THE GOUVERNEUR HEALTH SERVICES PROGRAM
An Historical View

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Two previous articles on the Gouverneur Health Services Program of the Beth Israel Medical Center have cited some aspects of its origin, its early history, its philosophical framework and its organizational structure.[1,2] In light of the expanding interest in neighborhood-based services and the proliferation of neighborhood health centers around the country, this article attempts to give a more complete picture of the development of the program in the hope that it may be helpful to those contemplating the organization and administration of similar, free-standing, health service facilities.

If this program had no other value its importance could be measured by its having demonstrated that it is possible to recruit well-trained physicians to work in neighborhoods of low socioeconomic level; that such physicians can render high-quality, comprehensive care with a minimum of fragmentation, overlapping and duplication of service; that given the desire, the freedom and the support of the health power structure "first line" health services can be delivered to large numbers of patients in a manner that makes maximum use of scientific advances; that the involvement and support of the community in the program not only provided the program with "muscle" in its negotiations with other agencies, but also provided the administration with insights to patient needs it could not possibly

have achieved in any other way; that untrained, neighborhood personnel could be trained to perform meaningful job tasks—in many cases more efficiently and effectively than their professional counterparts—giving the community a greater feeling that this was their program, thus stretching already overtaxed professional manpower and creating new careers in the health field; that the freedom to operate on a "decentralized" basis with all of the benefits inherent in controlling one's own selection of personnel, purchasing and budgetary priorities provides the necessary flexibility to keep the program a viable, moving organism; that attention to the amenities is at least as important as the level of scientific proficiency in making a program meaningful for the consumer.

That the Gouverneur Health Services Program was a forerunner to the Office of Economic Opportunity Neighborhood Health Center program and serves as one of its models, and that Gouverneur has also served as New York City's "showplace" for much that is now being incorporated in its Neighborhood Family Care Center program, is ample testimony to its impact. The irony of this situation is that very little is really new in what has been done, most of it having been suggested in the literature for many years. It having been done, however, is significant in that the health field has now broken a number of barriers that were more psychological than physical. As in most such instances the likelihood is that similar changes will take place at an accelerated pace.

In the late 1940's and early 1950's, the quality of medical care in the Gouverneur Hospital began to deteriorate rapidly as the hospital found it increasingly difficult to attract American-trained interns and residents to its house staff. In addition, the city's long standing indifference to the most routine preventive maintenance techniques, coupled with its cumbersome repair and purchasing procedures, resulted in a deteriorated physical plant that was more detrimental to the health of its patients than it was therapeutic. This downward spiral continued unabated despite community alarm, professional concern and a decreasing utilization rate, which not only increased the cost of operation but made it an even less desirable place to work for the neophyte physician as well as all other health personnel. Ulti-

mately, an affiliation with the New York University School of Medicine was terminated by the school and, subsequent to that, the hospital lost its accreditation by the Joint Commission for the Accreditation of Hospitals.

In 1958, long after the Lower East Side Community had recognized the inadequacy of the Gouverneur facility, it successfully extracted from Mayor Robert Wagner a promise to construct a new Gouverneur Hospital. By that time the Gouverneur Hospital had become the last treatment facility of choice on every opinion poll conducted in the community and its residents, more often than not, either went without much needed care or sought care from a variety of local practitioners with questionable qualifications, or from other municipal and voluntary hospital clinics some distance away. When the Van Dyke[4] report was published it recommended closing of the Gouverneur Hospital, and was followed by the city's expression of intent to comply with that recommendation. The community, which had once before mobilized itself in the face of the crisis created by open warfare between "bopping" gangs intent upon establishing their own "turfs," moved to convey to the city administration the depth of its feelings about what it felt was a unilateral decision.

In what has by now become a classical illustration of community organization practice in schools of social work, the Lower East Side Neighborhoods Association, a group of 80 social, religious, political, cultural, civic and business organizations—with the help of thousands of petitions and torchlight parades around the hospital and City Hall—succeeded in preventing the city from closing the Gouverneur facility entirely. The community did not question the desirability of immediately closing the inpatient part of the operation nor, indeed, was it interested in maintaining any services in the 63-year-old ward building provided substitute services could be made available in another, conveniently located site. The community rejected, however, the notion that Bellevue Hospital, Beekman Hospital or Beth Israel Hospital were adequate substitutes noting, as it did so, that it did not question the quality of the services rendered in those institutions. Rather, the people cited the unique needs of the population, which consisted of a large proportion of single, elderly

people along with an exceptionally high percentage of fatherless households with many children for whom any trip constituted gross inconvenience. They also cited the traditional organizational pattern of clinic care which resulted in fragmented care, long waiting periods, lack of continuity of care and a structure geared to the convenience of the institution and its staff rather than the needs of its patients. They suggested, in fact, that what the community needed was a community based facility similar, in most respects, to The Hunterdon Program with which the new Commissioner of Hospitals, Ray Trussell,[5] had been connected.

