The Detroit Medical Center: Race and Renewal in the Motor City

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make me start writing but now that I'm done I'm really grateful for this), and love than I ever thought possible in a marriage. He keeps me laughing nearly constantly, and I honestly could not have done this without him. I've been a much worse partner to him than he has been to me these last several months, but I am looking forward to having the rest of my life to make it up to him. Nick, I love you more than I could ever put in to words. Thank you for being you.

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This dissertation and is also dedicated to the people of Detroit—those whose bodies still live there and whose souls have never left.

Speramus meliora; resurget cineribus

Abstract

In 1956, the City of Detroit began plans for the Detroit Medical Center—the largest urban renewal project in the nation. This hospital campus, motivated by leadership at four inner-city hospitals, sought to use public funding to raze the surrounding "blighted" neighborhood to attract private patients, thus providing a new industry for a city in economic decline. This strategy was ultimately unsuccessful and instead further contributed to both the city's economic decline and the continued poor health of Detroit's residents. This dissertation argues that the development of the Detroit Medical Center, which largely used federal funding for its completion, was built for what the city planners and officials hoped for rather than for the city that existed. In doing so, planners and officials ignored pleas from activists and demographic trends, pouring money into a project that did not serve the community that utilized this institution. This, in turn, further taxed the city's municipal hospital, Detroit Receiving, as the city continued to experience economic decline and the population of poor and indigent patients grew. Even as the violence of the Detroit Riots in 1967 highlighted both the extreme unease of Detroit's black community and the central importance of adequate medical provision for Detroit's most vulnerable populations, the city was ultimately unable, or unwilling, to prioritize the needs of its residents. This stigma associated with medical provision for Detroit's indigent population even resulted in the continued failure of the individual hospitals of the Detroit Medical Center to merge into one integrated medical center, which external marketing consultants had deemed essential for the success of the Detroit Medical Center.

Ultimately, the development of the Detroit Medical Center contributed to the economic decline of the city of Detroit. Rather than investing in its immediate community, Detroit Medical Center planners continued to make choices and spend money in attempts to court suburbanites and private patients. This resulted in continued financial strain on the city when these investments were not recuperated because most of the center's patients and clientele always remained near the hospitals of the Detroit Medical Center – an area of concentrated poverty. By not investing in its community through the largely publicly-funded Detroit Medical Center, the city of Detroit did not ensure adequate health provision for its neediest residents. This contribution to the creation of a perpetually unhealthy, and poor populace. A community must be healthy to work, to become educated, to be engaged consumers; the city of Detroit was not interested in making its residents healthier, and this is demonstrated by its actions during the development of the Detroit Medical Center. Because of this, the Detroit Medical Center never fulfilled its potential, and caused the city even further financial stress. In the end, this development is a symbol of what could have been but never was.

As a study of the ways in which a struggling city attempted to use medical care as an engine of economic recovery, this dissertation provides a case study for historians interested in health and medicine in American urban cities and encourages planners and contemporary urbanists to consider the consequences of not providing adequate health provision to a city's most vulnerable residents.

Table of Contents

List of Tables

List of Figures

Detroit is just like everywhere else, only more so—a lot more so. —Jerry Herron[1]

There are other cities that get by on their good looks, offer climate and scenery, views of mountains or oceans, rockbound or with palm trees. And there are cities like Detroit that have to work for a living. –Elmore Leonard[2]

Introduction

The person that history has deemed founded Detroit, Antoine de la Mothe Cadillac—yes, like the car—doomed the city. While it sounds glib, we Detroiters believe that there is irrefutable proof that an Indigenous elder who could divine the future did everything they could to warn Cadillac about the red dwarf that haunted the city. But rather than acquiesce to the dwarf's requests once the Frenchman finally met this spirit, Cadillac hit and taunted the dwarf. As a result, the Nain Rouge ensured that bad luck followed Cadillac for the rest of his life—and the city he founded—for all of eternity.[3]

This Detroit folk tale has provided the city a scapegoat for all Detroit's ills and "bad luck." Each spring, locals gather for the *Marche du Nain Rouge* in hopes of taunting and scaring the dwarf out of the city, hoping the next year will be better than the last.[4] But the "bad luck" Detroit has experienced—war, riots, economic decline, arguably the worst NFL team in the history of the league[5]—is not "bad luck" at all, but rather the result of deliberate and specific actions by city officials, planners, and funders. This is not

[1] Jerry Herron, "Dispatches from Detroit," *The Journal of Law in Society* 15:1 (Fall 2013).

[2] Elmore Leonard, quoted in Marc Gunther, "Detroit's Battle-Tested Admen Cope," *CNN: Money—Assignment Detroit* https://money.cnn.com/2009/12/04/news/companies/detroit_ads.fortune/?section=magazines_fortune (accessed April 15, 2019)

[3] Marie Caroline Watson Hamlin, *Legends of Le Detroit.* (Detroit: Thorndike Nourse, 1884), pp. 22-29.

[4] Interestingly, the March has started to gain protesters who see this as an allegory for a quickly gentrifying downtown area as folks try to taunt and displace "someone" who has "lived" in Detroit for centuries.

[5] OK, maybe not this one, although the Fords' decision to keep Matt Millen as General Manager for as long as they did is certainly inexplicable and indefensible.

to say that certain intangibles did not contribute to these negative outcomes, but to chalk it all up to raw deals and bad luck does a disservice to the residents of the city because it removes the opportunity to apply a critical lens and learn from these actions.

This dissertation is the culmination of many of my life experiences, but two parts of my identity have shaped how I came to this work more than any other: being born in Detroit and being raised as a nurse's kid. As a child, it did not take long for me to realize that my city was different. Urban ruins, brownfields, and other symbols of decline and poverty were more visible in Detroit than other cities my family visited; in many cases those things existed in other cities, but they seemed better at hiding them. When I asked why, I tried to answer the best I could based on what I saw on the news and the answers from my white working-class family. My family moved out of the city to Downriver,[6] and their own experiences shaped their truth about the decline of city. I held this understanding until my sophomore year of college, when I was introduced to two things that blew my mind: the concept of the social construction of race and Thomas Sugrue's *The Origins of the Urban Crisis.* Sugrue's work (perhaps more meaningful to me coming from a fellow Detroiter) challenged my long-believed notions of Detroit's decline, namely that Detroit was thriving until the Detroit Riots drove all white residents and businesses (and therefore all the wealth) out of the city. Using demographic and

[6] Downriver is an area made up of eighteen smaller communities immediately south of Detroit, or "down" the Detroit River. It is a community of working-class suburbs. Its oldest communities, like Ecorse and Lincoln Park, were founded in the 1920s, but most of this community came from expansion due to white flight after World War II. It is not often this community that is meant when people discuss "suburban Detroit;" that focus is mostly on wealthier, middle class Oakland County. What makes the case of Downriver so interesting is that it experiences economic struggles similar to those of the city of Detroit, but it is (still, although it's growing more diverse) majority white. Downriver is not a part of this dissertation at all, but because of the peculiarity of the economic similarities but racial differences with the city proper, it would provide a wealth of opportunities to ask questions similar to this dissertation.

economic data, Sugrue demonstrated that manufacturing jobs started moving out of Detroit immediately following World War II, and the increased competition over these jobs highlighted Detroit's racial tensions and promoted racist policies. These important lessons helped me to reconcile my own past and experience and slowly begin to know how to ask historical questions and understand that racism was a significant contributing factor to Detroit's current state.

These teachings came in tandem with something I already understood well: different people received different standards of health care. In my family growing up, we were expected to share details about our day around the dinner table. My mom was a nurse and, to her immense credit, talked about her job as though she was talking to colleagues and not her young children. This covertly taught my sister and me difficult concepts about disease, reimbursement, and health insurance. Toward the end of her career she worked more in administration, and so these conversations became less about the medical concerns of individual patients and more about her frustrations with the systems in which she operated. These complaints were more frequent with cases of patients receiving public aid and other markers of poverty. It became clear to me that health care was not a right but a privilege in our current system, and poorer patients had more difficulty accessing this privilege.

Growing up curious about both the city's current state and my mom's experiences trying to help her patients, it has always seemed to me that these two things—the economic health of cities and the physical health of its residents—were linked. Therefore, when trying to find a dissertation topic, I was struck by the press release I found in the

City of Detroit's archives about the development of the new Detroit Medical Center [DMC]. I was very familiar with this campus—my sister and I were both born there—but I never questioned its history. When I learned that this medical campus was the result of the largest urban renewal project in the nation at the time it was designed, I grew curious. I knew the negative connotations of urban renewal, in part because of my earlier exposure to Sugrue's work. But I also knew that Detroit was still a city struggling—the summer I did the bulk of my archival research, Detroit filed for Chapter 9 bankruptcy. It was the largest municipality ever—both in size of city and amount in debt—to do so.[7] Research on the current state of my city and the poor economic and physical health of its residents made the DMC a natural case study to help me understand the paradox of a facility that was supposed to save the city and the reality that the city seemed in more trouble than before it was built.

This dissertation uses the DMC to ask questions about the origins of the current state of Detroit and the ways that struggling cities use medical care, both as an engine of economic recovery but also as an essential service for its most vulnerable residents. Examination of the development of the DMC from its official proposal brought forth to Detroit City Council in 1956 through its incorporation as a nonprofit in 1985 provides a lens through which to analyze the actions of not only city officials and planners, but also the activists and community this hospital development served.

[7] Monica Davey and Mary Williams Walsh, "Billions in Debt, Detroit Tumbles into Insolvency," *The New York Times.* July 18, 2013, https://www.nytimes.com/2013/07/19/us/detroit-files-for-bankruptcy.html?pagewanted=all&_r=0 (accessed April 1, 2019).

In the chapters that follow, I argue that the development of the DMC, which largely used federal funding for its completion, was built for the city that planners and officials hoped for rather than for the city that existed. In doing so, planners and officials ignored pleas from activists and contemporary demographic trends, pouring money into a project that was meant to attract patients with resources rather than local residents, some of whom were displaced by its very construction. This, in turn, further taxed the city's municipal hospital, Detroit Receiving, as the city continued to experience economic decline and the population of poor and indigent patients grew. Even as the violence of the Detroit Riots in 1967 highlighted both the extreme unease of Detroit's black community and the central importance of adequate medical provision for Detroit's most vulnerable populations, the city was ultimately unable, or unwilling, to prioritize the needs of most of the city's residents. This stigma associated with medical provision for Detroit's indigent population even resulted in the continued failure of the individual hospitals of the DMC to merge into one integrated medical center, which external marketing consultants had deemed essential for its success.

It is impossible to discuss the economic decline of the city of Detroit without including the role of the DMC. Rather than investing in its immediate community, DMC planners continued to make choices and spend money in attempts to court suburbanites and private patients—a task that became more difficult as competing hospitals often drew these patients first.[8] Their policies resulted in continued financial strain on the city when

[8] The competing hospitals in question include Henry Ford Hospital, a private hospital located a few miles Northwest of the hospitals of the proposed DMC, and in later decades, the University of Michigan Medical Center in Ann Arbor, Michigan. Henry Ford Hospital was a private hospital established by the Ford Motor Company for its employees in the early twentieth century. The State of Michigan wholly financed the construction of the modern

these investments were not recuperated because most of the center's patients and clientele always remained near the hospitals of the DMC—an area of concentrated poverty. By not focusing on the local community through the largely publicly funded DMC, the city of Detroit did not ensure adequate health provision for its neediest residents. This contributed to the creation of a perpetually unhealthy and poor populace. A community must be healthy to work, to become educated, to be engaged consumers. Leaders in the city of Detroit were not interested in making its residents healthier, and this is demonstrated by its actions during the development of the DMC. Because of this, the DMC never fulfilled its potential and caused the city even further financial stress. Ultimately then, this account of the hospital complex reveals a vision of what could have been but never was.

Because of its place as a city whose rise and decline came more sharply and suddenly than other American cities, Detroit has long served as a focus of study for historians. The aforementioned *The Origins of the Urban Crisis* is not only the definitive work on Detroit history but arguably of American urban history. In it, Sugrue explores housing and job discrimination in Detroit after World War II, arguing both that Detroit's decline began much earlier than many thought (immediately following WWII and not beginning in the late 1960s and 1970s in response to the Detroit Riots). Sugrue also

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University of Michigan Medical Center in the 1970s. These characteristics made these two hospitals' paths to success through the courting of suburban, private-paying patients less difficult than the DMC's. Neither of these hospital campuses are discussed in depth in this dissertation, knowing a bit about their histories helps to contextualize this dissertation. The most comprehensive history of Henry Ford Hospital is available on its website; my instinct is that because this has always been a private hospital, it is difficult for historians to access the records necessary to write an independent history of this hospital. For more information, see https://www.henryford.com/about/culture/history/hfhs. A celebratory history on the planning and development of the University of Michigan Medical Center is available. See: Frederick W. Mayer, *A Setting for Excellence, Part II: The Story of the Planning and Development of the Ann Arbor Campus of the University of Michigan.* (Ann Arbor: University of Michigan Press, 2017).

charges that homeownership (and the policies surrounding it) was a bigger factor in the racial segregation of Detroit—and its subsequent economic decline—than almost any other.[9] Other works on Detroit's history, like David M. P. Freund's *Colored Property: State Policy and White Racial Politics in Suburban America* and Sidney Fine's *Violence in the Model City: The Cavanagh Administration, Race Relations, and the Detroit Riot of 1967* make similar arguments, centering housing, state and federal policies, and the discrimination against black Detroiters to explain the economic decline of the city of Detroit.[10]

While there is plentiful secondary literature in urban history to contextualize my dissertation, I had more difficulty finding secondary literature in the history of medicine. One reason I was drawn to this work is because of the dearth of scholarship in this area in our field—not just in the city of Detroit, for which I have found no secondary literature at all, but in American cities generally after World War II. However, in earlier periods, historians of medicine have done admirable and important work about health and medicine in American cities. Understanding the need for a careful examination of the way that race, policy, and institutions intersected to affect the lives of sick people—but also how sick people shaped the way that New York City thought about race, policy, and its institutions—Charles Rosenberg essentially invented a new historiography that we know as the social history of medicine through the publication of *The Cholera Years*.[11]

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[9] Thomas J. Sugrue, *The Origins of the Urban Crisis* (Princeton: Princeton University Press, 1996).

[10] David M.P. Freund, Colored Property: State Policy & White Racial Politics in Suburban America (Chicago: University of Chicago Press, 2007) and Sidney Fine, Violence in the Model City: The Cavanagh Administration, Race Relations, and the Detroit Riot of 1967 (East Lansing: Michigan State University Press, 2007).

[11] Charles E. Rosenberg, *The Cholera Years*: *The United States in 1832, 1849, and 1866*, 2nd Edition. (Chicago: University of Chicago Press, 1987).

The decision to center his study in a densely populated city was no accident. Beyond the obvious reason that this population density provided the ideal environment for the spread of cholera to epidemic levels, he demonstrated the reaction to this epidemic affected the way that the city treated immigrants, sanitation, and housing. The city, in a sense, was another historical actor in Rosenberg's study.

Since the publication of that work nearly six decades ago, many other historians have published excellent works in a similar style to this work that also center the American city, including Nancy Tomes, Vanessa Northington Gamble, Samuel Kelton Roberts, Jr., and Susan Craddock.[12] While all these exceptional works provide a greater examination of the ways in which disease and health provisions changed life in American cities, these studies stop before the mid-twentieth century.

Very few historians of medicine have worked on issues related to health and medicine in American cities beyond this time period, but the ones that have all demonstrate their belief that the history of medicine has a distinct and needed role in providing guidance to contemporary health policy issues. The three most influential for me in writing this dissertation were Keith Wailoo's *Dying in the City of the Blues*: *Sickle Cell Anemia and the Politics of Race and Health*, James Colgrove's *Epidemic City: The*

[12] Examples include: Susan Craddock, City of Plagues: Disease, Poverty, and Deviance in San Francisco, (Minneapolis: University of Minnesota Press, 2004); Vanessa Northington Gamble, Making a Place for Ourselves: The Black Hospital Movement, 1920-1945, (Oxford: Oxford University Press, 1995); Samuel Kelton Roberts, Jr., Infectious Fear: Politics, Disease, and the Health Effects of Segregation, (Chapel Hill, University of North Carolina Press, 2009); Nancy Tomes, The Gospel of Germs: Men, Women, and the Microbe in American Life, Reprint Edition, (Cambridge: Harvard University Press, 1999).

Politics of Public Health in New York, and Beatrix Hoffman's *Health Care for Some: Rights and Rationing in the United States Since 1930.*[13]

In *Dying in the City of the Blues,* Wailoo uses sickle cell anemia—a disease primarily affecting black populations—in Memphis, a city from whose riches and creativity the entire country has benefitted, to explain how politicians, hospitals, and researchers used this disease to reach their own goals. Wailoo's narrative provided a model for this dissertation by exploring how federal policies and national movements played out on the local level. However, Wailoo's work, while placed in urban America and doing exceptional work in analyzing how race affects the ways that disease is both treated and exploited, does not fully engage with the specific policies and aspects of urban life that drew me to this case study—policies of urban renewal, displacement, and economic revitalization.

Colgrove's *Epidemic City* engages with local policy more than Wailoo's work, but only the policies the New York City Department of Health dealt with directly and explicitly from 1965 to 2005. Colgrove explains masterfully how the changing social meaning of health led to public health solutions to the city's economic problems like poverty, housing, and substance abuse. Additionally, he chronicles how the economic recession of the 1970s resulted in staffing difficulties at the Health Department, forcing layoffs and forcing the remaining public health workers to further prove themselves as worthy professionals for their survival in a struggling city. This contextualization was

[13] Keith Wailoo, Dying in the City of the Blues: Sickle Cell Anemia and the Politics of Race and Health, (Chapel Hill: University of North Carolina Press, 2001); James Colgrove, Epidemic City: The Politics of Public Health in New York, (New York: Russell Sage Foundation, 2011); and Beatrix Hoffman, Health Care for Some: Rights and Rationing in the United States Since 1930, (Chicago: University of Chicago Press, 2013).

helpful in this dissertation, especially in the examination of Detroit Receiving, the city's municipal hospital. However, while Colgrove explores the effects of local policies on public health and health delivery, he does not further engage with the motivations for these city policies. Colgrove's work seems to place urban public health as reactionary, when, in the DMC case, it was clear that health services and the development of health delivery systems could be drivers of urban policies.

Hoffman's work gets closest to answering some of the questions I address in my dissertation, but her study remains focused on the nation at large. In *Health Care for Some*, Hoffman tracks federal legislation that sought to expand health care coverage for Americans but proves that these policies always ensured the legal lack of health care access for America's most vulnerable populations—the poor and the non-white. Because the United States has avoided defining health care as a right owed to its citizens, it remains a luxury good, rationed only for those who the federal government has deemed worthy. Hoffman carefully traces legislation that is crucial to the story in Detroit, like Hill-Burton, which supported hospital construction and development in areas of need in the United States beginning in 1946. Hoffman argued that this program centralized medical care in hospitals, and, in the eyes of policy makers, provided a viable alternative to universal health care in the United States. However, the legal refusal of care at hospitals and emergency rooms in both Southern and Northern States—like at the DMC and later, Detroit Receiving—show that policymakers excluded coverage in the development of these regulations. Continuing her study through the Patient Protection and Affordable Care Act, or Obamacare, Hoffman demonstrates convincingly why the

United States' health care system is so fractured, expensive, and exclusionary. This study was crucial in providing the national context for this dissertation's local case study.

In addition to this lack of research in the history of medicine in cities during the postwar period, my search for secondary literature also demonstrated that there was little analysis about the cyclical relationship between health services and city policies, or how hospitals and medical centers played a central role in urban renewal across many cities in the United States. One scholar looking to remedy this is Merlin Chowkwanyun. Chowkwanyun explores questions about the community health and social movements in American cities, noting that racist policies often result in further health inequalities. In his work on community health reform and race riots in Cleveland, Chowkwanyun notes that urban renewal policies that resulted in the development of the Cleveland Clinic were a motivator in that city's civil unrest—similar to my argument in this dissertation about the DMC and Detroit Receiving.[14] Chowkwanyun, however, does not follow the full trajectory of this institute's development.

This dissertation intervenes in the historiography of medicine and health in the postwar period by intertwining construction for health provision and an analysis of urban renewal. In that process, it centers race as an essential factor and provides an analysis of how the public policies affected vulnerable populations in Detroit.

Chapter one explores the initial medical center development plan presented to City Council in 1956, and the reaction from black activists when they realized that this development excluded black residents from the economic prosperity a new DMC offered.

[14] Merlin Chowkwanyun, "Cleveland vs. the Clinic: the 1960s Riots and Community Health Reform," *American Journal of Public Health* 101 (November 2018).

Both white planners and black activists, however, saw the true power of the DMC as a site of future education, training, and employment. Little attention was paid to the ways this development could also function as a site of improved access and care for Detroit's growing indigent population. By chronicling the 1956 proposal in the context of a city already exhibiting signs of economic decline and deindustrialization, this chapter argues that, despite the focus on hospitals, planners were still operating within the more traditional goals of urban development: slum clearance and economic revitalization. The initial medical center plan's emphasis on educational opportunities was to be offered through an expanded Wayne State University School of Medicine, which would, in turn, use the four hospitals of the DMC to train residents. Neither city planners nor black activists from the Detroit Urban League seemed to recognize that adequate health provision for Detroit's neediest populations should be an important facet of urban renewal, and thus, a path to economic stability for Detroit residents.

While this is perhaps what we would expect from white city planners during the mid-twentieth century, the Detroit Urban League's lack of concern is perhaps more surprising. Scholars from many fields—not just history—have been slow to reject the "black experience" as a monolith, often writing about black Americans as having all shared social, cultural, and economic experiences.[15] In the history of medicine, this is no different, although some works expertly engage with the intersections of race class, and gender (although these works are typically not about American urban history).[16] It is,

[15] Kenneth W. Goings and Raymond A. Mohl, *The New African American Urban History*, (New York: SAGE Publications, 1996).

[16] Examples include: Patricia D'Antonio, American Nursing: A History of Knowledge, Authority, and the Meaning of Work, (Baltimore: Johns Hopkins Press, 2010); Wendy Kline, Bodies of Knowledge: Sexuality,

unfortunately, not surprising that the history of medicine works that best achieve this are by historians who identify as black themselves.[17] This is a failing both of our field's lack of diversity and the continued lack of accessibility of academia more broadly, but also of white-identified historians who either largely ignore these important stories in the history of medicine or whose own biases result in a narrative unworthy of the rich tapestry of experiences of black Americans.[18] This first chapter adds to works that do engage the diverse experiences of black folks in the history of medicine.[19]

Chapter two focuses on Detroit's long-standing "hospital of last resort," the city hospital Detroit Receiving. Initially located about a mile south of the proposed DMC, this hospital sought to provide care to all those in need regardless of their ability to pay—a population that was growing due to the demographic and economic changes the city experienced after World War II. The faith the city placed in the DMC development as a means for economic revitalization meant that funding and other boosterism were strongly directed at the new medical center at the expense of Detroit Receiving. Although external consultants had noted that this development would be more successful if the city worked to integrate its municipal hospital as the emergency trauma hospital of the new DMC, planners and officials never acted upon this request for fear of the negative connotation

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Reproduction, and Women's Health in the Second Wave, (Chicago: University of Chicago Press, 2010); Rebecca M. Kluchin, Fit to Be Tied: Sterilization and Reproductive Rights in America, 1950-1980, (New Brunswick, NJ: Rutgers University Press, 2009).

