Introduction

“What do you mean ‘no room’? If you want to [admit me] badly enough you’ll find a place.” This was the complaint of a Jewish immigrant to the superintendent of Mount Moriah Hospital in New York’s lower East Side in 1909. Mount Moriah was a “penny hospital,” supported by the “pennies” of working people who were members of the Galicia-Bokovina League, a society of Eastern European Jewish workers who had emigrated to the United States in the preceding decades. In this particular hospital the superintendent himself felt “upset that ... many applicants [were] rejected for lack of space,” because he understood that people who lived in cramped quarters would find it difficult to accept being turned away from a hospital for such a reason. “I have five children and three boarders in the same four rooms,” remarked one applicant for admission. If space is tight in the hospital, the patient argued, the superintendent should “push the beds together and squeeze in another.”

Mount Moriah was an extremely small hospital cramped between “two adjoining tenements” and supported by the local immigrant working-class community to care for its own members. Because the administration was informal and there was relatively little hierarchy in its social relationships, patients felt confident that the superintendent would take their complaints seriously. Whereas patient care in other institutions sometimes seemed harsh and cruel, Mount Moriah’s administrators had a personal relationship with their patients. In the late nineteenth and early twentieth centuries, there were a number of small, idiosyncratic hospitals like Mount Moriah that were organized quickly in response to a particular need in a community. Often the trustees of these small facilities would act as personal guardians or patrons of particular patients, even to the extent of visiting them regularly to check their medical and moral progress. In some small facilities patients were expected to do cleaning and other housekeeping chores as part of their treatment and as a way of supporting the institution.

Larger nineteenth-century facilities like New York Hospital or Presbyterian had more characteristics in common than did the smaller ones. Generally, these hospitals drew their support not from local
2 Introduction

Presbyterian Hospital as it opened in 1872. In front, the churchlike administration building; in back, the ward building.

community patrons but from merchants or clergy who were important throughout the city. Because patients also came from diverse communities within the city, these hospitals were more varied in their ethnic composition. Large facilities usually had formal admissions procedures and a hierarchical bureaucratic structure, and their trustees took a paternalistic if impersonal interest in their patients. Beyond these common characteristics, however, there was great diversity among large facilities. Institutions organized by particular religious groups placed great emphasis on providing moral guidance for patients, or even converting them. Women’s hospitals often provided shelter and food for pregnant unwed women and mothers for a year or longer, and children’s institutions tended to resemble orphanages rather than hospitals. In this sense, both small and large hospitals reflected the idiosyncratic goals of their founders or the particular needs of their clientele much more than they conformed to any shared social definition of what a hospital should be.1

This volume looks at hospitals in Manhattan and Brooklyn between 1885 and 1915. During this period, the hospital system underwent a number of changes that ultimately transformed it from a series of
Introduction

Idiosyncratic institutions to a system of acute-care facilities much like what we have today. For one thing, the number of hospitals in New York grew tremendously during the period. Whereas there were only a handful of hospitals in existence before the Civil War years, one incomplete listing compiled in the 1920s shows that at least twenty-one hospitals were organized in New York City in the 1870s, thirty-six in the 1880s, twenty-four during the 1890s, and more than forty-six in the first decade of the twentieth century. Some of the institutions that appeared between 1885 and 1915 lasted but a short time, and of these we have little record. The overwhelming majority were privately organized “charity” or “voluntary” hospitals, which, though large in number, were generally small in size. As late as the 1920s, over 37 percent of all hospitals in New York City had fewer than 100 beds. The 114 independent institutions listed in an important 1924 study had an average size of under 160 beds. By the end of the period, when hospital construction began to slacken, what had started as a set of tiny local enterprises had become a major commitment: Although the hospitals were small in size, their numbers had grown to such an extent that there were six general hospital beds for every thousand residents of the city, a ratio that is close to today’s figure and substantially higher than the current New York City government goal of fewer than four beds per thousand people.

