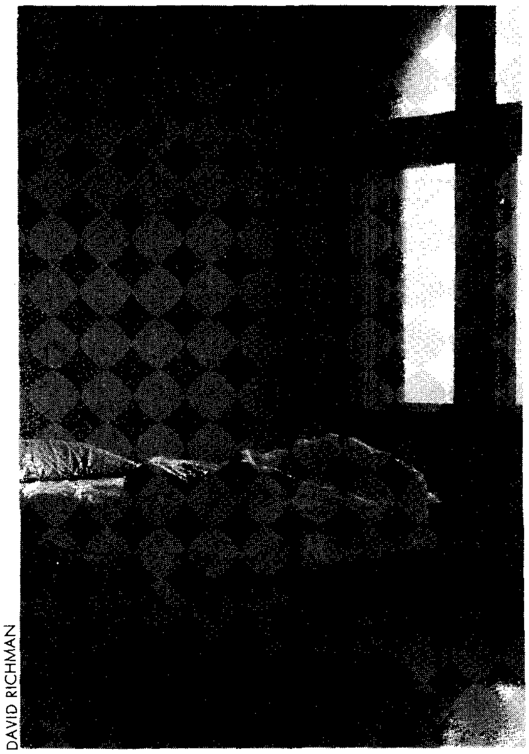
A MATTER OF LIFE AND DEATH

The Scandalous Conditions at Boston City Hospital



DAVID RICHMAN

We lost a patient last week. . . . We would not have lost her if we had not had an inexperienced anesthesiologist.
–Dr. John C. Norman,
Boston City Hospital

On the morning of Thursday, January 8, 1970, the City of Boston woke up to discover that the century-old and long-respected medical-training center of its three prestigious schools of medicine, Boston City Hospital, had been denied accreditation for the first time in 104 years.

"CITY HOSPITAL LOSES ACCREDITATION" was the front-page headline in the *Boston Herald-Traveler*. "REPORT CITES 52 DEFICIENCIES. INCLUDES HOUSEKEEPING, FIRE SET-UP . . ."

In its letter rescinding the hospital's accreditation, according to the press, "the Joint Commission made 52 separate observations covering a number of deficiencies ranging from fire extinguishing systems to book-keeping practices to purported medical facility inadequacies." In the final category, the commission pin-pointed the need "for improvement in housekeeping in specified locations, need for re-location of the surgeon's dressing room to reduce potential outside contamination . . . and urgent need . . . for facilities to provide for proper separation of infected gynecological patients from the obstetrical-newborn area."

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The storm that broke loose on that day in 1970 has not yet quieted, even though BCH was re-accredited in late December. It is the same storm that has engulfed such institutions as the Harlem Hospital and Lincoln Hospital in New York City, Cook County Hospital in Chicago and a dozen other ghetto hospitals in a dozen other major cities. The issue is not the old and almost comfortable issue of archaic plant or antiquated apparatus. The issue is black people. The issue is white medicine. The issue is colonial health-care in its most blatant and most devastating form. The issue is two-class medicine in a racist and divided social order. Yet these are the words nobody wants to use.

[*"Unnecessary mortality . . ."*]

Reaction in Boston was, from the start, defensive and apologetic. Initial response was overseen by John H. Knowles–at that time the best-known medical administrator in the nation. (After provoking a controversy at the Department of Health, Education and Welfare, he became director of the Rockefeller Foundation in New York.) In the curious position of being at once one of the nine trustees hand-picked by Boston's mayor to govern Boston City Hospital and director of prestigious Massachusetts General Hospital, Knowles' national reputation as a health-care liberal seemed to be imperiled by the Joint Commission report.

"There's shenanigans going on here," Dr. Knowles announced. "It's like being hit in the face with a cold codfish." Then, with a nod to the traditional faith in cost-free and inevitable progress voiced forever by the academic liberals of Beacon Hill, Knowles proceeded to promise: "Six months from now this hospital will be fully accredited."

