

Biocitizenship

The Politics of Bodies, Governance, and Power

Edited by

Kelly E. Happe, Jenell Johnson, and Marina Levina



NEW YORK UNIVERSITY PRESS

New York

Biocitizenship on the Ground

Health Activism and the Medical Governance Revolution

MERLIN CHOWKWANYUN

Introduction

Throughout the 1960s and into the early 1970s, community health workers, neighborhood activists, and young medical students and physicians challenged long-standing traditions and practices in the American health care sector. They posed fundamental questions about inclusion and citizenship within the post–World War II medical boom: namely, who actually enjoyed its fruits, and who should have a say in how its institutions operated? Programmatically, key participants in this agitation fought to increase the decision-making power of nonphysicians and nonprofessionals, especially that of laypeople, and decrease hierarchy within medicine.

I call this contest of biocitizenship the “medical governance revolution.” In other controversies around biocitizenship, subjects have questioned the authority of risk assessment from nuclear catastrophe and debated the embedded assumptions of novel genetic testing, to name just two.¹ The resolution of these conflicts over biological truth has high-stakes consequences for the ability to make claims on the state. Likewise, the subjects I studied turned their sights, too, on a highly rarefied field of biological practice, the American medical system. In the process, they reordered rarely questioned chains of authority in medical institutions.

To analyze my subjects’ fortunes, I use three cases. I start with the rise of activism at a site not typically associated with political ferment: the American medical school. Like their undergraduate counterparts, medical students in the 1960s demanded more of a say in their educational

experiences and how their institutions operated. They pushed medical school deans for more responsive outreach and sharing of medical resources beyond campus boundaries, a fraught demand given the wave of ongoing urban riots in the deeply segregated urban neighborhoods where medical schools were often located. Medical student activism also extended to the classroom, with widespread efforts for curricular overhauls that would supplement traditional biomedicine with course material on the social context of health.

From medical schools, I move on to New York City, specifically the South Bronx, where a group of residents and interns converged in 1970 on Lincoln Hospital, one of the most dilapidated public hospitals in the United States. Calling themselves the “Lincoln Collective,” they planned to use their critical mass to implement major changes in how a hospital was run, shifting major authority to activists and nonphysicians. Democratizing a single hospital would provide, in turn, a prototype for other health activists not just elsewhere in the city but throughout the entire country.

My last case also takes place in New York City but on the Lower East Side, home to an experimental outpatient clinic called Gouverneur Health Services. From the experiment’s inception in 1961, Gouverneur blurred the boundary separating the clinic from its patient pool, employing community organizers and door-to-door health workers—most from the neighborhood itself—to gauge common problems in the area and encourage more use of its services. Gouverneur soon became an inspiration for the fledging federal neighborhood health centers program. It was funded by the Office of Economic Opportunity (OEO), which made facilitation of nonprofessional and laypeople’s participation in administration a condition for new federal funds from President Lyndon Johnson’s ambitious War on Poverty legislative agenda.

The medical governance revolution was an instantiation of what might be called biocitizenship on the ground. I use this phrase to accentuate how it differs from some of the more prominent case studies that have helped articulate the biocitizenship concept. The majority of these focus on the clash between expert knowledge—sometimes sanctioned by the state—and parallel lay suspicions or critical discourses. By contrast, the stories here focus less on controversies over bodies of establishment knowledge than they do on attempts to alter *practice* on the

ground and at the micro-level. Stirring rationales for alternative ways of knowing and thinking—often in the form of manifestos or extended writings—were, of course, always present. But the central goal was less about transforming scientific knowledge production than on catalyzing changes in day-to-day institutional practice.

These three cases showcase different sites and facets of the medical governance revolution. Medical campus activism stemmed from tensions within medical training that contributed to students' personal alienation from the professionalization process. The Lincoln Collective's members, fresh out of medical school, constructed a new postgraduate outlet for the political energy that swept through medical campuses in the 1960s. Granted a large amount of autonomy to devise a new residency program, they sought to infuse it with the new emerging governance principles. *Gouverneur*, meanwhile, operated under more formal auspices. It showed the challenges of implementing formal governance mandates imposed from above, in this case federal War on Poverty stipulations for lay participation.

Alas, the medical governance revolution was an incomplete one, hampered by many internal and external obstacles. Its most energetic organizers led parallel personal and professional lives, resulting in turn-overs in leadership and their being pulled in multiple directions, often away from political organization altogether. Underlying class and racial hierarchies hampered activist unity, especially when they mapped onto professional and nonprofessional status differences. This, in turn, contributed to interpersonal tensions, emotional exhaustion, and frequent burnout. Throughout, lingering questions surrounded all three experiences. Ambiguity surrounded "community," a key concept invoked on its members' behalf to argue for the community's right to participate in administrative decisions. Above all was the question of how much such activism, in the end, really mattered in the face of major structural transformations, by the mid-1970s, in the health care sector and a changing and turbulent American political economy.

Medical Student Organizing

In June 1968, the American Medical Association (AMA) met in San Francisco, but the meeting did not proceed as planned. Out in front,

some Bay Area medical students were picketing the building alongside Black Panthers and other activists. During the actual proceedings, a Stanford University medical student, Peter Schnall, walked to the podium and asked if he could address the audience. He got no reply, so he began reading a speech to the AMA delegates: “The health care system in the United States, long failing, now may well be collapsing. This disintegration is due in no small part to racial discrimination, economic discrimination, and archaic, poorly delivered and inadequate health programs.”² As Schnall spoke, one could hear booing and hissing. But the delegates mostly watched in surprise. Schnall accused the AMA of capping medical school admissions artificially to increase physicians’ salaries. It condoned segregation in its southern chapters, Schnall claimed, and it had long lobbied against Medicare and Medicaid, passed just a few years prior. It embodied, in short, professional insularity at its worst. “I don’t think you people have the right to call yourselves humanists—much less the right to treat the poor,” he shouted at the most powerful physicians in the country.³

Peter Schnall did not emerge from a vacuum. He was a by-product of what a prominent medical magazine would later call “unrest on the medical campus” in the 1960s.⁴ Much of the action revolved around what would eventually be called Student Health Organizations (SHO), which originated at the University of Southern California (USC) School of Medicine through the efforts of William Bronston, then a medical school senior, and Michael “Mick” McGarvey, a sophomore. SHO focused initially on disseminating new ideas to medical students, publishing a newsletter, *Borborygmi* (whose title means “intestinal rumbling”), in September 1964, and hosting a lecture-discussion forum on such topics as “Discrimination in Medicine,” “Medical Malpractice,” and “Physician, Heal Thy Society!”⁵

