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THE MUNICIPAL HOSPITAL SYSTEM IN TRANSITION

The Anniversary Discourse

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THE title of this presentation implies that changes are occurring in the New York City municipal hospitals, and indeed they are. Since the municipal hospitals are such an important segment of the health service resources of the community, it is timely to report to an audience such as this.

For those who may not be familiar with the administrative structure of the Department, the four essential elements are the Commissioner and his staff; the Board of Hospitals; the Advisory Council of Medical Boards; and the individual hospital administrators, medical boards, staffs and their vast array of services, training programs and research activities. The Commissioner is appointed by the Mayor and reports to him. The Board of Hospitals is appointed by the Mayor and is the policy-making arm of the Department. The members of the Advisory Council of Medical Boards are elected by the medical boards of each institution. Except for those institutions where contractual arrangements with uni-

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versities or voluntary hospitals provide otherwise, all medical staff nominations, promotions, elections and time extensions must be confirmed by the Commissioner before they become final.

Few people realize the scope and type of responsibilities of the Commissioner and the Board of Hospitals, as defined in the City Charter. The main points are quoted here as background for the discussion of current events which is the main theme at this meeting:

"The commissioner shall have all the powers and duties of the department except those vested by law in the board of hospitals."

"The department shall:

1. Maintain and operate all hospitals, sanatoria, almshouses or other institutions of the city for the care of sick, injured, aged or infirm persons, except as otherwise provided by law, and shall have charge and control of the ambulance service provided by the city and, except as otherwise provided by law, over any psychopathic service for the examination, observation and treatment of persons and any other service maintained by the city for the care of sick, injured, aged or infirm persons as may be assigned to the department or the commissioner by law.

2. Visit, inspect and license in the discretion of the commissioner all private proprietary institutions where human beings are receiving or may receive medical attention and/or nursing care and/or custodial supervision, including private proprietary hospitals, sanatoria, nursing homes, convalescent homes, homes for the aged or for chronic patients, unless such institutions are non-profit corporations incorporated by special act of the legislature or under the general laws of this state or are maintained or operated by such corporations or are duly licensed under the provisions of the mental hygiene law or of section two thousand five hundred twenty of the public health law. Any such institution shall be subject to the jurisdiction of the department as provided in this subdivision, notwithstanding such institutions may also be subject to the inspection, supervision and regulation of the state department of social welfare. A license issued under this subdivision shall expire one year from the date of issuance thereof, unless, in the discretion of the commissioner, it shall be sooner revoked, and may be renewed. The Board of Hospitals, notwithstanding any other provision of law, is hereby authorized to promulgate and include in the hospital code necessary rules and regulations to carry out the purposes of this subdivision to protect the public health and welfare, which shall, before the same becomes effective, be filed with the city clerk and published in the City Record for three days and shall thereafter have the force and effect of law. The establishment and/or maintenance of any such institution without a license therefore as in this subdivision provided shall be a misdemeanor punishable by a fine not to exceed five hundred dollars, or by imprisonment for a period not exceeding one year or by both."

"The board of hospitals shall have the power and duty to:

1. Develop and maintain long range programs of hospital service for the

care of sick, injured, aged and infirm persons who are the responsibility of the department.

2. Establish and promote the highest possible standards for the care of sick, injured, aged and infirm persons to be complied with by institutions under the jurisdiction of or subject to licensing by the department and by institutions which care for any such persons at the expense of the city.

3. Develop, establish and promote standards and methods for increasing the efficiency of operation, maintenance and management of facilities for the care of sick, injured, aged and infirm persons in institutions under the jurisdiction of the department.

4. Approve the capital and expense budget estimates of the department before submission to the appropriate city agencies.

5. Review, within its discretion, any action of the commissioner with respect to the revocation of a license."

"The board of hospitals is hereby authorized and empowered to promulgate a hospital code and from time to time to add to and to alter, amend, or repeal any part of such code. Such hospital code shall consist of such rules and regulations, not inconsistent with the constitution or the laws of this state or with this charter, as may be necessary to carry out the powers and duties vested by law in the department of hospitals and the board of hospitals."

