree of agency in the decision to embrace more American Jewish practices.[73] Polsky may have underestimated the importance of cultural capital and the advantages that come with it. It is also possible that the second wave Jewish immigrants considered themselves "Jewish" by birth and felt a sense of agency in defining their Jewish

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[71] Polsky, "The Great Defense, A Study of Jewish Orthodoxy in Milwaukee," 85.
[72] Polsky, "The Great Defense: A Study of Jewish Orthodoxy in Milwaukee," 78.
[73] Jonathan D. Sarna, *American Judaism: A History* (New Haven, CT: Yale University Press, 2004), 97-98.

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practices. Philosopher Michael Krausz noted the contribution of descent to the construction of an individual's Jewish identity. The ascribed status by way of an individual being born or converting to Jewish either by birth conversion created an established sense of a Jewish self. The West Side Jewish that did embrace East Side cultural norms and practices may have done so as a matter of personal choice, that is by assent.[74]

Despite the criticism, the Settlement and later, Abraham Lincoln House, succeeded in providing a common meeting place for West Side Jews under the guidance of the East Side workers. Historians Swichkow and Gartner remarked that, "Like similar institutions in American Jewish communities during this age, the Milwaukee Jewish Settlement was also a meeting ground for native and immigrant young people."[75] The Settlement offered a variety of social and vocational programs and provided the opportunity for some East and West Side Jews to socialize, albeit in the context of charity. Abraham Lincoln House provided immigrants with public baths, a library, and classes in American history and civic lessons.[76] In 1913, an article in the *Milwaukee Sentinel* announced the formation of a "new league" intent on helping "foreigners" in Milwaukee, "to give legal aid" to those that wanted to become citizens. The new entity was affiliated with the national organization called the American Foreign Aid league, which had branches in New York, Philadelphia, Boston, and Baltimore.[77]

Despite the efforts of both the Federated Jewish Charities and The Settlement, the majority of indigent immigrants in Milwaukee, Jewish and Gentile, lacked access to health care. Some of the most successful men from the East Side Jewish population in Milwaukee established a Jewish hospital for the medical needs of indigent immigrants. The Federated Jewish Charities

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[74] Michael Krausz, "On Being Jewish," in *Jewish Identity*, ed. David Theo Goldberg and Michael Krausz (Philadelphia, PA: Temple University Press, 1993), 268.
[75] Swichkow and Gartner, *The History of the Jews of Milwaukee,* 226.
[76] Swichkow and Gartner, *The History of the Jews of Milwaukee,* 119.
[77] Newspaper clipping," New League Formed to Asst. Foreigners," *Milwaukee Sentinel*, October 1, 1913, Lizzie Black Kander Papers.

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began operations in 1902. It represented a new period in Milwaukee Jewish philanthropy, as emphasis shifted from emergency aid to systematic social service. The Jewish Hospital Association began to plan Mount Sinai in the same year. The hospital opened less than one year later.

PLANS FOR MOUNT SINAI HOSPITAL

Rabbi Victor Caro formed the Jewish Hospital Association in 1902 to create a Milwaukee Jewish hospital. Rabbi Caro led the B'ne Jeshurun congregation on the West Side and was dedicated to serving the original West Side Jewish community and the city of Milwaukee.[78] Rabbi Caro spoke out against his fellow Jews who criticized the new immigrants for being too religiously observant. His willingness to criticize other Jews made him controversial, a status of which he was aware. He stated "I know I have not pleased many of you because I have spoken often in forcible and bold language. I have done so because I will be held responsible at the bar of justice."[79]

Caro believed that Milwaukee needed a hospital for Jewish patients. The Hebrew Relief Association provided some medical care assistance at a small clinic before joining Federated Jewish Charities.[80] After the merger, the Hebrew Relief Association created a new mission of social service. Swichkow and Gartner note that, "The founding of the Federated Jewish Charities opened a new period in Milwaukee Jewish philanthropy, as emphasis gradually shifted from emergency aid to systematic social service."[81]

At this time, health care assistance was considered emergency aid. Members of the Jewish

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[78] Ruth Traxler, *The Golden Land, 150 years of Jewish Life in Milwaukee* (Milwaukee Wisconsin: Sesquicentennial Celebration, 1994), 54.
[79] Ruth Fromstein, *In This Place: Congregation Emanu El B'ne Jeshurun's First 150 Years* (Bloomington, IN: Author House, 2006), 11.
[80] Swichkow and Gartner, *The History of the Jews of Milwaukee,* 225.
[81] Swichkow and Gartner, *The History of the Jews of Milwaukee,* 225.

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Hospital Association assumed responsibility for the creation of the hospital. Raising money was the biggest obstacle. Through his role in the Hospital Association, Rabbi Caro solicited financial support from the Milwaukee community, but he fell short. At about this time, a wealthy Jewish philanthropist from Iowa provided an initial donation that led to the creation of Mount Sinai Hospital. He continued to support the hospital even after death. His name was Abraham Slimmer.

ABRAHAM SLIMMER: PHILANTHROPY AND RELIGIOUS IDENTITY

The existing archival information about Abraham Slimmer indicates that he believed it was his religious duty to donate money to worthy causes. He supported Mount Sinai Hospital from the start. Historians differ in their descriptions of the man; Swichkow and Gartner describe him as "a Jewish millionaire who lived nearly in seclusion in Dubuque, Iowa."[82] His donations to Mount Sinai Hospital "indulged his hobby of endowing Jewish hospitals."[83] Gurda describes Slimmer as "a non-observant Jew and confirmed bachelor [who] developed a second career as a philanthropist, giving away millions to hospitals and homes for the elderly across the Midwest, with a particular fondness for institutions run by Catholic nuns and Jewish businessmen."[84] Historian Stanley Bero described him as "Iowa's humblest and best citizen, and described his actions in a positive manner.[85] These interpretations are not definitive. It is true that Slimmer was rich, but felt it was his religious duty to give his money away. Philanthropy was not a second career; it was his self-described expression of Jewish religious beliefs.[86]

The early life of Abraham Slimmer remains, for the most part, a mystery. Interviews he gave

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[82] Swichkow and Gartner, *The History of the Jews of Milwaukee,* 228.
[83] Swichkow and Gartner, *The History of the Jews of Milwaukee,* 228.
[84] Gurda, *One People, Many Paths,* 73.
[85] Stanley Bero, *Abraham Slimmer: Iowa's Humblest and Best Citizen* (New York: Jewish Immigrant Bulletin, 1914), 20.
[86] Interview with Abraham Slimmer, *Milwaukee Sentinel*, May 1913, Box 51, Folder 1, Sinai Samaritan Collection, Golda Meir Library Archives Department, University of Wisconsin-Milwaukee, Milwaukee, Wisconsin (hereafter cited as Sinai Samaritan Collection).

to reporters at the time revealed attitudes about his charitable activities, but details about his upbringing remain unknown. He was born in Prussian Poland "about four miles from Posen" and in the words of one Interviewer he "prefers to be silent about this period of his life."[87] He emigrated from Poland and settled in New York when he was fifteen. He moved to Little Rock, Arkansas until the Civil War. He claimed to be inspired by the passage in Isaiah about making swords into plowshares and decided to start a farm.[88]

Slimmer settled in Waverly, Iowa, and founded a cattle farm. Bero described the event in Slimmer's life that shaped his philanthropic philosophy. When Slimmer's first shipment of cattle arrived before he could pay for delivery, he approached a local banker for a loan. When asked what collateral he could offer to secure the loan, he replied "my word." The banker refused the loan and went home to lunch. The banker's wife urged her husband to accept Slimmer's word after he related the exchange, and the banker did extend the credit and Slimmer repaid the loan.[89] This experience shaped his rationale for contributing money. When asked about how best to help the poor, Slimmer was quoted as saying, "To put the honest and poor on their own mettle by giving them credit without interest so they might be able to compete with those whom fortune has favored more liberally has been his method of promoting good citizenship and of guaranteeing for himself the comfort of their friendship."[90] He believed that assistance created a sense of community spirit for the poor. The requirement that the community match his donation fostered a sense of gratitude on the part of the receiver.

Slimmer gave money to a variety of causes, but all had to meet two conditions. The community had to match his donation in order to receive the donation, and the cause had to be

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[87] Stanley Bero, *Abraham Slimmer,* 25.
[88] Stanley Bero, *Abraham Slimmer,* 27.
[89] Stanley Bero, *Abraham Slimmer,* 27.
[90] Stanley Bero, *Abraham Slimmer,* 15.

nonsectarian.[91] He was committed to giving funds wisely to causes that were open to all worthy of need, consistent with the emphasis on worthiness touted by the scientific charity movement. Bero explained, "He does know what to do with his wealth and accomplishing his purpose in life. This purpose is a two-fold. One that the giving away of vast sums of money but without working a hardship in place of a benefit."[92] He wanted the funds he donated to improve the lives of the poor; he did not want to replace the hardship of poverty to be replaced by the hardship of dependence in keeping with the tenants of scientific charity. In a response to a question about why he gave away his money, Slimmer answered, "I regard my wealth as God given. I am merely the temporary custodian of the money with which I am blessed. It was ordained that I should have this money to use and Providence will hold me to account for my stewardship."[93] Slimmer believed the indigent would not and could not improve their lives without assistance from the more affluent in their communities and the community at large. His requirement for a matching donation from the public was a means of verifying the commitment of the population toward the goal of addressing the economic inequalities that led to poverty.[94]

Rabbi Caro approached Slimmer in 1902, at the start of the Jewish Hospital Committee's efforts. Slimmer may have visited the early Dispensary operated by the Hebrew Relief Association, in disguise in order to determine Mount Sinai's worthiness. He had done that in the past when approached for contributions.[95] He pledged five thousand dollars to the hospital in early 1903 on two conditions: the community had to match his gift and the hospital must be nonsectarian. With the five thousand dollars from Slimmer, and the five thousand from donations by the Milwaukee

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[91] Interview with Abraham Slimmer, *Milwaukee Sentinel*, May 1913, Box 51, Folder 1, Sinai Samaritan Collection.
[92] Interview with Abraham Slimmer, *Milwaukee Sentinel*, May 1913, Box 51, Folder 1, Sinai Samaritan Collection.
[93] Interview with Abraham Slimmer, *Milwaukee Sentinel*, May 1913, Box 51, Folder 1, Sinai Samaritan Collection.
[94] Stanley Bero, *Abraham Slimmer,* 27.
[95] Stanley Bero, *Abraham Slimmer,* 20.

community, the Jewish Hospital Association planned their hospital.[96] It took them less than a year to open Mount Sinai Hospital.

Historian Rosemary Stevens describes the expectations placed on hospitals in the early twentieth century. Stevens notes that the charitable hospital functioned as a "household," each one establishing "portals" of entry and rules for those lucky enough to gain entry. Patients seeking charity care had to abide by the house rules during treatment. Institutions ensured the patient did not become too comfortable with charity. The institution instilled the rules in their patients. Hospital staff monitored patients' signs of dependency and educated them about the perils of charity.[97] The investigations required before the impoverished received care were often less stringent than for cash or food. Historian Michael B. Katz illustrated the difference between poor relief and health care needs using the case of Mrs. B, an elderly woman denied help for food after the investigation determined she was slothful; once discovered deathly ill she was brought to a hospital, where she died 2 days later.[98] Mrs. B received assistance only after becoming very ill. Up to that point, the goal of preventing dependency and denying the undeserving remained an important objective.

Some charitable association leaders in American cities at the time worried that too many organizations depressed overall relief resources. For example, in Boston, in 1909, Jewish and non-Jewish citizens opposed plans for a Jewish hospital. They accused hospital organizers of "highway robbery" and of "fleecing" the Jewish community for more charity; they felt their community could not sustain existing programs and a new hospital.[99] In Newark, New Jersey, it took years for the Jewish community to establish Beth Israel Hospital, despite a much larger

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[96] Interview with Abraham Slimmer, *Milwaukee Sentinel*, May 1913, Box 51, Folder 1, Sinai Samaritan Collection.
[97] Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century* (New York: Basic Books 1989).
[98] Michael B. Katz, *Improving Poor People: The Welfare State, the "Underclass" and Urban Schools as History* (Princeton, N.J.: Princeton University Press, 1995), 172.
[99] Arthur J. Linenthal, *First a Dream: The History of Boston's Jewish Hospitals 1896 to 1928* (Boston: Beth Israel Hospital 1999), 93.

Jewish population than in Milwaukee.[100] In Milwaukee, some of Jewish leaders feared that the hospital costs threatened the emerging social service network. Morris Miler, the president of Federated Jewish Charities in 1903, voiced concerns that the hospital would decrease the resources available for new social services. The decision to consolidate all medical services at the new hospital assuaged those concerns. The hospital assumed responsibility for all health care services, leaving Federated Jewish Charities to develop social service assistance programs.[101] There were some on the Board of Federated Jewish Charities that disagreed with the decision, citing the number of hospitals already serving Milwaukee. The hospital effort got an important boost when the Federated Jewish Charities decided that the new hospital actually provided the means to move forward with their plans for expanded social services. The five thousand dollars from Slimmer, and the matching raised from the Milwaukee community, financed the purchase of a building at 4th and Walnut for the new hospital.[102] The Jewish community was grateful for his gift. Rabbi Caro remarked, "We can return our gratitude for his assistance in placing in this city a monument which is and which we hope in the future will be worthy of his and our highest ideas."[103]

Mount Sinai Hospital Milwaukee was dedicated on June 12, 1903. Hospital Board Secretary Leopold Hammel declared, "This occasion demonstrates an era in Judaism, not in the country or in this commonwealth, but in the city of Milwaukee. On a foundation wide in scope we have builded [sic] a house wherein shall be nursed the sick and distressed of all races and of all creeds. Today we dedicate this house, where all alike, rich and poor, Jew or Gentile, will be welcomed."[104] Board President Max Landauer described Mount Sinai as, "hospital for all creeds,

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[100] Alan M. Kraut and Deborah A. Kraut, *Covenant of Care: Newark Beth Israel and the Jewish Hospital in America* (New Jersey: Rutgers University Press, 2007), 16.
[101] Swichkow and Gartner, *The History of the Jews of Milwaukee*, 233.
[102] Swichkow and Gartner, *The History of the Jews of Milwaukee,* 228.
[103] Interview with Abraham Slimmer, *Milwaukee Sentinel*, May 1913, Box 51, Folder 1, Sinai Samaritan Collection.
[104] Newspaper Clipping, "Jews Dedicate Hospital" *Milwaukee Sentinel*, June 12, 1903. Box 51, Folder 1, Sinai Samaritan Collection.

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where the rich or poor, the high or low, the Jew or the Gentile can receive free care."[105]

The hospital treated many indigent patients in 1903. They were usually referred to the hospital by Federated Jewish Charity workers and had been found eligible for care. However, acute illnesses and emergency situations were treated immediately.[106] Relief workers categorized health care needs, especially contagious illnesses, as urgent services. They usually bypassed any investigation until such time as the person had recovered.[107] Sixty-two of the one hundred seventy-five patients cared for in its first year received free care. In 1905, the hospital served 300 patients, over one half free of charge. In 1906, 245 patients were served, in 1907, 408, with the large majority being free cases. An addition in 1907 allowed Mount Sinai to treat more and more patients, many of them for free.[108] Its focus on serving the poor required a community fundraising effort. At the June 1903 dedication, Leopold Hammel stated the time would come when the hospital again asked for their help, "And when that summons comes to you may you be ready to answer as Abraham of old, 'Here Lord, am I.'"[109] The Mount Sinai Ladies' Auxiliary coordinated the 1907 drive to build the addition. The tradition of fundraising and organizational skills of the female volunteers at Mount Sinai supported the hospital from the beginning.

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[105] Newspaper Clipping, "Jews Dedicate Hospital," *Milwaukee Sentinel*, June 12, 1903, Box 51, Folder 1, Sinai Samaritan Collection.

[106] Esther Kovenock. "History of the Hebrew Relief Association," Box 1, Folder 2, Jewish Family Service Collection.

[107] Margaret Miller, "The History of JFC, November 6, 1957, Box 1, Folder 6, Jewish Family Service Collection.

[108] Newspaper clipping, *Free Press*, July 30, 1907, Box 51, Folder 1, Sinai Samaritan Collection.

[109] Newspaper clipping, "Jews Open Hospital," *Milwaukee Sentinel*, June 6, 1903, Box 51, Folder 1, Sinai Samaritan Collection.

MOUNT SINAI LADIES AUXILIARY

In Milwaukee, the Ladies' Auxiliary assumed much of responsibility for funding the hospital. The Auxiliary was formed in 1902 as part of the Jewish Hospital Association. Auxiliary members worked at Mount Sinai year round at a variety of tasks, preparing bandages and linens and making clothes and toys for the children. They also served as volunteers at the hospital assisting the staff with patient care.[110] One of their major contributions was the annual Donation Drive held on President's Day, starting in 1904. The Mount Sinai women organized and hosted the event, with great success. By 1906, the hospital had outgrown the facility and hospital leaders announced the need for an expansion. The hospital received a percentage of $10,780 in that year. The exact amount is unknown as the yearly report listed on the names of the organizations that received money, not an exact amount.[111] Slimmer donated an additional $5000 after the community contributed $7,000 on Donation Day 1906 to fund a new expansion. The expansion opened in 1907.[112]

Donation Day contributions provided crucial funding for Mount Sinai Hospital. Colder winters than usual brought more patients some years. In 1913, a free Dispensary opened. The Ladies' Auxiliary staffed the free maternity program at Mount Sinai. Ten years into their mission, the hospital was treating more patients annually: 224 Jewish and 449 non-Jewish, with 374 being "charity cases, including 132 free maternity cases." In 1914, a new hospital building at 945 N. 12th Street was officially opened, treating a total of 1,489 patients (1,105 non-Jews, 384 Jews). The hospital publicized the urgent financial needs of the hospital, Dispensary, and the maternity programs to the community at large. A *Milwaukee Sentinel* editorial reported on February 19, 1915,

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[110] Newsletter, December 1963, Box 1 Folder 3, Ladies Auxiliary Collection, Jewish Museum Milwaukee Archives, Milwaukee, Wisconsin.

[111] 1906 Annual Report, Box 13, Folder 1, Jewish Family Service Collection.

[112] Newspaper clipping, "Donation Day a Great Success," *Milwaukee Sentinel*, February 23, 1906, Box 51, Folder 1, Sinai Samaritan Collection.

just before the annual Donation Day, that those needs are the "urgent reason why the institution should be liberally patronized on the annual Donation Day." Donation Day brought in $1500.[113] In 1917, the Donation Day appeal to the Milwaukee community on Mount Sinai's behalf was even more emphatic. The *Milwaukee Sentinel* noted that, "Demands upon Mount Sinai for free service, resulting from the extremely cold winter, combined with the abnormally high cost of medical supplies, food stuffs and other hospital requirements have been so large during the past year that officers and members of the board of directors of the hospital association believe the citizens of Milwaukee should extend liberal patronage."[114] The hospital raised $2300.[115] Federated Jewish Charities gave an unknown portion of a total of $31, 320 collected for the year to the hospital. Much of that money was dedicated to care for indigent patients.[116]

The large number of indigent patients at Mount Sinai Hospital provided a certain amount of validation for the Hospital Board of Mount Sinai Hospital; the number of poor patients treated in the first ten years verified the contention that Milwaukee urgently needed this hospital. Hospital Board Secretary Leopold Hammel stated, "Many claimed that there was no need for a hospital. Others even charged us with doing wrong by diverting from other charitable work the money given to us by our people. To all of these I desire to say that my humble opinion practicing charity in any form is good in the eyes of the Lord and ours is genuine charity."[117]

The hospital treated an increasing number of patients, but not many from the Jewish community. The number of Jewish patients treated at Mount Sinai was low from the beginning. Just a year after the hospital's founding, Mount Sinai Hospital's Board secretary Leopold Hammel

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[113] Editorial, *Milwaukee Sentinel,* February 19, 1915, Box 51, Folder 1, Sinai Samaritan Collection.
[114] Editorial, *Milwaukee Sentinel,* February 19, 1915, Box 51, Folder 1, Sinai Samaritan Collection.
[115] Newspaper clipping, Editorial, *Milwaukee Sentinel,* February 20, 1917, Box 51, Folder 1, Sinai Samaritan Collection.
[116] 1917 Annual Report, Box 13, Folder 1, Jewish Family Collection. There are no disbursement amounts listed for Mount Sinai in the yearly reports. The report only lists the total amount of donations and a list of charitable groups given assistance. There were no specific dollar amounts.
[117] Newspaper clipping, *Free Press,* November 1907, Box 51, Folder 1, Sinai Samaritan Collection.

stated, "Although we are a Jewish organization, the only Jewish hospital in the state, we have cared for more non-Jews in this first year than we have Jews." In 1907, President Landauer declared at the dedication of the new addition, "Since the erection of the hospital 3 years ago, we find by our records that less than ¼ of the patients treated were Jews. Another interesting feature is that 94% of the people taken care of were charity patients. While our organization is strictly a Jewish one, the hospital is not sectarian, and it is our aim to do all the good we can for all these classes of people."[118] The support of Jewish community in Milwaukee for Mount Sinai provided indigent care for mostly non-Jewish patients. The most likely reason for that circumstance is that the hospital was nonsectarian at its foundation. Swichkow and Gartner wrote that the percentage of Jews treated at Mount Sinai was lower than any "sizable Jewish hospital in the country and stirred considerable discussion. One hint came from a [n unnamed] Yiddish source, that Jewish patients felt no different in a Jewish hospital which celebrated Christmas than in any other hospital. The unavailability of kosher food was another probable cause."[119]

JEWISH CONCERNS AND A NONSECTARIAN HOSPITAL

Throughout the first decade of operation, Mount Sinai treated more Gentiles than it did Jews. Leopold Hammel was not concerned by the lack of Jewish patients. He explained the hospital's general mission, stating "While our organization is strictly a Jewish one, the hospital is not sectarian, and it is our aim to do all the good we can for all these classes of people."[120] In 1922, an editorial in the *Wisconsin Jewish Chronicle* chastised Milwaukee's Jews for failing to patronize the hospital: "The disproportionate number of Jewish patients suggests the thought of a lack of interest in a Jewish hospital on the part of the Jews of Milwaukee. With hearty cooperation, there can come

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[118] Newspaper clipping, "Hospital Opens Addition," *Milwaukee Journal,* July 6, 1907, Box 51, Folder 1 Sinai Collection.
[119] Swichkow and Gartner, *The History of the Jews of Milwaukee*, 337.
[120] Leopold Hammel, in *Free Press*, 1904, Box 51, Folder 1, Sinai Samaritan Collection.

only substantial settlement and we must strive to the public and especially the Jewish portions thereof, appreciate the objects and purposes of our uplifting mission and recognize the beneficent service performed by the hospital."[121] On July 8, 1922, another editorial asked

> But are the Jews of this city proud of their hospital, than which there is none better in the whole land? It doesn't seem that they are from this sentence in the report of Secretary Hammel, the disproportionate number of Jewish patients suggests the thought of a lack of interest in a Jewish hospital on the part of the Jews of Milwaukee. Do some Jews avoid Mount Sinai because it is a Jewish hospital? Is it less fashionable to be an inmate in a Jewish hospital than in a non-Jewish institution? To those who hold any such prejudices, we would suggest a visit and thorough inspection of Mount Sinai Hospital.[122]

Why were there so few Jewish patients? The surviving archival evidence hints at why contemporaries believed Milwaukee's Jews failed to patronize the hospital, but does not offer a definitive explanation. The religious differences within the Jewish community in Milwaukee could explain low Jewish patronage at Mount Sinai. The resentment of the West Side Jewish toward the East Side Jewish charity workers and their attempts to impose their own Jewish beliefs on the newcomers offers another possible explanation. The East Side Jews created a hospital intended for a population with whom they had little in common. It is possible that the West Side Jewish population considered Mount Sinai Hospital not sufficiently Jewish. The lack of Kosher food and differences in Jewish religious observance may have kept members of the Jewish community from coming to the hospital.[123] On the other side of the Milwaukee River, the East Side Jewish population may not have planned on using the hospital, believing it was for West Side Jewish patients.

The hospital continued caring for the sick, and the affluent members of the East Side Jewish population continued to support the hospital through donations and volunteer hours. However, the Stock Market Crash of 1929 and the Great Depression of the 1930s increased the number of

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[121] Newspaper clipping, Editorial, *Wisconsin Jewish Chronicle,* June 30, 1922, Box 51, Folder 1, Sinai Samaritan Collection.
[122] Newspaper clipping, Editorial, *Wisconsin Jewish Chronicle,* July 8, 1922, Box 51, Folder 1, Sinai Samaritan Collection.
[123] Swichkow and Gartner, *The History of the Jews of Milwaukee*, 227.

indigent patients who used Mount Sinai's services. The number of indigent patients at American hospitals increased generally, and the donations decreased as the affluent suffered the effects of the Depression. Mount Sinai Hospital sought solutions to address its financial difficulties. The hospital's leaders sought new methods in order to fund operations, including a new larger Dispensary and a hospital insurance plan. The Dispensary, which opened in 1935 succeeded in creating a cooperative health care network in Milwaukee. It provided medical care for those in need, training and education for doctors and nurses, and cooperated with other social service entities to provide care. The Dispensary remained open until the late 1960s. Also at this time, leaders at Mount Sinai tried to establish a hospital membership program to pay for medical care. It was designed as a form of insurance sold to prospective patients. This plan ended after strong opposition from the medical professionals in Milwaukee. However, it is indicative of the later struggles between insurance programs and hospitals and a precursor to the eventual Preferred Provider Organization agreements that began in the late 1970s and early 1980s.

CHAPTER 3 DISPENSARY CARE AND MOUNT SINAI HOSPITAL

This chapter discusses the creation of the Dispensary at Mount Sinai Hospital, in order to analyze the importance of the Jewish community in supporting the hospital. The Jewish contributions to the Mount Sinai Dispensary, opened in 1925 and renovated in 1935, were integral to the treatment of the poor in Milwaukee. Funds from the community and volunteer hours from the members of the Ladies Auxiliary sustained operations for medical services. Students at the Mount Sinai Nursing School, opened in 1924, also staffed the Dispensary, as did medical interns and residents. Medical care, child care, follow up care, inpatient and outpatient services were all part of the care network at Mount Sinai. Thirty-two agencies cooperated with the Dispensary during 1937 alone, including the Catholic Welfare Bureau, the St. Benedict the Moor Mission as well as Jewish Social Services Association, Family Welfare Association, Milwaukee Children's Hospital, and the Milwaukee Health Department.[1] This chapter includes a brief history of two other Milwaukee hospitals, The Passavant and Deaconess. For this research, Passavant Hospital will be called The Passavant, in order to distinguish it from William Passavant, its founder. The history of these two hospitals are relevant. The merger between them in 1982 provided an example of the impact of changes in funding for health care for the poor on private hospitals. That merger created Good Samaritan Medical Center, the facility that, after the 1987 merger with Mount Sinai, created Sinai Samaritan Medical Center.

In the 1920s, changes at American hospitals occurred rapidly. The increase in

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[1] Mount Sinai Hospital Committee Report on Free Work, page 6, Box 50, Folder 15, Sinai Samaritan Medical Center Records, Milwaukee Mss Collection 108, University of Wisconsin-Milwaukee Libraries, Archives Department (hereafter cited as Sinai Samaritan Collection).

medical training programs and the creation of research programs and a decrease in the number of dispensaries at urban hospital changed medical services for the poor. Dispensaries, the precursor to outpatient clinics, suffered in the wake of the modernization of hospitals. Dispensaries provided medical services for the poor in many American hospitals. Many of them began to close in the wake of the creation of medical specialties in the 1920s in order to make room for expanded education programs and medical specialty departments.[2] Mount Sinai Hospital is unique in that it opened and expanded the Dispensary during that same time.

Nursing schools opened at many urban hospitals during this time. The students staffed the hospital affiliated with their program as part of their education. Mount Sinai Hospital opened a nursing school in 1924. Historian Rosemary Stevens remarked that hospitals treated dispensaries as teaching laboratories for doctors and nurses to study the progression of disease and gain clinical knowledge, not to aid the poor. When hospitals expanded to accommodate their educational programs, dispensaries closed.[3] Historian Michael Katz also remarked that the growth of modern hospitals ended Dispensary care for residents in cities like New York and Boston because doctors preferred clinical experience in hospitals.[4] The new departments created medical specialties, which increased the occupational prestige of the doctors. The general hospital model and the dispensaries gave way to a modern approach to medicine based on specialized expertise. Historian Charles Rosenberg noted that dispensaries became "decreasingly central as hospitals increased in

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[2] Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century* (New York: Basic Books 1989), 58.

[3] Stevens, *In Sickness and in Wealth,* 58.

[4] Michael B. Katz, *In the Shadow of the Poor House: A Social History of Welfare in America* (New York: Basic Books, 1986), 138.

number and opportunities for clinical training expanded."[5] It was difficult for modern

hospitals to create specialty departments and continue to treat poor patients in dispensaries.

Medical students and doctors sought appointments in the new hospitals for their medical

experience and education and hospital closed their dispensaries to provide space for their

growing programs.

However, Rosenberg noted that these changes were not universally embraced. Some

hospital officials and doctors resisted the drive toward specialization of hospital care.

Leaders at New York City's Mount Sinai in particular believed that specialized medical

services dehumanized patients, transforming them until they were "not a person but a

configuration of organs and potential syndromes."[6] However, Mount Sinai New York

decreased Dispensary services and expanded medical education facilities to meet the

increased demand for doctors.[7]

Mount Sinai Hospital Milwaukee did not create a Dispensary for indigent patients as

part of a teaching laboratory. It established a Dispensary for the explicit purpose of serving

the poor. Milwaukee's Mount Sinai combined the missions of teaching and caring for the

poor at the Dispensary, something many urban hospitals did not consider for their

institutions.[8] The need for staff at the Dispensary meant professional opportunities for the

younger Jewish doctors in Milwaukee that were not available in larger cities. For example,

young doctors encountered long waiting lists at New York's Mount Sinai Hospital for staff

positions due to the number of doctors in need of internships.[9] At Chicago's Michael Reese

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[5] Charles E. Rosenberg, *The Care of Strangers: The Rise of America's Hospital System* (New York: Basic Books, 1987), 318.

[6] Rosenberg, *The Care of Strangers*, 314.

[7] Arthur H. Aufses, Jr., and Barbara J. Niss, *This House of Noble Deeds: The Mount Sinai Hospital, 1852-2002* (New York: New York Press, 2002), 6.

[8] Stevens, *In Sickness and in Wealth,* 58.

[9] Aufses and Niss, *This House of Noble Deeds*, 6. Young doctors also had to complete a famously difficult entrance

Hospital, a Dispensary opened in 1893. The staff of seventeen doctors treated fourteen

hundred patients a month during the first year.[10] The patients paid what they could, and

those without the means were treated at no cost. In 1899, the Dispensary expanded.

However, in the early twentieth century, Michael Reese leaders decided to expand medical

research and specialty departments at the hospital. They established the Medical Research

Institute in 1929 mainly because leaders believed medical research programs led to

increased funds.[11] Hospital leaders believed that "the new hospital building, which opened

in 1907, exemplified a number of new trends in architecture as well as in charity and

medicine."[12]

In Milwaukee, doctors, student nurses and Auxiliary members staffed the Dispensary.

The nursing school provided student labor for the wards, and the indigent population

provided the clientele. The financial commitments from the collective Jewish community

funded the new Dispensary and the main hospital.[13]

The 1923 *Report on Free Care* articulated Mount Sinai's mission to the people of

Milwaukee by way of the new Dispensary. The Committee submitted the report to Mount

Sinai's Board on October 14, 1923 "for the purpose of considering free work to the hospital

and recommending ways and means of increasing the amount thereof."[14] The hospital's

nonsectarian mission grounded the report. The report stated that "Mount Sinai Hospital,

pursuant to proper authority has sought to extend its service not only to those whose means

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exam in order to apply to the hospital.

[10] Sarah Gordon, ed., *All Our Lives: A Centennial History of Michael Reese Hospital and Medical Center* (Chicago: Michael Reese Hospital and Medical Center, 1981), 50.

[11] Gordon, *All Our Lives*, 61.

[12] Gordon, *All Our Lives*, 61.

[13] Dr. Harry Kanin, Interview by author, Milwaukee, WI, July 14, 2011.

[14] Mount Sinai Hospital Committee Report on Free Work, Page 1, Box 50, Folder 15, Sinai Samaritan Collection.

permit them to pay therefore, but also to the indigent, and those of limited means."[15] It recommended expanding and solidifying Mount Sinai's role in charity care especially to "those who otherwise might have been deprived of proper medical or hospital attention."[16] It urged the Board to reaffirm the hospital's original mission: to treat, nurse, and care for Milwaukee's sick, disabled, and infirm persons, regardless of nationality or creed. "Mount Sinai has won the appreciation of the people of this city," the report stated, "irrespective of religious belief or racial distinction. While full pay cases for all, irrespective of their religious faith, should be continued, such services should be subordinated to the greater service that can be rendered toward the deserving, without expense to them."[17]

By 1938, Mount Sinai developed a comprehensive and community-wide health care system at the Dispensary. The nonsectarian nature of the hospital provided the Dispensary with funds from places like Catholic charities, the Milwaukee County Fund, and other private charity concerns, in recognition of the services Mount Sinai provided to non-Jewish indigents. The Dispensary also had a new Occupational Therapy Department. This department was funded, organized, and staffed by the Ladies Auxiliary of Mount Sinai. The Auxiliary volunteers assisted patients in exercises in order to strengthen injured limbs and to increase fine motor skills after injury or stroke.[18]

The Dispensary was a success, but the efforts to raise money for operations revealed a decrease in support for fund raising efforts within the Jewish community in Milwaukee. During the 1935 fund raising drive, Felix Lowy called upon the younger generation of the Jewish community to take their place in supporting the Jewish institutions of Milwaukee

[15] Mount Sinai Hospital Committee Report on Free Work, page 2, Box 50, Folder 15, Sinai Samaritan Collection.
[16] Mount Sinai Hospital Committee Report on Free Work, page 2, Box 50, Folder 15, Sinai Samaritan Collection
[17] Mount Sinai Hospital Committee Report on Free Work, page 6, Box 50, Folder 15, Sinai Samaritan Collection.
[18] Mount Sinai Hospital Committee Report on Free Work, page 1, Box 50, Folder 15, Sinai Samaritan Collection

to meet the fundraising goal. The drive fell short. The failure to reach a funding goal surprised and concerned members of the Mount Sinai Hospital Board. They were growing older. The younger members of the Jewish community had not joined them in supporting the hospital. The ramifications of the decreased support from the community are key points in future chapters.