But a few months later, in January 1965, Bronston began turning the activities into more than an ephemeral affair. He called for the formation of the Student Medical Action Conference (SMAC, pronounced “smack”) that would combine the consciousness-raising of the discussion forum with actual practice. SMAC’s brief founding “credo” offered an expanded definition of the physician’s role, one that located duties beyond biomedical boundaries and highlighted the social and political aspects of medicine. Optimistically, it “resolve[d] to engage in active

community service, to critically examine issues that pertain to the public health, and to publish facts, information, and statistics concerning problems of health which have failed to engender appropriate community concern and action.”⁶ In the summer of 1965, the group launched year-long work: reviews of health care legislation, free auditory and vision screening of children, and dental care for the indigent. It also initiated ambitious summer projects that became the organization’s early hallmark. One sent thirteen students to work with migrant farmworkers across California, another three students to the South to provide “medical presence” for civil rights workers threatened daily with political violence.⁷

By the next school year, the group had spread nationally, and in Chicago, students agreed to form a new national organization. Chapters popped up in many locales. The Bay Area (of California), New York City, Boston, and Philadelphia were particular hot spots. In these early days, SHO attracted the support of medical and governmental elites. Activities at USC were championed by its dean, Roger Egeberg, and it soon received funds from President Johnson’s Office of Economic Opportunity (OEO), which dispensed most War on Poverty grants. This establishment backing would later cause friction in the organization. But for now, the focus was on real-world work. The OEO grant financed a summer project in 1966 that funded “90 medical, dental, nursing and social work students from 40 institutions in 11 states.” They worked across California in the state’s poorest areas, providing free basic screenings, referral services, and dental work at free clinics, camps for migrant farmworkers, and public hospitals.⁸

The summer work expanded its participants’ political horizons. Margaret Sharfstein, who had come to California from New York City to work at a public hospital, remarked: “Nurses and social workers go into the community. Why shouldn’t doctors? The patient is a whole human being, with a home and a social interaction all of his own. . . . To look at the patient as a disease alone seems inconsistent to me for the ‘healing professions.’”⁹ Other students recounted interactions with indigent patients who often delayed or simply did not seek health care because of the inefficiency or patronization they encountered within health care facilities. A favorable *Los Angeles Times* article labeled the students “a new breed.”¹⁰ They were forming what Alondra Nelson has called a “so-

cial health” perspective, one that saw links between medical ills and the social contexts that bred them.¹¹ By 1967, the summer projects scaled up, continuing in Los Angeles and now Chicago and New York City with sponsorship from medical schools in those regions and the OEO.¹² A recruitment pamphlet articulated the projects’ goals of expanding a physician’s imagination, declaring that “the majority of students in the health professions do not gain, in their formal curriculum, an accurate appreciation of the needs of the medically underprivileged in America, or of the difficulties faced by existing health programs and practitioners in poverty areas.”¹³

The service projects complemented parallel efforts to reform medical schools’ curricula and how they operated beyond campus walls. At Stanford, SHO members demanded that courses in community health become mandatory and that students have input into their content.¹⁴ The lobbying efforts for a more socially relevant medical school proved successful on many campuses. In November 1967, Dr. Martin Cherkasky, director of Montefiore Hospital and a dean at Albert Einstein College of Medicine, co-authored an article with Steven Sharfstein, an Einstein student. Appearing in the *American Journal of Diseases of Children*, the article affirmed the possibility of transforming the medical school into a more socially engaged institution. It declared that such institutions “can and must undertake the creation of imaginative, new organizational methods for delivery of medical care. The medical school should initiate, test, and critically evaluate pilot programs in community health.”¹⁵

Signs like these suggested a new era of medical school governance and harmony between students and administrations, academic medical centers, and their environs. But by the following year, in 1968, the tenor of SHO changed. One contentious moment at its annual meeting came when Bill Bronston, the organization’s co-founder, delivered remarks later printed in the *AMA News*. He declared: “We’ve got to disrupt and destroy the system where the fat cat doctor gets \$40,000 to \$50,000 a year.”¹⁶ The responses to Bronston from other SHO members revealed ideological fissures. John Fisher, a medical student from Detroit, wrote that “as a political moderate,” he was “very disturbed by some statements,” namely, Bronston’s, that the *AMA News* had carried.¹⁷

In addition to debates over rhetorical choices, some SHO members focused on the organization’s *raison d’être*. Tim Smith, chairman of the

Cincinnati SHO, cast the SHO's signature summer health projects as "temporary, project-oriented solutions" that, "though educational, are destined to eventual failure because they don't attack the roots of the problem."¹⁸ This debate unfolded in the summer of 1968 as SHO expanded the summer projects to seven areas: California, New England, Chicago, Philadelphia, Milwaukee, New York, and Cleveland. As in the past, participants, particularly first-timers, found them edifying and eye-opening. But others qualified their praise with criticism of the projects' ephemeral nature. In an evaluation, one participant asked hard-hitting existential questions not just about the longer-term purpose but also about who SHO and its projects were really for:

According to the project fellows and SHO literature, the main goal was "sensitization" of white, middle-class, medical students. A perfectly rational idea—from the white student's viewpoint. But from the moral point of view, this is an horrendous injustice to the community! How can SHP [summer health projects] invade a ghetto (to "help," of course) with an army of white medical students, and for ten weeks perform acts of charity and fellowship, but simultaneously have the anguish of the ghetto as a secondary reason for justifying the existence of SHP? The makeup and foundation of SHP must be changed.¹⁹

Racial tension simmered beneath subsequent exchanges. *Catalyst*, the Boston SHO's publication, bluntly characterized overwhelmingly white health students' interacting with predominantly poor and nonwhite patients. The cover drawing of one issue showed a light-skinned hand reaching downward toward a dark-skinned hand with visible skeletal structure beneath it.²⁰

Were SHO members, the internal critics asked, deriving pedagogical experience from indigent patients without leaving much permanent behind? Were they in the end primarily transforming themselves and their political gestalt but doing little else? What might be implemented instead that lasted longer than the duration of a summer project? In the summer of 1969, quotations and drawings of Mao Tse-tung, Ho Chi Minh, and Che Guevara dotted SHO's national publication, *Encounter*. In one issue, an article declared that "SHO is a liberal organization. Originally conceived as a refuge for all well-meaning and concerned,

left-of-center health student activists, it has long outlived that usefulness.”²¹ Service projects, curricular reform, and community involvement on the part of medical schools were “basically reformist” to “enhance the privilege of an already privileged group.”²²

By 1970, SHO imploded. When the early leaders graduated and moved on, they left a leadership vacuum, and SHO became the victim of a crisis of purpose and resultant infighting: on one side were those who were fine with the programming conducted heretofore; on the other side were those pushing for a major rupture from its past. But beyond revolutionary murmuring, what the latter path entailed was not exactly clear. In the five years since the organization’s founding on the USC campus, it had gained some input into administrative and curricular matters at multiple schools. And via the summer projects, SHO had contributed to thinning the walls that separated gilded academic medical centers and their surrounding neighborhoods. It was an undeniable shift in governance from the way things had been at the start of the decade. But it was also an undeniably limited victory, too. As indicated by the remarks of the more frustrated members, actual people living in poverty-stricken neighborhoods had not played major roles in the planning of programs designed supposedly to help them. And even if they had, it would not, many SHO members realized, ultimately attack the roots of health care maldistribution that SHO’s outreach work temporarily alleviated. This fundamental conundrum confounded the efforts of activists in the following episodes as well.

