synapse

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photo/dkw

San Francisco General Hospital

The Plight of Mission Emergency Room

The emergency room of San Francisco General Hospital (Mission Emergency or MEH) is the single most important medical service in San Francisco. Every person, rich or poor, who is injured severely in an accident is automatically brought there by city ambulance. Within its cramped confines, more lives are saved (and sometimes lost) than any other single medical facility in San Francisco. It also serves as the single open-admission drop-in clinic for the poor and minority communities of San Francisco.

But, Mission Emergency is itself sick — sick primarily from financial undernourishment. This is one reason that patients must undergo long waits to see a doctor. In 1969, the Mission Coalition did a study on Mission Emergency and found that the average wait before seeing a doctor was 2 hours and 10 minutes.

Long waits were also found *after* seeing the doctor — such as waiting for X-ray, and for lab results. About one-third of drop-in patients were given no significant treatment — even after the long wait — but were referred to another clinic.

Joining The Long Line

In addition to a total lack of adequate waiting facilities — there are only a few hard chair-benches lining the corrider — patients on gurneys must lie half- naked in the midst of the hall. To get registered for treatment, one must join the long line in the central hospital concourse.

Despite the fact that SFGH is a public facility and is supposed to bill only according to ability to pay, there are no eligibility workers on nights and week-ends to make a financial determination. Therefore, patients receive automatic full bills, and the hospital is able to collect no insurance, Medicare or Medi Cal revenues on MEH patients.

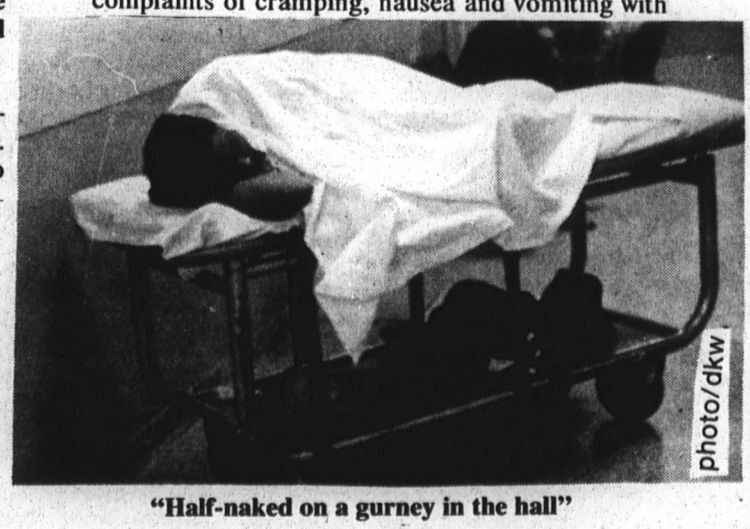
"We wouldn't send a dog there"

A survey of Hunters Point residents in 1969 revealed that 17,000 people in that neighborhood would be unwilling to go th SFGH for health care under any circumstances. Much of this discontent comes from Mission Emergency.

Some comments of community residents were "At county you sit and sit and suffer," "There are too many interns who don't know what they are doing" "People wait too long for poor service" "You just might sit there all night waiting for service" "They don't treat you as a human being" "I sat there by the hours" "We left after waiting four hours for assistance," and "We wouldn't send a dog to county hospital."

The following are incidents that occur frequently at Mission Emergency:

Mr. C. comes in Monday evening with vague complaints of cramping, nausea and vomiting with blood, but in no obvious pain. There are no seats so he must sit on the floor amidst of jungle of body-filled gurneys.



photo/dkw

"Half-naked on a gurney in the hall"

Mr. T. comes to MEH, sees the congestion, manages to get by all of it and turns around and never comes back.

Miss R. fell and injured her leg. She is thinly clad in a hospital gown and must lie on a gurney in the cold main entrance hallway waiting to have her leg x-rayed, becoming part of the normal congestion.

Mr. H. has the misfortune to spend Friday night in MEH being observed for seizure activity. Upon release Saturday morning he finds that his billfold, money and property are locked up. Either the Hospital Administrator must come in to open the property room, the MEH doctor may admit the patient (as a "social admission") or the patient may be discharged to the street without his property.

Mrs. H. comes to MEH with a look of great distress and gesticulates wildly toward her chest. Heart attack? Cramps? Trouble breathing? Who knows? No one, because she speaks Spanish and there is no interpreter.

Drop-in function

As with all urban emergency rooms, the majority of Missions' cases are not true life-or-death emergencies. The emergency room has become America's fastest growing health care institution — with patient loads increasing at a rate of 10% per year. Sixty to seventy per cent of cases in emergency rooms across the country are not true emergencies, but are drop-ins.

The enormous increase in emergency drop-ins attest to the failure of the American health care system. Were an adequate number of primary care clinics easily accessible in poor neighborhoods, the emergency room drop-in function would not be so vitally needed nor so rapidly growing. But, until the emergency room drop-in problem is solved by creating alternative sources of medical care, emergency rooms — including Mission — must continue to serve the drop-in function.

Groups of interns, social workers and Mission employees have made suggestions and demands about care at Mission. The 1969-70 interns won a major victory by demanding and getting money for paramedical triage doctors at Mission. Since then, however, few changes have come about.

More recent demands have been for shorter intern rotations, full-time social service, full-time lab

continued/page 8

continued from front page

from the other side. There is no substitute for experience."

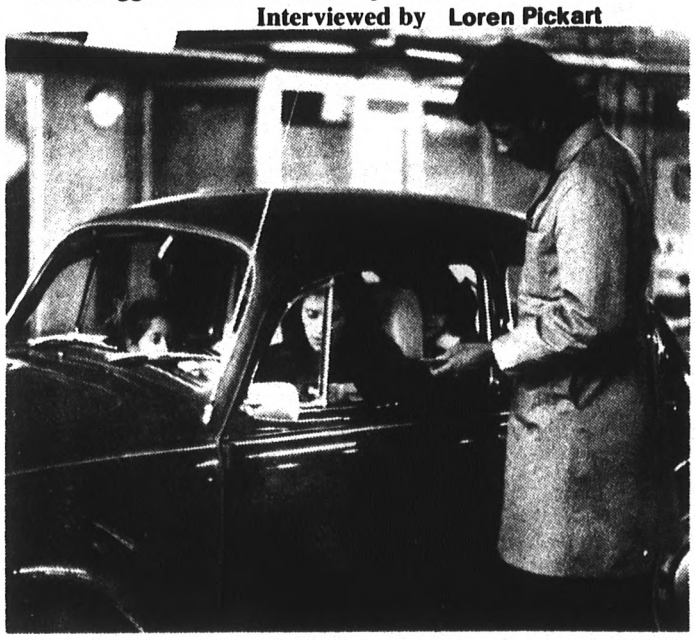
POLITICS AND THE UNIVERSITY

"The Regents of the University of California would never hire anyone who would rebel against the basic philosophy of the system. They would not appoint anyone that they can't control or eventually win to their side. To reach the top in business or the university, a person must sacrifice something, some portion of your manhood or principles or you are not accepted. And people that rebel against the chain of action are branded as radicals or irresponsible youth. The people who stand up and demand equal treatment are put down as being unstable. And basically our organization demands equal and fair treatment for all people. A lot of people in higher positions of the University know what we say is true, but are afraid to come forward for fear of being rejected by the system, branded as a troublemaker, and more often than not, fired."

REPRISALS AGAINST UNION LEADERS

"I'm not hung up on job security – or I'd be completely at the mercy of the establishment. It comes down to this: Do you sacrifice principle and live, to me, a non-meaningful life or do you stand by your principles, retain your manhood and try to bring about just changes that may not improve your conditions but sometime later may improve the conditions for someone else? To me, there is only one answer – you do and speak what you feel is right. And I also feel that by openly stating my position, I am probably jeopardizing my employment at the University, but I have enough confidence that the people will seek out the truth and then unite with us in our struggle and make this impossible."