The number of doctors affiliated with hospitals also grew during this thirty-year period. Before the 1880s, when a hospital appointment was a closely guarded honor bestowed on particular physicians by hospital trustees, only a very restricted number of physicians had any substantial contact with hospitals. By the 1920s, however, over one-third of all physicians in New York had hospital affiliations as visiting physicians or surgeons. The locus of medical practice was clearly shifting from the home and doctor’s office to the hospital.

During these three decades, the hospital was also dramatically reorganized, resulting in an increase in private services and in the number of patients paying for care. In the late nineteenth century, most patients were skilled and unskilled laborers who spent their hospital stays in large open wards. Because many of them were charity cases, they were cared for in the least expensive way. Gradually, however, the number of patients paying for their care shifted the balance from ward services to private accommodations. By the late Progressive period, over a quarter of all hospital beds in New York City were in private or semiprivate rooms. By the end of this period the hospital was much more like today’s institution, with relatively uniform admissions procedures; a hierarchy of doctors, nurses, and orderlies; and services that were primarily medical and were paid for by the patient.
4 Introduction

This book looks at the changes that transformed the hospital from a series of idiosyncratic community institutions into a larger, more bureaucratized system with a focus on medical treatment. It explores the forces behind many of the changes and the nature of the conflicts produced by these changes. The history of the American hospital, as far as it has been written, has been treated as part of the history of medicine and the medical profession. With the important exception of some recent work on the subject, the evolution of the modern hospital has been seen in the context of the important technical and scientific developments that transformed the medical profession during the past century. Certainly, these developments had a great deal to do with changes in the hospital. Primary among the advances in the field of medicine and surgery during the middle decades of the nineteenth century was the discovery of the anesthetic properties of ether, nitrous oxide, and chloroform. Both patients and doctors became more willing to consider surgical intervention after the introduction of anesthesia. Although the number of deaths owing to postoperative infections, sepsisemia, or gangrene remained high, and surgery remained a technique of last resort, anesthesia did make more invasive and complex procedures possible. As a result, surgeons were able to gain the experience necessary to make surgery a more proficient and technically exact specialty.

Equally significant as the discovery of anesthesia was the development of the germ theory by such European scientists as Louis Pasteur, Joseph Lister, and Robert Koch. The germ theory spurred a search for vaccines and antitoxins to protect against or cure a variety of infectious diseases like syphilis and diphtheria. The development of the diphtheria antitoxin in the 1890s gave impetus to the search for medical cures. In the field of surgery, the understanding of the germ theory led to the development of antiseptic techniques in England and aseptic techniques in Germany, and thus made possible a reduction in the number of deaths owing to cross infections during the postoperative period. In the United States, the use of carbolic acid as an antiseptic agent and the acceptance of the need for sterility in the operating environment made it possible for surgery to advance beyond the lancing of boils, the amputation of limbs, or the setting of broken bones to the performance of more complex operations. The successful removal of the appendix was perhaps the most dramatic testament to the ability of surgeons to operate and prevent infections. Certainly these changes in medical science made the hospital an increasingly attractive alternative to the home or private office. The growing hospital of the nineteenth century offered surgical rooms, equipment, and
a staff of cleaners, dieticians, orderlies, and nurses who could provide constant care and attention to very sick patients.

The germ theory also ushered in a profoundly different interpretation of disease. In the nineteenth century, differences in patients' susceptibility to various conditions like consumption, venereal disease, cholera, or other infectious illnesses were often explained as matters of a patient's social situation and individual morality. Within this context, medicine was a highly individualized art that demanded the utmost attention to the individual, his or her physical condition, and the social environment. By the end of the period, disease was understood in terms of the germ theory and not regarded solely as an indication of morality or social status. As a result, hospital trustees and staff came to see themselves as providers of medical treatment, not moral or social reformers.