Lincoln Hospital and the South Bronx

It is the atypical American internship and residency recruitment pamphlet that begins with a quotation from anticolonial theorist and psychiatrist Frantz Fanon. And yet, that is exactly how Lincoln Hospital’s 1970 House Officer Program in Community Pediatrics pitched itself to potential recruits, with an excerpt on the ambiguous role of the physician in an oppressive society. The passage read: “In the colonial situation, going to see the doctor, the administrator, the constable, or the mayor, are identical moves. The sense of alienation from colonial society and the mistrust of its authority are always accompanied by an almost mechanical sense of detachment and mistrust of even the things which

are most positive and most profitable to the population.”²³ At its most basic, what would become known as the Lincoln Collective consisted of two dozen physicians, most from pediatrics (but some in internal medicine and psychiatry), who designed a residency program with the intent of transforming how a hospital was run.²⁴ The project was the brainchild of Charlotte Phillips, a recent graduate of Case Western Reserve University’s medical school in Cleveland. While there, she and her husband, Oli Fein, had been members of Students for a Democratic Society and active in its Economic Research and Action Projects (ERAPs), the organization’s community organizing project.²⁵ Although Phillips herself was never a member of SHO, some of the other early members of the Lincoln Collective were.

One can read early Lincoln Collective statements of purpose as an attempt—whether or not created with SHO explicitly in mind—to transcend the limits of signature SHO activities. The break was not a clean one. Some of the programming mentioned in the recruitment pamphlet resembled SHO summer projects. For example, a “community elective” would require interns and residents to spend time outside the hospital disseminating information and conducting screenings, among other activities. But other sections revealed significant departures from the SHO days. One “affirm[ed] that we are in training to serve the community, and that we are committed to dealing with the problems of the urban ghetto community in a long-run way.” Most important, the Lincoln pamphlet declared “a shared commitment to the community” and made “transferring technical knowledge to the people” a priority.²⁶ At least rhetorically, this looked like it could be a departure from the one-way quality and seasonal length of the SHO summer health projects.

If the Lincoln Collective wanted more pro-activeness and action, it surely got that. Shortly after their arrival, its members were greeted by a one-day occupation of the hospital’s nurses’ residence. Planned by the Young Lords, a Puerto Rican nationalist group with symbolic and ideological similarities to the Black Panthers, the occupiers demanded door-to-door health services “for preventive care, emphasizing environment and sanitation control, nutrition, drug addiction, maternal and child care, and senior citizen services,” a permanent twenty-four-hour grievance table, a \$140 per week minimum wage, and a day care center for the community and hospital workers.²⁷ Its final demand, however, was the

most provocative and centered on governance. It called for community control, “total self determination of all health services through a community worker board to operate Lincoln Hospital.”²⁸ This demand—and how and whether to realize it—shaped many of the subsequent debates and activities of the collective’s members. In the wake of the occupation, the Young Lords left the task of Lincoln to the Health Revolutionary Unity Movement (HRUM), an adjunct organization consisting mostly of Young Lords members interested in health issues.²⁹

The Lincoln Collective and HRUM were organizing at what might have been the most underresourced hospital in the city. One official assessment from nearby Einstein Medical College, which was paid by the city to take on some administrative tasks, described it as a place where “the dirt and grime and general dilapidation make it a completely improper place to care for the sick or even run the complex administrative machinery that is required to do this.”³⁰ Against this backdrop, the collective wrestled with how to translate the framework of a program into practice. Politically, considerable heterogeneity existed within the group. Some members wanted to focus on improving service within the hospital. Others were much more overtly confrontational and wanted to deepen relations with HRUM. And some straddled both tendencies, such as the people who serviced the Black Panthers’ South Bronx Clinic, which conducted lead poisoning and TB level screenings.³¹ By the end of the year, the collective was regularly committing \$150 to \$250 per month to Third World revolutionary groups in its immediate orbit: the Panthers, the Young Lords, and most important, HRUM, with which it would later have the closest relationship.³²

The collective wrestled with its exact relationship with these outside groups, but hospital-level reforms drew the support of almost everyone, regardless of where they stood on the headier Third World solidarity questions. These reforms included the adoption of continuity-of-care clinics, where patients saw the same doctor each time they visited the hospital, much rarer in public hospitals at the time due to physicians’ large patient loads. For the collective, continuity of care added accountability to a doctor-patient relationship. That the change occurred within an existing institution gave it a more permanent quality than existed in a summer project. During the collective’s second major staff rotation in July 1971, its members strategized to ensure that continuity patients were

not randomly and suddenly shuffled to new doctors but were assigned to them by the more senior residents to ensure a smooth transition.³³

Other projects took more time to get off the ground. The “community elective” requirement took considerable time to gain traction.³⁴ A monthly report written approximately six months into its existence suggested the Lincoln Collective was having trouble identifying longer-term activities for it to undertake.³⁵ Meanwhile, class tensions between the collective’s physicians and everybody else—that is, the “community”—came ever closer to the fore. In one summer, a member hosted a hastily arranged party at his mother’s home in Connecticut that resulted in considerable introspection. Of all the attendees, only one was a hospital worker, someone who had come frequently to the collective’s meetings. The remaining guests had all been Lincoln Collective doctors who, after a quick discussion, had concluded that notifying workers would require too much time on too little notice. At the collective meeting where this event was recounted, the note taker summarized the situation by saying that “everyone knew they were exercising class privilege but were not talking about it.”³⁶

Frustration over how to create a real alliance among the Lincoln Collective, hospital workers, patients, and the community mounted by August 1971, which saw the departure of half the collective’s original members. One meeting’s rapporteur summarized the mood as one full of “feelings of ‘something missing’ . . . of dissatisfaction and frustration, of hopes unmet and actions not carried through. Of the ‘collective’ being an elusive and perhaps illusive concept.”³⁷ The relationship with Third World groups remained uneasy, as revealed later that fall during a meeting between HRUM and the Lincoln Collective. Boiled down to its essence, it revolved around the tension between an almost entirely white and upwardly mobile group and one composed of mostly working-class African American and Puerto Rican health workers. “They felt we were often guilty of having a colonizer attitude,” one member wrote at the time.³⁸ But far from “going home,” HRUM insisted, the collective needed to stay, for it possessed essential skills and technology that few others possessed, least of all in the resource-depleted South Bronx. To achieve more political symbiosis with HRUM, the collective underwent a major internal change, reorganizing itself into five subgroups, each of which would engage in “political education” on a new topic assigned

to it by HRUM that week.³⁹ In HRUM's view, the collective had to "accept" more leadership from HRUM, and it was chided for its overall "unwilling[ness] to accept leadership."⁴⁰

