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The Public Hospital

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THE PUBLIC HOSPITAL

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Introduction

A hospital is defined as:

1) A place of shelter and rest for travelers;

2) A charitable institution for providing and caring for the aged, infirm, and orphaned;

3) An institution where the ill or injured may receive medical, surgical or psychiatric treatment, nursing, food, and lodging during illness.[1]

How the word "hospital" is defined has dramatic implications for a society. The various definitions reveal the evolving role of the hospital throughout history. The origins of the modern responsibility of the hospital evolved from the almshouse and the hospice.[2] These early forms of care houses evolved into the development of both public and private hospitals in the nineteenth and twentieth centuries.

Hospitals in general developed a medical perspective based not only upon scientific advancement, but also upon the medical treatment of all types of patients, regardless of class. The hospital, therefore, became dissociated from the social philosophy that had been its historic origin.

This differentiation of the hospital purpose and administrative structure that occurred at the turn of the twentieth century must be understood in order to appreciate the special and troubled role that was left to the public hospital. The extraordinary progress in medical science, technology, and professionalism simultaneously brought remarkable clinical care to human kind and recognition

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1. WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY OF THE ENGLISH LANGUAGE (3d ed. 1986).

2. *See* PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 149 (1982). An almshouse was a place of refuge for travelers or home for the sick and the poor. *Id.*

that the traditional almshouses serving the indigent could not render proper healthcare. The question for society became whether there was a dangerous dissociation of humanity and medicine; this question remains today. Did the exclusive social focus of the almshouse and other early forms of hospital breed medical elitism that is separable from societal responsibility? This article outlines the development of public and private hospitals and examines the roles of each in society throughout history. This article then looks more carefully at public hospitals and their role in connecting medicine and social responsibility. This article concludes that the public hospital is a necessary institution in providing adequate healthcare to all members of society.

I. The Development of Public and Private Hospitals

A. Generally

Institutional care for illness originated in medieval Europe and was designed specifically for the poor, travelers, and those in prison.[3] The institution of the hospital was designed for, and served almost exclusively, the indigent and dependent.[4] The dependent included those afflicted with physical and mental disorders including the plague, insanity, those who were dangerous, the acutely and chronically disabled, and the impoverished, such as homeless women prior to and during childbirth. This initial phase of the development and utilization of the hospital emphasized the almshouse and workhouse concept because the affluent usually received care at home.[5] Because early hospitals served the poor, their efforts were often viewed as moralistic and those served considered unworthy. Only non-physicians managed the earliest institutions because the care was perceived as a social rather than medical problem.[6]

B. The Changing Role of the Hospital

Even during the early twentieth century, conflicts developed regarding the importance of social issues and the family and the role

3. *Id.* at 148-49.

4. *Id.*

5. *See* MORRIS J. VOGEL, THE INVENTION OF THE MODERN HOSPITAL: BOSTON 1870-1930 10 (1980). Most people received medical treatment in their homes because most medical care could be given equally well in the homes of the middle and upper classes except for the rarest of surgical procedures. *See* CHARLES E. ROSENBERG, THE CARE OF STRANGERS: THE RISE OF AMERICA'S HOSPITAL SYSTEM 5 (1987).

6. ROSENBERG, *supra* note 5, at 4-5.

of the hospital as a place for outpatient care and public health. Hospital and in-patient services grew throughout most of the twentieth century and the structure and finances of hospitals became based almost exclusively on the concept that only physicians could solve and understand the public health issues.[7]

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7. STARR, *supra* note 2, at 157. The great medical accomplishments of the nineteenth and twentieth centuries began to create an environment known for the practice of asepsis, diagnostic, and therapeutic interventions. VOGEL, *supra* note 5, at 61. This environment was fostered by the professional interests of physicians during a period when scientific methods were developing. *Id.* at 67. Simultaneously, there were advances in the teaching of medicine, consultation, and the focus on specific types of patient problems. *Id.* at 61-63, 78. As these characteristics of medicine developed in the twentieth century, there was an extensive expansion of hospitals throughout the country. The hospital's physical structure, role in society, and management began to change.