Interviewed by Loren Pickart



photos/Loren Pickart

classified

FULL SPEED FOR CAPE —

I shall
Set
Tight Course for
Cape of capes,
Contrast the Eastern sea
with my
Own
West of
Thought and Habit,
Stammer to the
Puffing
Wind in my Trans-
Planted
Tongue
Over--Whelmed with Whit-
man Measures.
Not Land of Pine nor
Sequoia Near,
Peaceful the
Inverted Sea
Rides in my
Dream, Pushing my
Dinghy of
High Art Closer to Eternal
Water-
-Ways of my
Soul Expressed
Skirt Circuitous Moorings
for
Cape of capes . . .

from
SHIP BOUND
FOR WHERE
— BY —
Kent Chamberlain

The Bum

If you don't sweat things too much
Even being a bum isn't so bad.
Mud may splatter on muddy clothes with
No prospect of getting them cleaned.
And you drop in the cold night from a lazy freight
A mile out of town
So the yard dick won't roust you out
And haul you before the judge.
It's a way of going places,
Though it's not the same as if you had a ticket.

And a woman whom you loved and
Would have died for,
And who even looking at you then,
Knowing she had to say what she had to say
Because for you providing isn't in the same catagory as dying,
Even then had a tender hurt that about choked her words.
But the words had to be mean and simple:
"You'll never be anything but a wothless bum."

Well, if you leave, hurt but accepting a name,
And you come not to sweat it too much,
It's not so bad.
You have your times and a much lived poem or two.
It's better somehow than being a king of men,
Whose doings can never be just doings in an island now,
And who in a frenzy of craving thrones of enduring moment
Grabs off a whole lifetime--
To watch it flow at last
Like sand through tired fingers
Without ever finding the gold
He panned so carefully for.

R. Solem

at night

**. . . night she comes along
alike the alley cat in
hunger fights we fight
we melt into for just
awhile the other one
without another one
without the light I
lose I find myself in
you we break in
two morning too she
will be along I'd like
to send me off for good
or bad since now that I
have had you once
again but why not be
a loser in this dark
mess until then . . .**

Greg Austin

LAB TECHNICIAN seeks employment in research. Responsible, able worker with 10 yrs. exp. in clinical labs (hematology, chemistry, urinalysis, blood banking, and bacti). Last job in component blood banking and radioimmunoassay. Unable to secure a Calif license. Am flexible, let's talk. Call Paul at 661-5706.

rentals

Female roommate wanted to share Twin Peaks house, own bedroom, furnished, days call Monica x 1117, evenings 647-7592

Furnished Room, private entrance and shower, men only. Edgewood Avenue, $75. Call 564-0907 or 681-5352.

Editorial

SFGH:
Plaguing Problems

photo/dkw

San Francisco General Hospital

San Francisco General Hospital mirrors the nationwide picture of urban health care. Problems of inadequate financial support, staff and equipment plague this hospital as they plague hospitals across the country.

Currently confronting the county hospital are the salient issues of accreditation and emergency room care. Frustration, antagonism and resentment comprise only a few of the sentiments which are engendered by this situation.

It is impossible to ignore that much of the discontent which is manifested at the hospital is directed toward the University of California San Francisco Medical Center, which reaps the benefits of this institution serving as one of its principal teaching hospitals. Often heard criticisms include: the house staff complaints of being ignored or relegated to Siberia while being overlooked for financial support and appointments, and the allegation that U.C. uses SFGH as a "dumping ground" for patients which it prefers not to treat.

With this issue dedicated to San Francisco General Hospital, the Synapse officially recognizes the significance of the hospital to the University of California. However, more importantly, we recognize and commend the efforts of a nucleus of concerned individuals at the hospital who are actively working toward the amelioration of hospital conditions and services It is this nucleus of people who are the main contributors to this issue. We express our special thanks to Dr. Ken Barnes and Carole Dicker for their assistance as co-ordinators of the issue.

by D. Kelly Weisberg
Loren Pickart

"Friend of those who have no friends...
enemy of those who make themselves our enemy."

synapse

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SFGH Dis-accredited?

San Francisco General Hospital has become a focal point in a nationwide struggle for better health conditions, and what happens to it in the next few months may have massive impact on every hospital in the nation.

When the Medicare Act was passed during the Kennedy Administration, Congress decreed that any facility receiving federal funds had to maintain minimal health standards. It delegated responsibility for setting these minimal standards and determining whether individual hospitals were meeting them to the Joint Commission on Accreditation of Hospitals, (JCAH) a body formed by the American Hospital Association, the American Medical Association, the American College of Physicians, and the American College of Surgeons.

Generous standards

Consistent with the institutional interests of its parent organizations, the Joint Commission proceeded to create standards which were generous to the affected facilities, to say the least. It dealt principally with organizational structure — yet failed to make any reference to the adequacy of hospital staff to deal with patient load, and set no standards for out-patient care.

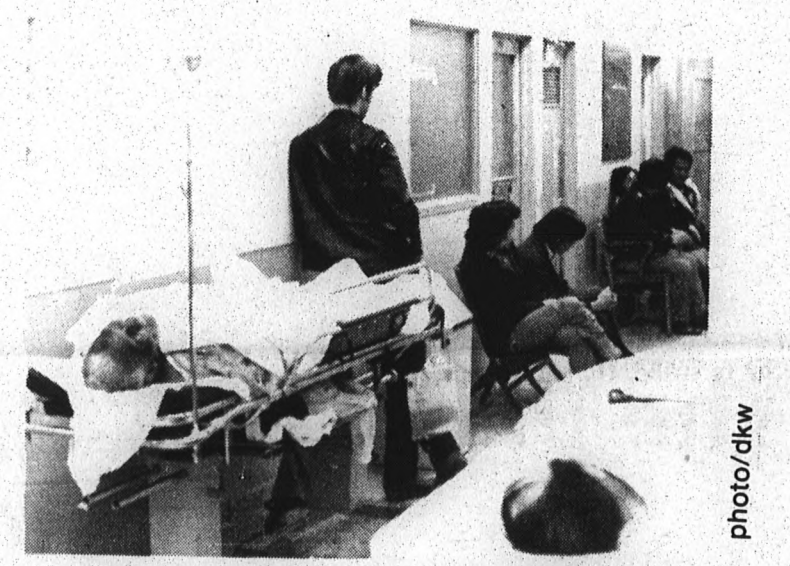
Even if the level of care provided by an institution was acknowledged by all to be deplorable, the hospital would still be accredited if it presented the proper chain of command and met certain technical requirements such as width of doorways, and frequency of inspection of fire extinguishers. And "inspection tours" by the "field representatives" of the Joint Commission were models of amicable interaction: the institution was given two month's warning, the "inspectors" were usually themselves hospital administrators, the "inspection" consisted of a few hours of quick touring about, interrupted by long lunches.

A few months or so later, the hospital would be informed that it had been re-accredited for another two years. From 1968 until 1972, only two hospitals had their accreditations lifted, and these two had undergone repeated "probations". After the dis-accreditation action they were swiftly "re-accredited" following some minimal changes. But in the 1971 tour of San Francisco General, a process was set in motion that could cost SFGH its accreditation and dissolve the Joint Commission itself.

Patient conditions

Learning of the impending Joint Commission "inspection tour" of the SF County facility in March 1971, groups of hospital workers, interns, and community groupsdetermined to use this opportunity to improve conditions at a hospital which — because of a starvation budget — had become a byword in San Francisco for inhumane patient conditions. Forming a loose ad hoc alliance and assisted by attornies from SF Neighborhood Legal Assistance and the Senior Citizen's Project of California Rural Legal Assistance, the group demanded, and got, from the Joint Commission an agreement to hold a public "interview" on the situation at SFGH.

Organizing inside and outside the hospital with a flurry of leaflets published by the Social Service Employees Union, the groups packed SFGH's Pathology Auditorium on March 24, 1971 to demand that SFGH be dis-accredited. The Joint Commission's field representatives (a retired administrator and a retired physician) were presented with a copy of a secret report that had been drawn up by a committee appointed by the SFGH Administrator to help the hospital meet accreditation. The hospital's own report stated in part:
"Patients involved in accidents are frequently kept waiting for extended periods of time . . . skylights are cracked and leak when it rains . . . the stench emanating from the dirty utility rooms was in some instances a mixture of raw urine and stale dirty water . . . the No. 80 building patients bathroom had dust about one inch thick . . . the meat grinder next to the coffee grinder in the main dining room had what appeared to be green mould on the lock that holds the grinders . . . the floors in the cafeteria were filthy . . . the diet kitchens throughout the hospital with one or two exceptions were filthy.



photo/dkw

A hallway amidst a jungle of body-filled gurneys

Some of the ward refrigerators contained medications, specimens, and food . . . many of the fire hoses gave the impression that if high pressure was applied they would burst. One of the fire hoses didn't have a nozzle at all . . . the surgical suite is an unsafe area for surgery because of the dirt in the area. The floors are dirty, the areas in which sterile supplies are kept is dirty, the fans have much lint in them . . . There is lint all over the walls . . . The room where the sterile supplies are kept has dirty floors . . .