MOUNT SINAI, FREE WORK, AND THE DISPENSARY OF 1924

Mount Sinai opened the first of two large dispensaries in 1924. A small Dispensary existed prior to the creation of Mount Sinai Hospital, but closed after 1903.[19] The 1924 facility came about in part because of the recommendations found in the 1923 *Report on Free Care.* The report noted the need for heath care for the indigent Jewish population. It elaborated on the specific needs of the large Jewish population in Milwaukee, stating

> The rapid growth of the Jewish population of the city in recent years has, however, given rise to the need of extending the free work among our people, as well as those of other faiths to the fullest extent of our financial means, and hospital facilities. This hospital should serve as a center for the promulgation of health measures. It should be a health center, whither may come, not only those requiring strictly hospital attention, but also for those whose needs can be served in outpatient or similar departments.[20]

Despite the relatively low number of Jewish patients at Mount Sinai, the report specifically identified the commitment to Jewish patients as an important reason to build the new Dispensary. The lack of Dispensary services in Milwaukee included in the above quote served as another reason to build a Dispensary at Mount Sinai.

Another crucial recommendation of the committee was that Mount Sinai should

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[19] Louis J. Swichkow and Lloyd P. Gartner, *The History of the Jews of Milwaukee* (Philadelphia, PA: The Jewish Publication Society of America, 1963), 201.
[20] Mount Sinai Hospital Committee Report on Free Work, page 7, Box 50, Folder 15, Sinai Samaritan Collection

develop as a health center for the city of Milwaukee at Mount Sinai Dispensary. It stated the Board should "amplify its present policy toward free and partial pay cases, social service activities, and the like, by the establishment and maintenance of a free Dispensary, or outpatient department, and such clinics as may be recommended by the Medical Administration Committee and the Medical staff."[21] The committee wanted to create a Dispensary as part of a social service in order to provide comprehensive assistance to patients. The reported noted that,

> From time to time, the question has arisen in the minds of individual members of the Board whether the hospital has done all that should or can be done in and by an institution of this kind, not only in strict hospitalization work for the indigent and those of limited means, but also in extending our social service department so as to include preventive work, particularly with respect to the Jewish people.[22]

This was important in light of changes at other Jewish relief organization in Milwaukee. In 1921, the Hebrew Relief Association became Jewish Social Services Association(JSSA). This change reflected a reorganization of the Association. The new organization directed its resources to social work instead of emergency relief services. JSSA established programs to assist families with a number of social services, including referring patients to Mount Sinai for medical care. The JSSA served the Dispensary through the referral of patients and arranging home health services and other assistance after the patient was discharged.[23]

The committee suggested the transfer of the small clinic operations from the Jewish Social Service Association clinic to Mount Sinai and enlarging them meet the needs of the poor of Milwaukee.

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[21] Mount Sinai Hospital Committee Report on Free Work, Page 1, Box 50, Folder 15, Sinai Samaritan Collection.
[22] Mount Sinai Hospital Committee Report on Free Work, page 2, Box 50, Folder 15, Sinai Samaritan Collection.
[23] Newspaper Clipping, "New Dispensary Dedicated," *Wisconsin Jewish Chronicle*, May 6, 1938, Box 1 Folder 14, Mount Sinai Collection, Jewish Museum Milwaukee Archives (hereafter cited as JMM Archives).

The report stated,

> Your committee believes that the high standard and ideals of the medical profession will impel members of that profession to give of their time and professional skill toward the successful maintenance of these clinics, and the out-patient departments. We believe it to be the rule that the important and effective medical clinics which are maintained in hospitals the world over are under the guidance and supervision of members of the medical profession who have by their industry, skill and devotion to higher professional standards, attained fame and renown in the profession, and in the communities in which they live; and so it will undoubtedly come to pass that these clinics in Mount Sinai will not only reflect credit upon the hospital and its sponsors, but upon those physicians, surgeons, and dentists who will render service in connection therewith. It must be apparent to all that the innovations contained in this report will assure more free work in the hospital. The name Mount Sinai will stand for an institution absolutely unique among hospitals in this city and state. In short time the poor, the needy, and the distressed will look upon this institution as an agency for their relief. The hospital then will not only serve as a curative agency, but also as a center for the prevention of disease, and thus be a means toward upholding sanitation and health in the community.[24]

The centralization of charity health care at Mount Sinai facilitated the transition of the Hebrew Relief Association into a social service institution. The organization changed its name to the Jewish Social Service Association, and altered their mission statement to include social services for families and children.[25] The report suggested that working with JSSA, Mount Sinai could "Develop a heath care center. One that should amplify its present policy toward free and partial pay cases, social service activities, and the like by the establishment and maintenance of a free Dispensary."[26] The JSSA became one of Milwaukee's most comprehensive social service institutions. The Mount Sinai Dispensary represented one of the most centrally located medical institutions in Milwaukee. The JSSA and Mount Sinai worked together to provide medical and social services in Milwaukee.

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[24] Mount Sinai Hospital Committee Report on Free Work, Page 1, Box 50, Folder 15, Sinai Samaritan Collection.
[25] Swichkow and Gartner, *The History of the Jews of Milwaukee*, 234.
[26] Mount Sinai Hospital Committee Report on Free Work, Page 9, Box 50, Folder 15, Sinai Samaritan Collection.

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The transfer of medical services to Mount Sinai from the Jewish Social Service Association reflected the change in mission and focus at the JSSA, in that it no longer provided medical services. The JSSA referred patients to the Dispensary.[27] The Free Dispensary opened in 1924. Abraham Slimmer donated fifty thousand dollars, but the Milwaukee community raised an additional eighty thousand dollars, for a total of one hundred thirty thousand dollars.[28]

SERVICES AT MOUNT SINAI DISPENSARY: 1924

In the 1920s, medical advances spurred the creation of more hospital in cities around the United States as well as expansions at existing facilities. The demand for clinical experience for medical students in hospitals increased. In 1924, dispensaries at many urban hospitals competed for resources in the wake of the modernization of hospitals. The medical professionals, doctors, supported the creation of medical specialties and dispensaries closed to accommodate expanded medical programs.[29] Rosemary Stevens argued that the medical profession created and maintained an identity based on the increasing prestige of the doctors in the 1920s.[30] Hospitals closed dispensaries and built operating rooms, laboratories, and nursing schools. Many, including Mount Sinai New York, established themselves in their communities as elite institutions of medical learning.[31]

Mount Sinai differed from most urban hospitals by building and expanding its Dispensary when most hospitals closed them. Dispensary patients provided medical

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[27] Mount Sinai Hospital Committee Report on Free Work, Page 11, Box 50, Folder 15, Sinai Samaritan Collection.
[28] Newspaper Clipping, "New Dispensary Dedicated," *Wisconsin Jewish Chronicle*, May 6, 1938, Box 1, Folder 14, Mount Sinai Collection, JMM Archives.
[29] Rosenberg, *The Care of Strangers,* 317.
[30] Stevens, *In Sickness and in Wealth,* 59.
[31] Aufses. Niss, *This House of Noble Deeds*, 6.

education opportunities for doctors and nurses in Milwaukee. The addition of Dispensary services and outpatient programs established Mount Sinai as a community hospital for Milwaukee and much "like clinics which are maintained as well as a teaching institution for staff."[32] The Dispensary treated patients based on financial need. However, in addition to the eligibility investigation, the staff evaluated the medical needs of patients. That is, Dispensary staff treated patients after confirming they were worthy of help and the care they sought was appropriate. Patients with minor illnesses were more likely to be denied free care, in favor of those with more serious illnesses. Dispensary leaders prioritized the care of those most seriously ill, and sent less expensive, less serious cases to doctors for care. The rationale was that those with minor medical problems were less likely to suffer hardship from the cost of their care. The Dispensary was more likely to treat an expensive serious medical problem to keep the patient from increased financial hardship. For example, the Dispensary often sent paying patients in need of non-emergency care to a doctor in favor of an application from a partial pay patient or free care patient. The chronic or more serious condition required more care and follow up services. The Dispensary was much more likely to care for an unstable diabetic or surgically repair a hernia than they were to care for a less expensive condition. This policy provided the staff with learning opportunities similar to those found at medical schools in other city hospitals.[33]

The committee justified this policy in the report, stating,

> The committee submits these facts so that the Board may have in mind that these many men and women are devoting time and effort toward the proper maintenance of the hospital and your committee believes that it reflects the thought and feeling of each of these men and women in expressing the statement

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[32] Newspaper clipping, "New Dispensary Dedicated," *Wisconsin Jewish Chronicle*, May 6, 1938, Folder 14, Mount Sinai Collection, JMM Archives.

[33] Newspaper clipping, "New Dispensary Dedicated," *Wisconsin Jewish Chronicle*, May 6, 1938, Folder 14, Mount Sinai Collection, JMM Archives.

that these men and women are contributing this service in a spirit of philanthropy and benevolence, rather than from a desire to provide hospitalization for patients who have sufficient means to pay therefor.[34]

The hospital with a Dispensary model at Mount Sinai served as an example of how health care institutions utilized health care resources in the years before government and private insurance plans. Patients with serious conditions and in need of more expensive medical care received priority for assistance. Those who had minor issues went elsewhere with the understanding that treating their condition was not likely to cause undue financial hardship. This sometimes meant the Dispensary treated fewer patients, but the ones who received care were among the sickest and poorest. After the hospital took over medical operations from The Hebrew Relief Association, patients went to the Dispensary, the first point of contact for patients. Dispensary staff evaluated each case and referred patients appropriately.[35]

The Dispensary became part of one of Milwaukee's more comprehensive social and health care service institutions. The Mount Sinai Dispensary treated the patients Milwaukee County could not admit to their hospital. It provided services for patients designed to manage health conditions to the full extent of medical technology of the day.[36] Unlike patients at other dispensaries, patients at Mount Sinai benefited from the practices established by the hospital board in 1923. Hospital staff trained at Mount Sinai's Dispensary from 1924 through the 1960s. The Dispensary, later the outpatient clinic, was closed after the Medicaid Program was started. According to Harry Kanin, "The hospital

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[34] Mount Sinai Hospital Committee Report on Free Work, Page 8, Box 50, Folder 15, Sinai Samaritan Collection.
[35] Newspaper clipping, "New Dispensary Dedicated," *Wisconsin Jewish Chronicle*, May 6, 1938, Box 1, Folder 14, Mount Sinai Collection, JMM Archives.
[36] Newspaper clipping, "New Dispensary Dedicated," *Wisconsin Jewish Chronicle*, May 6, 1938, Box 1, Folder 14, Mount Sinai Collection, JMM Archives.

didn't think it was needed anymore."[37] There were changes coming. A global economic depression increased the number of indigent patients in need of assistance. Hospitals like Mount Sinai faced rising costs, more patients, and less money by way of both donations and payments for care. The Dispensary proved to be very successful at a time when other hospitals struggled to remain open.

HOSPITALS AND THE DEPRESSION

The Depression of 1929 caused a great deal of financial hardship for many city hospitals. The efforts to establish hospitals as elite places of healing resulted in a quandary for many hospitals. The number of indigent patients increased, and so did the cost of health care. Rosemary Stevens noted that "For patients and their doctors the lessons of the 1920s had been well learned. Because hospitals were now recognized as providers of an essential service, it was difficult to cut this service to the bone."[38] The success of the movement to create modern urban hospitals did cause a problem of increased demand for services and increased indigent patients. Stevens remarked, "Hospitals were prisoners of increased demand— both from doctors seeking to hospitalize patients and from a growing group of patients who could not pay."[39]

A number of hospitals, Mount Sinai Milwaukee included, attempted to raise funds by offering prospective patients the opportunity to purchase hospital days through memberships which offered the benefit of a fixed number of hospital days per year in exchange for a fee and a subscription payment. In 1930, according to Mount Sinai Superintendent L.C. Austin, hospitals in Milwaukee were losing an estimated three to four

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[37] Dr. Harry Kanin, Interview by author, Milwaukee, Wisconsin, July 14, 2011.
[38] Stevens, *In Sickness and in Wealth,* 142.
[39] Stevens, *In Sickness and in Wealth,* 142.

dollars a day. Mount Sinai Hospital reported a deficit that year because It treated slightly fewer paying patients, while the proportion of patients unable to pay rose considerably. An emergency fund raising drive covered the debt, but Austin explored other options for raising money.[40] Leaders at Mount Sinai reasoned that the Depression led to an increase in the need for charity care and also made it difficult, if not impossible, for donors to maintain the level of funding for the hospital received in the 1920s.[41]

In 1935, Superintendent Austin announced a plan to sell prepaid hospital services. Austin attempted to fund the hospital by selling what he called "hospital memberships." The plan seemed simple enough and Mount Sinai's leaders hoped this would wipe out deficit caused by the increased care of indigent patients during the Depression. The idea was based on a program already in place at Mount Sinai Milwaukee. Starting in 1928, expectant mothers could pay five dollars a month throughout their pregnancies. By the time the baby was delivered, the bill was already paid.[42] Hospital leaders believed the same principle could be applied to all prospective patients. Under the new plan, clients purchased health care services at Mount Sinai including a set number of hospital days, room and board, operating room services, laboratory and x-ray work, and some medications.[43] For ten dollars, the member purchased 21 days of hospitalization for the year. Austin believed that the plan would ease the burden of charity care debt on the hospital.[44] The plan could be purchased in advance for use throughout the year.

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[40] Newspaper clipping, "Average Milwaukee Hospital Loses $3-$4 per Day per Patient," *Milwaukee Sentinel*, September 16, 1930, Box 1, Folder 4, Mount Sinai Collection, JMM Archives.
[41] Newspaper clipping, "Average Milwaukee Hospital Loses $3-$4 per Day per Patient," *Milwaukee Sentinel*, September 16, 1930, Box 1, Folder 4, Mount Sinai Collection, JMM Archives.
[42] Earl R. Thayer, *Seeking to Serve: A History of the Medical Society of Milwaukee County, 1846-1996* (Milwaukee, WI: Medical Society of Milwaukee County, 1996), 57-58.
[43] Thayer, *Seeking to Serve*, 58.
[44] Newspaper clipping, "Average Milwaukee Hospital Loses $3-$4 per Day per Patient," *Milwaukee Sentinel*, September 16, 1930, Folder 4, Mount Sinai Collection, JMM Archives.

The costs of indigent care were very high. In 1931, the hospital had lowered prices because of the Depression. The hospital lost $21,000 in 1932. Austin explained that private hospitals like Mount Sinai were in danger of closing. "Sixty percent of all hospital beds in the United States are in independent and public hospitals. The public hospitals are today taxed to capacity and would not be able to care for the patients who would be dumped on them if the private hospitals were forced to close."[45] In 1933, Mount Sinai leaders needed $35,000 for direct patient care. They hoped membership sales would raise at least this sum.

However, The Medical Society of Milwaukee County issued a statement saying that a program like this threatened other hospitals and the livelihood and authority of doctors. This Society was relatively new. Starting in 1902, members of the Society tried to unify Milwaukee County doctors.[46] There was serious concern on the part of the doctors about the state of available medical education in Milwaukee. At this time, charges that The Milwaukee Medical College conferred degrees to improperly trained doctors.[47] They established a committee in 1913 to study the economic conditions for doctors and found that in relation to other professions, doctors earned significantly less money. The Society drafted a plan designed to increase income for doctors in order to entice doctors to join the Society. The plan included investigations of all patients to ensure all who could pay for care did so. In addition, it suggested that younger doctors assume the majority of the responsibility for indigent care, leaving older and well established doctors "unburdened"

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[45] Newspaper clipping, "All Sectarian Sponsorship Effort," *Wisconsin Jewish Chronicle*, May 3, 1935, Box 1, Folder 12, Mount Sinai Collection, JMM Archives.

[46] Thayer, *Seeking to Serve*, 42.

[47] Norman H. Engbring, *An Anchor for the Future: A History of the Medical College of Wisconsin, 1893-1990* (Milwaukee, WI: Medical College of Wisconsin, 1991), 8.

by such work.[48] There was another reason for opposition. The Society attempted to create an insurance system in the years before WWI. The war delayed that initiative.[49] The Mount Sinai plan threatened plans to renew their own insurance program.

At the time of the Mount Sinai Membership plan, the Society advocated for the "business, socioeconomic, and political work' on the doctor's behalf.[50] The Mount Sinai plan represented a threat to Society members in that the plan required patients to use Mount Sinai. The Wisconsin State Medical Society remarked that "The plan would develop a system of medical practise [sic] in which the patient would be dealing with the hospital, so that the selection of physician might become a matter of choice by the hospital rather than the patient. It is our belief that a plan as proposed will result in a much greater demands upon the hospital than the income derived through the plan will warrant, and the service will be seriously cheapened."[51] Doctors rejected the notion that patients could form relationships with hospitals directly when their choice of a doctor was out of their hands. Austin responded that fear of change was not a good enough reason for Mount Sinai to end its plan. He declared that medical societies and doctors were frightened by innovation.[52] Doctors considered the choice of hospitals part of the medical care under their authority. Membership plans, like the one at Mount Sinai, threatened that authority.[53] The pressure from the Society ended the membership drive at Mount Sinai. The two hundred people who bought memberships received their hospital benefits.[54]

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[48] Thayer, *Seeking to Serve*, 46-47.
[49] Thayer, *Seeking to Serve*, 49.
[50] Thayer, *Seeking to Serve*, 53.
[51] Newspaper clipping, "All Sectarian Sponsorship Effort," *Wisconsin Jewish Chronicle*, May 3, 1935, Box 1, Folder 12, Mount Sinai Collection, JMM Archives.
[52] Newspaper clipping, "Doctors Remonstrate with Mount Sinai on New Pay System," *Milwaukee Journal*, May 24, 1933, Box 1, Folder 7, Mount Sinai Collection, JMM Archives.
[53] Stevens, *In Sickness and in Wealth,* 142.
[54] Newspaper clipping, "Doctors Remonstrate with Mount Sinai on New Pay System," *Milwaukee Journal*, May 24, 1933, Box 1, Folder 7, Mount Sinai Collection, JMM Archives.

Austin also tried to address what he called "the common charge that hospital expenses are too high for the purse of the average citizen" by relating a story about an appendicitis case. The patient chose a hospital and had hired a nurse and stayed 18 days for a cost of $334. The man complained that the total was too much, and he blamed it solely on the hospital's "terrible prices."[55] Austin explained that the line item bill showed the of the $334, $150 was paid to the doctor for his visits to the patient at Mount Sinai, $100 for the operation, $50 for visits, $49 for the special nurse who was paid about 60 cents an hour for her work. The largest hospital cost was $90 for a room for 18 days. The nurse bought her meals at the hospital, which translated to $6.25 in revenue to the hospital. After expenses, the hospital lost $3 on the operating room; it broke even on the anesthetic charge, and lost on the rest of the bill at the rate of $3.60 a day.[56]

After ending the membership initiative, the Board of Mount Sinai sought funds from a familiar source, the Milwaukee Jewish community. Mount Sinai still faced a serious financial situation and the organized opposition had made the membership drive unsuccessful. Hospital leaders organized a new charity drive. The drive was decisively more successful than the membership plan. It expanded the existing Dispensary at a time when many hospitals closed because of the Depression.

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[55] Newspaper clipping, "Doctors Remonstrate with Mount Sinai on New Pay System," *Milwaukee Journal*, May 24, 1933, Box 1, Folder 7, Mount Sinai Collection, JMM Archives.

[56] Newspaper clipping, "Doctors Remonstrate with Mount Sinai on New Pay System," Box 1, Folder 7, *Milwaukee Journal*, May 24, 1933, Mount Sinai Collection, JMM Archives. The total of the figures listed is actually $439.00.

1938 MOUNT SINAI DISPENSARY EXPANSION

The Great Depression caused much financial hardship for individuals and organizations. The Jewish community contributed money to support existing operations and fund the expansion. However, this particular drive required a great deal of support from the Gentile population in Milwaukee. The combined efforts of Jewish and Gentile community members raised the necessary funds. The Mount Sinai Dispensary and hospital survived; despite the country's economic crisis, the benefactors of Mount Sinai continued their support. In fact, in 1938, the Dispensary expanded its services to include new services like Occupational Therapy and expanded surgery facilities, transitioning into an outpatient department.[57] The growth of medical specialization at other hospital led to the creation of new departments at the Dispensary. The Jewish Social Service Association and Mount Sinai's Ladies Auxiliary provided crucial resources to the Dispensary and the means to expand operations.

SOLICITING COMMUNITY SUPPORT FOR COMMUNITY CARE

The fund raising drive of 1935 revealed weakened support from the Milwaukee Jewish population. Donations and volunteer numbers decreased. By 1935, the leaders of Mount Sinai realized that the Dispensary was in need of expansion and improvement. The Depression increased the number of indigent patients who came in search of medical help. The Hospital Board, in conjunction with the Ladies Auxiliary, started another fund raising drive to expand the facility. The Board decided the appeal for funds would be made to the Jewish and non-Jewish communities, in order to raise $75,000. Max Freschl, former

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[57] Newspaper Clipping, "Fund Raising Drive Begins," *Wisconsin Jewish Chronicle*, May 3, 1935, Box 1, Folder 14, Mount Sinai Collection, JMM Archives.

president of the Federated Jewish Charities, issued a statement to the Milwaukee Jewish community for their non-Jewish associates:

> A Message to Remember. When a patient enters Mount Sinai hospital for healing of any injury or sickness, there is only one concern of the hospital and that is to do the best that modern science and skill can do to heal or cure. . .In this regard Mount Sinai exemplifies the spirit of mercy, charity and humanity common to all religions. . .it is for this reason that Mount Sinai appeals to persons of all faiths to help carry it on, for Mount Sinai, though founded under Jewish auspices, is nonsectarian in service. This is the message you should carry to your friends who are not of the Jewish faith.[58]

They sent a different message to Milwaukee's Jewish community. Ed Osterman, Chairman of the Emergency Campaign of Mount Sinai Hospital wrote:

> A Message to the Jewish people of Milwaukee. Permit me to emphasis the fact that the forthcoming campaign is the only source through which may continue to function. The hospital is no longer a recipient of funds from the Federation, and is not affiliated with any other fund raising group. It is merely a matter of facts and figures that if the hospital does not obtain sufficient financial aid from the community to carry on its work, it cannot survive. I need not amplify that dire possibility. I am confident to the utmost degree that the Jewish people of Milwaukee will not permit Mount Sinai Hospital to even curtail any of its life saving and health preserving functions.[59]

In total, 700 workers joined the Drive, with women taking the lead. There were 27 Women's teams, each with 12-25 workers at the beginning of the Drive. The Men's Division was still in the process of organization at the start of the drive. The Drive included personal appeals for funds and an extensive publicity campaign. Volunteers mailed an eight-page pamphlet to over five thousand people. They distributed thousands

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[58] Newspaper Clipping, "Fund Raising Drive Begins," *Wisconsin Jewish Chronicle*, May 3, 1935, Box 1, Folder 14, Mount Sinai Collection, JMM Archives.
[59] Newspaper clipping, "Fund Raising Drive Begins," *Wisconsin Jewish Chronicle*, May 3, 1935, Box 1, Folder 14, Mount Sinai Collection, JMM Archives.

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of single page leaflets to employees at the larger industrial and commercial institutions of the city and placed several thousand large posters in stores and shops.[60]

The pledges came in slowly. The final amount raised, $54,000, was not enough; in order to raise the final $21,000, the Jewish leadership recruited past members of the Mount Sinai Board and spoke directly to the younger members of Milwaukee's Jewish community. Judge John C. Karel offered his support to the workers who had already brought in over fifty thousand dollars by telling them they were over half way there and urging them not to quit. He referenced Rabbi Caro and reminded the volunteers that he had helped the Rabbi secure the original Mount Sinai Hospital building.[61]

Felix Lowy, a member of the Fund Raising Committee stated he was happy to do his part, but made a strong plea for support from the younger members of Milwaukee's Jewish Community:

> I want to take this opportunity to call on the younger men and women to assume their rightful share of communal responsibility. It is high time that the many thousands of Jewish people in this city develop newer leaders to take the place of the very few veterans who are called upon year after year to assume the heavy burdens of conducting our institutions and also of raising the funds for their support. Mount Sinai should not be the concern of only a few men and women who are willing enough to devote their time and energy to it. The hospital is a Jewish responsibility for the entire community of Jews not just a few individuals. The hospital never was designed as paying business. Its function is to cure the sick, heal the injured, save human life and preserve the health of the community without regard to profits or even balancing its budget by selling its service. No Jewish hospital in the world worthy of the name is operated on a strictly paying basis.[62]

The appeals raised more money but at the end of the drive the Hospital had collected only

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[60] Newspaper clipping, "Fund Raising Drive Begins," *Wisconsin Jewish Chronicle*, May 3, 1935, Box 1, Folder 14, Mount Sinai Collection, JMM Archives.

[61] Newspaper clipping, "Fund Raising Drive Begins," *Wisconsin Jewish Chronicle*, May 3, 1935, Box 1, Folder 14, Mount Sinai Collection, JMM Archives.

[62] Newspaper clipping, "Fund Raising Drive Begins," *Wisconsin Jewish Chronicle*, May 3, 1935, Box 1, Folder 14, Mount Sinai Collection, JMM Archives.

sixty thousand dollars for the hospital and Dispensary.[63] The Board drew up plans to expand the facility despite the fact that the goal of $75,000 was not reached and opened the expanded Dispensary in 1938.

DISPENSARY SERVICES, STAFF AND PATIENTS

The dedication of the new facility received a great deal of media attention in Milwaukee. Hospital leaders supplied a great deal of information about the facility and held a large ceremony to mark the occasion. On May 6, 1938, the *Wisconsin Jewish Chronicle* published several articles about the dedication of the Dispensary at Mount Sinai. These articles reported the services now available at the facility, and the fund raising efforts. Articles about the kind of care the Dispensary provided its patients appeared as examples of the success of the new facility. These articles reveal the cooperation between the Dispensary, Mount Sinai Hospital, and the social service agencies in Milwaukee in providing comprehensive care for patients.[64] The articles included stories about the patients and their treatment, Jewish and Gentile. However, those stories do not include direct quotes from the patients themselves and appear to be written by Dispensary staff, in order to advertise their services.

One story was about "Mrs. Rose Blank" who now needed an operation after years of chronic illness and putting off care for other bills and necessities. Her husband was laid off and her acute gall stone "troubles" were at a peak. The article also noted she was "A lady 'of the old school,'" and "adhered to the ancient ritual practices" and "observed the dietary laws." The idea of going to a public hospital was "revolting, clean enough in

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[63] Newspaper clipping, "Fund Raising Drive Ends," *Wisconsin Jewish Chronicle*, June 4, 1937, Box 1, Folder 14, Mount Sinai Collection, JMM Archives.

[64] Newspaper clipping, "Fund Raising Drive Begins," *Wisconsin Jewish Chronicle*, May 3, 1935, Box 1, Folder 14, Mount Sinai Collection, JMM Archives.

hygiene" but what of "intangibles like spiritual cleanliness and the proper way of life" for a Jewish woman, in keeping with God's laws? The inclusion of God's laws in the article is difficult to explain. The nonsectarian tradition of Mount Sinai remained paramount, but many of the accounts of patient experiences read as testimonials rather than assessments from the actual patients. They are written in the third person, and do not include many quotes directly attributed to the patients. The article reported that at Mount Sinai's Dispensary, she finds the care she needs; it is the only place to go. There she is among "friends." If in her pain she "should suddenly cry out in *mamanloschen*" [the mother tongue] she would not be looked at askance, "like a stranger in a strange place."[65] The article described Mount Sinai thus, "This is her hospital. At Mount Sinai, the people here know what she meant by 'spiritual cleanliness.' Rose felt ownership of the hospital for hadn't she, during the 'good years' contributed according to her modest means to its regular campaigns?"[66] The staff at Mount Sinai could also understand that "rooted in her east European ancestry was a fear of officialdom, and despite her confidence in the hospital and its personnel, she feared the ordeal of questioning."[67] This was why her first contact with the hospital is through a social worker from the JSSA at the Dispensary. She told the social worker of her trouble and gave a financial history about ability to pay along with her medical information; the question was not whether she should receive care but whether she is in a position to get the same care privately at her own expense. Because of her more serious illness, Rose was accepted as a patient.[68] She was treated

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[65] Newspaper clipping, "New Dispensary Dedicated," *Wisconsin Jewish Chronicle*, May 6, 1938, Box 1, Folder 14, Mount Sinai Collection, JMM Archives.
[66] Newspaper clipping, "New Dispensary Dedicated," *Wisconsin Jewish Chronicle*, May 6, 1938, Box 1, Folder 14, Mount Sinai Collection, JMM Archives.
[67] Newspaper clipping, "New Dispensary Dedicated," *Wisconsin Jewish Chronicle*, May 6, 1938, Box 1, Folder 14, Mount Sinai Collection, JMM Archives.
[68] Newspaper clipping, "New Dispensary Dedicated," *Wisconsin Jewish Chronicle*, May 6, 1938, Box 1, Folder 14,

with "human kindness" and her tests revealed that no surgery needed; instead, primary care with follow up was prescribed, along with a diet which relieved her symptoms. After a time, Rose returned for follow up care and was found to be "in comparative good health and free from pain."[69]

Gentile patients were also included in the patient articles. Mrs. Santo Controfelli–whose name signaled she was Italian–was "troubled with bad eyesight" and applied for glasses at the Dispensary. After testing she was given a diabetes diagnosis, which required an eight day stay to start insulin and dietary therapy.[70] However, she had eight children; her husband works and she lacked other childcare. The Dispensary's Social Service Director called the family welfare association, which sent a housekeeper to assist her husband while she stayed in the hospital and received insulin therapy, and she "takes[it] faithfully and returns to the clinic for assessment." Her "dark Latin eyes flash with gratitude whenever the words Mount Sinai are mentioned."[71] The descriptions of patient treatment at Mount Sinai's Dispensary reveal a community cooperative health care system that assisted patients in a variety of ways. However, it is likely that the stories included in the article represented the assessment of Dispensary staff about the patient care experiences, not actual testimonials from them themselves.

The Mount Sinai Dispensary opened in Milwaukee despite a national trend that saw many hospitals closing their dispensaries. The *Report on Free Care of 1923* suggested that the hospital build it and partner with the newly formed JSSA to meet the medical

Mount Sinai Collection, JMM Archives.
[69] Newspaper clipping, "New Dispensary Dedicated," *Wisconsin Jewish Chronicle*, May 6, 1938, Box 1, Folder 14, Mount Sinai Collection, JMM Archives.
[70] Newspaper clipping, "New Dispensary Dedicated," *Wisconsin Jewish Chronicle*, May 6, 1938, Box 1, Folder 14, Mount Sinai Collection, JMM Archives.
[71] Newspaper clipping, "New Dispensary Dedicated," *Wisconsin Jewish Chronicle*, May 6, 1938, Box 1 Folder 14, Mount Sinai Collection, JMM Archives.

needs of the indigent in Milwaukee. The Dispensary expanded in 1938. By all accounts it was a successful and beneficial facility for the indigent patients and medical staff at Mount Sinai Hospital.

However, the efforts to raise money for operations revealed a concerning new reality to Jewish leaders and the Jewish community at large. For the first time in the history of the hospital, a fundraising drive failed to meet its goal. During the 1935 fund raising drive, Felix Lowy called upon the younger generation of the community to take their place in supporting the Jewish institutions of Milwaukee to meet the fund raising goal. The drive fell short. The Depression may have reduced the amount of money raised, but older Jewish leaders were concerned that younger members of the Jewish population were not as active as they had been. The failure to reach a funding goal surprised and concerned members of the Mount Sinai Hospital Board. They were growing older. The missed goal cast the future of hospital leadership and future funding in doubt. Members Milwaukee's Jewish population eventually moved to the suburbs. They established new institutions, or took existing ones with them to their new neighborhoods. Time and money for Jewish institutions in Milwaukee competed with new neighborhood programs. By the 1960s, Mount Sinai was one of a few Jewish institutions located in Milwaukee's downtown area. In 1967, Mount Sinai Hospital's leaders faced a critical question: relocate the hospital to the new suburban Jewish communities or remain downtown. Changes in government programs affected urban hospital like Mount Sinai, the cost of indigent care and the changes in funding became unstable. Hospital leaders decided to keep the hospital downtown, but twenty years later, the hospital merged in order to remain open. Changes in health care policy and the creation of government programs created new challenges for

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urban hospital like Mount Sinai.

Two other Milwaukee hospitals, The Passavant and Deaconess, faced these issues as well. They too had long histories of community service in Milwaukee. They also relied on the support of their religious communities for funds throughout their histories.

THE PASSAVANT

The original name of the first Lutheran hospital established in Milwaukee was the Milwaukee Hospital. It opened on August 3, 1863.[72] In 1966, the hospital was renamed Lutheran Hospital. It is referred to by three monikers in the literature; Milwaukee Hospital, Lutheran Hospital, and The Passavant.[73] I will consistently use the term The Passavant. It is a colloquial term used by the people who founded it.

The Passavant was one of the first hospitals established in Milwaukee. Reverend Johannes Muehlhauser, pastor of Grace German Church, was the first to recognize the need for a Protestant hospital. He was influential in establishing the Wisconsin Synod of the Lutheran Church and brought Lutheran ministers to Milwaukee to assist in the effort to create a Lutheran hospital.[74] One of the men he brought in was William Passavant, a minister and hospital administrator from Pennsylvania; as Victor Caro was to the creation of Mount Sinai Hospital, so William Passavant was to the creation of The Passavant. Passavant was raised in an affluent and religious German home. During his childhood he accompanied his mother on errands delivering relief supplies to the poor. As a young adult, he learned the German language and became interested in the German American

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[72] Ellen D. Langill, *A Tradition of Caring: The History of Milwaukee's Three Primary Service Hospitals－Lutheran, Mount Sinai, and Evangelical Deaconess* (Milwaukee, WI: Sinai-Samaritan Hospitals History Committee, 1999), 18.
[73] Langill, *Tradition of Caring*, 120.
[74] Langill, *Tradition of Caring*, 9.

community. Passavant published *The Lutheran Almanac* for the German American population as "a means of diffusing any information among our people" in order to stimulate interest in educational opportunities and benevolent organizations in the Lutheran religion.[75] He entered the ministry and sought to establish church-based institutions that aided the poor.[76] He had an established a national reputation of success in Pennsylvania when Reverend Muehlhauser brought him to Milwaukee.

After a few false starts, Passavant found a suitable location for the new hospital in 1863, at 21st Street between Kilbourn Avenue and State Street. During the negotiations, the seller of the property asked Passavant if he had the necessary one thousand dollars to seal the bargain. In response, Mr. Passavant stated his belief that the Lord would provide the money.[77] According to legend, an old acquaintance of Mr. Passavant dropped by during these negotiations and left an envelope containing the exact amount needed for the new hospital. It was later revealed that Mr. Passavant had signed the contract to purchase the hospital site without the thousand dollar deposit. Witnesses to the signing were shocked to realize that he had agreed to the terms of the loan with less than one dollar on his person.[78]

Pastor Muehlhauser relied on Passavant to engage support for the hospital from Milwaukee's Lutherans. Passavant believed that building the hospital required community cooperation for relief efforts for those in need. Much like Abraham Slimmer, he disapproved of sectarian ideology and encouraged community cooperation.[79] The Passavant opened on August 3, 1863. The Board of Visitors (later the Milwaukee Hospital

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[75] Langill, *Tradition of Caring*, 13.
[76] Langill, *Tradition of Caring*, 13.
[77] Langill, *Tradition of Caring*, 11.
[78] Langill, *Tradition of Caring*, 11.
[79] Langill, *Tradition of Caring*, 14.