[17] Examples include Gamble, Making a Place for Themselves; Roberts, Jr., Infectious Fear, and Wailoo, Dying in the City of Blues.

[18] Graham Mooney's forthcoming book project, *Harm City: Health and Injustice in Urban America*, may also prove to be a contribution to this field from a white-identifying historian of medicine.

[19] As a white woman working on this history, I know there will be inherent blind spots that my own experiences and identity bring to this work. However, I acknowledge that it is my responsibility to both work for the continued expanded inclusiveness of our field and incorporate this important perspective into my own work as someone who has chosen to study the history of urban America.

this hospital's patients would bring the rest of the DMC. However, it is precisely the enthusiasm over the DMC development that was a contributing factor in the city's decline. This chapter argues that continuing to ignore the problems of Detroit Receiving did not make them go away; instead, they became more severe. The primarily indigent patient population of this hospital grew, and the financial struggles incurred because of this population growth ultimately became insurmountable for the city. This chapter makes this claim by first introducing Detroit Receiving Hospital's mission, history, and increasing struggles within the changing demographics of the city. Then, through an exploration of a psychiatric patient crisis at the hospital, this chapter demonstrates how Detroit Receiving's patient population made the city and the DMC believe this hospital was an undesirable addition to the development, despite its increasingly intractable issues with declining physical facilities. It then explores a neighboring urban renewal project, University City Development, and the formalization of a relationship between Wayne State School of Medicine and Detroit Receiving Hospital—a relationship the city needed to maintain for its goals of increasing enrollment at the school to be successful. However, the relationship between Detroit Receiving and Wayne State was always at risk because hospital and school administrators and city planners repeatedly ignored structural and overcrowding issues at Detroit Receiving. These physical insufficiencies placed the hospital at constant risk of losing its accreditation. Finally, this chapter explores how by the mid-1960s, the city finally realized a new hospital was necessary, but officials were unable to prioritize this hospital over plans for the DMC Development and University City. This was despite Detroit Receiving's crucial role in the success for both projects.

Ultimately, the inability of city officials to prioritize a new Detroit Receiving resulted in uncertainty about this project's timeline and whether it could happen.

Chapter three centers Detroit Receiving in the analysis of the lead-up, progress, and aftermath of the violent incidents in July of 1967 that would become commonly known as the Detroit Riots. There is a long legacy of black activism conflating poor health access with advocacy for things like improved housing and jobs. Thus, when analyzing the Detroit Riots, it is important to consider the poor health services provided to indigent patients by the city as a potential motivator for this event. However, Detroit Receiving holds a complicated place in the history of this event. Its neglected and decrepit facility became a symbol for the position of poor, black, disgruntled residents, while its central role in the treatment of victims during this event resulted in an elevated respect for this institution unlike anything during its history. Although the enthusiasm for the plan was short-lived—as was the centering of the needs of these black patients in the future decisions of the city—the aftermath of the Detroit Riots was directly responsible for the city's approval of a new Detroit Receiving Hospital within the confines of the DMC. To demonstrate this, the third chapter first explores the landscape of national black health activism leading up to the 1960s in Detroit. It then chronicles the Detroit Riots, paying careful attention to the experiences of physicians and nurses at Detroit Receiving; the accounts of other participants in the violence have largely been lost to history. And then finally, the chapter includes the aftermath of this event as it relates to Detroit Receiving. While the city had finally approved a new facility within the DMC, federal urban renewal funds had run out, and the city was heavily in debt. To address these

financial concerns, Detroit's new mayor, Coleman A. Young, appealed directly to Michigan native President Gerald Ford. While able to secure funding for a new Detroit Receiving Hospital, it was too late; the city could no longer afford to operate this institution, and it was sold at a significant loss to the non-profit organization that oversaw the DMC.

The final chapter steps back and explores the attempts at consolidation between the institutions of the DMC. Consultants since 1960 had told planners that hospital administration at the individual sites that would become the DMC would be more successful if they would merge under one unifying body and absorb Detroit Receiving Hospital. The hospitals of the DMC struggled with this task for twenty-five years because the environment in which they operated was more competitive than collaborative. This chapter argues that the already-competitive environment created by these federal policies were exacerbated by continued racist and classist sentiments about indigent patients who would continue to frequent Detroit Receiving, and ultimately, the DMC. It does so by contextualizing this struggle for consolidation within federal policies that prioritized regionalism in health planning and the development of academic health centers through virtually unchecked biomedical research and development funding through the 1970s. The administration of the hospitals of the DMC and city officials were still unable to reconcile the fact that the world-class medical center they built was not patronized by their preferred (white, suburbanite, private paying) patient population, and instead was most utilized by those living within a five-mile radius of the development (predominantly black, indigent patients). This disappointment and continued attempts to remedy it further

eroded trust between these institutions, as they saw treating indigent patients a continued liability for their hospitals. In order to succeed, the hospitals of the DMC needed to enter enthusiastically into mutual benefit arrangements, resulting in the sharing of not only burdens, but profits. The competitive environment that resulted in part from federal policies and in part from the continued economic decline of the city made these institutions increasingly skeptical of each other and delayed the full incorporation of the DMC until 1985. The delay in consolidation meant a delay in reaping the intended benefits of the DMC development, like profits, and increasing the number of medical trainees. This postponement contributed to the continued economic hardships of the DMC, which continue to this day.

While this dissertation does address an important gap in the historiography of medicine in American cities, it has its limits. One such limitation is the lack of firm health statistics and financial data. I learned while completing this dissertation that a financially strapped city perhaps does not prioritize keeping complete and full archives. The few health statistics and financial data I did find were in the collections of activist groups like the Detroit Urban League, which kept random health department reports, seemingly based on when the group participated in a groundswell of activism. For this reason, the data I do have is sporadic, and I tried to use these metrics effectively throughout this dissertation. That said, the internal memos of city employees and meeting minutes of city organizations and boards included conversations about general trends in both the health of residents and the city's economic struggles, and these sources allowed me to piece together this narrative.

Another limitation is the lack of women in this narrative. Women were not absent in archives—named women served as administrators, hospital supervisors, and city workers—but this dissertation includes few. There was, however, an absence of women in the archival records of the activist groups in this narrative. Of course, it does not mean there were not women activists; there is great meaning in the archives' absences. Additionally, there are gender dynamics that are entirely underexplored in this dissertation. Wayne State University's priorities for health education were firmly with the medical school that taught primarily male physicians—not its thriving nursing school, which taught primarily women. In fact, the actors in this dissertation seem wholly uninterested in the nursing school, even during the expansion of Wayne State University to train future health employees at the DMC. Women served as nurses at the hospitals of the DMC, and labor conditions favored the male physicians; this was doubly true for the black women who worked as lower-status LPNs rather than RNs. In addition, it was typically white women who held administrative posts at these hospitals. However, an examination of these gender dynamics is not fully within the scope of this dissertation, so I reluctantly set aside the limited materials found to date. Women, of course, play an important role in the story of Detroit's past and future, and in the workings of the DMC. I look forward to examining this further in future studies.

Despite these limitations, it is my hope that this dissertation provides a new model of inquiry for historians of medicine, urban historians, and public health scholars. While employing historical methods, this dissertation is interdisciplinary at its core, and asks questions that can inform current discussions on how to remedy economic struggles in

cities like Detroit. In debates about how to provide for city residents, well-meaning planners and officials often cite housing, education, or jobs as residents' most pressing needs. As this dissertation makes clear, however, health provision is the primary requirement of residents. Until policies are enacted that define health care as a right and provide basic standards of health delivery, municipalities will continue to struggle. This dissertation provides the historical context for such a debate, demonstrating that a city's inability to prioritize the health of its most vulnerable populations is detrimental to its economic health.

Chapter 1

Blight is Bad for Business: The Potential for Economic Stability through the Development of the Detroit Medical Center

In 1940, Detroit was the fourth largest city in the United States, and was growing faster than any other American metropolitan area.[20] Its large manufacturing companies established the United States' model of employment-based health insurance to attract and keep workers in the era of wartime wage freezes.[21] This resulted in a large, prosperous workforce where employees could afford the products they spent hours on the line making.

Today, Detroit is the fastest shrinking city in the United States.[22] Post-war federal programs that favored suburbanization fostered "white flight" from the city, while state and local policies helped create dense, homogenous residential zones at its core.[23] These populations, mostly of color, found it nearly impossible to move out of the inner city.[24] The migration of the middle class to the suburbs, exacerbated by racial tension and freeway construction, contributed to the loss of manufacturing jobs in the 1950s.[25] As a

[20] Steven Ruggles, J. Trent Alexander, Katie Genadek, Ronald Goeken, Matthew B. Shroeder, and Matthew Sobek. *Integrated Public Use Microdata Series: Version 5.0* (Machine-readable database) [hereafter cited as IPUMS-USA]. Minneapolis: University of Minnesota, 2010. 1940 United States Census Data.

[21] Jennifer Klein, *For All These Rights: Business, Labor, and the Shaping of America's Public-Private Welfare State*, (Princeton: Princeton University Press, 2004), p. 205.

[22] IPUMS-USA, 1980-2010 United States Census Data.

[23] Sugrue, The Origins of the Urban Crisis.

[24] Freund, *Colored Property.*

[25] Sugrue, *The Origins of the Urban Crisis.*

result, the city's tax base eroded even earlier than when the full, outwardly visible effects of deindustrialization were realized in the 1970s and 80s.

In 1957, there were 6,200 factories in the Detroit area, which employed nearly 587,000 people residing in Detroit city limits according to statistics from the Detroit Board of Commerce.[26] That number was down from just ten years earlier—between 1947 and 1957, Detroit lost an estimated 75,000 manufacturing jobs, as automakers built twenty-five new plants outside of city limits.[27] This transfer of jobs to the suburbs, and therefore population, also signaled a racial shift. This racial shift also carried with it an economic shift—in 1960, black families earned only fifty-four percent of what white families did in the city of Detroit. And in most of these black families, both parents worked; in white middle-class families, it was common for only the father to work outside of the home.[28] City officials knew that these changing demographics could also result in a loss of economic prosperity for the city. Detroit was built on the auto industry and the blue-collar labor that supported it, but the city truly came to prominence during the wartime labor efforts.[29] In an attempt to remain out of combat but support our allies, President Franklin D. Roosevelt promised that America would support the war effort by building planes, vehicles, and other necessities; no city was more important in this indirect fight than the city of Detroit, which became the "arsenal of democracy."[30] The

[26] Proposed Statement Prepared for Hearing Before Common Council on Medical Center Redevelopment, January 15, 1960. Box 75, Folder: Temporary Committee Hospital/Medical Services, 1951- 1960. Detroit Urban League Collection, Bentley Historical Library, Ann Arbor, Michigan.

[27] Sugrue, Origins of the Urban Crisis, p. 126.

[28] "Proposed Statement on Medical Center Redevelopment," January 15, 1960. 75, Temporary Committee Hospital/Medical Services, 1951- 1960. Bentley Library.

[29] Gregory Hooks and Leonard Bloomquist, "The Legacy of World War II for Regional Growth and Decline: The Cumulative Effects of Wartime Investments on U.S. Manufacturing, 1947-1972." *Social Forces* 71:2 (December 1992), pp. 303-337.

[30] Ibid.

patriotism associated with manufacturing led to a rapid growth of war materials and employment. When the war ended, these jobs were not as needed, and layoffs became common.[31] City officials understood the implications of the war's end and began to forecast the consequences of the factories leaving city limits. They knew that they needed an alternative industry that would allow the city to power through the uncertain future ahead.

Once federal urban renewal funds became available after World War II, several ideas were put forth by local government officials as a potential focal point for the city's potential prosperity including a research park, a downtown plaza, and an alternative energy think tank. But no project had more enthusiasm behind it than the DMC. This project sought to rehabilitate a "blighted" neighborhood by joining the services and expanding the physical structures of four voluntary hospitals in the city center.

Using successful health centers at Columbia University in New York City and Johns Hopkins University in Baltimore as their models, the postwar administrators at four voluntary hospitals in Detroit's inner core believed that a revamping of their surrounding neighborhoods would improve their ability to properly provide business services to patients.[32] Despite the Depression, Columbia-Presbyterian Medical Center had experienced growth through the years 1929-1941, boasting more than twelve institutions under the purview of the medical center, anchored by a reputable medical school. This institution credited its survival—and its ability to thrive—to the formal affiliation

[31] Ibid.

[32] Richard A. Ryan, "Detroit's Medical Center: A Dream Coming True," *Detroit News*, p. 6B, 9 Oct. 1967. Box 15, Folder 15-7 Children's Hospital Groundbreaking Ceremony; Correspondence Feb-Jun 1967 Children's Hospital of Michigan Records, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

between its medical school and its hospitals.[33] Early promotional materials for Columbia-Presbyterian Medical Center called this institution the "Fortress in the Heights," noting its preparedness for not only disease but also against the social ills of the neighborhood.[34]

It was this spirit that DMC planners hoped to replicate. By the leadership at these four voluntary hospitals in a "blighted" area joining with the local medical school and city government to form an "integrated" medical center—sharing services, costs, and profits as did their model institution—DMC officials were hopeful that they could weather the storms as well as did Columbia, despite the DMC partnering with a public institution.

The administration at these hospitals feared, however, that population loss and a racial concentration of black Detroiters in the city core were contributing to a "blighted" neighborhood surrounding some of the city's busiest hospitals.[35] Federal urban renewal dollars were the primary source of funding that would make the DMC possible, and traditional thinking about urban renewal—meaning slum clearance—framed the ways that its planners and officials about the project. The planners emphasized the importance of training programs and providing professional jobs on this hospital campus, and thus the transformation of the neighborhood was central to planners' vision of a prosperous

[33] Seventy-Five Years of Healing on the Heights: Columbia University Medical Center Celebrates the 75th Anniversary of Columbia-Presbyterian Medical Center, 1928-2003. Glenn A. Peterson, ed. (New York: Columbia University Press, 2003).

[34] Ibid.

[35] Samuel Kelton Roberts writes about the "medicalization of blight" in *Infectious Fear,* where urban renewal was intrinsically viewed as a public health effort through the removal of unhealthy, dangerous slums. During the development of the DMC, this was not a prominent conversation among Detroit planners. However, it is important to note that this was a contemporary concern for urban planners. The planners in Baltimore also created segregated, unhealthy areas through their "medicalization." The medicalization of blight, where planners—even imperfectly—take health into the consideration of urban planning decisions is in contrast to the "traditional thinking" about urban renewal that happens in Detroit, where despite this funding resulting in the construction of a hospital campus, the focus remains primarily about economics rather than health.

Detroit—largely, white and middle class.

Even among black activists who were committed to increasing equality and access within the city's hospitals, the priority of this development seemed to ensure equal access to the jobs it would create for black middle-class residents rather than creating better health care access for poor black residents. The Detroit Urban League, the local chapter of the national nonprofit organization that advocated against racial segregation on behalf of black Americans, was the leading activist organization at the center of the DMC development. Advocating for nearly a decade, the Detroit Urban League was successful in delaying the construction of the DMC until the city agreed to stop its segregationist policies and discriminatory hiring practices for nurses, physicians, and other hospital staff. While this organization campaigned for an equitable medical center for both patients and professionals, this group was most dedicated to advocating on behalf of black workers. It is important to recognize that the Detroit Urban League, a group of mostly educated and middle-class black activists were advocating for other black residents to have access to the middle class through the same paths through which they had achieved this status.

Historian Touré F. Reed has traced the intellectual history of the National Urban League as a college-educated erudite group that applied its leaders' liberal sociology training.[36] He writes about how this group emphasized data gathering and surveys to develop their advocacy. This evidence-based format, argued Reed, did not address the structural violence nor discrimination black residents faced in the cities where active

[36] Touré F. Reed, Not Alms but Opportunity: The Urban League and the Politics of Racial Uplift, 1910-1950, (Chapel Hill: University of North Carolina Press, 2018).

local chapters of the Urban League worked because of their focus on the "reorganization" of black working-class life to one that assimilated into white middle-class life.[37] The solutions of the Urban League, argues Reed, victim-blamed black residents implicitly. Its leadership sought to convince white professionals that there were "good blacks," which only highlighted class differences between black residents.[38] Other historians, like Kevin K. Gaines, have argued that racial uplift ideology—essentially, that the upward mobility and social progress of black Americans would result in the elimination of racism—actually contributed to negative stereotypes of black Americans by emphasizing class differences, and was therefore ineffective against fighting racism.[39] This was the case in Detroit where the advocacy of the Detroit Urban League ignored the most vulnerable among Detroit's residents, namely, the increasing population of indigent patients. This development created more housing and job insecurity for those residing in the area that would become the DMC development. While the Detroit Urban League did express concern over the displacement and failure to plan for rehoming residents, their ultimate concern and greatest advocacy was toward the opportunities for jobs and training at the new DMC.

Understanding the genesis of the DMC demonstrates that direct advocacy to protect civil rights and end racial discrimination was necessary, even in diverse northern cities. But it also demonstrates the way that even those speaking on behalf of marginalized peoples had within their own population their own hierarchies and ignored

[37] Ibid.
[38] Ibid.
[39] Kevin K. Gaines, Uplifting the Race: Black Leadership, Politics, and Culture in the Twentieth Century, (Chapel Hill: University of North Carolina Press, 1996).

constituencies. Both city planners and the Detroit Urban League used rhetoric about patients and care to debate the importance of the DMC, but the actions from representatives of both groups indicate that concerns about employment were valued more than improving health in this community.

The Origins of the Detroit Medical Center Plan

The four voluntary hospitals at the center of the DMC development—Harper, Hutzel,[40] Children's, and Grace—all had histories in the city dating back to the nineteenth century. Harper University Hospital, the oldest of these four, began in 1863 as a hospital for Civil War soldiers. It had since become a hospital affiliated with the local nursing school, Wayne State University College of Nursing.[41] Hutzel Hospital was established next in 1868 to serve the city's women, but this hospital began serving men as

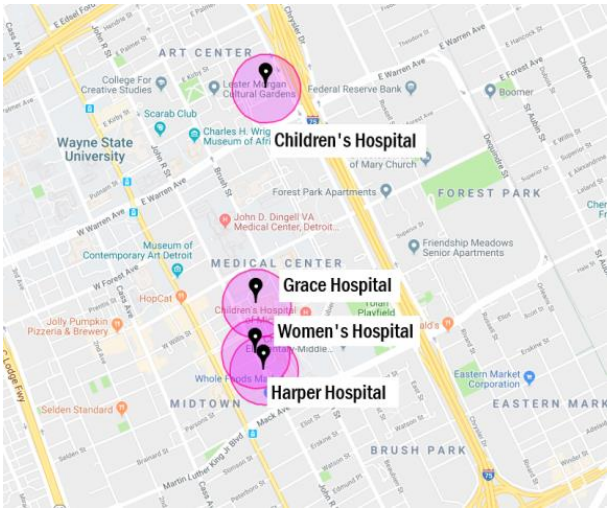

Figure 1: The original locations of the four hospitals that would become the DMC on a map of modern-day Detroit. The area shown on this map is approximately two square miles.

[40] This hospital was called Women's from its beginning until 1955, but for consistency throughout this work, it will be referred to as Hutzel.

[41] Kathleen Schmeling, "Missionaries of Health: Detroit's Harper Hospital School of Nursing," *Michigan History* 91 *(*2002), pp. 26-31 and Carl Ole Haven, *History and Development of the Detroit Medical Center: A Thesis Prepared for the Committee on Credentials in Partial Fulfillment of the Requirements for Fellowship.* (New York: New York University Press, 1981), p. 97.

well in 1929, followed by Children's in 1886, and Grace in 1888.[42] These hospitals were all developed in close geographical proximity to each other, and through the rest of the nineteenth and early twentieth centuries, saw a dense residential area develop around them.[43] These hospitals were all formed by charitable, Christian organizations that prided themselves on caring for all regardless of their ability to pay; perhaps this is why these hospitals soon became among the busiest in the state.[44] In 1955, one-twentieth of all hospital patients in Michigan received care from one of these four institutions.[45]

While these hospitals were well utilized, they were not financially well-off. By the mid-1950s, fewer patients were able to pay for their care.[46] Hospital administrators blamed this on the changing neighborhoods surrounding their buildings; the densely populated neighborhood was home to a large population of Detroit's black working class. Not only did this mean that those who came to these hospitals from the surrounding catchment area were poorer, but that those from outside of the city no longer wanted to attend these hospitals in "blighted" and unsafe areas.[47] The area of the greatest concentrated poverty in the state of Michigan was located in the neighborhood directly surrounding these four hospitals.[48] And for those who traveled through this neighborhood

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[42] Haven, *History and Development of the Detroit Medical Center*, p. 77.

[43] Ibid.

[44] Ibid.

[45] Detroit Medical Center Committee, A Proposal for A Detroit Medical Center, May 23, 1956. Box 142, Folder 4-University City. Jerome P. Cavanagh Collection, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

[46] Chart of Proposed Medical Center Hospital Usage, undated (circa 1955). Box 82, Folder 82-52 WSU-Affiliated Hospitals, 1950s-1960s. Detroit Commission on Community Relations/Human Rights Department Collection Part 3, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

[47] Susan d'Olive Mozena, "The Detroit Medical Center: A Case Study" (Master's Thesis, University of Michigan, 1984), 21.

[48] Richard A. Ryan, "Detroit's Medical Center: A Dream Coming True," *Detroit News*, p. 6B, 9 Oct. 1967. Box 15, Folder 15-7 Children's Hospital Groundbreaking Ceremony; Correspondence Feb-Jun 1967. Children's Hospital of Michigan Records, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

to visit these hospitals, either for their care or for work, this poverty signaled increased crime—or at least the perception of it. In the early 1950s, nurses and other women who staffed the hospital reported that they were afraid to walk through the parking lots before and after their shifts.[49] Hospital administrators believed that the only way to save their hospitals was to drastically change their surroundings.

There had been a dearth of federal funding to support urban renewal for nearly two decades by the mid-1950s, and so cities like Detroit were ready to enact plans that had long existed—like the DMC—by the 1950s. The administrators of these four voluntary hospitals had developed the idea for a new medical center in as early as 1936, but a lack of secure funding meant this project was delayed until the availability of urban renewal funds. This plan, eventually presented to Detroit City Council in 1956 when health infrastructure and urban renewal funds became available, included the modernization of Harper, Grace, Children's, and Hutzel, as well as the widening of city streets and green spaces surrounding the development.[50] The DMC plan also included nearby residential housing units for the physicians who would seek employment at the new DMC.[51]

City planners decided that a medical center in the core of the city would help to address the loss of jobs in the manufacturing industry. These federal funds allowed

[49] Edwin Chen, Edwin Chen, "Detroit Medical Center Urban Renewal Success" *Detroit News,* 9 Sept. 1977. Box 6, Folder 6-3 News Clippings, Grace Hospital Records, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

[50] Detroit Medical Center Citizens' Committee, "A Proposal for a Detroit Medical Center" Submitted to the Detroit City Plan Commission on May 23, 1956. Box 75, Folder: Temporary Committee Hospital/Medical Services, 1951-1960. Detroit Urban League Collection, Bentley Historical Library, Ann Arbor, Michigan.

[51] For the DMC plan as presented to city council in 1956, see Appendix I.

Detroit officials to move forward on plans for a new, integrated hospital campus that would expand the physical space of the hospitals into the surrounding neighborhood.