The toilets throughout the building are filthy . . . Generally speaking, all of the wards, except for those in the No. 70 building, were dirty. Walls were dirty, hoppers for bed pan cleaning were dirty, patient toilet areas were dirty . . . outdated medications, dirty duty brooms hanging from pipes, encrusted bottles, poisons and irritants were stored together . . . lab counters are in the middle of the hall with techincians running lab tests in the middle of the thoroughfare . . . all radiology sinks were filthy and were stopped up with cigarette butts . . . aproximately one half-million laboratory reports, X-rays reports, EKG's and other special service reports are not appended to the medical records on an inpatient level due to the lack of personnel, due to the lack of storage space in the department, and supplies are stored in the women's toilet area . . ."

Audience forced agreement

After slide presentations, testimony of numerous persons, supportive cries from the audience and the glare of television lights, the two field representatives seemed gray and shaken. They got up to start on what they thought would be the quieter part of their inspection, but the audience forced an agreement that an intern and a community representative would accompany them on the rest of their tour. Two days later they left, and local city officials fumed.

In a front page article on March 25, the *Examiner* reported that Dr. Francis Curry, the Director of Public Health had "assailed what he called 'destructive' elements which are threatening the renewal of San Francisco General Hospital's accreditation . . . he said the medical care is generally good and even superlative . . . He said the dissidents — 'a very small minority' — resembled those who enroll in schools and colleges and then 'challenge the structure and threaten to destroy them.' "

And the Joint Commission, obviously dumbfounded at this turn of events in its usually uneventful existence, delayed any action on SFGH for five months until its full governing body could hold its once-yearly meeting in August, 1971. The SFGH Administrator and Director of Public Health flew to Chicago to plead SF County's case, and the Joint Commission came up with a "compromise" — SFGH was placed on one year "probationary" accreditation, with a three page, 34 item recommendation for change.

The Joint Commission, however, refused to issue the report to anyone but SFGH or even to reveal to anyone what its accreditation decision was. Nevertheless, workers and attornies secured a copy of the report and it turned out to confirm virtually every allegation that they had made. Its concluding paragraph stated: "The attention of the medical staff, governing board and administration is directed to the major deficiencies which include failure to provide a clean safe environment within

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Turmoil, Trouble and Thursday Noon

San Francisco General Hospital (SFGH) is the county hospital serving most of the city's quarter of a million poor people.

The University of California sees SFGH primarily as a site for training students and house staff. The University is desperately dependent upon SFGH as one of its major teaching hospitals. At least one third of the medical school's students and house staff receive training at SFGH.

Many faculty members maintain their University appointments and research subjects through their relationship to the General. And generally, many training programs could not exist anywhere in San Francisco except at SFGH.

Yet, for neither the city nor U.C. is patient care a priority. Prodded by the contempt which the hospital exhibits toward them, health consumers and hospital workers have mounted a series of attacks upon SFGH.

In March 1970, San Francisco Mayor Alioto refused to grant hospital workers salary increases sufficient to keep pace with the galloping cost of living. The mayor also claimed that the city had no money to meet intern demands that patient servi s be improved.

By the second week in March, both the interns and the unionized hospital workers were ready to strike. On March 13, the hospital workers walked off the job and formed picket lines around the hospital. They were joined by 10,000 other municipal workers who struck simultaneously over their own wage demands. With the prospect that the city would be paralyzed by a general strike, the interns decided not to strike, having been cowed into passivity by the threatened loss of their medical licenses.

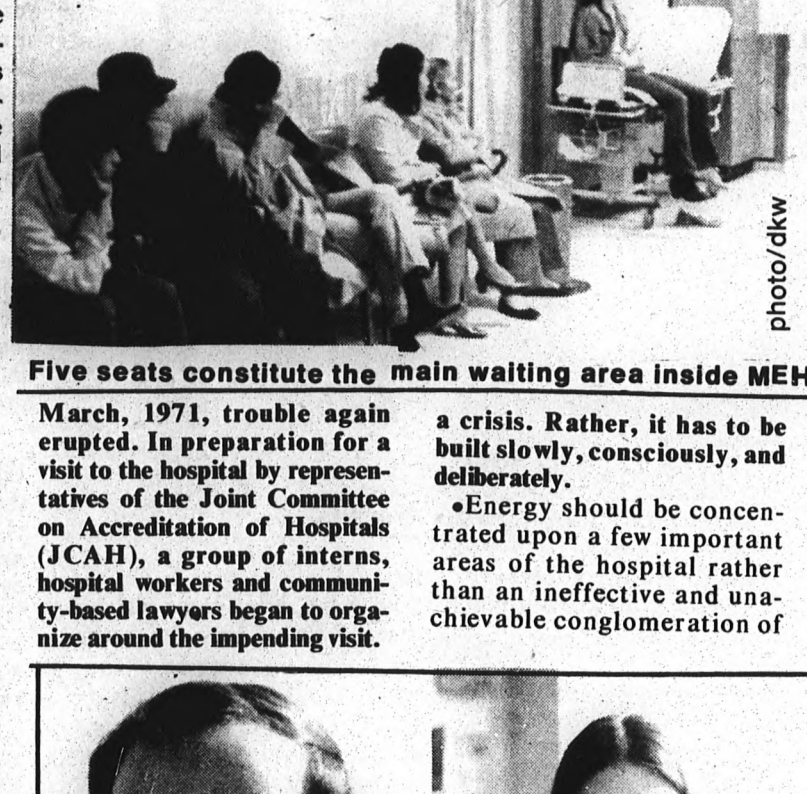
By the next workday, the union capitulated, winning only minimal wage gains and leaving many hospital workers keenly disappointed. The patient care demands never made it to the picket line and action upon them was, once again, shelved.

By January 1971, the chickens again roosted at SFGH. For four days 90% of the interns went out on strike. Two months earlier, they had detailed 101 demands for improved patient services as well as demands oriented around the needs of non-professional hospital workers.

However, the interns had failed to win prior support for their demands from either patient/community groups or the hospital workers. When, as should have been anticipated, no one came to their support, the interns' strike was defeated. The 101 demands were forgotten.

Summing up the two years of turmoil at SFGH, one involved doctor said, "The struggles may have led to increased consciousness and awareness about the political aspects of health care, **But this is a highly subjective matter and can't be measured. What can be measured are the objective improvements in patient care and worker benefits at the hospital: there were none."**

Dissatisfaction, however, at the hospital continued and by March, 1971, trouble again erupted. In preparation for a visit to the hospital by representatives of the Joint Committee on Accreditation of Hospitals (JCAH), a group of interns, hospital workers and community-based lawyers began to organize around the impending visit.



photo/dkw

Five seats constitute the main waiting area inside MEH

This ad hoc group documented hundreds of instances of filth and medical neglect at SFGH. In a crowded public hearing, the Joint Commission heard about SFGH's deficiencies from community people, hospital workers and house staff. As a result, the JCAH placed the hospital on one year "probationary status". The JCAH chided the hospital's administrators that if seventeen deficiencies were not corrected, accreditation will be lost altogether next year.

In July, 1971, a small group of hospital workers, mostly young doctors and social workers, began to meet and talk amongst themselves. Many members of the group, which came to be known as the Thursday Noon Committee, had participated in earlier intern initiated actions but were frustrated at having struggled so hard only to accomplish so little. It was clear to the group that a different, long-range strategy had to be developed.

The Thursday Noon Committee decided upon three basic principles:

- The group must be more broadly based than house staff alone. The energy for change should be provided by a group of progressive activists rather than having a few radical house staff attempting to lead a large group of conservative or apathetic interns.
- **The building of a coalition of forces — professionals, hospital workers, and community activists. But this kind of coalition could not be developed as an afterthought during the midst of a crisis. Rather, it has to be built slowly, consciously, and deliberately.**
- Energy should be concentrated upon a few important areas of the hospital rather than an ineffective and unachievable conglomeration of innumerable (i.e., 101) demands.

The Thursday Noon Committee chose two programmatic priorities for 1971-1972:

— followup action on the accreditation issue

— emergency room improvements.

But almost before the Thursday Noon Committee could embark on these choices, the hospital's administration created new headaches for itself. The hospital instituted new billing procedures. The procedures were in response to a MediCal "reform" provision which lowered the income and savings level of patients below which they could receive free care at SFGH. Before this "reform", patients received no, or very small bills.