In addition, the links between medical education and hospitals came under scrutiny in the Flexner report prepared by Abraham Flexner for the Carnegie Foundation in 1910. *See generally* ABRAHAM FLEXNER, MEDICAL EDUCATION IN THE UNITED STATES AND CANADA: A REPORT TO THE CARNEGIE FOUNDATION FOR THE ADVANCEMENT OF TEACHING (1910). In the introduction of the report Carnegie Foundation President Henry S. Prichett stated:

> It is the same answer that one receives from the medical school which, with wholly inadequate facilities, is turning out upon an innocent and long-suffering community men who must get their medical education after they get out of the institution. In many of these ill manned and poorly equipped institutions there is to be found a large measure of devotion, but the fact remains that such devotion is usually ill placed, and the individual who gives it loses sight of the interests of education and of the general public in his desire to keep alive an institution without reason or right to exist.

Id.

The development which was suggested by Prichett for medical education was conditioned largely upon three factors:

> [F]irst, upon the creation of a public opinion which shall discriminate between the ill trained and the rightly trained physician, and which will also insist upon the enactment of such laws as will require all practitioners of medicine, whether they belong to one sect or another, to ground themselves in the fundamentals upon which medical science rests; secondly, upon the universities and their attitude towards medical standards and medical support; finally, upon the attitude of the members of the medical profession towards the standards of their own practice and upon their sense of honor with respect to their own profession.

Id.

Flexner's efforts in analyzing medical education revolutionized medical education. Flexner stated that the profession is based upon "[t]he application of free, resourceful, unhampered intelligence to the comprehension of problems—the problems of disease, the problems of social life—bequeathed to us by history and complicated by evolution." *Id.* The rigor of American medical scholarship is directly related to his Carnegie Foundation report. Some of Flexner's report is particularly pertinent to our current debates. For example, the report includes the following statement:

> Practically the medical school is a public service corporation. It is chartered by the state; it utilizes public hospitals on the ground of the social nature of its service. The medical school cannot then escape social criticism and regu-

The combination of twentieth century medical progress, physicians' organizational efforts, and an increasing public faith in medical treatment led to the development of private institutions.[8] These institutions were initially very primitive but respectable.[9] This evolution of the role of the hospital led to the ill and injured considering hospitalization as a form of treatment unrelated to destitution.

The first institutions, which were of a municipal or religious nature, were joined by private institutions organized according to patient class and type of care.[10] The "new" patients at private hospitals were drawn to medicine's potential for care and cure.[11] The differentiation of hospitals was extensive, and, as the affluent became hospital patients, the economics of care became vital for hospitals.[12]

Different types of hospitals developed for specific diseases, ages, and sexes.[13] The hospital assumed many functions previously considered merely social concerns. This medicalization of many social issues prompted the transformation of the hospital and the perception of medicine. Although many of the medical advances reached the public hospitals because of the numerous links to medical education, however, the social and cultural barriers that separated the public from private institutions remained.[14]

C. Legislation

The development of federal legislation, including the Hill-Burton Construction Funds and Medicaid and Medicare, as well as anti-dumping legislation, improved the legal standing of the most disenfranchised.[15] The Joint Commission on Accreditation of Healthcare Organizations mandated that hospitals care for patients

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> lation. It was left to itself while society knew no better. But civilization consists in the legal registration of gains won by science and experience; and science and experience have together established the terms upon which medicine can be most useful.

Id.

8. VOGEL, *supra* note 5, at 101-103.

9. *Id.*

10. STARR, *supra* note 2, at 159.

11. *Id.* at 157-58.

12. *Id.* at 159.

13. *See generally* IVAN ILLICH, MEDICAL NEMESIS: THE EXPROPRIATION OF HEALTH (1976).

14. VOGEL, *supra* note 5, at 60.

15. STARR, *supra* note 2, at 348-49, 369-70.

without regard to finances.[16] The Hill-Burton construction program also required hospitals receiving funds to provide a minimal level of care to those who have no financial resources.[17] The legislation helped form what is called the health care "safety net."

Yet there remains an enormous gap between the right to care and actual access to quality health care. Medicaid covers an ever-decreasing number of the poor, and public hospitals disproportionately care for the unemployed and those with jobs without health benefits.[18] Also, Medicaid revenues are less than the expenditures for uncompensated care.[19]

The gap between expenditures and revenue places a great burden on public institutions, while at the same time, societal responsibility for the care of others is continuously questioned. This gap also threatens the "safety net" concept. In 1990, public hospitals in the nation's 100 largest cities averaged 210,000 outpatient visits and 74,000 emergency department visits compared with 73,000 and 25,000 visits respectively in their private counterparts.[20] Large urban public hospitals serve the highest volume of the uninsured and one third of the nation's uncompensated care.[21] This nationwide network of great public hospitals has become, by default, the country's national health insurance.