Changing Federal Policies

The Hospital Survey and Construction Act, more commonly referred to as Hill-Burton, was introduced by Congress in 1946 in response to the American Hospital Association finding that many rural areas in the United States lacked basic services at hospitals—or hospitals at all.[52] This federal legislation was the first in nearly two decades aimed at directly improving the health infrastructure of the United States.[53]

Although not official until a 1964 amendment, Hill-Burton funds began going to urban hospitals after its 1954 funding expansion, and it was common by the late 1950s such support went toward urban hospital construction.[54] Between 1946 and 1964, over two billion dollars were allocated throughout the United States, Guam, Puerto Rico, and the Virgin Islands for the construction and redevelopment of general hospitals, mental hospitals, tuberculosis hospitals, public health centers, nursing homes, diagnostic and treatment centers, rehabilitation centers, and projects aimed at improving hospital services.[55] Although it is difficult to find statistics demonstrating the exact ratio between urban and rural Hill-Burton construction, the focus of construction was different in each

[52] Carla J. Smith, "The Hill-Burton Act: A Basis for the Prevention of Urban Hospital Relocation," *Indiana Law Journal* 55 (1980), p. 698.

[53] Ibid.

[54] "Hill-Burton Amendments," *Congressional Quarterly Almanac* 1964. https://library.cqpress.com/cqalmanac/document.php?id=cqal64-1304266 (accessed January 17, 2019).

[55] U.S. Commission on Civil Rights Staff Paper, "The Hill-Burton Program." Box 55, Health and Welfare Department General File, 1964 [a19-2]. Detroit Urban League Collection, Bentley Historical Library, Ann Arbor, Michigan.

locale; in rural areas, building deficiencies were in ”service departments” like pharmacies and laboratories, and the urban deficiencies were related to nonconformities in fire and safety codes.[56]

The Hill-Burton legislation coincided with other urban renewal policies that were directed at improving urban infrastructure. This provided the landscape for the Michigan State Legislature and Detroit City Council to pass laws making the construction of the DMC a bit easier. The Federal Housing Act of 1949 was the beginning of federal legislation that provided financing for slum clearance and reconstruction, usually resulting in the development of public housing units.[57] While its authors planned for this legislation to prioritize residential construction, these projects only accounted for about half of the cleared sites and the rest of the construction happened at public facilities including hospitals and schools.[58] The residential buildings that were razed were not replaced.[59] By 1959, the Housing Act was amended to increase grant authorization for nonresidential development by ten percent, signaling a shift in the intentional focus of urban renewal. Policymakers' intent was to make sure that there were colleges, hospitals, and businesses in a city center to support the concentrated populations, as well.[60]

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[56] Comptroller General of the United States, "A Report to the Health Subcommittee, Committee on Labor and Public Welfare United States and Senate: Review of Certain Aspects of the Hill-Burton Health Facilities Construction and Modernization Program." May 3, 1974 https://www.gao.gov/assets/120/113233.pdf (accessed on March 27, 2019).

[57] Guian McKee, "Health Care Policy as Urban Policy: Hospitals and Community Development in the Postindustrial City," *Working Paper Series: Center for Community Development Investments. Federal Reserve Bank of San Francisco* (December 2010).

[58] Ibid.

[59] LaDale Winling, "Students and the Second Ghetto: Federal Legislation, Urban Politics, and Campus Planning at the University of Chicago," *Journal of Planning History* 10 (2011): 56-89.

[60] Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century* (Baltimore: Johns Hopkins University Press, 1999), pp. 294-5; and Congressional Research Service Report Prepared for the Committee on Banking, Finance, and Urban Affairs and the Subcommittee on Housing and Community Development House of Representatives 103rd Congress First session, "A Chronology of Housing Legislation and Selected Executive Actions, 1892-1992," December 1993 https://www.huduser.gov/portal//publications/pdf/HUD-11661.pdf (accessed

Perhaps emboldened by these federal policies and the promise of funding for development in the state's larger cities, the Michigan State Legislature passed a law in 1949 in which "any city or incorporated village, having a population over 500,000" would be required to "establish a medical center commission and prescribe its duties, to acquire and dispose of real property in the medical center district, to prescribe the methods of finance and exercise of these powers, and to declare the effect of this act."[61] The City of Detroit responded to this state legislation, and passed its own ordinance in 1950 to create a Medical Center Commission to "encourage the centralization of a number of institutions, governmental, and non-governmental, into a Medical Center District."[62] While noteworthy as the first official organization to work toward the development of the eventual DMC, their progress was stagnant until the development of the Medical Center Committee five years later.

The Medical Center Committee

In 1955, at the discretion of City Council and Mayor Albert Cobo, the director and two trustees from each of the four hospitals of the proposed medical center, and the Dean of the School of Medicine at nearby Wayne State University formed The Detroit Medical Center Committee [DMCC]. The DMCC took five years to organize itself while city officials worked to secure likely funding for this project.[63] This body articulated the

March 27, 2019); and Francesca Russello Ammon, *Bulldozer: Demolition and Clearance of the Postwar Landscape.* (New Haven: Yale University Press, 2016).

[61] Mozena, "The Detroit Medical Center," p. 24.

[62] Ibid.

[62] Mozena, "The Detroit Medical Center," p. 30.

[63] Crane and Gorwic Associates, Inc. Planning and Design Consultants, "Detroit Medical Center Progress Report," (Detroit: August, 1966).

purpose the medical center development, stating that they were determined to create a "great medical center" that would utilize the already-existing hospitals as a "core" to develop additional institutions for medical care and teaching.[64]

The Detroit Medical Center plan was part of a "comprehensive plan for making Detroit a better place to live" and its planners worked to make sure that "every detail of [the] physical plan [was] evaluated on the basis of its contribution to human dignity and to the welfare of all" Detroit residents.[65] Building an "integrated medical center" like that at Columbia, which shared responsibilities and services across institutions and was anchored by a medical school, would, the DMCC and city planners hoped, create a "specific and much more important…active relationship" between the hospitals within the medical center.[66]

The DMCC believed that a redesign of these four hospitals with a formal relationship with Wayne State University would help to make up for the shortage of physicians within city limits. Physicians were already opting to have their offices outside of the city of Detroit as early as the 1950s, and this development would help transform the medical school into a "well-established and well-rounded postgraduate[67] program" able to build new programs with hospitals that offered specialty care services.[68] DMC

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[64] Ibid.

[65] Detroit Medical Center Citizen's Committee, "The Detroit Medical Center: A Proposal for the Re-use of Land Cleared under the Federal and City Urban Renewal Program," 1958.

[66] Detroit Medical Center Citizens' Committee, "A Proposal for a Detroit Medical Center" Submitted to the Detroit City Plan Commission on May 23, 1956. Box 75, Folder: Temporary Committee Hospital/Medical Services, 1951-1960. Detroit Urban League Collection, Bentley Historical Library, Ann Arbor, Michigan.

[67] Undergraduate, graduate and postgraduate medical education refers to different categorizations from other students in university settings. Undergraduate medical education means students in medical school; graduate medical education identifies formal education programs after attaining an MD or DO, like a residency or fellowship. Postgraduate medical education generally refers to continuing medical education or other professional development opportunities.

[68] Ibid.

planners' medical center models, Johns Hopkins and Columbia, both had formal affiliations with hospitals that offered specialty care services, and these institutions saw their national profile grow as these affiliations resulted in breakthrough in biomedical research.[69] DMC planners hoped for the same. Additionally, the committee believed that having a program offering many options for clinical training would mean that medical interns and residents would stay and build their practice within the city of Detroit. Planners thought that the positive educational experience that these students would receive from Wayne State University School of Medicine at the new medical center development would instill loyalty, resulting in greater retention. Planners believed that this would be especially true with a planned move of the Medical School to the physical campus of the DMC, since this proximity would help to breed familiarity with the area.[70]

A crucial part of the DMC plan was attracting and retaining gifted young physicians who would join the DMC permanently after their medical residency. Wayne State University School of Medicine provided the perfect affiliation. Moreover, the relationship was mutually beneficial; as of 1956, Wayne State only had an affiliation with the city's municipal hospital, Detroit Receiving, and that only allowed for training its undergraduate population.[71] A formal affiliation between Wayne State University School of Medicine and the four hospitals of the proposed DMC—Harper, Grace, Hutzel, and

[69] Ibid.
[70] Ibid.
[71] Ibid. In medical education, "undergraduate" is meant to describe individuals still in medical school. Graduate medical education includes residencies and fellowships.

Children's—would serve as the "clinical base" the future of medical advanced education at Wayne State University.[72]

Once the plan began to take shape, the Detroit Medical Center Citizen's Committee involved Gerald Crane, an architect and Detroit city planner, who performed a feasibility study to determine if the land surrounding the four medical center hospitals could be cleared.[73] This was an essential part of the plan. It was the opinion of the Detroit City Plan Commission, the city government board tasked with approving and overseeing new development in the city, and other city officials that rehabilitating the area surrounding the hospitals was the greatest necessity of this development because it was

Figure 2: Aerial photograph showing density of land before the Detroit Medical Center development. In Mozena, "The Detroit Medical Center," p. 23.

[72] Detroit Medical Center Citizens' Committee, "The Detroit Medical Center," 1958.
[73] Crane and Gorwic Associates, Inc, "Detroit Medical Center Progress Report," 1966.

identified as blighted.[74]

While the DMCC was the central organizing body, the Master Plan for the Detroit Medical Center was a "cooperative effort" between public and private groups including the Detroit City Plan Commission, and citizens' groups and private consultant agencies like Crane and Gorwic.[75] The City Plan Commission slated nearly eight thousand acres of "contiguous land" for redevelopment as part of this Master Plan.[76] On these eight thousand acres surrounding the four community hospitals, the Master Plan also recommended the incorporation of residential services, including housing for nearly thirty-six hundred employees.[77] This housing would be for "comfortable income groups,"—or those with a professional, white-collar income. In addition, they planned for schools, shopping centers, parks, and parking areas near the medical center redevelopment to service a quite different population from the one being displaced, which was primarily black working-class families.[78]

The Detroit Medical Center Plan

The chair of the Detroit City Plan Commission, Ray Eppert, presented the Detroit Medical Center Plan to Detroit City Council on May 23, 1956. The plan included four major redevelopment phases. The first called for the smaller residential blocks in the neighborhood surrounding the hospital to be paved into larger "superblocks" to curb

[74] Ibid.
[75] Ibid.
[76] Detroit Medical Center Citizens' Committee, "The Detroit Medical Center," 1958.
[77] Detroit Medical Center Citizens' Committee, "A Proposal for a Detroit Medical Center," May 23, 1956.
75, Temporary Committee Hospital/Medical Services, 1951-1960. Detroit Urban League Collection, Bentley Library.
[78] Ibid.

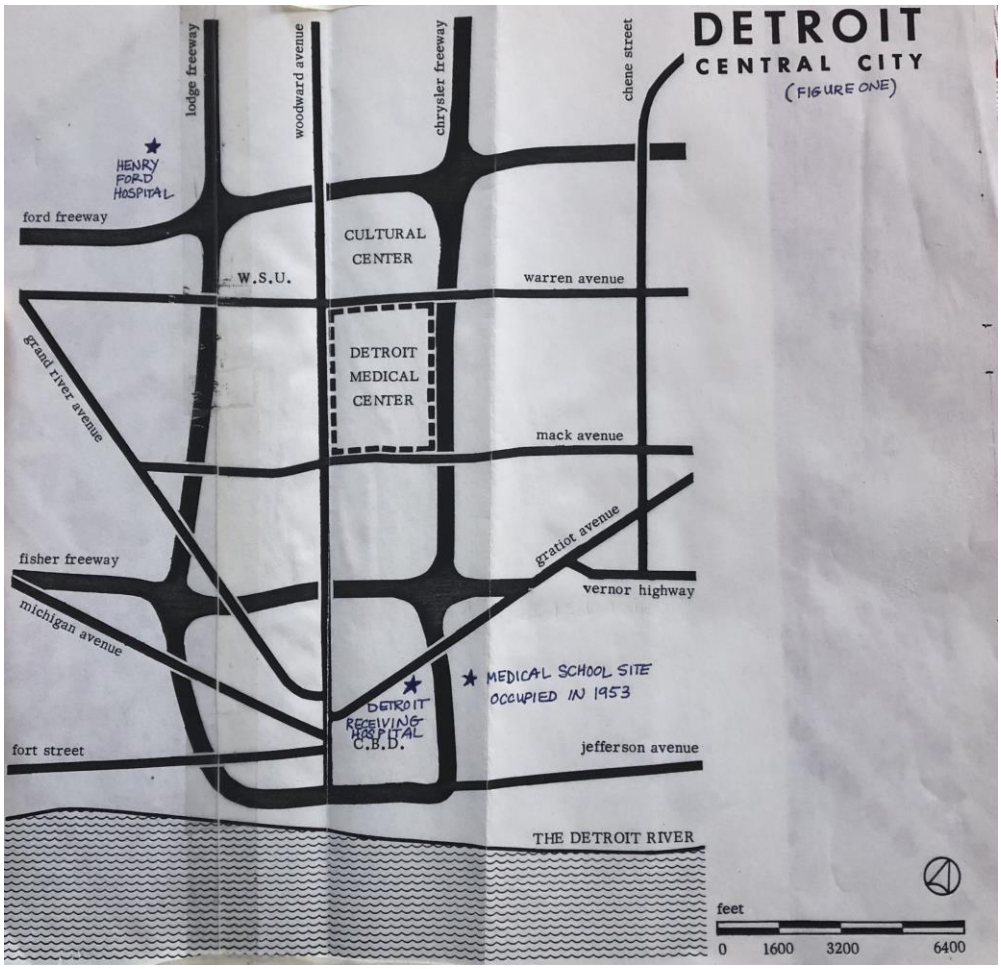

Figure 3: Map of Detroit Central City demonstrating the size of the proposed Detroit Medical Center, as well as the sites of Detroit Receiving Hospital and the site of Wayne State University School of Medicine in 1953. In Mozena, "The Detroit Medical Center" p. 23.

traffic and present more space for better utilization of land. The second phase of the plan called for complete separation of vehicular and pedestrian traffic, installing sidewalks, while also beginning work on hospital redevelopment and expansion. The third phase included a reorganization of the street system, including refiguring one-way streets, to "facilitate efficient movement of vehicular and pedestrian traffic."[79] The third phase was the slated phase for construction on Wayne State University School of Medicine. The

[79] Detroit Medical Center Citizens' Committee, "The Detroit Medical Center," 1958.

final, and most vague phase of the project—perhaps to allow for unanticipated changes and additions—sought to "provide maximum freedom for the utilization and expansion of existing institutions."[80] Planners established that the boundaries of the proposed project were Woodward Avenue on the west, Hastings on the East, Mack Avenue on the South, and Warren to St. Antoine and Ferry to the north (see Figure 2 above).[81]

The plan submitted in 1956 noted that this area of land played a "dual and contradictory role in the matter of [Detroit's] health," since the four proposed medical center hospitals—Children's, Harper, Grace, and Hutzel—were sites where good medical care was offered, but were "hemmed in by the worst slums in Detroit."[82] This is the only place in the initial medical center plan that alludes to the physical health of the surrounding community residents or the capacity of these hospitals to provide better health services if their buildings were rehabilitated.

This plan stated that the main objective for DMC development was to "try to get the neighborhood redeveloped in the shortest possible time," noting that capitalizing on the already-existing resources in the area, like Wayne State University School of Medicine, would be the quickest, most efficient way to remove the "blight."[83] But the plan also noted a second goal: to create an "integrated medical center" to "realize the full potential of the excellent resources for health care and medical education that are

[80] Crane and Gorwic Associates, Inc, "Detroit Medical Center Progress Report," 1966.
[81] Detroit Medical Center Citizens' Committee, "A Proposal for a Detroit Medical Center," May 23, 1956. 75, Temporary Committee Hospital/Medical Services, 1951-1960. Detroit Urban League Collection, Bentley Library.
[82] Ibid.
[83] Ibid.

currently in existence."[84] From its inception, this plan was about urban revitalization and job creation rather than a health-centered project.

The Chairman of the DMC Citizen's Committee noted that the resources available at Wayne State would be wasted if the city did not prioritize this institution and allow it to flourish, noting:

> "The Wayne State University College of Medicine is one of the finest in the country…We have a cyclical pattern to consider. Education and training, clinical practice, education, training, over and over again. This cyclical process of education, training, clinical practice, as it also involves research and experimentation, is most productive when we have an integrated relationship between a medical school and teaching hospitals to carry it on. This is what we have in mind when we speak of developing an integrated medical center."[85]

Wayne State University School of Medicine, arguably, was always the central focus of this development. The hospitals of the proposed DMC served primarily as the extended training facilities of this school and its capacity to train future health workers.

Because of the focus on Wayne State and the training these hospitals would provide, planners viewed these sites as places of eventual employment rather than sites of improved health care delivery for the surrounding neighborhood. Planners believed that modernized physical structures and a transformed surrounding community would result in not only greater interest in health workers coming to learn and work at the DMC but their staying throughout their careers. Planners noted that currently, "desirable categories of employees" move away or reject employment offers "because of the slums which

[84] Ibid.
[85] Ibid.

surround [these hospitals]."[86] It is important to note that planners did not speak of desirable individual employees rejecting these offers, only "desirable categories" of employees. While not explicitly stated in these planning documents, we should recognize this language as a racial dog-whistle, with planners growing increasingly fearful that white physicians would no longer want to work in poor, black communities.[87]

To clear out further "slums" in the area and ensure the neighborhood's total transformation, the plan also included single family homes and apartments for up to 3,600 future "employees of the four hospitals and their families."[88] Ultimately, the planners emphasized the necessity of this development, arguing that "adequate medical teaching, research, and practice is vital to the economic health of our community," although there was little concern for how this development would also help (or hurt) the physical health of the residents living in the surrounding community.[89] The planners' belief that "slum" clearance would improve the economic health of the community and city at large was not supported by any statistics or economic information.[90]

The City Council unanimously approved this plan. Planners hoped it would "provide a unique clustering of medical and related facilities [that could only] be brought

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[86] Ibid.

[87] For more reading on "dog-whistles" and the coded racial language white Americans have used to signal to each other (albeit from a slightly later period in American history), see Ian Haney Lopez, *Dog Whistle Politics: How Coded Racial Appeals Have Reinvented Racism and Wrecked the Middle Class*. (Oxford: Oxford University Press, 2013).

[88] Detroit Medical Center Citizens' Committee, "A Proposal for a Detroit Medical Center," May 23, 1956. 75, Temporary Committee Hospital/Medical Services, 1951-1960. Detroit Urban League Collection, Bentley Library.

[89] Ibid.

[90] This is a problem throughout these planners' discussions. Many of their motivations and actions seem to be based on anecdotes and their own personal feelings. Complicating the issue is that those in opposition, either to the DMC plan as a whole or to parts of it, also have a lack of evidence to support their beliefs. For example, in an oral history with the now-Vice President of Detroit-based health agency Authority Health, Dennis Archambault, noted that the planners' understanding of the neighborhood was inaccurate, and that the people displaced from their homes were middle class black families, and it was this intervention development that created the growth of black poverty in the area. Dennis Archambault, interview by author, Detroit, MI, March 17, 2014.

to fruition because of a fortunate set of circumstances and conditions," according to Harry J. Durbin, Director and Secretary of the Detroit Housing Commission.[91] "Foremost…[is] the availability of federal funds through passage of urban renewal legislation [like the FHA], and the passage of state enabling laws [such as the state legislation in 1949 supporting medical centers], and the enlightened attitude of a local administration—the members of which are eager to serve our citizens."[92]

Wayne State University School of Medicine at the Detroit Medical Center

Perhaps the most central institution in the proposed medical center plan was Wayne State University School of Medicine. Without it, the crux of the economic motivation for this plan—the training of future physicians—ceased to exist. Wayne State University is in the heart of Detroit and has long placed medical education at the center of its mission. In 1868, Civil War veterans founded the Detroit Medical College—the antecedent of what would become Wayne University in 1933.[93] In 1956, this institution evolved to Wayne State University through a charter passed by the Michigan legislature, calling for a university to be in the "industrial area of southeastern Michigan."[94]

Phase I of the DMC Master Plan reserved twenty acres for the relocation of Wayne State University School of Medicine to the medical center campus. The relocation

[91] Detroit Medical Center Citizens' Committee, "The Detroit Medical Center," 1958.

[92] Crane and Gorwic Associates, Inc., Planning and Design Consultants, "Harper Hospital Survey: A Physical Survey of the Hospital in Relation to the Detroit Medical Center: A Report to the Detroit Medical Center Citizens' Committee," (Detroit, MI, 1958).

[93] Paul Thomas, "The History of Wayne State University School of Medicine," Plum Health, https://www.plumhealthdpc.com/blog/2018/5/23/the-history-of-wayne-state-university-school-of-medicine (accessed on March 28, 2019).

[94] Michigan Legislature, *Wayne State University: Act 183 of 1956,* April 22, 1956.

would increase the size of the campus in anticipation of increased enrollment: from twenty thousand in 1956 to forty thousand in 1975 at the entire university, and nearly four hundred medical students for this new development to become the largest single-campus medical school in the nation, through the use of urban renewal and Hill-Burton funding.[95]

In a letter expressing his support, Dean of the College of Medicine, Gordon H. Scott wrote to supplement the 1956 plan:

> "In the past two years, we have made every effort to aid in the formulation of these plans and to help in their activation. It is our deep concern that these hospitals not only continue their high standards, but that they expand their efforts in new directions so that, with the cooperation of the College of Medicine, their facilities may become the proving ground for even finer teaching, research, and service."[96]

It is significant that like the planners, Dean Scott was most concerned about further developing this site for medical training as a vehicle for biomedical jobs, not necessarily for better patient access.

President of the University, Clarence B. Hilberry, understood the reciprocity of this arrangement, and saw the implications for the future of both the university and the city. He noted that the value of a world class medical center offering top rate medical education in the city of Detroit would bring taxpayers "millions of dollars."[97] That said, Wayne State thought that no such agreement for teaching and residency could be made

[95] Notes on Research Park, the Medical Center, and University City Urban Renewal Projects, undated (circa 1960). Box 62, Folder 29-Urban Renewal. Jerome P. Cavanagh Collection, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

[96] Detroit Medical Center Citizens' Committee, "A Proposal for a Detroit Medical Center," May 23, 1956. 75, Temporary Committee Hospital/Medical Services, 1951-1960. Detroit Urban League Collection, Bentley Library.

[97] Detroit Medical Center Citizens' Committee, "The Detroit Medical Center," 1958.

without "many changes" in both the "physical plants and in the area surrounding them," including new teaching auditoriums and laboratories in these hospitals, and removing the "blight surrounding the hospitals."[98] "Until these changes are made," President Hilberry wrote, "the community as a whole is prevented from realizing the most efficient use of its available medical teaching personnel and of its outstanding clinical facilities."[99]

Throughout these discussions, city planners and officials were most interested in the development of the DMC because of its potential to create future jobs for white-collar, educated workers in Detroit through its partnership with Wayne State School of Medicine. Improved health care delivery would be a welcome byproduct, but was never an explicit aim, or one that planners and officials seemed enthusiastic about addressing. To achieve their goals of the DMC development, the city planned on razing densely populated black neighborhoods displacing many black residents and black businesses, much to the dismay of activist groups.