Auxiliary) for the new hospital included some of Milwaukee's most prosperous men: John Plankinton, the owner of a large packing house, as well as German businessman August Uihlein, owner of the Joseph Schlitz Brewery, and Gustav Reuss, a banker at Marshall & Ilsely.[80] Although the hospital's religious foundation was Lutheran, community support was ecumenical. Historian Ellen Langill noted that "Within the first five years, the Protestant community of Milwaukee, including Lutherans, Presbyterians, Methodists, and Congregationalists, rallied around the Milwaukee [Passavant] Hospital, the only Protestant hospital west of Pittsburgh, and made its welfare its cause."[81]

Fund raising was crucial for hospitals. They maintained operations with the money from donations and volunteers staffing many urban hospitals. The Passavant was no different. The affluent board members of The Passavant gave generously, but the hospital was still faced with debt issues from the purchase of the property. The thousand dollar deposit from the unknown donor was not nearly enough to entirely fund the hospital. The hospital spent its money on patients and the initial cost of care for the community resulted in a deficit. Hospital's leaders did not have enough money to pay on the balance of the original lease. By November 1863, donors pledged six thousand dollars toward the debt of twelve thousand dollars owed for the new hospital. The *Milwaukee Sentinel* published an editorial in May of 1866 which argued that The Passavant was a worthy cause for charitable donations.[82] On October 31 of that same year, a successful benefit dinner was held, but the hospital was still struggling.[83]

The hospital eventually secured additional funds from the Wisconsin legislature for

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[80] Langill, *Tradition of Caring*, 21.
[81] Langill, *Tradition of Caring*, 17.
[82] Langill, *Tradition of Caring*, 29.
[83] Langill, *Tradition of Caring*, 29.

its charitable work. In the summer of 1867, The Passavant received an important patient base: The United States Secretary of the Interior designated The Passavant as the official marine hospital for Milwaukee's port. This crucial designation provided a steady stream of money for patient care. The continued fund raising efforts by the community enabled the hospital continue to treat Milwaukee residents and federal funds provided for the costs of care for sailors in port.[84] A renovation project was completed in 1894 on Kilbourn Avenue, the location where The Passavant Hospital remained for the rest of its years.[85]

EVANGELICAL DEACONESS

Deaconess was also a Lutheran hospital. However, it was staffed by subset of the work of the Lutheran Church. The term Deaconesses refers to young women who devoted themselves to charity work and dissemination of the religious missions of the Lutheran church. However, Deaconess Motherhouses also included members from other Protestant religions including Episcopalian, Methodists, and Evangelicals. It was "a special type of organized Christian service in the Lutheran Church."[86] The goal of the Deaconess mission was "educating and training Christian women for professional charity work."[87] The community that created it retained a great deal of its German identity long after other Lutheran churches embraced English language services and prayer books. The continued use of the German language set them apart from The Passavant community. For the

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[84] Langill, *Tradition of Caring*, 30.
[85] Newspaper Clipping "Two Hospitals Set to Tie the Knot," *Milwaukee Sentinel,* June 27, 1980, Box 2, Folder 61, Sinai Samaritan Collection. The Passavant building remained in use after the Good Samaritan/Mount Sinai merger but was closed after the Aurora/Sinai merger in 1992.
[86] Herman L. Fritschel, *A Story of 100 Years of Deaconess Service by the Institution of Protestant Deaconess Pennsylvania and the Lutheran Deaconess Motherhouse at Milwaukee, 1848-1949* (Milwaukee, WI: Lutheran Deaconess Motherhouse), 13.
[87] Fritschel, *A Story of 100 Years of Deaconess Service*, 13

purpose of this research, the use of the German language is most significant difference between the two hospitals. There were also differences in religious doctrine.[88] The Deaconess women adopted a way of life that represented "a paring of sorts between Lutheran and Catholic traditions." Deaconesses were akin to nuns, at a time where many members of the Protestant community "shunned all things Romish."[89] The Deaconesses embraced the "Inner Mission" brought over from Europe. The mission called for the increased attempts to spread the Christian gospel and expand charity work.[90] Deaconess Milwaukee was a smaller hospital that established a tradition of *Diakonia* (service) in Milwaukee distinctive from the larger Passavant Hospital.[91]

William Passavant brought the first Deaconesses to Milwaukee. He attended a conference in London on May 11, 1843. He was impressed by the presentation of representatives of the Deaconess Motherhouse in Kaiserswerth on the Rhine. Passavant visited the Motherhouse and before he left, recruited four Deaconesses for a Motherhouse in Pennsylvania.[92] Passavant visited Milwaukee in order to open another Motherhouse in Milwaukee. He brought Deaconesses and with Passavant's assistance and fundraising efforts, Deaconess Hospital opened in 1909. The new hospital was designed "to serve all as nonsectarian and as a refuge for the worthy sick."[93]

The Deaconesses included efforts to fulfill their inner mission at the hospital.[94] They continued many of the religious practices brought to America from Europe at a time where other Milwaukee Lutheran groups were ending such traditions. The Evangelical

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[88] For a more detailed account of Lutheran history in America, see Abdel R. Wentz, *A Basic History of Lutheranism in America* (Philadelphia: Fortress Press, 1964).

[89] Fritschel, *A Story of 100 Years of Deaconess Service*, 13-14.

[90] Fritschel, *A Story of 100 Years of Deaconess Service*, 14-15.

[91] Langill, *Tradition of Caring*, 44.

[92] Fritschel, *A Story of 100 Years of Deaconess Service*, 15.

[93] Fritschel, *A Story of 100 Years of Deaconess Service*, 19.

[94] Fritschel, *A Story of 100 Years of Deaconess Service*, 14-15.

Lutherans insisted on conducting services in German even as other Lutheran churches in Milwaukee adopted English. The Deaconess staff was comprised of missionary volunteers rather than paid workers, with stipends for room and board given in exchange for their work.[95] Evangelical Lutherans formed a Deaconess Service Society with the purpose of establishing a hospital built on the principles of *Diakonia*, benevolence, education, and poor relief.[96] On August 2, 1909, the Deaconess Service Society formalized a mission statement which included three goals: to establish a hospital for charitable care, establish a Deaconess Home to provide living quarters for the volunteers and nursing school students, and to create new charitable programs to meet the needs of the city.[97] The Evangelical Deaconess Hospital, consisting of a small pharmacy and only fifteen beds, opened on December 10, 1910 at 1807 Grand Avenue. By 1917, a new 50-bed structure was built next door at 1815 West Grand Avenue. The Society hoped to raise enough funds to build a Deaconess House and the nursing school.[98]

The Passavant and Deaconess received charitable support in Milwaukee, but there were differences between the two religious communities in both religious and cultural practices. Evangelical Lutherans at Deaconess retained much of their cultural norms from Germany, including the German language. World events highlighted the impact of that difference; when the United States entered World War I, the anti-German rhetoric decreased donations at Deaconess. All things German were suspicious after the United States entered the war; German newspapers closed and German language classes decreased dramatically.[99] The Passavant and Deaconess received charitable support in

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[95] Langill, *Tradition of Caring*, 44.
[96] Langill, *Tradition of Caring,* 44.
[97] Langill, *Tradition of Caring*, 56.
[98] Langill, *Tradition of Caring*, 45.
[99] Langill, *Tradition of Caring*, 46.

Milwaukee, but there were differences between the two religious communities in both religious and cultural practices. Evangelical Lutherans at Deaconess retained much of their cultural norms from Germany, including the German language. World events highlighted the impact of that difference; when the United States entered World War I, the anti-German rhetoric decreased donations at Deaconess. The Wisconsin Loyalty Legion held its first meeting in March 1918 with the self-appointed task of uncovering any opposition or disloyalty to the American war effort.[100] All things German were suspicious after the United States entered the war; German newspapers closed and German language classes decreased dramatically. Historian Bayrd Still estimated that during this time, at least 250 persons changed their German names in response to the backlash against German identity.[101] German organizations and businesses also altered their names at this time. The *Deutscher* Club became the Wisconsin and the German-English Academy became the Milwaukee Academy. The *Germania* Bank renamed itself the Commercial National Bank. In contrast, The Passavant was fifty-four years old by 1917 and had established strong ties with other religious groups because of William Passavant's commitment to a nonsectarian mission. The hospital administrators did not insist on the strict use of the German language in its literature and adopted many American cultural practices. Deaconess continued to insist on the use of German in much of their literature and supported German language education in public schools.[102] After the war ended, anti-German hostility faded and donations at Deaconess increased.[103]

In the decades following World War I, The Passavant and Deaconess expanded their

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[100] Bayrd Still, *Milwaukee: The History of a City* (Madison, Wisconsin: The State Historical Society of Wisconsin, 1948), 460.
[101] Langill, *Tradition of Caring*, 46.
[102] Langill, *Tradition of Caring*, 46.
[103] Langill, *Tradition of Caring*, 47.

facilities to meet the needs of the Milwaukee community. Additions were built at both hospitals to house nursing students. The Great Depression in the 1930s led to decreased hospital revenues in many hospitals in the United States, and The Passavant and Deaconess were no exception. A variety of cost cutting measures were implemented in order to continue treating the large number of non-paying cases; interns and nursing students volunteered their services and wages for staff were reduced by as much as ten percent at both hospitals. They remained open through the Depression because of these actions.[104] After World War II, The Passavant and Deaconess grew in order to meet the needs of the community and to take advantage of the advances in the field of medicine. The Hill-Burton Act, passed in 1946, allowed both hospitals to receive federal funding to modernize. Despite this aid, Milwaukee hospitals experienced massive bed shortages. The Passavant and Deaconess created additional beds to address the problem.[105] By the 1950s, many urban hospitals in America had begun to close, or relocate to the growing suburban areas because of overbuilding. Milwaukee hospitals, including The Passavant and Deaconess, grew during the 1960s.[106] It was not until the late 1970s that The Passavant and Deaconess began to feel the effects of expansion on their bottom line.

By that time, both The Passavant and Deaconess were on the verge of closing. A merger between the two hospitals offered a means to preserve the community service mission of each hospital. However, the merger was complicated by plans to build the Regional Medical Center in Milwaukee County. Initially, leaders at the Center proposed a merger with The Passavant. When that failed Deaconess leaders joined negotiations to create a final plan that included a merger between the new hospital at the medical

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[104] Langill, *Tradition of Caring,* 100.
[105] Langill, *Tradition of Caring,* 123.
[106] Langill, *Tradition of Caring,* 124-130

complex and the Passavant so they could remain open. Deaconess' representatives balked

at any proposal that closed their campus. The strong support for the regional complex

from both civic and business leaders in Milwaukee County and the precarious financial

situation at both The Passavant and Deaconess resulted in a merger. It took six years to

develop a merger plan acceptable to both parties. The two hospitals merged to create

Good Samaritan Medical Center in 1982. By 1987, the hospital merged with Mount Sinai

to avoid closing

CHAPTER 4 POLITICAL CHANGES IN HEALTH CARE: MERGERS AND
EXPANSIONS

This chapter does not speak specifically about Mount Sinai Hospital. Instead, it
examines three specific events in Milwaukee in the 1970s that impacted the merger
decision in 1987: the 1982 merger between The Passavant and Evangelical Deaconess
hospitals, the creation of a medical school at a new Regional Medical Center, and the
construction of Froedtert Lutheran Memorial Hospital as a new teaching hospital. Chapter
5 details how the creation of Froedtert Hospital and the Medical College of Wisconsin at
the Milwaukee County Regional Medical Center in 1980 ended plans at Mount Sinai
Medical Center to establish its own teaching hospital and medical school program.
Froedtert Hospital and its Medical College of Wisconsin also increased competition for
patients.[1] Leaders at both Mount Sinai Medical Center and the Regional Medical Center
wanted to establish medical schools to address the physician shortage for the Milwaukee
area. The Regional Medical Center garnered support from civic and political sources
through its board, the Hospital Area Planning Committee (HAPC). The members acted to
capitalize on changes in policy and funding to create their desired medical center. These
resources, in addition to the actions of the local government and private entities expedited
the medical center project.[2]

These three events also reveal the ramification of specific changes in the delivery of
health care services in America. Mergers increased between 1970 and the mid-1980s.[3]

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[1] Newspaper clipping, "Hospital Aid in Jeopardy" *Milwaukee Journal,* February 19, 1976, Box 51, Folder 8, Sinai
Samaritan Medical Center Records, Milwaukee Mss Collection 108, University of Wisconsin-Milwaukee Libraries,
Archives Department (hereafter cited as Sinai Samaritan Collection).
[2] Steven M. Avella, "Health, Hospitals and Welfare: Human Services in Milwaukee," in *Trading Post to Metropolis:
Milwaukee County's First 150 Years*, ed. Ralph M. Aderman (Milwaukee, WI: Milwaukee County Historical Society,
1987), 238.
[3] Avi Dor and Bernard Friedman, "Mergers of Not-for-Profit Hospitals in the 1980s: Who Were the Most Likely

Also during the 1970s and 1980s, local government entities gained significance power in health care decisions, specifically over hospital construction, and used that influence to make the changes they wanted, sometimes over the protests of hospital leaders. The histories of the Medical College of Wisconsin and Froedtert Lutheran Memorial Hospital illustrates the amount of agency a well informed and influential local government regulatory board had over the local health care market. I argue that the ability of the local government regulatory boards to approve construction for a regional medical center contributed to the decline in available patients for other Milwaukee hospitals. The merger between Deaconess and the Passavant occurred because influential members of the Milwaukee population wanted to see the regional center built. To that end, they used their political power and polity knowledge to secure funding and facilitate the necessary merger of Deaconess and The Passavant.

Increased costs of health care compelled hospital leaders and administrators to examine their business practices and make changes in order to offset the rising price of health care. Scholars identified many possible reasons for the rise in health care. This chapter focuses on three viable reasons for the rising cost to hospitals for care: the growth of medical technology and specialized care, overbuilding and a surplus of hospital beds, and changes in funding for Medicare and Medicaid patients. Of the three, I argue that the changes in funding for the two federal programs offers the best explanation for rising hospital costs. This chapter explains the impact of local government action on both the number of hospital beds in the market and construction decisions. Chapter 5 takes up the discussion of changes in funding for Medicaid and Medicare.

The creation of Good Samaritan Medical Center is discussed first. The merger

Targets?," *Review of Industrial Organizations* 9, no.4 (1994): 394.

between The Passavant and Deaconess is significant because it created Good Samaritan Medical Center, the institution with which Mount Sinai ultimately merged. This merger also illustrated the difficult experience of combining hospitals. Health care providers realized the need for major changes in their management style during the 1970s. Hospital leaders understood that some of these changes represented a paradigm shift in the American health care system, primarily in funding.[4] Mergers represented one of the most profound changes in the business of health care. The construction of the regional medical center is also discussed. The establishment of the center illustrates the increased power held by local political and private groups. Political and private groups worked together to build an ambitious institution. I argue that their power facilitated not only the center, but the merger of Deaconess and The Passavant. The merger may have eventually occurred, but the regional medical center would not have happened if not for the actions of local groups in Milwaukee.

VOLUNTARY HOSPITALS AND FINANCES

Rosemary Stevens noted that the traditional community assistance to hospitals all but ended by the mid-1970s. Hospital leaders searched for additional ways to fund health care services. Hospitals no longer received gifts from donation drives, the responsibility for capital fell on the hospital leaders themselves. Management focused on growing capital through market forces and collecting fees for patient care. Stevens noted that "No longer heavily dependent on community gifts and fund drives, voluntary hospitals were no longer gaining capital from public sources on a voluntary basis, that is from their local

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[4] Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century* (New York: Basic Books 1989), 298-99.

communities. Instead, in their capital formation, voluntary hospitals were now similar to major business corporations."[5]

Hospital leaders began to adopt a decidedly corporate approach to health care. Economists Avi Dor and Bernard Friedman explained that hospital mergers were considered part of a rising trend of corporate mergers and plant closings in the 1980s. This meant that some opponents of mergers sought to block mergers under antitrust laws that protected business interests from unfair limitations on competition and trade. Hospital leaders designed merger agreements meant to maintain services and preserve positive community reputations in the cities they served. Hospital board members tended to accept a merger over outright closure.[67] Economists Erwin A. Blackstone and Joseph P. Fuhr, Jr. stated that since many hospital board members were business leaders in their communities, they supported the notion that the hospitals should hold down costs and limit competition as much as possible. Mergers offered a means to that end.[8]

Merger attempts revealed sources of conflict in the process of combining different organizations. Conflict between merging organizations can occur even between businesses that appear to be closely similar. One possible source of conflict stemmed from conflict between corporate cultures. Economists Roberto A. Weber and Colin F. Camerer observed that a sense of culture is developed in an organization through common experiences over time. The longer the company history, the more likely conflict will arise during the merger process.[9]

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[5] Stevens, *In Sickness and in Wealth*, 300-01.
[6] Dor and Friedman, "Mergers of Not-for-Profit Hospitals in the 1980s," 394.
[7] Dor and Friedman, "Mergers of Not-for-Profit Hospitals in the 1980s," 396.
[8] Erwin A. Blackstone and Joseph P. Fuhr, Jr., "An Antitrust Analysis of Non-Profit Hospital Mergers," *Review of Industrial Organizations* 8, no.4 (1993): 474.
[9] Roberto A. Weber and Colin F. Camerer, "Cultural Conflict and Merger Failure: An Experimental Approach," *Management Science* 49, no. 4 (April 2003):400-401.

Kevin J. Dooley and Brenda J. Zimmerman described the merger process using a marriage metaphor. Merging health care organizations seek collaboration through mergers, acquisitions, alliances, and resources in order to gain profit or reduce costs. Much like a marriage, each organization hopes to gain value from the new relationship.[10] Similarities and differences between the merging interests present unique challenges to the relationship.

> The opposites, while appreciating at one level the differences, are often challenged by the stress of having to work at understanding the other's assumptions and make one's own position heard. The relationships between more similar partners may find subtle but significant differences in their ways of doing things that challenge their relationship. For a merger where the focus is on creating new opportunities, having too much similarity may limit the potential to see new options.[11]

There was a great deal of similarity between Deaconess and Passavant. They were in the same health care service market. Both hospitals enjoyed decades of community support, and formed their own traditions and culture. But leaders at each hospital felt forced into a "marriage of convenience" which led to distrust and a protracted merger process.

Mergers were relatively rare before the 1980s. Hospital administrators considered mergers a means for their struggling hospitals to remain open. Merger supporters considered them a favorable alternative to relocation or closing a hospital. Hospital mergers increased in American cities part because of the provisions of the federal Medicaid and Medicare legislation of 1965, which created fiscal advantages for hospital consolidation. Sociologists Jack Reardon and Laurie Reardon described the situation

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[10] Kevin J. Dooley and Brenda J. Zimmerman, "Merger as Marriage: Communication Issues in Postmerger Integration," *Health Care Management Review* 28, no. 1 (January/March 2003): 55-56.
[11] Dooley and Zimmerman, "Merger as Marriage," 56-57.

facing hospitals in terms of profit and debt. Mergers provided an easy way for hospitals to increase revenue without building additional facilities. The easiest way to grow was to take over an existing institution.[12] Lower patient cost of care was the manifest function of the legislation.[13] Dor and Friedman found that many merger agreements tended to include hospitals that were in relatively good financial shape, these mergers succeeded more than those which included failing hospitals.[14] Economist Tony Ugur Sinay argued that merger activity in the late 1980s was meant to reduce production costs by the elimination of waste and duplicate units at hospitals in close proximity. Mergers occurred to ensure long-run survival for the merging hospitals.[15] The American Hospital Association (AHA) data indicated that most hospitals involved in a merger or consolidation between 1987 and 1990 were located in or around the same metropolitan areas.

There was a latent function associated with the financial incentives in Medicare and Medicaid legislation. Investor owned hospital systems grew out of the unintended fiscal advantages associated with buying a single hospital. Hospital systems were created from these provisions.[16] Hospital mergers permitted the reduction of operating costs for hospital systems. For example, after a hospital merged, the newly formed hospital received discounts from suppliers based on volume. Investor-operated hospital systems in Milwaukee include Humana, Hospital Corporation of America (HCA), and American Medical International. These systems of investor-owned hospitals over time became

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[12] Jack Reardon and Laurie Reardon, "The Restructuring of the Hospital Service Industry," *Journal of Economic Issues* 24 (1995): 1064.
[13] Reardon and Reardon, "The Restructuring of the Hospital Service Industry," 1064.
[14] Dor and Friedman, "Mergers of Not-for-Profit Hospitals in the 1980s," 404.
[15] Tony Ugur Sinay, "Pre-and Post-Merger Investigation of Hospital Mergers," *Eastern Economic Journal* 24, no. 1 (Winter 1998): 94-95.
[16] Reardon and Reardon, "The Restructuring of the Hospital Service Industry," 1064.

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powerful interest groups at both the federal and state level.[17] As the hospital systems grew, doctors saw changes in their private practices; they became part of the hospital systems. Hospital systems began to acquire physician networks that brought the entire medical practices of doctors into the corporation; health care networks were able to establish complete health care systems with these purchases. The purchase of both hospitals and physician networks provided the facilities and medical staff for the growing hospital systems.[18]

Mergers, along with the purchase of physician's practices and other services as part of the deal, led to the advent of antitrust lawsuits against hospitals under the Sherman Act and the Clayton Act. Prior to the 1970s, antitrust legislation was considered inapplicable to the business of health care work, based on a traditional sense that heath care work was noncompetitive and performed by specialized professionals.[19] The first two sections of The Sherman Act prohibit restraints on trade through contracts and forbids the creation of a monopoly in the market.[20] The first section of Clayton Act outlaws any merger that would substantially decrease competition in any geographical market.[21] Two antitrust cases set precedence for possible antitrust allegations against hospital merger plans: the 1975 *Goldfarb v Virginia State Bar* decision[22] and the 1976 *Hospital Building Company v Trustees of Rex Hospital* decision[23] in 1976. *Goldfarb* struck down the idea that

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[17] Reardon and Reardon, "The Restructuring of the Hospital Service Industry," 1066.
[18] Stevens, *In Sickness and in Wealth*, 207.
[19] Owen S. Mudge and Allan Gibofsky, "The Developing Application of Antitrust Laws to Hospital Mergers," *Journal of Legal Medicine* 15 (1994): 357.
[20] The Fair Trade Commission. The Antitrust Laws, https://www.ftc.gov/tips-advice/competition-guidance/guide-antitrust-laws/antitrust-laws (accessed December 31, 2015). Sherman Antitrust Act, 15 U.S.C.A. 1 (1973 & Supp. 1993).
[21] The Fair Trade Commission. The Antitrust Laws, https://www.ftc.gov/tips-advice/competition-guidance/guide-antitrust-laws/antitrust-laws (accessed December 31, 2015). Clayton Act, 15 U.S.C.A. § 18 (1973 & Supp. 1993).
[22] *Goldfarb v. Virginia State Bar*, § 421 U.S. 773 (1975).
[23] *Hospital Building Co. v. Trustees of Rex Hospital*, § 425 U.S. 738 (1976).

hospitals were automatically absolved from antitrust regulation, and *Rex* ruled that hospital mergers could be blocked under the Sherman Act on the basis of concerns over limiting competition in the overall hospital market.[24] Blackstone and Fuhr observed that the vast majority of nonprofit mergers were not challenged.[25] In the years between 1981 and 1993, less than 4% of the 394 merger applications were challenged under antitrust legislation.[26]

There are two distinct types of mergers: horizontal and vertical. Horizontal mergers seek to increase the market share for the merging facility. Vertical mergers seek to gain control over resources like medical supplies and physicians, and secure their place in that diversified market. The Deaconess/Passavant merger was horizontal. Opponents to the Deaconess/Passavant merger did not cite antitrust issues as a deciding factor in trying to stop it. That did not mean that the merger was without controversy. By 1978, three hospitals remained in downtown Milwaukee: Mount Sinai, The Passavant, and Deaconess. They continued to treat patients, but administrators and Board members at each hospital faced the same challenge: how could the hospital stay in Milwaukee and remain fiscally viable? The practical answer to that question was complicated. All three hospitals eventually decided to merge with another hospital in order to continue treating patients. They maintained their traditions of community service but lost their individual identities in the process.[27] The collective fiscal problems of these three hospitals led to a series of mergers in the early 1980s. First, The Passavant and Evangelical Deaconess merged to create Good Samaritan Medical Center in 1982. Then, in 1987, Mount Sinai Medical

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[24] Mudge and Gibofsky, "The Developing Application of Antitrust Laws to Hospital Mergers," 357-59.

[25] Blackstone and Fuhr, "An Antitrust Analysis of Non-Profit Hospital Mergers," 488.

[26] Update, "Most Hospital Mergers Go Unchallenged by Justice Department," *Healthcare Financial Management* 48, no. 10 (October, 1994): 7.

[27] Dr. Jay Larkey, Interview by author, Milwaukee, Wisconsin, August 17, 2011 and Dr. Harry Kanin, Interview by author, Milwaukee, Wisconsin, July 14, 2011.

Center merged with Good Samaritan to create Sinai Samaritan Medical Center.

THE COST OF HEALTH CARE AND BUILDINGS

Rosemary Stevens noted that one of the most salient explanations for the increase was the rise of medical specialties and new technology. Health care cost more because it included unprecedented technological advances.[28] In the case of Milwaukee hospitals, the creation of cardiac centers, emergency departments, neonatal wards, and other medical specialties competed for patients at an increased cost. Mergers made sense because consolidating services at a single hospital saved money for both the patient and the provider. Philosopher Daniel Callahan believed that medical technology was a blessing and a burden for patients and the hospitals that treat them. The costs of providing care increase with advances in care. Uninsured and underinsured patients are essentially priced out of assistance for their health care needs, leaving the hospitals to collect the cost of care from those who cannot afford it. Hospitals compete with each other to draw patients, but charge more for the treatment offered. He cites the nature of the "private sector" as a salient reason cost controls on health care fail. The private sector has autonomy in its business decisions and exercises that ability to set costs.[29]

These high cost led to more financial problems. Advancements in the national health care industry contributed to the financial problems at urban hospitals in that they led to shortened hospital stays for patients.[30] In addition, some health services kept patients at home instead of in a hospital bed. This cut hospital revenue even further at renovated

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[28] Stevens, *In Sickness and in Wealth*, 220
[29] Daniel Callahan, *Taming the Beloved Beast: How Medical Technology Costs Are Destroying Our Health Care System* (New Jersey: Princeton University Press 2009), 63.
[30] Stevens, *In Sickness and in Wealth*, 296.

medical facilities.[31] Many Milwaukee hospitals and experienced low patient census

numbers and financial shortfalls in the 1970s.

Overbuilding and duplication of services made possible by government programs are

another possible explanation for higher costs. Dor commented on the situation saying that

by the 1980s, hospitals that had expanded their facilities faced the task of "restructuring"

and mergers offered a means to that end.[32] Stevens observed that many American

hospitals expanded their facilities in order to draw in patients.[33] Simultaneous

renovations at many Milwaukee hospitals time created an excess of hospital beds.

Historian Ellen Langill noted that hospitals that were overcrowded in the 1960s built

expansions in the 1970s and were virtually empty at times by the 1980s.[34] Hospitals

raised room rates in order to address the loss of patients to their competitors.[35]

Three Milwaukee hospitals with over a century of history among them—The

Passavant, Evangelical Deaconess, and Mount Sinai Medical Center—eventually

disappeared into a single hospital through a series of mergers caused in part by these

changes.[36] Administrators at the three hospitals, as in other American urban areas at the

time, approved expansion plans during a building boom in the early 1970s. Hospital

administrators and board members believed that the larger facilities and specialized

medical services would bring in more money. However, the overall number of beds in

Milwaukee decreased the number of patients at each of the three hospitals. Expanded

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[31] Stevens, *In Sickness and in Wealth*, 296-97.
[32] Dor and Friedman, "Mergers of Not-For-Profit," 394.
[33] Stevens, *In Sickness and in Wealth*, 295-96.
[34] Ellen D. Langill, *A Tradition of Caring: The History of Milwaukee's Three Primary Service Hospitals—Lutheran, Mount Sinai, and Evangelical Deaconess* (Milwaukee, WI: Sinai-Samaritan Hospitals History Committee, 1999), 138.
[35] Langill, *A Tradition of Caring*, 136.
[36] Langill, *Tradition of Caring*, 136.

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choices and the decreased length of hospital stays decreased hospital revenue.[37] The new

departments needed *more* patients to offset operation costs associated with creating new

treatments and to fund new technological procedures and tools.[38]

The 1982 merger was deemed necessary in order to reduce the number of beds in

Milwaukee. It was offered as an alternative to closing either hospitals. In addition, local

government officials wanted to build a regional medical center. The number of hospital

beds in Milwaukee had to be reduced. Mergers between hospitals were difficult because

none wanted to close. The merger between The Passavant and Evangelical Deaconess

illustrates the challenges of the merger process. The historic commitment to community

service at both hospitals complicated the merger negotiations.[39] The Passavant and

Evangelical Deaconess hospitals were established by members of Milwaukee's German

Lutheran community and had served the people of Milwaukee for decades. The merger

created Good Samaritan Medical Center after years of negotiation and conflict caused by

the desire on the part of the representatives from both The Passavant and Deaconess to

stay open.

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[37] Lawton R. Burns, "The Transformation of the American Hospital: From Community Institution toward Business Enterprise," *Comparative Social Research* 12 (1990): 89.

[38] Stevens, *In Sickness and in Wealth*, 317.

[39] Merger Memo, May 27, 1977, Box 4, Folder 11, Sinai Samaritan Collection.

MERGING INTERESTS: THE PASSAVANT AND EVANGELICAL DEACONESS

The Passavant and Deaconess were two of Milwaukee's oldest hospitals, established and sustained by two religious communities in Milwaukee. Both were committed to serving the city of Milwaukee. The merger between these two hospitals was contentious and conflicted, and it took six years to complete. Tensions remained after the creation of Good Samaritan Medical Center; the merger did not alleviate the discord between the administration and staff from both hospitals. It exacerbated it.[40]

Mergers between hospitals often turned into conflicted and time consuming endeavors. The boards of each hospital had to agree on matters of both administrative and day-to-day operations. New leadership boards had to make decisions on personnel and location. The employees who worked in the new hospital had the responsibility of making those changes work. At first glance, it may not seem that the merging of two Christian hospitals would be overly difficult; but representatives of both hospitals wanted to preserve the individual history of their respective institutions described in the previous chapter.[41]

At the time of the merger, the main point of contention between The Passavant and Deaconess was preservation of each hospital's mission. Their traditions, their daily operations, and the location of the new hospital mattered most.[42] As noted above, each hospital wanted a relationship, a "marriage" that yielded valuable benefits.[43] The merger between these two hospitals took years to complete due in part to the stipulations offered by Deaconess' administrators, the smaller and younger hospital. They insisted the final

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[40] *Vital Signs,* Newsletter Deaconess Hospital, July 1977, Box 4, Folder 11, Sinai Samaritan Collection.
[41] Merger Memo, May 27, 1977, Box 4, Folder 11, Sinai Samaritan Collection.
[42] Langill, *A Tradition of Caring*, 56.
[43] Dooley and Zimmerman, "Merger as Marriage: Communication Issues in Postmerger Integration," 55.

merger agreement had to include their campus. This conflicted with The Passavant

leadership's efforts to do the same for their own facility.[44]

MERGERS AND COMPLICATIONS: THE MAKING OF GOOD SAMARITAN

This section details the merger between Deaconess and The Passavant. The merger

between two of Milwaukee's oldest hospitals was complicated and conflicted. Both

hospitals had decades of history and a strong sense of community pride. The actions of

the HAPC, the committee planning Froedtert Hospital, during the 1970s alienated leaders

at both the Passavant and Deaconess Hospitals and delayed any merger. Leaders at

Deaconess and The Passavant resented the idea of merger and remained suspicious of the

motives and machinations of the Greater Milwaukee Committee and HAPC involved in

creating the new regional complex. Initially plans for Froedtert Lutheran Memorial

Hospital included a merger with The Passavant to create a single Lutheran hospital in

Wauwatosa. However, The Passavant was not willing to relocate to the complex.

Throughout the merger discussions with The Passavant, HAPC leaders tried to convince

Passavant leaders to join the new complex, especially when merger negotiations between

Deaconess and The Passavant lagged. These actions irritated Deaconess leaders, due to

ongoing the merger discussions between Deaconess and The Passavant. The distrust grew

to the point that Deaconess' leaders halted merger negotiations a few times before 1980

merger.[45] The HAPC was determined to build Froedtert Hospital and sought to secure

any merger agreement as quickly as possible. In the negotiations with The Passavant and

Deaconess, the reference to Froedtert Memorial Hospital as a possible merger partner was

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[44] Report, "The Deaconess Position on Merger of Froedtert, Lutheran and Deaconess Hospitals," June, 1977, Box 4, Folder 1, Sinai Samaritan Collection.
[45] *Vital Signs,* News Letter, Deaconess Hospital, January 1977, Box 4, Folder 13, Sinai Samaritan Collection.

remarkable in that the hospital did not yet exist. It may have been that leaders at both hospitals accepted the inevitable creation of Froedtert Hospital and fought to preserve as much of their missions as possible.

The publicized financial troubles at both the Passavant and Deaconess drew the attention of the members of HAPC. They entered into negotiations with The Passavant and Deaconess to negotiate a merger agreement and build the regional hospital.[46] Deaconess' leadership suspected that their hospital, as the smallest, was targeted for outright closure.[47] The GMC had hoped to partner with The Passavant to create a single Lutheran hospital at the new Center. Deaconess leaders believed their exclusion from the merger negotiations meant both the Passavant and the HAPC sought to close their hospitals.[48]

Deaconess' leaders remained skeptical and eventually refused any affiliation with Froedtert Hospital.[49] The leaders of The Passavant and Deaconess fought against any plan that closed either hospital. But the construction of the regional medical Center hinged on closing beds in Milwaukee. The Passavant and Deaconess were losing money, and when The Passavant leaders left merger negotiations with Deaconess over a dispute about the final location of the new hospital, the regional medical Center representatives tried to convince The Passavant to merge with their facility instead. This caused anger and distrust between Deaconess and the leadership at new medical Center. The local newspapers contextualized negotiations between these three hospitals as a "rocky

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[46] Report, "The Deaconess Position on Merger of Froedtert, Lutheran, and Deaconess Hospitals," June 1977, Box 4, Folder 13, Sinai Samaritan Collection.
[47] Report, "The Deaconess Position on Merger of Froedtert, Lutheran, and Deaconess Hospitals," June 1977, Box 4, Folder 13, Sinai Samaritan Collection.
[48] Report, The Deaconess Position on Merger of Froedtert, Lutheran, and Deaconess Hospitals," June, 1977, Box 4, Folder 13, Sinai Samaritan Collection.
[49] Report, "The Deaconess Position on Merger of Froedtert, Lutheran, and Deaconess Hospitals," June, 1977, Box 4, Folder 13, Sinai Samaritan Collection.

marriage" that resulted in the merger of The Passavant and Deaconess and the creation of the Regional Medical Center.[50] Good Samaritan Medical Center and Froedtert Memorial Hospital were the end result of years of conflict, discord, and hostile negotiations.