With the new "reform" many patients who formerly received free care were told they would receive bills. In response to the new billing procedure, the Thursday Noon Committee issued a leaflet which described, in detail, exactly how the new billing rules affect patients and linked the emerging struggle to rescind the new billing rules to the accreditation issues.

The leaflet stated: "If SFGH does not bring its own health care up to minimal standards, and then bills patients as if they were in a private hospital, the question immediately arises: *Why should SFGH continue to exist?* Is someone trying to set up SFGH to be closed down as "unnecessary," and is this the real motivation behind the high bill policy?"

Thursday Noon demanded that no patient be given a bill higher than what he would have received under the old SFGH standards, and warned that, "it is going to be impossible to serve the poor community of San Francisco and serve them bills at the same time."

A few weeks later, following negotiations between Thursday Noon and various city and hospital officials, the battle of the billing policy was won. Dr. Curry, Director of Public Health for the city announced that SFGH would return to its former, more lenient billing standards. In addition, Dr. Curry agreed to a second demand that a billing Committee be formed from a cross-section of the hospital's staff to advise the hospital administration on the formation and enforcement of all billing policies.

"Both of these actions," in the words of Thursday Noon, "represent major victories for hospital workers in their struggle for a more humane billing system." The victory was made possible by the ability of Thursday Noon to stay on top of the situation by gathering, publishing and disseminating accurate and detailed information about the billing system."

Of equal importance, Thursday Noon through leaflets and personal conversation, provided hospital workers with a steady stream of information concerning each and every memo, conference and negotiation session which took place around the billing struggle. The conclusion by Thursday Noon was that "it seems that a relatively small number of hospital workers can work important changes in the area of hospital functioning through tenacity and use of their heads rather than through strikes or sudden spasms of activity."

With the billing action won, Thursday Noon Committee was able to turn its attention back to its emergency room program. Like most other city based hospitals, its emergency room service for acutely ill patients is relatively good. However, patients who are unable to find care elsewhere in the city and use the emergency room for less than life-treatening problems are given short shrift at SFGH's Mission E.R.

Thursday Noon Committee's first response was to research and document the inadequacies of the existing care in the emergency area. Then, a "draft proposal" for a plan to improve services was distributed to hospital workers. The bulk of the report consisted of evaluations and proposals for change of the various aspects of the emergency room's care including sections on the triage process, the use of space (with floor plans included), and the admitting office.

The report modestly concluded with a call for workers to meet and discuss the governance of the Mission Emergency Room. The modesty was justified by the Thursday Noon Committee's recognition that "we are doctors and social workers and don't pretend to speak for workers generally in the emergency room.

It is the feeling of the Thursday Noon Committee that, "only through meetings can the workers gain an effective voice in governing Mission emergency room." Thursday Noon Committee voices the hope that "eventually a workers' council may develop that has (significant) policy making functions."

It is too early to predict what the success will be of the emergency room plan at SFGH. Thursday Noon Committee has no intention of prematurely staging a confrontation without a base of support among other hospital workers and community groups. To this end, the Committee has been able to use its specific focus on the emergency room proposal as a point of discussion with workers and community organizations.

Although many of the proposals to improve the E.R. can be accomplished with the expenditure of little additional funding, the more sweeping suggestions for change will be expensive. The city, which through the Board of Supervisors, ultimately has the responsibility for governance of the hospital, agrees that the E.R. in particular and the hospital in general, are in acute need of improvement.

However, the city claims that it does not have the money to meet the needs. The Thursday Noon Committee recognizes that the city of San Francisco could, potentially, exercise its option to tax industry and banking to the maximum as a means of increasing city revenues. But, the Thursday Noon Committee also recognizes that the city will not voluntarily opt for this action.

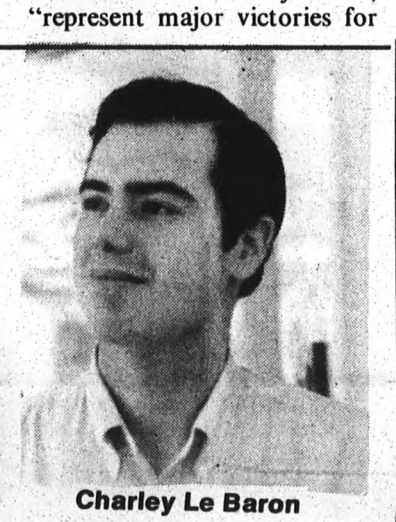
The city's other options are to beg for handouts from the federal or state governments (neither Nixon nor Reagan are notably generous when it comes to services geared for the poor); or to further tax the already overtaxed working class. In San Francisco, however, taxing the working class, predominately white, is a political liability. The city of San Francisco is finally left with one last option: shortchange the financing of public services.

U.C.'s "concern" for SFGH is also very limited — U.C. wants to preserve its own training and research fiefdom at General Hospital. When, for example, interns in the past have protested the patient care rendered at SFGH, and have demanded the abolition of San

continued page 8

Dr. Tom Bodenheimer

Carole Dicker



Charley Le Baron

Members of the Thursday Noon Committee

Mother Country vs. Colony: Two Opinions

Interview with Dr. Julius Krevans, Dean of the Medical School (UCSF)

What are the dimensions of the relationship between U.C. and SFGH?

The relationship between U.C. and SFGH goes back to the start of the medical school. There has been a continuing relationship between SFGH and medical education. It's been a relationship in which the medical school has added to the environment of SFGH medical talent through its faculty, both clinical and full-time, and its ability to attract young physicians to the house staff. The city has added to the resources of medical education by having a hospital in which medical education takes place.

How much validity do you attribute to the description of U.C. as the "mother country" and SFGH as the "colony"?

That's a national feeling whenever a university hospital is on the main campus and the city or county hospital is not. To a certain extent it's unavoidable that a major part of the house staff at the hospital should feel they are the "step children" of the mother campus.

What are your feelings about accreditation? Do you want to see SFGH accredited?

Certainly. The probationary accreditation given toSFGH was not a result of the visiting team questioning the quality of professional services given to the patients. It was all a matter under the rubric of "housekeeping." They didn't withhold full accreditation because the doctors were not there or were not adequate. It was a matter of maintenance; they gave to the administration a"laundry list" of things which had to be improved.

What would it mean for U.C. if SFGH were not accredited?

It would be a serious blow to our educational resources and I think a serious blow to the provision of health services to a lot of people. The ambulatory and in-patient service is an important resource to the community — not just for the people of the immediate neigborhood. For example, there's no question, if I were in an automobile accident, as loyal as I am to U.C. I'd prefer to go to Mission Emergency — it really serves the whole community.

Do you feel there is any validity of the San Francisco Medical Society wants to see the hospital closed?

I don't know . . . Officially, the San Francisco Medical Society has been strongly supportive in their official pronouncements of the bond issue for the construction of the new hospital. There are, however, obvious differences of opinion among various people. For example, the Director of Franklin Hospital in a recent letter to the *Chronicle* suggested that SFGH should be closed. My own feeling is that the hospital is needed by the community.

Originally, $400,000 was allocated for accreditation. That sum has now been reduced to $120,000. In addition, an equipment requisition for MEH and ICU equipment was recently refused. In view of this, do you believe there is some pressure at City Hall working against accreditation?

I think, rather, it is a reflection of the financial dilemma which the city of San Francisco is facing. I do know that we are going to help Dr. Curry in his struggle to get the necessary funds to make sure the hospital gets adequate services.

photo/dkw

Dean Julius Krevans

Last year after the Joint Commission (JCAH) came, a SFGH ad hoc committee found 286 violations whereas the JCAH found only 17. In view of this, do you think the standards of the JCAH are high enough?

The JCAH is a very professional outfit. They look for major problems effecting the operation of an institution as a safe and reliable provider of health services. There isn't any question that they might be willing to overlook some detail of an internal ad hoc group. On the other hand, it has to be realized that they have been doing this all over the country and they have national standards to compare with. They don't just provide "white wash" because many hospitals do not get their accreditation. It has not been a history of whitewashing existent institutions — the fact of probationary approval confers validity on this.

What are you doing for accreditation? What can U.C. do to help SFGH retains its accreditation?

