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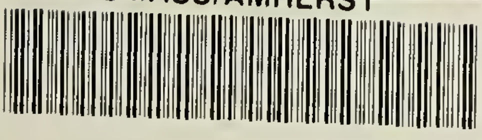
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THE PROBLEM WITH PLANNING: SPRINGFIELD HOSPITAL AND THE DEVELOPMENT OF THE U.S. HEALTHCARE SYSTEM 1890-1980

A Dissertation Presented

by

BRUCE SAXON

Submitted to the Graduate School of the
University of Massachusetts Amherst in partial fulfillment
of the requirements for the degree of

DOCTOR OF PHILOSOPHY

September 1996

Department of History

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THE PROBLEM WITH PLANNING: SPRINGFIELD HOSPITAL AND THE DEVELOPMENT OF THE U.S. HEALTHCARE SYSTEM 1890-1980

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BRUCE SAXON

Approved as to style and content by:

David Glassberg, Chair

Bruce Laurie, Member

Martin Kaufman, Member

Diane Flaherty, Member

Bruce Laurie, Chair
Department of History

ABSTRACT

THE PROBLEM WITH PLANNING: SPRINGFIELD HOSPITAL AND THE DEVELOPMENT OF THE U.S. HEALTHCARE SYSTEM 1890-1980

SEPTEMBER 1996

BRUCE SAXON, B.A., UNIVERSITY OF CHICAGO

M.A., UNIVERSITY OF MASSACHUSETTS AMHERST

Ph.D., UNIVERSITY OF MASSACHUSETTS AMHERST

Directed by: Professor David Glassberg

This dissertation traces the history of Springfield Hospital from 1890 to 1980. I examine the case of Springfield Hospital as a springboard to examine the larger developments in the U.S. healthcare system in the twentieth century. Medical historians have done yeoman work in charting the story of hospitals to 1920 in terms of case studies: In this work, I try to take hospital history up to the present. Medical historians have also constructed powerful interpretative frameworks of national hospital development in the twentieth century. I build on their work and in some cases take issue with their analysis based on my examination of Springfield Hospital.

Among my findings: Spingfield's medical staff records reveal real ambivalence among physicians about the development of the medical center model of healthcare. The records show as well a concurrent fight among physicians over competing definitions of professionalism. Trustee and Superintendent records suggest that the numbers of those

unable to pay for healthcare was perhaps higher than has been commonly believed. Furthermore, Springfield's case indicates that private hospitals (and not just the largest urban teaching hospitals usually surveyed in hospital histories) did provide for large numbers of such individuals and did not simply try to hive them off to public facilities. Moreover, the cost and complications of caring for the medically needy substantially shaped Springfield's priorities and finances. This exacerbated tensions among the medical staff over the development of Springfield into a medical center. Most importantly, the problems associated with caring for the indigent made impossible effective realistic long-term planning. At Springfield, this helped cause the decline of the medical center model of health care and laid the basis for the dominance of local Health Maintenance Organizations.

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CHAPTER 1

INTRODUCTION

In this dissertation, I explore the history of Springfield Hospital from 1890 to 1980. In preparing to research this history, I found it paradoxical that while hospitals have been a central factor in the nation's economy, culture and politics, there are virtually no academic case studies of individual private hospitals. Leading medical historians such as Paul Starr, Charles Rosenberg, and Rosemary Stevens have written overviews of apparent national developments and other historians have assumed that their analysis is accurate and holds true for the local level as well. A local history, then, might provide minor variations and interesting details to what are otherwise incontrovertible narratives. These narratives have as their center the unfolding of such grand themes as the rise of professionalism among physicians and the growth of the medical center model of health care. In general, such narratives suggest that the development of America's current health care system was basically uncontested and largely preordained by the prevailing medical culture. They are largely based on extensive research into the records of the American Medical Association, the American Hospital Association, and other affiliated organizations, and documents from select major hospitals in the largest urban areas.

There are two fundamental problems with the standard approach to twentieth century hospital history. The interpretation assumes that what happened in the most advanced sector of health care simply filtered down or was otherwise replicated down below. The second more important problem is that these accounts assume that the rhetoric of the various interest groups contained in their papers accurately reflected and represented local realities and perceptions. I find instead that standard narratives miss crucial aspects of the development of hospitals and misstate the role and beliefs of central participants--particularly physicians. These histories tend to overemphasize the coherence and unity of physicians, miss physician's ambivalence about much of the evolution of medicine, neglect physician's difficult experience with government at the city and state level, and discount physician's objections about government involvement in health care as either paranoia, greed, or rank disinformation.

In my study, I try to show some complexities that traditional accounts miss and in so doing attempt to fashion a somwehat different view of hospital history in the twentieth century. In the first chapter, I begin with a quick overview of the state of medicine and health care in the 19th century. I then discuss important changes in medicine, and in the medical profession and link these

changes with the rise of hospitals at the beginning of the twentieth century. Next, I focus on Springfield Hospital's early decades to 1920. The standard literature argues that hospitals in order to get increased revenues turned from charitable operations to profit-making enterprises. In so doing, they reduced services to lower class patients either by diverting them to public hospitals or else by charging new fees and that the result of all this was to make private hospitals solid financially. I find to the contrary that, at least in Springfield Hospital's case, despite its increasing reliance on paying patients, Springfield continued to face major financial problems throughout this period precisely because charity care continued to occupy a large portion of patient admissions. Moreover, the problem of providing for charity care made it difficult for Springfield Hospital to expand or to even think in terms of long-term planning. I suggest that this sort of pattern would be a recurring dynamic throughout Springfield's history.

In my second chapter, I begin with a survey of medicine and hospitals circa 1920. I discuss the enviable public image and position enjoyed by physicians. I then show how physicians were actually less exalted from 1920 to 1940 than commonly believed or rendered in most standard accounts. A central point here is that in important respects, in outlook, training, and practice, the medical

profession was hardly a tight corporate body; that few professional organizations opposed the state of affairs, that those who did so were unsuccessful in their efforts to win over the rest. In the chapter, I illustrate the truncated professionalism then current at Springfield Hospital as shown in the areas of education, patient records, cooperation among physicians, and community service. I argue that financial problems of the period caused in large part by the expense of caring for charity patients prevented Springfield from expanding patient services or even to offer proper patient care--further reenforcing physician's prevailing brand of professionalism.

In the third chapter focusing on the years from 1940 to 1960, I begin by recounting the amazing growth of Springfield Hospital's operations--much of which was due to the increased numbers of patients with health insurance. I describe the advantages and limitations of health insurance for both providers and patients. I link the growth in patient revenues and admissions to the decision by some Springfield physicians and administrators to make Springfield more like its sister institutions in Boston and New York. The remainder of the chapter addresses the battle royale that followed, a contest hardly mentioned in existing literature, over new definitions and new demands

of professionalism and the degree to which Springfield would be restructed accordingly.

In my fourth chapter, I survey Springfield from 1960 to 1975. Not till the mid 60s, I argue, did a medical center model of health care--as opposed to a community hospital approach--take hold at Springfield. Furthermore, even at that point, Springfield remained rent by dissatisfaction with the new regime, which was exacerbated by the latter's inability to provide an ample supply of new services and programs of high quality to physicians. As earlier, the cost and space devoted to caring for the indigent derailed Springfield's development. Springfield also faced damaging competition from its cross town neighbor--Wesson Memorial Hospital--which enjoyed a more balanced mix of primary care and acute care services. I then discuss the efforts of health care planners and local businessmen to rationalize the area's health care services. Their efforts culminated with Springfield's merger with Wesson in 1975. I then briefly examine the merger's impact through 1980. In the conclusion that follows, I summarize Springfield's history and discuss its relevence to current hospital historiography and contemporary debates about HMO's and health care reform.

CHAPTER 2

SPRINGFIELD HOSPITAL TO 1920

Until the end of the 19th century, few Springfield residents would be caught dead in a hospital. They shared this conviction with Americans in general. The accepted wisdom was that if you wanted to stay healthy or overcome illness, it was best to stay away from hospitals.

Hospitals emerged after the Civil War to take care of the sick poor. Until mid-century, those unfortunates in Springfield and elsewhere without visible family support who fell ill were carted off to almshouses and dumped there together with the rest of a pathetic mass: the mad, the blind, the crippled, the chronically arthritic. The almshouse was generally last stop for the sick poor and hardly anyone noticed or cared about their passing.

Profound economic and demographic changes spurred the widespread development of hospitals. The surge of industry helped draw millions from abroad (and many thousands of others from American rural areas) to cities where they labored under unhealthy and often deadly conditions for pitiable wages. They crammed into noisome, unventilated tenements. They subsisted on substandard diets, drank dirty water and impure milk. They lived in the midst of raw sewage, horse droppings, and the carcasses of spent or slaughtered animals. They breathed soot from untreated burning coal and inhaled the poisonous vapors pouring from

industrial plants. The number of impoverished urban folk who fell ill, or who were injured, who were unable to adequately care for themselves, and had no one to properly look after them grew enormously. [1]

Almshouses were overwhelmed by the hordes of sick or broken persons who streamed through their doors. The plight of almshouses and those who beseeched them for assistance caught the attention of individuals and groups from many quarters. These included social reformers, politicians, businessmen, labor officials, philanthropists, and leaders of numerous ethnic and religious orders and societies. In city after city, they set about building hospitals to care for the needy. [2]

Support for hospitals came from various motives, ranging from the paternalism of the wealthy and fortunate to those in hapless circumstances, to the desire of elites and ordinary citzens to demonstrate political leadership and civic virtue. Rarely though were hospitals intended to house its benefactors. These shelters for the helpless were for "them."

Besides, given the limitations of medical care, there was virtually nothing that could be done at most hospitals that wasn't available at a decently appointed home. Rest, good food, warmth, ventilation were the major tonic for illness. Also important was attentive nursing by loving family members who relied on potions and procedures derived from almanacs, medical dictionaries and remedies handed

down from generation to generation. Mainly though, nature was left to work its wonder, whether horrific or beneficent. Hospitals were largely irrelevant in determining the outcome.[3]

Home care was favored over hospital care because hospitals were notorious for their untrained staff who gave desultory care. In such places, oftentimes, if typhus didn't get you (as a medical patient) than gangrene would (as a surgical admission). Hospitals were notorious for being dingy and dirty. They were known as pesthouses (not only those that quarantined patients) not only because of the contemptuous attitude of some to the "inmates" as they were known then but because conditions were often vile with all types of vermin crawling through the darkened corridors and shabbby wards. For the luckless patients, it was a terrible humiliation, for their relatives-if they had any in the vicinity- a stain on the family that a member would be consigned to such surroundings. [4]

Aside from the grubby setting and miserable treatment by so-called nurses, there was another reason to favor home care over hospital confinement; this was to avoid dealing with the physicians who roamed the premises. Most Americans--whatever their economic status--rightly disdained physicians whose skills and training were usually barely adequate or atrocious. They either completed a brief apprenticeship before being turned loose on a not-wary-enough public, completed a half-baked program at one of the

numerous propietary schools, or avoided the inconvenience of attending lectures altogether by going the correspondence school route. [5]

Physician licensing was as unregulated at the time as medical education. As a result, the U.S. had more physicians per capita than any major country in Europe. Nearly anyone could set himself up as a practitioner though few had much scientific knowledge of the causes or treatment of illness and disease. In fact, as James Cassedy has remarked, "doctors if they were lucky knew just a little more than most patients they practiced on." Practiced indeed! [6]

Partly because the field was so overcrowded, few physicians in the 19th century were able to make a decent living-much less today's handsome salaries-just by practicing medicine. Physicians resorted to barracuda-like behavior including patient stealing to try to "make their nut." This did not endear them to the public. Physicians were further discredited by the open warfare then current between the various sects of medicine, each claiming the one and true approach to practicing medicine. Hydropaths pushed the "water cure;" Christian Scientists swore by the restorative power of "mental healing;" Thomsonians claimed that roots and herbs properly used were the principal weapon against illness; Homeopaths insisted that the application of minute amounts of otherwise toxic medications to ill individuals would work wonders. Of

course, none of the sects had anything but a vague understanding of the bases of illnesses. [7]

To call medicine a respectable profession would have invited derision from most Americans. Today's image of physicians as caring professionals would be incomprehensible to any 19th century American familiar with physicians' harsh therapies, including bleeding, purging, and blistering. The sick were sensible to pass these by, to try a herbal remedy, to seek out a midwife, a mortician, a family member or a friend for help, or simply wait and pray that their particular affliction would pass. At least most non-medical treatments were relatively benign. If they did no good, they caused no further harm unlike those of so many physicians of the day. [8]

Given the marginality of both hospitals and physicians, it is not surprising that Springfield had been incorporated as a city for more than 25 years before the idea of building a general hospital for the sick was even considered. Also, the city's attention and resources in the seventies and eighties, as true throughout the country, were fixed on the grave and dramatic public health problems of the day- notably matters of proper garbage disposal and creation of a workable sewer and water system. Even after Springfield Hospital was incorporated in 1883, raising money was an inordinately slow and cumbersome process. In the first five years, not enough support was forthcoming to even produce a plan for the proposed hospital.[9]

Boosters, though, did not abandon their idea for a hospital. They made appeals through the city's municipal register for support. They also appealed to clergy who organized "hospital sundays" at local churches to raise funds. A few wealthy individuals offered sizable donations but only in return for special treatment at the future facility. Perhaps they feared contamination from run-of-the-mill patients or they feared neglect by the regular staff. Whatever the case, the Board of the still non-existent institution tactfully declined the offer, "While the board is of the opinion that special arangements can be made with the hospital to accommodate the proper demands of special services at the proper time...at present it seems inexpedient at this time to receive any but unconditional subscriptions except as to time and manner of payment." Though records are sketchy, there does seem to have been a plan to build a hospital specifically for private patients, but members determined that there was not enough interest from prospective well-to-do patients to justify a separate building. However, Board members did choose to establish a special section of private rooms. With that decision, gifts from affluent citizens increased significantly. Most notable of these was Dorcas Chapin, a long time resident and scion of one of Springfield's leading families. She gave twenty-five thousand dollars to Springfield hospital on condition that its corporators raise a matching amount. It took them a year to do so.

Construction on the hospital finally began in 1888 and it opened in 1889. [10]

Popular attitudes toward the hospital were explained in a newspaper article in 1889 shortly after its opening, "In most minds the hospital is associated with paupers and criminals and what are termed the unfortunate classes...Even to visit such a place is distasteful to most people and the sick hesitate to come there." [11]

Forty years later, a veteran physician recalled that at the turn of the century most viewed Springfield hospital as "an institution having little advantage over a jail except for the matter of its being easier to depart from and not always by the back door." The public's misgivings and suspicions of the hospital were warranted. Springfield hospital was a hazardous oftentimes deadly place and not for patients alone. Through the 1890s, the casualties many times included hospital personnel. There came to be a stock phrase used in such bleak moments: Nurse Smith or Physician Jones was stricken "in the midst of [his/her] usefulness." Nurses were particularly vulnerable. Through the decade many were forced to resign because of ill health; this might account for the large number of those students- about one third- who quit during their first year. [12]

What was the patient profile that first decade? Given that native-born Americans of means preferred home care, the patients at Springfield hospital who filled the wards

tended to be impoverished immigrants, more of them men than women, more likely to be single than married, and young rather than old. The hospital divided its patient load depending on whether the patient was a medical or surgical case. On the medical side, the main ailments were infectious diseases reflecting the recurring epidemics of malaria, tuberculosis, typhoid, and influenza in the period. These composed the majority of patient admissions. On the surgical side, many cases involved persons who had been crushed or otherwise mangled generally about their limbs including ankles, arms, feet, hands, and legs. Industrial accidents reached epidemic proportions in late 19th century America. Springfield's prominence as a manufacturing and transportation center ensured that these sort of injuries accounted for a large number of patient admissions in the 90s. [13]

Injuries received while working for one of the railroads that criss-crossed the area were especialy common. Railroads at the time were notoriously unsafe workplaces. Injuries among railroad workers increased nationally from twenty thousand in 1880 to seventy thousand at the turn of the century. In 1900 alone, four percent of railroad workers were hurt on the job and one of every four hundred killed. In Springfield, not only rail workers but also area machinists and mill hands were vulnerable to industrial accidents. If they were lucky, the casualties received appropriate sutures or had their fractures set.

In more serious cases, amputations whether of fingers, hands, arms, toes, and legs, were the rule. In the most serious accidents, nothing could be done. There was simply recorded the notation "death from shock of injury." When the hospital's death rate increased in 1892, it was attributed to a sharp rise in "hopeless injuries." In fact, the death rate hovered at over ten percent for much of the decade, and the medical staff eager to draw new patients took pains to explain that the gloomy figure was no reflection on the quality of care at the hospital. Rather, the figure simply indicated that most of those admitted suffered from either fatal injuries or incurable diseases. [14]

In the 1890's, Springfield offered little in the way of specialized or complex medical services. Like most other hospitals its strong suit was simply the possibility of rest, shelter, and food for the indigent sick. Springfield's skeletal administration offered little else to patients. Its non-medical personnel consisted of a superintendent, steward, and matron. They were responsible for hiring and firing staff, obtaining supplies, keeping the institution in proper order and cleanliness, and overseeing the half dozen nurses and handful of other workers. Physicians on staff typically volunteered for one to three month stints, providing service to the community and occasionally snagging paying patients then or hopefully later either through gratitude or good word (for

data on Springfield's budget and numbers of patients and personnel, see table in appendix). In the early nineties, there were four physicians and four surgeons who shared the duties yearly. [15}

Given all the limitations of health care at Springfield hospital in those early years, it is not surprising that public support at the outset was modest, at best. In 1890, hospital administrators put on a brave front, noting that the "sympathy of the public continues" for the hospital and went on to refer to various gifts received. But the report later explained that the matron had been sacked. Though the hospital staff was minuscule and received little more than room and board, the costs of employment were deemed excessive. Not only that, there were not enough patients to warrant her duties. It was decided to wait until patient numbers improved before hiring another matron and in the meantime to include her tasks in the steward's responsibilities. [16]

Hiring decisions also reflected the ambivalence of doctors about their involvement in the fledging enterprise. The 1893 medical staff report explained that the hospital would soon have to recruit a full-time physician to oversee patient admissions and treatment. Why? While the volunteer staff of physicians had been "faithfully attending their onerous duties," in the near future that would no longer be possible. The reason given was that as patient numbers increased, physicians faced a growing

conflict between their hospital duties and other responsibilities. This may have been so, but other factors were surely at work here. Granted, patient numbers were increasing, but not much. The hospital remained relatively small (less than seventy patients at any one time) through the decade. And certainly, there were scores of physicians in the city who might have been called upon to plump up the volunteer corp. Another explanation for this request is that most patients were primarily indigent and offered no renumeration to the physicians. Moreover, volunteering to treat such persons did not generally help boost a physician's status among the affluent. It is likely for these reasons that volunteers remained few and those that did help out were hesitant to enlarge their hospital responsibilities--thus the need for a full-timer. [17]

For the first decade, the hospital primarily catered to the poor, with less than ten percent of patients paying full freight. It was a charity operation with all the unpleasant connotations: substandard quarters, dependency, and often the anonymous impending demise of the inhabitants. From the beginning the hospital faced the problem of how to pay the expenses incurred by its predominately indigent patient population. Initially, it agreed to take all patients sent to it by the city. But this quickly became an excessive burden. Within the first year, trustee members fixed on the pattern that they would continue for half a century. While private charity would

continue, government funds-mostly from the city- would supplement these. [18]

In 1890, Formal contracts were drawn up with city officials from Springfield and surrounding towns. The Hospital agreed to take the sick poor and in return receive annual appropriations. This relationship continued through the nineties. By then, the hospital was receiving more than five thousand dollars annually for this purpose. At the turn of the century, patients under the guardianship of the state overseer for the poor were also routinely receiving care at the hospital. In the teens, a new group--patients covered by the state workmen's compensation board--were added to the list. The hospital was generally willing to take those with limited or no resources and cooperated with the state for this purpose. [19]

Pointed appeals for donations show that existing state support was insufficient to keep Springfield Hospital afloat. In the first decade, it was uncertain whether Springfield could survive. In a statement typical of the period, in the 1892 annual report, the President remarked that while "no organized appeals have been made recently, it will be necessary to do so at once...and with earnestness, if the hospital is to continue to do good and efficient work." Were his comments then and similar statements made through the decade by other trustees a matter of crying wolf, of exaggerating the hospital's difficulties simply to whip up public support? Trustee

records indicate genuine anxiety in this period that the Board might be forced to refuse patients, curtail programs, and cancel building expansion because of insufficient public backing. [20]

Springfield could not generate sufficient resources to substantially improve its facilities. The hospital grew only in fits and starts with no possibility of overall planning. This was the case even in the most basic matters. An adequate heating system and laundry, for example, were not complete till 1893. When the hospital opened, surgical and ward patients shared the same ward. The President of the medical staff made repeated appeals to the public for funds to create a separate wing for surgical cases. As he explained, noting the hazards involved in continuing the existing arrangement, "the mixing of patients sick with fevers with those who are injured or who have open wounds is obviously a great disadvantage to us." Despite his entreaties, monies were not forthcoming and for five more years, the two units remained joined. Also, in the nineties, physicians pressed trustees to build a new surgical unit. Senior staff members explained that the existing facility was too small, ill-equipped, and unhygenic, "in view of advancements in surgical technique during the past few years, the time seems to have come to provide Springfield hospital with a building adequate and equipped as to meet requirements of asceptic surgery of today." The Board approved the proposal in 1893 but three

years later the project remained incomplete. In the early years of the new century, the Board agreed to another expansion project, this time to build an additional wing for a new ward and to refurbish another. This project was not finished for ten years. [21]

Funding the hospital was a constant scramble. Income from patients never matched operating expenses. Donations were an unreliable source of income. The bulk of Springfield's operating funds were initially provided by philanthropists, well-heeled city boosters, and some of the more enlightened members of the city's business and professional elite. New Board members were chosen in hopes of procuring hefty donations from them while alive, and hopefully bequests when they departed.