On November 2, 1976, representatives of The Passavant and the HAPC, representing the not-yet-extant Froedtert Hospital, released a statement saying they had agreed to merge. The announcement was apparently made without prior notice to Deaconess Hospital representatives, who still believed they were exploring a merger with The Passavant.[51] If the November 2, 1976 announcement was intended to intimidate Deaconess leaders into a quick and final merger, it did not succeed. If anything, the announcement prolonged negotiations. Eight months later, in 1977, Deaconess leaders offered a merger plan that would allow the planners of Froedtert Hospital to join the merger between The Passavant and Deaconess Hospital, but on Deaconess' terms.[52] Deaconess leaders hoped to exploit the efforts of the HAPC, and use it to their advantage in the final merger plan. The beds at Deaconess acted as a barrier to those who wanted the new center. Deaconess sought to protect what they could by opening themselves up to any inducements HAPC might offer, in order to stay open.[53] It stated that the proposed merger plan excluded Deaconess. Deaconess's leaders believed that the information cited by the Southeastern Wisconsin Health System Agency, (SEWHSA), responsible for collecting the data supporting hospital bed reductions for the new center, forced HAPC to act. Representatives for Deaconess believed the announcement was a ploy to get any

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[50] Newspaper clipping, "Two Hospitals Set to Tie the Knot," *Milwaukee Sentinel*, June 27, 1980, Box 2, Folder 61, Sinai Samaritan Collection.
[51] Report, "The Deaconess Position on Merger of Froedtert, Lutheran, and Deaconess Hospitals," June, 1977, Box 4, Folder 13, Sinai Samaritan Collection.
[52] Statement on Policy on Merger, Board of Directors, Deaconess Hospital, May, 12 1977, Box 4, Folder 13, Sinai Samaritan Collection.
[53] Statement on Policy on Merger, Board of Directors, Deaconess Hospital, May, 12 1977, Box 4, Folder 13, Sinai Samaritan Collection.

merger agreement: "this agreement, which was negotiated without the involvement of Deaconess obviously cast Deaconess' role in a joint venture with Lutheran [The Passavant] in some doubt."[54] This was, to say the very least, an understatement. Deaconess' leaders refused to discuss any merger plans unless their own stipulations were included for serious consideration and were now convinced that the only reason they were invited into the merger discussion was to close Deaconess:

> It is now obvious that Deaconess was sought as a party to the Froedtert/Lutheran situation in order to: satisfy health planning officials that a significant number of beds could be eliminated and provide a way to keep the lagging Lutheran [Passavant] facilities operating while Froedtert was under construction, by closing Deaconess and taking over its many programs. These objectives could only be accomplished by elimination of Deaconess Hospital's facility. The entire planning process to date has been slanted in this direction.[55]

Deaconess leaders became wary of any future merger plans with The Passavant. One of the most obvious signs of animosity between Deaconess and Froedtert occurred after the November 1976 announcement: Deaconess refused to merge with The Passavant if Froedtert was involved in any way.

Without the Passavant, Deaconess would have had to find a new merger partner, relocate, or close.[56] It is entirely possible that the merger announcement was a negotiation tactic designed to force an agreement. The announcement may have been designed as a means to intimidate the Deaconess leadership and force them to reengage with The Passavant on the stalled merger negotiations. The leaders of The Passavant were highly committed to the legacy of their hospital; it is unlikely that they would have

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[54] Report, "The Deaconess Position on Merger of Froedtert, Lutheran, and Deaconess Hospitals," June, 1977, Box 4, Folder 13, Sinai Samaritan Collection.
[55] Report, "The Deaconess Position on Merger of Froedtert, Lutheran, and Deaconess Hospitals," June, 1977, Box 4, Folder 13, Sinai Samaritan Collection.
[56] Report, "The Deaconess Position on Merger of Froedtert, Lutheran, and Deaconess Hospitals," June, 1977, Box 4, Folder 13, Sinai Samaritan Collection.

agreed to a final merger with the regional medical complex that closed their own downtown campus.[57]

By November 2, 1976 Deaconess resumed discussions with The Passavant. However, if the announcement of a merger between Froedtert and The Passavant was designed to intimidate Deaconess into accepting a predetermined plan, it was not successful. Deaconess leaders continued to issue statements designed to ensure their official positions on all matters relating to the merger were known. Deaconess wanted more than equal representation on the new administrative Board. Deaconess insisted that a full fifty percent of the Board be Deaconess representatives and the other fifty percent to be split between The Passavant and Froedtert leaders.[58] In addition, Deaconess stipulated that the final terms of consolidation were to be defined as a multi-facility system rather than a single site.[59]

By July 18, 1977, Deaconess announced that "with information to date, Deaconess, Froedtert and Lutheran [Passavant] Hospitals are not ready to commit to the principle of merger."[60] The final agreement to resume merger discussions did not include Deaconess' stipulation about Board composition; each hospital had a one-third interest in leadership decisions, but Deaconess was willing to talk. Each hospital formed legal teams to protect their interests. The official position of the merger team was, "The proposed structure protects the interests of each hospital in such key areas as medical staff by-laws, employee assets, corporate policy and budgetary and operational control. It guards the

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[57] Report, "The Deaconess Position on Merger of Froedtert, Lutheran, and Deaconess Hospitals," June, 1977, Box 4, Folder 13, Sinai Samaritan Collection.
[58] *Vital Signs* Newsletter, Deaconess, Box 4, Folder 30, Sinai Samaritan Collection.
[59] Merger Report, "Chronology of Merger Events," Board of Directors, Deaconess Hospital, August 27, 1977, Box 4, Folder 10, Sinai Samaritan Collection.
[60] Merger Report, "Chronology of Merger Events," Board of Directors, Deaconess Hospital, August 27, 1977, Box 4, Folder 10, Sinai Samaritan Collection.

religious affiliations of each hospital since the original corporate parent bodies and their religiosities are maintained."[61] The hospitals appeared ready to discuss creating a cooperative health care agreement between both locations. The merger team planned to conduct feasibility studies.[62]

It was not to be that simple. A surprise announcement in February 20, 1978 halted the merger process yet again. Deaconess called off the merger, citing a loss of twenty million dollars a year if a new facility was created without closing The Passavant. Passavant leaders now balked at implication that their facility was the most logical choice to close because of its age.[63] The Passavant representatives were opposed to their own closure and refused any merger that included HAPC, the Froedtert representatives. It is quite likely that the HAPC leadership capitalized on Deaconess' hostility in order to force their hand on a merger, whether with The Passavant or with them. On August 26, 1977, Deaconess announced that The Passavant leadership rejected the July 18th merger proposal over the inclusion of Froedtert. This decision ended any chance of the three hospitals merging and Froedtert hospital was no longer a part of the merger discussion.[64]

This turn of events meant that a merger between The Passavant and Deaconess was an alternative to closing both hospitals. The Passavant leadership refused to close and Deaconess representatives had a very strong commitment to the preservation of their hospital as well.[65] Merger negotiations had reached an impasse. The distrust between Deaconess and The Passavant over the role of Froedtert hindered the renewed merger process and the final agreement for the new facility even after Froedtert left the

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[61] *Vital Signs,* Newsletter, Deaconess Hospital, July, 18, 1977, Box 4, Folder 11, Sinai Samaritan Collection.
[62] Merger Memo, Deaconess Hospital, May 27, 1977, Box 4, Folder 11, Sinai Samaritan Collection.
[63] *Vital Signs*, Newsletter, Deaconess Hospital, February 20, 1978. Box 4, Folder 11, Sinai Samaritan Collection.
[64] *Vital Signs*, Newsletter, Deaconess Hospital, August 26, 1978, Box 4, Folder 11, Sinai Samaritan Collection.
[65] *Vital Signs*, Newsletter, Deaconess Hospital, August 26, 1978, Box 4, Folder 11, Sinai Samaritan Collection.

negotiations. The official statement from Deaconess in 1977 about any future proposed

merger was unambiguous:

> Representatives of Froedtert and Lutheran knew or should have known the
> qualifications with which Deaconess had agreed to enter into further
> discussions. Instead of acknowledging these qualifications, approval for
> Froedtert Hospital was sought from the state health planning agency based
> upon, among other things, the impression that Deaconess had agreed to a
> merger between the three hospitals. This was never true. It is obvious now
> that Deaconess was sought as a party to the Froedtert Lutheran situation in
> order to satisfy health planning officials that a significant number of beds
> could be eliminated, provide a convenient way to keep the lagging
> Lutheran facilities operating while Froedtert was under construction by
> closing Deaconess and taking over its many programs.[66]

Even without Froedtert, Deaconess leaders were suspicious of their counterparts at

The Passavant. Another two years passed before the hospitals reached an agreement. The

fact that neither hospital closed during the prolonged negotiations leads to the question:

were either one of the hospitals facing imminent closure? The merger discussions and

statements indicate concern over keeping the hospitals open. Deaconess representatives

reiterated stipulations to The Passavant officials that neither hospital close. They

supported the creation of a cooperative system between their hospital and The Passavant.

Deaconess wanted to form operating relationships with other hospitals in Milwaukee,

keeping them all open but treating distinct groups of patients. Cooperation between the

hospitals left each hospital's identity intact, which was the main goal for Deaconess

Board members from the beginning.[67] Deaconess leaders wanted to keep both hospitals

open and invite other hospitals to join them.[68]

Deaconess' leaders began approaching other hospitals to explore possible

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[66] Report, "The Deaconess Position on Merger of Froedtert, Lutheran, and Deaconess Hospitals," June, 1977, Box 4, Folder 13, Sinai Samaritan Collection.
[67] Report, "The Deaconess Position on Merger of Froedtert, Lutheran, and Deaconess Hospitals," June, 1977, Box 4, Folder 13, Sinai Samaritan Collection.
[68] Report, "The Deaconess Position on Merger of Froedtert, Lutheran, and Deaconess Hospitals," June, 1977, Box 4, Folder 13, Sinai Samaritan Collection.

partnerships. They wanted to create a system of shared services and active ties with Children's Hospital until the construction of the new facility at the regional complex.[69] Deaconess also sought a relationship with St. Luke's Hospital in order to "Begin a feasibility study for the purpose of exploring areas where shared services and programs between the hospitals might lead to improving the quality, economy, and efficiency of health care."[70] The partnership with St. Luke included referrals from Deaconess to St. Luke's Cardiac Care center, and orthopedics services. St. Luke's in turn, referred patients to Deaconess for ambulatory care and emergency services.[71] Deaconess leaders knew their hospital was in dire straits and tried to establish a relationship with St. Luke's on its own, to perhaps claim a sense of autonomy in the decisions for its future or to secure an alternative agreement with St. Luke's in case the relationship with The Passavant ended.

After more negotiations, a new merger plan between Deaconess and The Passavant was finally announced in June, 1980. The official statement from SEWHSA applauded the agreement, saying, "The long term saving and efficiencies will be tremendous. This consolidation is just what the doctor ordered in light of today's rising cost of health care."[72] An editorial in the *Milwaukee Sentinel* on June 27, 1980 also approved of the plan, "Two major causes of today's obscenely high health−care costs−which everyone more or less shares at least indirectly-are excess hospital bed capacity and duplicated medical services. Merger is the key to curing both problems."[73] An article published the same day reported the merger plan in terms of marriage, stating that after a "rocky four

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[69] Report, "The Deaconess Position on Merger of Froedtert, Lutheran, and Deaconess Hospitals," June, 1977, Box 4, Folder 13, Sinai Samaritan Collection.

[70] Report, "The Deaconess Position on Merger of Froedtert, Lutheran, and Deaconess Hospitals, June, 1977, Box 4, Folder 13, Sinai Samaritan Collection.

[71] Report, "The Deaconess Position on Merger of Froedtert, Lutheran, and Deaconess Hospitals," June, 1977, Box 4, Folder 13, Sinai Samaritan Collection.

[72] Press Release, SEWHSA, June 26, 1980, Box 32, Folder 27 Sinai Samaritan Collection.

[73] Newspaper Clipping, Editorial, *Milwaukee Sentinel*, Box 31, Folder 61, June 27, 1980, Sinai Samaritan Collection.

year courtship," the two hospitals had finally "consummated their marriage" and agreed to "tie the knot," ostensibly leaving Froedtert at the altar.[74] The final plans to create Good Samaritan Medical Center were in place. The merger was approved on September 11, 1980 and on September 29, 1980, an announcement made it official; Good Samaritan Medical Center had arrived.[75] Froedtert Lutheran Memorial Hospital opened in the same year. It partnered with the Medical College of Wisconsin as a teaching hospital.

GOOD SAMARITAN MEDICAL CENTER

Initially, Good Samaritan Medical Center implemented the vision of Deaconess' leadership. The two hospitals remained open even as they shared leadership. Deaconess remained on Wisconsin Avenue and The Passavant on Twenty-First Street and Kilbourn Avenue. Services were redistributed between the two sites. By 1984, St. Luke's Hospital joined Good Samaritan as a "health care associate." The hospitals shared some services but did not merge with the new facility. St. Luke's continued as a stand-alone hospital and maintained its previous relationship with Deaconess.[76] The combined hospital sites of Good Samaritan and St. Luke's shared patients based on services offered at each site. St. Luke's received cardiac patients from Good Samaritan. The Deaconess site received pediatric and maternity patients and The Passavant site treated emergency cases from the other two hospitals. They shared services such as CAT scan technology and surgery cases. Shuttles transported patients between sites.[77] The merger appeared to have met its goal of cost savings by July 7, 1986 when John Schwartz, President of Good Samaritan

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[74] Newspaper clipping, Editorial, *Milwaukee Sentinel*, June 27, 1980, Box 31, Folder 61, Sinai Samaritan Collection.
[75] Press Release, SEWHSA, Box 32, Folder 27, September 29, 1980, Sinai Samaritan Collection.
[76] Langill, *A Tradition of Caring*, 138.
[77] Langill, *A Tradition of Caring*, 140.

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announced that "the ink at Good Samaritan was finally black again."[78]

Exactly how that ink changed back to red was a matter of controversy. Staff reductions were one of the ways that the new hospital cut costs. Workers at both hospitals were concerned about their employment status months before the merger. In the July 3, 1980 edition of *Vital Signs*, the newsletter of Deaconess Hospital, Kenneth S. Jamron, president of Deaconess Hospital addressed this concern:

> One thing that you should keep in mind as you hear rumors about cutting the workforce: we have all been the target of a bureaucratic attack on that they call 'excess beds.' The pressures applied to downtown hospitals to merge or close have been based on that questionable statistic. Even giving them the benefit of a doubt however, look again at what they're talking about−EXCESS beds. They don't claim we're caring for too many patients, just beds. Let them preach all they want−how much of your work is involved with tending to the needs of a nonexistent patient? [79]

Projections for the future for Good Samaritan Hospital and the fiscal bottom line were hopeful due to lessons learned in the merger process; Jim Schwartz, President of Good Samaritan Medical Center, explained, "We were losing a bundle of money. We were worried about how deep we could cut, and if we cut too deep, would the whole thing collapse?"[80] The article warned readers that "instead, he found that, much to his surprise [,] that you could not cut too deep. There may be a few more layoffs at the hospital."[81]

Layoffs were a source of tension at the new facility, but the most controversial change after the merger was final was the closing of the Deaconess Campus of Good Samaritan. On March 30, 1985, Good Samaritan leaders announced closing of the

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[78] Newspaper clipping, "Good Samaritan Ink Finally Black Again*," Milwaukee Sentinel*, July 7, 1986, Box 31, Folder 1, Sinai Samaritan Collection.

[79] *Vital Signs,* Newsletter, Deaconess Hospital July 3, 1977, Box 4, Folder 11, Sinai Samaritan Collection. Capitals in original.

[80] *Vital Signs,* Newsletter, Deaconess Hospital July 3, 1977, Box 4, Folder 11, Sinai Samaritan Collection.

[81] Newspaper clipping, "Deaconess Campus of Good Samaritan Medical Center To Close," *Milwaukee Courier*, March 30, 1985, Box 31, Folder 1, Sinai Samaritan Collection.

Deaconess campus. Staffing cuts had not provided enough cost savings. It was just too expensive to keep both hospitals open. After all the struggle and the insistence on the part of the merger team that the histories of each hospital would be preserved, the original Deaconess building was sold to Marquette University and razed, leaving only a plaque, including its motto *Diakonia,* at the site of its campus on Wisconsin Avenue, the sole reminder that the hospital had ever existed.[82] The news on the decision to close included the sentiments of the Deaconess representatives, albeit only after justifying the decision:

> The rich history of Deaconess Hospital accounts for the very mixed feelings about its closure. On the one hand this represents a sound and logical business decision, but on the other, we cannot help but see it as an event fraught with emotion. However, the final chapter of Deaconess Hospital's history is read. It is a prime example of the tremendous change occurring in health care today and the absolute necessity for flexible management.[83]

The closure of the Deaconess site did alleviate some of financial burden at Good Samaritan Medical Center, but it did not result in increased revenue for the hospital; the overall savings in overhead costs were still not enough to finance both operations. Good Samaritan leaders continued to pursue cost cutting measures to strengthen the fiscal situation and continue operations in Milwaukee. A stipulation in the merger agreement was that Good Samaritan Medical Center would continue to provide medical services in the city; the mission included a formal commitment to the Milwaukee neighborhood around Twenty-First Street and Kilbourn Avenue. The administrators of Good Samaritan assisted in the establishment of the Avenues West Association, which brought Near West Side businesses and charitable concerns together to address social and economic

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[82] Langill, *Tradition of Caring*, 139.
[83] Newspaper clipping, "Deaconess Campus of Good Samaritan Medical Center to Close," *Milwaukee Courier,* March 30, 1985, Box 31, Folder 1, Sinai Samaritan Collection.

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challenges in the neighborhood, but did not result in increased patient revenue or census numbers.[84]

The protracted merger process between Deaconess and The Passavant Hospitals illustrated the lack of agency private hospitals had in the context of new government regulations. The leadership at Deaconess aggressively fought off attempts by the proponents of the Regional Medical Center to force a merger, but their efforts could not overcome the advantages held by those supporting the new Center. The political support for the new Center, combined with the threat of closure, brought about the merger and cleared the way for construction.

The actions of Deaconess leaders illustrated an awareness of the power shift between private hospitals and government regulatory institutions. The suspicious and antagonist press releases, culminating in the Merger Memo, indicated an understanding that their hospital was at risk of closing. Their agreement to the merger came in response to the perceived risk of closure. The closing of the Deaconess campus soon after the merger is ironic in that the merger was supposed to keep the hospital open. Rather than close Deaconess under their own terms, the decision came after the creation of Good Samaritan, when Deaconess leaders no longer had the final say in such matters.

During the six years spent finalizing the merger creating Good Samaritan Medical Center, and the establishment of Froedtert Memorial Hospital, Mount Sinai Hospital continued to struggle financially. In 1987, Mount Sinai and Good Samaritan announced their own merger. The merger process was just as complicated as its predecessors and the final plan also had to satisfy two distinctly different religious traditions. In addition, the health care networks in Milwaukee were growing and absorbing other hospitals in

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[84] Langill, *A Tradition of Caring*, 138.

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Milwaukee. In light of consolidated health care services and dwindling resources for health care services for the poor, Mount Sinai Hospital administrators felt that merger was the only option available to them that allowed some sense of the historic commitment to Milwaukee by the Jewish community to continue.

THE REGIONAL CENTER AND MEDICAL SCHOOL: POLICY AND POLITICS

The context of the state, for the purpose of this research, is one that sees the political aspect of social discourse and policy as a theoretical meeting place, or arena, in which the public and the government of elected officials accept and reject social policy. Elected members of the formal political structure and the members of the public at large can use this concept of the state in order to air their differences and their views about the direction of policy and possible changes in social programs.[85] According to sociologist Ellen Immergut, public policy is not assumed to be a linear orderly process incorporating the needs and wants of individuals or the economic sphere, nor is it the end result of any one actor or interest. Political decisions "emerge from highly complex combinations of factors that include . . . systematic features of political regimes. . . .Institutions do not determine behavior, they simply provide a context for action that helps us to understand why actors make the choices they do."[86] Sociologist Robert H. Cox elaborates on the role of the state in creating social policy outlined by Immergut and posits that, in the realm of public policy, the state acts as a framer when successful in its quest for new social spending programs to the voting public. In matters of social policy, the state is both an identifier (or an enumerator) of problems faced by the citizens and the market, and also

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[85] Cal Clark and Rene McEldowney, "The Health Care Financial Crisis: Reorganization and Evidence-Based Medicine as a Response to an 'Unholy Trinity.'" *Policy Studies Review* 17, no.4 (Winter 2000).
[86] Ellen Immergut, "The Theoretical Core of the New Institutionalism," *Politics and Society* 26 (1998): 5-34.

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defines the proposed legislation as addressing a "social problem" or as a "needed reform." The state defines the need for help on the part of its people and works within the market system to bring about a solution. In the case of welfare programs like health care, policy institutions, like the government, show whether the state has a part to play in the formation of new or innovative programs.[87]

The local government boards in Milwaukee sought to shape policy in the matter of hospital construction as they saw fit. The merger process created an adversarial relationship between The Passavant, Deaconess, and the Hospital Area Planning Committee (HAPC). The HAPC represented the future Froedtert Lutheran Memorial Hospital. Deaconess representatives ended negotiations at times because of their distrust of Froedtert leaders.[88] The foundation for that distrust came from the actions of two Milwaukee County committees: The Greater Milwaukee Committee (GMC), which in turn created the HAPC. These two committees strongly supported the new regional Center hospital, and Deaconess' leaders distrusted their motives. The GMC and HAPC concurrently raised funds for the new facility while negotiating with Deaconess and The Passavant. They planned to build a medical school and bring other health care institutions together on a large campus.[89]

The Greater Milwaukee Committee (GMC) was a major influence in Milwaukee business and civic affairs. Avella argued that from the 1930s, the group was instrumental in monitoring and capitalizing on federal funding opportunities for Milwaukee's development.[90] The GMC established itself in the local political arena in order to get

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87 Robert H. Cox, "The Social Construction of an Imperative: Why Welfare Reform Happened in Denmark and the Netherlands but Not Germany," *World Politics* 53 (2001): 463-498.
88 Merger Memo, Deaconess Hospital, May 27, 1977, Box 4, Folder 11, Sinai Samaritan Collection.
89 Avella, *Trading Post*, 239.
90 Avella, *Trading Post*, 236.

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approval for the center.[91] The surplus of hospital beds in Milwaukee was an issue, but it is not the only reason for the drive to create the Center. The GMC wanted to create a centralized medical center and wanted a medical school in order to receive research grants. Public support for a regional medical center grew, and the findings of two commissioned studies, the McLean Report of 1953 and the Willard Report of 1959 supported the construction of a regional medical center in Milwaukee.[92] After County Executive John L. Doyne took office in 1959, the GMC worked to establish a large scale regional medical facility.[93] Avella analyzed the change saying, "The Doyne-GMC combination was to mastermind the delicate and difficult process that culminated in the establishment of the Regional Medical Center in 1969."[94] This Center ultimately ended the separate entities of The Passavant and Deaconess.

Federal government funding through Titles 18 (Medicare) and 19 (Medicaid), and the federal Regional Health Care Act of 1965 financed the plans to establish a regional medical center. This act set aside federal funding for areas that had no such facility. A subcommittee of the GMC, dubbed the Heil Committee after committee member Joseph Heil, Sr., issued a report in 1967 that became a road map for the creation of the center. The report supported the creation of the center and drew its attention on the benefits to those institutions that planned to join the project, not the hospitals in merger discussion.[95] The report stated that Milwaukee was one of three major metropolitan regions of the country without such a facility. The committee recommended a location for the Center in Wauwatosa. The final draft of the Articles of Incorporation and by-laws established by

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[91] King, *The Incredible Journey*, 38.
[92] Avella, *Trading Post*, 237.
[93] Avella, *Trading Post*, 239.
[94] Avella, *Trading Post,* 238.
[95] King, *The Incredible Journey,* 45.

members of the business and health care communities completed the proposal. On November 20, 1969 the committee announced the regional medical Center "officially called into existence," as a goal for the future. Essentially speaking, this announcement represented the position of the GMC that the center was a foregone conclusion. The GMC established the Hospital Planning Board (HPB) with the ultimate goal of using federal funds from the Regional Health Care Act of 1965 to establish a regional medical Center outside the city of Milwaukee.[96]

Beginning in the 1960s, hospitals were required to submit plans for expansion to a new organization: The Southeastern Wisconsin Regional Planning Committee (SEWRPC) established in 1960.[97] Its twenty-one members were appointed by the governor, the Secretary of the Department of Development, and the seven southeastern Wisconsin county boards. Three members from each of the counties participating (Milwaukee, Ozaukee, Washington, Racine, Kenosha, Waukesha, and Walworth) served six-year terms. SEWRPC had no acting authority; its role was to conduct research to plan for development in the region to avoid overbuilding in the represented counties. Any recommendations made by SEWRPC were carefully considered before approval for county projects.[98]

Their recommendation was that the Regional Center could not add to the number of beds in the Milwaukee Count area. It was not binding. However, given the new authority, neither The Passavant nor Deaconess could act independently and risk losing revenue under the Development Act of 1974. This act included penalties for violations of any of the recommendations of the local board. In order to build the regional medical center, a

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[96] Avella, *Trading Post*, 238.
[97] Avella, *Trading Post*, 235.
[98] Avella, *Trading Post*, 235-36.

decrease in the current number of hospital beds in Milwaukee had to occur. Construction could not begin until some sort of agreement to reduce the number of beds overall was finalized. SWRPC's report provided the organizations with a vested interest in creating the Regional Medical Center, the GMC and the HAPC, an important recommendation supporting their plan. Avella stated that "With the cooperation of Doyne [,] a vision developed of a coordinated health care Center located on the County Institution grounds, with the medical school and a host of other independent health care facilities in close proximity or attached by bonds of affiliation."[99]

As much support as the regional medical center plan had from local political leaders, the plan for a medical school at the center led to a fortunate situation on the issue of funding. The Medical College of Wisconsin brought prestige to the project. As a teaching hospital, the new hospital gained support from the public.

MEDICAL COLLEGE OF WISCONSIN

The planning board of the new regional Medical Center wanted a medical school to create a teaching hospital at the new center. HAPC members approached representatives at the private, Jesuit School of Marquette University. Marquette University School of Medicine was formally chartered in 1918. By the 1950s the school faced a severe financial crisis. An accreditation team of the Association of the American Medical Colleges flagged the college with a status of "confidential probation" in 1952 because of financial problems.[100] Marquette officials approached trustees of the Kurtis R. Froedtert estate for financial help. Froedtert was a prosperous brewer who had died in 1951. He had

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[99] Avella, *Trading Post*, 239.
[100] Avella, *Trading Post*, 238.

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been a devout Lutheran and left a trust for the construction of a teaching hospital to be named after him.[101] The Marquette Medical School failed to secure any of the funds; the trust money was held up in local business projects, and a lawsuit filed on behalf of the Lutheran Men of America denied the Marquette University School of Medicine's funding requests in part because it was a private Catholic university. They felt the money should go to a Lutheran institution.

Years of declining enrollment and the flagging of its credentials led to a financial crisis that could not be solved by many public funding options because of its private school status. Hill-Burton Act of 1946 provided funds for private hospitals treating patients on Medicare and Medicaid. Hospitals used Hill-Burton funding to build additions and establish specialty departments. State agencies applied for funds to build facilities. Private medical schools could not apply. However, a medical school, as part of a public hospital, did qualify.[102] Marquette was ineligible for government grants through the National Institute of Health and the Hill-Burton Act of 1946 because of its private school status. Each of these federal sources provided millions of dollars to various public institutions for construction and research.[103] Proponents of the Medical Center secured funds for its medical school program because it was eligible for various public financial sources through the Hill-Burton legislation.[104]

The Center leadership's commitment to establish a medical school stemmed from the projected physician shortages in Milwaukee identified in the Heil Report of 1967. GMC leader Edmund Fitzgerald believed the medical school was an integral aspect of the

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[101] Avella, *Trading Post*, 236.
[102] Avella, *Trading Post*, 237.
[103] Avella, *Trading Post*, 237.
[104] Avella, *Trading Post*, 237.

whole Center. The existing program at Marquette University School of Medicine provided an opportunity to include a medical school at the Center. Fitzgerald facilitated the transition of Marquette's medical program from a private religious school to a nonsectarian entity. The Heil Report recommended that the new facility needed a medical school to provide crucial training for future doctors who, in turn, would staff the proposed hospital. After the transition, the medical school became eligible for expanded public funding opportunities.[105] The combined efforts of the GMC and The HAPC succeeded in quickly establishing the medical school at the regional center campus. On September 30, 1967, the medical school program left Marquette University, and in February of 1969 received over one million dollars in state funding for relocation to the Center. Avella noted that because of the actions of the members of the planning board, the school was approved: "After having fended off a court challenge to the aid, the school moved to a new status, changing its name in 1970 to the Medical College of Wisconsin.[106]

This plan for a medical school and an affiliated teaching hospital and the strong support for the Center outpaced Mount Sinai Medical Center's efforts to establish its own medical school.[107] For the leadership of Mount Sinai Hospital, the establishment of a teaching hospital affiliated with a medical school so close to their facility was profoundly disappointing, in part because Mount Sinai Hospital *had* attempted to establish a relationship with the Medical College. Mount Sinai Board members wanted to establish the hospital as a teaching hospital, something they felt would add to the prestige of an already "great" hospital.[108] Mount Sinai needed more patients and hoped to attract them

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[105] Avella, *Trading Post*, 239.
[106] Avella, *Trading Post*, 241.
[107] Avella, *Trading Post*, 238.
[108] Dr. Paul Jacobs, Phone Interview by author, November 2, 2011.

with a medical education program. The renovations in 1972 and 1976 coincided with simultaneous expansions at The Passavant and Deaconess, two hospitals in close proximity. Mount Sinai established a partnership with University of Wisconsin-Madison to create a residency program for new doctors, but only after ending its plans for a medical college of its own. Mount Sinai Board member Ben Marcus remarked that despite several overtures during the 1970s on the part of Mount Sinai, the Medical College "never" responded.[109] The new construction at the hospital included expanded obstetrics and emergency departments, but the leaders at Mount Sinai abandoned plans for a medical school and teaching hospital. This decision increased the financial difficulties at the hospital. The renovations had not brought in more patients and the loss of the teaching hospital and medical school option influenced the merger decision.[110] Mount Sinai leaders searched for another way to establish a teaching program and bring in new patients. This led to two new initiatives at the hospital: a relationship with the University of Wisconsin-Madison and the attempt to establish a Jewish brand for the hospital. The relationship with UW-Madison was a modest success and the attempt at establishing a Jewish brand was for all intents and purposes, unsuccessful.

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[109] Newspaper Clipping, "Addition Gives New Life to Mount Sinai," *Wisconsin Jewish Chronicle*, February 19, 1976, Box 51, Folder 8, Sinai Samaritan Collection.

[110] Newspaper Clipping, "Mount Sinai Hurt by Loss of Payments," *Milwaukee Sentinel,* March 5, 1976, Box 53, Folder 7, Sinai Samaritan Collection.

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CHAPTER 5 IDENTITY, CHANGE, AND INNOVATION AT MOUNT SINAI

Many of the descendants of original East Side Jewish population no longer lived within Milwaukee city limits by the mid 1960s. Jewish doctors had established practices in Milwaukee because of Mount Sinai Hospital. The acceptance of Jewish doctors at other Milwaukee hospitals allowed the doctors to expand their medical practices, facilitated upward economic mobility, and allowed many to follow their patients to the suburbs.[1] As the Jewish community dispersed beyond the city of Milwaukee, in the mid-1960s, Mount Sinai's leaders debated whether the Jewish hospital should go with them. After a great deal of time and effort on the part of the Jewish leadership and the Milwaukee Jewish community at large, they decided not to move. The *Milwaukee Jewish Chronicle* reported that the decision to stay downtown was because, "They [the hospital leaders] believed there was a continued need for a hospital that would serve both the city's Jewish population which had long since moved out of the area, and the residents near the hospital which had become dependent on its services."[2]

The line in this editorial about the hospital "serving the Jewish population that had long since moved of the area" was quite puzzling; the Jewish population *needed* the hospital along with the patients downtown, but why? The small number of board members made the decision to remain downtown. There is no indication that any vote was taken about the future of Mount Sinai. It is possible that the success of the fundraising drive that financed expansion implied support for the downtown location.[3]

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[1] John Gurda, *One People, Many Paths: A History of Jewish Milwaukee* (Milwaukee, WI: Jewish Museum Milwaukee, 2009), 197.

[2] Newspaper clipping, "Addition Gives New Life to Mount Sinai," *Wisconsin Jewish Chronicle*, February 19, 1976, Box 51, Folder 8, Sinai Samaritan Medical Center Records, Milwaukee Mss Collection 108, University of Wisconsin-Milwaukee Libraries, Archives Department (hereafter cited as Sinai Samaritan Collection).

[3] Newspaper clipping, "Addition Gives New Life to Mount Sinai," *Wisconsin Jewish Chronicle*, February 19, 1976, Box 51, Folder 8, Sinai Samaritan Collection.