As an individual, I can protest that the city is not doing what it should, but we have no power over the city. There has been a continued valued relationship between the city and the medical school. If the hospital is jeopardized, the medical school and the campus would work very hard in any way we could to make sure the hospital would continue to give good service. There are two reasons behind this: 1) I'm persuaded that the city needs this hospital and 2) the selfish motive that it's a valuable part of our total educational resources.

There is a great deal we can do — call on the Mayor, and Mr. Mellon, saying that we have joint interests and we can capitalize on that. However, in terms of power, our power is the power of persuasion; we can't control the budget of the city.

What are your sentiments about the Mission Emergency Proposal of the Thursday Noon Committee concerning worker-community participation in policy-making decision of SFGH, especially pertaining to the governance of the emergency room?

I have not seen the proposal yet. However, in general, I feel that it is important that services be improved by making them more responsive to the needs of the community. Whether the means of achieving that goal is community control is another question entirely. To make the hospital more responsive to the needs of the community is essential; however, there are many ways of doing that.

Interview with Dr. Frank Yatsu, Chief of Neurology Service (SFGH)

What are the dimensions of the relationship between U.C. and SFGH?

At the present time, the faculty is a part of the U.C. system. The degree and amount of support given from U.C. and the attitudes of U.C. toward SFGH depends in large part on the department involved. There is a general feeling here, though, that we're looked down upon as a "poor cousin."

How much validity do you attribute to the description of U.C. as the "mother country" and SFGH as the "colony"?

I do think there's a degree of truth to that — both psychologically and financially. For example, the department chairmen are all at U.C. And, to a large extent, the control of personnel and budget is from U.C., although that again varies from department to department. In Neurology, for example, we've had excellent support for personnel and research.

What are your feelings about accreditation? Do you want to see SFGH accredited?

Most definitely — for a number of reasons. As a vital arm to the UCSF campus, we provide excellent teaching, but as important or more important perhaps, we take care of patients in this area. There are only two hospitals for 200,000 patients south of Market Street.

What would it mean for U.C. if SFGH were not accredited?

The direct consequence of non-accreditation would be non-certification which would lead to closure. This would have a devastating effect as far as training medical students and residents is concerned.

photo/dkw

Dr. Frank Yatsu

Do you feel there is any validity to the allegation that a section of the San Francisco Medical Society wants to see the hospital closed?

There are certain vested interests in the private sector that would like to see SFGH closed, primarily due to the problem of decreased bed occupancy. Bed occupancy of private hospitals is dropping — if it drops below a certain figure, the hospitals do not remain viable. Several hospitals in the city are in serious trouble because of this. They would like the patients of SFGH and think that the services provided by SFGH could be equally well delivered by the private institutions in the city.

However, it has to be realized that SFGH has many special areas of excellence that cannot be duplicated elsewhere — the Trauma Unit of Mission Emergency, the dialysis and alcohol-drug detoxification unit. In addition, we're in closer proximity to the city's population that has been traditionally denied adequate medical care.

Originally, $400,000 was allocated for accreditation. That sum has now been reduced to $120,000. In addition, an equipment requesition for MEH and ICU equipment was recently refused. In view of this, do you believe there is some pressure at City Hall working against accreditation?

In general, those dealing with SFGH, such as Dr. Curry, Director of Public Health, and Mr. Mellon, Chief Executive Officer, are sympathetic and aware of our needs. A major problem appears to be the bureaucratic process of obtaining public funds. But more importantly, health care needs for the lower socio-economic groups just seem to take a low priority.

Last year after the Joint Commission JCAH came, a SFGH ad hoc committee found 286 violations whereas the JCAH found only 17. In view of this, do you think the standards of the JCAH are high enough?

I think that the JCAH and the other committee were not necessarily looking at the same things. For example, some areas the JCAH does not cover — such as the comprehensive care we give to Spanish-speaking patients. Instead, they assess administration, records, cleanliness, etc. which do not necessarily reflect on the care of patients.

What are you doing for accreditation? What can U.C. do to help SFGH retain its accreditation?

As co-chairman of the Self-Accreditation Committee, I can testify that we've been working very hard. We've been meeting weekly to accomplish a number of things: 1) to identify and justify all the items which the JCAH thought absolutely essential for accreditation and to submit a budget to the city; 2) to increase morale of SFGH through campaigns and posters; and 3) to increase the effectiveness of patient care, e.g. MEH facilities. There, the problems are of insufficient space, personnel and equipment.

As far,as what U.C. can do, since U.C. has a vital interest in our survival, it can use its influence to support the needs of SFGH./U.C. could help directly by financial support and by providing more personnel, especially physicians. The Dean and Chancellor are behind us but we need the ground swell of faculty support and, in the final analysis, the mobilized support of the public.

What are your sentiments about the Mission Emergency Proposal of the Thursday Noon Committee concerning worker-community participation in policy-making decisions of SFGH, especially pertaining to the governance of the emergency room?

I think that the Thursday Noon Committee's recommendations are commendable and appropriate. The "consumer" needs an Emergency Room with more space, more adequate facilities and personnel. I also agree that there should be input from all levels. This should be a collaborative effort in the spirit of co-operation in which the consumer should have a voice in how medicine is delivered.

Interviewed by D.K.W.

Abortions and Ambivalence

The Therapeutic Abortion (TA) Clinic at SFGH will see 12 women per week. The criteria for acceptance here are simple: no other alternatives. The demand for the service exceeds the supply two and three times over.

As the Intake Social Worker who screens and schedules patients for the TA Clinic, I receive anywhere from 20 to 40 phone calls and drop-in visits per week and determine who will be seen in the clinic, when they will be seen and how much it will cost them.

Waiting period held down

If a woman has any other means of obtaining an abortion, such as MediCal (welfare) or apparent eligibility for Medi-Cal, adequate health insurance, cash or loan potential, she will be referred elsewhere. By this sort of stringent screening, the waiting period between the initial contact and the actual admission for the abortion has been held down to between one and a half and three weeks. In an emergency situation, a woman can generally be admitted sooner.

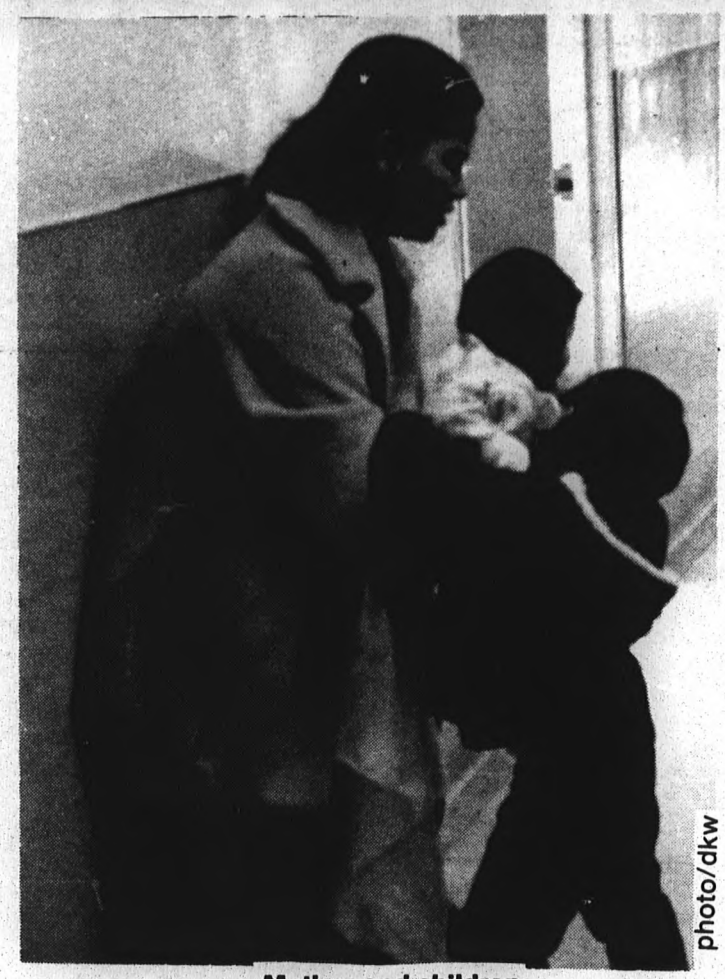
It is the intent of the Ob-Gyn Service at SFGH to provide therapeutic abortions within a context of comprehensive maternal health care. For this reason, a complete preoperative workup is done by the staff, and a heavy emphasis is put on contraceptive information and supplies. SFGH staff feels, as do most professionals involved in abortions, that this procedure should be only a backup to a full range of preventive contraceptive measures.