The DMC development was part of a larger urban renewal strategy in the city of Detroit called "The Detroit Plan," which joined the three largest projects in the city—the Gratiot Area Redevelopment Project, the development of the Brewster and Douglass housing projects, and the DMC development—and all resulted in the destruction of the most solidly black neighborhoods in the city of Detroit.[100] Urban renewal previous to the Detroit Plan, like the construction of highways through other Detroit neighborhoods that were mostly populated with black residents, like Black Bottom and Paradise Valley,

[98] Ibid.
[99] Ibid.
[100] Sugrue, Origins of the Urban Crisis, p. 49.

displaced black residents without assistance when they had difficulty finding new housing due to redlining and other legal acts of housing segregation.[101] These events also contributed to the increasing density of housing in poor areas of the city. Mayor Albert Cobo, a staunch supporter of the urban renewal projects in the city called this residential displacement an "inconvenience" that was simply "the price of progress," even when these residents were only given thirty days' notice to vacate.[102] As more black residents moved into public housing, which was built using urban renewal funds, as a result of displacement from other urban renewal projects, activists started stating that "slum removal equals Negro removal."[103] When the DMC development plan began to gain traction, activists representing Detroit's black community realized they needed to mobilize to create more equitable development.

Involvement of the Detroit Urban League

The neighborhoods that Detroit planners identified as "blighted" were inhabited by black Detroiters, meaning that the results of this development would disproportionately affect Detroit's black communities. The Detroit Urban League, a black activist organization that worked to provide residents with equal opportunities at economic prosperity, noted that the changing demographics were obvious to those living in the city, writing that:

> "Oakland and Macomb Counties have more than doubled their increase in white population since 1950. Conversely, marked gains in Negro population

[101] Sugrue, Origins of the Urban Crisis, p. 47-48.
[102] Sugrue, Origins of the Urban Crisis, p. 48.
[103] Sugrue, Origins of the Urban Crisis, p. 50.

> increases, appear to be occurring most strikingly in Detroit proper. This seems to reflect the general opinion that Detroit City is increasingly becoming more heavily populated with Negro people and the surrounding communities are becoming more thickly populated with white persons."[104]

The Detroit Urban League was interested in improving the lives of black residents who were affected by these demographic changes, including mobilizing around unequal employment opportunities as job competition increased through these demographic changes.[105] The Detroit Urban League viewed equal access to employment as the most effective way to improve the economic standing of black residents. To act on its mission, the Detroit Urban League closely monitored urban renewal developments that displaced black businesses, including the DMC development.

Detroit's Blight

The language of "blight" became a self-fulfilling prophesy. Housing discrimination in Detroit in the 1930s and 1940s forced Detroit's black residents—already relegated to the city's lowest paying, most insecure jobs—to live in the city's oldest housing stock, which needed constant repairs and maintenance for standard livability. Already paying a greater percentage of their income for housing than their white counterparts, banks would not loan black residents the funds for home improvement to improve these properties.[106] Thus, the already-deteriorating housing in these neighborhoods continued to decline, with some of these properties eventually

[104] "Proposed Statement Prepared for Hearing Before Common Council on Medical Center Redevelopment," January 15, 1960. Box 75, Folder: Temporary Committee Hospital/Medical Services, 1951- 1960. Bentley Historical Library, Ann Arbor, Michigan.

[105] Sugrue, The Origins of the Urban Crisis.

[106] Ibid.

becoming condemned, resulting in greater "blight." As these neighborhoods declined, the inaction of homeowners to improve their properties contributed to continued housing discrimination, providing evidence for white homeowners that black residents were irresponsible, and the continued deterioration of black neighborhoods demonstrated to banks that these neighborhoods were a credit risk.[107] The continued disinvestment in the neighborhoods that were most densely populated with black residents caused the "blight" that urban renewal in the 1950s, like the DMC development, sought to correct.

The Detroit Urban League noted that initial plan presented to City Council in the Spring of 1956 lacked any sort of clear detail, including a work plan, time frame, or plan for financing.[108] This concerned the Urban League since previous urban renewal projects had not clearly communicated to residents about the timeline of their displacement, and this organization feared the lack of details in the early stages of planning would result in more short-notice removals of black residents.[109] The only certainty this development plan offered, seemingly, was an assurance that the city would raze black neighborhoods.[110] The Detroit Urban League petitioned the city requesting to learn if displaced groups would be allowed to return post-construction, but also began to raise questions about the particular meaning of this development for the very community it sought to displace. The Detroit Urban League also became interested in learning more

[107] Sugrue, Origins of the Urban Crisis, pp. 35-36.

[108] "Suggested Statement for the Medical-Hospital Committee's Consideration," Box 75, Folder: Temporary Committee Hospital/Medical Services, 1951-1960. Urban League Collection, Bentley Historical Library, Ann Arbor, Michigan.

[109] Ibid.

[110] Crane and Gorwic Associates, Inc., Planning and Design Consultants, "Harper Hospital Survey: A Physical Survey of the Hospital in Relation to the Detroit Medical Center: A Report to the Detroit Medical Center Citizens' Committee," (Detroit, MI, 1958).

about how this plan would improve opportunities for black residents. Noting that "inasmuch as the acquisition of land will be based on the theory that the development of the project is 'in the interest of the public welfare,'" the organization sought to understand how the development would have on the "presently racially restricted policies and services of the hospitals in the area."[111]

Legal Discrimination[112]

A major factor that resulted in the declining support of Detroit's black community for the DMC development was the known segregation that occurred at the four hospitals of the future medical center. Alleged discrimination in training facilities pointed out the lack of residency opportunities and restrictions on the number of internships available to black physicians. While there appear to be no metrics as of the mid-1950s about the racial demographics of residencies and internships, the Detroit Urban League had begun collecting anecdotes from trainees who had been denied opportunities at hospitals outside of the black hospital system in Detroit.[113] This was the same for restrictions on the number of the staff privileges of black physicians and the denial of employment opportunities of qualified black workers to fill the many and varied positions found in general hospitals.[114] By the administrators of the larger, more mainstream hospitals

[111] "Suggested Statement for the Medical-Hospital Committee's Consideration." Box 75, Folder: Temporary Committee Hospital/Medical Services, 1951-1960. Detroit Urban League Collection, Bentley Historical Library, Ann Arbor, Michigan.

[112] For a more thorough examination of these policies, see Hoffman, *Health Care for Some.*

[113] "Suggested Statement for the Medical-Hospital Committee's Consideration." 75, Temporary Committee Hospital/Medical Services, 1951-1960. Detroit Urban League Collection, Bentley Library.

[114] "Partial Listing of Medical-Hospitals for Urban League Board Consideration," December 9, 1964. Box 64, Folder: Research Reports, 1962 Reports, Review of Equal Opportunity in Detroit Hospitals. Detroit Urban League Collection, Bentley Historical Library, Ann Arbor, Michigan.

excluding black trainees and employees, instead relegating them to continue their work at Detroit's large system of "black hospitals,"[115] hospital leaders contributed to not only a segregated, two-tiered system of health care, but also a segregated, two-tiered system of health care employment. These hospitals had fewer resources, and therefore offered lower salaries for their employees.[116]

Despite the plethora of anecdotal evidence, the only claim of discrimination the Detroit Urban League could substantiate with corresponding data was that these four voluntary hospitals that would become the DMC had an absence of black members on administrative committees.[117] The lack of black representation on these decision-making boards continued a culture of segregation at these hospitals because neither employment nor care of black residents was a priority.

This was a particularly egregious offense, as Hill-Burton legislation had been intended to improve conditions in segregated hospitals. As condition of receiving these funds, hospitals needed to provide equal treatment to their patients, even if wards remained separate. The non-discrimination clauses of Hill Burton included prohibiting patient admissions to "that portion of the facility for which federal funds were sought," and no patient could "be denied a service essential to his medical care."[118] But this clause

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[115] Detroit had a thriving black hospital system (of which none of the DMC hospitals or any city hospitals, including Detroit Receiving, was a part). The most comprehensive information on this system is the Kellogg African American Health Care Project, which contains oral histories of black health care practitioners in Southeast Michigan between 1940-1969. This collection is housed at the Bentley Historical Library. For an overview of this project and its contents, see Valerie Gliem, "History of Detroit's Black Hospitals Detailed in Project," *The University Record,* November 6, 2000. http://ur.umich.edu/0001/Nov06_00/10.htm (accessed May 26, 2019).

[116] Ibid.

[117] "Suggested Statement for the Medical-Hospital Committee's Consideration." 75, Temporary Committee Hospital/Medical Services, 1951-1960. Detroit Urban League Collection, Bentley Library.

[118] U.S. Commission on Civil Rights Staff Paper, *The Hill-Burton Program,* Box 55, Folder: Health and Welfare Department General File, 1964 [a19-2]. Detroit Urban League Collection, Bentley Historical Library, Ann Arbor, Michigan.

still allowed for active discrimination in areas of the hospital *not* receiving Hill-Burton funding. Urban hospitals mostly received funds for repairs and additions, meaning entire wards could exist without the receipt of any federal funding, still allowing segregation.[119] While it appeared that the intent to minimize discrimination was built into the legislation, historians have identified that "separate but equal," which was still enshrined in Hill-Burton until 1963, was a way to perpetuate legal discrimination at hospitals through the allowance of continued segregation.[120] Historian Beatrix Hoffman has demonstrated that the allowance of "separate but equal" institutions actually contributed to expanded segregation in the American South.[121] So long as there were alternative care facilities for black patients within the "territorial area" of the Hill-Burton applicant, there was no need to provide integrated health care, thus providing the federal sanctioning of Jim Crow.[122] This legislation also allowed the discrimination in hiring at these hospitals under the same principles of its enshrinement of Jim Crow health care for patients, stating "professionally qualified persons could be denied staff privileges on account of race, creed, or color."[123]

Discrimination at Hill-Burton hospitals was deemed unacceptable with the Fourth Circuit ruling in *Simkins v. Cone (1953).*[124] In this case, black health care professionals

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[119] Ibid.

[120] Rosemary Stevens, American Medicine and the Public Interest: A History of Specialization. 2nd Edition. (Berkeley: University of California Press 1998): pp. 269; 510-513; Colin Gordon, Dead on Arrival: The Politics of Health Care in Twentieth Century America. (Princeton: Princeton University Press 2003): pp. 193-195; Alan Derickson, Health Security for All: Dreams of Universal Health Care in America. (Baltimore: Johns Hopkins University Press 2005): p. 128.

[121] Hoffman, Healthcare for Some, p. 64.

[122] Hoffman, *Healthcare for Some*, p. 111.

[123] U.S. Commission on Civil Rights Staff Paper, *The Hill-Burton Program,* 55, Health and Welfare Department. Detroit Urban League Collection, Bentley Library.

[124] Reynolds P. Preston, "Hospitals and Civil Rights, 1945-1963: The Case of Simkins v. Moses H. Cone Memorial Hospital," *Annals of Internal Medicine* 126:11 (June 1, 1997): 898-906.

and providers faced alleged discrimination at hospitals in Greensboro, North Carolina.[125] The black plaintiffs had asked the Court recognize and enforce the following acts as unconstitutional under the protections of the Fifth and Fourteenth Amendments: 1) to order that hospitals cease denying black physicians staff facilities based on race, 2) to restrain hospitals from denying and "abridging" admission of patients based on race, 3) to stop hospitals from denying patients get treated by their home physicians and dentists based on race, and 4) to end the "separate but equal" provision of the Hill-Burton Act.[126] The Fourth Circuit Court ruled in favor of the plaintiffs, and, when the Supreme Court of the United States refused to hear the case, this ruling was upheld.[127] This resulted in The Surgeon General publishing a new regulation in the Hill-Burton legislation in 1964, stating:

> "Before a construction application is recommended by a State agency for approval, the State agency shall obtain assurance from the applicant that all portions and services of the entire facility for the construction of which, or in connection with which, aid under the discrimination on account of race, creed, or color; and that no professionally qualified person will be discriminated against on account of race, creed, or color with respect to the privilege of professional practice in the facility."[128]

This regulation meant that no additional "separate but equal" projects could be approved after March 1964, and projects that had been previously approved as such and were in progress needed to remedy to become nondiscriminatory institutions.[129] This ruling was supported through Title VI of the Civil Rights Act of 1964, which made discrimination

[125] U.S. Commission on Civil Rights Staff Paper, *The Hill-Burton Program*, 55, Health and Welfare Department. Detroit Urban League Collection, Bentley Library.
[126] Ibid.
[127] Ibid.
[128] Ibid.
[129] Ibid.

on the basis of race illegal for any program that received federal assistance.[130] Medicare mandated compliance with this title after its implementation in July 1965.[131] Desegregation would happen across the country either voluntarily by the hospital, through state ordinance, court action, subsequent approval of applications of Hill-Burton, or through the application of Medicare reimbursements.[132]

Detroit Urban League Activism

While federal policies would help to make discrimination at hospitals receiving federal money illegal in 1964, when the DMC plan was put forth in 1956, the Detroit Urban League realized the only way to stop discrimination at these hospitals was to take matters into their own hands. Members of the black community had long complained of discrimination at these hospitals when they sought to receive treatment.[133] In addition, members of the Detroit Urban League criticized the hospitals of the proposed DMC for using discriminatory hiring practices—a crucial criticism due to both the development's focus on employment opportunities and the mission of equal opportunity of the Urban League itself.[134]

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[130] Michael J. Pentecost, "Medicare and Desegregation," *Journal of the American College of Radiology* 12:12 (2015): 1245-1246.

[131] Ibid. Another effect of the passage of Medicare was the funding for graduate medical education [GME] to ensure that Medicare beneficiaries had access to the highest quality hospitals. Medicaid regulations do not specifically require this, but CMS allows it. Still today, Medicare and Medicaid distribute an estimated $14 billion annually to support GME. For more information, see Committee on the Governance and Financing of Graduate Medical Education, *Graduate Medical Education That Meets the Nation's Health Needs.* Ed. J. Eden, D. Berwick, and G. Wilensky. (Washington, DC: National Academies Press, September 30, 2014).

[132] U.S. Commission on Civil Rights Staff Paper, *The Hill-Burton Program,* 55, Health and Welfare Department. Detroit Urban League Collection, Bentley Library.

[133] Letter from Charles P. Anderson to Leonard Procter, August 13, 1962. Box 66, Folder 12-Board of Health. Jerome P. Cavanagh Collection, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

[134] "Suggested Statement for the Medical-Hospital Committee's Consideration." 75, Temporary Committee Hospital/Medical Services, 1951-1960. Detroit Urban League Collection, Bentley Library.

The Detroit Urban League operated under the auspices of The National Urban League. Regarding health care and black Americans, the National Urban League designated four action areas: 1) the elimination of racial segregation and discrimination, 2) the development of citizen leadership for the health field, 3) a solid demonstration in maternal and child health services, and 4) health career recruitment and training.[135] Additionally, the National Urban League believed that it was its own responsibility to find "strong, well-informed leadership within the Negro community" to develop.[136] At the local level, they believed that good leadership could enforce national priorities by helping to:

> "…mobilize the community and professional teamwork required; first, to rectify smoldering civil rights injustices in medical institutions and health agencies; second, to assure the best utilization of available manpower and facilities; and third, to plan comprehensive high-quality health services for all people regardless of color or income."[137]

And so, taking the lead from their national chapter, local leaders in the Detroit Urban League first organized to provide comment to Detroit's City Council about how they feared many of the aspects of the proposed DMC plan would negatively impact the lives of black Detroiters, including relocation of housing, the reinforcement of the dual-system of care in the city due to the continued segregation of care, and the lack of employment opportunities for black Detroit residents.

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[135] Committee to Secure the Rights of Negro Business Concerns Located in the Proposed Detroit Medical Center Site, undated (circa 1960). Box 69, Folder: Reference File Health-Care Miscellaneous (1). Detroit Urban League Collection, Bentley Historical Library, Ann Arbor, Michigan.

[136] Ibid.

[137] Ibid.

The Detroit Urban League agreed with the ultimate goals of the development; however, they wanted to ensure that black Detroiters could also share in the positive gains brought by a new medical center. In a report that the Urban League presented to Detroit City Council in 1956, they wrote:

> "In view of the expanded medical and hospital service that this Proposal would offer the residents of the city, in view of the potential expansion in medical and nursing training opportunities that may develop and in view of the communal benefits that may derive from the eradication of some slum conditions and the attending deteriorating factors which contribute to neighborhood decay, the Urban League herewith affirms its endorsement of these socially desirable goals inherent in the proposed medical plan. The creation of a medical oasis in a health deteriorating neighborhood, characterized by conditions that create and ever-increasing demand for more and better health facilities, would be an accomplishment for our city in which the League would like to share."[138]

The Detroit Urban League noted that they would support any work that could help alleviate the social plight of Detroit's black residents, including better access to health care. They again echoed the National Urban League in this sentiment, stating that:

> "no community or region has a working plan that assures the best use of what is available. Such a plan would identify and fill gaps, eliminate duplication, promote excellence of performance, and make it possible for each individual to have a personal doctor and a comprehensive range of health services. These services should have continuity, emphasize preventative and prompt care, be family centered, and respect the dignity of the individual as much as the science underlying modern medicine."[139]

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[138] Presentation at the Public Hearing before the Common Council Regarding the Urban League's Position Toward the Proposed Medical Center Plan, undated (circa May 1956). Box 42, Folder: Community Service Department—Topical File—Hospital and Medical Center Studies, undated [A6-22]. Urban League Collection, Bentley Historical Library, Ann Arbor, Michigan.

[139] Walter J. Lear, M.D., "Negroes and Health Services," National Urban League Subcommittee, Deputy Health Commissioner of Philadelphia, Presented at the 1964 National Conference of the Urban League, Tuesday August 4, 1964, Louisville Kentucky. Box 55, Folder: Health and Welfare Department General File, 1964 [a19-2]. Detroit Urban League Collection, Bentley Historical Library, Ann Arbor, Michigan.

While the Detroit Urban League was clear that they supported this development in theory, they expressed concerns in three main areas: segregation of health care services at the hospitals of the DMC, a lack of a democratic relocation process for the displaced families during the DMC's construction, and discriminatory hiring practices at the hospitals of the DMC for Detroit's black residents.

Initially, it was an exciting prospect for the Detroit Urban League that this development could contribute to the improved health status of the residents they represented. In Detroit in 1950, black residents died five years earlier on average than their white counterparts.[140] The Detroit Urban League suggested that hospital discrimination was a contributing factor to this, citing an adherence to racialized intake quotas, segregation of patients in their ward and room assignments, and denial of black patients at obstetrical wards forcing laboring mothers to deliver in the emergency room at the city's municipal hospital, Detroit Receiving.[141] The Detroit Urban League petitioned City Council in hopes of getting their elected officials to understand the serious problems that this segregation did to the health status of black residents. Detroit Urban League leaders also hoped that their testimonial would encourage City Council to realize the importance of ending this segregation now that this project was receiving federal dollars, stating: "tax dollars bear no racial identification."[142] The Detroit Urban League leaders

[140] Robert M. Pankin, "The Determination and Elimination of Racial Discrimination in Hospitals: A Position Paper," undated (circa 1956). Box 42, Folder: Community Service Department—Topical File—Hospital and Medical Center Studies, undated [A6-22]. Detroit Urban League Collection, Bentley Historical Library, Ann Arbor, Michigan.

[141] Thomas Batchelor, "Medical Issues," undated (circa 1956). Box 42, Folder: Community Service Department—Topical File—Hospital and Medical Center Studies, undated [A6-22]. Detroit Urban League Collection, Bentley Historical Library, Ann Arbor, Michigan.

[142] Detroit Urban League Statement Prepared for Hearing Before Common Council, January 15, 1960. Box 43, Folder: Community service Dept Topical File Hospital and Medical Center Studies, 1960 [A7-3]. Detroit Urban League Collection, Bentley Historical Library, Ann Arbor, Michigan.

continued, arguing that they "fail[ed] to comprehend any reasonable grounds for limiting, by race, the services which they have created. To impose such limitations might precipitate grave legal, as well as moral, implications."[143]

In addition to discrimination that black Detroiters experienced at the four hospitals of the DMC when they sought health care services, the Detroit Urban League challenged City Council to realize the difficulty that would be experienced by the twelve-thousand families that this construction would displace.[144] This development required that surrounding commercial buildings were razed, also, meaning that two-hundred black-owned businesses would be displaced without any financial support from the city.[145] Knowing the outcome of previous urban renewal projects, the Detroit Urban League noted to City Council that there would not be enough public housing to accommodate all those displaced by this construction, and the planned replacement residential housing "suggest[ed] preferential controls favoring white professionals, and economic restrictions designed to exclude Negro families from residing in this area."[146]

The Detroit Urban League also noted the lack of medical residencies, restrictions on internships, restrictions on staff appointments, the lack of black nursing supervisors, and the lack of black individuals in leadership or administrative positions at the four hospitals of the DMC as evidence of the exclusionary efforts of black Detroiters to share

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[143] Ibid.

[144] "Working Copy—Suggested Statement for Presentation at the Public Hearing Before the Common Council Regarding the Urban League's Position Toward the Proposed Medical Center Plan," May 23, 1956. Box 42, Folder: Community Service Department—Topical File—Hospital and Medical Center Studies, undated [A6-22]. Detroit Urban League Collection, Bentley Historical Library, Ann Arbor, Michigan.

[145] Committee to Secure the Rights of Negro Business Concerns, undated (circa 1960). 69, Folder: Reference File Health-Care. Detroit Urban League Collection, Bentley Library.

[146] Ibid.

in the economic potential of this development.[147] The Detroit Urban League believed that the needs of Detroit's black community, like equal access to the jobs new developments offered, would be exacerbated by its construction—not helped. Ultimately, the Detroit Urban League could not support what they called a "Pyrrhic victory gained at the expense of family disorganization and human deprivation."[148] However, the Detroit Urban League did state that if their concerns were assuaged by the hospitals of the proposed DMC ending discriminatory practices in hiring and treatment and ensured democratic relocation for the area's black residents and businesses.[149]

While the Detroit Urban League was initially dedicated to addressing their concerns over the lack of equal health provision and housing displacement as a result of the medical center development, their focus would shift primarily to the training and employment opportunities afforded at the institutions of this development. This may be both due to the centrality of equal employment opportunity to the Urban League's core mission, and potentially because this seemed to be the focus of the city's acknowledgement of the Detroit Urban League's grievances. While the explicit motivations for this change no longer exist in the archives, the actions of the Detroit Urban League through the early 1960s demonstrate that their focus was to work toward equality in training and employment at the DMC; in that process, they no longer

[147] Batchelor, "Medical Issues," undated (circa 1956). 42, Folder: Community Service Department, undated [A6-22]. Detroit Urban League Collection, Bentley Library.

[148] Lear, "Negroes and Health Services," Tuesday August 4, 1964. 55, Folder: Health and Welfare Department. Detroit Urban League Collection, Bentley Library.

[149] Batchelor, "Medical Issues," undated (circa 1956). 42, Folder: Community Service Department, undated [A6-22]. Detroit Urban League Collection, Bentley Library; Committee to Secure the Rights of Negro Business Concerns, undated (circa 1960). 69, Folder: Reference File Health-Care. Detroit Urban League Collection, Bentley Library.

emphasized displaced black residents and health service accessibility for indigent patients.