Medical historians have also explained how changes in the requirements for medical education affected the nature of the hospital. At the turn of the twentieth century the American Medical Association, the American Association of Medical Colleges, and a number of private industrial foundations worked together to raise standards for medical education. Their reform efforts culminated in the famous report written by Abraham Flexner and sponsored by the Carnegie Foundation that proposed more extensive laboratory experience and clinical exposure for students. To satisfy these demands and to gain accreditation it became necessary for medical schools to affiliate with hospitals so that they might guarantee students access to patients and clinical experience.

In this book, I look at the history of the American hospital from a somewhat different perspective. Viewing the hospital as a social institution, I consider the external political, economic, and social changes that occurred during the Progressive era and that transformed the hospital. Massive immigration, political realignments, urban expansion, and a devastating economic depression placed tremendous pressure on hospitals, doctors, and other health institutions in New York during this period. For these reasons a full understanding of the changes that occurred in the hospital must take into consideration factors that profoundly affected the goals of hospital trustees, the problems to which the hospital was forced to respond, and even the nature of its patient population. Certainly changes in the nature of the hospital affected the lives of the patients and doctors who used it and in some instances even produced changes in the urban environment. The hospital was not an insular institution around which the outside world revolved, but a satellite of the larger community that reflected and was support-
6 Introduction

ed by that community. The growth and transformation of the hospital
is part of the transformation of the American city and illustrates some
of the tensions, problems, and conflicts that arose during this signifi-
cant moment in American history.15

A social history approach encourages us to look at aspects of the
history of the hospital that have previously been overlooked. For ex-
ample, a small community institution like Mount Moriah provides a
wealth of data for understanding the experience of its patients. Smaller
institutions also provide insight into the lives of the vast majority of
nineteenth- and twentieth-century physicians, who never had access
to large medical centers and who spent their working lives practicing
in their neighborhoods and in the wards of their local hospitals. Unfor-
fortunately, if one looks at the hospital solely in terms of great medical
advances, the nature of people’s experience with the hospital and the
role it played in their lives can be overlooked.

A historian who considers the experience of patients and community
practitioners is less likely to view the history of the hospital as one of
steady progress. In fact, the concentration of care in sophisticated
medical centers was often accomplished at some expense. As facilities
became increasingly large and bureaucratized, and as doctors assumed
more responsibilities in the hospital, care became focused less on pa-
tients’ overall social and moral well-being and more on their physical
and medical needs alone. Changes intended to introduce order and
efficiency into the haphazard and idiosyncratic health system of the
nineteenth century often resulted in a more complex, equally disor-
dered, and sometimes less responsive system. Our modern hospital
has greatly improved the quality of medical care, but in the process the
hospital has lost part of its role as a community institution responsive
to broader social needs that are locally identified.

My purpose is not to refute the importance of medical science in the
transformation of the hospital but to examine the effect of social,
economic, and political factors on the organization of the hospital and
medical practice. My research focuses on institutions in Brooklyn and
Manhattan at the turn of the century in the belief that the pressures
on these institutions were similar to those on hospitals in other cities
where industrialization and urbanization were transforming the social
environment. Brooklyn’s health system was composed primarily of
small community-based institutions that were greatly altered and some-
times forced out of existence by external pressures. Manhattan had a
greater number of large, elite medical facilities that were able to sur-
vive the pressures of change and even shape their own future. Yet the
issues with which administrators and staff were forced to struggle
Introduction

were similar in many nineteenth-century institutions. Lay trustees and medical staffs debated whether the hospital was a place for general and varied kinds of care or a place for medical care. Private doctors who began to view the hospital as an appropriate place for treating patients had to deal with their patients' reluctance to go to a "charity" facility that had long been associated with indigency. As medicine became more specialized, community physicians found themselves competing with hospital physicians and specialists for patients. Even the long-standing system of fee-for-service payment for doctors was called into question when physicians began treating private patients in the hospital. Not until new administrative and organizational relationships among doctors, trustees, and patients were developed did the community practitioner see the hospital as a suitable place to practice. Nor were upper-class and professional people willing to use the hospital until private services and private rooms were created for them. Their entrance into the hospital often forced trustees to relinquish the stewardship role they had adopted with working-class patients and the poor.