At this time, the therapeutic abortions are performed by second year U.C. Ob-Gyn residents, who rotate through the Abortion Service every ten weeks. They are not responsible solely for the TA patients, however.In addition to Abortion Clinic, surgery and postoperative care, the resident attends in OB Clinic four days per week, acts as a backup in the GYN Clinic, attends rounds and has night and emergency call duty.

Residents ambivalent

The residents generally seem to be ambivalent about the Abortion Service. They recognize the medical and social need for this service. However, they are concerned with learning as much as possible during their residency. They feel that too much of their time is spent on the Abortion Service where the learning potential is extremely limited.

Here, as elsewhere at SFGH, the needs of the community hospital should be served. The educational purpose of the U.C. teaching programs is not always in agreement. The contradictions implicit in this system have never really been resolved. An uneasy balance has been struck so far, with 12 women per week receiving abortions, and at least that many more being turned away.



photo/dkw

Mother and children

If a woman has no other alternative, wants an abortion, and finds out about SFGH, she sees me first. I take down basic biographical and financial information, determine how much she will have to pay (generally very little or nothing) and schedule her appointment in the TA Clinic This appointment will (usually) be a week to a week and half away.

Emotional Support

In the Clinic, she will be seen by the resident and by Bonnie Dauber, a paramedical counselor who offers emotional support, abortion and contraception information and general counseling. There is no psychiatric examination required. The patient will be admitted to the hospital for her abortion about a week after the clinic visit.

More than half of the therapeutic abortions performed at SFGH are simple aspiration abortions. This is the procedure used to terminate a pregnancy of not more than 12 weeks duration. The remainder are saline abortions (to terminate pregnancies of more than 12 weeks, and performed between the sixteenth and twentieth week) or combinations of abortions and sterilization.

When a patient is admitted for the abortion, she is seen on the ward by Bonnie, who holds a group rap session the night before the abortion, and she sees the woman again after she has had the operation. She provides psychiatric referrals if she, the doctor or the patient feels this would be helpful. SFGH is the only hospital in the United States, according to Dr. Ron Smith, Chief, Ob-Gyn, to have a full time Abortion Counselor on the staff, following the patient during the entire procedure. This is just one of the unique aspects of this special clinic.

by Janet Mc Fadden

Who controls SFGH??

SFGH has two, often opposing, administrative controls: the University of California Medical School and the San Francisco city and county government. Basically, U.C. is responsible for staffing the hospital with doctors and the county government is supposed to provide enough money and non-physical personnel to operate the hospital. However, when it comes to the actual running of the hospital and providing good patient care, the two areas of control become intertwined, interdependent and equally responsible.

In 1959, the U.C. School of Medicine made a contract with the city and county of San Francisco giving the medical school complete control over medical personnel at SFGH. Under this contract, the medical school names all interns, residents, and medical staff who must be U.C. faculty, and determines what duties these doctors shall perform.

The medical school agrees to provide a sufficient number of adequately trained medical staff doctors so as to insure competent treatment of patients. The city promises to operate the hospital with sufficient administrative, nursing, housekeeping, maintenance, and medical records personnel, and sufficient equipment, supplies and space.

By this contract, then, U.C. receives an entire hospital for its teaching purposes, and the city gets, in return, the supposed excellence and expertise of the medical staff.

Whereas non-doctor personnel are hired and paid for by the City (excepting clinical labs, anaesthesiology, pathology, and the cardiopulmonary unit, which are run under separate contracts by U.C.), all doctor personnel — house staff and medical staff — are hired by U.C. Interns and residents are paid by the City, and medical staff are paid partly by the City and partly by U.C.

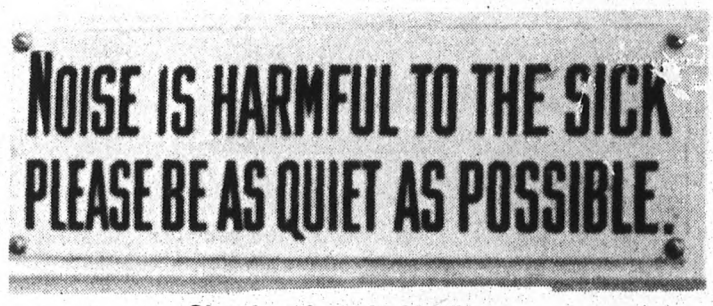
The Dean of the School of Medicine, Julius Krevans is the U.C. person charged with implementing the contract. The Dean also has his man on the spot, the Associate Dean at SFGH, Moses Grossman.

However, the Dean, by no means, has complete control of the situation. Interns and residents are heavily controlled by the powerful U.C. department chairmen. There chairmen, not the Dean, decide what rotations house staff have, how many nights on, and how much outpatient time. SFGH department heads have a certain amount of decision-making power, but in crucial matters they must often give way to their U.C. chiefs.

Some U.C departments are more powerful than others in their ability to get faculty, space and money. The largest department in terms of budget (instructional plus research budget) is medicine (3.3 million in 1969-70), followed by surgery (2.1 million), radiology (1.8 million), pediatrics (1.3 million) and pathology (1.1 million).

Control over the faculty is far more complicated than control over interns and residents. Some faculty have hard-money positions (paid by state legislature appropriations). The number of these positions, and who is hired to fill them, is decided on by a complex process of recommendations by the U.C. department head, review by Dean Krevans, further review by the budget committee of the Academic Senate, the Chancellor, the President of the statewide University of California, the Board of Regents, the Governor, and the State Legislature.

Recently, hard-money positions have been cut by the Governor. Should new such positions become available, the various departments fight over who gets them. Once a hard-money position has been filled, the U.C. department chairman has the most power over that faculty member.



Sign in a hospital hallway

Soft-money positions are those paid for by grants — usually NIH research grants. Forty per cent of medical school faculty are paid for these grants, reflecting the fact that the U.S. government gives almost as much money ($23.5 million in 1969-70) to U.C. as does the State of California, which supposedly runs the school.

In this way, research groups like the Chest group, rental group, cardiopulmonary unit, are run as autonomous fiefdoms by their chiefs, with accountability to no one in the hospital or U.C.

If more interns and residents, are wanted, one must go to the city to get more positions funded. If one wants to change the way in which house staff uses its time, one goes to department heads (starting with SFGH chief, but the real source of power is the U.C. chief).

If one wants more faculty, one goes to the city to ask for more salaried faculty positions, or to the Dean or department heads to request new hard-money positions. If one wants the present faculty to use their time in different ways (for example, the work in the OPD) one must go to the SFGH department head, to the U. C. department head and — in the case of soft-money faculty — to the head of the research group involved.

The hospital budget is the means through which the county government holds the purse strings to good (or bad) patient care at SFGH. The Mayor and the Board of Supervisors ultimately decide how much money and personnel will be allotted for the running of SFGH — how many nurses, orderlies, clerks, porters, and social workers will be hired, whether there will be a new x-ray room or whether the old one can be repaired, whether there will be enough catheter tubes, x-ray films, blankets, wheel chairs, typewriters or even light bulbs.

Initially, the budget is formulated by each department in the hospital, such as medicine, surgery, or nursing. The SFGH Administrator coordinates and sends it to Dr. Francis Curry, Director of Public Health who can change it however he wants. Chief Administrative Officer Thomas Mellon — appointed for life and recently given a 4 1/2 year extension above the retirement age — receives the budget for review next. He, too, can either add or decrease or cut from the budget.

There is no doubt that the budget can be influenced by hospital staff — doctors and workers alike at all levels — from the initial formulation by each hospital department head up to the mayor and the Board of Supervisors. If the department can prove that it needs more money after the annual budget is passed, it can request a "supplemental budget," which is not an unusual occurance.

Yet, even after the budgets have been approved, administration in the city and the hospital itself will refuse unless pushed to spend the money allotted for certain items and personnel despite the fact that they exist in the budget.

Almost all hospital staff other than doctors are supposed to be hired on a merit system basis through Civil Service. However, because of its mal-functioning, Civil Service has been unable to provide enough steady workers to efficiently run SFGH.

It does not hold enough exams to hire personnel on a permanent basis, and therefore hires large numbers of employees on a "temporary" basis about 1/4 of the non-physical staff at SFGH. And, when it does hold exams, they inevitably do not relate to the job and are impossible for many minority persons (who are already "temporarily" performing the work adequately) to pass.