Employment Discrimination Studies

In May 1956, Detroit City Council approved the DMC plan. After this approval, the Detroit Urban League continued to testify before and appeal to Detroit City Council to create a more equitable development before planners began construction. But ultimately, planners were more concerned with moving forward to secure this project's funding rather than ensure its equitable opportunities. By 1957, the city had secured enough funding from federal urban renewal policies and Hill-Burton to move forward with the project. City planners, however, had made no progress on addressing the issues raised by the Detroit Urban League only a year before.

Later in 1957, representatives from the Detroit Urban League appeared before City Council to again deliver the message that they could never support a plan for this sort of development at segregated hospitals, and to remind City Council that soliciting public funds should mean greater responsibility to provide equal treatment at these hospitals.[150] When it appeared to Detroit Urban League leaders that City Council would again be unable to provide the outcomes they desired, they turned to the tactics of the National Urban League.

The National Urban League saw the role for its local chapters as groups that would "gather evidence of continued discriminatory practices as an aid to Federal

[150] "Proposed Statement," January 15, 1960. 75, Folder: Temporary Committee Hospital/Medical Services. Bentley Library.

enforcement activities."[151] Thus, leaders of the Detroit Urban League understood that data gathering would be the most helpful way to support the National Urban League's mission to improve the economic security and job prospects of black residents. As a potential solution to the concerns that the Detroit Urban League expressed about the DMC development, the Medical-Hospital Committee of the Detroit Urban League submitted a program to its Board of Directors, suggesting that they form a committee to host a conference with community leaders and conduct a study on opportunities for black medical professionals at the DMC hospitals.[152]

This study committee, with members of the Detroit Urban League's Medical-Hospital Committee and led by Dr. Thomas Batchelor—the first black physician employed at Detroit's municipal hospital (or any hospital in the city that was not a traditionally segregated hospital)—would submit a survey to all of the hospitals of the proposed DMC and ask its administrators about their hiring practices and opportunities for black professionals like physicians, nurses, and medical technicians.[153] This study committee would then report regularly back to the Detroit Urban League's Executive Board who would then, in theory, make further evaluations and provide any necessary guidance to City Council for ending discrimination in the DMC hospitals. The Detroit Urban League also simultaneously planned how to enforce the recommendations to City Council that would come from the study findings. While planning the study, they also

[151] Committee to Secure the Rights of Negro Business Concerns, undated (circa 1960). 69, Folder: Reference File Health-Care. Detroit Urban League Collection, Bentley Library.

[152] "Recognized Inequalities in Detroit's Voluntary Hospitals," February 10, 1955. Box 75, Folder: Temporary Committee Hospital/Medical Services, 1951-1960. Detroit Urban League Collection, Bentley Historical Library, Ann Arbor, Michigan.

[153] Ibid.

met with the Michigan Hospital Services—the precursor to Blue Cross—to encourage representatives to not reimburse services at hospitals that discriminated against patients or black physicians; the payors were not responsive to this request.[154] This response was in line with the attitude of other private health insurers at the time, whose welfare capitalist policies, in the end, still prioritized capitalism.[155]

Perhaps understanding the seriousness with which the Detroit Urban League petitioned City Council, the city of Detroit began to organize its own study related to the employment opportunities for and current status of black workers in the four hospitals of the DMC. Leading this charge was the city's newly formed Hospital and Medical Study Committee, an organization of hospital representatives organized by the Medical Center Citizens' Committee and the Commission on Community Relations. The Hospital and Medical Study Committee was the precursor to the city body tasked with overseeing equal opportunity for city employees. This Advisory Committee entered a joint statement to City Council on March 27, 1957, which stated that their general purpose was:

> "to advise and assist the Commission on Community Relations on the elimination of racial factors and discriminatory practices in medical, college-nursing, and hospital nursing school training; in nursing and medical staff appointments, and in-patient admission and bed assignments in Detroit area schools and hospitals as reviewed by the Hospital and Medical Study Committee."[156]

Despite being the likely source of motivation for this survey, the Detroit Urban League was not tapped for guidance after their initial opposition to the DMC plan.

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[154] Ibid.

[155] Jennifer Klein, For All These Rights.

[156] Advisory Committee on Hospitals, "Report to the Commission on Community Relations," May 20, 1963. Box 69, Folder: Reference File Health-Care Hospital Survey (1). Detroit Urban League Collection, Bentley Historical Hospital, Ann Arbor, Michigan.

The Committee on Community Relations began the study of area hospitals in 1958.[157] For reasons that are unclear—perhaps because this body did not contain a statistical expert or because it was hastily assembled—this study did not contain quantitative data. It relied on the perspectives of the hospital directors and trustees, who produced information that downplayed the accusations of discrimination. In fact, the only data in this study was interviews with the members of the Board of Directors and Hospital Trustees at each of the four proposed medical center hospitals.[158] Hospital representatives submitted their own data to this committee—usually a letter from its president or lead administrator summarizing the environment of the hospital. If study personnel determined that a "discriminatory policy or practice" existed in "any phase of a hospital's operation," the committee sought out members of that particular hospital to "clarify the problem with the Board of Trustees and seek those actions that would, in fact, demonstrate compliance."[159] Additionally, relying only senior members of the hospitals themselves to report on the status of discrimination at their institutions when they were reinforcing discriminatory practices—perhaps sometimes unknowingly—all but ensured an ineffective basis to address fundamental problems.

The hospital administrators all reported how these hospitals did not practice discrimination in hiring and promotion. Many of their statements included statements we now recognize as problematic, like: "I'm not prejudiced. Some of my best friends are

[157] Ibid.
[158] Ibid.
[159] Ibid.

Negro physicians."[160] Representatives from the Detroit Urban League were present at the City Council meeting where the Committee on Community Relations revealed their findings, where they heard what they believed were inaccurate overestimations at best of the number of black physicians and nurses at the four hospitals.[161] But there is no evidence that city study representatives interviewed these black health professionals for their own perspectives. Leaders from the proposed DMC hospitals reported that they had "at least one or two" physicians and believed this to be "enough" since "the intern matching system assure[d] equal opportunity for all applicants."[162] Hospital representatives in their study materials stated that the low number of black physicians was indicative of lower desire for these positions and not because of any systemic discrimination.[163] This was consistent with arguments put forth at the time justifying discrimination on the lack of willingness or interest on the part of black folks; those in power saw no barriers or fault with their own actions, and the lack of non-white representation was blamed on a lack of interest or incompetence. Therefore, City Council determined the claims of Detroit's black community and various committees put forth by The Urban League were unfounded.[164]

Perhaps in a peace offering to appease the Detroit Urban League and stop their petitions, the four hospitals of the Detroit Medical Center signed non-discrimination

[160] Detroit Urban League, "Review of Equal Opportunity in Eleven Detroit Area Voluntary Hospitals," December, 1962. Box 64, Folder: Research Reports, 1962 Reports, Review of Equal Opportunity in Detroit Hospitals. Detroit Urban League Collection, Bentley Historical Library, Ann Arbor, Michigan.

[161] Ibid.

[162] Advisory Committee on Hospitals, "Report to the Commission on Community Relations," May 20, 1963. Box 69, Folder: Reference File Health-Care Hospital Survey (1). Detroit Urban League Collection, Bentley Historical Hospital, Ann Arbor, Michigan.

[163] Ibid.

[164] Ibid.

agreements in January 1960, but the Detroit Urban League alleged that this discrimination continued because these policies were not enforced.[165]

Continued Discrimination

As discussed earlier, ending discrimination against black hospital employees was a priority of the National Urban League, since their mission was to improve economic prosperity for black individuals nationwide. Black activists in this group were hopeful that the growing Civil Rights Movement in the early 1960s would make their attempts at more inclusive health care and medical training more effective. Simultaneously, the Detroit Urban League continued to work for the city's changing attitudes about this development so that a more inclusive medical center would appear. The National Urban League, and as a result its local chapters, saw their role in working for equal rights not as disrupters or enforcers, but instead to "alert the administrators of the existing inequities and their resultant community unrest" in hopes that this work would "initiate orderly, democratic changes."[166] Other activist groups were more militant, but the National Urban League was a more middle-class organization that saw its greatest chance for success through the court system and with direct government advocacy.

Dissatisfied with the study results that came from the 1958 city-sponsored survey and seeing that the non-discrimination agreements at the hospitals of the proposed DMC were not resulting in any meaningful change, the Detroit Urban League again sought to

[165] Ibid.

[166] Letter from George Henderson to Department to Francis Korengay, November 6 1962. Box 69, Folder: Reference File Health-Care Hospital Survey (1). Detroit Urban League Collection, Bentley Historical Library, Ann Arbor, Michigan.

begin its own survey later that year. Led now by its Community Services Department[167] and run by volunteers who did not charge for their work, the Detroit Urban League surveyed Detroit's eleven largest voluntary hospitals in Metro Detroit, including the four hospitals of the proposed DMC. More hospitals than just these four were surveyed to investigate if this was a city-wide problem and to provide a benchmark.[168]

Lead researcher Dr. Thomas Batchelor—now the head of the Detroit Urban League's Medical-Hospital Study Committee—ran this study from April through December of 1962. The Detroit Urban League's study asked hospital administrators, physicians, and nurses about the discrimination at their own hospitals, but rather than request a letter from study participants about their perception of their hospital's discrimination, Dr. Batchelor prepared a standard survey and asked hospital administrators to address these questions in person.[169]

Batchelor was also adamant that this study should secure quantitative data in order to measure the degree of discrimination. In 1962, the black population of Detroit had grown to twenty-nine percent, but the Detroit Urban League alleged that this this was not nearly the percentage of the city's black physicians, nurses, or other support staff at these hospitals, which they believed should be representative of the population of the city.[170] By quantifying the number of black workers at each hospital, the Detroit Urban League hoped their data would provide a better illustration of the level of discrimination

[167]This group consisted of Urban League Director George Henderson, officers Lowell E. Jones and Robert E. Pankin, and various Community Service Assistants. It oversaw the Detroit Urban League's Medical-Hospital Study Committee.

[168] Detroit Urban League, "Review of Equal Opportunity in Eleven Detroit Area Voluntary Hospitals," December 1962. 64, Folder: Research Reports. Detroit Urban League Collection, Bentley Library.

[169] Ibid.

[170] Ibid.

at Detroit hospitals. The Urban League also hoped for conversation with the hospital administrators after the survey, since "through the exchange of ideas" they could "accelerate positive action."[171]

The results of this survey showed that not only were there few opportunities for black employees at these hospitals, but those that found jobs lacked support services or the necessary advanced training that would help them succeed.[172] The survey found that there were only minor changes made at the DMC hospitals from 1948 through 1962, leaving the Detroit Urban League still dissatisfied with the current employment structure.[173] The Detroit Urban League also warned that unless "hospital administrators decide to initiate abatement of inequities, people outside the hospitals…will actively and emotionally seek such changes"—a statement that is cryptic in hindsight because of the violence that happened in Detroit during July 1967.[174]

The degree of discrimination varied between each hospital for each position. For example, Children's Hospital had two-hundred-seventy staff physicians, none of whom were black. But nearly eight percent of its medical residents identified as black—by far the highest of these four medical center hospitals.[175] On the other hand, Harper was the hospital that was the most integrated for registered nurses—21.5 percent of their one-hundred-fifty-two registered nurses identified as black, and the most beds—26.5

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[171] Letter from George Henderson to Department to Francis Korengay, November 6, 1962. 69, Folder: Reference File. Detroit Urban League Collection, Bentley Library.

[172] Ibid.

[173] Ibid.

[174] Ibid.

[175] Detroit Urban League, "Review of Equal Opportunity in Eleven Detroit Area Voluntary Hospitals," December 1962. 64, Folder: Research Reports. Detroit Urban League Collection, Bentley Library.

percent—designated beds for black patients.[176] Additionally, the head dietician at Harper Hospital was black.[177] The Detroit Urban League admitted this was impressive progress, considering that until about 1957, there was an "unwritten policy" that "Negroes would not be admitted to the different schools" for nursing and residency at Harper.[178]

However, the Detroit Urban League recognized that there were opportunities for improvement at these hospitals. The Detroit Urban League made nine recommendations from this study upon its completion in 1962 that they shared with Detroit City Council to inform the medical center development. These recommendations included:

1. Place qualified black applicants on the boards of directors at the four medical center hospitals. Certainly, qualified applicants can be found from a city of 500,000 black residents that currently was home to only 180 black physicians.
2. Patient admissions should be made solely on need, not color of patient.
3. Qualified black physicians should be given internships and residencies whenever possible.
4. Black physicians should be given full staff and surgical privileges.
5. Promotions should be granted based on ability and not color.
6. Every hospital facility should be integrated, including beds in all wards.
7. These study findings should be made available to the public through the Detroit Commission on Community Relations Advisory Committee.
8. Black physicians should be able to utilize community resources.
9. With the initial groundwork being completed, the individual hospitals needed to continue to take regular surveys to keep track of their nondiscrimination policies.[179]

[176] Ibid.

[177] Conference with Dr. DeBusk of Grace Hospital, October 5, 1962. Box 69, Folder: Reference File Health-Care Hospital Discrimination. Detroit Urban League Collection, Bentley Historical Library, Ann Arbor, Michigan.

[178] Ibid.

[179] Detroit Urban League, "Review of Equal Opportunity in Eleven Detroit Area Voluntary Hospitals," December 1962. 64, Folder: Research Reports. Detroit Urban League Collection, Bentley Library.

While there are recommendations regarding segregation against patients, most of these recommendations are on the employment, admission, and promotion of black residents rather than on patient access.

After the survey and these recommendations were released to the four DMC hospitals, Hutzel Hospital—one of the worst offenders of discriminatory practices according to the Detroit Urban League's data—wrote to "correct" the findings. While the survey showed that there were no internships available for black physicians from 1957 to 1962, Hutzel Hospital Administrator Catherine M. Maloy wrote to say that during that time, they did train one black doctor, Solomon Payne, as an intern during the 1959-1960 academic year, noting that this was "enough."[180] In the margins of the study data, a researcher wrote that Maloy did not disclose the intern in earlier conversations, and that she had been "quite reluctant to give information to staff."[181]

In the Detroit Urban League's study, not a single hospital administrator admitted to discrimination based on race.[182] Regarding patient segregation, one hospital administrator suggested that patients are placed in racially similar wards because "happiness was essential to their recovery," and being placed with others who identified as their own race would result in this happiness.[183] Perhaps one of the most egregious examples of racial discrimination in the hiring process was Grace Hospital refusing to fill a residency vacancy despite the application of two qualified black physicians.[184]

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[180] Letter from Catherine A. Maloy, to Julian P. Rogers, October 24, 1962. Box 69, Folder: Reference File Health-Care Hospital Survey (1). Detroit Urban League Collection, Bentley Historical Library, Ann Arbor, Michigan.

[181] Ibid.

[182] Detroit Urban League, "Hospital Study," 1961. Box 69, Folder: Reference File Health-Care Hospital Discrimination. Detroit Urban League Collection, Bentley Historical Library, Ann Arbor, Michigan.

[183] Ibid.

[184] Ibid.

After the Detroit Urban League submitted the study to the City Council, black individuals—both patients and hospital employees—reported to the Detroit Urban League that there was further discrimination at hospitals around the city that this study did not capture, including an adherence to a quota system in intake, segregation of patients in ward and room assignments, fixed maximum of private or semi-private rooms for black patients, limitations in facilities for obstetrical care and treatment for black patients, restrictions on use of facilities for special surgeries and therapies—like iron lung, physical therapy, oxygen, etc.—and restricted board membership.[185] There was also reported alleged discrimination in training facilities that confirmed the Detroit Urban League's data, like a lack of medical residency opportunities, restrictions on the number of internships available to black physicians, and restrictions on the number of the staff privileges, absence of black members on administrative committees, and denial of employment opportunities of qualified black applicants to fill the many and varied positions found in general hospitals.[186] The Detroit Urban League did not officially validate these through an additional formal survey.

City Council was sent the results of this study, but no one from the Detroit Urban League ever got on the agenda to publicly present the data to the Council.[187] Instead, City

[185] Detroit Urban League, "Partial Listing of Medical-Hospitals for Urban League Board Consideration," December 9, 1964. Box 64, Folder: Research Reports, 1962 Reports, Review of Equal Opportunity in Detroit Hospitals. Detroit Urban League Collection, Bentley Historical Library, Ann Arbor, Michigan.

[186] Ibid.

[187] Lovell E. Jones, "Department of Health and Welfare Detroit Urban League Second Quarterly Report," June 1964. Box 55, Folder: Health and Welfare Department Reports, 1964-1958 [a19-1]. Detroit Urban League Collection, Bentley Historical Library, Ann Arbor, Michigan.

Council continued to work specifically with city-sponsored study data through communication with hospital administrators and trustees.[188]

The City's Response

The Community Coordinating Council of Metropolitan Detroit was a commission started in 1957 to address race relations in Detroit. It was headed by a white Episcopal Reverend, Richard S. M. Emrich who hoped that "Detroit may become the first major city in the nation to fully reflect nondiscrimination in the health, hospital, and medical services available to all its citizens."[189] The Community Coordinating Council of Metropolitan Detroit drafted an Ordinance on Hospital Discrimination that was eventually signed in 1963 by the Detroit City Council.[190] Responding to continued pressure from the Detroit Urban League, the city recognized this ordinance in August 1963, which read that:

> "No hospital, nor any person acting as super or manager, or who is otherwise in charge or control of such hospital, nor any person connected with or rendering service in any hospital in any capacity whatsoever, nor any agent or employee thereof shall deny to any person admission for care or treatment, equality of care of treatment in a hospital, or the use of any of the hospital facilities and services relating to care or treatment of such person, including placement in hospital rooms, on account of race, color, creed, nation of origin or ancestry, provided that a member of the medical staff of said hospital or an authorized physician designated to act for him

[188] Ibid.

[189] Richard S. Emrich, "Summary of Activities of the Citizens' Advisory Committee on Hospitals of the Detroit Commission on Community Relations," November 16, 1961. Box 43, Folder: Community Service Department Topical File Hospitals and Medical Center Studies, 1961-1962 [a7-4]. Detroit Urban League Collection, Bentley Historical Library, Ann Arbor, Michigan.

[190] Community Coordinating Council of Metropolitan Detroit, "Proposed Ordinance on Hospital Discrimination." Box 83, Folder 83-10: Detroit Hospital Bias Ban, 1963. Detroit Commission on Community Relations/Human Rights Commission Collection—Part 3. Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

> may examine such person and determine the need of such person for medical care or treatment."[191]

This ordinance was very responsive to discrimination of patients, but not to the discrimination that most bothered the Urban League—discrimination against black workers looking for employment opportunities at the four hospitals of the Detroit Medical Center, the ultimate concern for the Detroit Urban League. As construction continued, the Detroit Urban League continued to work for equal employment opportunities for Detroit residents at the four hospitals of the DMC.

Conclusion

In the same year of the Detroit Urban League's study in 1962, Detroit elected a new mayor—Jerome P. Cavanagh. The case of the DMC provides a lens for the way that black residents interacted with city government when they were upset over the lack of equal opportunities in employment and health care in the late 1950s and 1960s. Cavanagh capitalized on this, running against incumbent mayor Louis Mirani in 1961, and won an upset mayoral election by criticizing the way that the city government treated its growing black population.[192] For a while, at least, Cavanagh kept his campaign promises to prioritize Detroit's black communities.

One of the biggest issues facing the city was the DMC development. Cavanagh familiarized himself with the controversy surrounding this development and appeared to side with the Detroit Urban League. Stating that a medical center could only exist if it

[191] Ibid.
[192] Fine, Violence in the Model City, 2007.

was "free of the blight and cancer of discrimination against persons because of his or her race, religion, or national origin,"[193] the city partnered with the Urban League in late 1963 to create a new acceptance system for medical residencies, ensuring that an applicant would not be excluded based simply on his or her race.[194] This partnership did not, however, include a provision to ensure that the August 1963 ordinance that promised non-discrimination extended to hospital patients.[195]

Detroit has a long history with labor—most visibly associated with the auto industry, of course. But some may find it difficult to find a city more closely associated with work than Detroit. Perhaps this is why once the auto industry began declining shortly after such an intense period of prosperity, planners looked toward alternative sources for a new industry that could power the city. Working with the resources already in place—four hospitals that provided much of the state its medical care and a growing medical school—city planners in the 1950s and 1960s believed that a new medical center could provide Detroit these opportunities for work and employment that had long brought people to this city. This focus on employment by the initial planners, as well as the focus on equal employment opportunity on behalf of its national organization, explains why the Detroit Urban League focused most of its advocacy on the employment capabilities of this institution rather than its health provision.

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[193] Statement from the Detroit Medical Society to the Detroit Common Council, January 25, 1960. Box 43, Folder: Community Service Dept Topical File Hospital and Medical Center Studies, 1960 [A7-3]. Detroit Urban League Collection, Bentley Historical Library, Ann Arbor, Michigan.

[193]Ibid.

[194] Vocational Services Department, "Detroit Urban League Hospital Study," October 5, 1961. Box 43, Folder: Community Service Department-Topical File-Hospital and Medical Center Studies, 1961-1962 [A7-4]. Detroit Urban League Collection, Bentley Historical Library, Ann Arbor, Michigan.

[195] Ibid.

Within the context of the mid-twentieth century, this makes perfect sense. Several other Rust Belt cities—including Cleveland and Pittsburgh—were able to use federal urban renewal funding to transform their local economies into medical destinations.[196] And for the Detroit Urban League, the importance of regular employment paired with the cultural and social benefits afforded by white-collar work and educational opportunities cannot be understated.

However, historians must closely examine the origins of these developments—both the initial plans and the response from the activist communities most affected by the projects—to investigate the full implications of urban renewal. In the case of the DMC development, the focus on employment rather than health provision reveals the role that planners felt urban hospitals played during the period of urban renewal in manufacturing cities. Additionally, it demonstrates that even activists who represented black residents were willing to compromise for their vision of a future city that left behind indigent patients.

The outcomes of this development and its focus on employment meant that black indigent patients continued to be excluded from the care offered at the DMC. This resulted in greater struggles and more work for Detroit's municipal hospital, Detroit Receiving. The next chapter explores how a continued focus on the DMC resulted in further separation from Detroit Receiving because of the negative connotations

[196] Merlin Chowkwanyun, "Dilemmas of Community Health: Medical Care and Environmental Health in Postwar America," PhD Dissertation, University of Pennsylvania, 2013; Andrew Simpson, "Making the Medical Metropolis: Academic Medical Centers and Urban Change in Pittsburgh and Houston 1945-2010," PhD Dissertation, Carnegie Mellon University, 2013.

surrounding the patients that hospital treated, and its incongruity with the Detroit planners' vision for the new DMC.