Income from patients, the affluent, and government agencies was supplemented by occasional rummage sales, and contributions of items ranging from flowers to furniture to food. Fundraising benefits were also critical in sustaining Springfield during its first decade of existence. Lavishly appointed charity balls brought together business leaders, debutantes, society swells, and politicians from near and far. They flocked to hear entertainment provided by the likes of John Phillip Sousa or the Philadelphia Philharmonic. [22]

Hospital leaders tried various devices to raise additional funds. Trustee members and senior medical staff formed a fundraising committee, streamlined hospital

operations, hired a collector to dun deadbeats, decided to charge non-Springfield residents higher rates, debated whether to close the nursing school in 1897, and even refused admission to some patients after the city temporarily dropped its subsidy due to budget problems in 1899. However, none of these measures proved effectual in cobbling together a reliable financial base for the institution. The revenue derived from the few paying patients was not enough to offset the costs of care rendered to the rest at reduced prices or gratis. [23]

A New Century

In 1899, on the tenth anniversary of the hospital's opening, the president recounted that in the early years the hospital "was a feeble institution...struggling for its existence...in a period when the purpose and value of the hospital was not fully understood or appreciated." However, he was confident that Springfield Hospital was rapidly becoming an accepted and vital part of the community. His comments were not the crowing and wishful thinking of a hospital supporter. A number of factors at the turn of the century and later caused the public in Springfield and much of the country to rally around physicians and hospitals [24].

The American Medical Association's role was key in increasing the competence and authority and public regard for physicians. Founded in 1846, by 1900 the AMA finally gathered the membership, the resources, and the will to

become the nation's principal gatekeeper of medicine. The AMA worked to clean its own house in the early twentieth century by helping tighten physician licensing laws, increasing regulations over legitimate medical schools, forcing out the fly-by-night facilities, and fashioning rules for the upkeep and inspection of hospitals. It supported laws against unethical conduct by physicians, including physician advertising. Moreover, it supported school health inspections and the passage of the Food and Drug Act.[25]

The AMA's Council On Medical Education worked with the Association Of American Medical Colleges and later the Carnegie and Rockefeller foundations to institute a rigorous standardized curriculum for medical schools. This was sorely needed at a time when less than ten percent of physicians graduated from recognized medical schools and twenty percent had never attended medical school lectures. They introduced a research component and internships into medical school programs, and generally helped ensure that students graduated with genuine technical and diagnostic skills. [26] Until then, the rule of thumb for most medical schools was that if you had the cash, they had a spot for you. No longer. Now, rigorous exams determined acceptance or rejection, and acceptance into school no longer guaranteed graduation. Students now had to pay close attention to their courses. Final exams became much more demanding. No longer could students at Harvard and

elsewhere pass their finals by simply responding to a few questions in a brief oral exam. [27]

Earlier graduates were mostly jack-of-all-trades and masters of none. This rapidly changed. Increased attention to basic science and research in medical schools led to advances in physiology, anatomy, pathology, and bacteriology. This was a crucial factor in the development of the specialties. Surgery was the outstanding example but they also included pediatrics, obstetrics, opthomology, orthopedics, and urology. [28]

Physicians, whatever their specialty, also enjoyed new accuracy in diagnosis and treatment thanks to new chemical procedures to test blood, stool, and tissue samples. Moreover, advances in pathology enabled physicians to chart more closely the genesis and progression of disease. [29]

The benefits of scientific medicine extended to public health. Regulation of the milk and water supply reduced mortality rates. These years also saw a test for syphillis, a diptheria anti-toxin, and vaccines for tetnus and typhoid. All of these, very visibly, helped save lives. They also helped raise physicians' standing and that of the medical establishment in general. [30]

One of the major factors at Springfield Hospital that helped boost public support for both physicians and hospitals were improved surgical techniques. In 1901, the Board's president explained, in years past, "many useless and harmful operations have been done" but now "good

results are becoming more and more the rule. Operations rare and almost unthought of ten years ago are common now." [31]

Major surgery in the hospital had been limited to only the most dire of circumstances. Even in most cases of head or abdominal injuries, physicians usually let nature take its course rather than open body cavities except when "outside forces like a horse or buggy or street car had already started the job." [32]

Until the turn of the century, surgery was restricted in part because of the pain it caused (and the death from shock that often followed). When surgery was unavoidable, doctors used hypnosis and alchohol or opium to try to distract the patient, but this was not always successful. It was difficult to get the job done when the poor fellow was screeching and struggling. Some surgeons also believed that pain was part of the healing process, that it was best to leave out painkillers altogether; patients were admonished to simply ignore or put up with the torture. Few were able to do so. For these reasons, both physicians and patients had long limited surgical procedures to minor fractures, superficial wounds, and ulcers. But the development and rapid refinement of anesthesia made more complex operations possible and tolerable. [33]

Another factor behind Springfield's Hospital's increasing number of surgical procedures was that physicians there as elsewhere were learning how to prevent

post-operative infection. Post-operative surgery death rates hovered around twenty-five percent till the turn of the century. And dealth rates were significantly higher in hospitals than in private residences because conditions were not sanitary in most hospitals. This began to change by the turn of the century. Physicians and nursing staff at Springfield Hospital and nationally learned how to practice sterile procedures from textbooks, post-graduate training, and on the job instruction. As John Duffy and others have written, medical personnel learned the importance of washing their hands before touching patients and of wearing rubber gloves while conducting operations. They learned to properly clean instruments instead of just smearing blood and other less vital fluids on their gowns before going back in for another try and to sanitize instruments that fell on the floor instead of simply continuing to use them. Physicians stopped the practice of moistening suture threads with saliva. Nurses learned to dress bandages to keep them clean instead of using dirty ones over and over again. [34]

With these changes surgery became more successful and safer. More patients were now willing to go under the knife, and physicians were more confident that patients would survive operations and recover. Surgery, especially of the abdominal and pelvic region, became a routine procedure. Appendectomies (practically unknown in 1890) and gynecological operations became commonplace. Formerly,

those with peritonitus (inflammation or infection of the abdominal cavity) were "condemned to death" because physicians were unable to operate on them; now such operations could go forward and patients more often than not would recover. As a result, the annual number of abdominal operations doubled at century's end from twenty-eight to sixty while the death rate which had been seventeen percent when Springfield Hospital first opened fell to just eight percent. [35]

As was true of hospitals elsewhere, in these years public perception of Springfield Hospital began to shift from a place evoking dread and fear to one inspiring hope and confidence. As one newspaper editorial explained in 1908 "The wonderful cures wrought by the skill of the surgeon and the trained nurse are the miracles of the 20th century....Many people think of the hospital as the place where pain is caused. I wish it were possible to estimate the amount of pain that is cured....Springfield is a veritable temple of healing." [36]

By 1900, patients were much more willing to enter Springfield Hospital and put themselves under the care of its physicians. Individuals were no longer stigmatized for entering a hospital. Family members could now rest easy knowing that their kin were getting professional care there. As a result of improved and expanded treatment, more affluent patients gained genuine confidence in hospital care. The way was now clear to admit more paying

patients, an appparent solution to the hospital's chronic financial travails.

Springfield Hospital like many other institutions turned to private patients and patient fees to keep itself afloat. Patient fees, by World War One, would account for more than half of hospital revenues. Already, by the end of the century, there were a few private rooms for well-to-do patients. A few years later, semi-private rooms were built with sliding scale fees that the middle class could afford and thereby get treatment while avoiding association with persons in general wards. Board members tried to encourage area physicians to treat more private patients in the hospital and formed a joint committee with physicians for advice on how to make the hospital a more welcome place for private patients. Records were also kept of the total number of patients admitted by each physician per month, detailing the proportion of paying versus charity patients with an eye to motivate physicians to try to improve the ratio. [37]

By all accounts, the decision to aggressively court private patients paid off handsomely at the outset. Springfield Hospital doubled its income from 1902 to 1904 from nineteen thousand to thirty-five thousand dollars. With the infusion of these monies, the hospital increased its number of beds from sixty to one hundred and purchased much needed equipment. Perhaps most impressive was the increase in patient admissions. As the President noted in

1909 "the custom of using our hospital has materially increased in the past five years. In 1902 these jumped fifteen percent over the previous year, the largest increase in its history." During the following year, 1903, patient admissions increased forty percent to 773. From 1901 to 1908 patient admissions tripled from 465 to 1,337. Income from patients now represented about two-thirds of total revenues, twice the proportion of the 1890s. Testifying to both physicians' willingness to do invasive surgery and patients' increasing acceptance of the procedure, about two-thirds of patient admissions were now surgical cases, also twice as many as in the early days of the facility. By 1912, there were three times as many patients admitted for surgical cases as for medical ones, outstripping even national trends. The gender mix changed as well. In the 90's, patients admitted were predominately male. But by the teens, women were the majority. In the occupation list of patients, the largest category was now housewives, who were coming in increasing numbers for childbirth. Their growing trust in hospital care is reflected also in the rising numbers of operations of tonsilectomies on their children. [38]

To get more paying patients, Springfield administrators made special arrangements to make certain hospital beds private. Like other hospitals nationally, Springfield contracted with numerous professional and business organizations in the years before World War One to

pay to have their members specially provided for in the hospital. A 'free' bed was set aside for members of a local church in return for a large contribution from one of the parishoners. A manufacturing concern gave several hundred dollars a year to set aside bed service for its employees. A prominent citizen from Chicopee gave five thousand dollars for a free bed for town residents in need of treatment. New England Telephone bought a bed for five years to cover the care of its employees. [39]

Reorienting the patient pool towards paying patients seemingly represented a fundamental shift at Springfield Hospital. Some hospital leaders, while supporting the decision, also expressed a certain ambivalence about the new policy. They feared that care would become two class, the poor would be neglected, and some might be shut out altogether. [40]

It cannot be denied that charity work henceforth occupied a decidely less central place in the considerations of hospital personnel and in the day-to-day operations of the institution. The decision to reorient the institution to the care of private patients was certainly hard-nosed. But was it hardhearted?

It is true that the patient mix changed. Private patients quickly dominated the admission pool, surging from less than ten percent in the 1890s to more than two thirds ten years later. It is also true that increasing numbers of private and semi-private patients elbowed aside poorer

patients to some extent. The records indicate extreme crowding in the wards during the following decade, including at one point three times the desired number in the children's wards. Some of the poor may have been refused admittance altogether. It is also true that accommodations in the general wards were not upgraded as needed because many of the available discretionary funds were sunk in facilities for more solvent patients. One glaring example: In 1910 there were still not separate sections for surgical and medical cases in the open wards. [41]

On the other hand, the increased revenues from private patients made possible a general expansion of the facility allowing for more charity patients. The equation was simple: without private patients, the increased numbers of public patients could not have been covered. Granted, private patients enjoyed creature comforts and personal care not available for ward patients. But, overall, care was far better for both private and public patients than ever before, and many more poor treated. The move to private patients was not the act of a souless corporation but an appropriate shift given the paucity of public funding for the facility.

To relieve crowding at the hospital, and the crowding of more affluent patients by working class persons, in 1911 hospital officials explored the possibility of organizing a dispensary. In 1913, Hospital officials voted

to help fund a district nurse who arranged for patients to convalesce at home and to visit them there as needed. By 1914, these visits totalled more then two thousand yearly. [42]

Still the poor came to the hospital and were not turned away. To its credit, Springfield Hospital took them in, if it did not actively encourage them. In these years, it was not unusual for less than twenty-five percent of patients to pay the full cost of care and forty percent to pay half or less. The hospital tried to establish more semi-private rooms but there were not enough of these to offset losses elsewhere; in any case, even the patient fees frequently did not completely cover the costs of care. Regular contributions were not enough to make up the difference; neither were state subsidies. [43]

For a few years following the turn towards private patients, the crush of patients and infusion of cash was enough to comfortably fund the hospital. However, the windfall from the new crop of patients lasted less than a decade. Springfield soon found itself in somewhat straitened circumstances. It turned once again to public authorities for help. Squabbles arose between the hospital and local and state officials over appropriate renumeration and reasonable length of stay for charity patients. And periodically, in times of mounting debts, trustees sold off real estate holdings, stocks, and other assets to generate capital. [44]

In 1914, the Hospital managed to raise sufficient funds to erect a new wing with more patient rooms. The addition had been part of a more comprehensive plan for seven new buildings first unveiled in 1910. The rest of the plan was never implemented. Instead, for several years following, Hospital officials frantically tried to somehow increase the number of regular subscribers (contributors) to the hospital to simply get through each year and to defray the mounting debt which by 1917 topped one hundred fifty thousand dollars. [45]

Conclusion

The problems hospital administrators, physicians, and trustees faced from 1890 to 1920 would remain the pattern throughout Springfield's history. Improvements in technology and services resulted in increased numbers of patients treated but also additional costs of expansion, materials, physical plant, supplies, equipment, and personnel. Moreover, covering the cost of treatment of the poor would remain a special problem. Unlike some hospitals in other cities, Springfield did not have a public hospital to siphon off the indigent sick. There was no public versus private hospital split in Springfield largely because there was no significant public hospital to speak of. Was Springfield the exception or the rule here? If Springfield's experience was more representative of typical communities in the country, than the financial well being of the nation's hospitals was considerably weaker than

historians have generally indicated. The burden of the cost of treatment of the poor was a central factor for such hospitals. Increased numbers of private patients never translated into sufficient patient fees to match the increased costs. Sooner or later hospital operations deteriorated marked by overcrowding and an inability to afford needed renovations. By the 1920s--the moment of the city's greatest prosperity--exactly this sort of scenario would unfold. [46]

Notes

1. Especially helpful has been John Duffy, From Humors To Medical Science (Chicago, Ill.: University Of Illinois Press, 1993); James H. Cassedy, Medicine In America (Baltimore, Maryland; Johns Hopkins University Press, 1992).

2. Charles Rosenberg, The Care Of Strangers (New York, NY.: Basic Books, 1988), ch. 4.; Diana Long, The American General Hospital (Ithaca, NY.: Cornell University Press, 1990).

3. Rosenberg, ch. 5.; Cassedy, op. cit., ch. 3.; Duffy, op. cit., ch. 6.

4. Rosenberg, ch.12.

5. Duffy, op. cit., ch. 9; William Rothstein, American Medical Schools And The Practice Of Medicine (New York, NY.: Oxford University Press, 1987), ch. 4; George Rosen, The Structure Of American Medical Practice 1875-1941 (Philadelphia, PA.: University Of Pennsylvania Press, 1983), ch. 1.

6. David Rosner, A Once Charitable Enterprise (New York, NY.: Cambridge University Press, 1982), p.16; Rosemary Stevens In Sickness And In Wealth (New York, NY.: Basic Books, 1990) p. 53; Rosenberg, op. cit., p. 59; Duffy, op. cit., pp. 141-143.

7. Paul Starr, Social Transformation Of American Medicine (New York, NY.: Basic Books, 1981) pp.94-99; Norman Gevitz, Unorthodox Medicine In America (Baltimore, Maryland; Johns Hopkins Press, 1988).

8. Duffy, op. cit., ch 5-6, ch. 9.

9. Cassedy, op. cit., p. 4; John Duffy, The Sanitarians(Urbana, ILL.: University Of Illinois Press, 1990); For the difficulties faced by Springfield's early backers, I have relied on contemporary accounts in early trustees records coontained in Box 1.00, BMC collection

10. Springfield Republican May 5, 1929; Board Of Trustee Minutes, May 1887, Springfield Hospital. Baystate Medical Center Collection (hereafter referred to as the BMC collection), Box 1.00. Both held by the Connecticut Valley Historical Museum. Also on file at the museum are the Springfield Municipal Register Public Health reports in the 1880s, which detail the effort to garner support for the proposed hospital.

11. Scrapbook volume 1, 1889 (undated) on file at the Media Relations office of Baystate Medical Center, Springfield, MA.

12. Springfield Republican May 5, 1929, p. 10; I have arrived at this figure from reading the Superintendents Annual Report for 1891-1892 as well as 1895-96 and 1898-1900. Springfield Hospital, Annual Report 1890, Presidents Report, p. 9. Box 2.01, BMC collection.

13. Rosenberg, op. cit., p. 100; Rosner, op. cit., p. 27; Springfield Hospital, Ibid., 1890, Medical Staff Report, p. 15, p. 18; Springfield Hospital, Ibid., 1891, Medical Staff, p. 17,20, Box 1.02, all in BMC collection.

14. Starr, op. cit., p. 201; Springfield Hospital, Ibid., 1892, Medical Staff, p. 17,21, Box 1.02, BMC collection.

15. Springfield Hospital Board Of Trustees Minutes, May 5, 1892, p.1. Box 1.00, BMC collection.

16. Springfield Hospital, Ibid., 1890, Presidents Report, p. 9, Box 2.01, BMC collection.

17. Ibid., 1893, p. 7, Box 2.01, BMC collection.

18. Ibid., 1892, p. 10, 1893, p. 8, 1894, p. 8, 1895, p. 10, 1896, p. 10, Box 2.01, BMC collection.

19. Board Minutes, May 5, 1891, p. 1, May 5, 1892, p. 1, May 2, 1893, p. 1, April 1, 1902, p. 1, December 3, 1912, p. 1, February 3, 1914, p. 1, Box 1.00, BMC collection; Board Minutes, December 5, 1916, p. 1. Box 1.01, BMC collection.

20. Annual Report, op. cit., 1892, p. 9, Box 2.01, BMC collection.

21. Board Minutes, op. cit., January 9, 1900, p. 1, January 7, 1902, p. 1, April 7, 1903, p.1, Box 1.00, BMC collection.

22. Annual Report, op. cit., cf. sections detailing gift giving for the first decade.

23. Annual Report, Ibid., 1896, p. 8, 1897, p. 11, 1899, p. 10, Box 2.01, BMC collection; Medical Staff Report, p. 19. Board Minutes, May 18, 1902, p.1, Box 1.01, BMC collection.

24. Springfield Union, February 2, 1937, p. 5, Springfield Republican, May 1, 1932, p. 7.

25. Duffy, Sanitarians, p. 86; Starr, op. cit., ch. 3.; Duffy, Ibid., p.141. The standard account of this of course is Rosemary Stevens, Medicine And The Public Interest (New Haven, CONN.: Yale University Press, 1971),; Duffy, Ibid., p. 223.

26. Starr, Ibid., pp. 102-123; Stevens, Ibid., p. 63.

27. Duffy, Ibid., ch. 13.

28. Rosenberg, op. cit., ch. 6.

29. Rosenberg, Ibid., pp. 154-161.

30. Starr, Ibid., pp. 135-138; Rosenberg, p. 159; Samuel H. Preston, The Fatal Years (Princeton, NJ. Princeton University Press, 1990); Andrew Wear Medicine In Society (Cambridge, MA. Cambridge University Press, 1992). ch. 8.

31. Annual Report, 1899, p. 12, Box 2.01, BMC collection.

32. Springfield Union, February 2, 1937, p. 7; Springfield Republican, May 1, 1932, p. 5.

33. Duffy, The Sanitarians, p.116,118; Cassedy, op. cit., p. 75.

34. Rosenberg, op. cit., pp. 126-147.

35. 1897 Annual Report, Medical Staff Report, p. 20, Box 2.01, BMC collection; 1899 Annual Report, Medical Staff Report, p. 19, Box 2.01, BMC collection; 1900 Annual Report, Medical Staff Report, p. 17, Box 2.01, BMC collection.

36. Springfield Republican, June 6, 1908, p. 10.

37. Rosner, Ibid., pp. 45-82; Stevens, Ibid., p.23; Board Minutes, January 8, 1901, April 2, 1901. p. 1. Box 1.01, BMC collection.

38. Annual Report, Ibid., 1902, Medical Staff Report, p. 18; Ibid., 1903, Presidents Report, p. 10; Ibid., p. 11; Ibid, 1908, p. 13; Ibid, 1909, p. 11; Ibid, 1912, Medical Staff Report, pp. 26-31. These are all contained in Box 2.01, BMC collection. This development is, of course, directly related to the medicalization of childbirth and the concurrent displacement of midwives in this period throughout the country.

39. Board Minutes, January 25, 1899, June 22, 1908, p. 1, February 3, 1903, p. 1, June 2, 1903, p. 1, March 5, 1912, p. 1. These are all contained in Box 1.02, BMC collection; Rosenberg, Ibid., p. 241.

40. Annual Report, Ibid., 1901, Presidents Report, pp. 13-14, Box 2.01, BMC collection.

41. Annual Report, Ibid., 1901, Presidents Report, p. 12, 1910 Annual report, Ibid., p. 13; 1911 Annual Report, Ibid., p. 13. These are all contained in Box 2.01, BMC collection.

42. 1914 Annual Report, Visiting Nurse, p. 42; 1915 Annual Report, Presidents Report, p. 16. Both contained in Box 2.01, BMC collection.

43. Annual Report, Ibid., 1914, p. 16; 1915 Annual Report, p. 13; 1916, p. 13; 1917, Statistics, p. 14. These are all contained in Box 2.01, BMC collection.