Commissioner Trussell had already concerned himself with the overall difficulties of the Municipal system, particularly as this related to staffing problems and the quality of care. This concern led to the idea of affiliation with strong, voluntary, teaching hospitals as a means of upgrading the quality of care and overcoming staffing problems. He thus proposed that the Beth Israel Hospital (later to become the Beth Israel Medical Center) staff and administer the Gouverneur Ambulatory Care Unit (later to become the Gouverneur Health Services Program), a proposal which the Beth Israel Board of Directors accepted with some trepidation. The Board of Directors identified strongly with the Lower East Side on a personal basis and Beth Israel itself had started within walking distance of the Gouverneur site, but this was a new venture in service to the community and very much different from anything most major medical institutions were interested in trying. That the Board accepted this responsibility is tribute to the foresight and persuasiveness of Mark Freedman[6] who was then Executive Director of the hospital.

The affiliation contract gave Beth Israel far-ranging power allowing for the hiring of a completely new staff, for the direct purchase of supplies and for a wide range of discretion as to what constituted patient need and the best way to serve that need. The hospital granted virtual autonomy to the Medical Director of the Gouverneur Ambulatory Care Unit insofar as the running of the Gouverneur program was concerned, asking only that decisions related to the broadest of policy matters be cleared with Beth Israel's Executive Director. Decisions related to working with the community and how to involve

the community in the program were completely given over to the Gouverneur administration. Decisions related to budgeting were, likewise, left to the discretion of the Gouverneur administration. Beth Israel's only mandate to Gouverneur in this area was that it not run a deficit operation since Beth Israel, in its first three-year contract with the city, had forfeited the right to an indirect cost factor, and also it did not want to further tax its own board of directors.

BASIC OPERATING PRINCIPLES

From its inception, Gouverneur operated under certain basic tenets including, but not limited to the following:

1. The service belonged to the patients and therefore should be geared primarily to meet their needs rather than those of the staff.
2. The services the patients were to receive were services to which they were entitled by right rather than by privilege and, therefore, were to be delivered in a manner which was conducive to meeting the patient's psychological, social and emotional needs as well as his biological ones.
3. The patient functioned as part of a larger milieu—in his own home and in the broader community—and these forces, therefore, must be taken into account if the service rendered was to be meaningful.
4. The community at large was entitled to a voice in the program and should share in the decision making process wherever possible.
5. The staff's activity, if it was to be meaningful, could not be confined to the functioning within the four walls of the Gouverneur structure.
6. Professions other than medicine had significant contributions to make to the philosophical stance of the institution and functional aspects of the program, and these views

should be formally represented on a policy making board similar to the Medical Board of Hospitals.

7. Every effort would be made to make the physical facility an attractive one to which patients would come without revulsion and creature comforts of the patients would be reasonably catered to.

8. Lack of facility in English should not be a deterrent to communicate with staff and toward this end as many multilingual neighborhood people as could be, would be employed to further the patient's sense of familiarity and comfort.

9. The service would be made accessible, as well, from a geographical and time standpoint to the degree that financing allowed.

10. The traditional clinical subspecialities, which treat body organs rather than individuals, would be eliminated or reduced to the lowest possible number.

11. Patients would be seen, with the exception of care for acute needs, through a staggered appointment system.

12. The notion that lines were inevitable in clinics would not be tolerated and every effort would be made to keep lines from forming or people from standing while waiting for a particular service.

13. As many full-time or half-time physicians as possible would be hired so that patients could return to the same doctor and identify with him as their family physician.

14. Full-time staff would have no outside practice and that all staff would be paid for service at the clinic so that the tendency toward primacy of interest in fee-for-service practice might be eliminated, or reduced to the barest possible minimum.

15. The notion that one's work was done when one saw his last patient was not to be tolerated since this inevitably led

to collusion between doctors and nurses to "run patients through" with an eye toward going home early.

16. All professionals were paid for time—not just for services rendered—and consequently would be expected to work the hours agreed upon prior to employment.

17. One's status as an employee did not entitle him to subject a patient to any indignity or scorn or derision and reports of such behavior would be severely dealt with irrespective of the station of the employee involved.