Chapter 2

"You Cannot Wish Away a Patient Population": The Detroit Medical Center's Contributions to the Continued Struggles of Detroit Receiving Hospital

While public funds were directed toward the construction of the new Detroit Medical Center [DMC], the city of Detroit long had a public hospital facility: Detroit Receiving Hospital. Historians have shown that urban public hospitals were the de facto site of all medical care for the poor, non-white, and indigent, resulting in the issues typical at this sort of institution: overcrowding, noncompliance with safety regulations, and a stigma against this site as a hospital *only* for poor patients.[197] These same problems plagued Detroit Receiving. For this hospital, these challenges grew in tandem with enthusiasm for the DMC; the city saw the new medical center as the future of the city's health care, and officials began to wonder if maintaining Detroit Receiving was even worth the trouble. This was reflected in the failure of planners to give serious consideration to integrating Detroit Receiving with the hospitals of the medical center; the city and county provided inadequate funding to this hospital to address its accreditation violations, and they were also unable to understand the seriousness of the immediate needs of patients who utilized this hospital. This failure—either through their inability or unwillingness—of the city of Detroit and Wayne County to sufficiently operate Detroit Receiving Hospital contributed to perpetual strife at this hospital. Compounded with the growing population of poor, indigent residents in Detroit who

[197] Harry F. Dowling, *City Hospitals: The Undercare of the Underprivileged.* (Cambridge: Harvard University Press, 1982); Rosemary Stevens, *In Sickness and in Wealth;* Beatrix Hoffmann, *Health Care for Some.*

relied on Detroit Receiving, this hospital became a burden that cost the city greatly. These issues were only exacerbated by the development of the DMC.

Housing has long been the lens by which historians explore the impact of the urban renewal policies of the mid-twentieth century. Many historians have noted that the federal policies of the mid-twentieth century resulted in continued racial segregation that the nation is trying still to recover from today. Most often, these conversations center housing policy as the primary driver of this continued segregation.[198] This makes sense: housing is a base need, and is therefore primary for wealth creation, job security, and familial relations. Housing restrictions through financial policies like mortgage refusals and local redlining only served to reinforce the federal housing policies that cleared the "slums," disproportionately affecting neighborhoods with black residents.[199] But as discussed in the first chapter, federal urban renewal policies resulted in the expansion and development of institutions like hospitals and universities in the city center. While historians have examined the housing crisis that resulted from federal urban renewal policies, particularly as a result of razing and displacing communities to make space for these urban institutions, this only examines half of the story. Urban renewal policies also resulted in the development of commercial buildings and institutions, which also contributed to the displacement of communities.

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[198] In addition to Sugrue, *The Origins of the Urban Crisis* and Freund, *Colored Property,* see Kenneth T. Jackson, *Crabgrass Frontier: The Suburbanization of the United States* (Oxford: Oxford University Press, 1987); Jane Jacobs *The Death and Life of Great American Cities* (New York: Vintage Press, 1961); Andres Duany, Elizabeth Plater-Zyberk, and Jeff Speck, *Suburban Nation: The Rise of Sprawl and the Decline of the American Dream*, 10th Anniversary Edition (New York: North Point Press, 2010); and Richard Rothstein, *The Color of Law: A Forgotten History of How Our Government Segregated America* (New York: Liveright, 2018).

[199] S. Rose-Ackerman, "Racism and Urban Structure," *Journal of Urban Economics,* 2:1 (1975): pp. 85-103; S. Rose-Ackerman, "The Political Economy of A Racist Housing Market," *Journal of Urban Economics,* 4:2 (1977): pp. 150-169; E. Avila and M. H. Rose, "Race, Culture, Politics, and Urban Renewal: An Introduction," *Journal of Urban History,* 35 (2009): pp. 335-247.

Two of these institutions that came from urban renewal, hospitals and universities, require a closer analysis. By analyzing the impact of provisions within urban renewal policies to support their construction and expansion, historians can ask important questions about the public benefit these institutions are intended to provide to their communities. Because of their role as service providers, most hospitals have been exempted from paying taxes to their local and federal municipalities since the early twentieth century. Policy makers argued that these institutions served their community through their services and thus did not need to support the community through property taxes.[200] In the case of the DMC and many other institutions built with urban renewal funds across the country, the provision of public funds increases the obligation of public institutions to meet community needs.

This chapter argues that the excitement around the promise of the new DMC supported by urban renewal funding further contributed to the economic decline of the city. This is because the continued focus on a new DMC created false expectations and resulted in city officials continually ignoring the needs of Detroit Receiving Hospital and its patients. The city's continued emphasis on the DMC and its neglect of an already-existing municipal hospital meant that its role in the lives of Detroit's neediest populations was ignored. This cost the city greatly. Understanding the struggles of Detroit Receiving in the 1950s and 1960s serves as an allegory for the troubles of the city. Ultimately, the story of the decline of Detroit Receiving demonstrates a lack of

[200] Paul Arnsberger, Melissa Ludlum, Margaret Riley, and Mark Stanton, "A History of the Tax-Exempt Sector: An SOI Perspective." *Statistics of Income Bulletin* (Winter 2008), p. 107. https://www.irs.gov/pub/irs-soi/tehistory.pdf (accessed February 1, 2019).

understanding on the part of city government of how their city and its residents were changing in the mid-twentieth century. Even as the indigent population continued to grow in the city and the specific requirements of this patient population expanded, city and county officials continued to ignore these needs in favor of boosting the DMC development in hopes of courting private patients. Vulnerable populations need adequate provision of health services to thrive, and the absence of this provision further stressed existing municipal services.

In making these arguments, this chapter contributes to the historiography of urban renewal policies and their effects on vulnerable populations, including poor black patients. Historical analysis that centers hospitals like the ones of the proposed DMC and the city's municipal hospital, Detroit Receiving, during the period of urban renewal highlights how these policies contributed to racially segregated and discriminatory cities. This happened not only through the well-documented housing crises throughout the second half of the twentieth century, but also through the continued discrimination at the hospitals of the DMC and the further strain on Detroit Receiving because of the environment these policies created. In addition, due to increasing economic discrepancies between races related to the job discrimination at these hospitals, explored in the first chapter, the policies aimed at improving the city made no improvement in the health status of the residents most in need of medical services.

Detroit Receiving Hospital

From its founding in 1915, the center of Detroit's medical services has been Detroit Receiving Hospital. Located on St. Antoine Street near the growing, bustling downtown neighborhood,[201] this city-owned hospital complemented the voluntary hospitals in the city by promising to provide care regardless of a patient's ability to pay for their services. After the hospital's transfer to the city's health department in 1949, Detroit Receiving also served as the central primary care center for the city.[202] Detroit Receiving was one of the busiest—and costliest—urban hospitals in the nation.[203] Still today, half of all of Michigan's emergency physicians are trained at this hospital.[204]

By 1950, Detroit Receiving Hospital was the largest operation of the Detroit Board of Health, operating at a loss of nearly two million dollars a year throughout the 1950s.[205] This hospital saw 24,000 admissions, 200,000 outpatient visits, and approximately 200,000 ER visits in 1961.[206] Ninety-five per cent of these patients were black, and only thirty-six percent of these patients carried private insurance—explaining the financial loss. The hospital was so overcrowded that, on average, 9,000 patients were turned away or transferred to other hospitals annually due to lack of space.[207] Primarily a hospital that saw patients for acute concerns, its promise to provide care to all those who sought it became an increasingly more difficult one on which to deliver during the 1960s.

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[201] Refer to Figure 2 in the first chapter.

[202] Joseph G. Molner, and Vlado A. Getting, "Medical Care Functions of the Detroit Health Department," *American Journal of Public Health* (July 1955): pp. 855-861

[203] Ibid.

[204] Detroit Medical Center, "Our Locations: Detroit Receiving Hospital," https://www.dmc.org/our-locations/detroit-receiving-hospital (accessed April 12, 2019).

[205] Letter from Charles Anderson to Jerome P. Cavanagh, May 24, 1962. Box 66, Folder 14: Hospital Study and City-County Personnel Interchangeability Committee. Jerome P. Cavanagh Collection, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

[206] Ibid.

[207] Ibid.

In 1962, the operating cost of Detroit Receiving was approximately ten million dollars, and the city was able to recuperate only about six million.[208] City taxes provided 1.9 million dollars of this hospital's funding, and Wayne County designated four million dollars annually to Detroit Receiving in exchange for taking all of the county's indigent patients. This made the hospital not only Detroit's municipal hospital, but also the county's, doing little to minimize its overcrowding problems.[209] Detroit Receiving's leaders assumed in its budget that patient fees would make up the remaining four million dollars in operating costs, although that consistently fell short; the majority of Detroit Receiving's patients could not pay.[210] The problems at this hospital were cyclical; increasing unemployment and poverty meant fewer privately insured and more indigent patients, and with fewer public funds to pay for these patients, the hospital sank further into debt.[211] The growing challenges at Detroit Receiving were due, in no small part, to the changing demographics of the city and its residents' increasing poverty.

The Changing Landscape of Detroit

The demographic changes in Detroit during the period immediately following World War II are well known.[212] But lesser studied are the declining health statuses of the Detroit residents that remained living in the city. Jobs in Detroit, especially during the period of highest population before World War II, were largely manufacturing with

[208] Ibid.
[209] Ibid.
[210] Ibid.
[211] Derickson, *Health Security for All.*
[212] Sugrue, *Origins of the Urban Crisis* and Freund, *Colored Property.*

strong union bases that included access to health insurance as part of the employees' wages.[213] Immediately after the war, Detroit's manufacturing jobs moved out to the suburbs—as did many of their workers, leaving behind large numbers of unemployed workers without access to health insurance. In 1954, inner city Detroit—the neighborhood of the eventual DMC—had an infant mortality rate of 33.9 per one thousand births. [214] By this point, the neighborhood was solidly black. Residents in this area experienced death rates from pneumonia and influenza of 37.5 per one thousand persons, and a tuberculosis death rate of 27.9 per one thousand persons.[215]

While inner-city black residents were getting sicker, the gap between the health status of these residents and their white counterparts was increasing. In the northwest corner of the city where many middle-class white Detroiters resided, the infant mortality rate was 16.6 per one thousand, while deaths from pneumonia and influenza occurred at a rate of 6.0 per one thousand. In this area, there were no deaths from tuberculosis.[216]

These trends in health disparities worsened throughout the 1960s. In 1962, inner-city Detroit saw a rise in infant mortality to 43.5 per one thousand individuals. The death rate from pneumonia and influenza increased to 72.1 per one thousand individuals, though there was a slight decrease in tuberculosis deaths to 24.6 per one thousand cases.[217] In the northwest corner, there were only ten infant deaths for every one thousand babies born. The death rate from pneumonia and flu of was 15.4 per one

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[213] Klein, *For All These Rights.*

[214] Detroit Medical Center Committee, "Appendix II Detroit Department of Health Statistics: Hospital Area Redevelopment: Outline of Factors Involved in the Redevelopment of the Hospital Area, 1954." (July 1955).

[215] Ibid.

[216] Ibid.

[217] Detroit Health Department, "Vital Events Which Occurred to Detroit Residents in 1962, Detroit Public Health and Hospitals Annual Report," 81st Edition, 1962.

thousand individuals, and the death rate of tuberculosis was 5.4 per one thousand cases.[218]

The inner city was unhealthy. People were dying from diseases for which there were effective therapies provided the patient could see a physician early enough, such as antibiotics in the case of pneumonia and tuberculosis. In Detroit's inner city, barriers prevented poor Detroiters from accessing primary care, with deadly consequences. These barriers to access included a lack of insurance as unemployment continued to rise, and the move of physicians to private offices outside of inner-city Detroit—inaccessible to many Detroiters without reliable transportation.[219]

Between 1942-1962, the number of patients who came to Detroit Receiving had increased 150 percent, although the proportion of private paying patients were steadily decreasing.[220] The unemployment rate, gradually increasing in the United States since World War II, resulted in increasing numbers of the medically indigent. In strong union cities like Detroit, insurance was typically linked to employment so as workers lost their jobs, they also lost their health insurance.[221]

The Medically Indigent and the Reliance on Detroit Receiving

As access to physicians grew more difficult, the emergency room at Detroit Receiving was becoming the source of primary care for many Detroiters. In September

[218] Ibid.

[219] Letter from William G. Milliken to Gerald R. Ford, February 8, 1975. Box 18, Folder: Michigan (2). James E. Falk Files, Gerald R. Ford Presidential Library, Ann Arbor, Michigan.

[220] Letter from Charles Anderson to Jerome P. Cavanagh, May 24, 1962. 66, Folder 14. Cavanagh Collection, Reuther Library.

[221] Klein, *For All These Rights.*

1964, the emergency room at Receiving saw 2,351 patients. The medical staff reported that only 751, or one-third of these were actual medical emergencies.[222] The situation at Detroit Receiving, and in the inner city more generally, was in part due to a shortage of primary and preventative healthcare services at other locations in the inner city. Medical students were increasingly choosing their medical residencies and careers in procedure-heavy specialties like cardiology, oncology, and radiology because there were greater opportunities for reimbursement than in family and internal medicine.[223] Primary care provides the stopgap for patients, making emergency care only necessary for actual emergencies, but it is only truly accessible with adequate health insurance—and difficulties in understanding public insurance and differing reimbursement levels mean that it is often only privately insured patients who utilize primary care.[224] Physicians understood this, too, and placed their offices in places where they had a greater patient census and a higher number of insured patients, often far out of the inner city.[225] The lack of public transportation for residents between the city and its surrounding suburbs made it nearly impossible for indigent patients to reach these offices, even if these physicians would accept patients without insurance in the first place.[226] By the 1960s, only one out of every twelve thousand residents of inner city Detroit had access to a physician for their primary care needs.[227] Emphasizing the class and racial dimensions of healthcare access,

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[222] John W. Hushen, "Panel Tackles Confusion over ER," *Detroit News*, January 20, 1965. Box 257, Folder 7 Health Department 1965. Jerome P. Cavanagh Collection, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

[223] Dennis Archambault, interview by author. Detroit, MI, March 17, 2014.

[224] John S. O'Shea, "The Crisis in America's Emergency Rooms and What Can Be Done," *Executive Summary Backgrounder Published by The Heritage Foundation* 2092 (December 28, 2007).

[225] Ibid.

[226] Hushen, "Panel Tackles Confusion over ER," *Detroit News*, January 20, 1965. 257, 7 Health Department 1965. Cavanagh Collection, Reuther Library, Detroit, Michigan.

[227] Ibid.

by comparison, Oakland County, the mostly white, middle and upper-class community immediately north of Detroit's Wayne County, had one primary care physician for every three hundred people.[228]

Sociologist Michael Harrington has stated that these indigent patients in the early 1960s—some forty or fifty million in the United States—were "socially invisible" to the rest of America.[229] This "invisibility" meant that institutions like Detroit Receiving and other public hospitals across the nation became more important for the poor as a source for medical care. Public hospitals across the country provided care for the poorer and often uninsured folks in society, with higher concentrations of black and other non-white patients.[230] Voluntary hospitals, which were also not-for-profit (like the four hospitals of the proposed medical center), still saw many white patients who carried private insurance.[231] This, conflated with the migration of physicians to the suburbs left the hospital emergency room as the "primary source of care" for many who lived in cities across the United States.[232] Between 1954 and 1964, emergency room visits increased by 175 percent nationwide.[233] With these departments already stretched thin, this dramatic increase resulted in a drop in the quality of care offered, and unhappy and overworked physicians.[234]

City officials in Detroit seemed to realize that there were these differences in

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[228] Ibid.

[229] Michael Harrington, *The Other America: Poverty in the United States* (New York: Macmillan, 1962) cited in Rosemary A. Stevens, "Health Care in the Early 1960s," *Health Care Financing Review* 18:2 (1996): 11-22.

[230] Ibid.

[231] Ibid.

[232] Ibid.

[233] Ibid.

[234] MH Silver, "The Emergency Department Problem," *Journal of the American Medical Association*, 198:4 (October 23, 1966): 380-383.

healthcare access for people depending on their income level, if not their race. Mayor Cavanagh commented that there was a clear linkage between a person's health and their income level, calling poverty "one of the most serious deterrents to the improvement community health in Detroit."[235] He reiterated that his administration was dedicated to "the elimination of poverty from our midst," and that the "Department of Health has a vital role to play in this total effort."[236] As the largest operation of the Department of Health, Detroit Receiving was crucial in this fight.

Growing Challenges at Detroit Receiving

Despite the decrease in population for Detroit itself, the patient census and intake numbers at Detroit Receiving continued to grow. On its busiest days in the early 1960s, Detroit Receiving could see one thousand outpatient visits with an additional six-hundred-and-fifty emergency department patients.[237]

One of the biggest struggles the staff at Detroit Receiving faced was the electrical load the hospital's high patient amount had with its subpar infrastructure. It was not uncommon for tasks like surgery to be interrupted by power outages at the hospital, especially in the early 1960s.[238] It was also not unusual for what had become typical hospital tools, like x-ray machines and other diagnostic tools, to be unusable because of the inability of the electrical load to support such machines. This resulted in large

[235] Jerome Cavanagh, March 31, 1964. Box 141, Folder 141-6 Health, Board of. Jerome P. Cavanagh Collection, Walter P. Reuther Library of Labor and Urban Affairs, Detroit.

[236] Ibid.

[237] Ibid.

[238] "Hospital to End Surgery's Fear—A Power Failure," *Detroit Free Press,* July 28, 1963. Box 128, Folder 128-10 Board of Health-Newsclippings. Jerome P. Cavanagh Collection, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

backups and bottlenecks. In a complaint to Mayor Cavanagh about the conditions at Receiving, Health Commissioner Charles P. Anderson wrote:

> "When demands are the greatest, all appearance of order is lost. The halls are so crowded that it becomes a major problem to get from one portion of the outpatient division to another. There isn't space to wait at the registration desk, and it is almost impossible to pass the elevator area. Similar crowding occurs on the first, second, and third floors of the hospital."[239]

In 1961, almost ten thousand patients were turned away because the hospital was too crowded.[240] It was clear that for Detroit Receiving to survive, the physical space would need to be expanded to accommodate this growing population.

Detroit Receiving and the Detroit Medical Center

While Detroit Receiving's problems became worse in the 1960s, DMC planners had known about the strain at the city's municipal hospital at the development's inception. In 1960, external marketing consultants had suggested to the Medical Center Development Committee that Detroit Receiving be absorbed into the new medical center. This implied that these external consultants understood not only the importance of Detroit Receiving, but also the need of this hospital to operate in an adequate space. The consultants suggested that the DMC would be more successful with an integrated Detroit Receiving Hospital to serve as the emergency care and trauma care hospital in the new

[239] Anderson to Cavanagh, May 24, 1962. 66, Folder 14. Cavanagh Collection, Reuther Library, Detroit, Michigan.

[240] Ibid.

medical campus.[241] Despite this, throughout the 1960s officials refused to develop plans to incorporate Detroit Receiving into the new medical center.

The DMC plan in 1956 which used urban renewal funds to rehabilitate the land around four centrally located voluntary hospitals—Grace, Harper, Hutzel, and Children's—excluded plans for incorporation of the city's municipal hospital, despite the continued declining state of this hospital. Planners stated that this was due, explicitly, to a lack of space in the development.[242] The DMC plans had already zoned all land surrounding the four hospitals for housing for the medical staff they hoped would live near these hospitals.[243] But implicitly, critics like boosters from the Detroit Health Department believed that it was because of the difference in clientele, and therefore perceived reputation, of Detroit Receiving and the future DMC hospitals.[244] Success of the new DMC was dependent on attracting private paying patients to this campus; the Medical Center Development Committee feared that association with Detroit Receiving would make this less likely to happen.

Detroit Health Commissioner Anderson saw any medical center development that did not prioritize Detroit Receiving Hospital as a mistake.[245] However, realizing the limitations of his solo advocacy, Anderson was hopeful that the new DMC, built about two miles north of Detroit Receiving with talk of a potential wing of four-hundred beds

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[241] Ibid.

[242] Susan d'Olive Mozena, interview by author. Wayne, MI, March 27, 2014.

[243] Detroit Medical Center Committee, A Proposal for A Detroit Medical Center, May 23, 1956. Box 142, Folder 4-University City. Jerome P. Cavanagh Collection, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

[244] Susan d'Olive Mozena, interview by author. Wayne, MI, March 27, 2014.

[245] Anderson to Cavanagh, May 24, 1962. 66, Folder 14. Cavanagh Collection, Reuther Library, Detroit, Michigan.

built for "charity" patients, would help to lessen the burden at Detroit Receiving. Undoubtedly he hoped, this would provide more space for patients who frequented Detroit Receiving to gain access to the new DMC.[246] Anderson understood the changing demographics of the city of Detroit, and saw the growing poverty issues in the city of Detroit as being a signifier to more people needing care at places like Receiving, stating:

> "It is my personal believe that if this population change continues at the same rate, by the time the new medical center is completed there will be a need for it and old Receiving with the same present level of service being offered at both places."[247]

It was the understanding of Commissioner Anderson and the rest of the Detroit Board of Health—and also the community it served—that the public funds from urban renewal that were being spent on the development of the DMC would mean that public patients would be welcomed at this hospital.[248] This eased some anxiety, as Anderson understood that both the DMC and Receiving would have to work in tandem to meet the needs of this population of patients. In practice, however, DMC planners continued to prioritize economic imperatives over community health needs by limiting the number of indigent patients the DMC would accept. The result was increased pressure and patient load on Detroit Receiving. One case that demonstrates this is the discussion of the formal removal of psychiatric patients at Detroit Receiving Hospital.

Psychiatric Patients at Detroit Receiving

[246] Ibid.
[247] Ibid.
[248] For more information on this fight, see the first chapter of this dissertation.

One in ten patients at Detroit Receiving were hospitalized for mental health services—a three percent increase from 1960-1963.[249] Black patients were diagnosed with serious mental illnesses like schizophrenia at higher rates during the post-war period because of the correlation of this disease with markers of stereotypical blackness, like aggression and impulse control, as historian Jonathan Metzl has shown.[250] Because Detroit Receiving's patients were predominantly black, increasing diagnoses of mental health in this population could explain the increasing incidence at Detroit Receiving. Additionally, hospitals in Wayne County were expanding the reimbursement criteria for mental health diagnoses. At hospitals in Wayne County, the county health department had categorized any hospitalization from violence, substance abuse, or some accidents as a mental health issue.[251] Both of these factors contributed to the increase in mental health hospitalization in Detroit in the early 1960s.

More than seven thousand psychiatric patients were admitted to Detroit Receiving annually in the early 1960s. As James Graves, the Director of Psychiatry at Detroit Receiving Hospital, admitted, the "psychiatric needs of the community are growing and are likely to do so for many years to come."[252] This hypothesis was informed in no small part by the change in city population and economic status that he had observed. The area surrounding Detroit Receiving Hospital was the most "blighted" in the city, and crimes

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[249] Summary Report of the Temporary City-County Mental Health Committee, November 8, 1963. Box 182, Folder 192-9 Det-Wayne Co. Jerome P. Cavanagh Collection, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

[250] In Metzl's study, this increasing diagnosis was a specific response to civil rights activism. Jonathan Metzl, *The Protest Psychosis: How Schizophrenia Became a Black Disease,* (New York: Beacon Press, 2010).

[251] JoAnn Hardee, "Seek Aid for Children's Mental Health Clinic," *The Detroit News*, January 11, 1963. Box 128, Folder 128-12: Proposed Transfer of Receiving Hospital Psychiatric Division to Wayne County (Board of Health). Jerome P. Cavanagh Collection, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

[252] Letter from James Graves to Richard Strichartz, June 25, 1962. Box 66, Folder 13-Herman Kiefer Hospital. Jerome P. Cavanagh Collection, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

like drugs and sex work—now categorized by Wayne County as forms of mental illness—were visible throughout the city.[253]

Dr. Graves was particularly concerned about the greater burden of psychiatric care, because the psychiatric ward at Detroit Receiving had not been updated since 1927 despite the growing needs of this population.[254] This resulted in a shortage of beds for these patients, and an increasingly taxed staff resulting in lower quality care. There were also no current plans to invest in the hospital's psychiatric services; finances were tight, and the amount of money this facility was getting from Hill-Burton funds were already slated for other projects, including expansions at all four hospitals of the proposed DMC.[255] For Graves, the increasing psychiatric needs of the community would tax Detroit Receiving's already over-burdened psych services.