44. Board Minutes, February 2, 1904, p. 1, February 6, 1903, p. 1, December 3, 1907, p. 1, January 21, 1908, p. 1, February 2, 1909, p. 1; November 1, 1910, p. 1; January 7, 1913, p. 1; These are all contained in Box 1.01. Board Minutes, February 2, 1915, p. 1, (2/25/1901) Box 1.02, BMC collection.

45. Board Minutes, February 20, 1911, p. 1; April 12, 1912, p. 1; Both contained in Box 1.01, BMC collection. Board Minutes, September 18, 1914, p. 1; February 2, 1915, p. 1; December 7, 1915, p. 1; December 4, 1916, p. 1; May 1, 1917, p. 1; October 4, 1917, p. 1. These are all contained in Box 1.02, BMC collection. !915 Annual Report, pp. 14-16; 1916 Annual Report, pp. 12-19; 1917 Annual Report, pp. 16-17; 1918 Annual Report, pp. 15-16. These are all contained in Box 1.02, BMC collection.

46. This is stated most baldly in Rosner's work but also creeps into Rosenberg's as well as Stevens' analysis. Cf. for a superb discussion of public hospitals, Harry Dowling, City Hospitals (Cambridge, MA.: Harvard University Press, 1982).

CHAPTER 3

SPRINGFIELD HOSPITAL 1920-1940

Something momentous happened in American health care by about 1920. Thanks to continued improvements in standards of training, diagnosis, and treatment, an ailing person who consulted a doctor stood better than a fifty-fifty chance of benefiting from the encounter. Many Americans who less than a generation earlier would have disparaged doctors as quacks now glorified them as saviors. Thanks to the joint efforts of public health workers and doctors, the country had nearly wiped out infectious diseases. Compared to decades past, when so many--children and adults--succumbed to an early and sudden death, Americans felt almost invulnerable. Moreover, with several diseases now regarded as potentially curable, ailments like colds or sore throats that patients previously had ignored now became a concern of patients and doctors alike.[1]

In novels and films, the press and pulpit, doctors were praised as selfless and devoted healers, who stamped out disease and invented remedies for diabetes, vitamin deficiencies, and hormone abnormalities. The grateful nation rewarded them with high incomes and unprecedented influence-notably among civic groups, legislators, and businessmen.[2]

Hospitals, of course, benefited from improvements in health care, from doctors' lofty status, from Americans'

heightened attention to their physical well being. For one thing, hospitals no longer had to advertise for customers. In fact, following cure or recuperation, patients occasionally lingered in hospital premises which were said to combine the conveniences of well-appointed homes with the amenities of luxury hotels. Also, the nation's foundations showered hospitals and affiliated medical schools with 150 million dollars for the latest and greatest research projects, in stark contrast to the time when they had given just thousands and that grudgingly; medicine became the best funded of philanthropic causes.[3]

At the pinnacle of the hospital establishment were doctors, deans, and administrators at major medical schools and the largest teaching hospitals in Cambridge, Baltimore, New York, Philadelphia, and elsewhere. Brimming with fungible capital, scientific knowledge, highly skilled personnel, and up-to-date technology, the achievements, rules, and methods, of these institutions were expected to spread to hospitals everywhere. Hospital superintendents, medical staff, local medical societies, national professional organizations, and governmental agencies would all eagerly implement the healthcare visionaries' plans. Ultimately, medical leaders predicted, healthcare would be socialized like major utilities, and the public's health managed by government as thoroughly as public safety.[4]

Certain that America would adopt social welfare policies similar to those found in the advanced countries of Europe, Many medical leaders regarded the development of a coordinated universal health care system as both inevitable and imminent. It was neither. Such a system could only develop if physicians joined together en masse, embraced the idea, and assumed a leading role in its creation. That did not happen. Despite the hosannas given physicians and medicine being the queen of the professions, their regal position was not altogether deserved and was not universally accepted. Physicians could not be innovators when their medical education promoted an insular view of medical practice, so long as physicians adhered to narrow parochial interests, and important health services remained sparsely distributed.[5]

Physicians were thought to possess exemplary and demonstrable expertise. Yet, improvements in educational program standards the previous twenty years had, in some respects, been surprisingly modest. Most medical students had a high school education plus some college courses. They did not need more in the way of background, because most medical school courses included very little basic science or clinical work, and required little analysis of medical or scientific problems. Furthermore, students used textbooks that (unbeknownst to them) recommended treatments that were often ineffective or even harmful. Finally,

after completing their coursework, students served hospital clerkships that oftentimes lacked supervision or any genuine training.[6]

Following graduation, about one quarter of the newly minted M.D.s took licensing exams. Few states required such exams (Massachusetts was a notable exception). However, those who chose to take and pass exams hoped to reassure prospective patients of their competence; perhaps it was best for all concerned that patients were unaware that the exams usually were multiple choice and tested knowledge of lists and definitions recapitulated from medical school courses.[7]

A small minority of medical school graduates went on to internships and residencies. These post-graduate programs were not much better then medical school clerkships: few hospitals even had formal relationships with medical schools, much less well organized programs. Interns and residents invariably filled the lowest priority staffing needs in hospitals; attending physicians cared little about providing advanced education and training to recent graduates. It was more convenient to assign the drudge work to the newcomers.

The popular image of physicians as specialists who combined research with patient care was based on the acomplishments of those practicing at elite urban teaching hospitals. However, most physicians in this period, as

before, were full-time general practitioners who worked in small general hospitals. Full-time board certified specialists comprised less than one-third of all physicians even by 1940. Others called themselves "specialists" but they often had no substantive training, or they were "partial specialists," moonlighting general practitioners, who had skipped their residencies and who had not taken or passed the specialty exams. It was easy for them to begin lucrative and prestigious practices (specialists often made three times the income of general practitioners).[8]

Acceptable standards for medical education and practice remained lax because the profession was not nearly as united as its leaders claimed, or as the public was led to believe. Americans believed that specialists were the apex of the profession; specialists regarded themselves as the most influential of doctors. Both specialists and laymen were mistaken. Specialists were a small minority of the profession, and their opinions were outweighed by those of general practitioners in all but the largest cities--partly because specialists themselves were a highly disparate lot.

The profession's cardinal principle was that each physician should freely determine the scope of his own practice. That freedom intensified the perpetual search for patients, and diverted physicians from considering more expansive notions of health care. Without agreed upon

standards among practitioners, fierce competition was more common than comity or cooperation. Specialists vied with generalists; sub-specialties--more than a dozen of them--squared off against one another; rivalries were particularly intense between pediatricians and obstetricians and gynecologists, between psychiatrists and neurolgists, and between surgeons and internists. Each of the subspecialties had separate certifying boards which were really professional clubs whose major priority was to stake out turf and prestige--insuring that specialists were expert practitioners was not always their highest priority. Instead of policing themselves, they condoned incompetent physicians; building social networks was their primary goal. Virtually anyone claiming to be a specialist could get a specialty board to vouch for them.[9]

Instead of working in tandem, medical factions debated one another in medical societies, in schools, and in hospitals. With no agreed upon overarching national standards, standards were established arbitrarily by whomever held the most power at any given moment in a hospital, medical school, or medical society.[10]

Hospitals formed their own national accrediting organization, but its standards were only attained by large urban hospitals dominated by specialists and which employed a paid staff that generally had close ties to area medical schools. Aside from this tiny minority, most physicians

and administrators routinely flouted accreditation recommendations. Where hospital inspections occurred and guidelines for improvement provided, they were not likely to be implemented. When penalties were assessed, they were too mild to have an impact on hospital affairs. When accrediting agencies condemned inept or indifferent physicians, administrators fiddled and diddled because they needed the physician's business. Furthermore, physicians often had admitting privileges at several hospitals. Hospitals that physicians judged as unfairly restrictive quickly lost business to their neighbors down the street. Hospitals' survival depended on pleasing physicians with dubious medical expertise and questionable ideas of professional service --regarding who was fit to perform operations, who was qualified for appointments to the staff, how to maintain case records and conduct postmortems, and so on.[11]

Physicians' business practices and intramural catfights were not usually privy to laymen. One reason was that John Doe rarely saw a physician. Most Americans continued to rely on a priest, family member, or friend for medical advice. For medications, Americans turned to itinerant salesmen or local grocers and probably spent more for patent medicines than for physician consultations.[12]

One reason why the sick rarely consulted phsycians was that few could easily afford health care. Most Americans

had a difficult time paying their medical bills. This is why the majority of Americans saw a physician less than once a year. For the working classes, disaster was apt to strike those who fell ill and went without medical care; sickness was the leading cause of destitution. In the largest cities, where free care was most readily available, one quarter of the population relied on clinics and other outpatient services.[13]

Aside from cost, another reason patients rarely saw doctors was that the latter's actions belied their popular image. In diagnosis they were prone to say the obvious and not provide much in the way of solutions. The miracles promised by x-ray machines and tb tests did not come to pass; in many instances these and other instruments produced faulty or ambiguous information, or produced accurate findings that were then misinterpreted by doctors. Furthermore, doctors could do little to treat cancer, tuberculosis, mental illness, or chronic ailments (the latter, then as now, was the fastest growing patient pool); doctors avoided these fields, and focused their attention on those areas--like surgery--that offered more favorable outcomes for both doctor and patient.[14]

Doctors may have appeared to be prosperous but not every doctor had a lucrative practice. While city physicians in the 1920s usually made from $8,000 to $12,000 yearly, overall, average yearly earnings were less than

half that amount. Specialists made much more than generalists. And whatever their locale or field, few doctors did well financially in their early years of practice.

Doctors opposed anything that might undermine their independence or threaten their economic stake. Most were adamant that the government should keep its mitts out of medical practice and therefore fought state aid to veterans and the chronically ill, to child welfare and venereal disease clinics, or to cancer research. Doctors who deviated from the party line were ostracized by their colleagues, were drummed out of local and state medical societies, denied referrals from other doctors and admitting privileges at many hospitals.[15]

One reason why doctors so vehemently opposed state involvement in health care was that many doctors--especially general practitioners--felt more embattled than exalted in the twenties. Ironically, while the public image of physicians had improved, the actual practice of medicine had in certain ways become more difficult. All the hullabaloo about the glories of scientific medicine seemed to undermine those practicing the art of medicine. Researchers and specialists got the lion's share of public attention and adulation. General practitioners were treated as the dinosaurs of the profession, doomed for extinction once the medical and social planners had their

way, even though general practitioners comprised the majority of physicians and saw the vast majority of patients. Many of them felt squeezed by outside institutions, including representatives of accreditation agencies, medical schools, foundations, government agencies, and at times by some of their own organizations.[16]

Medical Care And Health Care In The City Of Springfield

In the twenties, large numbers of city residents and individuals from surrounding towns streamed to Springfield Hospital--many for the first time in their lives. More people of all classes made use of Springfield's facilities. In fact, its growth rate was double that of the city's population. Operations alone jumped more than 100%; non-surgical admissions rose even faster, and lab exams and x-rays, which previously were so infrequent that they were left unrecorded, now totalled many hundreds yearly.[17]

Already by the early twenties, Springfield Hospital reached its maximum capacity. Patient care soon deteriorated in severely overcrowded wards. To absorb the overflow, patients were shipped off to three make-shift units in adjacent houses. Occasionally, it proved too difficult to provide even basic amenities, and patients

were turned away; many others faced long delays in treatment.[18]

Through the twenties, the refrain came from the superintendent and medical staff: All facilities are being utilized to the utmost, renovation and expansion of the institution must begin as soon as possible. This was not hyperbole. Constant crowding, overwork, and use of antiquated equipment strained Springfield's staff. Springfield needed larger facilities to meet the crush of new patients but was hardpressed just to meet its ongoing expenses. Finding the funds quickly to construct a new building was impossible--the building was not completed for a decade.[19]

Difficulty in collecting patient fees was Springfield's major financial problem. Prevailing economic industrial conditions largely determined patient income. Free work and late payments were inevitable and unavoidable aspects of doing business. Springfield was severely handicapped by these circumstances; it could never budget for major expenses, or plan for the future.[20]

The matter of erratic payment illustrates another fact about patients in the twenties; a majority of them were from working-class or lower middle-class backgrounds. Many were the first in their families to seek out and receive hospital care and came to Springfield in much larger numbers than ever before. In the mid-twenties, free in-

patient care comprised between ten and twenty percent of the total number of patients treated, and another ten to twenty percent were city or state subsidized.[21]

Where the care and comfort of paying patients was concerned, Springfield's Superintendent, John Gardiner, was especially attentive. He issued memos to physicians reminding them to make sure that foreign objects not be left behind in patients after operations or examinations. Concerning indigent patients he was less solicitous, expressing alarm, for example, at the increasing numbers of free beds and the burdensome expenditures stretching into the thousands of dollars to pay for them. His alarm was understandable, since such expenditures amounted to a significant portion of the hospital's yearly deficit--sometimes reaching one-half of the total.[22]

Established in 1925, the outpatient department was the main provider of care for the working and lower middle classes. Within a few years of its 1925 opening, the department handled a caseload of more than ten thousand patients a year. To help the department run smoothly, a social worker-Mrs. Jeanne Dixon-was hired. She had two major responsibilities; her first was to provide non-medical services to patients that would help in their treatment and recovery. She purchased braces, located nursing homes for the growing numbers of chronically ill elderly, comforted patients whose attending physicians

changed every month or so, and referred patients and family members to various agencies, as appropriate. Mrs. Dixon's other responsibility was to be the gatekeeper for the hospital in terms of patient admissions and payments. To do this she investigated each potential patient's employment and financial status.

Mrs. Dixon had to serve the patient's needs and also serve the hospital's interests in terms of controlling operating costs and crowding. It was an awkward position. Hospital administrators and doctors insisted that she get patients in and out as rapidly as possible, and, above all, that she bar solvent patients from free services. Trying to mesh two very different goals in the service of two very different constituencies was a source of ongoing tension between Mrs. Dixon and hospital officials; and the tension was illustrated in her monthly reports.[23]

Mrs. Dixon's reports offer the first detailed glimpse of patients at Springfield Hospital. They reveal something of the entry of large numbers of working-class patients into the hospital. The reports also indicate something else: Mrs. Dixon was intent on persuading administrators, physicians, and trustees that indigent working-class patients deserved healthcare--even for non-emergencies.[24]

Mrs. Dixon reported that her clients, due to poverty, had rarely if ever received medical treatment. Now, for the first time they were getting help. One early case

involved a female factory worker who had had a draining abscess of tubercular origin for several years which had deformed her leg and made it excruciating for her to stand while at work. Another case concerned a girl of fifteen who was brought in complaining of breathing problems and a goiter. She had been kept at home since infancy because her parents believed her to be an invalid. The physician discovered no serious medical problems, and concluded that the girl be sent to school and get regular exercise.[25]

One case may have been the most telling of all. A sick young girl was brought to the hospital. Several weeks later, after her condition had apparently improved, one of the nurses noticed that no one had visited her. The social worker investigated and discovered that the parents had abandoned their daughter and left town. It was a callous act, to be sure. And it was certainly shocking. However, it is quite possible that the parents felt unable to care for her themselves, that by abandoning her, private agencies would come forward to do a better job, that her access to healthcare would be greater as an orphan than as a member of a destitute family.[26]

Dixon's stories were designed to reassure Springfield staff skeptical of the worth of the outpatient department and dismissive of Dixon's contributions. Some felt, with good reason, that the department was a financial drain, that Springfield could ill afford. Hospital administrators

and medical staff could never be certain that the social worker--or the outpatient department itself--actually reduced inpatient care for the indigent.

Mrs. Dixon also was suspected of aiding the undeserving by providing care gratis for persons who could easily afford to pay. She periodically tried to reassure physicians, administrators, and trustees on this point, explaining that all prospective patients were thoroughly vetted in full view of the rest to determine whether they merited special financial consideration based on the "patients social and financial status and previous medical treatment." She determined that fewer than five percent of outpatients were actually able to pay for private medical care, that very few patients ever tried to abuse the service--and none succeeded. In the summer of 1927, she reported the case of one such freeloader; a middle-aged single man, a laborer, who was treated at the clinic for an undisclosed ailment. Having no savings, he asked that he be given free care. The social worker sternly chastised him for his desultory spending habits. He assured her he had learned his lesson. From then on, he vowed, he would set aside part of his meager wages in case something similar ever happened again.[27]

Through her reports, Mrs. Dixon tried to demonstrate the usefulness of her work and the genuinely worthy state of her charges. She was not terribly successful in her

campaign. Springfield's outpatient department, like clinics elsewhere, clearly ranked low among hospital priorities as evidenced by its abysmal funding and general neglect by physicians and administrators. On the other hand, however much Springfield officials may have recoiled at the expansion of outpatient services, they did not exclude indigent and lower class patients from medical care. Charity at Springfield in the twenties was more extensive and more costly for the hospital than ever before.[28]

Volunteers helped Mrs. Dixon sustain outpatient services. But there were never enough volunteers and so clinics were severely crowded and understaffed; when volunteers' committment flagged, the already woefully limited programs ceased. Occasionally, volunteers suggested that programs be expanded or new ones be established. However, their proposals were rarely taken seriously or ever implemented by Springfield's hierarchy.[29]

Hospital volunteers were part of a loose network of individuals--many of them middle and upper-class women--involved in numerous social welfare projects in groups like the Family Welfare Association, the Visiting Nurses Association, the Junior League, the Women's Club, and the Community Chest. At a time when government was generally uninvolved in such matters, when the vast majority of

residents had no health care provisions in jobs, when the majority of children six years or younger had never had a physical exam, they alerted Springfield officials and ordinary citizens about pressing health care needs and encouraged increased public and private support for health services.[30]

The Visiting Nurse Association, typical of other charitable organizations, provided care for mothers and children, the elderly and incapicitated. The VNA cared for thousands of residents, and of those only a minority were immigrants or the impoverished; only one-third received totally free care; only one-third were born outside the U.S.[31]

Due to anemic support from both the city and from private donations, the VNA's budget was always bare-boned. With an inadequate budget, it could never hire enough nurses and could only pay them a pittance. Due to the low salaries and enormous work loads, the VNA could only recruit inexperienced and sometimes incompetent student nurses, or marginal graduate nurses who tended to be disloyal and irresponsible.[32]

In addition to already trying circumstances faced by the VNA, the organization faced charges of patient poaching from physicians. Physicians worked with VNA nurses but only reluctantly and insisted on two conditions for their cooperation: visiting nurses could see patients only

following a medical referral. Yet, most of these patients couldn't afford physician fees; just one quarter of patients contacted a physician prior to seeing the VNA nurse. Physicians also insisted that VNA nurses restrict themselves to educational work. In practice, of course, since patients were unlikely to get medical help otherwise, this demand was also ignored by nurses and patients.

Finally, Visiting Nurses were supposed to be working primarily on a charitable basis. The problem was that if nurses treated too many for free, physicians attacked them for harboring chiselers; if they charged too many too much, they were attacked as competitors. The VNA, like other non-hospital based health care providers, skirmished with physicians over competing responsibilities. The VNA was victorious to the extent that it provided care for twenty percent of Springfield's residents. Yet, their work never received commensurate city or private support.[33]

Through the twenties, overwhelmed by public demand for their services, the VNA and similar groups regularly implored city officials to assume greater responsibilities for the costs of clinics and for the visiting nursing care. They wanted adequate health care to be a true community responsibility, and not contingent on the good deeds of volunteers, philanthropists, and overworked staff. However, the prevailing view among the city's elite was that private charity was intrinsically more responsive than

government, was a more profound demonstration of duty to one's neighbors, that increased government aid would actually harm health care services by making them bureaucratic and unprofessional.[34]

Despite the lack of adequate public support for community healthcare, graduate nurses in the VNA valiantly tried to meet working class healthcare needs. At Springfield Hospital, student nurses worked as the major patient care providers--especially to charity patients. Nursing was the best many young women could hope for, aside from being a clerk, a salesgirl, or a secretary, at a time when women were mostly excluded from the professions.[35]

Nursing 'professionalism' was different than that of male-dominated fields like medicine and law; nurses were expected to be utterly subservient to physicians, to master rituals of deference such as standing when physicians entered a room or giving up their seats to physicians. They learned to be attentive to physicians' every motion, mood, or instruction, to refrain from ever making important decisions about patient care, to labor without reward or relief and with little hope of education or occupational advancement. The professionalization of nursing was thereby delayed for decades; instead Springfield nurses simply aped existing women's roles in which nurses recapitulated behaviors of wives, daughters, and servants.[36]

Springfield relied on student nurses to accommodate the growing number of patients while saving money and evading laws restricting the hours of licensed nurses. However, the supply of competent student nurses never kept up with the demand. Springfield Hospital couldn't recruit or retain an adequate nursing corps because nurses suffered gross exploition.[37]

Little had changed since 1893 when Springfield Hospital Nurse Training School first opened. From the beginning, 'instructors' emphasized practical training on the wards with little time devoted to lectures or lab instruction. Nurses were expected to be mulish and obliging to all demands. Such behavior was viewed as emblematic of womanly values of the time and notions of "separate spheres." Ideal candidates had had extensive experience either as mothers helpers or as servants.[38]

Nurses were expected to sacrifice their own health, if need be, to the needs of patients. That they agreed to do so was evident by their presence in large numbers as patients (unlike physicians)--at times comprising half of general ward patients and a major hospital expense. Ill health forced many nurses to take lengthy leaves of absence; the dropout rate sometimes totalled thirty percent; dismayed by so many of their classmates falling ill and forced to leave school, student nurses could only wait and wonder how long they would remain healthy.[39]

Even if nursing had not been an exhausting, thankless, and dangerous job, it would have been difficult for administrators to recruit student nurses. Recruitment was doubly difficult because the job offered little in the way of professional rewards. Pay, for example was generally significantly less than for teachers or for social workers. As a result, it was nearly impossible to draw what it viewed as "more desirable" students. Springfield officials hoped that its candidates would be from the "better sort," refined young women with "diction and the right style," those with more education (a significant proportion of students in the twenties lacked a high school diploma) who could presumably better minister to the needs of the middle classes flocking to the hospitals. In hopes of reaching this better sort, hospital recruiters made regular presentations at area high schools. To woo the most promising young women, recruiters also staged elaborate receptions at the new nurse's residence to show off the victrola, and grand carpets gracing the living room-downstairs from the rather modest student quarters.[40]

None of these measures succeeded in bringing the desired types of students to Springfield Hospital. Conditions were too difficult and wages too low to get or keep such "respectable" young women. Instead, it was the ill educated and the unpolished who composed the core of

the student staff. This proved a constant tug of war between the nursing superintendent and students regarding the proper comportment, disposition, and behavior of nursing students.