It is from this perspective that the public hospital must be viewed. Medical communities have evolved from a social effort into profit, non-profit, private, public, teaching, and non- teaching hospitals. In many cities, there are two hospitals and two medical communities; in effect, two societies. One hospital typically serves aliens and the alienated, the mentally ill, and those without jobs, homes, education and insurance. The other hospital serves those with education, homes, jobs, and insurance.

The only method of establishing equity is the emergency department. All other hospital departments permit discrimination by payer class; diversion, delay, and denial of care for those with marginal finances is legally acceptable. In a country without a universal healthcare system, this seemingly unconscionable and unethical behavior is routine.

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16. *Id.*

17. *Id.* at 389.

18. *See* Dennis P. Andrulis et al., *Public Hospitals and Health Care Reform: Choices and Challenges*, 86 AM. J. PUB. HEALTH 162 (1996).

19. *Id.* at 163.

20. *Id.* at 162.

21. Joel Weissman, *Uncompensated Hospital Care: Will It Be There If We Need It?*, 276 JAMA 823, 825 (1996).

II. Role of the Public Hospital

America's first public hospitals were founded in the 1730's in Philadelphia, New Orleans, and New York City.[22] Three other major public hospitals date back to the latter half of the nineteenth century: Boston, Cook County (Chicago), and Los Angeles County.[23] A review of the functions of public hospitals is essential to understanding their roles in society, and the reasons for their continued existence and potential approaches to change. The public hospital exists for all members of the community. The closure of public hospitals has become frequent and debate of additional closures has made an analysis of their roles essential.[24]

The National Association of Public Hospitals categorized the population served by public hospitals as "vulnerable."[25] The healthcare provided, education offered, and research accomplished at our public hospitals has contributed much to American medicine. The major societal problems — poverty, plagues, prison health, psychiatry, trauma, and alcoholism — have not changed, and it must be decided whether medical professionalism and societal responsibility can be achieved in the absence of public hospitals.

A. Poverty

The role of the public hospital in the care of the impoverished, disconnected, and recent immigrants is substantial. Most public hospitals care for two to three times as many men as women, and for a disproportionate share of nonwhite Americans.[26]

The legal and illegal, ethical and unethical referral of patients with difficult medical and social problems to public hospitals is a long-standing issue.[27] The legal and illegal transfers of poor patients to public hospitals, often called "dumping," "abandonment," or "wallet biopsy," have become very common in cities with public hospitals.[28] Even though Medicaid and Medicare programs have made patient access more democratic, many poor and medically demanding patients at private hospitals are sent to public hospitals

22. ROSENBERG, *supra* note 5, at 18.

23. *Id.* at 18, 110.

24. *See, e.g.*, Andrew B. Bindman et al., *A Public Hospital Closes: Impact on Patients' Access to Care and Health Status*, 264 JAMA 2899 (1990).

25. Andrulis et al., *supra* note 18, at 162.

26. ROSENBERG, *supra* note 5, at 338-39.

27. *See, e.g.*, Emily Friedman, *Public Hospitals Often Face Unmet Capital Needs, Underfunding, Uncompensated Patient Care Costs*, 257 JAMA 1698 (1987).

28. Emily Friedman, *Problems Plaguing Public Hospitals: Uninsured Patient Transfers, Tight Funds, Mismanagement and Misperception*, 257 JAMA 1850 (1987).

after little or no assessment.[29] Some are transported long distances even though their care suffers and medical expertise and beds are available at the private transferring institution.[30] Other public hospitals receive patients who have been given partial treatment at a private institution and a transfer note suggesting further care would best be rendered in a public hospital.[31]

The lack of essential social services at many hospitals other than public hospitals is another factor that brings the poorer members of society to the public hospital doors. Institutions such as Bellevue have had twenty-four hour emergency department social workers for approximately twenty years while comparably sized private institutions do not have emergency department social workers.