Psychiatric patients had long been ignored in the provision of care in Detroit. While the city and county policies favoring private patients implied that patients in poverty were less important generally, psychiatric patients carried an additional level of stigma. Dr. Graves noted this, and advocated for improved psychiatric hospitals stating:

> "A vital choice must be made now that will affect the development of psychiatric services in Detroit or the rest of the 20th Century. It would be tragic if this increasingly important public service were once more, as it has been for so many decades, neglected and exposed to callous indifference by those municipal officials responsible for the quantity and quality of mental health services in Detroit."[256]

[253] Ibid.
[254] Ibid.
[255] Ibid.
[256] Ibid.

The choice Dr. Graves was referring to was how to afford to pay for psychiatric patients. It was becoming untenable to meet their needs at the increasingly decrepit Detroit Receiving. Ultimately, the care of psychiatric patients at Detroit Receiving cost the city one and half million dollars a year; the city was able to collect about half of that back from other government agencies, insurance companies, and private pay, resulting in an annual deficit of about seven-hundred fifty thousand dollars a year—the greatest of all services provided in the city.[257]

Mayor Cavanagh, City Council, and representatives from the Board of Health believed that reducing the number of patients receiving psychiatric care at Detroit Receiving was the best way to control its costs. To do this, city officials believed that moving psychiatric services from Detroit Receiving would be the best option—a move that would save the city money and free up space at Detroit Receiving for other services. One potential solution was to close the tuberculosis wing at the nearest county hospital, Herman Kiefer, as tuberculosis beds became less needed into the 1960s due to the availability of antibiotics to treat this disease.[258] Mental health, in contrast to tuberculosis, was becoming an "increasing public health problem."[259]

In addition to the extra space this would afford the city at Detroit Receiving, the move to Herman Kiefer, a Wayne County hospital, would mean that the county would assume responsibility for these patients—not the city.[260] But first, rehabilitation of the

[257] Letter from Charles Anderson to Gerald H. Starkey, September 1, 1964. Box 141, Folder 2, September. Jerome P. Cavanagh Collection, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

[258] John F. Murray, Dean E. Schraufnagel, and Philip C. Hopewell, "Treatment of Tuberculosis: A Historical Perspective," *The Annals of the American Thoracic Society* 12:12 (December 1, 2015).

[259] Graves to Strichartz, June 25, 1962. 66, 13. Cavanagh Collection, Reuther Library.

[260] Ibid.

space at Kiefer would have to adequately support and house these patients, or else the problems of Receiving would simply replicate at this new hospital. City Council in collaboration with county officials developed a plan was to use Hill-Burton funds for a pediatric psychiatric wing that would provide both service, and run a fund-raising drive from local nonprofits.[261] To complete the fifth floor where these psychiatric services would be housed at Herman Kiefer, the city still needed $250,000. The plan's authors gave no indication of how they would pay for the rehabilitation of the sixth floor where the adult psychiatric services would be offered.[262]

Mayor Cavanagh did not support this plan, however. For Cavanagh, the costs to renovate Kiefer would create even greater deficits to the city's finances. Instead, the mayor's office developed an alternative plan to move psychiatric emergency patients to Wayne County General Hospital, where the rest of Wayne County's psychiatric patients were treated. This hospital was in Inkster, about a thirty-minute drive from Detroit Receiving.[263] This plan was only supported by the mayor and his immediate staff; it did not have the support of City Council or Wayne County officials.[264]

These opponents believed that this move would not adequately address the underlying problem of overcrowding, since those in the surrounding community experiencing psychiatric crises would still come to Detroit Receiving first, if nothing else, out of habit.[265] Additionally, there was concern that this would diminish the level of care

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[261] Letter from Richard Strichartz to Ray Girardin, June 26, 1963. Box 66, Folder 13-Herman Kiefer Hospital. Jerome P. Cavanagh Collection, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

[262] Ibid.

[263] Ibid.

[264] Ibid.

[265] Letter from J. Gottlieb to Jerome Cavanagh, April 12, 1963. Box 82, Folder 18-Detroit Receiving Hospital. Jerome P. Cavanagh Collection, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

provided to already-needy patients by discouraging care—there was no public transportation from the center city to Wayne County General Hospital, and if a person was experiencing a psychiatric emergency, even if they owned a car, it would be unsafe for that patient to drive. Because of this, critics saw this as a plan intended to remove undesirable patients from Detroit altogether. Dr. J. Gottlieb, President of the Michigan Neurology and Psychiatry Society and director of Psychiatric Emergencies at Detroit Receiving, wrote to Mayor Jerome P. Cavanagh regarding this plan, stating:

> "the innumerable problems will be well beyond the savings in costs, which is evidentially the motivation for this consolidation. Many patients we see are homicidal or suicidal. These patients would still find their way to the hospital, even if on other services and require at least a consultation service."[266]

He added, identifying what he believed to be the main motivation for such a move, "It is impossible to wish away a patient population."[267] Still, Mayor Cavanagh's office believed that this would be the solution that would best address the needs of city residents because it would make the least impact on the city's and county's finances.[268]

Moving psychiatric patients to Wayne County General Hospital was not a popular choice among city residents either, with residents in the surrounding neighborhood calling "shipping them off…outdated."[269] Community members cited the size of the city of Detroit—at this point well over 1.5 million residents—and the growing problem of drug addiction as reasons why Detroit needed to prioritize psychiatric emergency services

[266] Ibid.
[267] Ibid.
[268] Ibid.
[269] Letter from Marcelle Mason to Jerome Cavanagh, April 16, 1963. Box 82, Folder 5-Board of Health. Jerome P. Cavanagh Collection, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

within the City of Detroit.[270] The Detroit Medical Society, a group of black physicians intensely opposed to the move, criticized Cavanaugh's policy as a racist and classist move to displace the neediest patients seen at Detroit Receiving.[271]

Opponents also invoked the surrounding community's safety as a reason to continue care at Detroit Receiving. Police cars drove patients in psychiatric emergencies to this hospital to "protect them and the public," and this service would not be able to continue if the patients were moved to Wayne County General Hospital.[272] Residents were also concerned that this move to save money was shortsighted, and would result in greater burden on other areas, like the Detroit Police Department. If a patient could not get a ride out to Wayne County General Hospital, the Detroit Police Department, according to the Travelers Aid Society of Detroit, would:

> "be placed in the position of having to provide shelter for emergency psych patients, since police stations and the jail would necessarily be the resource for dangerously mentally ill people. This would not only be a return to the practice of a century ago…but would add a great burden to an already understaffed and overworked police department."[273]

City officials all agreed that Detroit Receiving was not able to accommodate psychiatric patients in its current state, but there was still contention about where these patients should be moved. John Graves, a professor at Wayne State University School of

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[270] Letter from Thomas Petty to Jerome Cavanagh, December 15, 1962. Box 83, Folder 18-Receiving Hospital (Board of Health Subfile). Jerome P. Cavanagh Collection, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

[271] "Drop Plans to Shift Patients from Receiving to Wayne County General Hospital," *Detroit News,* August 5, 1963. Box 128, Folder 128-12 Proposed Transfer of Receiving Hospital Psychiatric Division to Wayne County (Board of Health). Jerome P. Cavanagh Collection, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

[272] Letter from Agnes A. Jackson to Jerome P. Cavanagh on Behalf of the Travelers Aid Society of Detroit, April 17, 1963. Box 83, Folder 19-Receiving Hospital. Jerome P. Cavanagh Collection, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

[273] Ibid.

Medicine and physician at Detroit Receiving Hospital, suggested that "no enlightened medical educator can long remain ignorant of the fact that a psychiatric unit is most essential for general hospital unity and is not well considered to be detachable," arguing that there could be no movement of these patients because psychiatric care was so essential to providing any sort of general care for residents.[274] Other critics warned that this move would be no way to establish Detroit as a leading city in any way, calling it "medieval, going back to the Dark Ages," since no other major city in the United States did not have an emergency psych unit.[275] Administrators tried to appeal to officials' humanity, likening emergency psychiatric care to getting into a car accident, emphasizing that anyone could find themselves needing psychiatric care, regardless of class, educational status, or race.[276]

Mental health advocates and physicians at Detroit Receiving argued that patients should not be moved to Wayne County General Hospital over thirty miles away from Detroit Receiving because it "would cut the ties between patients and relatives, between the staff and the Wayne State University School of Medicine, and discourage community social agencies from work they now perform."[277] For them, the move to Herman Kiefer was preferable.[278] But the discussions at the internal committee meetings discussing these

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[274] Graves to Strichartz, June 25, 1962. 66, 13. Cavanagh Collection, Reuther Library.

[275] Warren Stromberg, "Receiving Official Assails Planned Mental-Care Move: County Hospital Proposed as Site," *Detroit Free Press*, May 12, 1963. Box 128, Folder 128-12 Proposed Transfer of Receiving Hospital Psychiatric Division to Wayne County (Board of Health). Jerome P. Cavanagh Collection, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

[276] Ibid.

[277] Don Hoenshell, "Mental Patients Encouraged by Truce in Receiving Rose," *Detroit News*, October 20, 1963, page 4B. Box 83, Folder 19-Receiving Hospital. Jerome P. Cavanagh Collection, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

[278] "County Hospital Bars City's Mental Patients, Mayor Says," *Detroit News*, May 24, 1963. Box 128, Folder 128-12 Proposed Transfer of Receiving Hospital Psychiatric Division to Wayne County (Board of Health). Jerome P. Cavanagh Collection, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

moves was tumultuous; at the "height of the fight," the *Detroit News* reported that the entire staff at Detroit Receiving planned to resign.[279] Many in the city government, including Anderson himself, preferred the move to Wayne County General Hospital because it would cost the city "virtually nothing."[280] On the other hand, remodeling a wing to make it work for psychiatric patients at Herman Kiefer would cost upwards of an estimated three-hundred fifty thousand dollars, the source of these funds was uncertain.[281]

While even Anderson admitted that staying at Receiving was untenable because of inadequate space, Mayor Cavanagh told constituents that "much more [was] at stake than the saving of money…[he was] much more interested in helping human beings who need help than in attempts to cut costs," a position that leadership at Detroit Receiving like Dr. Gottlieb found less than convincing.[282]

There is no explicit evidence in the sources to indicate why Cavanagh was so opposed to a move to Herman Kiefer instead pushing for the move of psychiatric patients to Wayne County's hospital. However, we must view his motivations in the context of his desire to be on the national public stage, which required support from the wealthier suburbs and outstate.

Jerome Cavanagh was elected in 1961 in no small part due to the overwhelming support of Detroit's black community. Cavanagh told this constituency that he recognized

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[279] Don Hoenshell, "Mental Patients Encouraged," *Detroit News,* October 20, 1963. 83, 19. Cavanagh Collection, Reuther Library, Detroit.

[280] Ibid.

[281] Ibid.

[282] Meeting in Mayor's Conference Room regarding the Proposed Transfer of Psychiatric Division from Receiving Hospital to Wayne County General Hospital, July 15, 1963, and Letter from Ray Girardin to Thomas A. Petty, December 18, 1962. Box 83, Folder 18-Receiving Hospital (Board of Health Subfile). Jerome P. Cavanagh Collection, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

the changing demographics of the city and would be a mayor that worked to center the black community in his decisions about the future of this city. This resonated with Detroit's black voters, especially after the Cobo and Miriani Administrations. Mayor Cobo razed black neighborhoods in the name of progress, and black Detroiters believed that Mayor Miriani condoned police brutality. By 1960, about thirty percent of Detroit's population by 1960 was made from black residents.[283] Once entering the mayoral office, due in no small part to Detroit's black voters, it became clear that Cavanagh had higher political aspirations. Quickly befriending President Kennedy, and then later Johnson, Cavanagh was often on the short list for political appointments for both men, and had ambitions of achieving a Governorship or serving as one of Michigan's Senators.[284] When Cavanagh was encouraged by President Johnson to run for Senate in 1966, he lost handily and did not even carry Detroit.[285] Perhaps Mayor Cavanagh, in order to achieve his political ambitions, realized that he needed to politic outside of the city and sought to garner goodwill outstate and throughout greater Wayne County. Moving these psychiatric patients away from the city center—which city officials saw as a destination for suburbanites and white, college-educated families for both living and tourism—would perhaps "clean up" one of the city center's biggest problems and result in a more welcoming environment for those Cavanagh hoped to court. Perhaps he was, as Graves had suggested, "wishing away" this population.

[283] Tim Kiska, "The Election and Downfall of Jerome Cavanagh," *The Detroit History Podcast*, Episode 7, March 11, 2018.

[284] Michael D. Barone, "Cavanagh on the Make," *The Harvard Crimson.* December 11, 1965. https://www.thecrimson.com/article/1965/12/11/cavanagh-on-the-make-prumor-has/ (accessed March 18, 2019).

[285] Kiska, "The Election and Downfall of Jerome Cavanaugh."

At no point during this contentious discussion did anyone from the city government, Wayne State University, or activist groups suggest moving the growing number of the city's psychiatric patients to the DMC. This seems like a blind spot—the patients at Detroit Receiving that were of concern to this group were public patients, and the hospitals of the DMC were receiving a significant amount of public funds for expansion to serve the city. Additionally, administrators at Wayne State School of Medicine were actively seeking to establish a deeper relationship between the university and these hospitals; providing a solution for the city on where to care for their psychiatric patients seems an obvious solution. However, the stigma of this population—not only as a group of indigent patients but also dangerous, violent, and deeply misunderstood—did not fit the vision of who should utilize the DMC for their care. It seems intentional that this development was never considered for the care of these patients, despite the hope that the hospitals of the DMC would share some of the burden of Detroit Receiving's service to its surrounding community.

The concern over what to do with psychiatric patients at Detroit Receiving is illustrative of how the focus on the development of the DMC continued to create a dual system of care despite medical center boosters claiming that this construction would work to remedy health problems in Detroit. Patient dumping was proof that the DMC construction did not resolve this issue, especially for vulnerable patient populations like Detroit Receiving's psychiatric patients. While the four hospitals of the DMC very near Detroit Receiving were getting a large influx of public funds to remodel and expand their buildings, there was never a realistic chance that psychiatric patients could be cared for at

these hospitals. It was likely never considered because of the tacit understanding that while the new DMC was to be a hospital campus that treated all, it was not intended for indigent, needy patients, especially those in psychiatric distress. This tension between rhetoric and practice is made evident by the frequent dumping practices at the hospitals of the DMC.

Dumping, still a concern in many major American cities today, occurs when a hospital transfers an indigent patient to a city's public hospital or another medical center of "last resort." This way, the private hospital does not have to absorb the costs of a patient who is unable to pay. Throughout the 1960s, Detroit Receiving staff would frequently find an abandoned patient, often in a hospital gown or with minimal clothing, on the curb outside of their hospital's Emergency Department. Detroit Receiving staff conducted investigations to find that these patients most often came from the hospitals of the DMC. Dumping was a way for the DMC hospitals to avoid lower levels of reimbursement from "unattractive" patients without obviously breaking the law.[286]

Perhaps because dumping was already such a concern for Detroit Receiving, activists had correctly identified that in a psychiatric emergency, patients would still come to this hospital regardless. Because of this, the city ultimately decided to keep psychiatric patients at Detroit Receiving. In April of 1963, Mayor Cavanagh approved a 1.2-million-dollar expenditure to update and expand the psychiatric ward to keep these patients at Detroit Receiving. This solution came with the caveat that if their stay

[286] "Demand Probe of Blue Cross Policy," *Michigan Chronicle*, 25 Dec. 1965. Box 83, Folder 83-38 Committee on Hospital Utilization 1966. Detroit Commission on Community Relations/Human Rights Department Collection—Part 3, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

extended five days, they would be transferred to Wayne County General Hospital.[287] City officials knew that this was a short-term fix for a growing problem, however, and so they continued to look for ways to lessen the financial and physical strain on Detroit Receiving to keep this hospital open for as long as it possibly could. One way to do so was formalizing the long-standing relationship between Detroit Receiving and the growing Wayne State University School of Medicine.

University City

In the early 1960s, as plans to develop the DMC were underway, the city started a second federally funded urban renewal plan. Located close to the site of the DMC, University City was a project to expand and redevelop the campus of Wayne State University. By 1961, the city had secured over eighty million dollars in federal urban renewal funds for this project that would further develop the campus around Wayne State University.[288] Wayne State had only become a university recently under a 1958 Federal Act which provided more public funds for increased scientific research and an increase in the student body.[289] Already at this time, the health services programs were among the strongest at this institution, and the city and state wanted to capitalize on this.

[287] Don Hoenshell, "Mayor Backs Plan to Shift Mental Patients to County," *Detroit News,* April 11, 1963. Box 128, Folder 128-12 Proposed Transfer of Receiving Hospital Psychiatric Division to Wayne County (Board of Health). Jerome P. Cavanagh Collection, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

[288] Letter from William L. Slayton to Jerome P. Cavanagh, "Planning Advance of $80,969 Approved for University City Urban Renewal Project No. 1." 1961. Box 62, Folder 25-Urban Renewal Department Council. Jerome P. Cavanagh Collection, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

[289] Frank X. Tuohey, Press Release, December 21, 1963. Box 240, Folder 240-3 Wayne State University. Jerome P. Cavanagh Collection, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

The University City development would secure twenty acres within the DMC for the larger and relocated medical school and a new, four million dollar medical research building.[290] While this was the first stage of development, the final project would total over three hundred acres with planned completion by 1975; this additional land would be used for full university expansion, residences, and commercial development. This expansion was part of a plan for an increased enrollment at Wayne State from twenty-thousand in the 1960s—a mid-sized university—to over forty-thousand by 1975, making it one of the largest universities by enrollment in the country.[291] DMC planners were involved from the beginning of the University City project, hoping that the medical school expansion that was central to this plan would facilitated a closer partnership for graduate medical education.[292] Wayne State University already had an existing relationship with Detroit Receiving, but the increase in enrollment at the medical school would necessitate additional training sites. However, the continued stigma of Detroit Receiving and its patient population made DMC officials leery of an official partnership.

Wayne State at Detroit Receiving

While an informal relationship had existed between Wayne State and Detroit Receiving for years, allowing medical students to receive hands-on clinical training, in 1962, the School of Medicine recognized that the "increasing responsibilities and

[290] Notes on Research Park, the Medical Center, and University City Urban Renewal Projects, undated (circa 1962). Box 62, Folder 29-Urban Renewal. Jerome P. Cavanagh Collection, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

[291] Ibid.

[292] Ibid.

complexities of patient care and the continued growth of the College of Medicine" required formal affiliation.[293] The school's leaders stated that that the "chief purpose of such an agreement [was] to ensure that the patients in Receiving Hospital receive the highest standard of medical care" and that "medical students, interns, and residents receive the best teaching and training."[294] The agreement, which was finalized in 1962, made "all members of the [Detroit Receiving] professional staff" faculty at Wayne State University—a typical facet of such agreements.[295] Wayne State paid these employees' salaries, saving Receiving several hundred thousand dollars annually. Administrators at Detroit Receiving were hopeful that this would relieve the hospital's current financial woes.[296] There seemed to be few downsides to such an agreement. But already by 1962, the formal affiliation was threatened by accreditation concerns that came with the decrepit state of this hospital. This of course was detrimental to the continued educational opportunities available at Detroit Receiving.[297] In particular, Detroit Receiving was in risk of losing its accreditation to space and building safety concerns.[298] The only way to address these issues was to prioritize building rehabilitation and expansion.

Leadership at Detroit Receiving had begun advocating and planning for an expansion to provide education at the hospital since before the start on the University City project had officially begun. In 1951, when the Department of Health took over

[293] Affiliation Agreement Between Wayne State University and the Board of Health of the City of Detroit, 1962. Box 66, Folder 12-Board of Health. Jerome P. Cavanagh Collection, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

[294] Ibid.

[295] Ibid.

[296] Ibid.

[297] Hospital Study and City-County Personnel Interchangeability Committee Meeting Minutes, April 17, 1962. Box 66, Folder 14-Hospital Study and City-County Personnel Interchangeability Committee. Jerome P. Cavanagh Collection, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

[298] Ibid.

Receiving Hospital from the Welfare Department, the city set aside 7.7 million dollars for expansion, capital improvements, and equipment at the hospital.[299] The Board of Health had planned to expand the Emergency Department in 1951 into a teaching auditorium, which had provided extra space only for lectures since it was "practically unknown for large teaching hospital[s] affiliated directly with a medical school to operate without such accommodations."[300] As proposed in 1951, the auditorium was estimated to cost five thousand dollars, but the construction never happened, presumably because the funds were never actually secured.[301]

After the formal agreement was reached between Detroit Receiving and Wayne State in 1962, city officials knew that they needed to deliver on the plans for expansion to provide a teaching space for the students that the University City development would bring in. While the building improvements were needed at Detroit Receiving regardless of its affiliation with Wayne State and the University City project, this provided the impetus for city planners to prioritize this construction.

In a report to City Council in 1964—two years after the formal agreement between Detroit Receiving and Wayne State began—Commissioner Anderson noted that the conditions had "reached the point of such terrific overcrowding, which was a definite threat to the health and safety of patients in these areas."[302] When city planners developed their plan for Detroit Receiving expansion in January 1964, the costs for this construction

[299] Letter from J. Hanlon to Richard Strichartz, November 4, 1964. Box 141, Folder 4-November. Jerome P. Cavanagh Collection, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

[300] Address from Charles Anderson to Common Council, August 18, 1964. Box 141, Folder 141-1 August 1961. Jerome P. Cavanagh Collection, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

[301] Ibid.

[302] Ibid.

had increased greatly since 1951; the City Engineer estimated the cost at twenty-five thousand dollars with air conditioning, or fifteen thousand dollars without.[303] The Board of Health, responsible for this construction, had secured some of this funding: five thousand dollars from the Receiving Hospital Research Corps, seven thousand dollars from the School of Medicine, five hundred dollars collected from private donations from residents themselves, and thirty-five hundred dollars in additional individual contributions.[304] Anderson approached Common Council to pay for the remaining six thousand dollars under the justification that the Board of Health already had approved a five thousand dollar expenditure in 1951, and they had never received those funds.[305] The city had already promised to provide the labor for the construction of the auditorium.[306] No additional funds or support were given by the city for this proposal; Mayor Cavanagh noted that he did not believe that this expansion was a good use of the limited funds of the Detroit Board of Health.[307] This lack of prioritization of the standards of an adequate teaching hospital put the accreditation of Detroit Receiving continually at risk.