It was one of several promises to the black and poor of Boston on which the medical power structure was not able to deliver. For more than 30 months, beginning January 1970, BCH would serve low-income blacks and Spanish-speaking people of Boston on a quasi-legal basis: lacking full accreditation.

Apologetic, however, evaporated quickly in the wake of still more seri-

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ous revelations. The latter were made public by an unexpected coalition of young interns, residents and nurses. Beginning in the summer of 1971, and continuing through the course of much of the next year, the House Officers (residents and interns) of BCH began to bombard Boston's press and public with a number of disturbing revelations.

• ITEM: Incompetent administration, near-total chaos in the patient record files, possible contamination of the pediatric wards, and worse—all of this had led to a massive emigration of the nursing staff, as 276 nurses walked out of BCH in less than one year. Statistics tabulated by the residents and interns for June-July 1971 demonstrated the results: Wards were left uncovered for as long as eight or sixteen hours in one day. Eight hours of supervision, according to a statement given to the press September 2, was "a rule rather than . . . an exception."

• ITEM: On ten occasions, during one week of observation, "an entire ward was . . . without a nurse for an eight-hour shift." Over the weekend of August 27 to August 29, according to the press release made public on September 2, "there were 15 such occasions."

• ITEM: According to a later press release (October 29, 1971), wards were still being left uncovered: this over a period lasting often "up to, and beyond, eight hours." Said the House Officers: "The patient suffers from this situation." The situation, they added, had reached the point at which it had begun to cause *"unnecessary morbidity and mortality* . . ." (italics added)

• ITEM: Medical records, said the doctors, were in total disarray. The Medical Records Library, upon which a physician must rely in order to make judgments in regard to diagnosis, surgery or medication, "currently has a backlog dating back to 1969." According to the doctors, 4500 records "are not complete and on the shelf . . . There are approximately 39 letter-file drawers packed with loose reports, not filed in patients' records . . . The medical record retrieval rate for the clinics is approximately 80 percent . . ." Since BCH clinics handle about 1000 appointments in an average day, this means that 200 patients every day were seen without medical records.

• ITEM: The report which had withdrawn accreditation from the BCH placed special emphasis on possible contamination of obstetric wards. In one of the items signed by a member of the pediatric staff of BCH, the additional point was made that chaos in the area of pediatric record-keeping was causing danger to the health of children. Said Dr. Patricia Moffat, in a statement that constituted the clearest possible warning to those people who had entrusted newborn infants to the care of BCH: *"We are having difficulty practicing good pediatrics in the present situation . . ."* (italics added)

The House Officers did not limit their condemnations to abstract polemics. In a series of documented narratives released on September 2, 1971, the residents and interns gave the Boston public a number of detailed instances of sickness, death and degradation in the wards of BCH:

• ITEM: The nursing office supplied a first-year nursing student to care for an elderly man suffering extensive burns. "Burns are extremely complicated, requiring a registered nurse, sterile-gowned and masked, to change dressings, apply medications, closely follow the vital signs, and give intravenous fluids. It was against hospital regulations for a first-year student even to take blood-pressures." The man died shortly thereafter.

• ITEM: "A 65-year-old woman four months after a heart attack was paralyzed by a severe stroke and admitted to a ward which housed two different medical services because of ward closings due to the nursing shortage. As she got better, she had to be moved to another ward which did not have continuous nursing coverage. Unable to call anyone to help her with a bed pan, she fell trying to get on a bedside commode unassisted and suffered a painful, non-healing fracture of the hip."

• ITEM: "A man with lung disease stopped breathing and was put on a respirator on a ward covered only by a licensed practical nurse who is not qualified to give the intensive care such a problem requires . . . The third day the patient was transferred to another ward where two registered nurses cared for 24 patients, ten on the danger list. He would have gone to the intensive-care unit if it was not operating at half-capacity due to lack of nurses. He died after five days in the hospital.