The iconic Star of David edifice added with the 1972-74 expansion and the hiring of a full time Rabbi who was also a *mohel* signified a Jewish presence, but the changes were more cosmetic than substantive as religious expressions.[4] These additions sought to set Mount Sinai apart as a Jewish brand, rather than change the nonsectarian mission and adopt a religious identity. Pat Kerns stated that "we wanted to give something back." The decision was announced by board president Ben D. Marcus who "lauded the hospital for making the decision to remain downtown."[5]

That decision, combined with the approved construction of the Regional Medical Center, rendered their plans to brand Mount Sinai as a teaching hospital moot. There was considerable conflict between hospital administrators and board members over the issue of increasing revenue at Mount Sinai. Mount Sinai leaders realized a collaboration with the Marquette Medical School to become a teaching hospital was no longer possible. The Regional Medical Center had a medical school already, there was no need for another full medical school in Milwaukee. Two different approaches to address the growing financial shortfall; surfaced, one championed by Ray Alexander, Vice President of Mount Sinai, the other from board members and doctors at the hospital. Alexander believed that establishing a religious identity at Mount Sinai would increase hospital census numbers. The board members wanted to look at other Jewish hospitals and identify any changes or new ideas that could be brought to Mount Sinai. The literature presented thus far sheds light on the reason for the conflict: the different approaches to measure and establish Jewish identity. Ray Alexander's action suggest that he believed that instituting religious practices at the hospital created a Jewish identity for the hospital. The members of the

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[4] Rabbi Tsvi Schur, Phone Interview by author, March 23, 2011.
[5] Newspaper clipping, "Addition Gives New Life to Mount Sinai," *Wisconsin Jewish Chronicle*, February 19, 1976, Box 51, Folder 8, Sinai Samaritan Collection.

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board and the doctors acted to emphasize their presence at the hospital as a way of bringing attention to the Jewish leadership and medical practitioners present since the hospital opened.

Ultimately, the answer to the question about what actually constituted Jewish identity became less important in light of the effects of government programs created in 1965. The Medicaid (Title XIX) program initially covered the full cost of care for patient treatment. As medical costs increased, reimbursements for costs of care for those using Medicaid and Medicare fell behind the costs to the hospital. These programs ended the community funding for private hospitals. In a sense, these government programs severed the relationship between communities and hospitals.

For a time, Board members and physicians believed that by branding Mount Sinai as a Jewish hospital, it was possible that new patients, assuming they believed in the conventional wisdom about how Jewish hospitals were among the best, would use the facility in greater numbers. They hoped to capitalize on that stereotype in an effort to bring more private paying patients to Mount Sinai.[6] Their attempts to do so foundered due to the conflicts between Alexander and the board and doctors about what exactly constituted a Jewish identity. Ray Alexander, Vice President of Mount Sinai from 1969-1976, committed a great deal of time and support toward the goal of establishing a Jewish identity centered on establishing religious practices and iconography at Mount Sinai.[7] Dr. Paul Jacobs, on the other hand, reported that hospital board leaders and many of the doctors wanted to emphasize the fact that the hospital was Jewish without radical

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[6] Dr. Paul Jacobs, Phone Interview by author, November 2, 2011.
[7] Executive Vice President Report, May 1971, Mount Sinai Hospital Collection, Box 1, Folder 1, Jewish Museum Milwaukee Archives (hereafter cited as JMM Archives).

changes to its administration, design, or practices.[8] The two positions are best described as a choice between establishing a Jewish identity and establishing a Jewish brand. A Jewish identity required a departure from the nonsectarian history of the hospital. Establishing a Jewish brand meant capitalizing on the history of Mount Sinai and the contribution of the Jewish population in Milwaukee.

Establishing a Jewish identity through the recognition of specific Jewish religious practices as proposed by Alexander at Mount Sinai Milwaukee represented an attempt at major change while continuing the mission of the hospital. He advocated the idea that making Mount Sinai more "Jewish" would complement the historic nonsectarian mission of the hospital. Alexander hoped that by doing so, Mount Sinai- Milwaukee could attain the success of other Jewish hospitals. Mount Sinai New York opened in an area with a higher number of Jewish residents. It began as a Jewish hospital and eventually adopted a nonsectarian mission.[9] Beth Israel in Newark also treated a large Jewish population and began as a Jewish hospital, with a nonsectarian mission adopted later.[10] Beth Israel in Boston did the same.[11] These hospitals were considered Jewish from the very start. Michael Reese in Chicago adopted a nonsectarian mission, but treated a large Jewish population. It was also recognized as a Jewish hospital.[12]

By comparison, Mount Sinai Milwaukee began as a nonsectarian hospital and historically had more Gentile patients. Observing the Sabbath, an increased emphasis on celebrating Jewish holidays, and offering Kosher meals were not part of the hospital's

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[8] Dr. Paul Jacobs, Phone Interview by author, November 2, 2011.

[9] Arthur H. Aufses, Jr., and Barbara J. Niss, *This House of Noble Deeds: The Mount Sinai Hospital, 1852-2002* (New York: New York Press, 2002).

[10] Alan M. Krause and Deborah A. Krause, *Covenant of Care: Newark Beth Israel and the Jewish Hospital in America* (The Jewish Historical Society of Metro West, 2007).

[11] Arthur J. Linenthal, *First a Dream: The History of Boston's Jewish Hospitals 1896 to 1928* (Boston: Beth Israel Hospital, 1999).

[12] Lucy Freeman, *Hospital in Action: The Story of the Michael Reese Medical Center* (Chicago: Rand McNally & Company, 1956).

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practices.[13] At the time hospital leaders considered these changes, the hospital treated more Gentile patients than Jewish. The former Jewish neighborhoods near Milwaukee were now almost completely Gentile and black. Historian Joe Trotter found that African Americans settled in West Side neighborhoods near Jewish residents. In the 1920, African Americans and Jews lived in close proximity, in the sixth and tenth wards. After 1930, the African American population concentrated in areas vacated by the Jewish population.[14] By the 1970s, the neighborhoods adjacent to Mount Sinai Hospital were predominantly black.[15] The decision to remain downtown and treat Gentile patients signified the fact that Mount Sinai's leaders acknowledged the success of the nonsectarian mission. The number of Jewish patients at Mount Sinai was lower from the beginning. In addition, in the postwar years, Jewish patients in the suburbs of Milwaukee started using hospitals closer to their homes, instead of patronizing Mount Sinai exclusively. In addition, more Jewish doctors established themselves at other hospitals and more Gentile doctors began to practice at Mount Sinai.[16] Concurrently, the creation of a medical education program sought to elevate the status of Mount Sinai as teaching hospital, like many of the Jewish hospitals cited above. Like other Jewish hospitals in large cities, Mount Sinai Milwaukee hoped to create a reputation as an institution of innovation and learning.[17]

In light of changes in public policy, health care costs, and health care services emerging in the late 1960s and early 1970s, the Milwaukee Jewish community's support for Mount Sinai proved crucial. Their fundraising efforts paid for a massive expansion of Mount Sinai Hospital in the 1970s. Mount Sinai's leaders implemented two significant

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[13] Pat and Joan Kerns, Interview by author, Mequon, Wisconsin, May 24, 2011.
[14] Joe William Trotter, Jr., *Black Milwaukee: The Making of an Industrial Proletariat, 1915-1945* (Urbana: University of Illinois Press, 1985), 67.
[15] John Gurda, *The Making of Milwaukee* (Milwaukee, WI: Milwaukee County Historical Society 2006), 376.
[16] Dr. Harry Kanin, Interview by author, Milwaukee, Wisconsin, July 14, 2011.
[17] Dr. David Amrani, Interview by author, Milwaukee, Wisconsin, July 14, 2011.

initiatives during the 1970s to meet the needs of patients and stay financially viable: the attempt to establish a more distinct Jewish identity at the newly renovated Mount Sinai Medical Center and a partnership with the University of Wisconsin-Madison for medical interns and residents. The first floundered; the second was a mixed blessing.

STAYING IN MILWAUKEE: DECISIONS

The Jewish population in Milwaukee in the early twentieth century lived in neighborhoods on the east and west sides of the Milwaukee River. Between 1925 and 1950 the Jewish community established a concentrated presence in neighborhoods north and east of the downtown area. By 1963, the West Side Jewish population was concentrated in Milwaukee, in Sherman Park, while the East Side population had moved to the North Shore suburbs.[18] All the while, Mount Sinai Hospital remained in its location at Kilbourn Avenue and Twelfth Street.[19] Until the 1960s, Jewish doctors who established practices in Milwaukee could practice only at Mount Sinai Hospital. Other Milwaukee hospitals' withholding of privileges for Jewish doctors revealed one of Mount Sinai's crucial functions: it enabled the growth of a successful Jewish medical professional class that paralleled the established Jewish business class in Milwaukee.[20] Many Jewish businessmen and doctors were able to achieve the upward social mobility necessary to move their families out of the urban core.[21] Historian John Gurda referred to the years between 1945 and 1967 as "the golden age" for the Jewish community. Jewish institutions in Milwaukee were thriving in the post war years. Many Jewish families

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[18] Gurda, *One People, Many Paths,* 197.
[19] "Guidelines for the Development of Jewish Communal Services in Greater Milwaukee: A Report of the Planning Committee on Health and Medical Services, 1967," Page 21, Mount Sinai Hospital Collection, Box 1, Folder 5, JMM Archives (hereafter cited as The Rosenfeld Study).
[20] Dr. Harry Kanin, Interview by author, Milwaukee, Wisconsin, July 14, 2011.
[21] Pat and Joan Kerns, Interview by author, Mequon, Wisconsin, May 24, 2011.

relocated as a result of economic success, moving to more affluent areas outside of the city. They left behind the old neighborhoods that began to decline.[22] By 1967, Jewish doctors had gained privileges at other Milwaukee hospitals and were not practicing exclusively at Mount Sinai. Harry Kanin and Jay Larkey reported that by this time discriminatory practices at other Milwaukee hospitals ended and Jewish doctors were no longer barred from them.[23]

Their Jewish patients began to patronize other hospitals as well; many were now living outside the city limits in suburban Fox Point, Glendale, and Mequon and used the hospitals closer to their homes.[24] In this respect, the Jewish community of Milwaukee was not unlike the Jewish populations of other urban areas; after World War II, Jewish families were able to move to the suburbs in part because of their economic achievements. Historian Hasia Diner notes,

> If any era in the history of American Jewry could be considered a "golden age" it would be the twenty years following World War II. They crafted a series of new communal practices that reflected the dominant themes of the postwar age: prosperity and affluence, suburbanization and acceptance. Jews in their associations and organizations emphasized that they supported America's increasing commitment to end privilege based on race, religion, and national origin. In this era dominated by a new kind of Jewish mobility—the move from the cities to the suburbs—American Jews found ways to combine middle class comforts, social activism, and Jewish commitments.[25]

The descendants of the original Milwaukee East Side and West Side Jewish immigrants were part of that "golden age" of upward mobility and suburbanization. Even after relocating, their ongoing commitment to Mount Sinai Medical Center was the means by which Milwaukee's Jewish community gave back to their original neighborhoods.

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[22] Gurda, *One People, Many Paths,* 189.
[23] Dr. Harry Kanin, Interview by author, Milwaukee, Wisconsin, July 14, 2011 and Dr. Jay Larkey, Interview by author, Milwaukee, Wisconsin, August 17, 2011.
[24] Dr. Harry Kanin, Interview by author, Milwaukee, Wisconsin, July 14, 2011.
[25] Hasia Diner, *The Jews of the United States: 1654 to 2000* (University of California Press, 2004), 259.

Many Jewish civic organizations, including synagogues and community programs, followed Milwaukee's Jews out of the city; Mount Sinai Medical Center was the exception. This migration was not unusual; in many urban areas, the Jewish community and the organizations they established moved together.[26]

Jewish leaders were aware that keeping Mount Sinai in downtown Milwaukee would mean fewer Jewish patients, but that knowledge did not prompt them to relocate the hospital. A study commissioned by three major Milwaukee Jewish institutions, Mount Sinai Hospital, the Jewish Home for the Aged, and the Jewish Convalescent Center, influenced the decision to stay downtown. The Jewish Welfare Fund funded the study. It was the central charitable organization in Milwaukee.[27] The Rosenfeld study, which was referred to by the name of its main author, Eugene Rosenfeld, supplied data about the city's population distribution and suggestions and plan for the Boards of the four institutions to consider in order to improve their operations. The study also provided data to assist the institutions in determining what changes should be made to best serve the Milwaukee community through their cooperative efforts.[28] The study provided information about social and economic environment in Milwaukee in the geographic areas serviced by the Jewish organizations. It outlined and provided the information foundation for establishing a medical training and research program at Mount Sinai, including policy objectives, staffing, finances, and administrative structures required to coordinate their efforts.[29] In short, the Rosenfeld Study provided Jewish leaders at these four Jewish institutions with a great deal of data to assist them in decisions for the future

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[26] Donald Weber, *Haunted in the New World: Jewish American Culture from Cahan to the Goldbergs* (Bloomington: Indiana University Press, 2005).
[27] The Rosenfeld Study, Page 3, Box 1, Folder 5, Mount Sinai Hospital Collection, JMM Archives.
[28] The Rosenfeld Study, Page 1, Box 1, Folder 5, Mount Sinai Hospital Collection, JMM Archives.
[29] The Rosenfeld Study, Page 7, Box 1, Folder 5, Mount Sinai Hospital Collection, JMM Archives.

of Jewish Community efforts in Milwaukee. The decision solidified the commitment of the Jewish community to the city, even as the Jewish population moved outward. Mount Sinai continued as a nonsectarian hospital under Jewish sponsorship until the 1987 merger, in part due to this decision.

THE ROSENFELD STUDY

The Boards of the four facilities, Mount Sinai, the Jewish Convalescent Home, the Jewish Home for the Aged, and the Jewish Welfare Fund, commissioned the Rosenfeld Study to assist in the creation of a cooperative future between these institutions, which all served the health care needs of Jewish Milwaukee. The employees of Eugene D. Rosenfeld MD, of E. D. Rosenfeld Associates Incorporated, Hospital and Health Services, conducted the study and submitted the findings to leaders at each institution and the Milwaukee Jewish Federation.[30] These consultants from New York City conducted the study in order to "suggest short and long term guidelines for the development of health services for the Jewish community."[31] The study "suggested appropriate methods for the Jewish community to meet its obligations in health care to itself and the general community."[32] It measured the current and projected health and medical needs of the Jewish and non-Jewish communities in Milwaukee and made recommendations to the Jewish-sponsored agencies in respect to their specific and joint responsibilities to meet those needs. The study included suggestions and methods for meeting the costs involved. It also recommended that the Milwaukee Jewish Federation serve as a central

[30] The Rosenfeld Study, Pages 3-4, Box 1, Folder 5, Mount Sinai Hospital Collection, JMM Archives.
[31] The Rosenfeld Study, Page 4, Box 1, Folder 5, Mount Sinai Hospital Collection, JMM Archives.
[32] The Rosenfeld Study, Page 4, Box 1, Folder 5, Mount Sinai Hospital Collection, JMM Archives.

communication link between the health services of the three facilities.[33] Finally, it highlighted the need for the three health care facilities to develop new programs and define their functions and offerings to the Jewish community of Milwaukee and guided the leadership at the Jewish Welfare Fund in decisions about funding those efforts.[34]

The Rosenfeld researchers concluded that the residents of downtown Milwaukee, the majority of them non-Jewish, relied on Mount Sinai for their health care. The report then made suggestions for how Mount Sinai, the Home for the Aged, and the Convalescent Home could strengthen their cooperation and communication to serve Milwaukee residents. The study suggested partnerships between the facilities.[35] They discovered a relative lack of efficiency in each of the health care settings. All three facilities, Mount Sinai, Jewish Home for the Aged, and the Jewish Convalescent Center provided almost identical services. In addition, the study determined that some parts of the facilities at Mount Sinai were "obsolete, inefficient or inadequate" and suggested upgrades of some sort, either through relocation or remodeling.[36]

Pat Kerns recalls the Board meeting in 1967 that resulted in the decision to keep Mount Sinai Hospital downtown. In that meeting he stated only a few voted differently; the majority of the Board committed to keeping the hospital in Milwaukee to continue to mission of caring for the needy in Milwaukee. Leaders had already committed to staying downtown. The study included suggestions for the renovation.[37]

The demographic information in the Rosenfeld Study confirmed that the number of Jewish patients at Mount Sinai was very low, as was the number of Jewish families living

[33] The Rosenfeld Study, Page 4, Box 1, Folder 5, Mount Sinai Hospital Collection, JMM Archives.
[34] The Rosenfeld Study, Page 4, Box 1, Folder 5, Mount Sinai Hospital Collection, JMM Archives.
[35] The Rosenfeld Study, Page 6, Box 1, Folder 5, Mount Sinai Hospital Collection, JMM Archives.
[36] The Rosenfeld Study, Page 6, Box 1, Folder 5, Mount Sinai Hospital Collection, JMM Archives.
[37] Pat and Joan Kerns, Interview by author, Mequon, Wisconsin, May 24, 2011.

near the hospital. The majority of Milwaukee's non-white population was found to be most highly concentrated within the near north side area of the city, just north of Mount Sinai.[38] The patients living in Mount Sinai's neighborhood were less affluent than elsewhere in the city, and the report revealed that a full three-quarters of charity care patients at Mount Sinai lived in areas "immediately adjacent to the hospital."[39] Historian Joe Trotter noted that African Americans settled in Jewish immigrant neighborhoods in the central business district (CBD) as early as 1910. Mount Sinai was built on the western boarder of the CBD. The decrease in Jewish immigration in the 1920s and residential mobility decreased the number of Jewish families. The African American population grew as the Jewish population decreased.[40] Gurda notes that, "The Near North Side became the heart of Milwaukee's African American community. Between 1940 and 1960, black residents grew from 46 of the old Jewish quarter's population to 85 percent. Nearly all the old synagogues that survived the wrecking ball were purchased by African American congregations."[41]

The creation of the federal Medicaid program meant that poor patients did not have to travel farther away from their homes to the County Hospital. This hospital, which had served the downtown patient base, had relocated in 1968 from the city to the new Regional Medical Center outside of Milwaukee city limits, in Wauwatosa. City residents sought services closer to home. Mount Sinai Hospital was their hospital, even if they were not Jewish, because it was in their neighborhood.[42]

The Rosenfeld Study also suggested that the leadership of Jewish efforts in health

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[38] Pat and Joan Kerns, Interview by author, Mequon, Wisconsin, May 24, 2011.
[39] Pat and Joan Kerns, Interview by author, Mequon, Wisconsin, May 24, 2011.
[40] Trotter, *Black Milwaukee*, 64.
[41] Gurda, *One People Many Paths,* 160.
[42] Gurda, *One People, Many Paths*, 160.

care needed a strong board to take responsibility for policy decisions by "interpreting

the hospital's needs through its relationship with staff and administration." The

decisions about the future operations of the three institutions had to be collaborative.

The reason for the inefficiency stemmed from the lack of communication and

collaboration between leaders in health care service institutions in Milwaukee.[43] The

study recommended cooperation between the three facilities in order to serve

Milwaukee and highlighted the need for open and cooperative Jewish leadership,

stating,

> Historically, the Mount Sinai Hospital Board of Trustees has been a closed
> self-perpetuating body, not well representative of the Jewish community
> and concentrating too often on operational problems, without clear-cut
> long-range development goals on education, research, and facilities. In the
> past, it has not worked closely with the Welfare Fund and the Jewish
> community to obtain sufficient understanding and support of its program.
> The present policy and administration bodies should be strengthened and
> reorganized and eliminate confusion by creating a framework for each area
> to work from and with.[44]

The decision to remain downtown preserved the original mission to care for the poor in

Milwaukee. That decision could signify a tacit acceptance of the Rosenfeld Study's

findings. Archival documents do not contain any Board meeting minutes that illuminate

any debate. They committed themselves to strengthening the hospital's medical

reputation in order to draw more patients to the hospital by way of a large-scale

renovation of the existing facility. They explored options that would strengthen their

relationships with Milwaukee's other Jewish institutions and work together.

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[43] The Rosenfeld Study, Page 16, Box 1, Folder 5, Mount Sinai Hospital Collection, JMM.
[44] The Rosenfeld Study, Page 16, Box 1, Folder 5, Mount Sinai Hospital Collection, JMM.

FUNDING THE JEWISH BRAND

The issue of money remained problematic. Leaders at Mount Sinai believed the key to alleviating deficits from decreased reimbursements for care was to increase revenue. They resolved to enlarge the hospital and solicit support from more members of the Jewish community. If Jews would no longer be patients at Mount Sinai, they could remain volunteers and donors. Mount Sinai had a strong Ladies Auxiliary with experience raising funds and volunteering.[45] However, the Milwaukee Jewish community's historic financial support of the hospital was decreasing over the course of the 1970s.[46] Auxiliary members contributed many volunteer hours and sponsored an annual fund raising ball, but the formal charitable structure funding Jewish efforts fragmented upon their departure from Milwaukee. As the number of Jewish organizations to serve the suburban Jewish population outside of Milwaukee increased, the amount of money available to Mount Sinai decreased.[47] Also, the public perception that indigent care at Mount Sinai Hospital was covered through Medicare and Medicaid decreased the perceived urgency of raising funds for the hospital from the community. Mount Sinai's donors believed that the Medicaid and Medicare programs were paying for indigent care. In fact, in many cases, these programs covered only a portion of the total cost of patient care. In addition, patients with no insurance added to the hospital's overall deficit.[48] The relocation of the more affluent Jewish community meant that while Mount Sinai remained in Milwaukee, the Jewish community leaders were not as accessible as they had been before the move. The change in geography distanced them from the hospital. They established community

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[45] Pat and Joan Kerns, Interview by author, Mequon, Wisconsin, May 24, 2011.
[46] Pat and Joan Kerns, Interview by author, Mequon, Wisconsin, May 24, 2011.
[47] Dr. David Amrani, Interview by author, Milwaukee, Wisconsin, July 14, 2011.
[48] Dr. Paul Jacobs, Phone Interview by author, November 2, 2011.

centers and *shuls* near their new homes and devoted their time and resources to nurturing the new institutions. The Rosenfeld Study noted that over time and distance a problem arose; disagreement between members of the Jewish population existed over the degree of its responsibility for the maintenance of service for a large number of persons from Milwaukee as well as for the Jewish community now living outside the city.[49]

This situation was of particular significance for Mount Sinai Hospital. Some of the confusion stemmed from urban problems common to all cities and involved all types of voluntary entities. The Milwaukee Jewish population, like other immigrant groups, left the buildings of their community behind and built new structures in new areas. Many of the synagogues left behind were razed or purchased by others.[50] The hospital was different. It was not razed. It was not reestablished in a new Jewish suburban location, and it was not purchased by another entity. It was still the Jewish-sponsored nonsectarian hospital in Milwaukee.[51]

The Rosenfeld Study found that the Milwaukee institutions helped define and identify the Jewish population and served as an opportunity for Jewish civic involvement in Milwaukee, even after many Jewish families moved north of the city.[52] Its operations were a credit to the community. Gurda remarks that, "Landmarks like Mount Sinai and the JCC had raised the community's local profile."[53] The study highlighted the fact that the majority of the Jewish population had not been sufficiently involved in decisions of the role and direction for its remaining health care agencies. The study suggested engaging more members of the population. The study suggested Mount Sinai and the

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[49] The Rosenfeld Study, Page 21, Box 1, Folder 5, Mount Sinai Hospital Collection, JMM Archives.
[50] Gurda, *One People Many Paths,* 189.
[51] Gurda, *One People Many Paths,* 189.
[52] The Rosenfeld Study, Box 1, Folder 5, Mount Sinai Hospital Collection, JMM Archives.
[53] Gurda, *One People Many Paths,* 189.

other institutions needed that strong support.[54] The study recommended increasing the involvement of the Jewish population beyond fund raising drives. Ray Alexander hoped the decision to consider a more religious Jewish identity at the newly renovated Mount Sinai Medical Center would increase the involvement of the Jewish people. The Rosenfeld Study suggested that the leadership recruit new representatives beyond the "closed self-perpetuating body" of leaders identified in the study.[55] The Board sought ways to elevate the prestige of the hospital by appealing to the affluent members living outside Milwaukee. There is no mention in the Rosenfeld Study of creating religious programs or practices at these institutions.

The Rosenfeld Study also noted that medical training opportunities in Milwaukee lagged behind other large cities. Other Milwaukee hospitals were offering training in the emerging specialties for residents and interns, but the study noted that at Mount Sinai,

> The hospital itself is not providing the opportunities and the climate in which the capacities of the staff can flourish. This along with the negativism on the part of many staff members about teaching and lack of interest by others has been one of the great problems of Mount Sinai Hospital. . .On the whole; the older men are less committed and less willing to devote time and leadership to education and research. The younger men would like more facilities and services allocated to these activities and are discouraged about the hospital's failure to move in these directions. . .The absence of a comprehensive health center is perhaps the most obvious reflection of this weakness. Milwaukee is one of only three cities among the 25 SMAs in the United States that does not provide at least one major medical center for its citizens. One of three without one single outstanding general hospital of national note.[56]

The Rosenfeld Study, like the Heil Report commissioned by a subcommittee of the Regional Medical Complex planning board in 1967, noted Milwaukee's lack of a large-scale medical facility. This was one the reasons that leaders at Mount Sinai wanted

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54 The Rosenfeld Study, Page 12, Box 1, Folder 5, Mount Sinai Hospital Collection, JMM Archives.
55 The Rosenfeld Study, Page 12, Box 1, Folder 5, Mount Sinai Hospital Collection, JMM Archives.
56 The Rosenfeld Study, Page 12, Box 1, Folder 5, Mount Sinai Hospital Collection, JMM Archives.

to establish a medical school program; doing so would address the need for learning opportunities for doctors and create a regional medical Center. In Milwaukee, however, approval for the Medical College of Wisconsin at the County Regional Medical Complex in Wauwatosa usurped those plans. In 1974, Mount Sinai established a teaching program affiliated with a major Wisconsin university as an alternative way to accomplish both goals.[57] It was not quite what the Board members envisioned, but at the very least the partnership addressed the need for medical education at Mount Sinai. The Rosenfeld Study led to two significant initiatives at Mount Sinai during the 1970s: exploring a more Jewish identity and establishing a teaching partnership with the University of Wisconsin-Madison. Each initiative presented hospital leaders with additional challenges. The Jewish community in Milwaukee had never been religiously homogeneous, not even close, but a strong commitment to the city that had provided generations of Jewish residents with opportunities and acceptance transcended differences between the East Side and West Side Jews. Mount Sinai Medical Center remained a source of pride and civic service for the entire Jewish population, whether they lived in Milwaukee or not.

There was a great deal of disappointment on the part of Mount Sinai leaders over the unsuccessful attempt to partner with the new medical center in Wauwatosa. Many had personally approached leaders at the center in an attempt to strike a deal. Several attempts to establish any affiliation between the facilities failed.[58] Leaders at the medical college at the Regional Medical Center expressed no interest in partnering with Mount Sinai, citing a 1954 accreditation survey which recommended that the College "should not let

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[57] Newspaper clipping, "Medical School Affiliation Aids Hospital," *Wisconsin Jewish Chronicle,* April 22, 1976, Box 51, Folder 8, Sinai Samaritan Collection.
[58] Norman H. Engbring, *An Anchor for the Future: A History of the Medical College of Wisconsin, 1893-1990* (Milwaukee, WI: Medical College of Wisconsin, 1991), 283.

service to the community impinge on the academic mission."[59] By 1959, college leaders were urged to consolidate the facilities in Wauwatosa rather than disperse services to other hospitals in Milwaukee.[60]

They funded the ambitious renovation through a fund raising campaign named "Once in a Generation."[61] Board president Ben Marcus remarked that, "The Jewish community in Milwaukee is not only involved in Jewish causes, but it deeply involved in welfare, the arts, industry, and civic enterprises throughout the state of Wisconsin. We are willing to assume positions of leadership and we are proud that we care."[62] This drive raised enough money to create a facility fit for a medical college and the title teaching hospital. The new Star of David erected over the main entrance of Mount Sinai signified a Jewish hospital. But what *kind* of Jewish hospital? Differences in religious observance among members of the Jewish community complicated the exploration toward *being* a Jewish hospital. As a nonsectarian hospital, adopting a Jewish brand through the support of the Jewish population, the religious differences did not matter; but as a religious hospital, those differences became important and more contentious.

Alexander strongly supported the plan to establish religious observant practices at Mount Sinai; the board wanted to brand Mount Sinai Hospital Jewish. Alexander wanted to change the nonsectarian mission of Mount Sinai, and the Board wanted to capitalize on stereotype that Jewish doctors and Jewish hospitals were the among the best and establish a Jewish brand that celebrated the Jewish support for the hospital. But when he left his position, the Board pursued other options for the future of the hospital.

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[59] Engbring, *An Anchor for the Future*, 283.
[60] Engbring, *An Anchor for the Future*, 283.
[61] News Release, "Once in a Generation" Fund Raising Drive, June 29, 1972, Folder 9, Mount Sinai Hospital Collection, JMM Archives.
[62] News Release, "Once in a Generation" Fund Raising Drive, June 29, 1972, Folder 9, Mount Sinai Hospital Collection, JMM Archives.

A PRACTICING JEWISH HOSPITAL

Raymond Alexander was the Executive Vice President of Mount Sinai at the time of Rosenfeld Study. He came to Mount Sinai from Mount Zion Hospital in New York City. He dedicated a great deal of time and effort to the task of creating a Jewish religious identity at Mount Sinai and used his experience and contacts from New York and Mount Zion to further the cause of creating a Jewish religious presence at Mount Sinai Milwaukee.[63] In May of 1971, Alexander issued a report claiming that 1971 was "the most decisive year in Mount Sinai's history." He stated that the "boldness and foresight with which the Board and Medical Staff of Mount Sinai have moved" by creating new medical programs was commendable. He wanted to pursue a religious Jewish identity with the same level of determination.[64] He also stated that there was to be a new philosophy that Mount Sinai and other Jewish hospitals could embrace, one that advocated that "Health care should be a right and not a privilege, and that the heritage of Judaism with its emphasis on social justice. . .all concede to emphasize the health care role."[65]

Mount Sinai had already committed their hospital to serving health care services to those in need, as a nonsectarian hospital, in 1903. The decision to brand the hospital as Jewish really had less to do with a "new" commitment to social justice and more to do with making Mount Sinai a Jewish hospital as a marketing strategy.[66] Alexander pursued the establishment of a religious Jewish identity with what could only be described as

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[63] Executive Vice President Report, May 1971, Folder 1, Mount Sinai Hospital Collection, Jewish Museum Milwaukee.
[64] Executive Vice President Report, May 1971, Folder 1, Mount Sinai Hospital Collection, Jewish Museum Milwaukee.
[65] Executive Vice President Report, May 1971, Folder 1, Mount Sinai Hospital Collection, Jewish Museum Milwaukee.
[66] Newspaper clipping, "Hospitals Hold On To Jewish Identity," *Wisconsin Jewish Chronicle*, April 29, 1976, Box 51, Folder 8, Sinai Samaritan Collection.

"boldness." The Board sought to emphasize the fact that the Jewish doctors at their nonsectarian hospital treated all.

On January 24, 1971, Alexander invited Dr. Lowell Eliezer Bellin, the First Deputy Health Commissioner of the New York City Health Department, to speak at a celebration for newly appointed Chiefs of Staff at Mount Sinai. In his comments, Bellin addressed the importance of the relationship between Jewish hospitals and Jewish identity. He believed that Jewish hospitals were vital not just for the cities they operated in but for the Jewish community.

> But if Jewish hospitals were to vanish tomorrow from the United States, it would spell tragedy both for the general community and for the Jewish community. It is not chauvinistic to mention here that Jewish voluntary hospitals are among the best in the United States. They have set local and national standards for therapy, teaching, education, and general innovation. Substitutes for them in sufficient numbers are not imminent, and the mediocre institutions actually available to take their place would add morbidity and mortality of all ethnic groups. Moreover, the continued existence of the hospital under Jewish auspices accords with a sophisticated Jewish Realpolitik.[67] In some communities the mere threat of founding a Jewish hospital has been enough to encourage other local hospitals to liberalize their staff privileges to Jewish physicians. I anticipate no immediate reversion to the pervasive anti-semitism [sic] of the medical schools and the hospitals, which besmirched our nation until recently. Nevertheless, I agree with those who suggest caution before giving ourselves over totally to generalized de-ethnicized auspices. "The poor of your own city take precedence over the poor of another city," counseled the Talmud, opposing thereby an escapism into holism in which the poor of neither city receive succor.[68]

Bellin believed that Jewish religious hospitals had an important role in health care and in the Jewish community as a whole for the survival of a Jewish identity. He argued that Jewish communities had to reinvest in their religious institutions as part of a plan to "re-Judaize" their identities. He noted the potential for some Jewish communities to,

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[67] Emphasis in original.
[68] Dr. Lowell Eliezer Bellin, "The Role of the Jewish Voluntary Hospital in the 1970s–Leadership vs. Trivialization," January 24, 1971, Page 14, Folder 9, Mount Sinai Collection, Box 1, Folder 2, Jewish Museum Milwaukee.

Be indifferent and possibly hostile. To these. . . I would respectfully submit that during the next ten years any agency that is viewed as of dubious Jewish authenticity, of spurious Jewish particularism, and of ambiguous Jewish accomplishment will find it increasingly difficult to obtain support from the Jewish community that becomes increasingly assertive about its identity, and has many calls upon it from competing Jewish causes.[69]

The support for a distinct Jewish religious character for hospitals like Mount Sinai linked to the Jewish community as a whole. Bellin elaborated on his statements about Jewish identity and emphasized the merits of a strong Jewish identity for the community and highlighted the absence of such at Mount Sinai. He was particularly concerned about the lack of Jewish presence in the hospital and in the community, stating,

> The following areas are worthy of discussion: (1) It is grotesque that some Jewish hospitals in this country as a matter of policy do not hire pious Sabbath observers. There is no incompatibility between running a hospital 24 hours a day, 7 days a week, and having observant Jews on the staff. Similarly, there is no incompatibility between fiscal solvency and the maintenance of a kosher kitchen. (2) The Jewish hospital as a "Jewish" institution should be able, without defensiveness, to assert its religious identity. The Christmas tree on the lawn of the Jewish hospital has been cited so often that it has become a cliché. It is intolerable that there are Jewish physicians within Jewish hospitals who routinely urge their new Jewish mothers, for the sake of convenience, to circumcise their sons before the 8th day and thereby eschew the religious ceremony of the Briss [sic] altogether.[70]

After decades of service to Milwaukee as a nonsectarian hospital, Alexander urged the Board at Mount Sinai to seriously consider strengthening the Jewish presence at Mount Sinai by incorporating religious observance at the hospital. Mount Sinai did not provide Kosher food, had a nondenominational chapel for patients and families, and apart from the name, did not display a Jewish religious identity in the hospital. Sabbath observance was not part of hospital policy, but patients could elect to observe the Sabbath if they

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[69] Dr. Lowell Eliezer Bellin, "The Role of the Jewish Voluntary Hospital in the 1970s−Leadership vs. Trivialization," January 24, 1971, Page 14, Box 1, Folder 9, Mount Sinai Collection, JMM Archives.
[70] Dr. Lowell Eliezer Bellin, "The Role of the Jewish Voluntary Hospital in the 1970s−Leadership vs. Trivialization," January 24, 1971, Page 16, Box 1, Folder 9, JMM Archives.

wished. Norma Achter, a nurse at Mount Sinai for over forty years, reported that there were volunteers who lit Sabbath candles for patients, and staff avoided any unnecessary procedures if they violated the prohibition against working on the Sabbath.[71] The hospital was decidedly nonsectarian; Abraham Slimmer, the original benefactor of Mount Sinai predicated his continued support on the nonsectarian mission for Mount Sinai. Even the orthodox West Side immigrants used the hospital when it opened in 1903 had been expected to embrace the less ritualized Judaism of the East Side Jewish community that operated Mount Sinai while they were patients. By 1971, Slimmer had long since passed away, and the Board was now seriously considering embracing a Jewish identity for marketing the hospital.[72] The Board wanted to brand the hospital as Jewish, but did not support incorporating specific religious practices, their use of the term identity was, unsurprisingly, secular; they wanted to highlight the presence of Jewish doctors at Mount Sinai and the support that came from Milwaukee's Jews. Their understanding of Mount Sinai's Jewish "identity" resulted from the belief that the hospital was Jewish because they made it so, through their support.