18. Patients would have, at all times, access to the administrator so that they might voice their views on the service rendered or the individual rendering the service, and every such report would be checked out.

19. The administrative organization would remain as loosely structured as feasible to reduce to the barest possible minimum the amount of flexibility which might be lost through bureaucratization.

20. The administrative structure would be as "horizontal" as possible with the pushing down of both responsibility and authority to the level of least training which could perform the function required efficiently and economically.

21. Experimentation with new systems of care and administrative organization would be encouraged to reduce costs while increasing efficiency.

22. Experimentation in new uses of personnel and the creation of new jobs for neighborhood people were to be encouraged both as a socially desirable goal and as a means of stretching health manpower.

23. All staff would be encouraged to be innovative and to excercise as much initiative as they could muster in the interest of improving patient care.

24. The clinic facility was a vehicle for meeting patient needs

and as such would have no fixed territorial claims made upon it by staff or service seeking status or prestige in maintaining given offices or locations.

25. The clinic facility belonged to the community and as such should be made available to the community for meetings and so forth, provided these did not conflict with patient care.

METHODOLOGY AND RESULTS

Clearly, no panaceas were achieved nor, for that matter were the limited successes equal in every area. However, many significant improvements were made which resulted in marked changes in patient attitude and which clearly demonstrated the possibility of maintaining a reasonable level of patient care within an atmosphere conducive to patient comfort while maintaining a huge volume of service in an arena where every request for service had to be met. Toward those ends set forth above, the unit did the following:

1. Systematically set out to meet all of the community's leaders via formal and informal "get-togethers" at settlement houses, housing authority locations, community organizations, churches and any other location. Such meetings were arranged by the top administrative staff of the organization even before the unit saw its first patients and they were continued for each new key staff member upon hiring. The idea here was to maintain a personalized relationship so that a sense of community could be maintained to preclude the possibility of impersonal, written referrals being made between organizations. Since such referrals are very often made to avoid responsibility and since one is likely to think more carefully about the reaction of the receiving agency, the net result was that the unit found itself pushed to devise methods of delivering a more complete service. It was also made clear to the community that the unit did not consider the four walls of the clinic to be the limit of its sphere of functioning. Toward this end any number of staff members spoke to parent or club groups on their home territory as a means of bringing the unit's particular competences directly to the people. This in-

cluded speaking engagements, doing camp examinations at settlement houses, having nurses check on campers before they boarded busses and serving on a variety of boards and planning and advisory committees of existing community agencies.

2. Purposefully set about to hire as many people from the community as possible and to orient all staff members both to the community and to the idea that patients were to be treated with kindness and respect irrespective of their station in life. More significantly, the administration manifested its own interest in patient comfort by engaging a color consultant to plan the painting of the building and by reprimanding any employee who was observed in questionable behavior with a patient or who was reported to have been rude to a patient. As in so many other situations, this was terribly time consuming at the beginning, but a great time saver in the long run as the staff observed the administration's attitude and the administration's intent to press both the letter and the spirit of the law. Several years after the beginning of the program, when the staff chose Local 1199 of the Food and Drug Employees Union as its bargaining representative, one of the terms of the union agreement was that employees could be dismissed for discourtesy to patients and that dismissal on such grounds was not subject to the grievance machinery.

3. Installed the director of social service in a position of great importance in recognition of the value of the contribution to be made by the behavioral sciences to a community oriented program. Such placement had both real and symbolic value—its real value being in the influence which could be exerted on clinic policy and in assessing persons who applied for positions in the organization. Its symbolic value was in the indication that recognition was being given to the potential contributions of disciplines other than medicine in the health field.

4. Consulted with community leaders on their estimates of the patients' needs and found the community remarkably ready to leave medical policy to the unit while concerning itself almost exclusively to the amenities and conveniences of the services rendered. The pa-

tients who formerly shunned the Gouverneur facility returned not because they assessed the medical care as being qualitatively superior to that which existed before, but because they heard from the community grapevine that the facility was pleasant and comfortable, that no one had to wait long and that patients were treated kindly. The actual quality of care was incidental to all of this.

5. Hired a number of Spanish, Yiddish and Chinese staff members and created directional signs in those languages as well as in English to facilitate movement throughout the building. Only lack of budget prevented the hiring, at that time, of floor managers whose full-time responsibility would be to help patients with the complicated process of going through a medical facility. Such a person, as well as aide staff, was envisioned as being trained by airline hostess schools or visiting the offices of fee-for-service physicians in an effort to learn how to greet the public. The notion here was that a person seeking treatment for a health problem should be treated no less cordially than a potential customer in any department store.