• ITEM: Another patient was expected to die after having a massive brain hemorrhage: "His family was told, but they still harbored hope. He was moved out of an intensive-care unit which was half empty due to the nursing shortage and the same day died when his respirator was accidentally disconnected on a large ward with only one nurse."

• ITEM: "Mr. C. was naked in the middle of the hall being weighed on a bed scale that looked like a fork-lift truck; after his weight had been recorded he was noted to have died and was put back to bed . . . Mrs. D. was found dead in bed and a rectal temperature on the bedside chart showed she had previously been well on her way to room temperature. When the nursing student who took it was asked her condition she said that she was better behaved than usual . . ."

[*"On the brink of disaster . . ."*]

There are these words in a statement of the Executive Committee of the House Officers Association of the BCH: "The professional staff of the Boston City Hospital is well attuned to crisis since all of us have lived in a somewhat varying, but always critical, situation relative to patient care. Invariably, each crisis has been met with a response which has been barely adequate . . . At this point in the 104-year history of the Boston City Hospital, the always critical situation has become catastrophic . . . The professional staff cannot provide levels of patient care which are even minimally acceptable."

Sober, straightforward and well-documented statements of this kind pose the obvious question: how is it, then, that there has been so little real response? The answer will be startling to Bostonians.

Boston's three prestigious schools of medicine—Harvard, Tufts and Boston University—possess a vested interest of a rather dramatic and unexpected character in perpetuation of the two-class apparatus. If it were not for institutions such as BCH, it is not clear where medical researchers, students and professors could find the varied, plentiful and unprotesting "materials" they need, whether for education or for research. This does not mean that schools of medicine possess a vested interest in perpetuation of poor hospital conditions. It does, however, indicate that universities and deans of medicine, for reasons of political self-interest, do not dare to interrupt an amicable and non-provocative liaison with the trustees and directors of the ghetto hospital. Ethics might call for protest; plain good sense might call for transformation of the physical conditions; yet short-term politics and short-term calculation call for diplomatic silence, acquiescence and collusion.

This point—that of the symbiosis which exists between the ghetto hospital and the school of medicine—has been articulated in unyielding terms by one of the most reputable doctors in the Boston-Cambridge complex. John C. Norman is a cardiovascular surgeon on the staff of Harvard Medical School and BCH. Norman is an associate professor at Harvard, operates the Sears Surgical Research Laboratories, Harvard Unit, Boston City Hospital; commutes to Houston, where he works with Denton Cooley, and to Washington, D.C., where he serves on a number of government commissions. He is widely recognized as one of the most distinguished research surgeons in the nation.

In an article which drew considerable attention in Boston when it was published in the *New England Journal of Medicine,* (December, 1969), Dr. Norman wrote: "To raise the question of . . . racism in consideration of . . . the problems of the ghetto is naive . . . The ghetto resident offers, in the depersonalized language of the medical profession, excellent teaching 'material.' . . . What better way to perpetuate the system of exploitation than to learn basic clinical medicine from ghetto residents and subsequently deliver that expertise to suburban patients?" Cynically, Dr. Norman added, one could argue that the ghetto is "best-suited" for such exploitation.

In a personal interview last April, Dr. Norman made specific reference to the situation here within BCH: "We lost a patient last week . . . We would not have lost her if we had not had an inexperienced anesthesiologist . . . What can I say? The situation is obvious to all who work here. The atmosphere is antediluvian . . . The hospital functions on the brink of disaster."

In reply to a question bearing on the quality of clinic service, Dr. Norman answered in these terms: "If my own daughter were treated the way that I see people treated in this place, I'd tear the hospital apart."

Grim evidence of the debilitated character of clinic service at the BCH was brought to light in April 1972. A confidential survey, compiled by B.U. medical students who had served in the gynecological-obstetric ward, made allegations of criminal malpractice, racism and discrimination. The survey, as reported in the *Boston Globe* of April 29, 1972, included these extraordinary charges:

(1) Excessive and unnecessary surgery is performed—not for the benefit of the patients, often, indeed against their medical best interest, but because the interns and the residents have need of one particular operation for their training purposes.

