SPECIAL ARTICLE

ANNUAL DISCOURSE – THE BOSTON CITY HOSPITAL: A TALE OF THREE "CITIES"

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Abstract The Boston City Hospital, responding to economic pressures, has undergone a major administrative reorganization. Although faculty and students from Boston University, Harvard and Tufts medical schools will, to varying degrees, continue to participate on all services, Boston University School of Medicine has been vested with the responsibility for professional staffing. Current plans consist of limiting the Hospital's inpatient capacity to 500 beds, development of ambulatory and primary-care programs, consolidation of certain services with the adjoining University Hospital, and maintaining the Boston City Hospital's outstanding research and training capability. (N Engl J Med 289:503-506, 1973)

THE DECISION

ON February 28, 1973, the Board of Trustees of the Department of Health and Hospitals of the City of Boston decided, after months of negotiation, to vest with the Boston University School of Medicine (BUSM) the responsibility for professional staffing of the Boston City Hospital (BCH). Most agree that the Board's action was probably more important than any other taken in the Hospital's 109-year history. The interschool competition that preceded the decision was one of the fiercest ever in an institution that has brought academic politics to the level of a fine art.

It is not my intention to abuse this forum by indulging in partisan academic politics; not only would it be improper, but nothing I might reveal could compete for your attention with Watergate. Yet this particular event is worthy of your attention; in part, because it represents a milestone in the history of a great medical institution but also because the scenario includes all the elements and forces operating in the current national health-care crisis, particularly as it affects academic health centers.

The BCH has always had an impact on medicine much out of proportion to its size. One can neither dismiss lightly an institution housing the Thorndike, Mallory, Channing and Sears Laboratories nor treat cavalierly an institution that can count among its own a "who's who" of the past century of American medicine: formidable names such as Mallory, Sears, Finland, Peabody, Castle, Weiss, Cheever, Cobb, Minot, Blumgart, Keefer, Dowling, Faulkner, Wilkins, Foley, Strauss, Kimelstiel, Wilson, Ingelfinger, Bakst, Jeghers, Denny-Brown, Biguria, O'Hara, Berson, Monroe, Putnam, Dunphy, Councilman, Watson, Lahey, Churchill, Tenney, Thorndike, Strieder and Parker. Added to this list should be the myriad of deans, department chairmen, and investigators who were trained at this institution. The BCH has been a national resource; what happens at that Hospital has to be of national interest.

No sooner was it announced but the Board's decision was proclaimed as precipitous and disastrous by some, inevitable and long overdue by others. Some opined that they were witnessing the end of a glorious era; others could discern the beginning of a new, bright one. Charges that mischievous political machinations had produced this decision were countered by protestations that it was born of economic necessity and the only one consistent with sane management. Warnings of dire consequences to the quality of medical care were balanced by sanguine predictions of just the opposite. Cryptic telegrams to prospective house officers hinting that something was amiss were followed by telephonic reassurances. Faculty and house staff of Harvard and Tufts Medical Schools tried to reconcile pessimistic "wait and see," "better look elsewhere" advice from their leadership with offers of continued appointments at the BCH. Assurances of "no precipitous action" made by each of the schools before the decision were subsequently followed by indications that student programs might be phased out and faculty support withdrawn.

Adding to the confusion was the announcement of a contraction of the Hospital's bed capacity, while construction was beginning on a new 12-million-dollar Ambulatory Building. House officers, notified that their ranks were to be thinned by 20 per cent, were invited to apply for housing in a new 28-story apartment complex complete with swimming pool, gymnasium and squash courts. Nor were BCH nursing students and faculty spared conflicting signals; rumors were rife that their school might close while they toured the new Nursing School, outfitted with spacious lecture halls, modern laboratories and subsidized housing.

WHY?

It is possible to question the wisdom of the Board's decision, to dismiss the subsequent prophecies of impending doom as sour grapes, the defections as a natural response to uncertainty, and to attribute the chaos to poor communication. It is not possible, however, to evade the lingering question of what it was that prompted the Board to act so decisively under formidable political pressures.