Outside of the internal political and personal transformation the Collective was to undergo, its members also continued attempts to democratize medical practice at Lincoln Hospital. Toward the end of its first year, the collective established a Pediatrics Parents Association, which learned about children's problems, took part in occasional rounds, and, most important, had input into the house staff selection. Parents were allowed to ask candidates questions, and at one point a ten-year-old and an eleven-year-old also participated in interviews.⁴¹ More than 700 hospital workers and nurses received questionnaires about "the doctors' ability to practice their technical skills in a conscientious, humane manner."⁴² The collective restructured governing committees within the pediatrics department so that parents, nurses, and workers could attend and level complaints against physicians. In one such meeting, nurses complained that "some doctors [had] a poor attitude and [were] hard to locate." These changes were an attempt to "ignore professional hierarchies," as stated in the first collective recruitment pamphlet, and to widen the parameters of governance within medical institutions.⁴³

Word of the Lincoln Collective spread, and in 1972 it caught the attention of the Health Policy Advisory Center (Health/PAC). Founded in 1968, Health/PAC published a bulletin that situated the city's and the nation's health care systems in a political-economic framework that emphasized the role of a "medical-industrial complex" in the maldistribution of health care resources.⁴⁴ In a chapter titled "The Community Revolt: Rising Up Angry," published in its 1970 book, *American Health Empire*, Health/PAC had predicted a wave of neighborhood insurgency to come in the medical world.⁴⁵ It was no surprise, then, that the Lincoln Collective caught Health/PAC's attention, and the latter commissioned a lengthy analysis of what was going on in the South Bronx. The piece offered qualified support for the collective, praising its medical reforms, and argued that Lincoln represented "one of the first thin threads of a sustained struggle to achieve worker-community control within a health institution."⁴⁶ At the same time, it characterized the collective rather harshly for being driven by "a romantic notion about the medical savior

who leads other people's struggles or the voyeuristic tendency that defines a 'total politic' as 'rapping with the Lords.'⁴⁷

When it came to "worker-community control," the gap between ideal and practice remained. Around the time the Health/PAC dispatch appeared, the Lincoln Collective became embroiled in a seemingly trivial debate over meal tickets and HRUM's position that doctors should have to pay for meals, too. Some members of the collective recoiled at what they saw as HRUM's Third World guilt-tripping, and the exchanges quickly led to abstract discussions on the subject of proletarianization and revolution. One member, objecting to the idea of proletarianization of professionals, declared that he did not think revolution would "be led by workers in a traditionally Marxian concept," an implicit argument that rapid flattening of the hierarchy at Lincoln Hospital and elsewhere might be misguided. Another member stated that Third World people needed to allow white people "to evolve to revolution instead of laying down the line." An HRUM representative countered, accusing the collective of "enjoying" class differences.⁴⁸

Into the next year, conversations continued apace over the role of race and professional class privilege; doctors' proper place in social change; what "revolutionary" even meant, and how much of a revolutionary to be. On occasion, HRUM showed signs of moderating some of its positions, as in the spring of 1973, when it criticized its own "extremism," particularly attacks on hospital worker unions for strategic conservatism that tended to focus only on its own members' welfare. "The unions are working class organizations," read one of its newsletters, "and we can't just disregard the hard-won gains of the last few years."⁴⁹ Within the collective itself, however, there were signs of emotional fatigue extracted by lack of resolution over bigger existential questions and ideological impasses. Nearly all Lincoln Collective members whom I have interviewed have spoken of intense burnout and emotional exhaustion, all compounded by having to juggle both charged political discussions and the work week of a resident in a place like Lincoln. At one meeting, members discussed a "lack of unity" among themselves but also expressed frustration over atomization and a "failure to relate" to "other health struggles through the city and country."⁵⁰

Broadly, there was indeed even less sense of national connectedness, unlike the SHO days, when decentralized chapters nonetheless

shared a loose national structure through which ideas could travel and people could interface. By 1975, despite some of the innovations that it had managed to implement, the collective petered out. In its last year of existence, it had scaled back its activities to political education and writing pamphlets. Important as these broadsides might have been, they circulated without much institutional foment to complement them. The specter of “sustained struggle to achieve worker-community control,” of which Health/PAC had written, now looked like it would simply pass and dissipate.

Most members of the Lincoln Collective had developed new political consciousness during their time at Lincoln Hospital and gained new insights into the privileges that came with being upwardly mobile physicians in a municipal hospital. They succeeded in making some major changes in Lincoln’s operations, increasing patient accountability and participatory governance for those who lived near the hospital and might have to use it. In one year, the Pediatrics Department received a city rating that was nearly thirty points higher than the citywide average.⁵¹ But the exodus of the collective by the mid-1970s limited these reforms’ ultimate impact. And even if they had stuck, what did it all mean without a sustained movement outside of one institution and one city? At another facility at the other end of the city, these dilemmas were playing out as well.

Gouverneur and the Lower East Side

In 1967, the *Milbank Memorial Quarterly*, a prominent health policy journal, carried an article about a small public outpatient clinic on New York City’s Lower East Side. Written by the clinic’s two directors, Howard J. Brown and Howard Light, the article contained a list of twenty-five “operating principles,” the most striking of which read pithily: “The community at large was entitled to a voice in the program and should share in the decision making process wherever possible.”⁵²

The document beamed with optimism about what a new ethos in health care governance might look like: not just at Gouverneur but at other facilities as well. But Gouverneur differed from Lincoln Hospital in one major respect. As a recipient of newly created funds for neighborhood health centers—most of them small outpatient clinics in under-

resourced neighborhoods—Gouverneur’s initiatives had the backing of the federal government and the Office of Economic Opportunity, which required the creation of an administrative board composed of nonprofessional laypeople. Although these lay boards (called “health councils”) varied nationwide, the one at Gouverneur appeared to possess real teeth. Called the Lower East Side Neighborhood Health Council–South, its formal charge was the review of applicants for future OEO funds, program priority setting, and input into selection of a director. It was all part of the OEO’s commitment—one later racked by controversy—to “maximum feasible participation” of nonprofessionals, particularly the poor, in the decision making of the very programs created for their betterment.⁵³

In their early days, Gouverneur and the council focused on cultivating a feedback loop between the clinic and its surrounding population, which was 29 percent Puerto Rican, 8.2 percent black, and 3.2 percent Chinese, some first-generation immigrants. Gouverneur hired employees directly from the neighborhood and encouraged residents to use the facility.⁵⁴ In the summer of 1967, Lower East Side youth carried out a study on Gouverneur usage patterns, language barriers, and wait times, which were promptly reported back to the facility.⁵⁵ But within a year, the relationship between the OEO-mandated council and Gouverneur quickly became confrontational, largely as a result of sweeping changes in the New York City health care system in the 1960s. Earlier in the decade, Mayor Robert Wagner had signed off on an “affiliation plan” that subcontracted administrative operations of the city’s public facilities, including Gouverneur, to private medical centers. The plan had spurred an enormous amount of blowback, especially from critics who saw affiliation as nothing more than a power grab by the private medical establishment. For Gouverneur and the council, the affiliation structure affected the dispersal of OEO funds. Rather than go directly to Gouverneur, OEO money instead was managed by the clinic’s private affiliate: Beth Israel Medical Center. Beth Israel’s head, Ray Trussell, was no friend of bottom-up participation. He had recently left his post as commissioner of hospitals, having been the key architect in the affiliation plan imposed by fiat on the city’s health facilities. For all the talk about maximum feasible participation, then, this meant the OEO-backed council’s authority, in the last instance, rested with Trussell and Beth Israel administrators.