"The board of hospitals may embrace in the hospital code all matters and subjects to which the power and authority of the department extends."

The charter also establishes the Advisory Council, the medical staffs and boards, and the medical house officers.

"There shall be in the department an advisory council consisting of one representative from the medical board of each hospital, or other institution under the jurisdiction of the department, who shall be chosen by such medical board, and seven members appointed by the mayor, who may or may not be physicians.

The advisory council shall advise the commissioner in respect to all matters submitted by him and may on its own initiative recommend to the commissioner such changes of administration in the department or in any hospital or institution or service under the jurisdiction of the department as may seem to it advisable."

"There shall be a medical staff for each hospital or institution under the jurisdiction of the department. The medical staff shall be appointed by the commissioner and shall consist of such number of attending and consulting physicians as he may determine. The medical staff of each hospital or institution shall organize and appoint a medical board of such hospital or institution, subject to such general rules as the commissioner may prescribe.

Staff appointments may be terminated at any time by the commissioner after consultation with the medical board of the hospital or institution affected, and a vacancy in any staff or board may be filled by the commissioner after like consultation.

Members of the medical staff who are serving on the in-service of a hospital as part-time clinicians shall serve without compensation for any service in the wards of the hospital, except that they may accept medical fees for services rendered by them to patients under the provisions of the workmen's compensation law, or from patients who carry sickness or accident insurance which covers physicians' fees, or from persons who recover damages from cases in tort, as provided in the regulations made by the commissioner.

The commissioner may appoint medical house officers for any hospital or institution under the jurisdiction of the department on the nomination of the medical board of such hospital or institution, and may remove any such medical house officer after giving him an opportunity to be heard."

The medical board of each hospital or institution under the jurisdiction of the department, in conjunction with the superintendent or other head thereof, shall propose regulations to govern the medical procedure therein which, when adopted by the commissioner, shall be observed and enforced by the superintendent or other head of such hospital or institution."

The Department coordinates its work with other departments or agencies through the Interdepartmental Health Council made up of the Commissioners of Health, Mental Health Services, Welfare and Hospitals. The Council has a full-time executive secretary, working subcommittees and advisory committees.

Since Bellevue Hospital originally began as a six-bed infirmary in 1736, the various hospital services have gone through two and one-quarter centuries of development, expansion, change, progress, deterioration, reorganization and improvement. Certainly, the current situation is one of the more dynamic moments in medical history in New York City. Never has there been greater public and administrative awareness of the need for change. Never has the Department received so much help and encouragement in so short a time as during 1961. Nor is there any reason to believe that this favorable climate will not continue. The Mayor's platform not only covers this Department well, but orders have been issued since the recent elections to press ahead with implementation. Knowing that this is so places a great responsibility on the professions and the Department to make wise long-range decisions in the best interests of the community.

It should be kept in mind that the discussion concerns 22 institutions with about 19,000 beds; a current operating budget of about 180 million dollars; a personnel roster, exclusive of house staff and student nurses totaling about 35,000 people; a direct service load of about 275,000 admissions, 2,600,000 clinic visits and 400,000 ambulance trips

a year. The average daily home care census is about 2,100 patients. The psychiatric services at Bellevue and Kings County Hospitals admit as many patients each year as the 27 state mental hospitals. The Department collected through insurance, direct payments from individuals and agencies and from other sources about $52,000,000 in 1961. In addition, the Department certifies City charge patients in voluntary hospitals to the Comptroller for payment for care from the Charitable Institutions Budget. For 1960, such payments probably exceeded 40 million dollars. Such staggering figures are a sobering influence in overall community planning. Our voluntary hospital system is on the thin edge of solvency and the uncontrolled proprietary hospital building boom may push certain of these voluntary hospitals into bankruptcy and force governmental assumption of more responsibility through direct service or more subsidy. It is just because of such considerations that the Hospital Council has made its recent recommendations about the various ways in which municipal and voluntary hospitals can and should work together for reinforcement and better service to the community.