Nursing Superintendent Blanche Blackman was a well-educated and capable professional. Deeply respected by her peers, she later served as president of the state nursing association. Unfortunately, she couldn't help her students become comparable professionals; Blackman's job was to break her students, to turn them into pliable laborers.

Blackman rigidly controlled student nurses from morning to night. At breakfast, she commanded students to remain at their tables until she nodded her head and excused the group. Following breakfast, she led mandatory prayers. Then before going off to their duties, she measured their uniforms; for reasons of style and comfort (and mild mischief making) some students occasionally surreptitiously shortened their skirts. Blackman inspected every student to ensure their uniforms were not more than ten inches from the floor.

While all students had to observe strict protocols on virtually every aspect of their personal and working lives, first year students were especially singled out. They were probationers after all, the term connoting both a sentence and the uncertainty that they must have felt about their position. Blackman regularly punished students for a

variety of infractions, suspending many and expelling others. Her records are filled with notes like " A student was sent away for disobedience." "It was necessary to allow four students to go home until such time as their hair which they had bobbed had grown again." Students were dropped from the rolls for being "unsatisfactory material." In May of 1923, for example, one student was dismissed because of what was referred to as "a prolonged but thoroughly concealed disobedience" of the prohibition on fraternizing with male staff members. She hinted that the accused had associated with someone below her class (or would-be class), and possibly that she had become pregnant. Blackman's ruling in all such matters was final, and usually not very elaborate. More typical was the case of a student who was dropped from the rolls in March 1926 because "she lacked the qualities that we deemed to be desirable" or the student in the spring of 1929 whose resignation was requested. No explanation was offered or needed.[41]

Student nurses' experience was similar to that of other Springfield medical personnel--notably interns. In some large urban hospitals interns were regarded as ambitious upstarts who threatened the preeminence and perogatives of senior staff. Not at Springfield; interns were treated as indentured servants more than fearsome young rivals.

As with student nurses, the principal appeal of interns was that they provided cheap labor. Although internships were supposed to provide instruction and hands-on experience, interns' day-to-day assignments involved mostly the scut work of taking histories, conducting exams, and performing lab tests for senior staff. Such duties were typically learned in a matter of hours or days but were then done for months to spare senior staff the chores.

Aside from serving senior staff, interns served the general ward and the outpatient department. As with student nurses, interns subsidized Springfield's care of the lower classes while allowing senior physicians time to attend to more affluent patients and to cultivate referrals.[42]

Interns were ill equipped to handle the constant stream of outpatients. They had too little time and too little experience. They complained of offering haphazard care. They decried the separate and unequal treatment accorded inpatient and outpatient divisions, in which inpatient services got the lion's share of attention and resources, and urged that senior staff and administrators take action. Their pleas went unheeded. The division between outpatient and inpatient care would last for decades.[43]

Deplorable conditions in the outpatient department were the result of interns' crushing responsibilities

combined with the almost total absence of guidance by senior staff. Senior staff demanded much from interns yet made little effort to teach them in return. Few ever took the time to discuss cases with interns or to point out important facts and findings.[44]

Some staff members coaxed their fellows to involve interns more in their regular rounds. One urged "that private and semi-private patients be made more use of as teaching material" to benefit the interns. Others suggested that staff members systematically monitor the interns' performance "...that after interns have cases worked up, visiting men review their work for approval or constructive criticism." No formal action was taken. And Superintendent Walker usually steered clear of matters related to interns' training. Senior staff continued to neglect systematic instruction of interns.[45]

Walker's reluctance to challenge senior staff regarding teaching responsibilities was just one indication that the real power at Springfield rested with the senior staff. Senior staff were generally Springfield's most skilled and experienced physicians; the ones who held major appointments, who had full privileges in matters of patient admissions and treatment, who determined Springfield's policies, who commanded the attention of trustees, and dominated everyone below them.[46]

Comprising less than thirty percent of Springfield's physicians, senior staff were predominantly white male native born Protestants, many of them from old yankee families of long residence in Springfield. Many hailed from the finest medical schools of Boston and New York; many won wide recognition including the presidency of the local medical society, the presidency of the state hospital association, the presidency of the New England Surgical Society, and the presidency of the national radiology society.[47]

Staff meetings were held at the tony Colony Club--one of the gathering spots for the city's social elite. Though the meetings were convivial occasions they were not solely social events. Typically after dinner and a brief report from the medical staff president, special presentations followed usually consisting of general talks on subjects like the thyroid gland, gall bladder disease, or the treatment of diabetes with insulin, along with perplexing cases that physicians wanted to share and discuss with their colleagues.[48]

Patient deaths were rarely discussed. Reading of the "casualty" list was perfunctory and invariably the assembled unanimously ruled that deaths were caused by the primary disease with no discussion of how to handle such cases in the future. Occasionally the superintendent dissented and remarked that faulty sterilization of

instruments or other unnamed (or unrecorded) mishaps had caused a particular casualty. After his comment, the meeting continued as usual. Without an ongoing monitoring committee, physicians couldn't be closely supervised; there was no means of directing physicians in standard ways; sanctions could not be imposed on physicians for mistakes--assuming mistakes were ever discovered.[49]

In 1928, a few senior staff members tried to institute monthly group meetings to discuss what were referred to as "poor results" including wrong diagnosis, preventable deaths, and infections. They couched this proposal in terms of collegial learning and teaching but it caused considerable resentment even though attendance and participation was voluntary. The proposal was not implemented for more than twenty years.[50]

Superintendents Gardiner and Walker were more insistent that senior staff maintain proper records. Apparently there were growing problems with routine patient record keeping in the twenties. Patient charts lacked vital information; surgical notes included conflicting statements; interns' accounts of patients' progress clashed with those of attending staff; physicians failed to file patient progess reports, to take notes at admittance or discharge, to take histories or exams before operations, and were vague about what was done during operations. In

general, one quarter to one half of patient records were incomplete at any given time.[51]

On several occasions, the Superintendent implored the staff to be more careful. He flattered them when they temporarily made modest improvements and threatened them with disciplinary action when they returned to their usual habits. Nothing he did made a difference.

What was happening here? Possibly, physicians were becoming less vigilant about record-keeping. In the twenties and thirties a flood of new patients meant a staggering amount of additional record keeping (especially for city and state agencies for reimbursement purposes) which took time away from patient care. Some physicians let the paperwork slip rather than patient care. Moreover, agencies such as the American Medical Association, the American College of Surgeons, the American Hospital Association, also insisted on more exact standards for medical care. All of which necessitated more elaborate record keeping and tighter control over patient records.

Physicians were told to hold frequent staff conferences, to meet periodically to review and analyze hospital work, to be vigilant about attendance at staff meetings, and to produce thorough minutes of staff meetings. Such information was needed so that accrediting organizations could examine and evaluate hospital standards. Accreditation was said to be crucial if

Springfield was to continue to draw medical students, physicians, nurses, patients, and support generally from the community.

Despite the stated importance of staff attendance at meetings, physicians' attendance records were dismal. Superintendent Walker and the chair of the medical staff tried repeatedly to coax more physicians to attend reminding them that their presence was "tangible proof of their interests in the hospital" and that "it was their major chance to express their views and to influence hospital policy." These pleas had no discernible effect on the staff. Physicians had good reason not to attend meetings. Given the divisions within the hospital, staff meetings were not usually occasion for much comradery. Owing to the senior staff's stranglehold on policy, junior staff had little reason to participate. Moreover, due to competition among the senior staff, staff members were more likely to bicker than to be cheerful with one another. Also, whatever their status, physicians faced persistent new pressures from the Superintendent and outsiders which they could resist but never eliminate. Lastly, financial shortfalls meant delays in getting needed supplies and made expansion almost impossible. The staff had little power to remedy the situation.

Despite their vaunted corporate affiliations and allegiances, Springfield physicians were individualistic

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in the twenties and thirties; freedom to decide their own methods of practice was sacrosanct to Springfield physicians. Now, in the name of professionalism, they were pressured to surrender a portion of this precious right. Their response was to resist demands of colleagues and outsiders whenever possible and they withdrew from new responsibilities whenever they could.[52]

Springfield's physicians were successful in rebuffing stringent regulations until well after World War Two. Administrators allowed them to straggle along at minimum standards of accreditation organizations, content to operate at provisional status.[53]

Impact Of The Depression

In the early months of the depression, few in Springfield realized the severity of the economic crisis. The Chamber Of Commerce, for example, called conditions "basically good." It was difficult to remain optimistic however, when unemployment hit twenty-five percent in 1932 and stayed there for more than two years. Springfield residents lost more than their jobs; some lost their marriages and homes and became tramps; some lost their minds and became "mental cases."[54]

By the early 1930s, Springfield's welfare spending amounted to ten times what it had been earlier but this still wasn't enough to meet the emergency; city agencies,

however, had no more money to spend. Meanwhile, charity organizations were in no better shape; far more people used their services but contributions had tumbled.[55]

In lieu of giving money, city officials tried to provide for the needy by hiring them for juries, by distributing coal and flour, by establishing public gardens, and by organizing football and basketball fundraisers. For those who weren't satisfied with city aid, the Joyland Palace held dance marathons where contestants, except for comfort breaks and cat naps, shuffled around and around and around for weeks at a time.[56]

Under pressure from labor groups and others, city officials tried to shake industry's money tree; local manufacturers resisted the shakedown saying their branches were bare. In response, city officials called the wealthy uncooperative, selfish, and irresponsible. Some observers predicted riots and revolution. The Chamber Of Commerce, fearing potential social stife, finally took action. It formed a task force to recommend ways unemployed workers might best use their limitless leisure--aside from staging rent parties, pounding the pavement, foraging for food, or copulating.

In the early years of the depression, city officials insisted that Springfield could fully provide for its indigent and therefore, could do without outside

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governmental aid. The mayor's stance was that if all helped out, everyone would get by. Unfortunately, while his voluntaristic vision was uplifting, the support and cash to realize it never materialized.

Funding adequate health care by city agencies, private charities, and hospitals was very difficult because the legions of unemployed and underemployed and their families were more susceptible to disease, and suffered elevated rates of tuberculosis, pneumonia, and infant illnesses and yet couldn't pay for treatment. In a sense, this was a reprise of Springfield's experience in the past decade but on a much larger scale.[57]

With far more patients unable to pay their bills, Springfield Hospital's yearly deficit mushroomed. In response, the business office issued stern reminders to late payers, asked for payment prior to operations, and paid collectors to track down patients with delinquent bills.[58]

Concerned that patients might be "trying to secure a bargain," medical staff leaders urged physicians to carefully assay patients' financial health before deciding on admittance, and to skimp on testing whenever possible. Social workers spent even more time than before trying to determine which patients were 'deserving' and which were not.[59]

Outpatients were a particular problem for Springfield's smooth functioning. Outpatient department clinics like child guidance, cardiac, and dermatological, continued to grow far more rapidly than the rest of the facility; yet, few of the thousands who came by monthly could pay for their care. Superintendent Walker called the department a serious financial drain and a detriment; he wanted to review its status and enact maximum quotas for clinics. In the end, though, he did nothing. Springfield did not want to risk public condemnation by turning away large numbers of the needy.[60]

Staff physicians tried to devise ways to bring more paying patients into the hospital. One encouraged hospital trustees to get directly involved in "selling" the hospital, "why don't more acccident cases come to the hospital? Haven't our trustees any influence with city police or factory managements that can be brought to bear on this matter?" This followed a general discussion in the medical staff as to whether or not accident cases were financially rewarding to the hospital.[61]

The depression experience did not knit together the medical staff. To the contrary, it widened existing staff divisions. In Springfield, as elsewhere, there was more competition among doctors during a decade in which physician incomes in general declined precipitously and those of general practitioners fell even more.

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In an economy in which much care was paid by barter, every solvent patient counted. Those physicians who monopolized certain procedures commanded extra fees but antagonized their peers and exacerbated staff infighting as witnessed by the controversy concerning who could administer anesthesia and collect the accompanying fees. Superintendent Walker referred to "selfish interests" at work and "thoughts of personal gain" outweighing other considerations. This was a fight over turf and expertise within the medical staff. To the victor would go the commensurate rewards. Whether or not the victor was the best qualified to administer anesthesthia was another matter. Left unaddressed by Walker and other hospital officials through the decade was the question of who would decide such questions. Tensions remained.[62]

Springfield Hospital's finances had always rested on patient fees and donations, and to a lesser extent government and charitable aid. Unfortunately, sizable legacies were rare windfalls. Patients were notoriously unreliable about paying their bills; more than half of chronically ill patients paid nothing at all, and contributions of twenty-five to fifty cents per patient from the Community Chest and city agencies failed to cover hospital costs. Investments in the thirties produced paltry returns and dividends.[63]

Trustees sought more reliable sources of income; they got the Massachusetts Department of Public Welfare to assume a larger share of the costs for indigent cases; arranged with the federal Veterans' Bureau to care for its clients; and pried welfare payments from surrounding towns. Springfield's reliance on government support was a return to its earliest days and for similar reasons; individuals whether benefactors or patients or volunteers were unable to fund the hospital on their own.[64]

Increased government support was crucial to the survival of Springfield's healthcare institutions in the thirties. Until the depression years, city officials had viewed healthcare mostly as a private matter, their own role largely limited to monitoring and quarantining those with contagious diseases along with providing modest contributions for hospital care for the indigent and a clinic for venereal disease (vd) patients. Once the depression hit, health care outlays were cut by twenty-five percent and the vd clinic closed; the money was needed for schools, for the fire and police departments, and for emergency relief.

The VNA was one of the health care groups hardest hit by the depression. Like others, it saw its budget cut, staff reduced, services curtailed for emergencies, child welfare, and deliveries. The VNA and affiliated groups were unable to serve the many needs of masses of destitute

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persons at a time when one quarter of the population was receiving Community Chest aid and three quarters of that went for emergency relief.

Chest leaders rallied the community to assume greater responsibility for social welfare generally and health care in particular. They called on city officials to increase monies for free beds and outpatient clinics. Chest leaders declared that adequate health care was "vital to democracy" and a social right. As in the twenties, the VNA and kindred groups called on city leaders to devote more resources for healthcare. Unlike the twenties, however, this time their appeals were taken seriously by government officials.[65]

Social problems that had earlier been neglected by politicians and the public now became major social concerns. Springfield officials, like their counterparts across the country, could not long ignore the plight of the poor when their numbers doubled during the depression--the vast majority of them had never asked or needed help before. City officials could no longer ignore charitable groups like the Chest which spoke out on behalf of the indigent. A profound shift occurred in public attitudes about government aid; what had been regarded as a beneficence now was claimed as a right, what had had been a social disgrace had now become a matter of basic dignity; Soon, politicians like Mayors Dwight Winter and Henry

Martens "found" substantially more money for social welfare including health care because they knew that otherwise they would be summarily booted from office. City outlays for hospital care alone increased by ten times from 1930 to the mid-thirties.[66]

<u>Conclusion</u>

By the end of the thirties, charitable organizations had succeeded in helping to expand and improve the city's health care resources. Some Chest officials wanted to go further; they spoke of broader social planning to assure adequate health care. Such ideas did not get very far; their proponents were outsiders or minor players in the health care hierarchy who lacked any significant leverage in area hospitals, local politics, or the business or professional elite.[67]

As the city physician noted in 1938, Springfield's health care remained "fragmented and uncoordinated." Health care devolved onto individual physicians at individual hospitals--notably Springfield--with little effort to organize services within hospitals or between them or to coordinate hospital services with charitable organizations or city agencies.[68]

Springfield Hospital's experience and that of the city generally highlighted the weakness of the supposed vanguard of American medicine whether specialists, medical school deans, or hospital administrators. Though Springfield was

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no backwater institution in the thirties, its general practitioners generally reigned supreme. Springfield physicians successfully obstructed efforts to change the organization or delivery of services.

Physicians' sovereignity rested on maximum professional autonomy; the result had been systematic disarray; total autonomy led to increased staff divisions, poor service, low standards, and weak education. Yet, physicians' insistence on autonomy trumped other interests who lacked comparable professional authority. Neither administrators nor foundations, neither medical schools, accrediting agencies, or government filled the breach. Not until after World War Two did Springfield Hospital begin to develop an organizational structure commensurate with its growing importance to area residents.

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30. Peter Dobkin Hall, Inventing The Non-Profit Sector, (Baltimore, MD.: Johns Hopkins University Press, 1992) p. 59; Sonya Michael, Mothers Of A New World, (New York, NY.: Routledge, 1993) p. 2; Visiting Nurses Association, Nurses Committee January 23, 1920; Visiting Nurses Association 1921 Director's Report. All contained in VNA collection.

31. Springfield Union, February 20 1931 p. 8; December 13, 1927 p..14, September 30, 1928, October 20, 1925, p.10, September 13, 1927, p. 5; VNA Nurses Committee February 12, 1917, February 23,1918, August 5, 1923, December 30, 1921, December 18, 1921, February 1922, December 8, 1922, March 1922, February 9, 1923, March 14, 1930, June 1929. All contained in VNA collection.

32. Visiting Nurses Association Annual Report, 1918, 1924; Nurses Committee monthly report February 1918, May 1918, January 4, 1923, February 12, 1917. All contained in VNA collection

33. Springfield Republican, August 6, 1917; Visiting Nurse Association Annual reports 1926-1928; Nurses Comittee April 19, 1926, April 8, 1929; Visiting Nurses Association, Citizens Committee Report 1927 p.11. All contained in VNA collection. Springfield Union, February 14, 1930, p. 31.

34. cf. mayor's addresses these years. cf. editorials in Springfield Union, October 31, 1925, p. 10, October 11, 1922, p. 10, October 28, 1923, p. 10, January 29, 1922, p 10.

35. Penina Glazer, Unequal Colleagues, (New Brunswick, NJ.: Rutgers University Press, 1987), p. 75; Hummer, op. cit., pp. 14-15,64.

36. Robyn Muncy, Creating A Female Domain In America, (New York, NY.: 1991); Kathleen D. Mccarthy, lady Bountiful Revisited: Women, Philanthropy, And Power, (New Brunswick, NJ.: Rutgers University Press, 1990), ch. 2; Hummer, op. cit., p. 29; Glazer, op. cit., p. 14; Rima Apple, Women, Health, And Medicine In America, (New York, NY.: Garland Press, 1990), p. 461-467; Kingsdale, op. cit., pp.137- 150; Golden, op. cit., p. 62; Rosenberg, op. cit., p. 20.

37. Springfield Hospital Nursing Superintendent Annual Report for 1920, 1925; Nursing Superintendent monthly report December 1924.

38. Springfield Hospital Medical Staff Addresses to the Springfield Nurse Training School graduating class, 1894, 1895, 1899, 1900, 1903, 1916. All contained in Annual Reports for those years.

39. cf. Nurse Training School Annual Reports for 1920 and 1921; Nursing Superintendent monthly reports, January 1923, February 1925, October 1925, February 1926, October 1926, March 1930, March 1931, May 1931.

40. Nursing Superintendent monthly report September 30, 1923.

41. Nursing Superintendent monthly reports, October 1925, January 1923, March 1923, March 1926.

42. Stevens, op. cit., p. 65-67; Rosemary Stevens, American Medicine And The Public Interest, (New Haven, CT.: Yale University Press, 1971), p. 116-120; Rothstein, op. cit., pp. 134-135; Dowling, op. cit., p. 118; Superintendent Annual report for 1931, Box 2.06, BMC collection.

43. Medical Staff monthly report, April 1931, Box 5.07, BMC collection.

44. Senior Medical Staff monthly report, May 1933, Medical Staff monthly report, April 13, 1933. Both contained in Box 5.07, BMC colection.

45. Medical Staff monthly report, June 1933, April 13, 1933, November 8, 1934, September 12, 1935; Senior Medical Staff monthly report, December, 1933; Intern Committee Annual Report for 1936. All contained in Box 5.07, BMC collection.

46. I infer this from my reading of Springfield's Annual Reports, Trustee minutes, and Medical Staff Council records.

47. I have inferred this from surveying the backgrounds of notable Springfield physicians during the Hospital's early decades. For information on physicians' professional acomplishments in the thirties, cf. Superintendent Annual Report for 1938, Box 2.06, BMC collection.

48. Glazer, op. cit., p. 79; VNA Nurses Committee, May 31, 1923, April 10, 1923, May 12, 1925, January 9, 1923. All contained in VNA collection.