The next couple years saw protracted political conflict between the council and Trussell. In 1967, when the council identified a proposed full-time “health advocate” for Gouverneur, Trussell unilaterally refused. Only after learning of the council’s direct appeal to OEO’s headquarters in Washington, DC, did Gouverneur reverse its decision.⁵⁶ In August 1969, Trussell removed grant provisions for employee job training from Gouverneur’s annual OEO allotment without consulting the council.⁵⁷ Two months later, the council again felt marginalized when the Gouverneur directorship opened up and Trussell’s handpicked choice took office, despite the council’s disapproval. A final explosive turning point came in December 1969, when the council received a sympathetic letter from Harvey Karkus, a Gouverneur doctor who openly deplored Trussell’s conduct. A month later, Karkus lost his job, causing 120 people to show up at Trussell’s office in protest.⁵⁸

As if butting heads with Trussell was not enough, the council also faced tensions within its own ranks. Before they shifted their focus to Lincoln, the Young Lords and HRUM agitated intensely around Gouverneur. One of HRUM’s key leaders, Gloria Cruz, had been the council’s choice for a health advocate position. While Trussell would likely have paid little heed to any name put forth, the council’s choice of HRUM’s Cruz did not go over well with other parties either, many of whom bristled at HRUM’s combativeness. HRUM’s role raised important questions over what exactly “community” meant and the legitimacy of those who claimed to speak for it. In protesting Trussell’s conduct, HRUM consistently invoked “community” and its own role as a critical conduit between “community” wishes on one side and a hierarchical medical giant on other. But how much authority did it have to speak in such terms? One surprising critic of HRUM was Local 1199, the otherwise militant hospital workers’ union, which criticized HRUM in its newsletter.⁵⁹ “While HRUM claimed its goal was improved health care for the community,” read an article in the newsletter, “it was unable to demonstrate any significant community support. Although the HRUM group included better working conditions among its goals, its members ignored both their fellow union members and the union’s grievance machinery in dealing with management.”⁶⁰

Local 1199 was not alone in being sensitive to the ambiguities of the community rhetoric. A federal OEO consultant assessing the Lower East Side situation picked up on it, too. Brought in to adjudicate the standoff

over the Gloria Cruz hiring, the OEO's Laura Ackerman saw one root of the problem in the legislative language—"maximum feasible participation," "direct involvement of the people"—and its being squishy and open to multiple interpretations. Beth Israel, for instance, had "stated that Gouverneur is a city clinic and feels that community involvement is a process wherein non-professional people are given education by hospital professionals concerning health care and then serve as a public relations and information source." For Beth Israel, then, maximum feasible participation simply meant outreach. For the council, however, it meant that and also shared governance: real bidirectional sharing of administrative power between Beth Israel and its community constituents. In the words of Ackerman, the council saw "itself as a lay board of directors which understands the health needs of the community," and therefore was "qualified to have a policy making voice and to act as an advocate for patients."⁶¹ The OEO ultimately reversed Trussell's action, reinstated HRUM's Cruz, and ordered the council to come up with a "work plan" that stipulated what its duties were. It also required the council and Beth Israel to sign an agreement spelling out a formal system of negotiation in the event of a future conflict.⁶²

But conflict over community participation never went away. It came roaring back in 1971, when the city scheduled Gouverneur for handoff from Beth Israel back to the Health and Hospitals Corporation (HHC), a newly created municipal agency.⁶³ As part of the transition, Beth Israel had designated the HHC the sole grantee of OEO funds, and when the HHC applied for grant renewal, it left only vague provisions for the council's participation in governance. The HHC admitted as much, writing that "although the application does not demonstrate community participation and involvement in program policy development and implementation, it does discuss the contacts engaged in by the applicant with two community groups." It also spoke of "significant problems in relation to community participation" and implied there would be much less of it down the line.⁶⁴

The dispute set off another round of bickering, this time in federal court. The council filed a federal lawsuit charging administrators at the Department of Health, Education, and Welfare, at Beth Israel, and at HHC with violating legislative guidelines on community participation and condoning an "effective revocation" of its role. It asked for the court

to mandate the council's participation and filed a separate grant application to become a direct recipient of funds in the future.⁶⁵ On May 23, 1972, the U.S. District Court in the Southern District of New York handed down a decision favorable to the council, issuing an injunction that mandated the HHC and Beth Israel offer it an official participatory role. In his opinion, Judge Morris Lasker concluded that the HHC had made "no provision for a neighborhood health council," as required by OEO guidelines.⁶⁶

The council had won a new lease for itself, one fortuitously timed with the groundbreaking of a new fourteen-story, 216-bed facility in September 1972.⁶⁷ But the victory had a Pyrrhic quality. As the community battles raged on at Gouverneur, the political economy of the city was undergoing its own tectonic shift. The city's tax base had become increasingly insufficient, causing it to finance operations with bond sales. In 1975, it sold a staggering \$8.3 billion and \$900 million, respectively, in short- and long-term bond notes, an increasingly untenable strategy that papered over larger budgetary problems and immediately catalyzed a financial crisis that same year after a lender strike by banks that refused to service city debts further in the next cycle. These lending patterns had coincided with rollbacks in state and federal commitments to large urban municipalities that encouraged such borrowing in the first place.

With the Ford administration and the federal government's initial refusal to support aid packages, New York State imposed stringent financial discipline on the city via two ad hoc agencies, the Municipal Assistance Corporation (MAC) and the Emergency Financial Control Board (EFCB). These makeshift agencies' chief solution was to swap short-term bonds with long-term bonds while assuming control of city finances and imposing harsh austerity budgets in the hopes of restoring access to credit markets. When additional federal intervention did arrive, it came not in the form of aid but as short-term loans with rates 1 percent higher than Treasury bill interest rates. The cumulative result, Jonathan Soffer has noted, "creat[ed] a city in which almost nothing was maintained or repaired for a decade," after a 27 percent workforce reduction and a 75 percent decline in capital spending.⁶⁸

The effects on the HHC, already struggling to gain fiscal and administrative footing in its infancy, were extremely pronounced. From 1975 to 1980, a net payroll reduction of 17 percent decreased the total HHC

workforce to what it had been at the start. Service cuts complemented workforce shrinkage.⁶⁹ The cuts were directly propelled by fiscal stringency and the inability to sustain pre-1975 spending practices under MAC and EFCB oversight. And they hit Gouverneur hard. In 1973, two years before the fiscal crisis, the *Gouverneur Newsletter* reported that “in a few months 10% more may be cut and by the end of this year up to 40% or over 1 million dollars may be cut.”⁷⁰

By the middle to late 1970s, struggles on the Lower East Side had changed target and scope. The fight for governance and local control became of less importance to health activists than decisions made at the top, particularly around budgets. In short, crises in governance receded in importance relative to crises in finance. Driving the point home was a 1976 round of cuts that resulted in the closing of inpatient services at the new Gouverneur facility. Several more public hospitals would close over the next few years. Pitched as the battles over governance in the late 1960s and early 1970s had been, they took on a new—and less important—dimension relative to the new world that New York City, like much of the United States, was now entering. The Gouverneur experience paralleled that at Lincoln Hospital closely. Activists in both struggles came to question the value of radically altering governance in a single institutional node, even as the world around that node became ever more tumultuous.