By 1974, the Mount Sinai Jewish Hospital Study Mission was formed to investigate other Jewish urban hospitals in order to learn more about successful urban Jewish hospital. The Study Mission included Board members, doctors, Ladies' Auxiliary representatives, and Jewish community members at large.[73] Volunteers traveled to Jewish hospitals in Chicago, Detroit, Toronto, and St. Louis to meet with staff and reported their findings to the board at large. In a letter to Mrs. Ruth M. Rothstein of Mount Sinai Hospital Chicago, Alexander explained that the "Mount Sinai Study Mission" wanted to

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[71] Norma Achter, Interview by author, Reedsville, Wisconsin, May 15, 2011.
[72] Executive Vice President Report, May 1971, Box 1, Folder 1, Mount Sinai Hospital Collection, JMM Archives.
[73] Executive Vice President Report, May 1971, Box 1, Folder 1, Mount Sinai Hospital Collection, JMM Archives.

study medical departments, the Ladies' Auxiliary, and fundraising efforts. Alexander believed in the Study Mission and wrote in his letter, "If all works well, which I'm sure it will, we would be glad to reciprocate. Maybe we can start a national movement."[74] These study missions did not focus much, if any attention on the religious aspects of the institutions. The main focus was on matters of service and policies, medical departments, and census numbers.[75]

Mount Sinai board members visited Chicago on December 19, 1974. They met with administrators to learn about the emergency department, outpatient programs, hospital goals and objectives and relationships between Sinai Chicago and other hospitals. Milwaukee Sinai leadership learned that Chicago Sinai had a program to ensure patients were satisfied with their care and other customer service issues. The Milwaukee Sinai leaders took that policy under consideration.[76] There is no indication that the committee specifically targeted any Jewish religious practices at Sinai Chicago for consideration. The focus of the mission was on hospital operations and specific medical departments, not on Jewish religious identity. Alexander tried to use religious practices to impart Jewish identity on the hospitals. The Board wanted to implement proven operational strategies found at other Jewish hospitals.

Milwaukee Sinai representatives then traveled to Detroit Sinai and the Jewish Hospital of St. Louis in 1975. At the annual meeting of the Board of Milwaukee Sinai in May 1975, the mission report was presented to the full Board. The study mission members concluded that Mount Sinai Milwaukee was operating much like the hospitals

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[74] Letter from Raymond Alexander to Ruth Rothstein, December 1, 1974, Box 50, Folder 14, Sinai Samaritan Collection.
[75] Report to the Board and Corporate Body of Mount Sinai Medical Center, Box 50, Folder 14, Sinai Samaritan Collection.
[76] Report to the Board and Corporate Body of Mount Sinai Medical Center, Box 50, Folder 14, Sinai Samaritan Collection.

visited. The challenge for leaders was to determine why the other hospitals were more financially successful.[77] The mission study did not yield much new information for the leaders of Mount Sinai Milwaukee. The focus of the research was on matters of clinical policy and medical departments. The attempts to create a religious identity at Mount Sinai Milwaukee ended abruptly a year later. In May 1976, the hospital announced that Ray Alexander had left his position. *The Wisconsin Jewish Chronicle* reported that he left Mount Sinai for a job at Albert Einstein Medical Center in Philadelphia.[78] The board did not continue what Alexander had started.

There was no specific reason given why Alexander left Mount Sinai at such a crucial time, but his departure essentially ended efforts to create a Jewish religious identity at Mount Sinai. His efforts did not receive a great deal of support. Alexander wanted to institute practices at Mount Sinai to emphasize the Jewish religion and the mission wanted to establish a successful hospital using the business practices at other Jewish hospitals. The board wanted to create a successful hospital with the support of the Jewish community. It seems likely that Alexander left because he realized few, if any, of the changes he worked toward would ever become reality at Mount Sinai. As recently as April of 1976, he touted the changes made in Milwaukee to attendees at a conference of Jewish Hospital Directors, saying, "There has been an ongoing debate over many years as to whether or not a Jewish hospital will lose that identity if it serves a cross section of the community. Mount Sinai maintains its Jewish identity by giving free services to Russian immigrants, serving Kosher meals and cooperating with leaders in the Jewish

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[77] Report to the Board and Corporate Body of Mount Sinai Medical Center, Box 50, Folder 14, Sinai Samaritan Collection.

[78] Newspaper Clipping, "Alexander out at Sinai, Bound for Philadelphia," *Wisconsin Jewish Chronicle*, May 6, 1976, Box 51, Folder 8, Sinai Samaritan Collection.

community."[79] Mount Sinai had historically served more non-Jewish than Jewish patients; commitment to "the cross section" was the reason the hospital remained downtown. The Jewish community in Milwaukee had always supported Mount Sinai as a matter of *tzedakah* and as an expression of their Milwaukee Jewish identity.

In truth, the hospital did not need a Jewish *religious* identity to survive; it needed continued support from the Jewish community. Hospital leaders wanted a Jewish brand. There was a profound difference between Alexander and the members of the hospital research mission. Again a crucial difference between Alexander and the Board stemmed from different interpretations of what made the hospital Jewish. Ray Alexander wanted to add religious practices as an expression of Jewish identity, complete with traditional observance rituals at Mount Sinai. The Board wanted to accentuate a Jewish brand for the hospital using the historic contributions of the Jewish people of Milwaukee. Paul Jacobs noted that there was interest in creating a Jewish essence for the hospital, but in the context of staffing Jewish doctors and a medical education program. Alexander wanted to add significant religious elements to the hospital. Milwaukee had a deliberately nonsectarian Jewish hospital. A religiously observant Jewish hospital in Milwaukee had not ever existed. The effort toward making the hospital more religiously observant Jewish floundered after Alexander left, but the plans for a Jewish brand materialized. There were some changes to the hospital.

The Board focused on possible changes the hospital could make to improve their health services; after Alexander left the issue of instituting religious practices at the hospital was tabled and the leaders at Mount Sinai concentrated their efforts on creating a

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[79] Newspaper clipping, "Hospitals Hold on to Jewish Identity," *Wisconsin Jewish Chronicle*, April 29, 1976, Box 51, Folder 8, Sinai Samaritan Collection.

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teaching program at Mount Sinai. In fact, had Mount Sinai pursued plans to become a more religious hospital, the teaching program might not have been established.

UNIVERSITY MEDICINE: MEDICAL EDUCATION AT MOUNT SINAI

While the Mount Sinai Study Mission was visiting other hospitals, other Board members worked to create a teaching program for doctors. The decision to form a teaching relationship with a university was not without precedent for a Jewish hospital. Jewish hospitals in large urban areas like New York,[80] Boston,[81] and Newark[82] had strong relationships with university medical programs. The Rosenfeld Study recommended similar efforts to do so at Mount Sinai.[83] Creating a formal relationship with the University of Wisconsin-Madison represented the chance for a symbiotic relationship between the organizations. The city of Milwaukee offered the medical students the opportunity to observe and learn about a variety of medical procedures in an urban environment distinctly different from Madison.[84]

Mount Sinai wanted to partner with the struggling Marquette University program as part of their vision for a regional medical Center in the city. The Medical College of Wisconsin, formerly the Marquette School of Medicine, was a logical choice because of its location near Mount Sinai Hospital. However, Ben D. Marcus, President of the Board of Trustees at Mount Sinai, told the *Wisconsin Jewish Chronicle* that "We just could not get a hearing from them. They just didn't seem interested in using Mount Sinai."[85] The

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[80] Aufses and Niss, *This House of Noble Deeds*.
[81] Linenthal, *First a Dream*.
[82] Krause and Krause, *Covenant of Care*.
[83] The Rosenfeld Study, Box 1, Folder 5, Mount Sinai Hospital Collection, JMM Archives.
[84] Newspaper clipping, "Medical School Affiliation Aids Hospital," *Wisconsin Jewish Chronicle,* April 22, 1976, Box 51, Folder 8, Sinai Samaritan Collection.
[85] Newspaper clipping, "Medical School Affiliation Aids Hospital," *Wisconsin Jewish Chronicle,* April 22, 1976, Box

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pending merger between the Medical College of Wisconsin and Froedtert Lutheran, which moved their operations to Wauwatosa, may explain why the Medical College did not respond to Mount Sinai's overtures.[86] Marquette Medical College had severe financial problems in the early 1970s and could not secure funding because it was affiliated with a private religious college. The available funds came from government programs that did not fund private institutions. The decision to end the medical school program at Marquette University and move it to the Medical College of Wisconsin at the new regional medical center allowed the college to receive funds denied to a private university program.[87]

Marquette Medical College's lack of interest might also have stemmed from concerns that any affiliation with a religious hospital, however nonsectarian, would disqualify the program from government funding under the Hill-Burton Act. The religious differences between the medical school and the hospital presented another challenge. If funds had been secured, the institutions had to address these differences before establishing any program. The merger between Deaconess and The Passavant illustrated the possible difficulties facing both institutions in creating a partnership. Economist Teresa D. Harrison found that most hospital mergers occur between two nonprofit hospitals within the same health care service market.[88] The merger between these two hospitals represents one of the most common merger scenarios. Whereas Harrison concluded that more attention needed to be focused on the actual effects of mergers on competition after the merger, this research documents the battle between representatives of the merging

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51, Folder 8, Sinai Samaritan Collection.

[86] Newspaper clipping, "Medical School Affiliation Aids Hospital," *Wisconsin Jewish Chronicle,* April 22, 1976, Box 51, Folder 8, Sinai Samaritan Collection.

[87] Avella, *Trading Post*, 241.

[88] Teresa D. Harrison, "Hospital Mergers: Who Merges with Whom?," *Applied Economics*, 38, (2006): 640.

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hospitals and government entities.

The teaching program established at Mount Sinai was designed to create a "clinical arm" for University of Wisconsin-Madison's third year interns and medical residents in order to provide them with more experience in the "urban clinical environment."[89] Mount Sinai representatives approached faculty members at the Medical College of Wisconsin in order to recruit them for the purpose of creating a teaching program. Their attempts to establish any affiliations between the Medical College and Mount Sinai failed.[90] However, there was another available option in Madison. "In contrast with the situation at the Medical College of Wisconsin, UW-Madison lacked an adequate supply of patients and looked longingly toward Milwaukee. Mount Sinai, rebuffed by the Medical College, looked to Madison for an affiliation and was warmly received."

Hospital officials hoped the relationship would be the first step toward the goal of creating a full-scale teaching institution at Mount Sinai.[91] Student doctors, especially those interested in emergency medicine, needed a comprehensive education in the field. Milwaukee's cultural make-up was much more diverse ethnically, and the larger population offered more clinical experiences in urban-based hospital medicine. David Amrani described the clinical opportunities in Madison as limited. Milwaukee had a variety of cultures and provided a diverse patient pool. UW-Madison students at Mount Sinai gained experience in a variety of emergency cases. Madison offered a more homogeneous clinical experience.[92]

The Rosenfeld Study had concluded that it was "axiomatic that major Jewish

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[89] Dr. David Amrani, Interview by author, Milwaukee, Wisconsin, July 14, 2011.
[90] Engbring, *An Anchor for the Future*, 283.
[91] Newspaper clipping, "Medical School Affiliation Aids Hospital," *Wisconsin Jewish Chronicle,* April 22, 1976, Box 51, Folder 8, Sinai Samaritan Collection
[92] Dr. David Amrani, Interview by author, Milwaukee, Wisconsin, July 14, 2011.

training and teaching hospitals that were affiliated with universities were a drawing card, a magnetic attraction for interns and residents."[93] Madison students treated a variety of patients with diverse ethnic backgrounds, while Mount Sinai enjoyed the status of teaching hospital. It appeared to be a mutually beneficial relationship. However, conflict between university administration and faculty and hospital doctors arose; namely, the Milwaukee doctors gave and the University took.

MEDICAL EDUCATION AT MOUNT SINAI MEDICAL CENTER

The description of the relationship between the staff of UW-Madison and Mount Sinai's doctors comes from a member of the University staff, Dr. David Amrani, and Dr. Paul Jacobs, a Jewish Milwaukee doctor. Amrani was recruited from New York in 1980 as part of the UW- Madison clinical program research staff.[94] He had been to Milwaukee ten years earlier for personal reasons and had visited Mount Sinai. When the opportunity to work at the only Jewish hospital in Wisconsin arose, he accepted the position and moved with his wife to Milwaukee. Despite plans to stay in Milwaukee only for a short time, Dr. Amrani remained in Milwaukee for over thirty years.[95] He explained the relationship from his perspective; the program at Mount Sinai was a "clinical arm" of the University of Wisconsin-Madison Medical School. The hospitals in Madison were considered "narrow" in terms of patient demographics and clinical experience. The school sought opportunities to provide students with medical training in an urban hospital with a more diverse patient demographic. Mount Sinai Medical Center of Milwaukee

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[93] The Rosenfeld Study, Box 1, Folder 5, Page 12, Mount Sinai Hospital Collection, Jewish Museum Milwaukee.

[94] Dr. David Amrani, Interview by author, Milwaukee, Wisconsin, July 14, 2011.

[95] Dr. David Amrani, Interview by author, Milwaukee, Wisconsin, July 14, 2011.

provided that diversity.[96]

The agreement had advantages for the medical students from Madison and the doctors at Mount Sinai. It provided student doctors with medical experience. Those students, in turn, were valuable in providing much needed staffing help at the hospital. However, the new program resulted in conflict over hospital policy and procedures between the new UW-Madison leadership and the Milwaukee doctors. Amrani named Dr. Richard Rieselbach, from the University of Wisconsin-Madison as the "driving force" for the new program and stated the university essentially "overtook" the hospital under Rieselbach.[97]

At a 1976 symposium held at the Mount Sinai Medical Center, the program received praise for its initial success. In two years the program had already "improved patient care with better medical education."[98] Dr. John A.D. Cooper, president of the Association of Medical Colleges in Washington D.C., stated that medical schools gained from partnerships with urban hospitals because students get better clinical experiences working in a metropolitan hospital.[99]

Amrani believed that it was Rieselbach's support for the partnership that kept Mount Sinai in downtown Milwaukee. In 1979, an opportunity to buy land in Mequon arose; Mount Sinai again had the opportunity to relocate. Reiselbach used his influence to keep Mount Sinai in Milwaukee and touted its status as an urban medical campus to persuade Board members at Mount Sinai to stay in Milwaukee. He highlighted the fact that Mount Sinai provided downtown neighborhoods with access to university medicine. Hospital

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[96] Dr. David Amrani, Interview by author, Milwaukee, Wisconsin, July 14, 2011.

[97] Dr. David Amrani, Interview by author, Milwaukee, Wisconsin, July 14, 2001.

[98] Newspaper clipping, "Medical School Affiliation Aids Hospital," *Wisconsin Jewish Chronicle,* April 22, 1976, Box 51, Folder 8, Sinai Samaritan Collection

[99] Newspaper clipping, "Medical School Affiliation Aids Hospital," *Wisconsin Jewish Chronicle,* April 22, 1976, Box 51, Folder 8, Sinai Samaritan Collection.

leaders decided to pass on the possibility of relocating.[100]

The Medical program at Mount Sinai was a mixed blessing for the hospital; it was a source of pride for the hospital but it also ultimately altered the partnership between Mount Sinai and Jewish doctors in Milwaukee. The University academic staff from Madison "overtook" the main hospital and displaced the Milwaukee doctors in hospital administrative operations.[101] The Milwaukee doctors started practices at other Milwaukee hospitals. The historic relationship between the Jewish doctors and Mount Sinai diminished. One of the fundamental aspects of the hospital's Jewish identity weakened as the doctors practiced elsewhere.[102] Ironically, the establishment of a teaching program in the tradition of other Jewish hospitals in America affected the traditionally close relationship between Jewish doctors and hospital in Milwaukee.

Amrani explained that Milwaukee's Jewish doctors were not included in the decisions about the teaching program. Instead, they were literally displaced by the UW-Madison doctors; the non-university doctors had their offices relocated to the remodeled "professional building" away from the main hospital.[103] The displaced doctors resented being pushed aside and expressed the feeling that as non-UW doctors they were "second class" staff, subordinate to the new doctors from Madison.[104] The experts from the university, not the neighborhood experts, settled into positions of power at the main campus.

Paul Jacobs was a Jewish doctor practicing at Mount Sinai at the time of the university partnership. He reported that general practitioners at the hospital felt

[100] Dr. David Amrani, Interview by author, Milwaukee, Wisconsin, July 14, 2011.
[101] Dr. David Amrani, Interview by author, Milwaukee, Wisconsin, July 14, 2001.
[102] Dr. David Amrani, Interview by author, Milwaukee, Wisconsin, July 14, 2011.
[103] Dr. David Amrani, Interview by author, Milwaukee, Wisconsin, July 14, 2011.
[104] Dr. David Amrani, Interview by author, Milwaukee, Wisconsin, July 14, 2011.

resentment toward the university staff and left due to their dissatisfaction with the changes at the hospital after the teaching program began.[105] He stated that Milwaukee's Jewish doctors did not *have* to stay at Mount Sinai; they had chosen to remain there. Jacobs remarked that, "After the university program was established, the close feeling that this was our hospital and our attachment lessened a great deal. After moving to the professional building, some began to establish their practices at other hospitals."[106]

This rift led to a decrease in the amount of influence Milwaukee doctors had over policy and procedure decisions at a time when Mount Sinai needed the support of Milwaukee's Jewish community, including its doctors. The Board retained control of funding decisions and still held a great deal of power, but the doctors did not have the influence they once had in the hospital hierarchy. Amrani believes that in the late 1970s, Mount Sinai died as a Jewish community hospital and transitioned into an urban medical education institution. He explained, "Mount Sinai became the University of Wisconsin-Madison hospital for a period of time. By 1981, the doctors from the university were entrenched at the main hospital, with the Jewish Milwaukee doctors practicing off site."[107] The influence of the hospital Board in leadership and decision making matters weakened. The members of the hospital Board made major decisions among themselves for decades. Now, there was another entity in the hospital that wanted to have a say in matters.[108] This was not what the Rosenfeld Study suggested. It urged Milwaukee Jewish institutions to cooperate with one another. The conflict between the Milwaukee Jewish doctors and board members and the university administration resulted

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[105] Dr. Paul Jacobs, Phone Interview by author, November 2, 2011.
[106] Dr. Paul Jacobs, Phone Interview by author, November 2, 2011.
[107] Dr. David Amrani, Interview by author, Milwaukee, Wisconsin, July 14, 2011.
[108] Dr. David Amrani, Interview by author, Milwaukee, Wisconsin, July, 14, 2011.

in a strained relationship between Mount Sinai Medical Center and important members of the Jewish community, the doctors, at a time when a strong relationship was crucial. By 1984-85, the financial difficulties at Mount Sinai stalled any growth of the medical school program. Medical students continued to staff Mount Sinai, but there were no increased financial benefits to the hospital. Mount Sinai was broke and unable to dedicate resources to any expansion of the UW-Madison program.[109]

In 1967, the Rosenfeld Study provided suggestions for strengthening Jewish health care institutions in Milwaukee. The end result of the changes made by Mount Sinai's leaders was a weakening of the relationship between Jewish doctors and the hospital. It recommended creating a medical teaching program at the hospital. Despite the teaching program and remodeling project, the finances at the hospital did not improve. In addition, the program created a distance between the hospital and Milwaukee Jewish doctors. The Rosenfeld Study did not account for the importance of Jewish doctors to the Jewish identity at Mount Sinai. This was a crucial error. Hospital leaders erred as well; they did not solidify Jewish community support for Mount Sinai as the study recommended. The hospital needed the doctors even if they no longer needed the hospital. It also needed the continued community support, donations and volunteer hours, at this time.

The study also noted that there was no need for an exclusively Jewish hospital in Milwaukee, in part because Jewish doctors and patients were no longer barred from other Milwaukee hospitals. Ray Alexander was not able to create a more religious Jewish identity at the hospital, but leaders wanted a Jewish brand. The hospital had started as a nonsectarian hospital supported by the Jewish population. The Jewish support made the hospital Jewish. The other hospitals in Milwaukee accepted Jewish doctors. Leaders

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[109] Dr. David Amrani, Interview by author, Milwaukee, Wisconsin, July 14, 2011.

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implemented cosmetic elements to the new addition to brand the hospital as Jewish but did not realize the importance of the Jewish doctors. The doctors expanded their practices to other hospitals after feeling usurped by the new university program. The effects of these actions were that by 1980, Mount Sinai Medical Center had a small university education program for doctors, an expanded facility, and a strained relationship with Milwaukee's Jewish doctors and the Jewish community at large.

The financial difficulties brought on by changes in government programs led to a merger with Good Samaritan Medical Center in 1987. The hospital lost the foundation of its Jewish brand, community support, and Jewish doctors, when the doctors began to practice elsewhere. The volunteer hours from the doctors' wives decreased as well. Jewish patients went to other hospitals. The hospital could have moved with other Jewish institutions north of downtown. Mount Sinai could have joined the other relocated Jewish institutions in the suburbs. The decision against relocation sealed the fate of Mount Sinai. When the time came to consider a merger, the Jewish population did not see the need for a Jewish hospital for themselves any longer. Government programs replaced fundraising for indigent care. The community support of the original nonsectarian mission of the hospital to serve those in need and the desire to give back to the city led to the decision to surrender the hospital. The hospital remained downtown and after the merger became the main campus for Sinai Samaritan Medical Center.

CHAPTER 6: MERGER WITH GOOD SAMARITAN MEDICAL CENTER

The 1982 merger of Deaconess and Passavant Hospitals did not prevent the 1987 Mount Sinai merger with Good Samaritan. Why did Mount Sinai have to merge when the number of beds was reduced downtown? The merger of Deaconess and The Passavant significantly reduced the number of beds. Hospital leaders and local government officials believed that the reduction of total hospital beds in Milwaukee would help other hospitals in Milwaukee so what led to the 1987 merger? The answer to the question stems from a variety of changes in government programs, hospital administration practices, and changes in the fund raising practices within the population. Many urban hospitals struggled to meet the costs of patient care in light of decreased reimbursement rates in the Medicaid program. However, the location of Mount Sinai, in a downtown and poor neighborhood and the high number of poor patients led to a decrease in private insurance patients. This led to higher rates of shortfall between actual cost of care and the amount hospitals received. The hospitals then tried to address the shortfall by adopting a different organizational model, more "business like" in practice. The decrease in fund raising from the Jewish population and volunteer hours, combined with the declining funding for a growing number of Medicaid and uninsured patients led to the need to merge.

Changes in Medicaid funding did not fully illustrate the situation at many urban hospitals treating large numbers of indigent patients. In addition to the shortfall between full cost of care and government benefit payments, there were other latent functions to consider. The assessment that Medicaid was working as it was intended had been presented by David Rodgers et al. in 1982. The data they collected indicated that health care access

for poor people had indeed risen, with good outcomes.[1] More people were being helped, more care was being delivered, and the program was indeed working and expensive because hospitals recovered the total cost of care. The authors of that article assumed that cuts would be made to the program. The effects of those cuts remained to be seen.[2] The American taxpayers were now invested in the public health care system and subsidized health care expenditures for the poor.[3] Charles Rosenberg noted that from the foundation of the first hospital, the cultural belief was that patients in public hospitals should be expected to pay for their care, but not be denied if they could not afford it, while Starr remarked that toward the end of the 20th century, the poor should be cared for, with a caveat about wasteful spending on that care. Public medicine should be freely given but not at the expense of the fiscal health of the institution.[4]

The use of tax dollars affected the private hospitals that accepted patients on Medicaid, like Mount Sinai. Public perception pitted their own life situations against the needs of the poor and not wanting them to receive handouts they themselves could not get in hard times. The notion that no one be denied care because of poverty carried the stipulation that as long as the cost did not conflict with the needs of those not on aid, care could be given.[5] Soon, Medicaid patients found themselves increasingly vulnerable to the health of the economy. The commitment to helping the poor combined with unreliable funding sources resulted in many fiscal challenges for hospitals like Mount Sinai. For decades, private hospitals like Mount Sinai had distinguished themselves from the public hospitals by way of funding and

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[1] David E. Rodgers, Robert J. Blundon, and Thomas W. Molony, "Who Needs Medicaid?," *New England Journal of Medicine,* 307, no.1 (1982): 456.
[2] Rodgers, Blundon, and Molony, "Who Needs Medicaid?," 456.
[3] Jonathan Engel, *Poor People's Medicine: Medicaid and American Charity Care Since 1965* (Durham, N.C.: Duke University Press, 2006).
[4] Charles Rosenberg, *In the Care of Strangers*, 67; Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982).
[5] Engel, *Poor People's Medicine*, 182.

community support. They also benefited from their private hospital status. In the early history of American hospitals, public hospitals, like many other public institutions and poverty programs, were hampered by erratic funding sources and public perception about the way they treated patients.[6] Whereas at the start of the 20th century public hospitals were seen as a place for those with the lowest socioeconomic status, private hospitals treated those determined to be worthy of help through the efforts of various affluent community members.[7]

Historian Sandra Opdycke explained that the fundamental difference between a public and a private institution is that a public institution is bound by many social and cultural understandings about their mission.[8] Private hospitals rejected patients based on their inability to pay for care and could also discharge those who could no longer afford to pay for their care. They were much more likely to uphold the standard of guarding against the perils of charity, even in the event of severe illness. They were free to consider their economic health over the needs of the indigent.[9] The public hospital did not have that option, but there were rules for them as well. Public hospitals provided assistance for the poor freely when a life was at stake. They aimed to avoid creating dependency, and at the same time gave to those in need proper and respectful treatment.[10]

The creation of government health insurance programs relieved hospitals of the task of measuring worthiness. The programs also subjected private hospitals to the problems faced

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[6] Rosemary Stevens, Charles E. Rosenberg, and Lawton R. Burns, *History and Health Policy in the United States: Putting the Past Back In* (New Brunswick, N.J.: Rutgers University Press, 2006); Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982).

[7] Sandra Opdycke, *No One Was Turned Away: The Role of the Public Hospitals in New York City since 1900* (New York City: Oxford Press, 1999).

[8] Opdycke, *No One Was Turned Away*, 77.

[9] Ibid., 101.

[10] Alan M. Kraut and Deborah A. Kraut, *Covenant of Care: Newark Beth Israel and the Jewish Hospital in America* (New Brunswick, NJ: Rutgers University Press, 2007); Charles Rosenberg, *The Care of Strangers: The Rise of America's Hospital System* (New York: Basic Books, 1987); Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century* (New York: Basic Books 1989), 131.

by public hospitals, namely the insecurity of funds for patient care. Private urban hospitals began to treat more Medicaid patients and the decreased reimbursement rates began to affect the budget. However, one of the latent effects of treating a large number of poor patients was the decrease in patients who had the ability to pay in full. Economist Andrew Sfekas examined the possibility that private pay patients avoided hospitals with high numbers of Medicaid patients. He found that privately insured patients did exactly that.[11] These patients may have feared their own costs increased at these hospitals, to make up for the poorer patients. Economists David Dranove and William D. White studied private hospitals in California to measure the effects of increased numbers of Medicaid patients had on the hospitals. They looked for any instances of "cost shifting," charging private pay patients more to make up for the poorer patients, any incidents of cutting services to Medicaid patients, and whether or not hospitals treating high numbers of Medicaid patients were more likely to close. They found that there was no cost shifting, in fact many private patients paid less for services. But, some services for Medicaid patients were cut, especially at hospitals with the highest number of Medicaid patients. Finally, they found that hospitals treating a majority of Medicaid patients were more likely to close.[12]

That these hospitals were often in poor neighborhoods also kept wealthier patients away. David Amrani, a physician at Mount Sinai, suggested that the hospital's downtown location kept Jewish patients away. He believed that the Jewish population living northeast of downtown Milwaukee no longer felt comfortable at the hospital's location. The Board decided to make Mount Sinai Medical Center a "community hospital" by

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[11] Andrew Sfekas, "Is There a Medicaid Penalty? The Effect of Hospitals' Medicaid Population on Their Private Payer Market Share," *Health Economics* 22, no.11 (December 2013): 1360-1376.

[12] David Dranove and William D. White, "Medicaid-Dependent Hospitals and their Patients: How Have They Fared?," *HSR: Health Services Research* 33, no.2 (June 1998): 180-81.

staying downtown and that is exactly what it became: a hospital for residents who were predominantly black and poor.[13] Amrani reported that when his wife was pregnant in 1981, their decision to have the baby at Mount Sinai elicited surprised reactions from some of their Jewish acquaintances. He stated that the same people who had supported the idea of keeping the hospital in the downtown area would not use it themselves because of the "element" or the "urban population."[14] He noted that not all of their Jewish cohort said such things, but a noticeable number did.[15] He also thought that it seemed that it was the native Milwaukee Jewish community members who avoided the Mount Sinai neighborhood. Amrani and his fellow ex-New York residents grew up in a large diverse city and patronized Mount Sinai after moving to Milwaukee.[16]

While it may be that members of the Jewish community did not use Mount Sinai Medical Center in great numbers because it was downtown, it is clear that the people responsible for making the decision to stay downtown knew exactly what patients would use the hospital. Board member Pat Kerns, who attended the very meeting that chose to keep Mount Sinai at the downtown location stated that, "We wanted to give something back to, mainly the Black people really, at least half of the patients are Black, I would say in that area."[17] It is unlikely that the Milwaukee Jewish community did not realize that Mount Sinai would serve a majority of poor black patients. Dr. Harry Kanin noted that when the decision was made to stay downtown, Mount Sinai "got mostly Title 19 (Medicaid) and indigent patients."[18] Dr. Jay Larkey noted that the location of Mount Sinai was home to a large black population was common knowledge in the Milwaukee

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[13] Dr. David Amrani, Interview by author, Milwaukee, Wisconsin, July 14, 2011.
[14] Dr. David Amrani, Interview by author, Milwaukee, Wisconsin, July 14, 2011.
[15] Dr. David Amrani, Interview by author, Milwaukee, Wisconsin, July 14, 2011.
[16] Dr. David Amrani, Interview by author, Milwaukee, Wisconsin, July 14, 2011.
[17] Pat and Joan Kerns, Interview by author, Mequon, Wisconsin, May 24, 2011.
[18] Dr. Harry Kanin, Interview by author, Milwaukee, Wisconsin, July 14, 2011.

Jewish population.[19]

However, three major changes in indigent health care programs led to severe financial shortfalls at urban hospitals. One of the most profound changes came in the aftermath of the PL 93-641, federal legislation passed in 1974 as part of the Hill-Burton Act discussed in the previous chapter. It gave the government the power to set reimbursements on the medical care of Medicaid patients below the total cost of care. The Reagan administration began changing health care funding in 1982. New federal regulations on Medicare patients' care automatically disallowed two percent of the total cost of care, leaving the care provider to cover the balance. The creation of Diagnostic Related Groups (DRGs) lowered the amount of reimbursement for Medicare patients further through standardized medical coding. The changes represented an attempt to regulate federal funding for state programs. They required a great deal of work in order to remain in compliance with funding requirements. These changes led to the need for Mount Sinai to merge.

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[19] Dr. Jay Larkey, Interview by author, Milwaukee, Wisconsin, August 17, 2011.

POLITICAL CHANGE, POLICY CHANGE

The election of Ronald Reagan as U.S. president in 1980 was a pivotal event in history of American health care programs for the poor. The Republican governor from California and former actor used his inaugural address to lay out his plans for "public spending" and his intent to reevaluate current social programs:

> Idle industries have cast workers into unemployment, human misery, and personal indignity. Those who do work are denied a fair return for their labor by a tax system which penalizes successful achievement and keeps us from maintaining full productivity. But great as our tax burden is, it has not kept pace with public spending. For decades we have piled on deficit upon deficit, mortgaging our future and our children's future for the temporary convenience of the present. To continue this long trend is to guarantee tremendous social, cultural, political and economic upheavals. You and I, as individuals, can, by borrowing, live beyond our means, but only for a limited period of time. Why then should we think that collectively, as a nation, we're not bound by that same limitation? We must act today in order to preserve tomorrow. And let there be no misunderstanding--we are going to begin to act, beginning today.[20]

One of the first changes made by the Reagan administration was to the Medicare program. By 1982, government policy denied two percent of the total costs treating Medicare patients. This policy placed the responsibility for the balance on the institution providing care. Mount Sinai continued to treat Medicare patients and absorbed the disallowed costs; the program that had once paid in full for caring for uninsured patients was now adding to the hospital's deficit.[21] The same was true at other Milwaukee hospitals; Medicare patients were adding to the deficit and the hospitals were left to cover the shortfall.[22]

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[20] Ronald Reagan, "Inaugural Address," in *Representative American Speeches: 1980-81,* ed. Owen Peterson (New York: H.W Wilson, 1981), 12.

[21] Newspaper clipping, "Federal Cost Cutting Pushes Up Deficits of Non Profit Hospitals," *Wall Street Journal,* February 9, 1982, Box 50, Folder 37, Sinai Samaritan Medical Center Records, Milwaukee Mss Collection 108, University of Wisconsin-Milwaukee Libraries, Archives Department (hereafter cited as Sinai Samaritan Collection).

[22] Newspaper clipping, "Planning Panel Urges Health Care Coalition" *Milwaukee Journal,* February 1, 1982, Box 50,

Hospitals felt the effects of the decreased federal commitment to Medicare and the state regulations on Medicaid reimbursement almost immediately. J. Alexander McMahon, President of the Chicago-based American Hospital Association remarked that "When the government reduces payments or tightens eligibility rules for poor people, non- profit institutions as well as public hospitals continue to treat them. An underpayment simply becomes a non-payment."[23] The two major programs used by poor people for health care services at Mount Sinai Medical Center were paying less, while hospital leaders were limited in their ability to offset the loss through expansions or rate increases. The hospitals were caught in a Catch-22 situation. If they treated more patients on government programs, the hospitals lost more money, and they could not increase rates for their services to raise money.