6. Moved deliberately to hire as many full-time and half-time staff as possible so that by January, 1967, 20 full-time physicians and ten others who worked 20 hours a week or more had been hired. This greatly facilitated the possibility of seeing the same doctor on each visit, though nonappointment visits sometimes resulted in seeing another doctor. Not only did clinic visits quadruple in five years of operation, but also the number of referrals to other hospitals for both inpatient care and subspecialty consultation was reduced to less than one per cent of the total number of clinic visits. Although the percentage of patients seen without appointments increased on the pediatric and medical services by the end of the fifth year of operation, the kept appointment rate also increased and conceivably would have been even better if the staff had been able to educate the patient population to the use of the telephone. In the particular socioeconomic group being served, however, the lack of availability of a telephone or the difficulty encountered in trying to get through a busy switchboard are factors which contribute toward unnecessary visits. Physician concern about patients not following a particular

therapeutic regimen is another contributing factor to otherwise unnecessary clinic visits in this socioeconomic group. Finally, non-appointment patients who were "squeezed into" doctors' schedules where gaps were left for that purpose, should more appropriately have been considered appointment patients since they would be so considered in solo practice.

7. Various methods were tested in keeping the appointment system efficient, including, but not limited to, overbooking to account for projected broken appointments, doubling or tripling appointments for the beginning of the doctor's session as a device against the doctor waiting for patients when his day began, having ancillary staff process charts and patients before the start of the clinic session for the same purpose, doubling appointments at the end of the clinic session as some guarantee that the physician would work through his entire clinic session, weighting appointments toward the end of the week to reduce the traditional clinic overcrowding on Monday mornings resulting from weekend emergency room utilization, and weighting the doctor's clinic schedule from the bottom of the day up to reduce early morning crowding, as is also the case in most clinics. Most significantly, however, the administration, in receiving a weekly report of next available appointment by specialty clinic and by doctor, could shift the programming of such appointments or add sessions accordingly.

8. Toured the building several times daily to note conditions which needed change. More important, invited any interested parties to visit the clinics unannounced to see the operation as it really was. On tours of the building, the attention of various department heads was directed to anything that violated the basic principles of good patient care, thus demonstrating repeatedly the intention to give more than lip service to the principles espoused. The theory was that once the inevitability of queues has been accepted, they will fluorish, but if it is established that lines are not tolerable, the staff can and will find the ways to abolish them.

9. Demanded adequate documentation from department heads who asked for more staff. More often than not such requests are

based on the notion that numbers alone will resolve the problems inherent in meeting the needs of a large-volume operation. Unfortunately, this kind of thinking stifles, or at least reduces, the likelihood that the department will fully explore the possibility of using new systems or approaches toward problem solving. Here, again, the insistence that maximum utilization of manpower be achieved before more manpower was added resulted in surprisingly innovative economies.

10. Utilized every available space in the facility for as many hours of the days as possible. This frequently meant shifting clinic schedules to develop a more even patient flow. Such shifts were also intended to demonstrate the unacceptability of the notion that a fantastically expensive building could be constructed to service the population for a maximum of 33 per cent of the 24-hour day. When one considers that most facilities do not even use all of the available space on a 9:00 A.M. to 5:00 P.M. basis, the frequent result is that less than 20 per cent of the building potential is actually used.

11. Shifted clinics and personnel to areas that were more convenient for patients, which enhanced the clustering of services most frequently used. In large measure, the staff was periodically "shaken up" for its own sake as a means of avoiding stagnation. The resentment which this frequently engendered was felt to be worth the benefits which accrued from the sublimation of such feelings.

12. Threw problems back to the staff for resolution. It is amazing to note the resentment this engendered in professionals who spend a good part of their lives complaining about authority telling them what to do. It is equally amazing to see how many professionals complain about nonprofessional tasks, yet are loath to give them up when the opportunity is offered. In refusing to structure job responsibilities carefully and in refusing to assume the omnipotent and omniscient roles that the staff, in spite of itself, tries to impose on it, the administration created much anxiety and, in some cases, temporary paralysis. On the other hand, having carefully chosen individuals whose approach to medical care delivery was somewhat

iconoclastic, the administration inevitably reaped the rewards of their brightness and creative thinking once they recognized that the solutions to certain problems were theirs to devise.

13. Maintained one area of rigidity and an inflexible approach to the question of time and one's responsibility for fulfilling the responsibility of the time commitment agreed upon before hiring. This stance was clearly and definitively shared with every prospective staff member, as was the insistence on attitude toward patients. Although punching a time clock—which was required of all staff including physicians and administrators—for the first three and a half years of operation was felt by many to be carrying the principle too far, it nevertheless established more reasonably reliable data on which to base time studies than could have ever been possible otherwise. At the same time it symbolically and realistically reinforced the commitment to the idea of people being paid for time and not just for services.