49. Medical Staff monthly report, November 23, 1923; Senior Staff monthly report, October 9, 1923. Both contained in Box 5.07, BMC collection.

50. cf. a particularly detailed critique of physician practices in Medical Staff monthly report June 1933, Box 5.07, BMC collection.

51. Superintendent monthly report, July 14, 1925, November 1926, Box 2.05, BMC collection; Medical Staff monthly report, October 1926, December 1931, Box 5.07, BMC collection.

52. Medical Staff monthly report, summer 1933, July 1935, January 1936, Box 5.07, BMC collection.

53. Senior Medical Staff monthly report, September 13, 1935, September 6, 1935; Medical Staff monthly report, July

1, 1935, December 1, 1935, January 1936. All contained in Box 5.07, BMC collection; Superintendent report, summer 1925, May 1926, Box 2.05, BMC collection. Superintendent report, May 1933, July 1935; Both contained in Box 2.06, BMC collection. Medical Staff monthly report, April 1933, Box 5.07, BMC collection.

54. Springfield Republican, April 1, 1930, p. 1, March 21, 1930, p.14, July 31, 1930, p. 5 , December 12, 1929, p. 1, January 7, 1930, p. 8, May 29, 1930, p. 14, December 5, 1931, p. 1, July 22, 1933, p. 6, December 3, 1932, p. 1, July 19, 1934, p. 1.

55. Springfield Union, February 16, 1933, p. 5, June 6, 1932, p. 1, August 12, 1931, p. 14, October 23, 1931, p. 10, September 2, 1932, p. 6, October 26, 1931, p. 3, April 15, 1931, p. 1, February 12, 1934, p. 1, December 22, 1930, p. 1, February 10, 1931, p. 1.

56. Springfield Union, March 14, 1931, p. 1, January 21, 1932, p. 5, August 4, 1931, p. 8, March 24, 1932, p. 1, May 9, 1932, p. 1, August 24, 1932, p. 3, October 21, 1931, p. 7, January 19, 1932, p. 8, April 27, 1933, p. 8, March 4, 1933, p. 4.

57. Rosemary Stevens, In Sickness And In Wealth, (New York, NY.: Basic Books, 1990). ch. 6; James Patterson, America's Struggle Against Poverty, (Cambridge, MA.: Harvard University Press, 1980), p. 8-16; Stern, op. cit., pp. 117-118.

58. Medical Staff monthly report, April 13, 1933, Box 5.07, BMC collection.

59. Medical Staff monthly report, June 18, 1932, November 3, 1935; Medical Staff Annual report for 1935. All contained in Box 5.07, BMC collection; Social Service Annual Report for 1936; Superintendent Annual Report for 1938, Box 2.06, BMC collection.

60. Medical Staff monthly report, January 19, 1932, April 13, 1933, May 1933, June 1934, December 1935. All contained in Box 5.07, BMC collection; Superintendent monthly report, February 11, 1932, Box 2.06, BMC collection.

61. Medical Staff monthly reports, April,May, 1933, Box 5.07, BMC collection.

62. Cf. interview with Dr. Joseph Hahn, August 1989 (in author's possession); Superintendent's Annual Report for 1931, Box 2.06, BMC collection; Medical Staff monthly report, January 19, 1932, Box 5.07, BMC collection. Superintendent Annual Report for 1932; Superintendent monthly report January 1933, Superintendent Annual report

for 1936; Both contained in Box 2.06, BMC collection. Cf. Rosenberg, op. cit., for his discussion of role of medical boards in resolving such disputes. Rosenberg suggests that medical boards were willing and able to impose more stringent standards relatively painlessly. At Springfield, by contrast, physicians effectively frustrated the efforts of reformers on medical boards for several decades.

63. Board Of Trustees monthly report, January 22, 1935, Box 1.03, BMC collection.

64. Anderson, op. cit., p. 109; Board Of Trustees monthly report March 16, 1937, December 27, 1938, January 18, 1933, October 17, 1933, March 1931, March 1, 1934; All contained in Box 1.03, BMC collection. Superintendent monthly report, Outpatient Department monthly report, January 1936, Box 2.06, BMC collection.

65. VNA Nurses Committee, February 10, 1933, March 13, 1931, October 17, 1935, Nurses Committee Annual report for 1935; Nurses Committee, October 9, 1931, September 20, 1935, March 16, 1934, April 10, 1931, May 12, 1933, April 1932; Nurses Committee Annual Report for 1930-1931, June 18, 1934 December 1, 1931, March 1,1933, October 13, 1933; All contained in VNA collection.

66. Springfield Municipal Register, Board Of Welfare for 1929, p. 215; Mayor's Address for 1930, 1931, p. 17, Mayor;s Address for 1934 p.15; 1935 Board Of Health p. 215; Brandt, op. cit., pp. 131,143; Anderson, op. cit., p. 119, Fox, op. cit., p. 76; Kingsdale, op. cit.,p. 334; Patterson, op. cit., p. 62; Community Chest Annual Report for 1935; Board Of Welfare, op. cit., for 1934, p. 217; Board Of Health Annual Report for 1938, p. 116.

67. Community Chest Annual Report for 1935, p. 9, Community Chest Annual Report for 1934; Both contained in Springfield vertical file (herafter referred to as SPVF) Box 160 held at the Connecticut Valley Historical Museum.<u>Springfield Union</u>, May 14, 1921, p. 8.

68. Springfield Municipal Register for 1938, pp. 138, 153; Kingsdale, op. cit., pp. 332-333,344-366. Stevens, op. cit., pp. 133,193

CHAPTER 4

SPRINGFIELD HOSPITAL 1940-1960

"Hundreds of people...for the first time have the means of paying... to remove some burden from mind and body...." reported the Springfield Union in May of 1943. During World War Two, Springfield's prominence as an arms' manufacturing center resulted in boom times for workers employed at Smith and Wesson, the Colt company, and other area firms. Many of these workers enrolled in company-sponsored insurance plans which had been first introduced in the late thirties but had dramatically expanded during wartime. By 1943 an estimated one half of daily admissions were carrying some sort of insurance. By 1944, the hospital derived the majority of its patient income from these sources.[1]

Although more people were covered by insurance plans than before, patient admissions remained level with those of the pre-war years. Due to staff shortages, (more than one third of Springfield's physicians as well as many nurses served abroad), as well as rationing of medical supplies, Springfield could not significantly expand its services. Following the war however, with the return of hospital personnel, continued prosperity, increasing numbers of persons covered by insurance as well as by public agencies, Springfield registered remarkable growth

in patient admissions and treatment. The emergency unit and outpatient surgery department, the laboratories and x-ray services all reported increases, sometimes jumping fifteen to twenty-five percent annually.[2]

By the late 1950s, more than 70% of Springfield's patients received health care through a combination of private insurance plans, federal, state, and city aid, and private relief agencies. Of all these programs, insurance was the most important; Springfield residents were among the more than 100 million Americans (up from 30 million in 1945)--covering more than half of the country's population--who received health insurance from one of more than 500 insurance companies.[3]

While health insurance immeasurably improved the well being and peace of mind for millions of Americans, it was not always a satisfactory arrangement for patients or providers. Insurance plans usually paid a fraction of hospital and physician fees. In the mid 50s, they covered one quarter of private expenses for health services which is one reason why loans for medical expenses were the mainstay of small loan companies. Insurance plans which typically covered a small portion of charges for acute conditions (leaving out many services like medications, rehabilitation, and home health care), had no provisions for treatment for those with chronic medical problems and barred persons with preexisting conditions. Some insurers

did offer special policies dubbed major medical plans to cover their own existing gaps in coverage but these were too expensive for most Americans--less than 10% of whom had major medical protection by 1960.[4]

Blue Cross and Blue Shield were the two major non-profit corporations that tried to cover the gaps of the private insurers. Aside from their regular subscribers, they also enrolled the elderly, the chronically ill, and others locked out of private insurance plans. Unlike the private insurers, they initially offered the same plan to all subscribers at the same cost in a given community and thus kept premiums relatively low for those with greater medical expenses. The "Blues" however steadily lost customers in the fifties to insurance companies offering cheaper plans to healthier enrollees, leaving Blue Cross and Blue Shield with the more costly patients. As a result, premiums were raised, which further drove policy holders into the arms of the "privates" and ultimately made policies too expensive for many, especially the elderly living on fixed incomes.[5]

Government agencies, whether city, state, or federal, were supposed to cover the gaps of the privates and the Blues. Unfortunately, state programs typically paid just one half of actual patient costs. Hospitals in turn tried to make up the shortfall by charging private insurers more who then passed on the added expense to their enrollees,

all of which made insurance more difficult to afford for everyone.[6]

Springfield's difficulties wresting adequate fees from third party payors came at a time when the Hospital's financial situation had become more volatile than ever before. Expenses soared due to rapid increases in the cost of labor and supplies, and the added expenses of new services, the decision by Springfield trustees and physicians to expand its medical education program and to construct many new facilities, and increasing government regulations. Planning budgets and then working within them thereby became a more difficult enterprise. And unlike earlier years, trustees could no longer settle accounts with a check at the end of the year.[7]

To make up for the shortfall, Springfield regularly raised its rates for patients covered by private health insurance. In the fifties, Springfield increased its rates from five to fifteen percent a year--double the previous decade and more than double the inflation rate overall. These were astonishing figures given that revenues from patients had soared four hundred percent since 1945.[8]

Springfield battled constantly with third party payors to obtain contracts that would provide some significant portion of the hospital's operating costs. Hospital administrators insisted that payors pony up the actual costs of services incurred by the hospital, wrangling with

Blue Cross and Blue Shield, insurance companies, the Workmen's Compensation Insurance Commission, the Department of Welfare, and the Community Chest. The disputes centered on whether payors should pay for the cost of their specific patients alone, or the more general costs borne by the hospital including medical education, outpatient, non-payors, and so on. How to define "usual" versus "special" charges, how to decide who would determine these, how to enforce these rates, and the means to challenge them as appropriate was the subject of continual negotiations in the 1950s.

Springfield's officials fretted over the many individuals who were unable to get group health insurance coverage (which provided the best coverage at the least cost) because of retirement, self-employment or employment in small businesses. According to Springfield's business office, the only option for 'insurance orphans' was to buy individual policies with "high premiums and very little protection," for whom claims were often rejected because "of certain well hidden clauses in the policies." The business office concluded, "many policy holders ...judge the workings of the voluntary health insurance unsatisfactory."[9]

Hospital officials issued guidelines to the medical staff explaining which insurance policies covered which procedures urging them to make sure that patients had

sufficient insurance coverage before ordering tests, and conducting thorough exams lest the patient's insurer fail to cover the charges and the patient fail to make up the difference leaving Springfield stuck with the bill. Also, even more than before, the outpatient department and emergency room became both the "doctor's office" for the indigent and the hardpressed and the preferred site of treatment for those without means in order to save beds for paying patients. These two departments outstripped nearly all others in the 40s and 50s in their increase in patient admissions.[10]

Elderly Springfield residents had the most difficult time paying for medical care. As was true nationally, they used health services more frequently than others and had greater health care expenses. Most insurance companies denied them coverage, cancelled coverage when they reached a certain age, or charged them prohibitively high premiums--representing about 15% of their income--for policies that covered very little.[11]

The Springfield Visiting Nurse Association helped the many elderly who could not afford hospital care, or who had been released precipitously from Springfield and other hospitals, or who could not afford to enter a nursing home. Most of the elderly ill lived alone-"shut-ins"-and were left to fend for themselves, though VNA staff judged 20% of

their patients should have been receiving immediate hospital care.[12]

The VNA provided as best they could for shut-ins but due to meagre private funding and a dangerously heavy caseload, VNA leaders found it practically impossible to hire or retain competent committed nurses. Moreover, with too many patients to care for, it was impossible to provide any of them decent care, causing much frustration and anguish among the nurses. The average thrice weekly visit lasted just 43 minutes though many patients needed daily visits for much longer periods.[13]

In one respect, though, the elderly served by the VNA were the lucky ones. At least they had some privacy and individual attention unlike the elderly poor lodged at the city's decrepit "infirmary." There, they shared jammed quarters with homeless families and unmarried pregnant women, along with the retarded and mentally ill. Due to understaffing (and underfunding), the city physician visited each patient approximately 30 seconds per day, "inmates" went without night time attendants, and apple sauce was the staple food.[14]

Springfield officials were reluctant to turn away indigent patients, but could not afford to take them all free of charge. That is why throughout the 40s and 50s, Springfield administrators spent an inordinate share of their time and energy at meetings and conferences,

wrestling with the "all important reimbursable cost problem." The hospital constantly tussled with public agencies over funding arrangements, reaching temporary agreements which were then rendered inoperable because of rising costs.[15]

Raising rates and the cost shifting that such increases were partly designed to enforce was partly Springfield's answer to stinginess of government and non-profit agencies. Springfield had an even greater problem with these payors than with private ones regarding full and timely payments. Hospital officials constantly complained about one sided, unfair arrangements where these were concerned. Neither government agencies nor the non-profits ever seemed willing to allocate what physicians and administrators deemed reasonable sums for payment.[16]

In the late fifties, Springfield, along with other hospitals, asked the Massachusetts Hospital Association to analyze hospitals' average costs so that state auditors could then determine satisfactory rates. The Association duly devised what it deemed appropriate guidelines, but these were rejected by the State. Springfield and sister hospitals throughout the state then fixed on other means to make up the shortfall. In anticipation of meagre payments from the non-profits and public agencies, they raised rates well in advance of new rates set by state bodies. They created a new "entrance charge," but this was quickly

discovered and banned by the Department of Public Health; they next tried to tack on an increased room rate for the first 5 days of patient stays. This too was struck down by state officials.[17]

Area-wide planning of services by Springfield's hospitals might have helped reduce costs. And in fact, beginning in 1946, federal legislation required that hospitals join planning ventures as a prerequisite for obtaining government loans for expansion purposes. Hospitals were to coordinate services under the auspices of state health departments on a local, state, and regional basis, would devise plans to meet present demands for health care and to anticipate future needs. However, these planning boards remained paper organizations through the fifties, and Washington simply issued the equivalent of blank checks to enable Springfield and sister institutions to expand their respective domains without any outside interference. Hospital planning would not occur until the mid sixties, and only under enormous pressure from state agencies and the public; even then planning was done only to a very modest degree and with much ambivalence by administrators, trustees, and physicians. Until then, Springfield officials' attitude about planning was simply, 'If we don't build the beds, someone else will.'[18]

Springfield and hospitals generally objected to inter-hospital planning ventures because these were to be

controlled by outsiders, especially state agencies; furthermore, their plans might have become compulsory, and therefore could result in reduction of services or restrict Springfield's future expansion. However, Hospital officials did embrace a planning proposal in 1946 presented by representatives of the Rockefeller Foundation. The Foundation in conjunction with physician and hospital associations, government agencies, leading insurance companies, and several major corporations had launched a planning effort that would be wholly voluntary, privately administered, and locally based.

The Foundation's proposal called for Springfield to become a full-fledged medical center and to constitute itself as the hub of a regional hospital network in the Pioneer Valley. The proposal called on Springfield to launch several new units, to purchase thousands of dollars' worth of new equipment, to form several new departments, to expand others, and to hire scores of new staff.[19]

The proposal met with enthusiasm from trustees, administrators, and physicians, eager to revitalize Springfield's operations after more than a decade of straitened circumstances. A "Future of Springfield Committee" was soon formed; Committee members quickly determined that radical changes were in order-- especially having to do with medical practice. Committee members believed that to improve and expand hospital services, it

would be necessary to reduce the medical staff's prerogatives. To assure higher standards of medical practice, closer oversight of physician performance was warranted. Committee members also believed that to meet the growing responsibilities imposed on hospitals by insurers, state agencies, and the courts (in the matter of liability), while satisfying the public's higher expectations for quality health care, physicians needed to be more accountable to hospital officials and under tighter control of medical staff and hospital governing authorities.[20]

News of the Committee's intentions caused a near revolt of some of Springfield's leading physicians including the Chair of the Staff Council. In January of 1947, Dr. W.A.R. Chapin delivered a speech to the Council in which he accused the trustees, the superintendent, and elements of the medical staff of upending traditional aproaches to medical care. He charged that the Committee and the Board had unilaterally overruled the Council's policy that physicians new to Springfield serve in a voluntary capacity in the outpatient department before receiving formal appointments, and that the committee had engineered a rush of promotions through the staff council without the approval of the staff council. He also claimed the committee supplanted the staff council

as the major governing body of the hospital, thereby creating a breach between the board and the staff.[21]

Chapin's declaration was a bit overblown. After all, four of the six members of the staff council were members of the new committee. If this was a takeover, it was partly from above. But Chapin was clearly on the mark in stating that the committee had supplanted the authority of the staff council; half of the committee's members were from the outpatient staff--men of short tenure and junior- not senior- staff. Clearly, Chapin represented a large portion of Springfield's staff; in the coming years, they would even occasionally outvote the insurgents. But Superintendent Eugene Walker and his allies were not dissuaded by the broadside. Walker even confirmed many of Chapin's charges. He defiantly remarked that if the staff was edged aside in some matters, it was "due to their own shortcomings." He granted that the medical staff had autonomy over medical matters but not over administrative policies; in those matters the Superintendent and trustees had proper purview, that in any event the Board's responsibility over the institution took precedence over that of the staff or the superintendent. Like Chapin, Walker was also being disingenuous. What were now declared administrative matters (and so the job of the superintendent and trustees) had long been conducted by the staff alone.

The effort to broaden physicians' responsibilities and to reduce their independence led to a long lasting tug of war between reformers (the "young turks" as they were called) and the hospital's old guard. Reformers tried to convince other members of the medical staff that relinquishing a measure of their independence and assuming new responsibilities would actually enhance their professional status. Springfield would vastly improve its functioning and staff members would thereby enjoy greater prestige, more hospital resources, increased patient referrals, and higher incomes.

Reformers shared several things in common; most were young men, specialists, Jewish, and, most importantly, veterans. As military physicians, their wartime experience had provided intensive training that otherwise might have taken many years of medical practice. They had learned about the latest new drugs and therapies and the most advanced methods of diagnosis and treatment. They had assumed responsibilities and leadership roles that, as junior physicians back in Springfield, would have been closed to them. Following military service, many of them had taken specialty courses in Boston, New York, and other centers of medical education and research. After completing those programs and returning to Springfield, they had much higher expectations of the institution than

their colleagues, and clear ideas about how to meet the local health care challenges of the postwar period.[22]

Many of the veterans were Jews who had earlier experienced discrimination at Springfield in staff assignments and in promotions--not to mention the slights and stings of being treated as social outcasts by the city's elite. However, following the war, anti-semitism had generally declined due to its association with nazism. Also, Jewish veterans had acquired a degree of medical expertise that could not be ignored or dismissed and was in great demand. And above all, Jewish veterans had served their country and now claimed their rightful place; they could no longer be denied a say in shaping hospital policies.[23]

Revamping medical education was key to reformers' plans for expansion. Interns were to be key figures in the new medical education program. Increasing the numbers and quality of interns (and later residents) would help visiting physicians attend to the growing numbers of patients; interns would largely staff the outpatient clinics and wards; their medical school training would provide visiting staff with exposure to the most up-to-date therapies and diagnostic techniques, and their post-graduate training at Springfield would provide them the experience necessary to become top-notch practitioners. All of this would put the hospital in the good graces of

accreditation authorities, the Springfield community, government agencies, and private insurance companies.