B. Emergency Care

In the 1960s and 1970s, it became obvious that many emergency departments were neither physically adequate, nor staffed by trained personnel. Departments were organized without respect to patient needs and were based upon patient finances or staff interest. While there was some progress in the development of pre-hospital care, much of it was provided in ambulances and little in emergency departments. The National Highway Safety Act of 1966 allowed each governor to spend part of the federal gasoline excise tax for funding the development of emergency medical services (EMS).[32] Increasing societal interest and demand led to the Emergency Medical Services Systems Act of 1973, which transferred EMS authority from the Department of Transportation to the Department of Health and Human Services.[33] This act revolutionized care because it provided federal money for the development of a comprehensive and integrated EMS system. The so-called "seed money" was distributed to local Health Services Administration units, which planned, established and then expanded EMS throughout this country.[34] In many areas, EMS was integrated from outside the hospital to the emergency departments, the

29. *Id.* at 1850-51.

30. *Id.*

31. *Id.*

32. *See* R.K. Knopp & Lewis R. Goldfrank, *An Ethical Foundation for Health Care: An Emergency Medicine Perspective*, 21 ANN. EMERG. MED. 1381 (1992); L.M. Enfield & D.P. Sklar, *Patient Dumping in the Emergency Medical Department: Renewed Interest in an Old Problem*, 13 AM. J.L. & MED. 561-95 (1988).

33. *See* Enfield & Sklar, *supra* note 32, at 562.

34. *Id.*

intensive care units and the operating rooms.[35] An attempt was made to categorize and evaluate services such that trauma systems, coronary care systems, pediatric services, and poison control and information services were available to those represented by a Health Systems Agency.[36] These efforts had a dramatic impact on the development of emergency medicine.[37]

One additional legislative effort had a dramatic role in confronting what had become a common practice —the transfer and abandonment of complex, poor, or "uninteresting" emergency patients.[38] These demanding and costly patients had disorders such as alcoholism, trauma, substance abuse, or psychiatric disorders. The transfer of these patients led Congress to pass the Comprehensive Omnibus Reconciliation Act of 1986 (COBRA), that prohibited the transfer of unstable emergency patients for financial reasons by any hospital that accepted Medicare for payment.[39] COBRA created a limited form of emergency access for less desirable patients by mandating that any patient presented to an emergency department must have a screening examination and was entitled to stabilizing treatment in an emergency. This law and numerous common law precedents established a guaranteed access to the emergency department regardless of a patient's ability to pay. This concept of access was to be based solely on the patient's belief that he or she had an emergency condition.[40]

Emergency medical care has a unique place in public and private hospital care. Because most public hospitals' inpatient departments depend almost exclusively on admissions from the emergency department, the decisions made in the emergency department alter the course of hospital function. Emergency medicine is a unique specialty requiring an attending physician's presence. This has led to a distinct standard for the care of those who arrive in the emergency department that differs from all other hospital departments. This standard has created a special role for emergency department physicians, who often are the only physicians present in the hospital on evenings, nights and weekends. It has also created a special educational environment for these physicians regarding advocacy for the public hospital patient.

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35. *Id.*

36. *Id.*

37. Many patients have care initiated at a private institution emergency department, but are given follow up at a public hospital outpatient department. *Id.*

38. *Id.*

39. *See*, Knopp & Goldfrank, *supra* note 32, at 1381.

40. *Id.*

C. Prisoners

Prison health care has always been considered part of the public hospital's role. Inevitably, this is care for health problems including infectious diseases such as tuberculosis and Acquired Immune Deficiency Syndrome (AIDS), substance abuse (cocaine and heroin), alcoholism, trauma, and psychiatric disorders.

Many public hospitals such as those in Los Angeles County, Cook County (Chicago), Kings County (Brooklyn), and Bellevue have large prison wards.[41] The complexities of care for the newly arrested and those in prison place a great demand on public hospitals.

These patients receive care comparable to other patients, but their potential for danger to themselves and others forces the development and management of special wards. There is a unique relationship between the prisoners (as patients), corrections officers, and hospital staff.[42] The presence of armed officers has often led to fear, fights, shootings, and deaths in these institutions.[43]

D. Psychiatric Care

Large numbers of patients seek psychiatric care in public institutions. For instance, 30 percent of New York City's acute psychiatric care is provided in public hospitals.[44] This care is invariably for the poorest members of the population as well as the most impaired. At Bellevue hospital, 50 percent of admissions are homeless patients and many of these patients have records of extreme violence often associated with substance abuse and alcohol dependency problems.[45] Often, these patients have been hospitalized previously in state psychiatric facilities. These state facilities were to be replaced by community psychiatry services, services that have never materialized. This philosophic and economic abandonment of the psychiatrically impaired has dramatically increased the public hospital's role in acute and chronic psychiatric care.