None of the problems facing this Hospital were new; there was, however, a confluence of problems that

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reached a critical mass and forced drastic action. The precipitating event was clearly the sudden proclamation by Boston's Mayor that municipal austerity would force a drastic reduction in the Hospital budget. Yet other institutions have successfully responded to financial crises without subjecting themselves to such a bloodletting. What made the BCH different and was, in my opinion, the underlying problem was the administrative monstrosity with which it was saddled: three independent medical and surgical services and a dozen or so semiautonomous fiefdoms, accountable to three deans of three medical schools. The BCH consisted for all practical purposes of three competing hospitals under one roof. Under ordinary circumstances, an institution so divided might survive, and for over a century, it did; under financial, social and political stress it might not. The Board, despairing of its ability to respond to the financial crisis while saddled with the confusion, inefficiency, triplication and waste of the three-school affiliation, finally decided to replace this managerial madness with a simpler, more unified organization. It created single, unified medical and surgical services, and limited its affiliation to one medical school (BUSM). The Board did not, in any fashion, preclude a continuation of Harvard and Tufts participation at the BCH; it went to great lengths to ensure it. All three schools would to varying degrees participate on all services but the Boston University School of Medicine would have the ultimate responsibility for professional staffing.

Why BUSM?

Some expressed surprise that BUSM was given this responsibility. For all of its 109 years, the public has largely and appropriately identified the BCH with Harvard Medical School. The past century of medical progress at the BCH must be considered one of the proudest achievements of that school. The affiliation of Tufts University School of Medicine dates back to 1897, and that of BUSM to 1930; their roles at the BCH, until the past three decades, have been secondary.

To many, particularly those closest to the BCH scene, the recent turn of events came as no surprise. The BUSM had matured and grown in stature in recent decades, and its role at the BCH had expanded correspondingly. The BU Medical Service in particular has had an outstanding track record of accomplishment. Its geographic proximity helped. What was indeed surprising and requires explanation was the absence of a formal affiliation between the two institutions for more than ½ of the century of their coexistence across East Concord Street.

The explanation for this paradox is elusive, but the best speculation points to the Massachusetts Medical Society as the culprit. One hundred years ago the Society, after a notorious trial lasting for two years, expelled seven Boston physicians for practicing homeopathy. The leader of this group of "irregulars," as they were called, was Dr. Israel Tisdale Talbot, who presented the following unsuccessful defense:

> Our only professional pledge is to cure our patients by the best means in our power. For this purpose we stand as physicians, ready to receive any new truths; and we ask you to be as ready to receive, to examine what we have so carefully studied and believe to be true. When it is clearly proved that any drug or remedy in any case or form whatever is the best thing for the patient, it is the physician's duty to his patient and to his profession to administer such remedy, but until such a demonstration is given, it is equally his duty to give what he thinks is best, be it homeopathic, allopathic or heteropathic.

Although homeopathy is today little more than a historical curiosity, many of its tenets have a peculiarly modern ring to them, especially the criticism of the practice of prescribing large doses of potent drugs for relatively minor ailments. Dr. Oliver Wendell Holmes, in 1860, spoke to the same issue: "I firmly believe that if the whole materia media as *now used* (with few exceptions) could be sunk to the bottom of the sea, it would be all the better for mankind — and all the worse for the fishes."

Immediately after his expulsion from the Massachusetts Medical Society, Dr. Talbot negotiated an alliance between the New England Female Medical College and Boston University under the auspices of the Massachusetts Homeopathic Medical Society, established the Boston University School of Medicine in 1873 and became its first dean, managing to hold on to the job for 24 years.

It was not until 1886, 13 years later, that BUSM's (homeopathic) medical students were permitted to receive instruction on BCH wards. The Board apparently reasoned that since the BCH was a public institution, it could not deny places to students of any institution chartered by the Commonwealth. BUSM's women students were given access to BCH wards at about the same time, presumably for the same reason. There could have been no quarrel with the quality of the BUSM students, for its standards for admission and graduation were unusually high, in contrast to the disgraceful laxity in this regard of most schools of that time. The BUSM was the first American medical school to require three full years of training, the first to introduce an optional four-year course and the first to make the latter compulsory. BUSM faculty, however, may not have taught BUSM students at the BCH since the Massachusetts Medical Society bylaws required the disciplining of "regular" physicians who had professional associations, even consultations, with "irregulars" — i.e., homeopaths. Thus, although BUSM became "regular" in 1918 by formally dropping its association with homeopathy, some of its faculty undoubtedly continued to practice homeopathic medicine, and it is a reasonable speculation that it was this sectarian taint that interfered for so long with a formal affiliation with the BCH. Thus, the Massachusetts Medical Society was not only indirectly responsible for the establishment of the BUSM, but it was probably instrumental in delaying an affiliation be-