Little has been said so far about standards of care, yet this is the writer's main concern—not only in certain of the municipal hospitals, but in many proprietary institutions licensed by the Department, and in certain voluntary hospitals in which City charge patients are certified for care at public expense.

A convenient starting point for review of the changing scene is the appointment by Mayor Wagner of his Commission On Health Services early in 1959. This group of 40 laymen, professionals and public officials was given broad authority to review the health services of the City and to recommend action. The Commission had staff, an executive committee, and advisory committees. The executive committee met about 35 times, the full commission six times; there were many other meetings of working groups with advisory committees; a medical audit was conducted in a sample of proprietary nursing homes. Regardless of statements to the contrary, the commission never issued a press release or public statement of any kind. It did file a confidential report with the Mayor, who released it intact to the press within two days. The main focus of attention was on the deteriorating situation in the unaffiliated municipal hospitals; problems of house staff recruitment for some; problems of loss of approval of training programs; problems of per-

sonnel, maintenance, and coordination of services for all. Serious shortages of house staff were predicted as a result of the examinations given by the Educational Council for Foreign Medical Graduates (ECFMG). The Commission recommended full-time directors of services; affiliations financed by the City; closing or converting to other uses certain institutions; and various other steps to improve the overall situation.

Mayor Wagner assigned the Commission's report to the City Administrator's Office for follow-through in the fall of 1960. A number of positive actions were taken in the next several months. The Board of Hospitals rescinded the "grandfather clause" under which certain nursing homes with less than adequate physical facilities had been licensed, and plans were drawn up in the Department for a directorship program. In January of 1961 some of the Commission's predictions came true in a most dramatic way. As a result of failing the ECFMG examination, a substantial number of house staff physicians at the Harlem Hospital were restricted to non-patient care activities. This action came at a time when, due to weather conditions, a high accident rate prevailed in a community which normally makes extensive use of emergency room services. The result was an acute manpower crisis and an extremely distressful patient care situation developed. Let us hope that there will never be another. In a city as rich in resources as New York, injured people should not have to sit on benches for lack of stretchers; should not have fractures left unset for five days for lack of physicians; should not lie on stretchers on the floor for lack of beds—yet all this and much more occurred in those painful days a year ago, largely due to insufficient physicians and technicians.

Urgent measures were instituted at Harlem to increase coverage of the emergency room. The administration, looking to the future, supported the Rappleye Plan for installing full-time directors of service in unaffiliated municipal hospitals. The attacks on this proposal are a matter of public record and need not be recounted here, except to say that some of the vested interest issues are still with us. Nevertheless, the Board of Estimate took action in providing funds early in 1961, which the Mayor augmented in his 1961-1962 expense budget and for the first time in the history of New York City, the Department of Hospitals was ready to move on a basis of money in hand to realistically finance direct appointments or affiliations. Much credit is due my predecessor, Dr. Morris A. Jacobs, and Dr. Willard Rappleye, member of the Board

of Hospitals, for their leadership in this new venture.

Early in 1961, Mayor Wagner also appointed a Task Force to further expedite necessary changes. The Task Force is a smaller group than the Commission and has larger representation from the local governmental units essential to progress. The Task Force meets twice a month, has consultants, reviews problems and recommendations, and acts accordingly. As a mechanism for bringing together department heads, key members of the Mayor's cabinet, laymen and professionals interested in health services, the Task Force serves a very useful purpose.

When the writer became Commissioner of Hospitals on an interim basis on March 1 of 1961, he was assured of strong support by the Mayor, who simultaneously announced a program of action he wanted to have implemented. The events of the past ten months speak for themselves and are a credit to the Mayor's determination to get the medical and hospital problems in New York City squared away. His recent announcement of the writer's reappointment again affirmed his strong support and the cooperation of those key elements in governmental progress—the City Administrator, the Budget Director and the Personnel Director, all of whom have been exceedingly helpful.

The critical problems facing the Department in March of 1961 had been illuminated by its annual reports, the Visiting Committee of the United Hospital Fund, the Commission on Health Services, minutes of the medical boards of the various hospitals, inspection reports of the State Department of Social Welfare, and special reports and studies of various interested agencies.