(2) Too often, when there are several possible alternatives, the more radical and more dangerous option is selected—not to benefit patients, but again to give the interns and the residents useful "experience."

(3) Records of patients are left incomplete, and do not give correct description of the operations that have been performed. That is: *They do not accurately record unnecessary surgery.*

(4) Coercion is applied to patients to put signatures on surgical consent-forms; permission is obtained, especially from those who do not speak English, without a prior explanation of the actual operation they are legally inviting by their signature.

(5) In one of the most shocking items listed, but presented with painstaking caution in the choice of words, the medical students expressed concern over "the possibility" that black and Spanish-speaking women might "more often be sterilized by hysterectomy," while white women are more likely to be sterilized by "less radical" procedures: e.g., having their tubes tied off.

The medical students, observed the *Globe*'s reporter, "recognize" that this final allegation is "highly inflammatory . . ." They emphasize (he said) that their observations only raise "the possibility" of such extraordinary practice. . . .

In support of these allegations, the *Globe* extracted several individual case histories from the twenty-five to thirty which the medical students had compiled.

• CASE ONE: A seventeen-year-old woman was admitted to BCH twelve

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weeks into a normal pregnancy for an abortion. The medical students charge that the three procedures available for abortion were not explained to her. The three options were (1) suction evacuation, (2) saline induction, (3) hysterotomy. "The patient was told it was too late for her to have suction evacuation." Instead, she was told that a hysterotomy was necessary. "She was never told of the possibility of saline induction."

The students charge that the choice of a hysterotomy was made exclusively for teaching reasons, not out of consideration for the woman's welfare. In support of this charge, they quoted the following exchange:

Student: "Why didn't you do a suction evacuation?"

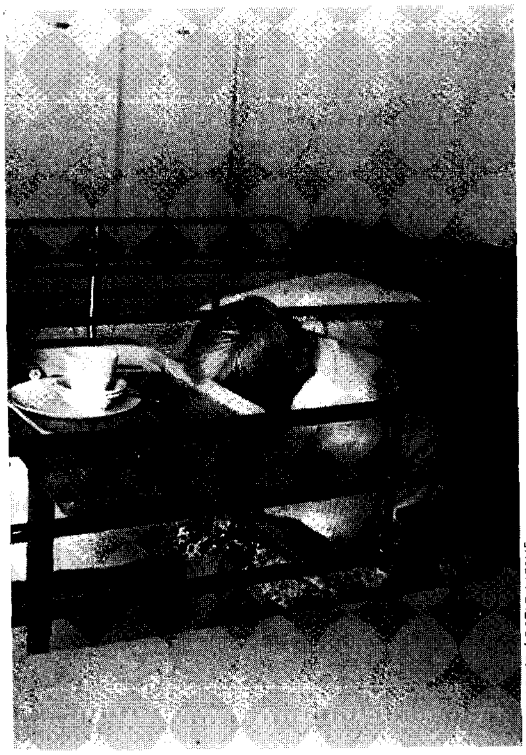
Resident: "Fifteen weeks pregnant

requires saline induction or hysterotomy." (*The patient was only 12 weeks pregnant.*)

Student: "Why wasn't a saline done?"

Resident: "Dr. X wanted a hysterotomy done for the experience."

In accord with the determination of Dr. X, the woman received a hysterotomy. If she ever intends to have children, she will have to have them by caesarean.



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• CASE TWO: A 36-year-old black Portuguese woman was admitted for sterilization. According to the medical students, there was discussion on teaching rounds with a senior resident "as to whether they could 'get' a vaginal hysterectomy 'out' of this case." The students allege that a resident outlined the following options in declining preference: (1) vaginal hysterectomy ... (2) total abdominal hysterectomy ... (3) bilateral tubal ligation (i.e., tying-off of the tubes.)