41. *See* Jo I. Boufford, *Public Hospitals in the Changing Health Care System*, 76 AM. J. PUB. HEALTH 12, 13 (1986).

42. *Id.*

43. *Id.*

44. *Id.*

45. *Id.*

E. Trauma

A single hospital, the Los Angeles County trauma center, cares for 28 percent of all major trauma victims in that county.[46] In New York City, six of the thirteen trauma centers are at public hospitals. The busiest of the two microsurgical replantation centers is at Bellevue Hospital.[47] Trauma care is often the most complex of acute surgical care and requires long hospitalizations and periods of rehabilitation. A revolution in pre-hospital care that changed American surgical services began during the Korean and Vietnamese wars. Trauma service models were developed with federal National Institute of Health trauma center training grants.[48] The patients at trauma centers are diverse—from infants to the elderly. Injuries range from vehicular and pedestrian injuries to knife and gun injuries, which are often associated with inner city violence and illegal substance abuse. The complexity of these injuries necessitates enormous organizational and financial resources. These resources include: evaluation in diagnostic imaging (CT scans), operating rooms, and rehabilitation and social services. The head and spinal cord injury centers found in some public hospitals are very costly in personnel particularly for surgical, rehabilitative and psychological services.[49] The progress in trauma care has offered unique approaches for education, research and collaborative success.[50]

F. Drugs, Alcohol, and Tobacco Abuse

Substance abuse and addiction cost New York City more than $20 billion in 1994, over $5.1 billion of which was allocated to health care.[51] The care for substance dependent patients and their families is estimated to fill 25 percent of public hospital beds in this country.[52] Although this figure is an estimate, it demonstrates the enormity of the problem. The care associated with intoxication,

46. *See* Edward E. Cornwell et al., *Health Care Crisis from a Trauma Center Perspective: The L.A. Story*, 276 JAMA 940 (1996).

47. *See* Boufford, *supra* note 41, at 12.

48. *See* Norman M. Cristensen, *City/County Hospitals: An Endangered Species*, 129 ARCH. SURG. 903, 906 (1994).

49. *Id.*

50. *Id.*

51. CENTER ON ADDICTION AND SUBSTANCE ABUSE AT COLUMBIA UNIVERSITY, SUBSTANCE ABUSE AND URBAN AMERICA: ITS IMPACT ON AN AMERICAN CITY: NEW YORK (1996).

52. *See* R.S. Hoffman & Lewis R. Goldfrank, *The Impact of Drug Abuse and Addiction on Society*, 8 EMERG. MED. CLIN. NORTH AMERICA 467 (1990).

withdrawal, infections, and violence are but a part of the medical and social problems that patients face. Alcoholism is often linked with tobacco use, lung disease, liver disease, gastrointestinal disease, fetal alcohol syndrome, and spousal abuse. The abuse of heroin and cocaine is linked to diverse infections such as hepatitis, endocarditis (cardiac valvular infections), and AIDS. Cocaine abuse often causes delirium, seizures, muscle injuries, and heart attacks. Female addicts suffer from many obstetrical-gynecological problems including fetal demise, abortion, and premature deliveries. Abandonment of these premature babies in hospitals and a new group of "border babies" are also becoming problems.[53] These complex problems often go unresolved because of patient dependency and inadequate psychological and supportive services for substance abuse.[54]

G. Infectious Diseases

Public hospitals have had a long-standing role in the care of those with infectious diseases. Some public hospitals focus solely on infectious diseases such as yellow fever, tuberculosis (TB), and AIDS. Currently public hospitals have the largest number of inpatients and outpatients with TB or AIDS. Some of these patients go to public institutions because of their economic status, while others come because they have lost all their finances or insurance. Many come to public hospitals because of the sophistication of the medical and social systems developed to care for these patients. Special services for the care of patients with AIDS at the San Francisco General Hospital and Bellevue Hospital Center have set standards from technical, humanitarian, and ethical perspectives.