If we look at the history of institutions, it becomes clear that significant changes in the shape of the hospital often occurred before new medical techniques were introduced. In many instances hospitals were reorganized for internal economic reasons before medical and surgical advances forced any reordering. Private and semiprivate rooms, privileges for attending and visiting physicians, full-time staff nursing, and other amenities characteristic of the modern hospital were introduced into many institutions with little regard to medical standards or necessity. In Brooklyn, for instance, trustees at one of the larger charity institutions decided to build private wings and wards well before they saw a need for an operating theater. As late as 1900, operations were performed in a hallway of the nurses' quarters. In other small hospitals throughout Manhattan and Brooklyn, largely unused private services were created by trustees at a time when the most complicated surgery was little more than the binding and bandaging of surface wounds. Even the implications of the germ theory were only partially understood. As late as 1905 a committee of physicians and laymen in New York suggested that there was little reason to throw away previously used bandages: "The same material used on clean wounds for dressings should be re-washed and re-sterilized and repeatedly used." Gauze swabs and bandages, the committee added, "can be re-washed, re-sterilized and used dozens of times instead of being thrown away." In the largest and most prestigious teaching hospitals, the use of the operating room was hardly commonplace during this period. At the Massachusetts General Hospital, for example, Saturday was called
8 Introduction

“Operating Day” as late as the 1920s, and as late as 1890, most major teaching hospitals rarely had more than one operation per day.16 These facts lead one to consider other factors that accounted for the changes in the reorganization of health care. Chapter 1 looks at the actual physical changes in the organization of the city, the breakup or rearrangement of neighborhoods and the physical separation of the upper and middle classes from the working class. In many instances industrialization and commercialization were the giants that disrupted stable communities and undermined their systems of charity health services. Upper- and middle-class groups escaped the increasingly crowded and noisy city by moving to the developing suburbs, taking with them many doctors and abandoning the communities whose health care depended on the commitment of wealthy patrons and the presence of community practitioners. Feeling a shortage of family practitioners, unskilled laborers and other working-class people turned to those small dispensaries and hospitals within their neighborhoods which had not been forced out by realtors, merchants, and planners seeking to develop the area for commercial uses. These institutions were generally unprepared for the increased number of patients created by a depression that left thousands homeless and sick. Nor were they prepared for the increase in patients injured in accidents or suffering from diseases related to industrialism. New health-care problems were created in the suburbs, as well, by demographic changes. Doctors often had to set up new private practices or travel to see their former patients. Patients had to find new doctors or get used to the idea of traveling out of their communities to see the old ones. As populations shifted, hospitals were not necessarily located in places adjacent to or convenient for people in need. Within a few decades the community-based charity health system was under tremendous pressure to adapt to external social and demographic changes.

Chapter 2 describes how the economic depression of the 1890s, the worst of the century, began to take its toll on the health-care system. Thousands upon thousands of workers who were unemployed for extremely long periods of time turned to the charity hospital for food, shelter, and medical care. As this depression intensified, charity institutions became overcrowded and faced a serious economic crisis. The long-term rise in the costs of medical care, a decline in philanthropic donations, and rapidly growing patient rolls all threatened the very existence of charity hospitals, especially the smaller ones. Trustees of these institutions reluctantly sought new ways to gain income. Some hospitals were forced to close; some were able to survive by decreasing services; and many reluctantly began to charge patients who had previously been treated without charge or for nominal sums.
Introduction

As hospital administrators began to move patients through the facilities more quickly in order to reduce costs and accommodate more needy patients, the trustees found their traditional role as stewards for the poor being undermined. No longer were patients present in the hospital long enough for trustees to assume responsibility for their social and moral improvement. Nor could pressured trustees who were charging patients continue to see their institutions primarily as services to the poor. In fact, many charity patients came to be seen by trustees as a burden, especially because demands for care were so high and the need seemed so overwhelming. In the face of the seemingly intractable poverty created by industrialization, trustees retreated from their previous commitment to charity and sought to narrow the scope of their hospitals.