Student: "Why is tubal ligation the last choice?"

Resident: "We want the teaching experience.... She's 36 and doesn't need her uterus."

The student's report included these remarks:

"The patient wanted a sterilization.

"The patient believed she was to have her tubes tied.

"The patient did not realize or understand the papers she signed authorized a hysterectomy.

"The patient was adamant in not wanting a hysterectomy."

The report states that the woman hastily signed herself out of Boston City Hospital—to the probable frustration of those interns, residents and doctors who saw in her another opportunity to "get" a hysterectomy.

• CASE THREE: A 30-year-old Spanish-speaking woman was admitted for sterilization by tubal ligation. The students quote a medical report, which "indicates both ovaries are completely normal." *The surgical report does not make any mention of a removal of one ovary.* Notwithstanding this fact, however, a "pathology report" exists in which a lab examination confirms the right ovary—*having been removed and studied*—to be completely normal. According to the students, the lab-report gives evidence that "a normal right ovary" *had been removed.* The unnecessary operation was not entered in the patient's record; nor was it entered in the surgical report.

• CASE FOUR: A teen-age girl was admitted for an infection of the external genitalia. The infection was determined to be herpes genitalis. The resident, according to the students' allegations, told the intern to perform the surgical procedure which is known as a "biopsy" (i.e., to cut away a piece of tissue.) He recommended only mild sedation (demerol), despite the fact that the lesions were described as "exquisitely painful."

The students' report continues with this charge: The senior physician advised the resident that a biopsy would not yield significant data of any therapeutic use—i.e. of benefit to the patient. The senior physician observed, in addition, "that a biopsy without general anesthesia in the operating-room would be ... unforgivably painful ..."

The resident, however, proceeded against the explicit counsel of the senior doctor: "Despite this advice, the patient is taken into a treatment room...." The unnecessary and "exquisitely painful"—surgery is carried out, "while the patient screams in pain."

These and other cases bear out the charge of racist exploitation of poor women for the sake of student preparation. We do not need to speculate for long upon the repercussions and reactions that we might expect if such allegations were lodged against The Mayo Clinic or The Doctors' Hospital.

Medical school reaction is well worth examination: The officials in charge of gynecology and obstetrics at B.U. were immediately brought forward to give answers. Initial defense was offered by the chairman of the Department of Obstetrics, Dr. David Charles: "Look," he began, "I was gone from the country for nearly three months." Having established that he was not present during the entire period in question, and therefore had no means by which to make informed replies, he then proceeded to attack the students' credibility and motives: "These students are trying to spread the blame around to some fine men ..." In the event that there might be some truth in what the students said, it still would be wrong—he said—to condemn the entire service "because of one bad apple."

The second-in-command of gynecology and obstetrics at B.U., Dr. Joel Rankin, offered a more serious refutation. These students, said Dr. Rankin, are not in a position to "evaluate" what they perceive or hear. Words, for example, spoken "in jest or bravado by a resident" could be easily "misinterpreted."

The response which carried the most weight, however, came from the dean of medicine at B.U., Ephraim Freedman. Dr. Freedman stated first that he had spoken with some of these students and had no reason to cast doubt upon their accuracy. This, however, was not the real point, in his view. The issue, he said, is not what has been done; it is the level of patient service that can be offered from the present moment onward. This, he said, "is above question or reproach." In regard to the past, he said he saw no reason to go "hunting" on the basis of "some allegations...."

In the opinion of several hundred black and Spanish-speaking women who had been mistreated in the previous 12 months within the B.U. service, there was, on the contrary, excellent reason to go "hunting" into "allegations," especially when those allegations raised some highly embarrassing questions about the ethics of those men who sought to neutralize their import.