tween it and the BCH for ½ a century. It is, therefore, not only fitting and proper but somewhat ironic that the Massachusetts Medical Society would invite the dean of the BUSM, during the School's centennial year, to discuss the events leading up to and the importance of the new relation of BUSM with the BCH.

Whatever the reasons, it required nearly another decade of persistent effort on the part of the then Dean of the BUSM, Dr. Alexander Begg, to arrange a formal affiliation of BUSM with the BCH. The Fifth (BU) Medical Service was established in 1930, followed 20 years later by the Third (BU) Surgical Service. BUSM faculty successively assumed administrative leadership of the BCH departments of Pediatrics, Urology, and Thoracic Surgery in the fifties and the departments of Radiology, Pathology, Obstetrics and Gynecology, Rehabilitation Medicine, Ophthalmology and Pediatric Surgery in the sixties. It was thereafter only a question of time before the progressive renaissance of BUSM as well as its geographical proximity to the BCH would manifest themselves in the recent action of the BCH Board.

The Present

The recent matching of interns yielded for the BCH its usual outstanding roster of house officers. Most of the professional staff of the three schools, including the house officers, have elected to stay, and medical students from all three schools will be taking clerkships and electives at the BCH during the coming academic year.

The opening of the South Block complex and the beginning of construction of the new Ambulatory Building have dispelled fears that the BCH is going to wind down. The Executive Director of the BCH has capitalized on the increased efficiency that he so painfully won and has maintained the momentum of his plans for consolidation and reorganization. On the negative side, however, is the sober realization that the Hospital remains a political football.

The Future

Now that the fates of the BUSM and the BCH are so closely linked, plans are being implemented that were heretofore hazardous even to contemplate.

Consolidation

The census of the Hospital has gradually diminished over the years roughly in proportion to the decrease in the population of Boston, and how fluctuates between 450 and 650 inpatients. Recognizing the impossibility that the BCH would remain economically viable if it perpetuated the practice of admitting patients as if its walls as well as its budget were flexible, the Board announced that by July, 1973, the capacity of the BCH would be limited to 500 beds; patients in excess of this number would be admitted to the many over-bedded hospitals in town. The newly appointed Commissioner of Health and Hospitals of the City of Boston has discovered an untapped reservoir of goodwill among the local hospitals and has elicited their co-operation in developing a plan for accomplishing this change in BCH admitting policy in a manner that will prevent patients from becoming lost in the shuffle.

What makes this plan feasible is the gradual shift of the responsibility to deliver on the right to health care from the municipal to the state and federal level. If the trend started by Medicare and Medicaid continues it will speed the return of the BCH from its present role as a municipal hospital for the medically indigent to the role that it had a generation ago as a community hospital for all of Boston's residents. Although it should provide excellent medical care to needy citizens of Boston as a whole, it should particularly serve those who live a short distance from the BCH and look to it as their local community hospital. It should focus on a continuum of care to these families through its excellent network of neighborhood health clinics, through ambulatory and emergency services at the Hospital, and by provision of back-up inpatient care.