The number one problem, of course, was an adequate supply of physicians in the unaffiliated hospitals. Seven of the municipal hospitals are manned by universities and the public is fortunate that this is so. This group, on an overall basis, has relatively few medical manpower problems. The remaining 15 hospitals have been experiencing varying degrees of difficulty in maintaining adequate numbers of attending staff and/or house staff. New York, which was once the largest center on which young physicians converged from all over the world for training in both municipal and voluntary hospitals, now must compete against a national network of approved graduate training centers in the face of a relative shortage of national and foreign graduates to fill the available openings. Not a single American-trained intern has been recruited by

an unaffiliated municipal hospital through the matching plan for several years. However, the Department does not hold the view that all of its institutions must be manned by interns and residents, no matter what their background. In the writer's opinion, the so-called house staff shortage for the average hospital in America is a myth; patient needs should be met by the attending staff taking turns being on duty or by physicians with adequate training, paid to be house physicians.

New York City's problems have been compounded by the large number of institutions it operates. No other city has gone so far in making municipal hospitals so available so close to local communities. It is paradoxical, in the face of so much effort to provide service, that the forces of history were eroding standards of care. At any rate, it is quite clear that New York City should not build any more unaffiliated municipal hospitals, and that the present system needs reorganization in the interests of improved patient care.

Certain steps have been and are being taken by the Department to deal with the medical manpower problem.

First, the Mayor made $1,200,000 available beginning last May 1, to employ part-time physicians for ward service. Each unaffiliated hospital was authorized to recruit as many as necessary. Coney Island, Fordham and Harlem appointed between 40 and 65 each. Altogether, more than 250 were employed in the entire system. As a result, only one department in one hospital was forced to stop admissions for a few days in July. At least three hospitals are now served entirely by voluntary and paid attending staff without any attempt at maintaining an intern and resident training program. Since it is a policy of the Board of Hospitals that such physicians must have completed an approved residency training program, it is not surprising that comments have been made about the sudden improvement in patient care.

In hospitals where qualified physicians, interns and residents are working in the same ward, each hospital is experimenting with its own method of administering the program. The Advisory Council of Medical Boards has been asked to evaluate the various schemes.

Looking ahead to the next training year, certain hospitals which are still unaffiliated but attempting to maintain a house staff training program are exhibiting what is now regarded in the Department as the first symptom of a fatal organizational disease. Not only will they have no interns, but recruitment to the first year residency in medicine and

pediatrics is not at the level of previous years. There is no difficulty in recruiting residents for surgery or in obstetrics and gynecology, although few are graduates of American medical schools. While we have an international obligation, a real question can be raised as to whether we discharge it in a satisfactory manner by maintaining intern and residency programs rejected by graduates of our own medical schools. This appears to be an unintentional form of segregation.

Within the past few weeks one director of a major service in an important but unaffiliated hospital has advised the Department that he expects to have no house staff next year and has submitted a table of organization for full-time and part-time specialists to man the service 24 hours a day. This positive approach unmarred by false pride is refreshing and will receive the whole-hearted support of the Department. It can be anticipated that more of this type of coverage will be required.

A second approach to reducing house staff requirements has been to close or change the functions of certain hospitals. The Gouverneur Hospital on the lower East Side of Manhattan was the first to close its in-patient service. An obsolescent plant, loss of affiliation, loss of residency approvals and loss of accreditation, together with staffing problems raised serious questions as to the wisdom of maintaining the in-patient services. After intensive study by a panel of consultants and a decision by the medical board not to go on, the in-patient services were closed. However, the clinics, emergency room, home care and ambulance services are essential in the area because of its cultural and economic characteristics. The Department and the writer are deeply grateful to the Beth Israel Hospital for assuming the responsibility for these services on a contractual basis for a three-year period. The residents of the area are fortunate in this guaranteed arrangement whereby all services will be rendered by qualified specialists and by residents in approved training programs under a full-time director who has been appointed by Beth Israel to supervise the services which began on December 1, 1961. We shall have cooperative services with the Health Department and the entire approach to comprehensive local care carefully integrated with good general hospitals offers an interesting opportunity to assess total care needs. Almost nine months have passed since Gouverneur was closed. It is reassuring to note that there is no lack of hospital beds to serve the people on the lower East Side. Yesterday morning Bellevue Hospital had 579 empty general care beds, Beekman Downtown Hos-

pital 17 empty ward beds, and Beth Israel 61 empty ward beds, to name only three of several hospitals serving the area. Furthermore, Beekman Downtown Hospital is planning an expansion program to double its present size.