It is perhaps only in an area of expertise which still is surrounded with the bogus sacerdotal aura of the medical profession that a liberal paper like the *Boston Globe* can seriously, and without sarcasm, quote from a man such as Ephraim Friedman in seemingly objective and compassionate exculpation of his own behavior: as if his words were not presented in the most explicit and straightforward justification of his own endangered reputation or that of his staff.

Few in Boston are prepared to say that deans and doctors in the well-known schools of medicine actually wish poor people ill. It is not difficult to show, however, that therapeutic, ethical and humanitarian considerations must repeatedly do battle, in the programs and priorities of medical professionals, with the more cold-blooded needs of research units and education faculties. It is only in this light that the deans of Harvard, Tufts and Boston University can explain their consistent opposition to a head-on revelation of illegal practices at BCH.

[*"The price paid . . ."*]

Statisticians, in health care as in other fields, tend inevitably to be conservative. Those responsible for health statistics in the state of Massachusetts are by no means an exception. Paul Parker, top-ranking statistician in the Massachusetts Department of Health and Hospitals, spoke to me in his office at Lemuel Shattuck Hospital in Boston during November 1971. Dr. Parker was reluctant, at the start, to recognize significant differences between his white and non-white infant death statistics. When at last, however, he sat down to spread before me sheets of statistical data which his office had prepared, two notable and disturbing items were immediately apparent:

(1) Figures for neo-natal death—death within the first four weeks of life—broken down by hospitals revealed that the rate of death at BCH in 1969 (the latest year for which reliable statistics were then available for Parker) was 20.1 per thousand. Statistics for the two prestigious hospitals which serve primarily white and well-to-do Bostonians presented an alarming contrast: figures for Beth Israel were 9.7 per thousand; those for the highly-respected Boston Lying-In were almost the same. Figures for Boston's two important Catholic Hospitals—those that offer pediatric and obstetric care, St. Margaret's and St. Elizabeth's—were 14.3 per thousand and 16 per thousand, respectively.

These statistics reflect in microcosm the classic breakdown of health service as it now is offered to poor people in this nation. In terms of infant death and early childhood survival, our chances are best if we are white and well-to-do; they diminish somewhat if we are white, but not so well-to-do; they diminish most of all if we are black or Spanish-speaking. Few available statistics speak with greater power, or with more disheartening arithmetic, to the price that is paid in life and death, in diminished cognition and in distorted growth, for the ongoing situation of race bias and class exploitation in our major hospitals.

(2) During my interview with Dr. Parker, I also was shown comparative statistics for infant malformation. These figures, which contrasted white to non-white infant malformations, were sufficiently grim that Dr. Parker asked me not to quote them without caution. He specifically asked me to be certain that I make quite clear that figures of this kind do not imply genetic differences: "There is danger, otherwise, that figures such as these might be misunderstood." They do *not* indicate genetic differences. They indicate, rather, that institutional discrimination in health services now offered in the state of Massachusetts—including (a) prenatal, (b) gynecological, and (c) obstetric services—does presently lead to an alarming rate of infant malformation, including mental retardation, among children who are non-white.

Dr. Parker had begun our interview in a rather cautious, apologetic and defensive state of mind. He concluded it, however, in a mood which was disturbed and sober: "In terms of neonatal death and of congenital malformation," he observed, "the figures for black children born in the United States are at least 50 percent greater, often two or three times greater, than the rate for whites. . . ."

"*The rate for blacks,*" he conceded, with the sigh of a man who, in the last event, cannot refute his own statistics, "*is just not coming down.*"

The national statistics present a similar story. Black children nationwide die within the first 12 months of life between two and three times as frequently as white children born in private hospitals. The national average (white and black combined) for deaths recorded not just in the first four weeks but in the first 12 months of life, is 20 infant deaths per thousand. In predominately white and middle-class hospitals, the rate is in the range of 10 to 15 infant deaths. In ghetto neighborhoods and rural slums, however, the figures start at 25 or 30 and go up sometimes as high as 60. In BCH, to take one obvious example, during 1971, the rate for infant deaths during the first 12 months of life—according to figures supplied by the hospital director—was 29 per thousand: 50 percent greater than the national (i.e., total black-white) figure, twice as high as the rate for whites alone.