During the war, few doctors had given the time and energy to properly train interns. As a teaching hospital, senior staff were supposed to closely involve interns in their activities, to discusss cases with them, to generally help interns integrate their theoretical training with practical experience. Yet, most doctors refused to be mentors. As before, interns largely unassisted tried to learn their trade on the general wards where the poor and elderly were unlikely to register complaints against what was at best lackluster care.[24]

The word went out on the medical school grapevine in the early forties that an internship at Springfield was a wasted year. Springfield was unable to get enough interns to staff its ward service. As the situation deteriorated, Springfield took virtually any medical school graduate who applied. Some were barely competent, and others were chosen "out of pity and despair."[25]

In the years following the war, many physicians still refused to aid the educational program; they were unwilling to increase the number of autopsies, which would have increased the amount of "material" available for study by house staff. Many physicians devoted only minimal time to ward service or outpatient clinics, leading to further overwork of the house staff. Of those physicians who

grudgingly participated in the educational program, many preferred "didactic conferences," in which interns would simply observe their senior colleagues during patient treatment rather than participating in any meaningful fashion, in order to avoid imposing on senior staff's patients. Meanwhile, in the late forties, interns worked far above the national norm of 120 hours a week and because of understaffing one intern often had to cover an entire ward for months at a time. When they faltered, student nurses were pressed into service for duties they were utterly unprepared for.[26]

Senior staff not only neglected intern training in the war years and immediately afterwards, they also neglected their own post-graduate education. Few attended post-graduate classes, despite Superintendent Walker's entreaties and occasional reminders from some senior staff. Few physicians engaged in ongoing self-education efforts either; the library depended on castoffs and donations, and received paltry grants from the Staff Council of just one hundred dollars a year. Such a pittance reflected the fact that few physicians spent any time there.[27]

Following the war, as before, hospital leaders appealed to the medical staff to fully support the educational program. As before, the requests had little impact. Now, however, sanctions were finally imposed against indifferent and recalcitrant physicians; pressure

from accrediting organizations (especially the AMA which was now under control of specialists and academic physicians) was the precipitating cause here. The limited scope of the education program and the limited involvement of senior staff threatened to jeopardize the hospital's standing and destroy plans for expansion.[28]

In 1951, physicians were informed that henceforth participation in the educational program would be a condition for staff appointment, reappointment and hospital privileges. Furthermore, junior staff were told that if they participated energetically in the education program they could expect rapid promotion; seniority would no longer be decisive in determining a physician's status and clout. Loyal and active younger men could now leapfrog over presumed deadwood in the hospital.[29]

By the mid late fifties, the education program had finally taken root. A full time Director of Education had been appointed and was in clear command. Senior staff were more thoroughly involved in the education program than ever before, holding regular rounds and conferences, and using their private patients to instruct interns. Interns were finally assigned specific operating rooms to guarantee that they would gain experience in surgery. The library was fully funded and amply stocked, and large numbers of physicians attended continuing education programs.[30]

As with the matter of physician involvement in intern education, until the postwar period, the use of anesthesia had been entirely the prerogative of Springfield physicians. The only exception was that gas anesthesia not be given to "anyone under fifteen or any colored person." Aside from this stipulation, anesthesia was not regulated either by the medical staff or hospital superintendent. Hospital officials simply hoped that "eventually" a given anesthesia might be administered in the same way at all times.[31]

The pitfalls of the laisse-faire approach were illustrated in 1943 when two patients died because of improper application of sodium penthathol. In the absence of detailed patient records from Springfield and comparable institutions, it is impossible to determine the circumstances surrounding these deaths. Still, the tragedy and its aftermath is worth noting. Apparently, the case was never investigated by legal authorities and no sanctions were taken against those at fault. Following the incident, senior medical staff members did ask that sodium penthathol be used only in "selected cases," but failed to define what "selected cases" meant or who would then be allowed to apply sodium penthathol. By the late forties, however, with the adoption of a more rigorous regime overseeing physicians, Springfield had established an Anesthesiology department which imposed strict guidelines

to determine physician competency to administer the various types of anesthesia.[32]

Increased oversight of medical practice was also evident in the formation of the Medical Audit Committee in the late forties. The committee was responsible for the thorough and timely compilation and review of all medical records especially those having to do with complications, deaths, infections, and wrong diagnoses.

With comprehensive medical records, and proper regular evaluation of them, physicians, hospital administrators, and accreditation agencies could better gauge the performance and quality of Sprngfield's medical care and problems could be brought to light and corrected.

The Medical Audit Committee was in the vanguard of reformers at Springfield Hospital. Some staff physicians fought the committee's actions at every turn, trying to keep the committee small and powerless; the few who were allowed to serve were overwhelmed by the work. In the early years of its existence, committee members were reduced to sending out letters to physicians, outlining their responsibilities and the expectations of the hospital as far as adequate and complete records were concerned.[33]

Relegated to the most basic accumulation and maintenance of records as far as monitoring doctors was concerned, Committee members walked softly and carried a thin reed. However, once Springfield faced losing its

accreditation over the matter, laggards were told they would lose admitting privileges or be passed over for promotions. They soon fell in line and the committee was able to properly do its job.[34]

Another fracas involving an oversight body occurred in 1952 when Springfield formed a tissue committee to better evaluate surgeon's work and to rate their competence. In response, several doctors-particularly surgeons-called for a combined Tissue and Medical Audit Committee. Surgeons who abhorred more extensive evaluation of their own work reasoned--correctly--that if the Committee had to do both, it would likely do neither well, or by default, it would concentrate on narrow record keeping.[35]

Accreditation authorities eventually entered the fray, insisting that Springfield abide by national standards for evaluation of surgeons. Soon the Tissue Committee was up and running. As in other disputes of the postwar period, some Springfield doctors succeeded in forestalling changes, but were ultimately compelled to implement them, under edict from outside agencies and the efforts of internal reformers.[36]

Most Springfield doctors supported the hospital's restructuring and the expansion of the local health care system in the fifties. Springfield doctors proudly highlighted hospital developments as a model of advances in medicine and surgery, in diagnosis and treatment. However,

physicians were fearful about the consequences of such changes. Springfield physicians felt pressured to adopt methods that at times seemed more akin to a mass production system and worried that they might soon become creatures of "hospital administrative militants" who would render them powerless. Moreover, physicians felt locked in mortal combat with outsiders over the organization, financing, and delivery of health care, and saw that their cherished independence steadily chipped away in a seemingly harebrain maze of regulations, accreditation requirements, and confiscatory arrangements with third party payors. Embattled physicians seethed whenever Blue Cross and other insurers revised its rates and coverage to the detriment of hospitals and physicians and when they read of new state laws restricting various aspects of medical practice. They felt degraded by the increased powers of the state's department of public health and resented the insurers demands for needlessly complex multiforms for claims that only covered half their costs.[37]

Springfield doctors had good reason to believe that the government, the Blues, and the private insurers, were all congenitally incapable of administrating health care in a rational, fair, or productive way. This is why they had favored the growth of private health insurance as the means to avoid government control of the health care system. Little did they realize that what would emerge in the

postwar period would be a maddening hybrid characterized by intrusive bureaucracy, dependency on a host of new outside agencies, increased costs, and unfair rates of compensation for medical services--just what opponents of government control had fought against.[38]

It could be argued that by 1960, Springfield had embarked on a thorough transformation. By insisting that doctors keep accurate records, by requiring them to be seriously committed to the education program, and by establishing means to evaluate physicians' competence, far-sighted doctors, administrators, and trustees fundamentally changed the hospital.

However, events at decade's end indicated that Springfield's restructuring was by no means complete or secure. Operating income failed to match expenses. The major reason was that ward admissions, which had been less than fifteen percent of total admissions in the early 1950s, soared to twenty-five percent by 1959--a striking reversal of earlier trends. Springfield officials reported that increasing health care costs was the reason for the growth in ward admissions, and that elderly patients in particular were less able to afford private health insurance. Many of the new ward patients were unable to pay in full for their care, others were subsidized by government programs that covered a small portion of costs. The hospital had to make hefty charge-offs, totalling

hundreds of thousands of dollars, for bad debts, for free work, and for underpayment from welfare cases. This led to mounting deficits. Revenue from patients who paid out of pocket and third party payors was not enough to make up the shortfall. Springfield could have sharply raised its fees, but chose not to. Apparently administrators feared adverse community reaction, especially after so many other rate increases in recent years. Also, if rates had been increased much more, even more patients would have defaulted on their bills and the hospital would fall into worse straits. As a result, in 1958 and 1959, Springfield faced serious financial problems, and to cover its losses was forced to make abrupt large-scale transfers from its endowment to its operating funds.[39]

As the situation deteriorated, Springfield's plans for further expansion were put on hold; hospital leaders were not sure if there was enough community support for such expansion. This was understandable as in recent years the hospital had not had to gauge community feeling before embarking on building projects, instead relying on government loans for the bulk of construction funds. Hospital officials, previously confident that the apparent benefits of expansion would be enough to win and sustain community support, were no longer so certain. What to do? Administrators and trustees explored the possibility of hiring professional fundraisers.

Hospital expansion had been the major balm for physicians harried by increasing controls on their medical practice. With the financial shortfall, departments like surgery, pediatrics, anesthesiology, and pathology, vied for funds, made appeals to would-be benefactors in annual reports, vented their despair and outrage in letters to high hospital officials, and used brinksmanship--complete with resignations and threats to resign if such and such was not bought, renovated, hired, and so on.[40]

The turmoil in the hospital caused great tensions between the staff and the administration. Under terrible pressure, administration officials were overwhelmed by the hospital's problems. Trustees and medical staff established a committee to try to determine appropriate priorities and organizational structures for the beleaguered institution. As early as 1957, such a committee had been proposed, but had been rejected by medical staff members who feared that the committee would act as a cabal that would encroach on staff prerogatives and overrule the opinion of medical staff. But with the hospital on the verge of disaster, the medical staff approved the proposal for a Joint Conference Committee. Significantly, staff members were apparently influenced--as they had been at so many crucial junctures in that decade--by reports and recommendations from the Hospital Council of the AMA stressing the importance of such committees. One

of the first acts of the committee was to hire an outside consultant to examine the state of the hospital, and to determine the "best methods of providing good and sufficient administration."

The decisions to hire a consulting firm, and to form a Joint Conference Committee, were sensible. Whether these would lead to long-term solutions to Springfield's problems was another matter altogether. It must have been ironic to hospital leaders that the decade of the hospital's greatest expansion, marked by a surge in patients, services, equipment, and personnel, was also the period of the greatest antagonism within the staff, the most ferocious conflicts between staff members and administration, and constant battles between Springfield and government agencies, along with enduring financial strains. Efforts to address these problems would consume the energies of Springfield officials well into the 1960s.

Notes

1. Board Of Trustees minutes, March 17, 1935, November 1938, September 21, 1937, Box 1.03, Baystate Medical Center Collection (herafter referred to as the BMC collection) held at the Connecticut Valley History Museum. See also the Superintendent's reports from the Annual reports for the years 1943 thorugh 1945 (Box 2.02) as well as Inpatient Reports from the Annual Reports from those years. Springfield Union, May 4, 1943.

2. I have tallied the figures gathered in the Annual Reports for these years. Cf. also Springfield Union May 6, 1948.

3. Odin Anderson, Health Services In The U.S.(Ann Arbor, MI.: Health Administration Press, 1985), ch. 3.; Rosemary Stevens, In Sickness And In Wealth (New York, NY.: Basic Books, 1990), pp. 260,426.

4. Daniel Fox, Power And Illness (Los Angeles, CA.: University Of California Press, 1993), p. 72; Richard Carter The Doctor Business (New York, NY.: Putnam Publishers, 1958) pp. 104-105; Stevens op. cit., p. 265.

5. Anderson, op. cit., pp. 124-127, p.146.

6. See E. H. L. Corwin, The American Hospital (New York, NY.: Commonwealth Fund, 1946), ch. 3 for a useful discussion of sources of funding for hospitals in the thirties.

7. Superintendent report for August 1947, Box 2.06, BMC collection; Communing With The Superintendent, July 1947, March 1948; Both Box 2.07, BMC collection. Superintendent's Annual report for 1947, Box 2.02, BMC collection; Senior Medical Staff Report for May 13, 1948, Box 5.08, BMC collection.

8. Superintendent report October 1947, April 1948, Box 2.06, BMC collection; Board Of Trustees, July 1947, April 15, 1947, Box 1.03, BMC collection. Springfield Union, October 1, 1947, May 24, 1946.

9. 1958 Annual report, Business Office, Box 2.03, BMC collection.

10. See Annual Reports for 1947 through 1949, Box 2.02, BMC collection; Executive Committee, Board Of Trustees, June 1948, Box 1.08, BMC colllection.

11. Sheri David With Dignity: The Search For Medicare And Medicaid (Westport, CONN.: Greenwood Press, 1985), ch. 1-2.

12. The Visiting Nurse Association Collection (unprocessed-hereafter referred to as VNA) is held at the Connecticut Valley History Museum. Report of the Executive Director, November 9, 1945, January 18, 1946; February 18, 1949; Board of Directors, October 21, 1955, October 16,1958.

13. VNA Board of Directors report, November 15, 1956. Executive Director's report November 20, 1953, February 1954, May 21, 1954, December 15, 1955, January 21, 1949, September 17, 1948, May 21, 1948, March 18, 1948, November 17, 1950, October 20, 1950, February 20, 1953. All contained in VNA collection. See also articles on the city infirmary, Daily News, January 4, 1949, April 23, 1948, Springfield Daily Union, March 24, 1948.

14. Springfield Union News, March 29,1947, June 18, 1947, February 2, 1948, March 14, 1947, March 21, 1947.

15. Cf for example, Executive Committe of the Board, November 27, 1959, Box 1.08, BMC collection.

16. Cf., for example, the 1958 Annual Report, Business Office, and the Executive Committee of the Board of Trustees, May 1957; Both contained in Box 1.08, BMC collection.

17. Executive Committee of the Board of Trustees, July 15, 1957, August 1956, August 1957, December 16, 1957, September 29, 1958, Box 1.08, BMC collection.

18. I have found helpful the notion of the role of the federal government as passive banker regarding health care planning contained in Edward Berkowitz and Kim Mcquaid Creating The Welfare State (New York, NY.: Praeger, 1988); Eliot Friedson, The Hospital In Modern Society (Glencoe, ILL.: The Free Press, 1963) p. 107; James Cassedy, Medicine In America (Baltimore, MD.: Johns Hopkins Press, 1992) p. 141; See Daniel Fox, Health Policies Health Politics (Princeton, NJ.: Princeton University Press, 1986) pp. 121-131 for discussion of acomplishments and weaknesses of voluntary planning. Duffy, op. cit., p. 340.

19. Board of Trustees April 20, 1948, Box 1.03, BMC collection; Superintendent report March 1947, Box 2.06, BMC collection; Superintendent report in the 1947 Annual Report, Box 2.02, BMC collection.

20. Rosemary Stevens, American Medicine And The Public Interest (New Haven, CONN.: Yale University Press, 1971) p. 276-283; Stevens, op. cit., pp. 239-249; T. R. Ponton Medical Staff In The Hospital (Chicago, ILL.: Physicians Record Company, 1955) p.10; Gladys Harrison, Control Of Medical Appointments In Voluntary Non-Profit Hospitals (Chicago, ILL.: American Hospital Association, 1963); Friedson, op. cit., pp. 126-128; Grace Budrys, Planning For The Nation's Health New York, NY.: Greenwood Press, 1986) p. 24; Temple Burling, Give And Take In Hospitals (New York, NY.: Putnam's And Sons, 1956)

21. Superintendent report, March 1946, Box 2.06, BMC collection; Staff Council Report, January 1947, Box 5.07, BMC collection.

22. Hampden Hippocrat, April 1943 (unprocessed), Springfield At Home And Abroad, April 1943, July 1943. May 1945, November 1943, March 1945, March 1944, June 1946, Baystate Collection, Box 2.10, BMC collection; Communing With The Superintendent, June 1946, Box 2.07, BMC collection.

23. My interviews with three longtime Springfield physicians, Joseph Hahn, Alan Johnson, and Louis Izenstein were essential in excavating this information. (interview tapes and notes are in the possession of the author).

24. Board of Trustees January 18, 1944, Box 1.03, BMC collection; Springfield At Home And Abroad, November 1943, Box 2.10, BMC collection; Senior Staff Minutes, April 1, 1943, Box 5.01, BMC collection.

25. Intern Committee Report, January 1939, February 16, 1939, January 4, 1940, April 1, 1943, Box 2.06, BMC collection; Medical Staff Council, February 5, 1939, Senior Medical Staff, November 7, 1940, Box 5.01, BMC collection.

26. Communing With The Superintendent, December 1951, Box 2.07, BMC collection; Senior Medical Staff, November 9, 1950; Outpatient Committee Annual report for 1950, Box 5.08, BMC collection.

27. Superintendent Report, November 13, 1941, September 9, 1943, October 14, 1943, September 1954, Box 2.06, BMC collection; Staff Council, January 4, 1940, February 6, 1945. Library Committee report, Summer 1942; Executive Committee, Board of Trustees, February 24, 1958, Box 1.08, BMC collection. John McGibony, Principles Of Hospital Administration (New York, NY.: G.P. Putnam's Sons, 1952), p.115.

28. Executive Committee, Board of Trustees, November 24, 1958, August 20, 1959, Box 1.08, BMC collection.

29. Board on Staff Appointments, January 1949, 1951 annual report on Staff Appointments, Box 2.02, BMC collection; Communing With The Superintendent, September 1950, Box 2.07, BMC collection; Medical Education annual report for 1958, Box 2.03, BMC collection.

30. Physician In Chief, Annual Report for 1954, Medical Education Annual report for 1955, both Box 2.02, BMC collection; Executive Committee, Board of Trustees, Janaury 1957, April 1956, Box 1.08, BMC collection; Executive Committee, Medical Staff, April 12, 1956, May 3, 1956, August 2, 1956, September 6, 1956, January 3, 1957; Springfield Union, June 7, 1958. Correspondance, Dr. Theodore Miner to Dr. Memery, August 28, 1958; Committee on Surgery, January 11, 1951; Communing With The Superintendent, March 1952, Box 2.07, BMC collection; Surgery Department Annual report for 1950, Medical Education Annual report for 1950, Box 2.02, BMC colection; Senior Medical Staff, March 18, 1948, September 1947, Box 5.07, BMC collection; Superintendent report, July 1946, June 12, 1947, Box 2.06, BMC collection.

31. Staff Council, January 4, 1940; Senior Staff, April 1935; Senior Medical Staff, November 7,1940, both Box 5.07, BMC collection.

32. Staff Council, September 2, 1943, July 1945, Box 5.07; Superintendent Annual report for 1943, Box 2.06, BMC collection.

33. Medical Audit Committee, April 12, 1953, Medical Audit Annual report for 1951. Both are contained in Box 5.08, BMC collection.

34. Executive Committee, Medical Staff, March 1953, February 5, 1953, September 2, 1954, September 1,1954, August 25, 1955, Box 5.08, BMC collection.

35. Executive Committee, Medical Staff, April 12, 1952, Box 5.08, BMC collection; Communing With The Superintendent, March 1953, Box 2.07, BMC collection.

36. Executive Committee, Medical Staff, May 7, 1953, December 3, 1953, Box 5.07, BMC collection.

37. Hampden Hippocrat, March 1958, January 1958, Winter 1953, Winter 1956, June 1957, Winter 1950, June 1958, Spring 1956, April 1957, Summer 1956.

38. Superintendent report, August 1947, Box 2.06, BMC collection.

39. Executive Committee, Board of Trustees, January 20, 1958, March 24, 1958, March 2, 1959, Box 1.08, BMC collection.

40. See letter from Surgeon In-Chief To the Board of Trustees, October 26, 1959, letter from William Lawrence, Chair of the trustees to Dr, Louis Izenstein, Physician-In-Chief November 3, 1959, and letter from Izenstein in response November 16,1959, Box 5.01, BMC collection.

CHAPTER 5

SPRINGFIELD HOSPITAL 1960-1980

By 1960, due to overcrowding, antiquated equipment, and staff shortages, Springfield's functioning sank to almost code blue status. Pathologists were unable to perform basic duties because of contamination in their makeshift space; laboratory personnel, due to abysmal conditions, could no longer conduct accurate or reproducible test procedures; due to substandard nursing care, patients were developing infections and complications. The most basic amenities and sanitary measures were neglected; one enraged physician reported that his patient's linen hadn't been changed in four days. Close to half of physicians took their patients to other area hospitals, and some openly spoke of switching hospital allegiances. The pressure and problems took their toll on the administration. In 1960 alone, the Comptroller, the Nursing Supervisor, the Nursing Director, the Assistant Executive Director, and the Executive Director all quit.[1]

The crisis in the nursing staff was particularly acute. Large numbers of resignations steadily cut nursing ranks. This posed a double threat to Springfield; due to the nursing shortage--only half as many nurses were employed as were needed--entire floors had to be closed, costing the hospital thousands of dollars per month.

Moreover, the nursing shortage foreclosed any possibility of future expansion.[2]

By the winter of 1962, Springfield's medical advisory board reported that the Hospital no longer met its obligations, either to staff or to patients, and was on the brink of disaster. Some months later, a senior staff member reported, "many patients are going to other hospitals. They are losing confidence in Springfield: they feel the hospital and physicians cannot be depended on. [Springfield's] public image continues to deteriorate...."[3]

Nonetheless, Springfield Hospital survived the crisis. It did so by accelerating its development into a regional medical center and thereby expanding its scope of medical services, widening its patient base and substantially boosting its revenues. It also forged closer ties with medical schools in Boston and Albany, and with Boston hospitals. Private organizations and government agencies, like the National Institutes of Health, the Dexter and the Ford Foundations, and the U.S. Department of Health, Education, and Welfare, all provided seed money for new programs ranging from cardiac surgery to cancer research.[4]

The financial problems of the early sixties dissipated by mid-decade. Construction of new facilities drew new inpatient admissions as did the growth of special services.