Another facility where changes have been in the making is Sea View Hospital. A monument to progress in the control of tuberculosis, Sea View today is a collection of old empty buildings together with one excellent facility and supporting services. The hospital has been combined with Farm Colony into the Sea View Hospital and Home and admits chronically ill and nursing home type patients. Medical care is provided by a substantial team of qualified specialists, largely from Staten Island. Somewhat similar changes are under way at Goldwater Memorial Hospital where an outstanding "homestead" care demonstration has been going on under the auspices of Dr. Howard Rusk and his associates. It is planned to expand this type of care. The writer considers Fordham Hospital to be on probation and will assess its progress periodically.

On another note, several activities are concerned with other changes in the services for which the Department or other departments making up the Interdepartmental Health Council are responsible. For many years the Health Department has been involved in standard-setting activities under the crippled children program, the medical rehabilitation program, the maternity and newborn program, etc. More recently, the Interdepartmental Health Council has had an advisory committee on amputee services which has recommended thirteen institutions as the first to be designated as approved amputee services. All amputees who are Welfare or City charge patients and who can be expected to benefit by fitting of prosthetics, and by rehabilitation and training are to be referred as soon as possible to such approved services. Further, the Department of Hospitals will require patients subject to elective amputation to be transferred to these centers unless they are being cared for in surgical or orthopedic services fully approved for residency training. This program which was announced this week by Commissioner Baumgartner has as its sole aim better patient care. It is accompanied by a new procedure whereby the approved amputee service can write prescriptions for prosthetic devices which can be secured from any of several manufacturers and with less delay.

A new program is now under study by a committee of distinguished

neurosurgeons augmented by the disciplines of orthopedics and of physical medicine and rehabilitation. The mission of this group is to develop criteria for approved neurosurgical services or centers and an emergency consultation program on a city-wide basis.

Such developments, while obviously in the best interests of patient care, will affect medical staff attitudes and training programs in hospitals not designated as approved centers. Considerable sophistication and a willingness to develop rotating residencies will be necessary to the long-range success of such programs.

Finally, but not least important, the Department, with the help of the United Hospital Fund and the Greater New York Hospital Association, has been developing cooperative relationships between municipal hospitals and their neighboring voluntary institutions to assure a community-wide patient admission program utilizing, through daily communication, the ward services of voluntary and municipal institutions in each area of the city where peak census problems may occur.

A third and very rewarding approach to improving certain municipal hospitals has been through new affiliations or associations with strong teaching voluntary hospitals or universities. This route assures those municipal hospitals fortunate enough to have such assistance of either complete staffing at all levels, or of individual departmental staffing, or of rebuilding for the future as a training center.

Examples and implications of the recent developments in linking certain municipal hospitals and certain voluntary hospitals or universities together are worth summarizing here.

The affiliation for staffing of a total institution which is most advanced is based on the pending contract between the City and Montefiore Hospital for Morrisania Hospital. Salaried directors and supporting staff will supervise the care of patients and direct the house staff on rotation from Montefiore. The medical boards and administrators of the two hospitals have proceeded in a most cooperative way to implement the merger. In addition, funds have been allocated in the capital budget for replacing the present Morrisania facility, relocated at Montefiore.

New affiliations at the departmental level are exemplified by the pediatric service at the Lincoln Hospital which for the past few years has been directed and partially staffed by the Department of Pediatrics of Albert Einstein Medical College. This affiliation has now been put on

a contract basis with a substantial increase in funds made available for the next training year. Contracts for coverage of two additional services at Delafield by Columbia University were arranged last spring. Throughout the city there have been additional offers of help for individual departments in almost every general hospital.