Conclusion: The Ambiguous Legacy of the Governance Revolution

Health care was hardly the only quarter of American life that underwent shifts in governance with ambiguous longer-term ramifications. In the 1970s, for instance, insurgents had chiseled away at the bureaucratic ossification and autocracy within some labor unions. But by the era of the failed Professional Air Traffic Controllers Organization strike, decades of capital flight, and automation in mining and in the automotive and steel industries, among others, these triumphs of governance seemed of much smaller importance. The same could be said of black elected officials in the aftermath of the Civil Rights Act of 1964, many of whom inherited what some analysts of the time called “the hollow prize”—that is, cities experiencing tail-spinning employment, dwindling revenue, and population loss on a scale far worse than that of New York City.⁷¹

And yet in health care, a sector historically riven with parochialism and exclusion, it was no inconsequential achievement to widen the boundaries of who had a say in the operation of its key institutions. By the early 1970s, medical students, community health workers, and laypeople had attained much more influence in health care decision making than they could have possibly anticipated just a decade earlier. Elites in the health care sector found themselves making some concessions to medical students, who demanded a more socially conscious curriculum and more responsive outreach. And they had to do the same with neighborhood activists who fought for the integrity of lay community boards and more input into facilities' operations, once all restricted to those in boardrooms. The medical world, for a brief moment anyway, looked like it might be turned upside down.

As one looks back with more than a few decades' perspective, though, the balance sheet of the medical governance revolution is decidedly mixed. Some of its achievements have indeed stuck. Today, even the most parochial medical schools, for example, genuflect commitment to the less fortunate who surround them. Often they do much more, in the form of service projects and the operation of year-round outpatient services for the indigent. Similarly, at many health care institutions, community health workers constitute a standard frontline conduit between patients and often imposing medical hierarchies. Within the academic sphere, community-based participatory research, whereby scholars mold research agendas in active consultation with those whom they study, has burgeoned. These examples of hierarchies flattening, insularity withering, and borders thinning—however slowly—are no doubt by-products, direct and indirect, of the medical governance revolution.⁷²

Still, these developments hardly characterize the dominant ethos of American medicine in the early twenty-first century. Unequal access, lack of affordability, and high costs remain—and at a magnitude far exceeding that of the 1960s and 1970s. Structurally, many health policy analysts predict a wave of mergers and consolidation in the coming decades. It all makes the targets of the medical governance revolution—the local single institution here, there, and elsewhere—look pretty quaint.⁷³ And it forces one to ask whether the accomplishments listed here were mere dents in an edifice that has changed more around its edges rather than fundamentally in the past fifty years.

Essays of this sort often end by lamenting the incompleteness of a revolution. But I want to close on a much more ambiguous note. The medical governance revolution's advocates focused almost exclusively on the local and on the process, even as the larger structures of health care—and politics and the economy more generally—were undergoing upheaval in ways that made new modes of institutional governance and participation much less impactful. So rather than lament that there wasn't more of a role for the grassroots and the "community," I want to argue instead that even if the medical governance revolution had come to full fruition, it might have been an achievement with the wrong target. It calls into question social movement organizing animated by the logic and goals of inclusionary biocitizenship that is incapable—intentionally or not—of also tackling other axes of political and economic power.

It may also be time to rethink a fundamental concept anchoring the governance revolution. The vocabulary of "community" was an ever-present but fuzzily defined term. To the extent that a consistent definition did emerge, it was composed of two tenets—local scale and increased participation—each with its own shortcomings. Localism encouraged seeing health politics through a granular lens that could not capture the full gamut of influences on the fortunes of health care facilities. And participation greatly overestimated not just its potential but also the actual interest that most laypeople really had in taking part in the grind of health care administration. Throughout, the term "community" was perpetually up for grabs, invoked constantly to bolster legitimacy even as who exactly constituted it was never entirely clear. These invocations of amorphous collective entities are often hallmarks of biocitizenship claims and counterclaims.

If there is another incarnation of biocitizenship on the ground in health care, it will have to focus not just on the single institutional type (the medical school) or neighborhood facility (Lincoln or Gouverneur) or the procedural (more community medical governance). It will instead need to turn to other parallel planes of decision making, including those in national-level and elite channels that are often viewed with suspicion, including, in recent times, when antistatist currents and romance for decentralization have surfaced in movements bookended by the Seattle World Trade Organization protests and Occupy Wall Street.⁷⁴ It will need, in other words, to go beyond what Daniel Immerwahr, writ-

ing about community development more generally, has called “thinking small” with an eye too close to the local and too far from “larger structures of power” and the “broader social order.”⁷⁵ This is a holism of political practice that transcends the often sector-specific single-mindedness of those in the health fields. But confronting the indignities and maldistribution in American medicine requires no less.

NOTES

- 1 Adriana Petryna, “Biological Citizenship: The Science and Politics of Chernobyl-Exposed Populations,” *OSIRIS* 19 (2004): 250–65; Dorothy E. Roberts, “Race, Gender, and Genetic Technologies: A New Reproductive Dystopia,” *Signs: Journal of Women in Culture and Society* 34, no. 4 (2009): 783–804.
- 2 David Perlman, “AMA Silences a Dramatic Protest Attempt,” *San Francisco Chronicle*, June 17, 1968; *Encounter: Bulletin of the Student Health Organizations* 3, no. 2 (Summer 1968), in Personal Papers of William Bronston, Sacramento, CA (hereafter cited as Bronston Papers). Bronston’s papers have since been transferred to the Bancroft Library, University of California, Berkeley, and processed, with additions to the collection from time to time. I have also retained a digital copy of all documents cited from the Bronston collection.
- 3 *Encounter: Bulletin of the Student Health Organizations* 3, no. 2 (Summer 1968), Bronston Papers; Frank Campion, *The AMA and U.S. Health Policy* (Chicago: Chicago Review Press, 1984), 299. The AMA finally passed a resolution, after years of failing to do so, that explicitly banned racist discrimination in all its chapters and threatened to expel chapters that continued with the practice. See Richard D. Lyons, “A.M.A. Vote Ends Bars to Negroes,” *New York Times*, December 4, 1968.
- 4 “Unrest on the Medical Campus,” *Medical World News*, October 13, 1967.
- 5 *Borborygmi* 1, no. 1 (September 8, 1964), in Papers of Fitzhugh Mullan, Box 4, Folder 2, Wisconsin Historical Society, Madison, WI (hereafter cited as Mullan Papers); *Borborygmi* 1, no. 4 (December 1, 1964), in Box 4, Folder 2, Mullan Papers; *Borborygmi* 1, no. 5 (February 15, 1965), in Box 4, Folder 3, Mullan Papers; *Borborygmi* 1, no. 7 (April 23, 1965), in Box 4, Folder 3, Mullan Papers; *Borborygmi* 2, no. 2 (October 18, 1965), in Box 4, Folder 3, Mullan Papers; *Borborygmi*, 2, no. 3 (December 6, 1965), in Box 4, Folder 3, Mullan Papers; Naomi Rogers, “Caution: The AMA May Be Dangerous to Your Health: The Student Health Organizations and American Medicine 1965–1970,” *Radical History Review* 80, no. 1 (2001): 5–34, offers an excellent organizational history of the early SHO. It asks questions different from this essay’s on medical governance.
- 6 “Student Medical Action Conference: A Call for Members,” ca. 1965, Bronston Papers.
- 7 *Borborygmi* 1, no. 6 (March 12, 1965), in Box 4, Folder 2, Mullan Papers; Mick McGarvey, “SMC Report,” *Borborygmi* 2, no. 1 (September 7, 1965), in Box 4, Folder