H. Ambulatory Care and Primary Care

Public hospitals established numerous creative approaches in ambulatory and primary care.[55] Those clinical sites have continuously expanded to meet the demands of the patients with the goal of providing rapid access to a clinic and a continuous relationship with a health care provider, either a physician and/or mid level provider such as a nurse practitioner.[56] Public hospitals are the only hospitals where those without insurance and resources are guaran-

53. *Id.*
54. *Id.*
55. *See* Boufford, *supra* note 41, at 13; Andrulis et al., *supra* note 18, at 162.
56. *See* Andrulis et al., *supra* note 18, at 163-64.

teed acute and chronic care. The responsibility of ongoing care for the impoverished is considered the hallmark of the public hospital.

Efforts in offering tertiary specialized clinics as referral networks for the poor have met with remarkable success. Chronic as well as acute care for the sexually abused, battered children and spouses, and victims of violent assault are special areas of interest. Tertiary ambulatory care efforts for those with hand, heart, head, and spinal cord injuries are also critical parts of the public hospital efforts at places such as Los Angeles County, San Francisco General, and Bellevue.

Public hospital ambulatory care services provide many of the primary outreach efforts for the poor in schools and shelters.[57] Immunization and screening for cancer, diabetes, hypertension, and lead are all essential roles of the ambulatory effort.

I. Education

The public hospital's role in American medical education is incomparable. Most of our greatest physicians and nurses obtained a substantial part of their experience at public institutions. The style of service and the special relationships between student nurses, student doctors, nurses, doctors, and patients forever alters their education, ethical standards, and practice of care.

The linkage between medical students and postgraduate medical education has kept inspired student physicians and residents at the bedsides of America's poorest patients. These relationships stimulate men and women to create solutions for what often appear to be impossible problems and makes public hospitals the center for diverse important research efforts. Research in trauma, poison management, alcoholism, domestic violence, and acute psychiatric disorders has been the special responsibility of the hospital. These efforts form the foundation for resident development as professionals practicing patient advocacy and rendering patient care.

Students and residents are educated in the spirit of Oliver Wendell Holmes. In an introductory lecture delivered before the medical class of Harvard University on November 6, 1876, Holmes stated: "[t]he most essential part of a student's instruction is obtained not in the lecture-room, but at the bedside. Nothing seen there is lost; the rhythms of disease are learned by frequent repeti-

57. *Id.*

tion; its unforeseen occurrences stamp themselves indelibly in the memory."[58]

Several years later in a valedictory address delivered to the graduating class of Bellevue Hospital College on March 2, 1871, Holmes repeated this message: "The young man is exceptionally fortunate who enjoys the intimacy of such a teacher. And it must be confessed that the great hospitals, infirmaries and dispensaries of large cities, where men of well sifted reputations are in constant attendance are the true centers of medical education."[59]

Although Holmes' observations are applicable to the development of all educated clinicians in all types of institutions, the importance for emergency medicine is maximized in the public hospital. The student and the resident are contemporaneously supervised by attending emergency physicians. The continuous supervision of patient care as well as student and resident education may be unique in American education.

J. Disaster Management

Public hospitals are integral parts of a city's public health and emergency preparedness system. Planning for disasters involves analyses of bed availability, emergency potential, intensive care, operating room accessibility, and hemodialysis potential. Evaluation includes the quantity of antidotes available for potential biological and chemical warfare due to examples such as botulism or organophosphate poisoning. Public hospitals' focus on epidemics and emergency care prepares them for natural or terrorist generated disasters. Public hospitals are organized to postpone or change any daily scheduled activities to respond to societal needs.

Conclusion

When the New York Academy of Medicine Task Force on Health Reform offered its analysis on the needs of urban communities, a challenge was presented to society.[60] They reported that the health status of lower income—inner city communities is markedly different from that of surrounding areas.[61] Inner cities are characterized by: (1) high infant mortality and morbidity, (2) high

58. OLIVER WENDELL HOLMES, SCHOLASTIC AND BEDSIDE TEACHING IN MEDICAL ESSAYS, 1842-1882 274 (1883).

59. OLIVER WENDELL HOLMES, THE YOUNG PRACTITIONER IN MEDICAL ESSAYS, 1842-1882 374 (1883).

60. *See The Urban Perspective*, 71 BULL. N.Y. ACAD. MED. 142 (1994).