Local businesses, labor groups, and health insurance firms explored the possibility of forming a collective group between themselves and Milwaukee's hospitals. The goal was to create coalitions between local businesses and Milwaukee health care institutions treating poor patients in order to minimize the projected shortfalls due to disallowed care costs at any one hospital. They tried to bargain for discounted rates for their services, with the goal of "reining in escalating hospitals costs over the next decade."[24] In essence they tried to create a network to share the burden of caring for underinsured patients on Medicaid and Medicare.[25]

A subcommittee of leaders from Milwaukee institutions formed to discuss the plan

Folder 9, Sinai Samaritan Collection.
[23] Newspaper clipping, "Federal Cost Cutting Pushes Up Deficits of Non Profit Hospitals," *Wall Street Journal*, February 9, 1982, Box 50, Folder 37, Sinai Samaritan Collection.
[24] Newspaper clipping, "Planning Panel Urges Health Care Coalition" *Milwaukee Journal,* February 1, 1982, Box 50, Folder 9, Sinai Samaritan Collection.
[25] Newspaper clipping, "Planning Panel Urges Health Care Coalition," *Milwaukee Journal,* February 1, 1982, Box 50, Folder 9, Sinai Samaritan Collection.

and noted that,

> While such a recommendation acknowledges that consumers would have less choice as to where they get their medical care. . .under the increased competitiveness under such a plan ought to improve system- wide cost effectiveness as hospitals provide services for the amount the purchasers are willing to pay.[26]

The proposed coalition was an attempt to meet the care needs of patients on Medicare and Medicaid while addressing the fiscal deficits created by underpayment for services at the hospitals treating them. The rationale was that cooperation between hospitals would lower hospital costs for all Milwaukee's hospitals. The problem with the plan was that an equitable way to direct poor patients to hospitals based on their particular health care issue, not the closest hospital, was not found.[27] The financial problems at many of Milwaukee's hospitals hindered any agreement between them. They all needed a great deal of help, and the proposed agreement did not offer enough. The subcommittee report stated,

> Also recommended that if the state decided to eliminate freedom of choice for Medicaid recipients in picking doctors and hospitals, the state should direct those patients to hospitals with lower costs for specific services. For example, the state could direct recipients to certain hospitals for high risk pregnancy but to a different institution for tonsillectomies.[28]

This recommendation represented an attempt to address a major issue in the treatment of the Medicare and Medicaid patients. It sought to compel Milwaukee's for-profit hospitals to care for them and absorb some of the shortfall from the government insurance program. The financial difficulties at hospitals like Mount Sinai Medical Center

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[26] Newspaper clipping, "Planning Panel Urges Health Care Coalition," *Milwaukee Journal,* February 1, 1982, Box 50, Folder 9, Sinai Samaritan Collection.
[27] Newspaper clipping, "Planning Panel Urges Health Care Coalition," *Milwaukee Journal,* February 1, 1982, Box 50, Folder 9, Sinai Samaritan Collection.
[28] Newspaper clipping, "Planning Panel Urges Health Care Coalition," *Milwaukee Journal,* February 1, 1982, Box 50, Folder 9, Sinai Samaritan Collection.

highlighted the success of the private hospitals established under the provisions of the Medicaid/Medicare legislation, and the creation of early hospital networks. The financial incentives for private businesses to take over struggling hospitals were not offset by any requirement that they accept Medicare/Medicaid patients. The acquisition of hospitals by business groups led to the growth of early health care networks and created hospitals that were free to deny medical services to those who could not pay in full. Rosemary Stevens writes, "The notion that hospitals are simply businesses was fueled by their financial success for most of the 1980s, by the financial environment in which they operate[d]."[29] David Amrani remarked that "businesses and business systems were able to manage their hospitals and clinics in order to make them more profitable. They changed medical practice in this town and all over."[30] One of the ways hospitals achieved the goal of making a profit was to be selective about the patients treated. Richard McDonald, President of McDonald, Davis & Associates, a Milwaukee advertising and marketing group, remarked in 1985 that "There is an all out war in the making between the providers of health care." He feared that proprietary hospitals could and would make it a priority to "turn down Medicaid recipients" in order to avoid any loss of revenue.[31]

That is exactly what happened. Mount Sinai Medical Center and other Milwaukee hospitals treated more and more underinsured and uninsured patients, while other hospitals in the area refused to care for patients using government insurance programs.[32] The for-profit hospitals utilized the practices of the earliest private American hospitals in order to maximize profits and reduce costs by running them as businesses and by refusing

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[29] Stevens, *In Sickness and in Wealth*, 332.
[30] Dr. David Amrani, Interview by author, Milwaukee, Wisconsin, July 14, 2011.
[31] Newspaper clipping, "Health Care Battle to Take Toll," *Milwaukee Sentinel*, April 3, 1985, Box 32, Folder 28, Sinai Samaritan Collection.
[32] Dr. Harry Kanin, Interview by author, Milwaukee, Wisconsin, July 14, 2011.

to care for Medicare and Medicaid patients to avoid underpayment.

In response to the report of the coalition of local business, labor and hospital leaders, the Southeast Health Systems Agency (SEHSA) released its own "Hospital Blue Print for the 1980s" in April of 1982 to address hospital costs and government insurance shortfalls. The Blue Print's suggestions attempted to consolidate health services in Milwaukee without input or final say from any of the hospitals. While the hospitals could offer their own ideas, the final decision came from the SEHSA.[33] The hospitals were bound to any decision made because of PL 93-641; as with the Deaconess/Passavant merger, other Milwaukee hospitals accepted the recommendations of the SEHSA Blue Print or faced the loss of any reimbursement for care.[34]

The Blue Print incident highlighted urban hospitals' weakened efficacy in creating revenue. The leaders and administrators at Milwaukee's hospitals were now effectively bound to the suggestions of the SEHSA. They could no longer act on plans of their own and in some cases had to act against their own wishes. Some Milwaukee hospital leaders were critical of the Blue Print; John Comesky, President of St. Michael Hospital, was vocal in his opposition to the SEHSA plan; he questioned the premise of the Blue Print that unused hospital beds or duplication of services increased cost by citing a study that apparently showed, "Unstaffed hospital beds accounted for a very insignificant portion of total hospital costs. Duplication was essential to provide reasonable access to hospitals. I beg all who believe mergers, linkages, consolidations etc. in the health care field reduce costs to read the literature and cite support for these ideas."[35]

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[33] Report, "Hospital Blue Print for the 80s," Southeastern Health Systems Agency, April 19, 1982, Box 51, Folder 9, Sinai Samaritan Collection.
[34] M. Allen Pond, "Environmental Quality as an Issue in the Legislative History of the National Health Planning and Resources Development Act of 1974 (PL 93-641)," *American Journal of Public Health* 68, no.6 (June 1978): 583.
[35] Report, "Hospital Blue Print for the 80s," Southeastern Health Systems Agency, April 19, 1982, Box 51, Folder 9,

The combined effects of government funding changes and the regulations on it were both a blessing and a curse to hospitals like Mount Sinai; a blessing when the full cost of care was covered, a curse when funds were cut to less than the costs to the hospital. Mount Sinai was struggling in 1982, with both Medicare and Medicaid underpaying for care when a new standard was introduced by the federal government.

STANDARD OF CARE

In 1983, federal legislation created a system meant to standardize care for Medicare patients, the Diagnostic Related Groups (DRGs). These groups evaluated clinical conditions and set reimbursement rates designed to keep costs of care within a specific range for hospital care.[36] The DRGs prevented hospitals from charging more money for procedures in order to increase revenue.[37] David Amrani described the establishment of the DRGs as "the roof falling in" when it came to what doctors and hospitals received in reimbursement for their services.[38] Before DRGs, doctors and hospitals set the rates for care, billed the insurance companies for that amount, and received the total amount. The DRGs created a system, using 467 diagnosis-related groups, to code the medical condition and treatment and base reimbursement on what the DRG found reasonable rather than actual cost.[39] Stevens explains the DRGs as an attempt by the Reagan administration to continue to cut the costs of Medicare by creating flat fees for services at all hospitals: "In the 1980s, as in the 1920s, standardization was defined by the practical politics of what can be regulated. Interweaving through the new standardization of

Sinai Samaritan Collection. It should be noted that in his statement, Comesky, cited "a study" but did not provide any further information about his source used to rebut the recommendation in question.

[36] Stevens, *In Sickness and in Wealth*, 323.
[37] Stevens, *In Sickness and in Wealth, 323.*
[38] Dr. David Amrani, Interview by author, Milwaukee, Wisconsin, July 14, 2011.
[39] Stevens, *In Sickness and in Wealth*, 323.

hospitals by government has been an increased ability to measure health-service utilization and financing."[40] Ostensibly, DRGs were intended to "level the playing field" between hospitals by preventing any one hospital from claiming that any higher costs of care at their facility were justified.[41] The DRGs established nationwide standards on the costs of care; all hospitals treating Medicare patients were responsible for any discrepancy between the DRG-computed cost and the total cost to the hospital. The plan grouped hospitals into regions and all hospitals in each region charged the same amount of money for procedures.[42] The DRG system gave the federal government the power to establish prices for the health care of over twenty million Medicare recipients on the assumption that their care could be sold as a standardized product, rather than as the unpredictable and varied process of treating human beings.[43]

However, a senior systems analyst and a Vice President of Finance at Rush-Presbyterian-St. Luke's Medical Center in Chicago, Illinois predicted a very serious problem. Cynthia Barnard, the analyst, and Truman Esmond, the Vice President, studied the plan to implement DRGs on hospitals. They identified a problem with the creation of the DRGs, namely one of timing. They determined that in their study it was unclear if hospitals in their data set had collected information about the cost of hospital stays concurrently or retrospectively, and that was vital in the case of setting reimbursement rates. They believed that hospitals may have entered concurrent data, which only included charges as of a few days before the patient was discharged.[44] They believed that in order for the DRGs to set appropriate rates, all hospitals had to submit retrospective data about

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[40] Stevens, *In Sickness and in Wealth*, 323.
[41] Dr. Harry Kanin, Interview by author, Milwaukee, Wisconsin, July 14, 2011.
[42] Stevens, *In Sickness and in Wealth*, 323.
[43] Stevens, *In Sickness and in Wealth*, 324.
[44] Cynthia Barnard and Truman Esmond, "DRG-Based Reimbursement: The Use of Concurrent and Retrospective Clinical Data," *Medical Care* 19, no.11 (November 1981): 1074.

total hospital costs for all diagnostic categories. Only then could the DRGs accurately standardize hospital prices. This information was integral, without it, hospitals stood to lose money.[45] They concluded that "Until the data can be adequately received and explained or replaced with appropriately retrospective data and the differences between billing and clinical data eliminated, the current case mix based on DRGs cannot be used to measure resource use and therefore will not accurately predict reimbursement needs."[46] Health Economist Sylvester E. Berki, in 1984, noted the fact that the issues raised by Barnard and Esmond had not been addressed, and he commented that,

> The basic effect of paying for care on the basis of a prospectively established price per treated case (PPS) is that it changes, as if by magic, revenue centers into cost centers. Additional days of stay and more intensive services before PPS were sources of additional revenue. Under PPS, each additional day of stay and every additional service is an addition to cost, a reduction in net revenue. What hospitals before were motivated to maximize, now they will have to minimize. If under retrospective cost- based reimbursement the hospital's role was to provide facilities and personnel required to produce the maximum combination of services physicians wished to order, now hospitals will wish to reduce the cost of treatment both by reducing the amount of services and by producing them more efficiently.[47]

The use of DRGs to set prices led to Medicare patients themselves literally suffering under the new guidelines. Sociologists Juanita B. Wood and Carroll L. Estes found that hospitals discharged patients when they reached the end of their standardized care, not when they were necessarily healthy. Their research indicated that patients were readmitted after discharge and used additional medical resources, increasing the cost of care at the hospital.[48]

The system challenged the right of the doctor to determine the course of care and

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[45] Barnard and Esmond, "DRG-Based Reimbursement," 1075.
[46] Barnard and Esmond, "DRG-Based Reimbursement," 1081.
[47] Sylvester E. Berki, "Grading DRGS," *Medical Care* 22, no. 12 (December 1984): 1065.
[48] Juanita B. Wood and Carroll L. Estes, "The Impact of DRGS on Community-Based Service Providers: Implications for the Elderly," *American Journal of Public Health* 80, no.7 (July 1990): 841.

length of hospital stay. Jay Larkey remarked that the new system of standardizing care was less than optimal from his perspective as a doctor: "I'm a Socialist, he said. When I was in the service, I never sent a bill to a patient, and I never had some high school dropout telling me that I had to discharge a patient out of the hospital."[49] David Amrani noted that hospital leaders at Mount Sinai Medical Center struggled with the regulations. One problem was that those responsible for comprehending and explaining the documentation involved with the new coding system were unable to do so.[50] Brenda Wagner, a staff member at Mount Sinai, remarked that the paperwork involved in getting funds was very time-consuming, and the forms had to be filled out correctly in order to avoid having the request denied. This was well before the Internet age; these forms were typed and mailed through the United States Postal Service.[51] Reimbursement was slow in coming, and took a great deal of labor in order to secure.

Hospitals sought solutions to the shortfalls caused by the new "standards of care" created by government regulations and the DRGs. Many hospitals, Mount Sinai Medical Center included, had to adopt a "business model" approach in order to survive. In October 1981, a Mount Sinai Status report stated that, "In response to continuous concerns regarding reimbursement from the federal (Medicare) and state (Medicaid) government, we have initiated additional steps to reduce payroll of the Medical Center below the reduced budget which was submitted."[52] The steps included layoffs due to low patient numbers and wage reductions for staff. The official statement about the steps noted that, "Although we are concerned with the emotional and financial welfare of our

[49] Dr. Jay Larkey, Interview by author, Milwaukee, Wisconsin, August 17, 2011.
[50] Dr. David Amrani, Interview by author, Milwaukee, Wisconsin, July 14, 2011.
[51] Brenda Wagner, Phone Interview by author, June 22, 2011.
[52] Manager Report, October 7, 1981, Box 50, Folder 37, Sinai Samaritan Collection.

employees, the realities of today's economy have necessitated these extraordinary steps."[53] Despite those "steps," the deficit continued to grow.

The continued strain between the commitment to delivering health care to all in need and the rising costs of providing that care without any increase in resources compelled hospitals like Mount Sinai Medical Center to explore mergers or face closing. Lawrence Tarnoff, Mount Sinai's Vice President of Marketing Development, told a reporter, "In the first six months [of 1984], total patient days dropped 9.5%. More and more hospitals are becoming sensitive to the fact that you cannot do business the same way you did four or five years ago. We realize we have to do business differently in order to maintain market share."[54] The decrease in days spent in the hospital by paying patients added to the hospital's difficulties.

Mount Sinai was not the only Milwaukee hospital struggling at this time. In 1986, many hospitals in Milwaukee were working together to stay open. An article published in the *Milwaukee Sentinel* noted that "Facing increased competition, declining patients counts, and unprecedented pressures to hold the line on costs, area hospitals are forming affiliations with other medical institutions at an accelerated pace."[55] Mount Sinai formed an alliance with Good Samaritan a year later. Bill Loebig, of Franciscan Hospital, remarked that, "I think in the next five years, it is imperative that the Catholic hospitals in the Milwaukee area be in some kind of alliance with one another. Virtually all hospitals will have connections with some major national or regional system over the next ten to 15 years. We are positioning our organization currently to look for meaningful partnerships and

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[53] Manager Report, January 12, 1982, Box 50, Folder 37, Sinai Samaritan Collection.
[54] Newspaper clipping, "Pace of Hospital Affiliations Quickens," *Milwaukee Journal*, April 3, 1984, Box 51, Folder 9, Sinai Samaritan Collection.
[55] Newspaper clipping, "Health Care Battle to Take Toll," *Milwaukee Sentinel*, April 3, 1985, Box 32, Folder 28, Sinai Samaritan Collection.

relationships that will vary across the spectrum from loose alliances to acquisitions."[56]

There were too many struggling hospitals and not enough alliances. A 1985 *Milwaukee Sentinel* article made a dire prediction about the future of the city's hospitals. "By the year 1990," it noted, "at least seven hospitals now in the Milwaukee area will have gone out of business. Proprietary for-profit hospitals are on the increase; by 1995, 50% of the hospitals in the country will be proprietary."[57] The changes in government policy for programs covering indigent care resulted in a mounting deficit for Mount Sinai that could not be covered as it once was: by increased revenue, expansion, or donation drives or other fund raising. The new medical center, Good Samaritan Medical Center, despite early success, was also struggling in 1985.

In the wake of increased costs of care, hospitals tried to increase the efficiency of their operations. Jonathan Engel notes that hospitals tried different hospital operation models to run their institutions. Hospitals adopted a more business oriented model in order to meet the demands of accountability and care for all in need. As hospitals took a more businesslike approach to health care, and federal and state funded poverty programs fell in and out of favor with Americans, they felt squeezed between the need to remain both financially solvent and accessible to those in need.[58] The fiscal reality of caring for patients as health care costs rose was often subordinate to caring for those in need.[59] The adoption of a more business centered model changed the way hospitals administered care; indeed, hospitals became businesses, and acted accordingly. David Cutler and Jill Horwitz note that

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[56] Newspaper clipping, "Health Care Battle to Take Toll," *Milwaukee Sentinel*, April 3, 1985, Box 32, Folder 28, Sinai Samaritan Collection.
[57] Newspaper clipping, "Health Care Battle to Take Toll," *Milwaukee Sentinel*, April 3, 1985, Box 32, Folder 28, Sinai Samaritan Collection.
[58] Engel, *Poor People's,* 234; Stevens, Rosenberg and Burns, *History*, 304.
[59] Lawton R. Burns, "The Transformation of the American Hospital: From Community Institution toward Business Enterprise" *Comparative Social Research* (12: 1990): 89.

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with this new business approach, hospitals had to adjust to these new fiscal realities, which threatened the core missions of many public institutions, treating all in need, regardless of ability to pay.[60]

The ramifications of the changes in both hospital ownership and operation models were most readily seen in the process of merging long standing private hospitals into a single institution within a hospital network. Many of the private hospitals in Milwaukee had always operated under the auspices of religious orders or private ownership. The creation of hospital systems made these hospitals part of an organization that had no personal affiliation with the traditions of the hospitals or the communities that had established them. As hospital systems streamlined operations in response to market forces and heeded the call to maximize utilization, hospitals with decades of community service faced difficult circumstances. Health care systems began buying struggling hospitals. The Hill-Burton Act included incentives for systems to buy failing hospitals, including money for renovations and tax breaks.[61] Another goal of the new regulation was to avoid duplication of services in cities. Jonathan Engel noted that it was intended to regulate hospitals in urban areas in order to enable "new investment in health care infrastructure and equipment through a newly created certificate-of-need [CON] process. A CON granted by a local Health Systems Agency was now required for most new construction, purchasing of major medical equipment, or institutional realignment."[62] A certificate of need was a governmental designation that imposed limitations and offered benefits to certain hospitals.[63] Mount Sinai was designated as a vital part of Milwaukee's hospital system,

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[60] David M. Cutler and Jill R. Horwitz, *Converting Hospitals from Not-for-Profit to For-Profit Status: Why and What Effects?* (Cambridge, MA: National Bureau of Economic Research, 1998).
[61] Stevens, *In Sickness and In Wealth*, 340.
[62] Engel, *Poor People's Medicine*, 133.
[63] Engel, *Poor People's Medicine*, 133.

and was therefore unable to relocate without government approval. [64]The bill transferred the power to regulate the operations of urban hospitals and make decisions about hospital expansion and operations policy from the individual hospital boards and administration to local government agencies. David Amrani pointed out that a CON was both good and bad for Mount Sinai; good in that any plans for expansion had a better chance of being approved, but any attempt to relocate after getting would not be approved.[65]

THE MERGER DISCUSSIONS

The decision to keep Mount Sinai in downtown Milwaukee was a conscious effort by the Hospital Board to continue the original mission of the hospital, *tzedakah* for the indigent patients. Many of those Interviewed believed that to be true. Pat Kerns remembers attending the 1967 Board meeting that decided to keep Mount Sinai in downtown Milwaukee: "The men that made that decision cared for the community, really cared about the community. I'll never forget that meeting, maybe two said no. We were accepted into Milwaukee and we had a wonderful Jewish community, we still do, and this is part of the whole thing."[66] He and the other board members believed that the decision to remain downtown was a *mitzvah* to the non-Jewish community in Milwaukee.[67]

The mounting debt caused by years of decreased reimbursements resulted to two alternatives for Mount Sinai's leadership: merge with Good Samaritan Medical Center or explore the possibility of relocating the hospital in Mequon. Both Kearns and Amrani mentioned the land in Mequon. It was purchased by Aurora Health Care in 1979. While this

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[64] Dr. David Amrani, Interview with author, Milwaukee, Wisconsin, July 14, 2001.
[65] Dr. David Amrani, Interview by author, Milwaukee, Wisconsin, July 14, 2011.
[66] Pat and Joan Kerns, Interview by author, Mequon, Wisconsin, May 24, 2011.
[67] Pat and Joan Kerns, Interview by author, Mequon, Wisconsin, May 24, 2011.

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land could have been used for a hospital, Amrani reiterated that there was no way to move Mount Sinai to Mequon in light of the CON. Mount Sinai Medical Center was vital to downtown Milwaukee's health care system.[68] Kerns recalls that it was the Board who rejected any offer to relocate to Mequon.[69] The hospital board rejected any plan to relocate the hospital, so a merger appeared to be the only alternative for keeping the hospital open.[70] Amrani remarked that by the time the decision about a merger was made, Mount Sinai Hospital was needed in its downtown location. The hospital had received a Certificate of Need in 1979, designating it as a vital hospital resource. "They couldn't leave, there wasn't [sic] very many hospitals left!"[71] Jay Larkey noted that of the six hospitals in the downtown area in the 1960s and 1970s, only two remained: "St. Anthony's at 10th and Wells, Deaconess at 18th and Wisconsin Avenue, Lutheran on Wisconsin Avenue, West Side Hospital on 24th and Wells, and Doctor's Hospital on 27th and Wells, all closed."[72] By 1986, Mount Sinai Medical Center and Good Samaritan Medical Center were the only two left. When they merged, only a single hospital remained to serve downtown Milwaukee.

MAKING MERGER EASIER

The merger between Mount Sinai Medical Center and Good Samaritan Medical Center was not as protracted or contentious as the Deaconess and The Passavant. Mount Sinai accepted the merger as a foregone conclusion, and this eased the process somewhat. The effects of the Reagan administration policies on both hospitals made a merger seem necessary. The ramifications for the Milwaukee Jewish community are relevant. The

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[68] Dr. David Amrani, Interview by author, Milwaukee, Wisconsin, July 14, 2001.
[69] Pat and Joan Kerns, Interview by author, Mequon, Wisconsin, May 24, 2001,
[70] Pat and Joan Kerns, Interview by author, Mequon, Wisconsin, May 24, 2011.
[71] Dr. David Amrani, Interview by author, Milwaukee, Wisconsin, July 14, 2011.
[72] Dr. Jay Larkey, Interview by author, Milwaukee, Wisconsin, August 17, 2011.

migration of Milwaukee's Jewish community to other neighborhood and other hospitals had significantly weakened the relationship between the community and Mount Sinai. The Board remained Jewish, but the hospital was no longer the only hospital for Jewish doctors and patients. David Amrani believes that "Society had changed, and there was no need for a Jewish hospital in the way that the hospital was originally needed. The 1903 reasons for a Jewish hospital did not exist in 1983. The reason there is not a great deal of involvement by the Jewish doctors and their wives, from a Jewish perspective is that there isn't, it's a very different animal now than it was even when I moved here thirty years ago."[73] And that is what happened; the hospital stayed downtown and announced a merger with Good Samaritan Medical Center in 1987.

Initial discussion between the two hospitals began in 1984. Leaders at both hospitals met to study a possible merger. There were a few leadership clashes between the two hospitals, but nothing like the conflict over the Deaconess/Passavant merger. On June 8, 1984, the two hospitals announced they were considering a merger to reduce health care costs at each hospital. On July 18, 1984, Mount Sinai President Daniel Kane outlined six major issues that needed to be studied before any merger. In a July 18, 1984 Milwaukee Journal opinion column published by the *Milwaukee Journal* he claimed that "Self-interest and practice, commitment of leadership, medical education and care, quality of care, consumer education, and a cost benefit analysis of creating a single medical Center through merger."[74] Eight days later the *Journal* reported that there were "anger signs" at Good Samaritan Medical Center over the opinion piece and merger discussion. Good Samaritan Medical Center leaders viewed Kane's opinions as presumptuous. They halted merger

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[73] Dr. David Amrani, Interview by author, Milwaukee, Wisconsin, July 14, 2001.
[74] Newspaper clipping, Opinion by Daniel Kane, Mount Sinai Medical Center President, *Milwaukee Journal,* July 18, 1984, Box 50, Folder 37, Sinai Samaritan Collection.

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discussions in order to allow both sides time to form committees to discuss the specifics of a merger. On December 13, 1984, Mount Sinai announced that Daniel Kane had abruptly resigned as President of Mount Sinai and the merger discussions stalled.[75] Sarah Dean was appointed acting president in January 1985, and merger talks began anew.[76] Patient census numbers at Mount Sinai Medical Center continued to decrease after 1984, putting additional pressure on the hospital leadership to negotiate a satisfactory merger agreement.

Good Samaritan Medical Center was also struggling. In March 1985, the Deaconess campus of Good Samaritan Medical Center closed.[77] Both Mount Sinai and Good Samaritan continued to treat a large number of poor patients, resulting in even more overall debt. The deficits caused by decreased reimbursements created a large shortfall for the hospitals. The shrinking number of total patients, combined with the underpayments from federal and state health care programs forced the cash-strapped hospital to make a decision on the proposed merger.[78]

The absence of a large scale concentrated effort from the Jewish community to help Mount Sinai Medical Center in the years of 1984-87 is significant. After decades of appealing to the Jewish community during fiscal crisis, there is no evidence of any sort of appeal to help the hospital during the years leading up to the merger. No appeals for donations, no fundraising drive, no appeal to the Jewish community of Milwaukee to save their hospital. The leaders left to decide the fate of Wisconsin's only Jewish hospital approved the merger to continue to care for the indigent in Milwaukee. Good Samaritan

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[75] Management Report, Mount Sinai Medical Center, December 13, 1984, Box 50, Folder 37, Sinai Samaritan Collection.
[76] Management Report, Mount Sinai Medical Center, January 25, 1985, Box 53, Folder 1, Sinai Samaritan Collection.
[77] Newspaper clipping, "Health Care Battle to Take Toll," *Milwaukee Sentinel*, April 3, 1985, Box 31, Folder 15, Sinai Samaritan Collection.
[78] Letter from the Board President of Mount Sinai Medical Center, June 18, 1987, Box 50, Folder 47, Sinai Samaritan Collection.

Medical Center also needed the merger in order to avoid closure. Three Milwaukee hospitals, Deaconess, The Passavant, and Mount Sinai, provided the foundation for the Sinai Samaritan Medical Center. The histories of the community contributions to the three Milwaukee hospitals that merged are not evident at Sinai Samaritan today.

On June 18, 1987, eighty-four years almost to the day, the Board announced the merger. Mount Sinai Hospital Medical Center, Wisconsin's first Jewish hospital, located at the corner of 12ᵗʰ and Cedar since 1913, was merging with the Good Samaritan Medical Center. The merger created Sinai Samaritan Medical Center. President of the Mount Sinai Board, Stanley Kritzik, announced the merger in a short, concise letter that explained that this necessary action would allow for the work at Mount Sinai to continue. As a stand-alone medical institution, Mount Sinai Medical Center was "excellent but underutilized downtown Milwaukee hospital. The goal of the merger is to form one high quality organization capable of more efficiently meeting the community's needs."[79] The merger agreement consolidated the downtown medical Centers in order to efficiently utilize departments within the existing facilities. The creation of Sinai Samaritan ended the history the only Jewish hospital ever to operate in Wisconsin.

After decades of service to Milwaukee, the hospital buildings remained downtown to continue the original mission of caring for those in need. The responsibility for funding that mission passed from the Jewish community to government programs. The decreased Jewish presence at Mount Sinai Medical Center had a profound impact on its Jewish identity. The Rosenfeld Study of 1967 suggested that there was no need for a Jewish hospital for Milwaukee's Jewish physicians because other hospitals had lifted the ban on

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[79] Letter from the Board President of Mount Sinai Medical Center, June 18, 1987, Box 50, Folder 47, Sinai Samaritan Collection.

Jewish doctors. However, Mount Sinai Medical Center *did* need the Jewish doctors, among others, in order to remain a Jewish hospital. Mount Sinai did not need to be religious in order to be a Jewish hospital; it had always been Jewish because of the Jewish Board members, Jewish doctors, Jewish patients and Jewish volunteers. The withdrawal of Jewish doctors, patients, and volunteers from Mount Sinai paved the way for the hospital's merger in 1987 with a Christian one. Elliot Lubar resigned from his position at Mount Sinai in 1982 stating, "I saw the handwriting on the wall, that this was not going to be a Jewish hospital much longer. The commitment went away and that was because the doctors went away."[80]

The decrease in Jewish community support, particularly the volunteer hours and fund raising, was significant in the decline of a sense of Jewish identity at Mount Sinai. The number of volunteers at Mount Sinai Medical Center decreased by the 1980s. Fears about personal safety is one possible explanations as to why the volunteers stopped coming to Mount Sinai. David Amrani noted that while Jewish doctors continued to admit patients to the hospital, albeit less frequently, the wives would not go. They cited the neighborhood "down there" and safety concerns kept them away.[81] The safety concerns stemmed from incidents in the 1960s. Civil unrest and riots in 1967 in Milwaukee influenced the attitudes of white suburban residents. In response to the overzealous response of the Milwaukee Police Department to relatively minor protests, Mount Sinai Medical Center worked with the Milwaukee police Department on a preparedness plan in case of riot and a large number of casualties. However, there were no major riots in

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[80] Elliot Lubar, Interview by author, Milwaukee, Wisconsin, May 10, 2011.
[81] Dr. David Amrani, Interview by author, Milwaukee, Wisconsin, July 14, 2011.

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Milwaukee.[82] Deindustrialization and increased poverty in Milwaukee led to urban blight in many neighborhoods, including Mount Sinai's.[83] Lehman stated there were instances of armed patients and an increase in the number of victims of violence treated at Mount Sinai. She stated that it was random but, "it exists, right outside the hospital, and when it does, it creeps into the hospital."[84] She also noted that Mount Sinai, like some of the best hospitals in urban areas are in "horrible neighborhoods" including Walter Reed National Military Medical Center in Washington D.C., where her son received medical services as part of the military: "it is in a horrible neighborhood, but President Bill Clinton went there for his care."[85] Mount Sinai was an excellent hospital in a declining neighborhood.[86]

Changes in the lives of women are a salient reason for the decrease in female volunteers during this time. Starting in 1970 women began to enter the paid labor force in large numbers, even after having children. In 1970, thirty-nine percent of American children had mothers who worked outside the home; by 2000, sixty-seven percent of children had mothers in the paid labor market.[87] Sociologists Vicki R. Schram and Marilyn M. Dunsing noted that college education and a husband that did not support a wife working outside the home increased the number of volunteer hours spent by married women in the 1970s. Younger women were also more likely to volunteer than older.[88] In 1965, the typical volunteer was married, female, aged 22-44 with a high school education

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82 Ellen D. Langill, *A Tradition of Caring: The History of Milwaukee's Three Primary Hospitals–Lutheran, Mount Sinai, and Evangelical Deaconess* (Milwaukee, WI: Sinai-Samaritan Hospitals History Committee, 1999), 110.
83 John Gurda, *The Making of Milwaukee (*Milwaukee, WI: Milwaukee County Historical Society 2006), 376.
84 Virginia Lehman, Interview by author, Milwaukee, Wisconsin, May 19, 2011.
85 Virginia Lehman, Interview by author, Milwaukee, Wisconsin, May 19, 2011.
86 Virginia Lehman, Interview by author, Milwaukee, Wisconsin, May 19, 2011.
87 Cynthia Costello, Vanessa R. Wight, and Anne J. Stone, *The American Woman 2003-2004* (Washington, D.C.: Woman's Research and Education Institute, 2002), 264.
88 Vicki R. Schram and Marilyn M. Dunsing, "Influences of Married Women's Volunteer Work Participation," *Journal of Consumer Research* 7, (March 1981): 378.

and no employment outside the home. By 1974, the typical characteristics of a volunteer changed little, the exception being she was now more likely to have a college education.[89] Sociologists Thomas Rotolo and John Wilson found that employment status and parenthood affected the number of volunteer hours. Women who worked part time volunteered more time, but those who worked part time and had children of school age volunteered more than homemakers with younger children.[90]

Many of the Mount Sinai Ladies Auxiliary members of the 1950s and 1960s were educated, married and did not work for pay outside the home after the birth of their children. They volunteered at the hospital for a variety of reasons, but not for a salary. Some had attended college but did not pursue careers.[91] Marilyn Kahn, a member of the Ladies Auxiliary, remarked on the change saying, "It was drastic to me. It was difficult to get volunteers, to get new volunteers. It was a great opportunity for young educated women of my time who really wanted to contribute to the welfare of others; some loved just being there. The new generation were not willing to be there as volunteers, and there was no group to draw on after we got older."[92] Kahn remembered one instance in which a younger woman was unwilling to serve on an art committee for the hospital as a volunteer, despite having a degree in art. Her art degree provided the means to establish a career.[93] Young women in the late twentieth century used their educations to gain employment, not to support exclusively volunteer activities. Volunteers at other Jewish institutions also decreased at the same time; leadership at the Sisterhood group at Congregation Emanu El B'ne Jeshurun reported that, "The end of the century [20th]

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[89] Schram and Dunsing, "Influences of Married Women's Volunteer Work Participation," 372.
[90] Thomas Rotolo and John Wilson, "The Effects of Children and Employment Status on Volunteer Work of American Women," *Nonprofit and Voluntary Sector Quarterly* 36, no.3 (September 2007): 499.
[91] Pat and Joan Kerns, Interview by author, Mequon, Wisconsin, May 24, 2011.
[92] Marilyn Kahn, Interview by author, Milwaukee, Wisconsin, June 7, 2011.
[93] Marilyn Kahn, Interview by author, Milwaukee, Wisconsin, June 7, 2011.

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brought important societal changes that slowed the activity of the Sisterhood under the weight of time crippling schedules for young family women, a great many of whom also filled jobs outside the home."[94] The decrease in women volunteers, Jewish doctors and, patients weakened the Jewish presence at Mount Sinai. Their contributions to the hospital had always been an aspect of Mount Sinai's Jewish identity. The Milwaukee Jewish population redirected resources that used to donated to Mount Sinai to institutions in their own suburban areas. The Jewish identity of Mount Sinai waned without the historically strong support of the community. The Star of David signified a sense of history and Jewish identity, but the sponsorship of Mount Sinai by the Jewish population ended with the merger. After eight decades, the work of the Jewish population of Milwaukee at Mount Sinai Medical center concluded.