The most important factor, however, in Springfield's improved fortunes was the introduction in 1966 of Medicare and Medicaid, government supported health care programs for millions of the poor, the elderly, and the disabled. These programs were the center-piece of the Johnson administrations's social welfare reforms. Federal budget outlays for health services alone tripled from 1965 to 1970: the major portion of the monies went to Medicare and, to a lesser extent, to Medicaid. The programs helped to dramatically reduce infant mortality and to increase the life expectancy of the elderly; they also narrowed the disparity between the poor and the middle classes and between blacks and whites with respect to health care access and health status generally. According to James Patterson, the safety net created by these programs helped cause a 50% drop in poverty rates between 1959 and 1974.[5]

Medicare and Medicaid enabled Springfield Hospital to increase its patient admissions but more importantly to sharply reduce its charity work (in 1966 alone, free work declined 15%). By 1967, as the result of government largess and Springfield's expanded operations, Springfeld's Finance Committee declared that the hospital's finances were stable and predictable; financial reports, which for years had been an occasion of much hand-wringing, now happily detailed Springfield's rosy curcumstances. So confident were the administrators about the hospital's

fiscal health that financial meetings were convened monthly instead of weekly, and employees were given ample increases in pensions, salaries, and other benefits.[6]

By 1968, Springfield's achievements in teaching, research, and comprehensive patient care had made it the dominant health care institution in Western Massachusetts; Trustees changed its name to Springfield Hospital Medical Center (and then to the Medical Center of Western Massachusetts) to register the fact.[7]

Springfield's development into a medical center proved controversial among the medical staff. Many Springfield physicians realized that primary care slipped to secondary importance in comparison to specialty care, that the lion's share of monies, of administrative posts, and of expansion projects were devoted to specialty services, and that specialty care was increasingly the focal point of Springfield's education program. Primary care physicians bristled at administrative actions that favored specialists in admitting privileges, in appointments, and in determining Springfield's general development.[8]

In the sixties and early seventies, in debates about staffing, about community services, about hospital programs, and other matters, advocates of primary care criticized Springfield's priorities. Primary care physicians argued that Springfield should devote more

resources to chronic rather than just acute care; they questioned the need and cost of special services like kidney transplant centers and elaborate cardiac surgery programs given the growing body of elderly chronic patients in the Springfield area. Hospital officials responded that chronic patients were not their appropriate purview and could simply be cared for in nursing homes, that they didn't need hospital care and most importantly were taking beds needed by acute patients who not incidentally usually had higher reimbursement rates. Hospital officials also believed that the surge in the numbers of chronic patients was a very temporary phenomenon and so were generally uninterested in building facilities for chronic patients.[9]

Various state agencies also pressured Springfield to modify its emphasis on acute care, persuading Springfield to open clinics and other facilities to combat alcoholism and drug addiction, and to offer health centers for the unemployed. Unfortunately, state agencies' interest in such projects was usually fleeting and episodic, and often not backed up by funds to help defray the costs of the clinics.[10]

Sometimes, grassroots efforts impelled Springfield to take action. In 1968, a coalition of community activists, University of Massachusetts Nursing and Public Health students, and some sympathetic Springfield physicians

established a clinic at a local housing project. While Springfield officials publicly supported the clinic, most hospital leaders viewed it as a distraction from their "real' mission of acute care, arguing that the clinic was trying to address social problems that were not Springfield's responsibility. Consequently, Springfield allotted just token monies for the clinic; without adequate funding, it soon ceased to provide adequate medical care and became a screening facility.[11]

In the early sixties, spurred by federal agencies and supported by the Citizens Action Committee, (a group of businessmen and professionals--the self-styled "real leaders" of Springfield who gathered regularly for lunches at a local insurance company to discuss worthy projects), a study was made of Springfield's health needs. Committee members visited all the health care facilities in Springfield; they met with the principal administrators and leading physicians, and gathered information about Springfield's health care problems. They discovered a serious "disjuncture between hospitals and the community" and "a serious lack of planning betwen the two," asserting that area hospitals neglected consideration of community needs in their planning and expansion ventures. Committee members urged that local hospitals undertake voluntary cooperative planning--conscious that compulsory measures would have been rejected by the parties involved as

unreasonable interference in hospital affairs. After all, the last thing anyone wanted was hospitals "run comparable to utilities and so subject to red tape." When the study was concluded, its chair explained that the committee's findings were not "to be smiled at and put on a shelf.... The idea is to get citizens to see the need and take action."[12]

One result of the Committee's work was the formation, in 1966, of the Connecticut Valley Health Planning Council (CVHPC) whose mission was to target unmet health care needs, to devise programs to meet them, and to help reduce duplication of services and to promote maximum economies. CVHPC was one of scores of such councils estblished nationally during the sixties as a voluntary venture between local hospitals and physicians and state and federal authorities. Springfield leaders initially welcomed the creation of the CVHPC. They thought it would help to forestall more intrusive government involvement; they assumed that Springfield would be the key player in the Council thus enshrining its own leadership, leading to greater public support for its projects, and resulting in additional funds for its programs.[13]

In its early years, the Council had a budget of less than twenty-thousand dollars, its operating funds donated by local hospitals, and a small staff of hospital administrators assigned on a rotating basis. Despite

Springfield's intentions, it failed to dominate the council; instead, Springfield settled for a tacit understanding with the other participating hospitals that the Council would impose few restraints on any hospital's expansion plans. Discussions focused far more on holding the line on nurses' salaries or joint purchase of supplies than on area hospitals' various building projects or on addressing community health care problems.[14]

Springfield officials proclaimed in their annual reports that all had access to its services and would be properly attended to. But, in fact, non-acute care occupied a marginal place in Springfield medical care. Senior physicians and residents avoided service in clinics and out-patient departments, in the emergency ward, and in preventive and primary care medicine generally. An evaluation committee in 1966 reported that patient care was variable at best and poor in the emergency ward and outpatient departments. Both emergency services and outpatient clinics were growing rapidly and served an important community need. Indeed, a survey determined that that one-half of recent clinic patients had had no previous medical contact of any kind. Despite these facts, few physicians or administrators took the departments seriously and at decade's end, ambulatory services still lacked departmental status and continued as an adjunct to other departments. Efforts to persuade major departments to

shoulder more responsibility for these services met with resounding failure through the decade.[15]

For concerned physicians, the emergency ward was a particular blight on the hospital. According to one concerned physician, instead of being operated by physicians "intimately familiar with and concerned for and understanding of the medical, social, and economic problems involved," the emergency ward was a place older physicians spent "their golden years quietly, with hours and times they deem necessary, with no standard operating procedures, or operating manual or fee standard or new innovations, or effort to add other physicians." No matter; administrators and senior medical staff were not overly concerned.[16]

Some medical staff members tried to buck the prevailing priorities of medical practice then current at Springfield. In 1969, for example, a leader in the pediatric department while stating his choice for the new director of the department called for upgrading and giving priority to ambulatory services "As we are a community hospital, we....require an individual who is interested in diverse aspects of pediatric care--and not a superspecialist."[17]

While primary care advocates had occasional victories, most were relegated to second class status at Springfield. There was, for example, little room for general practitioners--literally. They were generally excluded

from hospital privileges in the early sixties. Later, they were allowed to have "some role" but this was left undefined and they had no discernible influence on policy making. In 1971, some residents tried to enhance the role of primary care by calling for a family residency program. Their request was rebuffed; senior staff explained that Springfield lacked enough general practitioners on staff (no surprise since they had been made unwelcome for the previous decade) and did not have "sufficient facilities" for the practice of community medicine. In 1974, another call was made for a family practice department. The Physician-In-Chief brushed aside this request as well, stating that Springfield had many other more important priorities.[18]

The Joint Conference Committee and numerous advisory boards tried without success to bridge the differences between medical center supporters and those who wanted Springfield to remain a community hospital. Unable to agree on Springfield's priorities or purposes or long-term plans, Committee members stuck to bromides about the importance of education, of better medical care, of the value of new services, and so on. Such palaver deepened physicians' sense of frustration about Springfield's current state.[19]

By 1972 the Joint Conference Committee was practically moribund, its members still unable--after years of

meetings--to agree on Springfield's basic goals or philosophy, and admitting that, given the divisions among Committee members, it was "difficult to draw firm conclusions on the future of the Springfield Hospital Medical Center."[20]

Many Springfield personnel believed that growth could solve many of the problems facing the hospital, that with sufficient monies there would be room for all services and programs. The problem as in years past was that the state and federal government grew less and less able or willing to subsidize Springfield's endless expansion; it consistently underpaid Springfield's total costs and paid late at that. Springfield went to court to recoup government debts dating back in some instances nearly ten years. By the end of the sixties, Springfield was "losing" one-half million dollars a year on medicare rates alone and thousands more on welfare reimbursements which led them to sharply raise rates for their other patients adversely affecting public support for hospital projects. Hospital officials realized they could not long continue in such circumstances. Due to the cash shortage, administrators postponed buying equipment, scaled back various projects, floated bonds to raise monies for some programs, and finally met with the governor to plead Springfield's case for more funds.[21]

Physicians and administrators alike had assumed that operating revenues would take care of all expansion needs. However, by the end of the decade, with severe revenue shortfalls, this was no longer possible; as was the case in the late fifties, each department turned against the rest, all clamoring for their rightful share. Surgeons described their demands as "musts...we are already too far behind." Pathologists said that their facilities were taxed to the limit; others spoke of shortages as nearing the danger point and of staff turnover as vaulting to fifty percent a year. Each department trooped forth to board meetings--hat-in-hand--to explain their duties and acomplishments, and to press for their needs.[22]

Competition was particularly ferocious over bed allocation. The Medical Department Chair in 1969 described the existing arrangement as "disgraceful," charging that patients were being admitted to the emergency ward who should not have been "on the whim of the doctor or social status of the patient and not on the diagnosis or severity of illness and needs of the institution," while other patients were discharged who were not fit to leave.[23]

By the end of the sixties, Springfield was once again coming apart. Conditions were again unsafe or unacceptable, the staff again poorly trained, overworked, and unable to provide timely or basic care to patients, and equipment again constantly breaking down. In surveys,

patients expressed dismay at Springfield's dismal state and dissatisfaction with their medical care.[24]

Springfield's difficulties in the early seventies were compounded by actions of the local Planning Council. The building spree of Springfield and other hospitals had caused increasing consternation of local businessmen and politicians and even of some physicians, all of whom clamored for cost-cutting. Their views dovetailed with public opinion in Springfield and nationally and also reflected an important shift in government health care policy.

For all their achievements, Medicare and Medicaid had also created havoc within the health care system. With no effort to monitor hospital or physician charges, the programs issued, in effect, a blank check to providers and consumers alike igniting steep hikes in health care costs; with provisions for payment for construction and new services as part of their charges, the programs accelerated the purchase of high cost and low utilization equipment; with inadequate coverage and lower payments for primary, preventative, and chronic care, the programs helped strenthen a Medical Center model of health care at the expense of meeting basic community services.[25]

The continuing problems of access, quality, and costs created disillusionment about the efficacy of government efforts to improve health care and led many to wonder if

the country could afford the expense of providing health care to its citizens. While the U.S. health care system seemed to careen out of control, other western industrial countries had controlled costs and provided more health care coverage through tighter government oversight of the system. The U.S., in the early seventies, began to do likewise.[26]

The federal and state governments which had earlier stressed minimal interference in the workings of the health care system proceeded to severely clamp down on health care providers and consumers. It raised eligibility requirements, reduced coverage, and increased deductibles for Medicare and Medicaid (in the process formally abandoning the goal, oft stated since the mid-sixties, of offering all Americans comprehensive health care). It cut reimbursements for both doctors and hospitals; it instituted tighter surveillance of doctors' services, of patient admissions, of patients' length of stay, and of their treatment. State agencies were given the power to approve (or reject) hospital expansion projects or major purchases. Federal agencies were given the power to deny Medicare or Medicaid funding to hospital plans that failed to win state approval.[27]

Before the early seventies, the Planning Council, like its 200 plus counterparts across the country, had let each hospital go its own way regarding planning. It had served

simply as an advisory body without any clear plan how to structure the area's health care system, and had no means to implement its very limited proposals or to enforce its occasional recommendations. However, thanks to increased federal funding the Council ceased to be the creature of the local hospital establishment. Moreover, federal legislation mandating representation of consumer interests on Council Boards resulted in a more interventionist Council. The Council tried to improve area health care delivery by insisting on increased primary care services. And having gained the power to deny hospitals government reimbursement it finally had the clout neccessary to begin to reshape the health care system.

The Council restricted or rejected what it viewed as unnecessary, inappropriate, or prohibitively expensive hospital projects. In 1971, for the first time ever, the Council insisted that Springfield reduce the scope and cost of its current expansion program. Even more distressing to hospital officials, Council investigators demanded to know, also for the first time, just how Springfield's plans fit in with those of the city's other major hospital--Wesson Memorial.[28]

Compared to Springfield, Wesson had always had a more "low tech" primary care approach. Established as a homeopathic institution in 1906 nearly 20 years after Springfield's founding, Wesson Memorial never had had the

financial resources or inclination to match Springfield's facilities. Wesson's bread and butter was routine medical and surgical care: broken bones, hysterectomies, gall bladder surgery, and the like. The hospital had fewer specialists, fewer beds, and a smaller staff than Springfield and virtually no educational program in the sixties and seventies. For all these reasons, Wesson's operating budget was much smaller than Springfield's and its income more closely matched its expenses. Community fund drives were usually sufficient to make up deficits and Wesson's expansion was usually for the purpose of establishing more bed space rather than to purchase expensive equipment.

Wesson's doctors had their own brand of professionalism that emphasized patient contact over research, and eschewed the sort of fragmented medical care so prevalent at Springfield and other hospitals throughout the country. Wesson largely ceded the field to Springfield for the most advanced acute care; and where special services were concerned Wesson concentrated on ambulatory care such as the emergency ward, and the orthopedics and rehabilitation departments.[29]

In some respects, Wesson was more successful than Springfield. With a far more homogenous staff than Springfield, Wesson's physicians had fewer conflicts with one another. Moreover, the staff's values more closely

paralelled Wesson's day to day operations and so there was fewer conflict between physicians and administrators. Most importantly, Wesson better met the basic health needs of Springfield's residents and as a result enjoyed a better public image, and more community support for its expansion plans.

While Springfield was mired in severe problems, Wesson's popularity was such through this period that it became a direct threat to Springfield for patient dollars and public support. However, Wesson's decision to aggressively poach on what had been Springfield's turf was also due to financial pressures. In general, Wesson had enjoyed greater financial stability than Springfield through much of the sixties. However, it too relied more and more on Medicaid and Medicare as a principal source of income; it too suffered from what it felt was measly compensation and tardy payments from government agencies for indigent and elderly patients. Revenue shortfalls finally caused Wesson to modify its emphasis on primary care in favor of specialty services which offered the promise of higher reimbursables from both government programs and private insurance plans.[30]

Wesson and Springfield furiously competed with one another for state and private backing for their respective programs. Wesson, for example, much to Springfield's alarm, nominated itself as the region's heart, cancer, and

stroke center under the auspices of the federal government. Springfield derided Wesson's proposal, asserting that Wesson's staff was not up to the job, and argued that Wesson's real aim was to help boost her building program and get increased funding and public support. There was likely much truth to Springfield's claim but the same could well have been said of Springfield itself during this period. The Council counseled that the two institutions plan and apply together for the program. Springfield officials were queasy though about working with Wesson, worried that cooperation might give the upstart more credit than they deserved and raise Wesson's image even higher in the public eye at Springfield's expense. However, Springfield leaders feared that if they did not join with Wesson, Wesson might accrue all the credit to itself. The result seems to have been luke warm participation in Springfield's cooperation regarding a Regional Medical Program. For both hospitals, cooperation was a matter of convenience not of conviction and had no apparent impact at the time on either hospital's building or expansion plans.

In 1970, the state Department Of Public Health named Wesson as Western Massachusett's radiotheraphy center. Outraged Springfield officials sputtered that Wesson had no expertise in the field but could do nothing to reverse the decision. When Wesson later decided to order a new piece of expensive equipment, a cobalt 60 unit, Springfield

officials sharply criticized Wesson for fixating on one particular tool in the arsenal of anti-cancer agents. Still, Springfield doctors did refer patients to Wesson for use of that equipment and Springfield obtained one themselves just as soon as they could. Whatever its economy or praticality, keeping up with the jones was essential.

Physicians of each institution were in the vanguard of the inter-hospital contest to the chagrin of neutral observers like Dr. John Ayres, Director of the city's small chronic care hospital, and a leader of the district medical society. "Each hospital medical staff," he said, "zealously guards, support, and seeks to enlarge its own privileges, prerogatives, and status...for its mother institution. Can sectarianism which is prevalent throughout entire hospital programs be overcome?....Can the staff of separate hospitals be drawn together for the common good?" He thought not, and warned Springfield's and Wesson's partisans "medical planning will continue to be done by non-medical groups and rightly so long as we remain divided and fractionated."[31]

Writing in the district medical society bulletin, physicians urged that the two institutions unite to fight against cancer and endorsed regional hospital planning to this end. They encouraged Wesson and Springfield to form an oncology group for joint purchases to "reveal to

accusers and friends that doctors are interested in patients and community welfare." Neither hospital seriously considered their proposal. In 1971, Springfield officials were hopeful the Council would approve their contruction projects over Wesson's, convinced that Wesson was duplicating their own programs and were in any event inferior. They were stunned when word came from the Planning Council that Springfield's proposed additions were deemed too expensive, unnecessary, and economically wasteful. The Council ordered Springfield to resubmit its plans and to redesign the project, causing Springfield to drastically scale down its expansion plans. Springfield no longer could freely expand its facilities hamstrung by the planning council, and Wesson's opposition.[32]

In 1973, the Planning Council continued pushing the two hospitals to work together, and tried to get them to merge their cancer programs without much success. In 1974 the two did begin to create a tumor registry, and collaborated on some educational ventures, but that was the extent of their coooperation. There was no accommodation between the two where construction, equipment, and personnel were concerned.[33]

In 1974, both hospitals wanted expensive new cancer treatment equipment. The Council declared that for either to do so, they would have to increase cooperation in cancer management. The two hospitals duly fashioned a new

committee composed of Jimmy Fund executives, trustees, physicians, administrators, officials of Monarch Life Insurance Company and others. But cooperation along the lines of joint services and planning never materialized. Each hospital was determined to go its own way and not be bound by any outside committee. Springfield, for its part, launched a public relations campaign highlighting its medical center stature and arguing that it, and it alone, should rightfully acquire the equipment.[34]

Neither Springfield's nor Wesson's medical staff could rectify the multiple problems facing the two hospitals. In 1974, an editorial writer in the district medical society journal reported that the Planning Council had discovered a pattern of excess, a duplication of efforts, and a deficiency in both hospitals' personnel and functioning. He argued that these might be addressed if physicians were more involved and cooperative. Unfortunately, he explained, local physicians were too divided within their own medical staffs---not to mention with their rivals across town--to tackle the problems facing the two institutions.[35]

The conflict between Wesson and Springfield culminated in early 1975 when both filed proposals with the Planning Council to purchase cobalt 60 machines at a cost of one million dollars each, and presented competing construction plans totalling close to forty million dollars.

Springfield leaders feared that, "the public will not stand for two competing proposals, each appearing to be identical." And indeed that was the Council's reaction. Springfield's plans were blocked by Wesson's own bid.[36]

Springfield's problems were compounded by extreme financial problems. For more than three years, its general surplus had been swallowed up by shortfalls. The major culprit was Medicaid and Medicare whose debts jumped from two million in 1973 to close to ten million in 1975.[37]

The winter of 1975 was comparable to the financial emergency of fifteen years earlier; trustees again anxiously pored over the figures on accounts receivable. By spring, debts were increasing at a rate of two hundred thousand dollars a month, and three million six hundred thousand dollars had been borrowed to keep Springfield functioning. Furthermore, Springfield officials worried that the four million five hundred thousand dollars owed by Medicare might never be paid, and they were also informed that the state had ordered a freeze on increases for hospital rates.[38]

Springfield officials fired off a letter to state legislators, explaining that the institution could not operate without financial stability, that freezing one sector of the health care field was simplistic and counterproductive. They warned that to do so would cause

Springfield to delay or cancel the repair and replacement of needed equipment, and cancel crucial projects. Hospital officials urged the state to shoulder its rightful share of the burden of health care costs by paying its back debts and henceforth providing reasonable renumeration for hospital services. State officials ignored Springfield's appeals.[39]

By the spring of 1975, Springfield was close to running out of funds. The freeze on charges made it impossible to raise operating revenue; deficits continued to mount and worsened that summer, triggering severe cuts in hospital services. In July, Springfield and Wesson trustees conferred in hopes of reducing the antagonism between the two institutions. A few weeks later, following secret trustee negotiations, Springfield's Executive Director Harry Gifford was informed during a round of golf that Wesson and Springfield would soon merge.

The decision to merge the institutions was a bold step. It was an attempt by local business and political leaders to impose greater order and planning on the area's health care system. They hoped that the merger would result in greater economies, in improved services, in better patient care, in easier access to government monies, and in the reduction of unnecessary construction.[40]

The merger creating the Baystate Medical Center stirred considerable opposition from physicians from the former

Medical Center of Western Massachusetts and from Wesson Memorial Hospital. Partly, this stemmed from the outrage of medical staff towards trustees who had unilaterally decided something of great consequence to local physicians. The trustee's actions reenforced physicians' general belief that they were no longer in control of their destiny, that their views no longer determined hospital affairs. Moreover, physicians were dismayed and outraged that the trustees could in almost cavalier fashion join together two hospitals with vastly different resources, operations, medical cultures, priorities, facilities, and bylaws and that had competed with one another in a variety of services and programs.

Meshing the two institutions was a formidable and lengthy task. Many Wesson staff felt that their smaller community hospital was being cannibalized by the larger richer neighbor, and that the lion's share of the new hospital's budget would go to provide the most sophisticated technology at the expense of community needs. For their part, many from the former Medical Center of Western Massachusetts felt that their hospital would deteriorate in quality by incorporating Wesson Memorial whose medical staff and facilties they found inferior.

A series of task forces were created which then met regularly from 1976 to 1979 yet were unable to agree on a clear set of policies. An outside consultant was then

called in to try to recommend solutions to the many problems bedeviling the institution--many of which had earlier divided Springfield twenty years before when a consultant had been previously hired. The existing conflicts between a community hospital orientation and a medical center approach, between private practitioners and salaried personnel, between specialists and primary care physicians, and between specialists were now joined by the clash between two different medical staffs.

The combined medical staff fought among themselves for control of Baystate's resources. The medical staff fought over whether there should remain two separate hospital facilities and whether specific services should be integrated at one or the other institution. The administration and trustees having no overall plan only added to the frustration and low morale of physicians.