It is possible for this "temporary" employment to last for years; but more likely, the person will eventually be "bumped" out of the job because someone else is hired on a permanent basis, because the supervisor doesn't like him, or because of some other technical Civil Service Rule that no one is informed of.

Temporary employees have no health coverage, no social security deducation and no "Civil Service rights." It is obvious to city employees that the Civil Service system has become a spoils system where "troublemakers" who are temporary are "bumped" with no recourse, but persons who remain docile are shifted to other temporary positions when their current temporary job ends.

As a result of this system, the turnover is extremely high, employees are trained only to be replaced in a month. Frequently, employees are "bumped" or resign and there is no replacement at all for a number of months.

The effect on morale is catastrophic — it is so low it doesn't exist. Under these circumstances, employees do not perform their best on a job, nor can one expect them to care.

Civil Service is ostensibly run by a three man commission appointed by the mayor. The Civil Service Commission is now composed of Gary Vanelli, a young conservative lawyer, William Jack Chow, an attorney and former president of the conservative Chinese Six Companies, and William Kilpatrick, the 79-year-old labor representative.

The Commission holds a public hearing every Monday, Room 282 City Hall at 4 pm, to rule on the many appeal requests from city employees who feel they are not being justifiably treated. Although the Commission is supposed to hear any appeal request sent in in writing, they have taken to refuse to calendar anything they feel might be too controversial or "inappropriate."

The Civil Service Commission is supposed to appoint the department's Chief Executive (General Manager), but the mayor actually performs this task. Last month, Bernard Orsi, previously employed in Mayor Alioto's office was appointed as the new General Manager of Civil Service replacing George Grubb who had been there for 15 years. Orsi stated that his intentions are to give high priority to cleaning up this "temporary" mess, but whether he will do it to the benefit of "temporary" employees remains to be seen.

Mayor Alioto exerts a good deal of control over Civil Service through his appointments, and through the fact that all job requisitions that departments submit must be authorized by him. Often, he will "hold" these requisitions and not allow "temporary" employees to be renewed or permanent employees to be hired. Most of the time this is done quickly but at the moment there is an "official job freeze."

There is one thing about dual City-University control over certain aspects of the hospital — one can sometimes align with one side against the other, for the two institutions are often at odds. The medical school for example, is always unhappy about city budget cuts, and should help fight against them.

Director of Public Health Curry, on the other hand, is rightfully angry at U.C. for 1) not placing enough faculty at SFGH, 2) rotating residents through U.C., SFGH, and VA Hospital, thus wreaking havoc with the concept of continuity of care, and 3) refusing to place enough housestaff in outpatient positions even though the City pays housestaff and needs more outpatient doctors desperately. However, when it comes to the unified insurgency by community groups and hospital workers, then U.C. and the city can be expected to stick together to attempt to retain the status quo.

by Carole Dicker and Tom Bodenheimer

VICTORY ON BILLING

In a meeting with the "Thursday Noon Committee," Dr. Francis Curry, the Director of Public Health, announced that SFGH would return to its former, more lenient billing standards. Dr. Curry also agreed to the Thursday Noon Committee's suggestion that a SFGH Billing Committee be formed from a cross-section of hospital staff to serve as an advisory board on the formulation and implementation of all billing policies. Both of these actions represent major victories for hospital workers in their two and a half month struggle for a more humane billing system.

Dr. Curry opened the meeting by stating that he and Chief Administrative Officer Thomas Mellon had decided not to take the matter up with the full Board of Supervisors, since they had concluded that the issue could be resolved without necessity for legislative action. The Director stated that he was ordering that SFGH bill persons only according to hospital determination of their ability to pay, and that all October and November bills to patients be re-written to conform to SFGH standards.

Dr. Curry, however, also announced that SFGH would stay with the Medi-Cal assets ceiling of $600; he did agree to have the ceiling and the problems attendant upon it investigated by the new Billing Committee, which would be composed (by the request of the Thursday Noon Committee) of the Out-Patient Director, two house staff members, and one representative each from Administration, medical staff, nursing, billing, and social services.

In contrast to previous hospital functioning, such a committee will be a clearly visible body, with open meetings and public responsibility for its actions. It will also have the function of educating all hospital staff on billing procedures.

Both the admissions workers and the Thursday Noon Committee sent memo's to Dr. Curry thanking him for hisdecisions in this area. (The Director did not arrive at these decisions without some effort on the part of hospital workers). Dr. Curry replied with a note stating that he was pleased that all could work together on this issue and hoped that this could continue on other issues in the future. However, after two months no one has yet followed through with the task of setting up the SFGH Billing Committee.

SFGH Dis-accredited?

continued from page 2

the hospital; inadequate formal liason among the governing body, the administration and the medical staff; inadequacies in personnel staffing; inadequacies in equipment, and difficulties with drug supply distribution and control . . . The deficiencies noted are almost sufficient to lower the rating to no Accreditation. Concerted attention must be given to early effective implementation of all the above recommendations if accreditation is to be maintained."

"Dangerous precedent

Legal Assistance attorneys had requested to appear before the Joint Commission's governing board. The request had been turned down since, according to the Commission's Director, "it would create a dangerous precedent to allow consumer groups to appear before the Board." Information concerning the board's decision had been kept "confidential." When the attorneys wrote Elliot Richardson, Secretary of Health, Education, and Welfare, asking him to review the Joint Commission's action, the secretary refused, stating "the law does not give HEW authority to overrule (Joint Commission) decisions or influence the way in which the Joint Commission operates." Furthermore, said Richardson, the Joint Commission had refused to give even him the SFGH report or any information on SFGH other than that it had been accredited!

Within a month, the legal assistance attorneys, with the assistance of patient and worker groups, had filed a suit in court in Washington demanding that:

(1) SFGH be disaccredited (with the loss of millions of dollars of Medicare and MediCal revenues and the possible forced pull-out of U.C.),

(2) All medicare payments to all hospitals in the United States be halted until an adequate accreditation procedure be devised — one free of the institutional interests of such groups as the American Hospital Association, embodying strict and relevant standards, and conducted in an open manner.

This suit is now before a three-judge district court, headed by Gerhart Gesell, son of the famous pediatrician, and the judge who refused to suppress the "Pentagon Papers." In two pre-trial hearings, Judge Gesell denied a request that the complaint be re-written into more legalistic language and stated that he wanted the trial expedited as much as possible since "substantial Constitutional issues are involved."

Significantly, attorneys for HEW stated that the government was "reconsidering" its original position that it would not review the Joint Commission's accreditation actions. And, in an intriguing about-face, representatives of the Joint Commission offered to include representatives of patient groups on its governing body! A final pre-trial hearing is scheduled for February 15, with the issue going to trial in March.

Self-Accreditation Committee

Meanwhile, back in San Francisco, an alarmed Public Health administration had appointed a top-level "Self-Accreditation Committee", headed by SFGH Neurology Chief (and U.C. Professor) Frank Yatsu, to make sure that the Joint Commission's "recommendations" were carried out so that SFGH would at least pass its probation when the Joint Commission's field representatives come out again this March. After four months of almost weekly meetings, the Self-Accreditation committee submitted in December 1971 a request for a $400,000 supplemental appropriation by the city, as the minimum needed to bring SFGH up to accreditation standards.

The request was quickly approved by the SFGH Administrator the Director of Public Health, and the City's Chief Administrative Officer. It then landed on Mayor Joseph Alioto's desk. After some delay, the Mayor (who had never inspected hospital conditions) cut the request down to $120,000, with another $87,000 "probably" if more information is submitted.

In addition, request for new equipment — which was considered already approved — was also denied; and a strict hiring "freeze" with lay-off's of temporary workers was imposed. (Meanwhile, the City Planning Commission approved a $595,000 appropriation to refurbish the private offices of the 11 members of the Board of Supervisors.) Said legal Assistance attorney Fred Heistand, who filed the accreditation suit, "I see no chance that SFGH could be accredited in March on the paltry amount allocated by the Mayor."

No one can believe

Thus, while the suit that could discredit SFGH makes significant progress in federal court, the powers in the city of San Francisco will not even appropriate half of what is needed to get the hospital through another accreditation inspection. In fact, nothing could be clearer evidence of the lack of significance of the Joint Commission's actions; no one in city government can believe that would actually discredit SFGH.