61. *Id.*

rates of hospitalization for conditions normally treatable as outpatients (e.g. hypertension, diabetes, heart disease), (3) high rates of late or no prenatal care, (4) increasing numbers of children born to drug using women, (5) high rates of pediatric asthma and lead poisoning, (6) low immunization rates in preschool children, (7) high concentrations of human immunodeficiency virus (HIV) and AIDS, and (8) a growing incidence of tuberculosis, especially drug resistant, and (9) an epidemic of violence.[62] These are populations that historically have had limited access to medical care, particularly of a preventive nature. Large numbers of these people are homeless, mentally ill, and/or substance abusers. The political rejection of a universal national healthcare policy makes the inadequate health care of the poor a dominant societal concern for the future.

How will we truly analyze a society's, city's, or hospital's healthcare? It has been fashionable for several hundred years to say that public hospitals are inadequate. It is often true that they are inadequately funded, mired in bureaucracy with hostile owners and managers, and housed in aging facilities and in poorer areas of town. These circumstances make public hospitals responsible for the care of the complex medical problems of the inner cities.

How can you make the care of the society's poorest appear glamorous? As hospital management becomes more business dominated, who will be willing to assume responsibility for the destabilizing aspects of the care for the poor and other emergencies? Many portray these issues as solely a single financial crisis.[63] For example, the Los Angeles trauma analysis is simple: Treating an increased proportion of the uninsured leads to a higher proportion of un-reimbursed care with simultaneous use of increasing technology and resultant high costs of emergency care and a dramatic financial crisis.[64]

These debates are a subterfuge for a critical ethical dilemma. Political leaders lack the political courage needed to develop a system of care for the poor and non-insured. Government leaders are enamored with a back-to-business mentality that will bring some good to public hospital management, but neglects those patients whose treatment will not have a place in a business mentality. In these discussions, all responsibility for community health care is denied and the young nurses and physicians trained in this environ-

62. *Id.*
63. *See* Cornwell, et al., *supra* note 46, at 940-41.
64. *Id.* at 941.

ment will certainly not be able to adhere to the principles of the Hippocratic oath.

It does not appear that the current private hospital system is willing or able to care for those patients served in public hospitals. The meticulously organized systems of private hospitals cannot withstand the disaster of closing their operating rooms to the spouse of a member of the Board of Directors or delaying the admission of the President of a prestigious organization. The social integration of the private institutions would be revolutionary. Placing a CEO of a large corporation in the same room as a homeless man wouldn't affect the actual care of either of them, but how would the CEO and his or her family react? Maybe that is exactly the type of adjustment necessary, but without national health care and a reformed social philosophy this integration won't occur.

This problem is not just about the amount of beds or staff in private hospitals. Public and private hospitals serve different people with different needs. It is a question of the type of beds, type of staff, type of patients, and a philosophy of healthcare. Both types of hospitals are essential for a society to function safely.

When approximately 40 million Americans have no health insurance, we have an explosive problem. When presidential candidates do not care enough to talk about those who use public hospitals except to suggest that they are abusing the system, we have a national disgrace. I fear that we will lose a generation of idealists in healthcare if they are only exposed to the social Darwinian philosophies.[65] "It is economics—specifically the economics of care for the uninsured and other challenging patients," that makes many of us continue to believe that public hospitals are necessary.[66]

We do need our public hospitals more than ever. They do play a vital role. Like police and fire services, they perform an essential function. They do it better than anyone else can — if you are a victim of a catastrophic event on the streets of our cities — Bellevue, Ben Taub, Los Angeles County, Cook County and San Francisco General will offer the best chance to save your life. If these hospitals were not available, many vulnerable Americans would go without care. Imagine our cities without these safety nets. Unless we plan rationally for our nation's future with a healthcare plan, those in the business world will decide certain patients' health is

65. Lewis R. Goldfrank, *Healthcare Reform or a Return to Social Darwinism*, 25 ANN. EMERG. MED. 692 (1995).

66. Emily Friedman, *California Public Hospitals: The Buck has Stopped*, 277 JAMA 577, 580 (1997).

not economically feasible. The pretense that a governance change will improve the effort of public hospitals denies the fact that America's public institutions often have the most committed of America's nurses and physicians. They just do not have the money to do the job.