More recently, Mt. Sinai Hospital agreed to accept responsibility for the staffing of Greenpoint Hospital. This outstanding service to the community comes at a time when the hospital's plight is desperate. There are no interns and no medical or pediatric residents. The facility is only partially opened, yet it is a completely renovated building situated in a community with great need for municipal hospital service. The first five directors or assistant directors were nominated by Mt. Sinai and confirmed by the Dean's Committee within the past three weeks. Additional attending and house staff are being recruited and the hospital should be fully in use by July 1st.

Several other discussions or actual contract negotiations toward affiliation are under way but enough has been said here to illustrate what is happening. It is worthwhile to point out a few reality factors in these new developments. First, the affiliations are financed by the City through contracts which are periodically renegotiated. Second, they bring assurance of better patient care on a continuing basis. Third, the residency training programs of the parent institution are enriched by access to more patients. Fourth, the medical boards and staffs of the municipal institutions are strengthened. Fifth, the potential is created for conversion of some ward beds in the voluntary hospitals to semi-private and private care status. Since the affiliations which are developing are with the strongest teaching hospitals in the city, they automatically also are with those hospitals suffering acute shortages of beds for paying patients. New York City does not need more general care beds but has a disproportionate number of ward beds. For example, today there are about 3,000 empty beds in the municipal hospitals, and many additional empty ward beds in the voluntary hospitals. Since ward beds are a threat to the financial solvency of some voluntary hospitals, any shift of training costs to a tax base through an affiliation automatically strengthens the survival potential of the voluntary hospital system. Naturally, standards have to be observed and these are either written into contracts or assured by the requirement of the Board of Hospitals, Civil Service and the Bureau of the Budget that any director or assistant

director appointed directly under the Rappleye Plan must be endorsed by the Dean's Committee which serves in an advisory capacity to the Commissioner.

It is interesting to note that every unaffiliated general hospital has by now requested that from two to eight major departments be staffed by full-time directors and assistants. All want full-time coverage in pathology and radiology; some want one or more clinical services fully or partially covered; and at Harlem the maximum coverage is being developed.

Harlem Hospital and Columbia University with some of its affiliated hospitals are working together in a different way. A joint committee of Columbia faculty and Harlem Hospital medical board members consider potential candidates for departmental directors and assistant directors. Full-time directors of Surgery and of Anesthesiology have been appointed already, as well as a few assistant directors. Columbia faculty members have reviewed and advised on the plans for the new Harlem Hospital. Residents and some attending staff members from Harlem are going to the Medical Center regularly to participate in rounds, conferences, seminars, etc. Certain individual departments at the medical centers are developing their own working relationships with their counterpart departments at Harlem, and a few residents and consultants have been assigned to Harlem Hospital already. The long range potential for community service, training and research at Harlem is unlimited. The City Administartion is grateful for this invaluable assistance from Columbia.

Turning briefly to the capital construction program of the Department, the most significant items of interest are that plans for the new Bellevue and Harlem Hospitals are proceeding smoothly; Cumberland is being renovated and expanded, Kings County is being surveyed as to its total needs, a 200-bed psychiatric unit is being planned for Metropolitan Hospital, and a new Morrisania will be relocated at Montefiore. An additional 700 replacement beds are earmarked for the Bronx and will perpetuate the names of Fordham and Lincoln. However, until a decision is reached as to whether there will be a new medical school in the City and where it will be located, no decisions can be made about the location of these 700 beds. Certainly the City should never build another unaffiliated general hospital, nor is there a need for more such beds. What is needed, of course, is the current program of replace-

ment of old facilities and more publicly operated nursing homes and other chronic care facilities.

Having spent some time on several major issues, other changes will be more or less summarized to fill in the overall picture.

A special study of psychiatric services in the municipal hospitals has been completed by a committee chaired by Dr. Lawrence Kolb. As a result of their recommendations a number of specific steps have been taken or will be taken. Since they are to be the subject of a news release in the near future there will be no elaboration here.