EXPANSION OF THE PROGRAM

In 1965, with the arrival of Cecil G. Sheps, M.D., as the new General Director of the Beth Israel Medical Center, the name Gouverneur Ambulatory Care Unit was changed to the Gouverneur Health Services Program. This suggestion by Sheps was based on his feeling that the phrase Ambulatory Care Unit did not even remotely reflect the range of service being offered to the community in the building and without. Since the scope was so much broader than just delivering ambulatory care, the change was effected at about the time when Beth Israel itself changed its name to the Beth Israel Medical Center.

In 1965, the program, whose administration had provided consulting services for the Office of Economic Opportunity's Division of Health Affairs, also began to negotiate for OEO funds as a means of expanding services in new directions, which it could not do on its own limited budget. The Office of Economic Opportunity granted funds in the amount of $661,000 on February 1, 1966, and this

enabled the expansion of the evening clinic activity, to create an operation satellite in a remote portion of the geographical territory, to create a family care unit within the building, to add prenatal services, to add a staff of six public health nurses and to add a full-time health educator and community organizer to perform functions previously performed on an informal basis by a variety of staff. Although a number of dramatic changes occurred as a result of these additions to the program, the most noteworthy were:

1. Another surge in utilization and registration—clearly the reflection that the unit was now able to meet the needs of individuals to whom the service was previously inaccessible.
2. A 25 per cent decline in emergency room utilization—a clear confirmation of what every medical care expert had been saying for years: namely, that emergency room utilization for nonemergency care had markedly increased principally because other services were unavailable or inconvenient.
3. A rapid enrollment of prenatal cases which almost equalled the Beth Israel volume after six months of inception, with no appreciable decline in Beth Israel's enrollment; an indication that the services were being used by a group that had previously received no prenatal care or late prenatal care. These enrolees were almost all in the first trimester of pregnancy—another indication that these patients will come if encouraged and treated with dignity.
4. A formalization of the training program with Mobilization for Youth under a grant from the Office of Economic Opportunity and the Office of Manpower, Policy, Evaluation and Research.
5. A formalization and expension of programs in community organization, health education and public health, via the addition of personnel in those specialties.
6. The addition of a station wagon for the purpose of trans-

porting patients, records and laboratory samples between divisions of the medical center.

7. The creation of an operation satellite in the Judson Health Center, which was more accessible for patients living in the western half of the territory.
8. The creation of a family unit, staffed with specialists in internal medicine, pediatrics, obstetrics, public health nursing and social work with psychiatric consultation available at all times. This format, or variations of it, serves as the prototype for the soon-to-be-created Neighborhood Family Care Center practice unit.
9. Numerous other structural changes helped make the facility pleasant to come to though more crowded than was wanted.

Under the leadership of a new Medical Director,[3] Gouverneur is consolidating its earlier advances and moving toward new ones. Plans are afoot to convert the total delivery system to one of family units based on small group-practice models, to provide a 24-hour mobile crisis psychiatric unit and numerous other innovative programs which will be reported on in the future. With a new Gouverneur Hospital under construction and with the acute and extended care beds it will provide, the Gouverneur Health Services Program, with the help and concerted effort of the various city departments responsible for the delivery of health services, will provide an even more comprehensive program than has been provided heretofore. The unit will continue to be the focus of study on feasibility for new statistical and data-collection systems, new patterns of districting and new methods of integrating the various elements that go into making a comprehensive health program.

REFERENCES

[1] Light, Harold L. and Brown, Howard J., The Social Worker as Lay Administrator of a Medical Facility, *Social Casework,* 45, June, 1964.

[2] Brown, Howard J., and Alexander, Raymond S., The Gouverneur Ambulatory Care Unit: A New Approach to Ambulatory Care, *Journal of the American Public Health Association,* 54, 1661–1665, October, 1964.

[3]Stanley B. Kahane, M.D., is the new Medical Director of the Gouverneur Health Services Program. He was formerly Director of Ambulatory Care Services of the Bronx-Lebanon Hospital, New York City.

[4] Frank Van Dyke is Professor of Administrative Medicine at Columbia University.

[5] Ray E. Trussell is presently Dean of the Columbia University School of Public Health and Administrative Medicine.

[6] Mark A. Freedman is presently Vice President of the Associated Hospital Service, New York, New York.