Chapter 3 describes the evolution of a deliberate policy among hospital trustees and administrators to seek out paying patients. Trustees converted what were called “free” wards into paying wards and private rooms; they provided the option of private-duty nurses for those who could pay; they introduced better food and hired nurses and orderlies to do the maintenance chores previously done by patients. Every attempt was made to make paying patients feel that the hospital was little else than an “invalid’s hotel.” To alter the public image of the charity hospital as a place of death and suffering for the indigent or working class, trustees began to advertise their hospital services and their hotel-like accommodations. It soon became clear to trustees that even these efforts were not sufficient to attract wealthy clients who still had the option of being cared for by private family physicians in their own homes.

The decision of trustees to turn to private family doctors for help in bringing paying patients into the hospital is described in Chapter 4. Trustees reasoned that if they could make an alliance with the private doctors who controlled the therapeutic regimes of white-collar workers and of professional and other relatively wealthy patients, these doctors might encourage their own patients to use the hospital. Doctors had long been seeking hospital appointments in order to gain more clinical experience and to get access to patients in need of private follow-up care. Although trustees were reluctant to admit doctors for fear that they would assume too much control, the financial crisis left the trustees with little choice but to admit doctors as consultants and attending physicians. In an effort to maintain the ideals of charity while meeting the financial needs of the hospitals, trustees sought to maintain the former ward-based structure for nonpaying patients by giving doctors access only to private patient beds in private pavilions or private wards. As doctors gained clinical experience, improved their
Introduction

specialty knowledge, and increased in numbers, however, they felt confident about challenging the right of lay trustees to make important policy decisions, and they began to assume more responsibility in the hospital. Antagonism developed between the doctors and the trustees, and between the doctors and the hospital superintendent. Although trustees sometimes considered that the scientific and pecuniary interests of doctors were antithetical to the goals of the older charity institution, they were forced to acknowledge the growing authority of physicians in their institutions.

While the Depression and the growing problems of hospital financing severely affected the internal workings of charity hospitals, ongoing political changes in the city also forced institutions to abandon their locally defined objectives. As Chapter 5 illustrates, by the end of the nineteenth century it was apparent to many reformers that the charity hospitals lacked a commitment to the wider needs of the city as a whole. Most specifically, many institutions seemed to ignore the growing need for emergency medical and ambulance services throughout the city, and remained concerned only with local objectives. Using as a lever a long-standing financial arrangement in which charity hospitals received funds from the city government, city comptroller Bird S. Coler pressed charity hospitals to take responsibility for the care of certain types of medical cases, along with emergency and ambulance services. Using the rhetoric and tools of Progressive reformers of the period, Coler replaced the older system of flat-grant payments, a system by which ward boss politicians had been able to secure funds for local institutions, with a per capita, per diem method for reimbursing hospitals. By centralizing decision making and setting uniform standards, Coler hoped to introduce rationality, order, and efficient business practices into informally organized charity services and to undermine the authority of local groups and Tammany Hall politicians.

Underlying Coler’s reforms was the assumption that larger institutions would provide better and more efficient care. As a result, small institutions with limited bed capacity could expect funds to cover only as many patients as they had beds. Even if all their patients were charity cases reimbursable through the city, smaller institutions ended the year with less support from the city than they had obtained under the old flat-grant system.

Even as city government reforms were undermining small hospitals, the system of small charity dispensaries came under attack from the state. In the period immediately following the Depression, when these ambulatory clinics were receiving reduced incomes from the city, state inspectors set up standards and regulations that effectively crippled