Personnel problems have been met in several ways. Many categories of personnel have received salary increases; land has been assigned adjacent to the Bronx Municipal Center to provide housing; a special committee chaired by the City Administrator has been untangling a backlog of problems; a recruitment unit for the Department is to be established by the Director of Personnel. There are still many personnel problems but things are headed in the right direction.

Maintenance has been a problem due to understaffing and lack of funds. The Bureau of Engineering and Maintenance has been reorganized and augmented, and the Department has been assured of several million dollars for painting and refurbishing certain facilities such as Harlem, Lincoln, the Bellevue psychiatric unit, etc.

Laboratory and x-ray delays and lack of coverage have been offset by appropriations of about 1.1 million dollars for technicians and other necessary personnel. Bellevue Hospital alone received more than half a million dollars.

Operating room staffing problems are being attacked by providing funds to pay operating room technicians on a per diem basis, to pay nurses to be on call, and by a new ruling that nurses can work on a paid basis in municipal hospitals during their vacations.

Emergency room services and standards in unaffiliated hospitals are being upgraded. The emergency services are now the responsibility of the medical boards, who are recruiting qualified specialists in adequate numbers at realistic rates of payment. The community and professional response to this program which was recommended by the Advisory Council of Medical Boards has been excellent.

Finally, with respect to certain other responsibilities of the Commissioner and the Department, the following items can be mentioned as examples:

First, proprietary nursing homes are being required to upgrade their physical facilities or go out of business—23 have closed in the past three years. Second, a consultant is working on recommended revisions of the nursing home licensing code with respect to standards of care. He will be aided by an advisory committee broadly representative of the community groups interested in nursing homes. Third, the Board of Hospitals has adopted a new regulation that all proprietary hospitals must be accredited by the Joint Commission on Accreditation of Hospitals by January 1, 1965 in order to secure annual relicensure. Fourth, a hospital consultant and an architectural consultant are developing recommended revisions of the proprietary hospital code with respect to both physical and performance standards. This action is particularly significant in view of the serious questions raised about the quality of care in certain proprietary hospitals as well as in certain voluntary hospitals by the second volume of the Columbia studies on prepayment health insurance which is now being reviewed by five advisory committees prior to final submission to the Superintendent of Insurance and the Commissioner of Health of New York State. Fifth, the Department has advised all voluntary hospitals that if they are not accredited by December 31, 1962, City charge patients will not be certified for care in such institutions. Sixth, a new administrative policy has been established in the Department that before applications for expansion or new construction of proprietary hospitals will be favorably considered they must be referred to the Hospital Council, or its successor, for certification as to need. Uncontrolled proprietary hospital construction can be the death of both Blue Cross and voluntary hospitals. The Department is prepared to be a part of intensified regional planning and wishes to augment such activity wherever feasible. Seventh, the Department is prepared to work with the Department of Welfare to improve services to patients in proprietary nursing homes.

It would be a gross mistake to consider that all is well by now. The Department has a long way to go. Clinic services, record rooms and administrative staff are but three of a long list of important problems still to be attacked in addition to the follow-through necessary on what has already been started.

Our accomplishments to date have been due to the efforts of innumerable individuals and organizations who have stepped forward to help. The municipal hospitals are the community's and only the com-

munity can make them what they should be. To all who have helped, to those who are standing by if needed, and to a hard working staff, the writer offers his deepest thanks.

It has been an honor to make this presentation at the Annual Meeting of the Academy. A very long and involved story has been touched on summarily and incompletely before an audience well known for its interest in the best in medicine. The writer has not attempted to respond to all the points made in the excellent symposium here last April.* However, if this audience takes away the message that a strongly supported all-out effort is under way to bring modern medical care to all patients in New York City, and that all responsible physicians in the city are needed and must help, the evening will not have been in vain.

* Symposium on *The Hospitals of New York City*, held at The New York Academy of Medicine, April 6, 1961. Proceedings published in *Bull. N. Y. Acad. Med.* 37:524-50, 1961.