- 3, Mullan Papers. The phrase “medical presence” originated with the Medical Committee for Human Rights (MCHR), a group of physicians who believed their visibility alongside civil rights activists carried a potential preventative effect in at atmosphere of violence. On MCHR and the term, see John Dittmer, *The Good Doctors: The Medical Committee for Human Rights and the Struggle for Social Justice in Health Care* (New York: Bloomsbury, 2009), 54–55.
- 8 Mick McGarvey, “A Brief History of the Student Health Project,” *Encounter*, ca. early 1968, in Box 1, Folder 4, Mullan Papers; Harry Nelson, “Health Students Share Squalor to Help Poor,” *Los Angeles Times*, July 24, 1966.
- 9 David Perlman, “Health Workers Talk about Their Summer with the Poor,” *San Francisco Chronicle*, September 1, 1966.
- 10 George Getze, “‘New Breed’ Speaks Out: Health Care Called Right of All Citizens—Even the Poor,” *Los Angeles Times*, September 2, 1966.
- 11 Alondra Nelson, *Body and Soul: The Black Panther Party and the Fight against Medical Discrimination* (Minneapolis: University of Minnesota Press, 2011), 12.
- 12 “Student Health Project Summer 1967,” ca. 1967, in Bronston Papers.
- 13 Ibid.
- 14 “Student Resolutions,” *Encounter* 1, no. 4 (October 21, 1966), in Box 1, Folder 4, Mullan Papers.
- 15 Martin Cherkasky and Steven Sharfstein, “Opportunities in Medical Education: The Result of Domestic Social Forces,” *American Journal of Diseases of Children* 114 (November 1967): 531.
- 16 “Inside the Student Health Organizations,” *AMA News*, March 11, 1968.
- 17 John Fisher, letter, *AMA News*, May 6, 1968.
- 18 Tim Smith, *In Vivo* 1, no. 2 (ca. fall 1968), in Box 1, Folder 6, Mullan Papers.
- 19 United States Department of Health, Education, and Welfare, Public Health Service, *The Student Health Project of Greater New York: Summer 1968* (Washington, DC: U.S. Government Printing Office, 1969), 54.
- 20 *Catalyst* 2, no. 1 (November 1968), in Box 1, Folder 3, Mullan Papers.
- 21 *Encounter: Bulletin of the Student Health Organizations* 4, no. 2 (Summer 1969), in Bronston Papers.
- 22 Ibid.
- 23 “Albert Einstein College of Medicine Lincoln Hospital House Officer Program in Community Pediatrics,” ca. 1970, in Personal Papers of Michael McGarvey, New York, NY (hereafter cited as McGarvey Papers). Some of these papers have since been transferred to Columbia University Medical Center’s August C. Long Health Sciences Library. I have also retained a digital copy of all documents cited from the McGarvey collection.
- 24 For a memoir of a physician who played a central organizing role in the Lincoln Collective, see Fitzhugh Mullan, *White Coat, Clenched Fist: The Political Education of an American Physician* (New York: Macmillan, 1976).
- 25 For more on the ERAPs, see Kirkpatrick Sale, *SDS* (New York: Vintage, 1969), 95–115, 131–50.

- 26 “Albert Einstein College of Medicine Lincoln Hospital House Officer Program in Community Pediatrics,” ca. 1970, in McGarvey Papers.
- 27 “Demands of the Young Lords, Think Lincoln Committee & Health Revolutionary Unity Movement,” July 14, 1970, in McGarvey Papers.
- 28 Ibid.
- 29 For more on the Young Lords with respect to health, reproductive rights, and urban politics, see Jennifer Nelson, *Women of Color and the Reproductive Rights Movement* (New York: NYU Press, 2003), 85–112; Johanna Fernandez, “The Young Lords and the Postwar City: Notes on the Geographical and Structural Reconfigurations of Contemporary Urban Life,” in *African American Urban History since World War II*, ed. Kenneth L. Kusmer and Joe W. Trotter (Chicago: University of Chicago Press, 2003), 60–82.
- 30 “Report of the Ad Hoc Committee on Lincoln Hospital,” ca. 1970, in McGarvey Papers.
- 31 Collective meeting minutes, November 24, 1970, in Box 2, Folder 1, Mullan Papers.
- 32 Collective meeting minutes, February 16, 1971, in Box 2, Folder 1, Mullan Papers.
- 33 Collective meeting minutes, May 11, 1971, in Box 2, Folder 1, Mullan Papers.
- 34 Community elective report, January 1971, in Box 2, Folder 7, Mullan Papers.
- 35 Community elective report, Winter 1970–1971, in Box 2, Folder 7, Mullan Papers.
- 36 Collective meeting minutes, June 15, 1971, June 22 1971, in Box 2, Folder 1, Mullan Papers.
- 37 Collective meeting minutes, August 10, 1971, in Box 2, Folder 3, Mullan Papers.
- 38 Collective minutes, August 24, 1971, in Box 2, Folder 3, Mullan Papers.
- 39 Ibid.
- 40 Ibid.
- 41 Helen Rodríguez-Trías, “The Medical Staff and the Hospital,” *Bulletin of the New York Academy of Medicine* 48, no. 11 (December 1972): 1425; “Report to Workers, Nurses, Doctors, and Patients on the Evaluation of Doctors,” ca. late 1972–early 1973, in Personal Papers of Harold Osborn, New Rochelle, NY (hereafter cited as Osborn Papers).
- 42 “Report to Workers, Nurses, Doctors, and Patients on the Evaluation of Doctors,” ca. late 1972–early 1973, in Osborn Papers.
- 43 “Albert Einstein College of Medicine Lincoln Hospital House Officer Program in Community Pediatrics,” ca. 1970, in McGarvey Papers.
- 44 “The Medical Industrial Complex,” *Health/PAC Bulletin*, November 1969. For an analysis of the organization at this time, see Merlin Chowkwanyun, “The New Left and Public Health: The Health Policy Advisory Center, Community Organizing, and the Big Business of Health, 1967–1975,” *American Journal of Public Health* 101, no. 2 (2011): 238–49.
- 45 Barbara Ehrenreich and John Ehrenreich, eds., *American Health Empire: Power, Profits, and Politics (A Health/PAC Book)* (New York: Random House, 1970).
- 46 Ibid., 1.