In the late 70s, continuing government reductions in payments for Medicare and Medicaid patients compounded Baystate's problems. This caused a surge of debt that increased by sixty percent in a few years and led to a growing deficit for five years. In response, Baystate increased its rates yearly from thirteen to more than twenty two percent, about double the national yearly rate of inflation, which was passed onto private insurers and their customers in the form of higher premiums. Such financal

problems forced Baystate to raid its endowment and depreciation funds for operating revenue.

In 1980, Baystate was not demonstrably better off than five years earlier. In fact, the hospital was suffering physician defections to other local hospitals, and was plagued by deficiencies in patient care, its medical programs frozen because of problems of finance and administration.

Notes

1. Letter from members of the Surgery Department to Dr. Louis Izenstein, Physician-In-Chief, July 29, 1960, contained in Baystate Medical Center Collection on deposit at the Connecticut Valley Historical Museum (hereafter the BMC Collection), Box 5.02; Letter from Dr. Howard P. Kennedy to Louis Izenstein, January 18, 1960, Box 5.02, BMC collection; Letter from Dr. Joseph Hahn to Louis Izenstein, April 19, 1960, Box 5.02, BMC collection; Springfield Union, August 4, 1960, November 3, 1960.

2. Springfield News, August 7, 1962; Springfield Daily News, May 15, 1961; Executive Committee Medical Staff (ECMS), May 11, 1961, June 8, 1961, December 21, 1961, June 15, 1962, Box 5.02; Letter from Fred Fuller (trustee) to Trustees Executive Committee (TEC) report, June 8, 1961, Box 1.08, BMC collection; Trustees Executive Committee report, December 28, 1961, Box 1.08, BMC collection; Trustees Subcommittee of Medical Advisory Board, September 25, 1961, January 20, 1962, Box 1.08, BMC collection; Letter from Dr. Scola to Dr. Louis Izenstein, October 3, 1962, Box 5.02, BMC collection.

3. TEC report, April 30, 1962, May 27, 1962, Box 1.08, BMC collection.

4. Springfield Republican, July 26, 1961, December 1, 1968, May 15, 1968, March 31, 1968, May 10, 1964; Springfield Union, August 17, 1961, November 20, 1964; Springfield News, June 12, 1964; Springfield Daily News, August 17, 1966, September 15, 1966.

5. Standard accounts found in: Rosemary Stevens, In Sickness And In Wealth (New York, NY.: Basic Books, 1990), ch.11; Paul Starr, Social Transformation Of American Medicine (New York, NY.: Basic Books, 1982), pp.363-378. Stats found in James Pattterson, America's Struggle Against Poverty (Cambridge, MA.: Harvard University Press, 1994), pp. 57-185.

6. TEC report, February 25, 1963, April 29, 1963, October 28, 1963, December 20, 1963, April 27, 1964, October 26, 1964, January 28, 1965, February 24, 1965, March 25, 1965, May 27, 1965, July 26, 1965, September 30, 1965, October 25, 1965, December 27, 1965, January 27, 1966, September 29, 1966, all in Box 1.09, BMC collection.

7. TEC report, April 30, 1968, April 25, 1966, May 25, 1967, November 29, 1965, January 23, 1967, March 19, 1968, March 30, 1970, October 27, 1970, March 27, 1969, January 23, 1967, August 29, 1972, November 17, 1967, Box 1.09, BMC

Collection; Springfield Daily News, January 25, 1969; MSEC report, January 7, 1969, Box 5.04, BMC Collection.

8. This schism is illustrated throughout the records of the period. Cf. notes below.

9. TEC report, January 23, 1967, January 27, 1967, February 27, 1968, April 30, 1968, Box 1.09, BMC collection.

10. TEC report, September 30, 1965, May 25, 1967, Box 1.09, BMC collection.

11. TEC report, September 26, 1968, February 23, 1970, Boxes 1.09, BMC collection; Outpatient Department Annual report for 1969, Box 5.04, BMC Collection.

12. Springfield Area Health Study, June 10, 1964, July 22, 1964, August 26, 1964, all contained in Putnam Collection, Series 3, Box 40; Springfield Republican, June 10, 1964.

13. I have concluded this from my survey of the Board records from the respective hospitals in this period. Cf. Box 1.11, BMC collection and Box 1.21, BMC collection.

14. The relevant records from the Planning Council are contained (or were originally!) in Boxes 29 and 44 of the Western Massachusetts Health Planning Council collection (herafter referred to as WMHPC) stored at the University Of Massachusetts Dubois Library archives. News accounts of Springfield's public relations effprts are contained in scrapbooks in the BMC collection as well as in issues of the Hospital's inhouse organ Intercom.

15. MSEC report, January 5, 1963, Box 5.02, BMC collection; MSEC report, November 4, 1965, 1965 Medical Staff Annual Report, Box 5.03, BMC collection; Emergency Ward report, April 12, 1967; Emergency meeting of Emergency Ward committee, June 30, 1967; Ambulatory Service report for 1969, Box 5.04; TEC report, February 20, 1970, Box 1.10, BMC collection; MSEC report, February 17, 1967, July 6, 1967; Dr. Adham to Medical Staff, October 6, 1966, both Box 5.04, BMC collection.

6. Ambulatory Services report, July 6, 1970, Box 5.05, BMC collection.

17. Letter from Dr. Morris Medalie to Dr. Derrick, Chief of Medical Staff, March 21, 1969, Box 5.04, BMC collection.

18. Letter from Medical Care Committee to Trustees, December 24, 1973, Box 5.06, BMC collection; Medical

Education Committee, September 9, 1971, February 8, 1972, Box 5.05, BMC collection; MSEC report, January 8, 1974, Box 5.06, BMC collection.

19. Trustees Building Committee, May 25, 1967, Box 1.09, BMC collection; Physician-In-Chief 1966 Annual Report, Box 5.03, BMC collection; Letter from Dr. Grover to Dr. Hartshorn, March 27, 1967, Box 5.03, BMC collection; TEC report, May 25, 1967, September 28, 1967, Box 1.09, BMC collection; Joint Conference Committee report Jamuary 10, 1968, Box 1.09, BMC collection.

20. Joint Conference Committee, Goals Committee report, February 23, 1972, March 30, 1972, Box 1.14, BMC collection; TEC report, October 22, 1972, Box 1.10, BMC collection.

21. TEC report, May 25, 1967, October 24, 1966, Septembr 28, 1967, February 27, 1968, Aptil 30, 1968, June 25, 1968, March 28, 1968, October 29, 1968, December 17, 1968, Box 1.09, BMC collection; TEC report, February 24, 1969, April 29, 1969, May 28, 1970, August 25, 1970, May 27, 1971, January 29, 1972, April 27, 1971, Box 1.10, BMC collection.

22. Letter from Dr. Dinale to Dr. Derrick, July 16, 1968, Box 5.04, BMC collection; Letter from Dr. Medalie to Dr. Derrick June 28, 1968, Box 5.04, BMC collection; TEC report, October 24, 1972, Box 1.10, BMC collection; Radiology Department report August 29, 1969; MSEC report, January 26, 1970, Box 5.05, BMC collection.

23. Letter to MSEC from Dr. William Kaufman, April 9, 1969, Box 5.04, BMC collection.

24. Patient Evaluation Committee report, February 24, 1971, September 16, 1971, Box 5.05, BMC collection; Letter from Patient Evaluation Committee to MSEC, October 1, 1969, November 2, 1971, Box 5.05, BMC collection..

25. I have found the following helpful here: Joseph Califano, America's Health Care Revolution (New York, NY.: Random House, 1986), ch. 3; David Mechanic, A Right To Health (New York, NY.: John Wily & Sons, 1976), ch. 1,7; Irving J. Lewis, The Sick Citadel (Cambridge, MA.: Oelgeschlager, Gunn, & Hain, Publishers, Inc., 1983); Richard M. Magraw, Ferment In Medicine (Philadelphia, PA.: W. B. Saunders Company, 1966), ch. 9-11,12; William G. Rothstein, American Medical Schools And The Practice Of Medicine (New York, NY.: Oxford University Press, 1987), ch. 16-18; Rosemary Stevens, American Medicine And The Public Interest (New Haven, CT.: Yale University Press, 1971); Daniel Fox, Power And Illness (Los Angeles, CA.:

University of California Press, 1993); Barbara Ehrenreich, American Health Empire (New York, NY.: Vintage Press, 1971), pp.95-191; Frank Campion, The AMA And U.S. Health Policy (Chicago, ILL.: Chicago Review Press, 1984,) ch. 15-18.

26. Odin Anderson, Health Services In The U.S. (Ann Arbor, MI.: Health Administration Press, 1985), pp. 179-219 provides a useful overview. Cf also William Shonick, Government And Health Services, 1930-1980 (New York, NY.: Oxford University Press, 1995), ch.15.

27. Cf. Theodore Marmor, Political Analysis And American Medical Care (New York, NY.: Cambridge University Press, 1983), ch. 4-5; Robert Alford, Health Care Politics (Chicago, Ill.: 1975).

28. TEC report, October 27, 1971, November 23, 1971, Box 1.10, BMC collection.

29. Wesson Memorial Trustees (WMT) report, June 27, 1963, December 24, 1964, January 1965, July 29, 1967, Box 1.21, November 19, 1968, Box 1.22, BMC collection; Wesson Memorial Executive Committee (WMEC) Trustees report, April 29, 1971, Box 1.22, BMC collection.

30. WMT Planning Committee report, September 24, 1970, April 1, 1971, November 16, 1973, Box 1.22, BMC collection; Joint Conference Committee, May 17, 1970, October 28, 1971, March 30, 1972, Box 1.22, BMC collection; WMT report, July 29, 1967, June 30, 1968, March 26, 1970, April 27, 1972, Box 1.22, BMC collection; WEC trustees report, March 21, 1968, Box 1.21, BMC collection; WEC trustees report, June 18, 1969, February 28, 1973, Box 1.22, BMC collection.

31. John Ayres, "A Credible Umbrella", Hampden Hippocrat, April 1972.

32. Springfield Republican, June 13, 1971; ECMS report, June 6, 1972, June 27, 1972, Box 5.05, BMC collection.

33. MSEC report, September 4, 1973, January 8, 1974, December 3, 1974, Box 5.06, BMC collection.

34. TEC report, February 24, 1974, May 22, 1975, Box 5.06; Connecticut Valley Joint Planning Council, September 23, 1974, Box 29?. These documents are part of the Western Massachusetts Health Planning Council Collection held at the University Of Massachusetts at Amherst Library archives. Trustees Community Affair Committee report, February 25, 1975, Box 1.11, BMC collection.

35. "Getting It All Together," January 1974, Hampden Hippocrat.

36. MSEC report, February 11, 1975, July 11, 1975; TEC report, February 25, 1975, May 22, 1975, July 24, 1975. Box 1.11, BMC collection.

37. Letter from Executive Director Gifford to Representative Scibelli, October 25, 1973; TEC report, February 24, 1974, Box 1.11; Trustees Finance Committee report, December 19, 1974, Box 1.12, BMC collection.

38. TEC report, February 27, 1975, April 18, 1975, May 22, 1975, May 27, 1975, Box 1.11, BMC collection.

39. TEC report, May 25, 1975, Box 1.11, BMC collection.

40. Trustees Medical Care Committee, May 22, 1975, Box 1.12, BMC collection; TEC report, July 24, 1975, Box 1.11, BMC collection; Interview with Mr. Gifford, August 9, 1989. Tape in posession of author.

CHAPTER 6

CONCLUSION

Twentieth century private hospitals are usually depicted as gleaming palaces of medical science that emphasized specialty care and technical services to the middle classes who mostly populated them. Charity patients were but a small factor in their operations; Government monies, aside from occasional subsidies--notably provided by the Hill-Burton Congressional Act in the 1940s and Medicare in the 1960s--were not much of a factor in private hospitals' development. Such hospitals generally operated on a stable financial footing which enabled them to enjoy steady and mostly painless expansion of their physical plant and programs and personnel. The staffs of up-to-date physicians--consumate professionals--together formed a tightly knit medical community. The staff's behavior and beliefs closely paralelled that of their representative national professional bodies--particularly the AMA. Hospital physicians had a generally amicable partnership with administrators. And administrators and physicians alike enjoyed tight ties to the surrounding community in the form of ample contributions and widespread volunteer aid.

Springfield's history provides a startling counter example to the usual story of private hospitals. Springfield was a surprisingly grubby, chaotic, and

contentious institution throughout its history. Physicians especially were torn by personnel rivalries, town-gown conflicts, ethnic hostility, antagonisms between specialists and generalists, and they fought nearly continuously with administrators, trustees, and outsiders.

Professionalism of physicians as demonstrated by community service--namely through attending to Springfield's poorer patients--was sorely lacking throughout Springfield's history. Professionalism as shown by physician self-regulation to ensure high quality medical practice also came remarkably late to Springfield. In general, professionalism meant one thing above all--autonomy--and autonomy enabled many physicians to evade their responsibilities to provide the best care to patients and to generally improve the hospital.

There was an enormous gap between the standards of modern medicine and the actual norms and practice of many local physicians. The vaunted AMA and other kindred groups generally did not have much impact in the day to day affairs of Springfield for most of its history. Moreover, numerous edicts from professional groups were widely ignored until the late 1950s. When Springfield's physicians finally did consent to broader standards, and relinquished some measure of autonomy, they did so not from some internalized sense of professional propriety but because their continued affiliation with Springfield

Hospital was at stake. Their hospital privileges were jeopardized by the forceful actions of outside regulators like government bodies, accrediting organizations, and national professional groups.

Caring for charity patients was central and not tangential to Springfield's history. The numbers of those seeking treatment without the means to pay was a major factor causing crowding and deterioration of Springfield's services. The surge of charity patients necessitated Springfield's expansion while the deficits caused by uncompensated care made it difficult to do so, all made long term planning nearly impossible. Government aid for the poor was both bane and boon to Springfield--boon because it provided something in the way of payment for the poor but also bane because more often than not, such payments failed to cover the actual costs of care. contributing to chronic fiscal instabilities.

Springfield faced perennial problems because of its unsteady mix of public and private revenues. A large portion of its patient base could not afford medical care. The number of patients varied depending on the state of the local economy, the availability of reasonably priced insurance, the demographics of the area, the range of diseases prevalent and the expense of Springfield's services. All told, at any given time, perhaps thirty percent of patients were not paying their full cost of

care. The dilemma facing Springfield Hospital throughout its history was how to balance the hospital's bottom line considerations with the needs of charity patients. Many charity patients either did not get care or got it belatedly, or had to employ cajolery or subterfuge to get treated. When they received care, it tended to be of a lower quality than that received by private patients.

Pressure from charity patients and their advocates prevented their being turned away altogether. However, the medical treatment they received was of lower quality than that obtained by paying patients. While charity care did improve as it did for all patients, and charity care gradually more closely approximated that received by the well to do, provision for proper health care for charity patients was granted only grudgingly throughout this period.

Some non-medical personnel like social workers, volunteers, representatives of charitable groups, along with long-time outsiders like junior medical staff, outpatient staff, and Jewish physicians, did have a broader view of appropriate medical care and the responsibilites of physicians to the larger community. However, their proposals were blocked for years and sometimes even decades. Reformers at Springfield were stymied until they gained the support of outside professional and governmental agencies, until the broader medical culture favored their

views, or until there was widespread feeling in the community that the hospital was in a crisis that demanded immediate action.

Charity care taxed and destabilized Springfield Hospital in a variety of ways. Private patients paid more for their charges or insurance premiums to cover some portion of the costs of charity patients. When monies were available for expansion, hospital priorities--namely the search for maximium revenues--dictated that Springfield concentrate on specialized in-patient services for private patients. Emphasizing these services helped spur Springfield's development into a major medical center and also led administrators and physicians to neglect important health care problems facing Springfield's citizens--especially those having to do with primary and chronic care.

Springfield's transformation into a medical center was its most ambitious effort to grow itself out of its problems--financial difficulties above all. The problem it faced in the 70s was that government, employers, and insurers were increasingly resistant to paying for the higher costs associated with open ended growth.

Springfield Hospital strained for nearly a century to deliver high quality care to all at an affordable cost. The difficulties Springfield and other private hospitals experienced in trying to do so were the natural result of a

seriously flawed health care system, characterized by the autonomy of doctors, a fee for service payment system, thousands of individual institutions competing for their share of the health care market, the existance of a large number of persons unable to pay for their own care, efforts at cost shifting between hospitals and government agencies, from employers to insurers to patients, and the absence of significant social planning of hospital priorities.

(<u>Baystate Medical Center HMO Study Committee Final Report</u> November 20, 1980).

> "The question of HMOs...in many ways represents the core of many of our current healthcare questions. Cost is a major factor in today's healthcare world, and HMOs represent a significant possibility...for containment. Competition is a key word in today's healthcare world and HMOs represent competition--not only to each other and to traditional insurance plans but to the very heart of the life flow of most hospitals--their inpatient days. The questions of regulatory control and depth of government involvement in the health care arena in many ways focus on HMOs... with some saying that HMOs represent the last opportunities for the health care field to develop programs outside direct government control."

Medical historians have seriously misread the history of hospitals in the twentieth century. Partly as a result, they have been caught flatfooted when it comes to discussing contemporary developments. Who among them writing in the 1980s anticipated the explosive rise of Health Maintenance Organizations (HMOs)? Wedded to the notion that the US health care system was a johnny-come-lately to a "normal" health care system, ie. one with overarching government involvement--they either foresaw

growing government regulation or else expected that hospitals and physicians would join forces and embark on all sorts of novel proft-making ventures--from chains of emergicenters to dialysis facilities, but that otherwise the system would pretty much straggle along as it had. With a reflexive skepticism about the ability of the market to meet America's health care needs, none of them anticipated the enormous growth of hybrid health care organizations combining financing and the delivery of health services. Because they overestimated the strength of doctors and hospitals through the century, they assumed that these providers would torpedo efforts at meaningful reform. Medical historians writing in the 1980s recognized that the era of government and private insurers funding massive expansion of hospitals--funding which had also sustained providers' power--had passed. Yet, none of them anticipated that large employers and insurers and government would, by creating and supporting HMOs, utterly usurp providers' dominance in healthcare. HMOs have begun to dethrone the medical center model emphasizing acute inpatient care in favor of primary and preventative services. Furthermore, by installing primary care physicians as a major gatekeeper for patient services, HMOs have begun to restore primary care physicians to the center of medical practice.

It could well be argued that HMO's are a much needed improvement on the existing system bringing some measure of rationality and order to healthcare. Certainly, Springfield's experience suggests that individual hospitals or even hospitals as a group would not change much without being forced to as the result of powerful outside organizations like HMOs. And while available records for the period since 1980 are scanty and sketchy, they do indicate that Baystate Medical Center made an early and significant accommodation to HMOs. Baystate wisely chose to market itself to HMOs and reshaped its services to some extent to gain HMO support and customers. By doing so, Baystate expanded and diversified its facilities which made it more financially solvent, partly by reducing inpatient costs and partly by securing a steady stream of private patients to offset the large numbers of charity patients.

Though Baystate's experience suggests that HMOs might be good for individual hospitals, it remains to be seen whether the current system of managed care under HMOs can adequately reconstruct the nation's healthcare system. As Theodore Marmor in Understanding Health Care Reform, Philip Lee in The Nation's Health, Eli Ginzberg in Critical Issues In U.S. Health Reform and others point out, HMOs success is predicated on physician's compliance with cost control incentives. It is not at all clear whether physicians might evade these, or assuming that physicians comply,

whether doing so will lead to not just a reduction in costs but in the quality of care, or whether the cost of micromanagement will undermine savings to the system as a whole.

The sort of rule making characteristic of HMOs is unheard of in those countries where global budgets for operating and capital expenditures determine allocations of hospital programs, and services are determined at the provincial or federal level. What's more, quality in such regimes seems to be on par with our own. But in lieu of such a system being established here, perhaps this sort of rule making is a necessary step especially given American physicians well deserved reputation for technological imperatives. Lastly, and most importantly, even if costs are reduced, there is no guarantee that the savings will be used to ensure expanded access to care for the millions presently without it or to ensure that that their care is adequate.

Just as the specialized medical center model seemed invincible and permanent, yet lasted just a brief span of time, so it is unlikely that HMOs in their current incarnation will be the last reform of the healthcare system. It may be that the public's opposition to increased taxes or another big government program might be reduced if citizens lose heart in HMOs. It may be that physicians who have always seen big government as their

biggest bugaboo will turn against HMOs for reducing their salaries, depriving them of decision-making powers, adding to their paperwork, and making them employees of large corporations. Clearly, the reshaping of the healthcare system will preoccupy physicians, policy-makers, and ordinary citizens for years to come.

APPENDICES

A. THE GROWTH OF SPRINGFIELD HOSPITAL

YEAR	PATIENTS ADMITTED	EMPLOYEES	PHYSICIANS
1890	163	8	13
1900	487	18	24
1910	2,150	55	37
1920	3,911	99	50
1930	4,583	128	107
1940	6,270	156	122
1950	8,357	305	146
1960	13,000	898	207
1970	13,100	2,000	450
1980	39,700	3,800	1,000

B. THE DEVELOPMENT OF SPRINGFIELD HOSPITALS

YEAR	NAME	TYPE	FOCUS
1889	Springfield	non-denominational, private	general medical care
1898	Mercy	Catholic, private	general medical care
1906	Wesson Maternity	non-denominational, private	obstetrics
1906	Wesson Memorial	non-demoninational, private	general medical care
1948	Springfield Municipal	public	chronic illness & elderly care

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