In the interests of providing care to all members of the families in the community, first-class general services in medicine, surgery, child and maternal health are required. However, it may be neither appropriate nor necessary for the BCH to house an inordinate number of costly, often underutilized, special inpatient services. A number of these — radiotherapy, cardiac catheterization, cardiac surgery, renal dialysis and transplantation, and psychiatry, to name a few — can be made available by pooling of resources and co-operative arrangements with University Hospital and other components of the Boston University Medical Center. University Hospital, along with BUSM and the School of Graduate Dentistry and the BU-Commonwealth of Massachusetts Treatment, Training and Research Center in Mental Health, is a part of the Boston University Medical Center. Originally chartered in 1855 as the Massachusetts Homeopathic Hospital, it became the Massachusetts Memorial Hospital in 1918 and University Hospital in 1965. In many cases, the same Boston University professional staff has been providing duplicate services at the two hospitals, with needless inefficiency and excess cost to both institutions. Both hospitals have begun to re-evaluate their roles, with a view to unifying services wherever medically desirable and economically prudent. From the data already assembled, it is evident that both hospitals can effect major cost savings while providing excellent care by co-ordinating all, and amalgamating many, of their services. In addition to the financial advantage, such co-operative arrangements are logical outgrowths of the general principles of seeking rational area medical planning and one standard of quality medical care.

A Single Standard of Care

By the time the present Medicare-Medicaid programs expand and eventually culminate, as most be-

lieve they will, in some form of national health insurance or universal entitlement, the BCH will have to divest itself of the residua of its image as a charity hospital. Although many will continue to utilize the BCH out of either preference or habit, there will be others who will look upon the BCH as "second class" to the degree that it retains the appearance, practices, and aura of a charity hospital. When provided financial access to "first-class" facilities they will probably use them. It will matter little that some of the outstanding physicians in New England or in the nation staff the Boston City Hospital. The physical plant and the amenities, improving but still lacking, will become more important.

Another problem that will have to be faced during this period of transition is the potential impact of the recent amendment to the Social Security Law, HR 1, which discriminates between "charity" and "private" hospitals in its reimbursement of physicians' services. More ominous than the obstacle this poses for the recruiting and funding of staff is the apparent reinstitutionalization of two standards of care. The Medicare law of 1966 was instrumental in narrowing the gap between the care provided by public hospitals and private institutions. It could not do the whole job because there remained a relatively large number of medically indigent who were not covered. We appear to be witnessing a retreat — temporary, I hope — to a dual system of medical care.

Another facet of the same problem will be the necessity to staff the Department of Health and Hospitals (including Mattapan, Long Island Hospital, the BCH and its network of neighborhood health centers) with physicians who have a stake in the community who are not transients. The current socioeconomic and cultural gap between the physicians and their patients is too great to be consistent with the best medicine. Similarly, the need for more community involvement in the BCH is obvious if it is to become a true community hospital.

Research

The fame of the BCH has been derived to a great extent from the number and importance of the medical discoveries made at the BCH and from the number and quality of investigators trained there. Its standard of creative scholarship, originality and productivity in this arena has been awesome; great pains have and will continue to be taken to assure its perpetuation.

Training

The BCH has also had a great tradition of leadership in clinical and research training. The basis for this leadership was neither the clinical "material" nor the physical plant, but rather the tradition of excellence and presence of inspiring faculty and outstanding house officers. Whether the BCH will continue to be a magnet for excellence will depend on the quality of the present professional training environment. The outlook is bright.

Primary Care

The plight of Boston's inner city as far as personal health services are concerned is comparable to any other city and is well known. General practitioners have been replaced as primary-care providers by emergency rooms of large, urban hospitals, and services provided there, even when technically sufficient, do not approach the primary health-care needs as expressed by most patients, indigent or otherwise. By primary care is meant first-contact care and long-term responsibility for and the integration of health care for the patient and his family. One of the first steps taken by BUSM and BCH after the recent change in their relation was to begin planning a service and education program in primary care.

Although curriculum changes and new faculty will be necessary to implement this program, no facilities other than those existing or under construction will be needed since all the necessary components are already in place and need only be co-ordinated. The ambulatory services at University Hospital and the BCH are being reorganized, and the new BCH Ambulatory Building, which will include a new enlarged emergency facility, will be completed within two years.

Conclusions

The Boston City Hospital, responding to economic pressures, has undergone a major reorganization and has invited the Boston University School of Medicine to help it face the challenges of an uncertain future. The Boston University School of Medicine is proud of this vote of confidence, aware of its responsibility to protect this national educational resource, and is confident that its own goals and those of the BCH, the government, society and the local community are sufficiently congruent to make the next century of the Boston University School of Medicine and the Boston City Hospital as exciting and productive as the first.