However, with worker and patient groups organizing within the hospital, attorneys pressing a federal suit in Washington, the day of this kind of brinkmanship with the health care needs of poor persons may be drawing to a close. The events of the next three months may have far-ranging effects on American health care standards — and SFGH and its U.C. medical staff will be right in the middle. **by Charles Le Baron**

photo/dkw

Three lines of people wait in the pharmacy

Mission Emergency Is Sick

continued from front page

technicians, control of the police, more privacy, interpreters, and improved co-operation among employees. There have been complaints about insufficient staffing, slowness and disorganization of X-ray and general lack of rules and philosophy.

Thursday Noon Committee

Why have previous protests about Mission Emergency been ineffective? Because no concerted attempt has been made to push for the implementation of demands. For this reason, the group known as Thursday Noon Committee determined to work in a concentrated manner for improvement of Mission Emergency.

Thursday Noon spent about two months preparing a plan for Mission Emergency. Only after consultation with many people, especially Mission workers, was the plan made into an attractive booklet and circulated throughout the hospital. The plan deals with four major areas:

1. **Increased space.** The present quarters of the intake social workers would be converted into a drop-in clinic, more X-ray facilities and a waiting room.

2. **Additional personnel.** More social workers and more doctors and nurses are needed, as are paramedical triage workers, in order to decrease waiting periods.

3. **Separation of true emergencies and drop-ins.** A drop-in clinic is needed next to the actual emergency room

4. **An accountable governing body for Mission Emergency.** A visible decision-making apparatus would be set up so that everyone knows who is responsible. Mission personnel would have something to say about the functioning of their emergency room.

Change in the governance of Mission Emergency is given a high priority by Thursday Noon. Presently, the emergency room is not governed in a manner which is accountable to the needs of the patients and the workers.

Where does one complain?

Doctors are under the control of their own department heads and of the Medical Co-ordinator, Dr. Lim. Nurses are hired and controlled by nursing administration working through the Mission head nurse. Orderlies are controlled by nursing and civil service. Social service workers and clerks are under Mr. Griffin. Financial policy rests with the billing department. Lab and X-ray are departments unto themselves. The Emergency Room committee of the medical staff is essentially nonfunctional. Where does one complain or to whom does one turn in order to get something changed?

According to the Thursday Noon Committee, Mission Emergency should become an integrated unit. This means that one person or group of people should be responsible so that legitimate complaints about patient care or working conditions can be directed to one visible, accountable entity with decision-making power. In addition, this group or individual would be responsible for delineating a policy for the functioning of the emergency room which would apply to *all* workers in MEH.

An effective voice in governing

Critical to a well-functioning, responsive emergency room are regular meetings among Mission Emergency workers. Meetings should be held by all those who work in the Mission — nurses, orders, doctors. Only through such meetings can the workers gain an effective voice in governing Mission Emergency. Eventually, a workers' council may develop that has significant policy-making functions.

Thursday Noon's Plan for MEH concludes: "Mission Emergency has many faults — long waits, overworked staff, complex and confusing admitting and social service procedures — all of which lead to poor quality and dehumanizing medical care. The solution to these problems requires two levels of changes:

1) immediate reform including more staff, more space, and improvement in triage, admitting and social service functions;

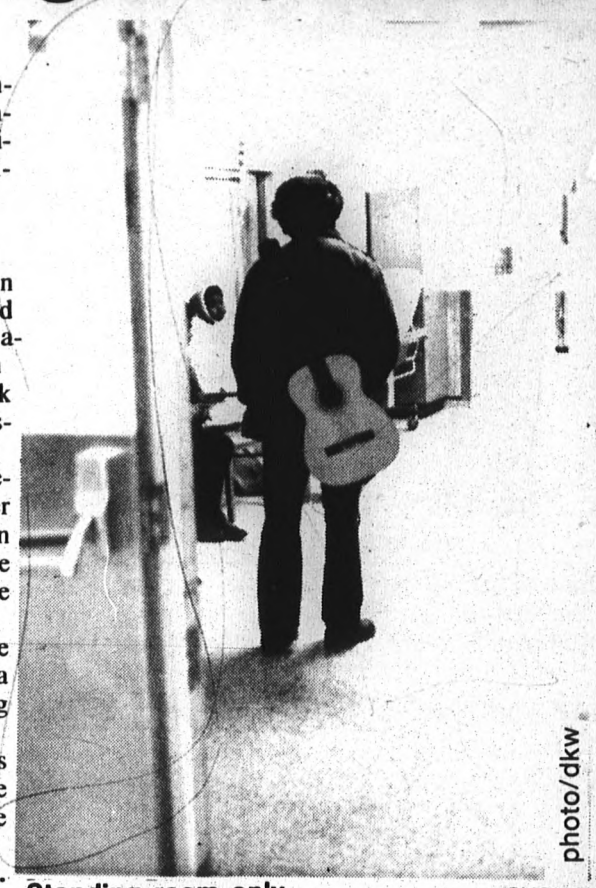
2) fundamental changes in the governance of Mission Emergency which would insure that the emergency room will always be responsive to the needs of patients and workers."

Innumerable Committees

How to implement the Mission Emergency Plan? First, Thursday Noon Committee is steering the plan through SFGH's innumerable committees: Mission Emergency Advisory Committee, Space Committee, Self-Accreditation Committee, Executive Committee. . . While this process is going on, Thursday Noon members are speaking to community groups about the Mission Emergency issue: Mission Coalition, Chinatown Community Clinic, Tenants and Owners in Opposition to Redevelopment, Public Housing Tenants Association, and the San Francisco Women's Health Collective.

The next step must be to pushthe money-requiring items in the plan through the city bureaucracy; Director of Public Health Curry, Chief Administrative Officer Mellon, Mayor Alioto and the Supervisors; and to work on the hospital administration and University for a change in the governance. The Mission Emergency issue is also closely related to accreditation, since the Joint Commission on Accreditation pointed to emergency room congestion as one of SFGH's severest problems. The pressure to accredit the hospital this spring will hopefully improve the Mission Emergency Plan's chances for approval.

by Tom Bodenheimer, Sue Skinner and Marie Feltin



photo/dkw

Standing room only inside the Emergency Room

Thursday Noon

continued from page 3

Francisco's two-class health system, U.C. perceived this as a threat to the very existence of its colonized fiefdom. Hence, U.C. reacted by threatening the dissident doctors with the loss of their medical licenses.

The faculty and deans of the medical school argue that if a fuss is made by medical personnel at the hospital, the city will stop construction of a new SFGH (the new building has been planned since 1965, construction is now underway and should be completed in 3-4 years.). However, university officials know that it is too late for the city to back off construction of a new county hospital and therefore, fall back upon a second line of defense against political struggle at SFGH — if the agitation doesn't stop, the city will ask the university to leave the hospital and the university won't be able to take advantage of the new edifice.

Despite the conflicts of interest, complexities and contradictions surrounding SFGH, the movement to radically upgrade the services which the hospital offers continues with undiminished intensity. But episodic protest in the past from various strata of the San Francisco population — professionals, non-professional health workers, the poor black and Chicano, and elderly community — reveals widespread discontent with the city and the university.

Up until now, protests have been largely uncoordinated, and all too often, at cross purposes with one another, leading to one defeat after another. The past eight months, however, have seen the beginnings of the emergence of a more united attack. The partial success of the accreditation hearing and the complete success of the billing struggle give reason for some optimism that things could be different.

Excerpted from a forthcoming article in the Health PAC Bulletin

classified

rentals

Female roommate wanted to share Twin Peaks house, own bedroom, furnished, days call Monica x 1117, evenings 647-7592

Furnished Room, private entrance and shower, men only. Edgewood Avenue, $75. Call 564-0907 or 681-5352.

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PORSCHE – 1960. White, red leather, new Michelin Radials. $1,050 or best offer. Ext. 2257

ANNOUNCEMENTS

ASIAN HEALTH CAUCUS will meet Monday January 24 at 12:10 p.m. in 214 S. All Asian students and workers, and friends, are urged to attend. Topics of discussion will include a discussion of a possible reorganization plan with elected officers, progress report of ongoing projects and plans for a fund raising event. PLAN TO BE THERE.....

SAMA REGIONAL CONFERENCE -The Student American MEDICAL Association will be having a meeting of medical students from the west coast medical schools and Nevada and Hawaii next weekend Jan. 28-30 at the UC Davis Medical School. Planning and discussion will be on medical legislative affairs, organized medicine, minority affairs, free clinics and community health projects, and medical education. Students and others interested in attending please contact Mitsuo Tomita 564-0261