If we look not just at total ghetto areas, but at specific census-tracts, we find entire blocks in which the infant death rate is a good deal higher. Dr. H. Jack Geiger, of Tufts New England Medical Center, reported in his well-known Lowell Lecture, "Health and Social Change," that there are "a number of northern ghetto census-tracts in which the infant death rate now exceed one hundred deaths for every thousand live births." This is close to ten times the rate in Scarsdale.

National figures are available also for the death rate among adults. The risk of dying prior to age 35 for those both black and poor is four times the average for the nation as a whole. Ten to 15 thousand people, mostly blacks and Puerto Ricans, die a death considered "medically unnecessary" each year in New York City. In the ice-cold language of health statisticians, they fall into the category of "excess mortality." The figure for "excess death" in newborn infants nationwide is estimated, in figures released by HEW, to

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ENDGAME

The Tactics of Peace in Vietnam

The Paris Agreements signed on January 27, 1973, are entitled "Agreement on Ending the War and Restoring Peace in Vietnam." Whether or not this will prove an apt designation remains to be seen. The historical precedents are not encouraging. Neither is the White House response to the settlement.

There are, at the moment, two very different versions of what was signed in Paris. The first is the text itself. The second is the version of the Agreements that is being presented by spokesmen for the U.S. government. The text itself is very close to the position the "enemy" has maintained more than a decade. Washington's version, which differs in fundamental respects, reflects the long-standing position of the U.S. government. We may ask whether the U.S. government version is merely rhetoric for home consumption or whether it is the framework for policy. It is probable that Nixon and Kissinger themselves do not know the answer to this question. They will feel their way, determining just how far they can go on the basis of the domestic and international response. One factor of no small importance will be the manner in which the U.S. intervention of the past 25 years is perceived within the mainstream of opinion in the United States.

The Paris Agreements state: "Foreign countries shall not impose any political tendency or personality on the South Vietnamese people" (Chapter IV, Article 9c). The White House "summary of basic elements of the Vietnam agreement" states: "The government of the Republic of (South) Vietnam continues in existence, recognized by the United States, its constitutional structure and leadership intact and unchanged." This government (GVN) has the right to "unlimited economic aid" and "unlimited military replacement aid." The latter will maintain in existence one of the more powerful military forces in the world (in terms of equipment at least) and a vast police apparatus. Furthermore, as Kissinger remarked in his press conference of Jan. 24, the U.S. maintains the right to provide "civilian technicians serving in certain of the military branches." He did not add that the U.S. will undoubtedly continue to train pilots and other personnel in the U.S. and elsewhere.

Kissinger further explained that the U.S. has adhered to its principle of refusing to "impose a coalition government or a disguised coalition government on the people of South Vietnam." The Paris Agreements, however, are broader. They require as well that the U.S. refrain from imposing on the people of South Vietnam a right-wing autocracy based on the military and a narrow urban elite, and consisting largely of former collaborators with French imperialism—namely, the Saigon regime. No serious observer can doubt that the GVN was "essentially a creation of the United States," in the wording of the Pentagon Papers, or that this regime has been maintained in existence through U.S. force. To take one crucial moment of recent history, it is generally conceded that the U.S.-imposed regime was on the verge of succumbing to a South Vietnamese revolutionary movement by late 1964, despite massive U.S. aid and direct U.S. military participation in combat and combat support for at least three years. General Thieu, for one, understands the present situation quite well. He has observed, in a recent interview, that "The French abandoned us in 1954,

Noam Chomsky's books include At War with Asia *and* Problems of Knowledge and Freedom *(Pantheon).* For Reasons of State *(also Pantheon) will be published soon.*

by Noam Chomsky