- 47 Susan Reverby and Marsha Handelman, "Institutional Organizing," *Health/PAC Bulletin*, January 1972, 16.
- 48 Collective meeting minutes, May 10, 1972, in Box 2, Folder 1, Mullan Papers.
- 49 Manuel Gomez, "HRUM at Lincoln," *Serve the People*, ca. 1972–1973, in Box 2, Folder 11, Mullan Papers.
- 50 Collective meeting minutes, February 7, 1972, in Box 2, Folder 1, Mullan Papers.
- 51 Helen Rodríguez-Trías to All Pediatric Staff, in Box 3, Folder 5, Mullan Papers.
- 52 Harold L. Light and Howard J. Brown, "The Gouverneur Health Services Program: An Historical View," *Milbank Memorial Fund Quarterly* 45, no. 4 (October 1967): 379.
- 53 On maximum feasible participation requirements, see Michael B. Katz, *The Underserving Poor: America's Enduring Confrontation with Poverty*, 2nd ed. (New York: Oxford University Press, 2013), 124–28.
- 54 "Demographic Characteristics of the Area," 1967, in Box 15, Folder "Lower Manhattan Community Mental Health Center," Papers of Mobilization for Youth, Rare Books, Special Collections and Archives, Butler Library, Columbia University, New York, NY (hereafter cited as MFY Papers).
- 55 Lower East Side Neighborhood Health Council–South, health survey, Summer 1967, in Personal Papers of Terry Mizrahi (hereafter cited as Mizrahi Papers).
- 56 "Proposal for Additional Worker for the Lower East Side Neighborhood Health Council–South," ca. 1967, in Mizrahi Papers; "Eight Months Struggle for a Health Council Staff," January 20, 1969, in Mizrahi Papers; "A History of the Struggle for Staff for the Lower East Side Neighborhood Health Council–South with Some Conclusions Drawn and Some Questions Asked," ca. 1968–69, in Mizrahi Papers; "Summary Minutes of the Meeting of Representatives of the Lower Eastside Neighborhood Health Council–South with the OEO Health Office in Washington, D.C.," May 31, 1968, in Mizrahi Papers.
- 57 Ray Trussell to Herbert Notkin, December 3, 1969, in Mizrahi Papers.
- 58 Harvey Karkus to Antonin Flores, December 2, 1969, in Mizrahi Papers; Health/PAC, "Health Rap," January 26, 1970; "Closing Gouverneur Clinic," *Gouverneur Reports: Community Health Bulletin* 3, no. 1 (January 1970), in Mizrahi Papers.
- 59 For more on the politics of Local 1199, see Leon Fink and Brian Greenberg, *Upheaval in the Quiet Zone: 1199SEIU and the Politics of Health Care Unionism*, 2nd ed. (Champaign: University of Illinois Press, 2009).
- 60 "1199 and the Gouverneur Clinic Case," *1199 Drug and Hospital News*, February 1970, in Mizrahi Papers.
- 61 Laura Ackerman, "Final Report and Evaluation of Activities with Gouverneur Health Services Program (GHSP) and the Lower East Side Health Council–South," April 14, 1970, in Mizrahi Papers.
- 62 "Work Plan for Lower East Side Neighborhood Health Council–South 1970–1971," July 29, 1970, in Mizrahi Papers.
- 63 "Notes for Meeting with Dr. English," ca. Fall 1971, in Mizrahi Papers.

- 64 “Fact Sheet on the Crisis at the Gouverneur Health Services Program,” November 29, 1971, in Mizrahi Papers; “The Gouverneur Health Services Program of the New York City Health and Hospitals Corporation: Continuation Application,” December 30, 1971, in Mizrahi Papers.
- 65 LESHHC-S, “Continuation Proposal for the Gouverneur Health Services Program on Behalf of the Lower East Side Neighborhood Health Council–South, Inc.,” January 3, 1972, in Mizrahi Papers.
- 66 Opinion of the Court, *Lower East Side Health Council–South, Inc. et al. v. Elliot Richardson et al.*, 71 Civ. 5160, U.S. District Court, S.D. New York (1972).
- 67 “Inauguration,” *Gouverneur Newsletter* 1, no. 2 (October–November 1972), in Mizrahi Papers; “New Gouverneur Opens as the 19th City Hospital,” *New York Times*, September 22, 1972.
- 68 Jonathan Soffer, *Ed Koch and the Rebuilding of New York City* (New York: Columbia University Press, 2010), 119. On the fiscal crisis more generally, see Ester R. Fuchs, *Mayors and Money: Fiscal Policy in New York and Chicago* (Chicago: University of Chicago Press, 1992), 86–93; William K. Tabb, *The Long Default: New York City and the Urban Fiscal Crisis* (New York: Monthly Review Press, 1982); and, especially, Kim Phillips-Fein, *Fear City: New York’s Fiscal Crisis and the Rise of Austerity Politics* (New York: Metropolitan Books, 2017).
- 69 Charles Brecher, “Historical Evolution of HHC,” in *Public Hospital Systems in New York and Paris*, ed. Victor Rodwin, Charles Brecher, Dominique Jolly, and Raymond Baxter (New York: NYU Press, 1992), 71.
- 70 “Pres. Nixon’s Cut and Gouverneur,” *Gouverneur Newsletter* 2, no. 1 (January–February 1973), in Mizrahi Papers.
- 71 The term was first used in H. Paul Friesma, “Black Control of Central Cities: The Hollow Prize,” *Journal of the American Institute of Planners* 35, no. 2 (1969): 75–79.
- 72 An exact causal accounting is another essay entirely, but one marker of this influence is the number of activists here who later ended up in strikingly prominent positions within elite medical institutions: several deans of medical schools, a deputy surgeon general, and many more in medical academia and health care institutions.
- 73 David M. Cutler and Fiona Scott Morton, “Hospitals, Market Share, and Consolidation,” *Journal of the American Medical Association* 310, no. 18 (2013): 1964–70.
- 74 See Tom Mertes, ed., *A Movement of Movements: Is Another World Really Possible?* (New York: Verso Books, 2004), for an outstanding collection of essays, some sympathetic, some more critical, on this politics. The historian Thomas Sugrue also notes localism’s entrenchment in administrative structures and activist responses alike. See his “All Politics Is Local: The Persistence of Localism in Twentieth-Century America,” in *The Democratic Experiment: New Directions in American Political History*, ed. Meg Jacobs, William J. Novak, and Julian Zelizer (Princeton, NJ: Princeton University Press, 2013), 301–26.
- 75 Daniel Immerwahr, *Thinking Small: The United States and the Lure of Community Development* (Cambridge, MA: Harvard University Press, 2015), 178–79.