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[94] Ruth Fromstein, *In This Place. . .Congregation Emanu El B'ne Jeshurun's First 150 Years* (Bloomington, IN: Author House, 2006), 86.

CONCLUSION

THE MILWAUKEE JEWISH FEDERATION AND COMMUNITY BUILDING

The Milwaukee Jewish Federation is in the process of exploring ways to unite the Jewish population in the state of Wisconsin. On June 26 and 27, 2011, approximately 300 members of the Wisconsin Jewish community met at the Milwaukee Public Museum for a 2 day "Jewish Summit." The event, officially recognized by Mayor Tom Barrett as the Milwaukee Jewish Summit Day, was advertised for weeks beforehand in the *Wisconsin Jewish Chronicle*.[1] The Milwaukee Jewish Federation, the current name of the former Federated Charities, viewed the Summit as a chance for the Jews in Milwaukee and other cities in Wisconsin to meet and discuss the future of the Wisconsin Jewish community. The Federation collects donations for a variety of local, national, and international causes. I attended this event. We received literature about current Milwaukee Jewish resources, from adult day care services to two free adult admissions to Jewish Museum Milwaukee. A booklet was distributed to all participants. The goal of the Summit was to ascertain the needs of the diverse Jewish community and the city of Milwaukee. It stated that the Summit's first task was to "Uncover and identify our strengths so that we can understand the elements that make our community special and give it life and meaning." The second purpose was "to dream a bold future for ourselves and for future generations emphasizing our deepest hopes and desires for Jewish Milwaukee." Finally, participants were to "to engage ourselves in bringing about the future we want to see, so that our dreams can come true."[2]

The first day of the event included round table discussions between randomly

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[1] Booklet, Milwaukee Jewish Summit, June 26-27, 2011, in possession of the author.
[2] Booklet, Milwaukee Jewish Summit, June 26-27, 2011, in possession of the author.

selected groups. The Summit included a luncheon, with an Orthodox member of the Milwaukee community on hand to insure the adherence to *Kashrut* laws. The summit was held on Sunday and Monday, to ensure that those who observed Sabbath could attend. Orthodox, Conservative, Reform, and unaffiliated Jewish people spent two days interacting in workshops and breakout sessions discussing Jewish identity and the state of the Milwaukee Jewish community.

The Federation used the data collected from the Summit and created thirty-two Dream Statements and eighteen Community Initiatives to bring together the Jewish people of Milwaukee. They created a scale in order to measure the political, social, and religious views of the attendees. Eighteen community initiatives were created using input from the Summit scale including a concierge program for new Jewish residents in Milwaukee to free Jewish education. There was no discussion of Mount Sinai Hospital.[3] The Dream Statements include passages meant to invite individuals into the Jewish community. For example,

> In our Jewish community each individual member is valued. We embrace our diversity and provide opportunities for all Jews, regardless of religious affiliation, marital status, sexual orientation, skin tone or economic status. An individual's financial resources are not a barrier to participation in Jewish education, Jewish social and cultural events and Jewish camping experiences. We provide for the needs of people who live alone, who are elderly, mentally ill or disabled. We collaborate to share our financial as well as personal resources. We ensure that all members of our community are aware of volunteer opportunities, and we view our human capital as a valuable resource to be efficiently managed. We immerse ourselves in the Jewish values of *tzedakah*, pride in our Jewish heritage, commitment to Israel and doing of good deeds.[4]

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[3] Milwaukee Jewish Federation, "Milwaukee Summit 2011," Milwaukee Jewish Federation. http://www.milwaukeejewish.org/reimagining/convening-the-community/1999-2/ (accessed December 31, 2014).
[4] Milwaukee Jewish Federation, "Milwaukee Summit 2011," Milwaukee Jewish Federation. http://www.milwaukeejewish.org/reimagining/convening-the-community/1999-2/ (accessed December 31, 2014).

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Another statement describes the ideal Jewish community,

> Our community will be a warm welcoming family, fulfilling the needs of all Jews as we learn more about our Jewishness. This can be facilitated through collaboration between institutions of the Jewish community (e.g., group purchasing, group planning, shared facilities). – There would be education of needs and similarities between the streams of Judaism to foster unity. Unity = respect of differences and connection through our similarities as we work side by side on our shared goals. – The values of community would be steeped in *Tikkun Olam*, *tzedakah*, and warmth. – Education would be available to all regardless of cost. To accomplish this we would use technology collaboration and volunteerism. – The elderly would have affordable services based on innovative design mechanisms.[5]

The leaders of the Milwaukee Jewish Federation are trying to strengthen relationships between diverse Jewish groups in Milwaukee. They are using scales, surveys, and other means to try to define a collective Jewish identity and appealing to individuals, welcoming them to a Jewish community. It is a good start. Sociologists Peter L. Berger and Thomas Luckmann argued that identity, once crystallized, is maintained, modified, or even reshaped by social relations. The social processes involved in both the formation and the maintenance of identity are determined by social structure.[6] In order to form stronger relationships between these present day Jewish residents, it is crucial to create opportunities to modify and reshape the social meanings of being from the East or West Side. Federation leaders must acknowledge the history of the conflicted relationship between East and West Side Jews, especially on matters of religious practice and ethnicity, in order to create social bonds within their population. As the Federation moves forward with these plans, it would be beneficial to their cause if leaders reacquainted themselves with the history of stratification and conflict within the population, in order to address

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[5] Milwaukee Jewish Federation, "Milwaukee Summit 2011," Milwaukee Jewish Federation. http://www.milwaukeejewish.org/reimagining/convening-the-community/1999-2/ (accessed December 31, 2014).
[6] Peter Berger and Thomas Luckmann, *The Social Construction of Reality: A Treatise in the Sociology of Knowledge* (New York: Random House, 1966), 173.

these same concerns as they seek to build a strong Jewish community.

Sociologist Ralph Segalman commented on the limitations of using scales for the purpose of measuring identity. They are often constructed in order to measure the strength of an individual's connection to established Jewish organizations, rather than measuring the strength of their Jewish identity.[7] Sociologist Simon N. Herman believed that a better way to measure an individuals' Jewish identity was to measure the impact of participation in Jewish organization on their lives.[8] The scales constructed for the Summit also do not reflect the contention religious diversity history as it relates to Milwaukee Jewish identity. The social segregation and differences in religious observance within the Milwaukee Jewish population remain crucial issues in light of the attempts at community building today. The history of Jewish participation at the former Mount Sinai Hospital is missing in their quest to define identity and build community. An articulate definition of identity is important to the leaders of the Milwaukee Jewish Federation, they hope that by defining Dream Statements and community initiatives, a collective Jewish identity will take hold and increased Jewish collective action will be a part of that identity. This research found that this will not be an easy process.

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[7] Ralph Segalman, "Self Hatred among Jews: A Test of the Lewinian Hypothesis of Marginality of Jewish Leadership," (PhD diss., New York University, 1966), 93.

[88] Simon N. Herman, *Jewish Identity: A Social Psychological Perspective* (Beverly Hills, CA: Sage Publications, 1977), 28.

The Jewish identity of Mount Sinai was not overtly religious. The available literature and interviews from members of Milwaukee's Jewish population reveal the original mission of Mount Sinai was nonsectarian. Mount Sinai served the city of Milwaukee for almost eighty-four years as a nonsectarian hospital. When Rabbi Caro approached Abraham Slimmer for funds to establish the hospital, Slimmer insisted on a broad, nonsectarian mission and matching community funds with his donations. The result of that stipulation was that Mount Sinai Hospital was a nonsectarian hospital that received support from the more affluent members of the Milwaukee Jewish community.

This research posited three distinct facets served as the foundation of Milwaukee Jewish identity: the conflict within the community between East and West Side Jews; a preference for Reform Jewish religious tradition by the first wave Western Europeans and the social distance from the later Eastern European immigrants due to ethnic differences; and philanthropy for all of the indigent of Milwaukee as a means of expressing civic pride through their collective action at Mount Sinai Hospital. The most salient part of early Milwaukee Jewish identity is not so much religiosity, but the conflict between the two ethnically diverse Jewish groups. All three facets of Milwaukee Jewish identity remain evident today.

The research of the early years of Jewish history in Milwaukee revealed discord between two different groups of Jewish immigrants. Historian Avraham Barkai noted that Germanic Jews acted with "The urgent aim was to wean newcomers, or at least their children, from their alien ways. The underlying fear was that the Eastern European Jews

would endanger their social status and achievements of the whole community."[9]

Historian Daniel Soyer noted that the relationship between more Americanized first wave German immigrants and later arrivals from Eastern Europe has been a subject of scholarly debate. Historians generally recognize that after initial tension and even hostility between the two groups, cooperative community action existed as the later arrivals gained prosperity and took their place in positions of influence in their communities.[10] This was the case in Milwaukee. Country of origin and the timing of arrival in Milwaukee were two crucial facets of the early immigrant experience. Rae C. Ruscha, an East Side Reform leader, observed in 1951 that "At about this time [turn of the century] I became conscious of the phrase, 'East is East and West is West and never the twain shall meet.' For no reason, some Jews living east of the river became imbued with the wierd [sic] notion that they were somewhat superior--of finer ilk than those living west of the river. The cleavage, entirely without merit, produced a logical resentment and resulted in somewhat strained attitudes."[11] Echoing Ruscha's thoughts sixty years later, Pat and Joan Kerns, an East Side Jewish couple, illustrated the lingering divide between the two communities;

> Joan: "Milwaukee was a very segregated city, it still is."
> Pat: "Not anymore."
> Joan: "A little bit, we still talk about people we were friends with."
> Pat: "That was way back."
> Joan: "They were West Side Jews."
> Pat: "We were just kidding."
> Joan: "Well, there is still a little bit of that mindset you know, never the twain shall meet."
> Pat: "It has something to do with where their parents and grandparents came from."

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[9] Avraham Barkai, *Branching Out: German Jewish Immigration to the United States 1820-1914* (New York: Holmes and Meier, 1994), 205.

[10] Daniel Soyer, "Brownstones and Brownsville: Elite Philanthropy and Immigrant Constituents at the Hebrew Educational Society of Brooklyn, 1899-1929," *American Jewish History* 88, no.2 (June 2000): 182.

[11] Rae C. Rauscha, "Those Serene, Placid Years Augured Tempestuous Changes," *Wisconsin Jewish Chronicle*, Sept. 23, 1951. Cited in Polsky, "The Great Defense," 78.

Joan: "Did your parents have any friends from the West Side? NO!"
Pat: "No."
Joan: "Pat's mother was so happy when he met me because I was an East Side girl, so it was a real division.
Pat: "The West Side boys used to come over because they wanted to date East Side girls. You remember that?
Joan: 'Sure, I went out with them." [laughs][12]

Class divisions and religiosity, were at the heart of the difference between the original East and West Side Jewish populations. Milwaukee afforded the East Side Jewish community many opportunities. Jewish businessmen, professionals, and politicians established themselves within the city's Germanic community on Milwaukee's East Side. The city granted suffrage to all male immigrants, Jews included, after a period of residency and did not impose punitive taxes on Jewish businesses. Many East Side Jewish men achieved financial success and established Mount Sinai to serve the indigent members of the West Side Jewish immigrant wave.[13] The hospital did not bridge the social gap between the Jewish East and West. The East Side community provided support for the care of those in need from the West Side. Some members of the West Side community established successful businesses of their own. They contributed to the hospital as well. Their success did not change the social differences in the community. East Side Jewish parents still wanted their children to marry on the East Side.

However, the West Side Jews eventually had opportunities to climb the socioeconomic ladder. The hospital was a meeting place for the Jewish population: common ground. There, they were united in their support for the mission. Pat Kerns related that with the right circumstances, namely religious affiliation and achieving upward social mobility, one could come from a West Side Jewish family and join the East

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[12] Pat and Joan Kerns, Interview by author, Mequon, Wisconsin, May 24, 2011.
[13] Louis J. Swichkow and Lloyd P. Gartner, *The History of the Jews of Milwaukee* (Philadelphia, PA: The Jewish Publication Society of America, 1963), 109.

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Side.[14] The West Side Jewish population grew quickly in the 1880s. The creation of

Mount Sinai Hospital, along with the Settlement and the Abraham Lincoln House, Jewish

Social Services, and the economic success of some West Side Jewish men allowed some

descendants of West Side Jews to join the East Side Jews in their new neighborhoods

north and east of downtown Milwaukee. Dr. Jay Larkey had Russian grandparents who

"envied the Germans." He lived on the West Side but remembers that when he was

younger he took a streetcar from his home at 2763 N. 53rd Street to Emanu-El Temple for

Confirmation classes, instead of preparing for a Bar Mitzvah at nearby Beth Israel.[15] He

was born and raised on the West Side, but his parents sent him to the Reform

congregation for religious education. Pat Kerns and Jay Larkey practiced Reform Judaism.

Pat Kerns grew up as a Reform Jewish man.[16] Larkey's parents put him on a streetcar to

get him across the Milwaukee River for religious education, and both define themselves

as East Side Jewish men.[17] Religiosity, in the more traditional observance sense, divided

the Milwaukee Jewish community in the early decades of the Twentieth century, but

remained one viable option available to signify the Jewish history at the former Mount

Sinai in 1992.

    This research revealed that in Milwaukee, the East and West Side Jewish populations,

historically divided along ethnic and class lines, formed a community at Mount Sinai

Hospital through their collective action to support their hospital. This support represented

one of the few collective community actions between the two groups, and the most

successful. The "Germans" and the "Russians" in Milwaukee did not eat, pray, or marry

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[14] Pat and Joan Kerns, Interview by author, Mequon, Wisconsin, May 24, 2011.
[15] Dr. Jay Larkey, Interview by author, Milwaukee, Wisconsin, August 17, 2011.
[16] Pat and Joan Kerns, Interview by author, Mequon, Wisconsin, May 24, 2011.
[17] Dr. Jay Larkey, Interview by author, Milwaukee, Wisconsin, August 17, 2011.

one another in great numbers. They did, however, work together for the good of "their hospital." It is their historic care and support for, and pride in their hospital, that best explains why a sense of Jewish identity mattered after the merger, why Sinai Samaritan had a menorah. The "Jewish identity" of the hospital prior to the 1987 merger came from the physical presence of the Jewish collective community. After the merger, after the dissolution of the Jewish Board and the sharp decrease in Jewish collective action at the hospital, Jewish ritual objects and observances replaced the people who used to make the hospital Jewish just by being there. Mount Sinai Hospital served as an icon in Milwaukee, representing the contributions of the Jewish population. Their commitment to the hospital continued even after much of the Jewish population moved outside of the city. Milwaukee Jewish gratitude for the opportunities provided by the city and the hospital explains their dedication. It is an important part of the Jewish narrative in Milwaukee. The Jewish community in Milwaukee continued to support the hospital even after relocating. It was by choice, and in the words of Pat Kerns, a duty for the community to "give back" to the people.[18]

    Mount Sinai Hospital contributed to the creation of the Jewish medical profession in Milwaukee. The Jewish doctors who worked at Mount Sinai cited anti-Semitism as a prevailing factor in creating a Jewish hospital in Milwaukee; it was as much about offering a place for Jewish doctors to practice as it was about treating Jewish patients. Jewish doctors established medical practices and professional careers because of Mount Sinai. Dr. Jay Larkey also noted the history of exclusion of Jewish doctors and the importance of a Jewish hospital in Milwaukee. There was no other option available to Jewish doctors," You have to remember the essential part of this story is anti-Semitism.,

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[18] Pat and Joan Kerns, Interview by author, Mequon, Wisconsin, May 24, 2011.

he said

> And the Jewish doctors that practiced in the city of Milwaukee had to practice at
> Mount Sinai or some of the smaller hospitals. They couldn't get on the staff of the
> major hospitals like St. Luke's, St. Joe's, Columbia; those were the upper echelon
> hospitals. . .Jewish doctors could not get on staff at these major institutions so
> they had to go to Mount Sinai Hospital.[19]

Dr. Harry Kanin related his early career in terms of the opportunity provided to Jewish

doctors in Milwaukee:

> One of the motivations was not so much to take care of Jewish patients but also
> provide a place a hospital for the Jewish doctors to work. Because they couldn't,
> they weren't accepted as a rule at the other hospitals. By the time I came here that
> was breaking down. There were Jewish doctors at various hospitals, not many but
> a few. But the reason I decided to do my internship here was simply because it
> was automatic; I just felt comfortable here.[20]

The plan to institute specific religious observations, closing for Jewish holidays and

erecting a Menorah for Hanukkah, in order to maintain Jewish identity, did not come

from any religious tradition at Mount Sinai over its eighty-four years of operation before

the merger.[21] The attempt, in 1992 after the merger, to retain a "Jewish identity" does not

necessarily represent a shift of opinion regarding the more religious and traditional

Jewish observances in Milwaukee's Jewish population. In the early years of Milwaukee

Jewish history, distinctive religious observances and traditions divided the East and West

Side Jewish residents. Dr. Harry Kanin recalls a sense of embarrassment on the part of

East Side Jews toward those who adhered to traditions from Europe.[22]

The East Side Jews, by virtue of being among the first to arrive, established

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[19] Dr. Jay Larkey, Interview by author, Milwaukee, Wisconsin, August 17, 2011.
[20] Dr. Harry Kanin, Interview by author, Milwaukee, Wisconsin, July 14, 2011.
[21] Louis J. Swichkow and Louis P. Gartner, *The History of the Jews in Milwaukee* (Philadelphia, PA: The Jewish Publication Society of America, 1963), 228.
[22] Dr. Harry Kanin, Interview by author, Milwaukee, Wisconsin, July 14, 2011.

themselves as the arbiters of what constituted Milwaukee Jewish identity, including culturally acceptable religious expression. Many of the individuals Interviewed about Mount Sinai Hospital for this project related similar narratives about the Jewish community who founded it. They described the "German" Jews who built the hospital for "Russian" Jews at the turn of the 20th century.[23] During their Interview, Pat and Joan Kerns reported that the Milwaukee Jewish community is now run by "The Russians" and related their experience with a "Russian Rabbi" from Milwaukee. After giving him a donation, he continued to call the Kerns until Joan finally told him not to call for additional donations.[24] The tone of that exchange was reminiscent of some of the reported interaction between East Side German and West Side Russian Jews a century ago.[25] However, when asked if the Russians in Milwaukee today were those that had arrived from the Soviet Union, he did not know for certain if that was accurate.[26]

The rational for the adoption of certain religious observances after the merger, the religious traditions and observances proposed to retain "Jewish identity," were most likely less about religious practices and more about Milwaukee Jewish history. These proposals represented an attempt to maintain the memory of Jewish contributions to Milwaukee at Mount Sinai. The intent was not to establish a religious tradition at Sinai Samaritan Hospital. It was designed to retain the Jewish past, after Jewish doctors established themselves at other hospitals and Jewish philanthropy stopped providing for indigent care. Milwaukee had a small Jewish population compared to Chicago, New York,

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[23] Dr. Harry Kanin, Interview by author, Milwaukee, Wisconsin, July 14, 2011; Pat and Joan Kerns, Interview by author, Mequon, Wisconsin, May 24, 2011; Dr. Jay Larkey, Interview by author, Milwaukee, Wisconsin, August 17, 2011.
[24] Pat and Joan Kerns, Interview by author, Mequon, Wisconsin, May 24, 2011.
[25] Pat and Joan Kerns, Interview by author, Mequon, Wisconsin, May 24, 2011.
[26] Pat and Joan Kerns, Interview by author, Mequon, Wisconsin, May 24, 2011.

Newark, and Boston and treated more Gentile patients than Jewish from the beginning.[27] However, the Milwaukee Jewish residents established a hospital for those in need, even if they did not use the hospital themselves. Jewish financial donations and Milwaukee's Jewish doctors and volunteers established a Jewish identity by virtue of their direct support and presence at Mount Sinai. It was Jewish by virtue of their very visible presence at Mount Sinai.

JEWISH COLLECTIVE ACTION AND HEALTH CARE TODAY

This research revealed the strength of Milwaukee Jewish collective action at Mount Sinai Hospital. They built and sustained it despite the vast differences between members. They donated time and money to this common cause at a time when East Side and West Side residents did not socialize with one another. Their legacy is one of caring for those in need in Milwaukee, and it is no wonder that the pride of those interviewed is evident. It is tempting to assume that the revival of collective community action at Mount Sinai Hospital by today's Jewish population would have the same results today. That is, to assert that if religious communities reclaimed their traditional roles in creating hospitals, somehow, free care for the indigent would materialize, would be misguided.

Health care was once a community effort, but the sense of ownership and personal connection that inspired the foundation of many American hospitals was weakened by the growth of hospital systems. Increased government regulations and existing hospital systems that also own physician networks limit the ability of any one community, no matter how dedicated, to establish a new hospital. Doctors and patients are also bound by

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[27] Newspaper Clipping, Editorial, *Wisconsin Jewish Chronicle,* June 30, 1922, Box 51, Folder 1, Sinai Samaritan Collection.

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insurance plans, which dictate where they can practice and receive care, respectively. However, the barriers to affordable health care for the poor in Milwaukee in 2016 are actually similar to those in 1903. There is still a need for health care assistance for the poor and no widespread community efforts to offer assistance. Hospitals, including Aurora Sinai, now ration Emergency Department services. Patients with ear aches, sore throats, and other minor complaints are referred to primary care facilities that many cannot use because of their limited transportation options.[28] Hospitals are businesses, and have adjusted their policies to reflect that model. Government programs remain unreliable, and the age old notion of worthy and unworthy poor lives on in a means tested system of limiting health care for the poor. Scott Walker, the current governor of Wisconsin, has declined to accept additional federal funds for Badger Care.[29] This could result in lost health insurance for current Badger Care participants and limits the chance of new patients to get covered. Many Milwaukee residents remain in need of medical care. The government programs that replaced collective community action fall short of providing care. Hospitals like Aurora Sinai continue to treat patients, even as they lose money in the process. The changes in the American hospital system and in funding for indigent care distanced many private religious hospitals from their communities of origin, and Mount Sinai was no different. The hospital changed names and ownership, but the needs of the poor did not disappear. Sociologists Cal Clark and Rene McEldowney postulate that there are three basic tenets of a comprehensive health care system. First, high quality care must be provided; second, there should be universal access to that quality health care; and finally, that high quality, freely accessed health care should be delivered at a reasonable price. The

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[28] George Hinton, Interview by author, Milwaukee, Wisconsin, December 2, 2011.
[29] Mark Peters, "A Medicaid Bet in Wisconsin; Gov. Scott Walker Says He Wants to Protect the Poorest; Critics Assail Him for Not Taking U.S. Funds," *The Wall Street Journal,* December 18, 2013

authors state this is the "trinity" of the health care sphere. The problem with the trinity, these authors note, is that changes in one of the facets will often negatively impact the other two parts of the whole.[30] The rising cost of health care made delivering health care at a "reasonable" price difficult for hospitals.

This was not always the case. Many American hospitals opened at the turn of the twentieth century because local communities wanted them, and were willing to support them. Hospitals today are a part of a health care industry. Government rules and regulations affect funding for the health care systems that treat the poor. Now, Aurora Sinai, the former community hospital, belongs to a large health network, Aurora Medical Group. It continues to serve the people downtown Milwaukee, many of whom are uninsured or depend on Badger Care, the means tested insurance program in Wisconsin. Medical Ethicist David M. Craig noted an important development in the reform of U.S. health care impacted nonprofits like Aurora Sinai. The Internal Revenue Service (IRS) developed a new Schedule H for nonprofit hospitals as part of its revised Form 990, the form that nonprofit organizations use to report the year's financial activities in 2008. He noted that

> This revision responds, in part, to the scrutiny of nonprofit hospitals' community benefits practices, which has come from Congressional committees, state legislators, Attorneys General, tax officials, and the Service Employees International Union. These critics argue that tax-exempt hospitals should be providing higher levels of uncompensated care to patients who are uninsured or underinsured. Nonprofit hospital leaders have countered. They cite the various benefits they already provide under the 1969 community benefit standard, including rising amounts of uncompensated care. They also note that the standard does not mandate charity care. Neither does the new Schedule H, but the form signals a set of priorities with moral implications for the public responsibilities of nonprofit hospitals, and treating poorer patients tops the list. Central to Schedule H is the question, what level and what kinds of responsibilities do nonprofit

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[30] Cal Clark and Rene McEldowney, "The Health Care Financial Crisis: Reorganization and Evidence-Based Medicine as a Response to an 'Unholy Trinity,'" *Review of Policy Research* 17, no. 1 (Winter 2000): 2.

providers have for the American health care safety net? This question has gained traction as the number of uninsured and underinsured Americans rises and as health care costs outpace public financing. The debate over community benefits has been the special purview of health care insiders and policymakers, but it anticipates important issues of access and public responsibility that loom large in the national debate over health care reform.[31]

These changes sought to address problems with the Community Benefit Standard of 1969. The creation of safety net programs in 1965 prompted changes in nonprofit operations. The Community Benefit Standard removed the provisions that required nonprofits to offer patient care free of charge or below actual cost of care. It granted tax exemption status to nonprofits that passed two tests. First, they had to operate as a nonprofit, with an open medical staff and community board. Second, the nonprofit had to promote health in the community it served.[32] The issue raised by David M. Craig is that there is no hard and fast rule about what exactly constitutes community benefit. He points to three models of "moral conceptions" about nonprofits and their obligation to the community at large, particularly hospitals as a way of determining what community benefits nonprofits owe the public. The social contract model views the tax exempt status of the nonprofit as a gift, and because of that gift, they owe the community and should provide care for the indigent. The common good model, found in many Catholic hospitals, believes that community benefits are part of the common good and include providing health care to all in need. Charity care is an essential community benefit, but the main goal is to improve health care delivery institutions by working with other groups to identify and

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[31] David M. Craig, "Religious Health Care as Community Benefit: Social Contract, Covenant, or Common Good?," *Kennedy Institute of Ethics Journal* 18, no. 4 (2008): 301-302.
[32] Craig, "Religious Health Care as Community Benefit," 304.

respond to the needs of poor patients in under-served areas.[33] Finally, the covenant model

is a more appropriate model to describe Jewish community efforts. These organizations

give priority to their original mission, in their communities.[34]

Mount Sinai Hospital was an important cooperative community accomplishment for

the Milwaukee Jewish community. The hospital served Milwaukee for eighty-four years

because of the support that came from a segregated and conflicted population. The two

groups worked together to support it. The Jewish population created the hospital through

collective community efforts. That effort created a sense of community between them that

did not exist elsewhere. David M. Craig's research provides "moral models" that could be

used as a starting point for the revival of the once successful community health care

setting—the Dispensary. Katz noted that dispensaries closed as hospitals expanded their

facilities and opened specialized departments.[35] Rosenberg believed that dispensaries

closed due to the increase in both the number of hospitals and the fact that hospitals

wanted to create opportunities for medical students.[36] The Mount Sinai Dispensary

worked with other religious community organizations to meet a variety of health care

needs. In Milwaukee, patients with diabetes, asthma, high blood pressure, and other acute

conditions used the Dispensary and doctors and nurses received training.[37] Social

workers assisted patients during their stay and after discharge. The staff of the Dispensary

worked with Jewish Social Services, and other hospitals to treat patients and provide

assistance. The Dispensary offered referrals for home care assistance, respite care for

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[33] Craig, "Religious Health Care as Community Benefit," 302.
[34] Craig, "Religious Health Care as Community Benefit," 315.
[35] Michael B. Katz, *In the Shadow of the Poor House: A Social History of Welfare in America* (New York: Basic Books, 1986), 138.
[36] Charles E. Rosenberg, *The Care of Strangers: The Rise of America's Hospital System* (New York: Basic Books, 1987), 318.
[37] Dr. Harry Kanin, Interview by author, Milwaukee, Wisconsin, July 14, 2011.

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families with children, and outpatient follow up care.

The history of the Milwaukee Jewish Federation provides insight as to the effectiveness of collective Jewish action. It began as the Hebrew Relief Association in 1889, and became Federated Charities in 1902. The charitable work of the organization expanded and the name United Jewish Appeal was first used in 1938.[38] It became the Milwaukee Jewish Federation in 1970 as a response to the changing needs of the Milwaukee Jewish community.[39] Individual members of the Jewish community continued to support the downtown Milwaukee hospital, but it no longer received support from the Milwaukee Jewish Federation.

The Star of David on the hospital signified a Jewish presence at Mount Sinai to Dr. David Amrani and led him to Milwaukee.[40] The removal of the Star in September of 1988 did not so much end the Jewish identity of the hospital, it removed one of the most obvious symbols of its Jewish past.[41] When the historic fundraising efforts for indigent care ended and Jewish doctors practiced at other hospitals, the proposed religious icons and observances in 1992 represented a desire to preserve the Jewish history of Sinai Samaritan. Despite the negative feelings of the founders of Mount Sinai toward the religious traditions of some of their brethren, these traditions now represented a means to preserve the Jewish legacy of the hospital.

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[38] Louis J. Swichkow and Louis P. Gartner, *The History of the Jews in Milwaukee* (Philadelphia, PA: The Jewish Publication Society of America, 1963), 342.
[39] John Gurda, *One People, Many Paths: A History of Jewish Milwaukee* (Milwaukee, WI: Jewish Museum Milwaukee, 2009), 256-57.
[40] Dr. David Amrani, Interview by author, Milwaukee, Wisconsin, July 14, 2011.
[41] Dr. David Amrani, Interview by author, Milwaukee, Wisconsin, July 14, 2011.

A COMMUNITY TRADITION

The tradition of philanthropy, one of the historic facets of Milwaukee Jewish identity, continues today. Members of the Jewish population continued to contribute to the hospital long after their families had left their original neighborhoods. Many Jewish residents had long since relocated, taking many of their synagogues and community centers north of downtown Milwaukee, outside of the city limits. Mount Sinai Hospital was one of the few institutions left in Milwaukee that represented the Jewish community as a whole. The shared sense of pride in the hospital on the part of those interviewed is evident. It was a Jewish institution in that it represented the Milwaukee Jewish tradition of *Tzedakah*. It was Jewish in that the Milwaukee Jewish community worked to keep it open. After the merger, an effort was made to find a way to replace that participation and keep the hospital Jewish in the eyes of the people of Milwaukee. The years of volunteer work and the donation drives were no more, the overt Jewish support for the hospital ended. The efforts in 1992 sought to remind those using Sinai Samaritan that the Jewish people of Milwaukee established, supported and eventually surrendered the hospital for the good of Milwaukee.

Sinai Samaritan is the only hospital in downtown Milwaukee. Their patients are primarily underinsured or uninsured.[42] Medical practices have also relocated from the neighborhood. Many patients use Mount Sinai for routine illnesses and acute conditions because it is the only medical facility to which they have access.[43] Today, one "harsh environmental condition" that contributes to poor health and high medical costs is lack of primary care for the poor. Increasing the number of indigent patients with chronic

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[42] George Hinton, Interview by author, Milwaukee, Wisconsin, December 2, 2011.
[43] George Hinton, Interview by author, Milwaukee, Wisconsin, December 2, 2011.

conditions in primary care situations is one possible way to demonstrate community benefit in Milwaukee. Physician Jane McCusker et al. found that uninsured patients tended to use the Emergency Department for their health care needs. Patients with chronic conditions like diabetes, asthma, and high blood pressure need primary care doctors in order to manage their conditions. When given the opportunity to receive primary care, patients with and without chronic conditions were more likely to seek preventive care rather than go to an emergency room for treatment.[44] In 1999, The East Side Community Practice, in Gainesville, Florida, began providing free primary care to patients admitted to the hospital through the emergency department. Physician Richard A. Davidson et al. noted that those patients significantly decreased the number of emergency room visits after entering into primary care.[45] Emergency Departments are not designed to treat chronic conditions; patients need primary care relationships for good outcomes. George Hinton remarked, "We believe the ED [Emergency Department] is not the place for managing diabetes, asthma and high blood pressure, episodic care. Patients need to have medical homes. It is not as easy as it sounds because we don't have enough [of them]. So we just push them into a system that is already overloaded, so automatically people end up right back here again."[46]

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[44] Jane McCusker et al., "Emergency Department Visits and Primary Care among Adults with Chronic Conditions," *Medical Care* 48, no.11 (November 2010): 978.
[45] Richard A. Davidson et al., "Evaluation of ACCESS, A Primary Care Program for Indigent Patients: Inpatient and Emergency Room Utilization," *Journal of Community Health* 28, no.1 (February 2003): 61-63.
[46] George Hinton, Interview by author, Milwaukee, Wisconsin, December 2, 2011.

The Mount Sinai Dispensary, between 1935 and 1967, worked within the community to meet a variety of health care needs. Patients with chronic and acute conditions, accidental injuries, and emergency cases used the dispensary. The staff of the dispensary worked with the hospital, Jewish Social Services, and other Milwaukee hospitals and social service agencies to treat patients and provide assistance. Home care assistance, respite care for families with children, and outpatient follow up care were offered at the Mount Sinai Dispensary. Former Aurora Sinai President George Hinton believes that, "The legacy of it [Mount Sinai] being a great hospital still remains; the pride of it is still here, the years and years of greatness. The legacy of all the hospitals that came together to form Aurora Sinai today [is] very much embedded here."[47]

Health care was once a community effort in, but the sense of community that founded many hospital has been weakened in light of the growth of hospital systems, George Hinton believes that, "The evolution of systems have [sic] kind of taken way the community feel of hospitals, and that is what I believe is trying to find that [sense of community] again."[48] He envisions a community effort at Aurora Sinai to "connect with the community. I've started that process because I want us to be perceived as part of a community solution instead of just a building sitting here waiting for people to get sick. The history of Sinai is not finished."[49]

Aurora Sinai continues to treat many patients in its emergency department and is currently exploring options to expand its services in community health initiatives, but how committed the hospital is to caring for those patients remains unanswered. A

[47] George Hinton, interview by author, Milwaukee, Wisconsin, December 2, 2011.
[48] George Hinton, interview by author, Milwaukee, Wisconsin, December 2, 2011.
[49] George Hinton, interview by author, Milwaukee, Wisconsin, December 2, 2011.

Jewish-sponsored community health movement in Milwaukee could help both the Jewish community and Aurora Sinai Medical Center continue the original mission of Mount Sinai Hospital. Political action on behalf of those in need of stable primary care for their chronic conditions and wellness programs to prevent those conditions are all viable possibilities. The Milwaukee Jewish Federation is invested in strengthening the Wisconsin Jewish community. Mount Sinai, now Aurora, does have a history of strengthening community ties; it strengthened the ties between two very different Jewish communities. The opportunity to revive the relationship between the Jewish Community and Milwaukee exists at Aurora Sinai Medical Center through participation and support of a community based health care program. The divided Jewish community created a hospital, a united Jewish community could, in the future, rebuild the community health care system of Mount Sinai in Milwaukee, on a foundation wide in scope.

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