During the early 1960s, the physical integrity of Detroit Receiving Hospital continued to get worse. In early 1963, the building had developed a slant, which on higher levels caused chairs and pens to roll on the ground. Workers joked that the hospital would "probably slide into a sewer within two years."[308]

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[303] Ibid.
[304] Ibid.
[305] Ibid.
[306] Ibid.
[307] Ibid.
[308] Don Hoenshell, "Mental Patients' Transfer Weighted," *Detroit News,* March 8, 1963. Box 128, Folder 128-12 Proposed Transfer of Receiving Hospital Psychiatric Division to Wayne County (Board of Health). Jerome P. Cavanagh Collection, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

Accreditation Crises

At the time of the next inspection in early 1964, Detroit Receiving received a probationary status from the Joint Commission on Accreditation because the overcrowding issues and lack of building updates from the 1962 probationary accreditation had not been addressed.[309] This meant that patients were being treated for emergencies, delivering babies, and (if they were one of the patients from the local prisons that used Detroit Receiving for care) restrained to radiators and pipes in hallways and waiting rooms.[310]

The Detroit Receiving staff were devastated by the probationary status. It was not the first time that their accreditation had been called into question, but this time the consequences were higher; losing accreditation meant that the hospital would lose its entire medical staff through an elimination of its partnership with Wayne State School of Medicine residency program, and no longer be able to operate at all. At this point, it became critical for city officials to address these struggles; the expansion of the medical school depended on Detroit Receiving's ability to provide training opportunities. If Detroit Receiving lost its accreditation and closed, it would put the expansion of the medical school at risk and threatened the very viability of the University City development.

[309] Memo from Booz, Allen & Hamilton Management Consultants to John Hanlon, December 15, 1965. Box 269, Folder 7 Board of Health. Jerome P. Cavanagh Collection, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

[310] Letter from Mattie J. Myers to Jerome Cavanagh, March 5, 1963. Box 82, Folder 3 Board of Health. Jerome P. Cavanagh Collection, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

Realizing the seriousness of this, Mayor Cavanagh and City Council approved funds for a renovated entryway and façade to Detroit Receiving—another short-term fix to a long-term problem. These two things were not identified as issues in the 1962 nor 1964 accreditation.[311] However, city officials' prioritization of this improvement seemed to highlight that their concerns with Detroit Receiving were only cosmetic. Detroit Health Commissioner James E. Franzen, who had replaced Charles Anderson when he left for a job in New York, was critical of the city's prioritization of the entryway and façade rather than expansions that would truly improve the outcomes for patients at Receiving, stating that for the City of Detroit:

> "It is far more important to care for the physical condition of the indigent than it is to have a pretty façade on a building. Receiving Hospital, which offers such good medical care, is always the first to get public criticism and the last to get financial help."[312]

Others, like the head city planner Francis P. Bennett, said that attention to the entryway was necessary because the entrance to Detroit Receiving was a "disgrace," and that the new addition would stop the "gathering of people on the steps of the present entrance, the litter that collects in two courtyards away and the danger of undesirable persons lurking after dark in the entranceway."[313] As a peace offering, Mayor Cavanagh in December 1964 set aside fifteen thousand dollars for a study for hospital construction at Detroit

[311] Memo from Booz, Allen & Hamilton Management Consultants to John Hanlon, December 15, 1965. 269, 7, Cavanagh Collection, Reuther Library, Detroit.

[312] JoAnn Hardee, "OK Plans for Addition to Receiving Hospital," *Detroit News*, February 6, 1964. Box 198, Folder 198-2 Board of Health. Jerome P. Cavanagh Collection, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

[313] Ibid.

Receiving in addition for the funds for an entryway addition.[314] Seeing no way out of the hospital's continuing problems, Mayor Cavanagh began to seriously push for a new Detroit Receiving Hospital in late 1964, when he asked Clyde Palmer, the City Engineer, to meet with Detroit Receiving Superintendent, Dr. Hanlon, to prepare a "comprehensive report on costs and other factors relative to the construction of a new Receiving Hospital in the Medical Center."[315]

In April 1965, Superintendent of Detroit Receiving Dr. Hanlon reported to the Joint Commission on Accreditation, asking that the one-year probationary period be lifted for a full three-year accreditation at Detroit Receiving. The fifteen thousand dollar needs assessment study that came as a compromise to the entryway and façade fiasco had proven to the city that much more funding needed to go to the hospital to resolve this crisis; Hanlon cited eight million dollars that the city had approved for the expansion of the hospital to go toward an auditorium and other teaching spaces, conversations about moving patients to alternative hospitals, and a higher salary offered to nurses to help eliminate the nursing shortage.[316] Hanlon emphasized that without accreditation, Detroit Receiving would cease to exist; Wayne State provided all staffing, and if this hospital folded, the hospitals of DMC would be unable to facilitate all the care necessary.[317]

The relationship with Wayne State and the subsequent actions by both the city

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[314] As We See It Editorial Board, "Hospital Need is Clear but What About Money?" *The Detroit Free Press*, December 5, 1964. Box 198, Folder 198-12 Board of Health. Jerome P. Cavanagh Collection, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

[315] Letter from Jerome Cavanagh to Clyde Palmer, October 22, 1964. Box 141, Folder 3-Oct. Jerome P. Cavanagh Collection, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

[316] Letter from John Hanlon to Denver M. Vickers of the Joint Commission on Accreditation, April 1, 1965. Box 211, Folder 2 Health, Board of. Jerome P. Cavanagh Collection, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

[317] Ibid.

and Detroit Receiving staff demonstrate again how urban renewal funds drove decisions in the city at this time, including decisions about indigent patients' care. Because University City was another project in the urban renewal pipeline, the future of Detroit Receiving became important for city officials—but only important enough to satisfy the conditions that the hospital remain open to serve as a training facility for Wayne State's School of Medicine, not to provide proper and adequate health care for those patients who relied on this hospital. This trend continued throughout the 1960s, as the city's focus remained on the hospitals of the DMC and not Detroit Receiving—the city seemed incapable of supporting both.

By 1965, things had gotten so dire at Detroit Receiving that hospital staff remained continually fearful of losing their accreditation due to the overcrowding that the 1964 front entryway expansion had not addressed. The hospital began checking to make sure that the patients that came to the emergency room were private patients. If an investigation from Detroit Receiving's billing department revealed that these patients were not private, and that there was an "inability of the patient to assume his fiscal responsibility," the staff at Receiving began taking advantage of a state law that placed the responsibility for indigent emergency hospitalization under the Wayne County Social Welfare Department at Wayne County General Hospital, and would transfer these patients to this hospital.[318] Even Detroit Receiving had begun dumping patients. This was because the hospital, and therefore the city, incurred "several millions of dollars…for patients who legally might be considered the responsibility of other governmental

[318] Letter from John Hanlon to Hank Gremore, January 6, 1965. Box 211, Folder 211-1, Health, Board of, 1965. Jerome P. Cavanagh Collection, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

jurisdictions."[319] This was the first time in the hospital's history where its actions were directly, and systematically, against its mission to provide care for all those in need regardless of their ability to pay.

A New Detroit Receiving Hospital

Mayor Cavanagh's decision to push for a new Detroit Receiving Hospital beginning in 1964 was a purely economic decision due to the hospital's necessity to retain accreditation to support Wayne State University School of Medicine. But as Detroit Receiving continued to decline through the mid-1960s, even young people who did not directly live in the area surrounding Detroit Receiving or the DMC were speaking out on behalf of those who depended on Detroit Receiving Hospital for their care. In 1964, high school students from suburban Detroit toured Detroit Receiving after their schools contacted the hospital to arrange a tour for students interested in the health professions.[320] Finding themselves "appalled at the conditions under which the staff must work," these students formed the Students for Practical Action through Community Effort activism group, or SPACE, believing "if we can afford to put a man in space, we can afford space for a man."[321] Recognizing the discrepancy between the physicality of Detroit Receiving and the investment in the DMC, these students advocated for a better use of the land around the medical center development, and suggested that the city could find space for a new municipal hospital on this campus. These students believed that

[319] Ibid.

[320] Letter from Harold Ballen to Jerome Cavanagh, April 11, 1964. Box 140, Folder 23 April Board of Health. Jerome P. Cavanagh Collection, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

[321] Ibid.

adequate health services were "vital to the community and to the growth of this dynamic city," but understanding the role that economic capacity building played in the new medical center development, they asked: "How much of this [revenue] ought to be spent on meeting some of the health problems of the people who were displaced by these urban renewal projects?"[322] They cited the city's willingness to spend twenty-five million dollars on a new stadium for the bid for the 1968 Olympic Games, and indicated that parts of the DMC development like wider streets and parking lots were "taking the place of lives" around Detroit Receiving rather than using that space for the hospital's expansion.[323] Noting the level of decline, student leader Patricia Mason stated that she would "rather stay at our new, modern jail than Receiving."[324]

SPACE submitted a proposal to Mayor Cavanagh suggesting that the city make, what they thought would be, better use of the space surrounding the DMC—a new municipal hospital. They believed that a newer, larger building serving the Receiving's patients would solve the old hospital's most pressing issues like wait times and poor conditions. Mayor Cavanagh did not agree with these students, nor did he take their proposal seriously, stating:

> "This is not a decision to be lightly made and I am sure you will understand my reservation in not wholeheartedly embracing this proposal…I think it is important for young people to be aware of community problems and try to inform themselves as you have. May I suggest you consider as an action project participation in summer tutoring for inner-city youngsters who have academic deficiencies as a means of helping the students in Detroit Public

[322] Ibid.

[323] Donna Calvin, "Student Seek 'Space for Man:' High Schoolers Ask Action to Expand Hospital Facilities," *The Detroit News,* April 15, 1964. Box 140, Folder 23 April Board of Health. Jerome P. Cavanagh Collection, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

[324] Ibid.

Schools."[325]

Perhaps deterred by Mayor Cavanagh's lukewarm reception to their activism, SPACE was not active past the summer of 1964. But in that same summer, Cavanagh reiterated his supported the development of a new Receiving, stating that:

> "Without modernization, hospitals cannot render good modern medicine unless these buildings and equipment are brought up to date by substantial alternations and installation of the most modern equipment made available by today's medical science."[326]

However, the mayor's verbal support was just that; there were still no formal plans to develop a new Receiving Hospital.

As of December 1964, the *Detroit News* and other media outlets were still unclear if there had been a new Detroit Receiving Hospital approved by the city, but "the need and inevitability [was] obvious."[327] They cited the continued threats of losing accreditation as a reason for the inevitability.[328] The *Detroit Free Press* struggled to identify where the funding would come for this new hospital, since city and county sources were "tied up with thorny problems of county indebtedness to the city, possible county home rule and the possible union of the city and county health department."[329] Once the mayor began to publicly advocate for the construction of a new hospital, rumors began to circulate in these newspapers about the incorporation of a new Detroit

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[325] Letter from Jerome Cavanagh to Patricia Mason, May 12, 1964. Box 140, Folder 24 May Board of Health. Jerome P. Cavanagh Collection, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

[326] Letter from Jerome Cavanagh to John J. Guenther, Executive Director of US Conference of Mayors, June 15, 1964. Box 141, Folder 141-9 The Greater Detroit Area Hospital Council (Bd of Health). Jerome P. Cavanagh Collection, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

[327] "Hospital Need is Clear But What About Money?" *The Detroit Free Press*, December 5, 1964. 198, 198-12. Cavanagh Collection, Reuther Library, Detroit.

[328] Ibid.

[329] Ibid.

Receiving Hospital into the DMC.[330] In response to these rumors, the staff and students at Wayne State School of Medicine submitted a resolution to Mayor Cavanagh to guarantee that they were involved in the entirety of planning of the new Detroit Receiving Hospital since they would be "responsible for patient care, education, and research."[331]

The Greater Detroit Area Hospital Council, a group of executives and administrators from the hospitals of the DMC and Detroit Receiving Hospital that city officials consulted about local hospital development, had received a federal research grant to study the needs for modernization, renovation, replacement, relocation, expansion, and conservation of hospitals in Detroit.[332] This group did not advocate for the development of new structures, necessarily, but understood that this might be necessary to achieve Mayor Cavanagh's vision.

In 1964, the Greater Detroit Area Hospital Council approved six projects. Only one of these were at the DMC: the modernization of the Hancock Building of Hutzel Hospital, which included an upgrade to patients' rooms, a surgical suite, and service departments.[333] Despite the mayor's public advocacy, this council did not include a new Detroit Receiving Hospital within the confines of the DMC.[334] The plans for a new Detroit Receiving Hospital, then, did not move forward, despite its accreditation struggles, further signifying the lack importance this hospital held for the city.

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[330] Ibid.

[331] Letter from James P. McCormick to Jerome Cavanagh, June 11, 1964. Box 140, Folder 25 June Board of Health. Jerome P. Cavanagh Collection, Walter P. Reuther Library, Detroit, Michigan.

[332] Cavanagh to Guenther, June 15, 1964. 141, 141-9. Cavanagh Collection, Reuther Library, Detroit, Michigan.

[333] Greater Detroit Area Hospital Council Meeting Minutes, "President's Annual Report," May 27, 1964. Box 141, Folder 141-9 The Greater Detroit Area Hospital Council (Bd of Health). Jerome P. Cavanagh Collection, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

[334] Ibid.

Conclusion

Even as Detroit Receiving struggled, the DMC development, which was the largest project using urban renewal funds in the nation, and University City, garnered national attention. From the *New York Times* in 1964:

> "Detroit will contain a project of national prominence in its 236-acre Medical Center. It is being expanded from a core of four existing major hospitals. Ground has been broken for the first phase, a Professional Plaza, 15 acres of medical office buildings and related facilities costing $25 million. The new Wayne State University College of Medicine campus will rise in the center. A related multi-million-dollar research facility will take occupants early this year. An $8 million Children's Hospital will rise nearby."[335]

The national news media depicted the DMC and University City projects as giving the city "national prominence" and credited them with Detroit's "renaissance." In an article that appeared in *Business Week* in 1963—much earlier than most think Detroit needed a "renaissance"—the publication reported that "Detroit has always been an unlikely spot for renaissance" due to its identification as a "dull industrial city whose people have rarely been interested in anything else but how well automobiles are selling."[336] However, the increase in automation, dropping car sales, and the "auto industry diversifying geographically away from the city" which resulted in unemployment of fifteen percent by 1961, a "cultural movement" became necessary to revitalize the economic environment in the city.[337] By 1963, unemployment had fallen to three-and-a-

[335] "Detroit," *New York Times* Supplement, March 1964. Box 142, Folder 142-3 University City Project. Jerome P. Cavanagh Collection, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

[336] "Detroit Dolls Up," *Business Week*, November 23, 1963. Box 128, Folder 128-20 Mayor's Office. Jerome P. Cavanagh Collection, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

[337] Ibid.

half percent, credited largely to the projects of urban renewal undertaken by the city, including the DMC project which transformed two thousand acres of land.[338]

From a national perspective, the DMC development was driving the success of a city in decline. But a closer, more local examination reveals a different story. While unemployment had dropped, Detroit continued to show signs of economic deterioration. In 1958, the city had a deficit of eight-hundred thousand dollars; by 1962, after the bulk of urban renewal projects had taken off, the deficit had grown to thirty-four million dollars.[339] And despite the new employment opportunities in science and medicine that these projects offered, about sixty percent of Detroit's 3.8 million workers' jobs were still tied to the auto industry.[340] The jobs offered by the DMC development, as covered in the first chapter, were developed largely for white Detroiters and suburban residents. Even national media acknowledged this deficit, noting that the Detroit "renaissance" would perhaps stimulate the tourist business "which offers jobs for the unskilled…The Negro community has been less helped than others by the city's diversification because man Negroes lack the needed skills and education."[341]

The unequal benefits of urban renewal in Detroit meant that those most in need continued to struggle while city services focused less on this group. No case demonstrates this this more clearly than an examination of the attitudes of city planners and officials toward both Detroit Receiving and the DMC during this time. Throughout the 1960s, construction at the DMC continued—all the existing hospitals were connected by tunnels,

[338] Ibid.
[339] Ibid.
[340] Ibid.
[341] Ibid.

streets were being widened, and land was being cleared around the complex to create a fully connected campus.[342] All the while the city's investment in Detroit Receiving declined. Emphasizing both the isolated nature of this development and its role in bringing a new industry to the city, local media had begun speaking about the DMC as a city within a city, referring to it as the Medical City.[343] This new moniker for the DMC also applied to the rest of the city as a replacement for the Motor City, identified most notably by Mayor Cavanagh at a groundbreaking ceremony for Professional Plaza at the DMC in 1965, where he stated that while Detroit had been known as the "Motor City," the DMC ushered in new opportunities.[344]

The influx of federal urban renewal and hospital infrastructure funding in the 1950s and 1960s created an environment in cities across the country where grand schemes for redevelopment could be realized. In Detroit, no development was as large or exciting as the DMC. This project transformed "slums" into world-class hospitals and housing for the professionals who would flock to Detroit to work at there. As Detroit continued to decline, city officials and planners became more dedicated and confident in this development's ability to bring the change they desired in their city.

But this excitement and investment came at the expense of already-existing city infrastructure, like its municipal hospital. Even with federal funding, the city's resources were limited, and the focus on the DMC meant that the challenges Detroit Receiving

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[342] Carl Konzelman, "16 New Buildings for Medical City: 25-Million Project Unveiled," *Detroit News,* January 22, 1963. Box 160, Folder 160 Detroit Medical Center. Jerome P. Cavanagh Collection, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

[343] Ibid.

[344] Gerald Storch, "First New Medical Center Building," *Detroit Free Press* May 19, 1965. Box 260, Folder 160-15 Detroit Medical Center. Jerome P. Cavanagh Collection, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

faced were never properly tended to. Additionally, the patient population at Receiving, while growing throughout the 1960s due to the city's continued demographic changes and economic decline, never seemed to be able to find a home at the hospitals of the DMC, despite this development's reliance on federal funds for its very existence.

The negative effects of federal urban renewal programs on cities' black communities has been thoroughly studied, especially regarding the housing and job crises created by these programs. But the specific role that public benefit institutions like hospitals and universities played is less well-known. By not centering these institutions in our narratives of urban renewal, historians have ignored a crucial component in this period in American history. Doing so helps us better understand the plight, and grievances, of black urban communities. A further study of these grievances related to Detroit Receiving and the DMC is developed in the next chapter.

Chapter 3

The Language of the Unheard: Detroit Receiving Hospital and the Violence of July 1967

The first and second chapters of this dissertation examined the role of the DMC as a symbol of urban development through the promise of industrial transformation and white-collar employment rather than a provider of health to vulnerable residents of Detroit's core. The actions of its planners and other city officials resulted in a two-tiered, segregated, and discriminatory health care system that resulted in poorer health outcomes for Detroit's growing black community. This coincided with the growing platform of national black rights organizations to incorporate health inequalities into their advocacy.[345] In Detroit, this echoed the initial advocacy championed by the Detroit Urban League that sought to encourage the Detroit City Council to build a more inclusive DMC to serve as the main center of health care for all residents of the city of Detroit. After the introduction of the Medical Center Development Plan to City Council in 1956, the Detroit Urban League increased its pressure on the city. This advocacy came after they learned how much public funding would go toward the construction of this center and that this development would displace thousands of black individuals and black-owned

[345] In addition to the advocacy that will be discussed further in this chapter on both a national and local level, several black advocacy groups worked to eliminate health care inequalities in their work. These groups include the Southern Education Conference Fund, the Black Panthers, and various national black feminist and womanist organizations. For more information, see Hoffman, *Health Care for Some*; Alondra Nelson, *Body and Soul: The Black Panther Party and the Fight Against Medical Discrimination.* Minneapolis: University of Minnesota Press, 2013; and Wendy Kline, *Bodies of Knowledge: Sexuality, Reproduction, and Women's Health in the Second Wave*. Chicago, University of Chicago Press, 2010.

businesses— "slum clearance" that all but ensured that the remaining neighborhood was a "slum."

Advocating for better health care access had always been central to the groups who fought for civil rights for black Americans. In the early twentieth century, activists like Booker T. Washington advocated for improved access to health care because they believed that this was a safer form of activism rather than overt and explicit activism for equal rights among the races.[346] And while civil rights leaders could differ in their philosophies, the most prominent leaders, including W.E.B. Dubois, understood the centrality of health to social and economic justice.[347] It is no surprise, then, that the continued poor health of Detroit's black residents throughout the early stages of the construction of the DMC, with an ever-increasing gap between black and white residents, was of primary concern for some of the city's most prominent black activist groups.

In 1942, the World Health Organization identified the "social roots of health," indicating that poor living conditions were directly responsible for health outcomes.[348] The National Urban League promoted these ideas about social determinants of health throughout the 1960s, including blaming shorter lifespans, higher infant mortality, and increased amounts of disease and disability on low incomes, inadequate education, and poor living conditions across the United States, especially in proportion to white counterparts, stating:

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[346] Sandra Crouse Quinn, PhD, "The National Negro Health Movement: Lessons for Eliminating Health Disparities Today," *Minority Health Today*, 2:3 (March/April 2001); pp. 42-43.

[347] Ibid.

[348] "Social Determinants of Health," World Health Organization, https://www.who.int/social_determinants/sdh_definition/en/ (accessed April 9, 2019).

> "The poor health of the Negroes retards education, lowers earning power, and prevents them from realizing their potential for full and worthwhile lives. It is our view, therefore, that specific steps to promote the health of the Negro population should be taken along with efforts to improve jobs, education and housing."[349]

This statement from the National Urban League emphasized the position that black activists had taken before them: better health, while important to advocate for on its own, was about much more. Poor health was just another—and perhaps the most pressing—symptom of poverty, but it was intrinsically linked to other conditions of poverty, like housing and jobs. The National Urban League went a step further to name the relationship as cyclical: lower economic conditions led to poor health, but that poor health continued to keep poor, black residents in lower economic conditions.

While local black activists had been engaged and active throughout the construction of the DMC, the 1950s saw a groundswell of national black activism that placed health care needs of black people at its core, and this activism led to federal legislation that attempted to force integration. On December 18, 1952, the President's Commission on the Needs of the Nation unanimously recommended in its "Building America's Health" report that "segregation in the use of hospitals be eliminated since it detracts from the efficiency and quality of care."[350] And as a final message from the federal level, the Supreme Court ruled in May 1954 that separate health facilities were

[349] Walter J. Lear, M.D., "Negroes and Health Services," Presented at the 1964 National Conference of the Urban League, Tuesday August 4, 1964 in Louisville, Kentucky. Box 55, Folder: Health and Welfare Department General File, 1964 [a19-2]. Detroit Urban League Collection, Bentley Historical Library, Ann Arbor, Michigan.

[350] Congress of Industrial Organizations (CIO), Resolution on Segregation and Discrimination in Hospitals, Undated (circa 1960). Box 75, Temporary Committee Hospital/Medical Services, 1951-1960. Detroit Urban League Collection, Bentley Historical Library, Ann Arbor, Michigan.

inherently unequal.[351] The first health system to act on this was the federally run Veteran's Affairs hospital system, which despite being integrated during even the Civil War, began segregating care after the *Plessy v. Ferguson (1896)* decision in the late nineteenth century.[352]

The National Urban League chalked up any meaningful integration in all parts of the United States, "even in the Deep South," to actions taken by the Veterans Administration, which practiced equal health provision even in places like "Birmingham, Jackson, and New Orleans."[353] The comparison was intentional—northern cities like Detroit had the potential for greater segregation than did cities in the South.[354] The National Urban League was disappointed, then, that other federal funding programs, like Hill-Burton, did not provide the same assurance for integration.[355] But the environment created by federal regulations seemed favorable for the elimination of segregation when, in 1956, the Detroit Urban League began its fight for the full integration of the DMC. However, as described in chapter one, the city was still reluctant to tackle the allegations of discrimination head on.

Emboldened by these legislations, Detroit activists rallied for better access and improved health care at Detroit Receiving and the DMC for indigent patients. The DMC development displaced thousands of black residents and forced many into public housing;

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[351] Ibid.

[352] Lear, "Negroes and Health Services," August 4, 1964. 55, Folder: Health and Welfare Department General File. Detroit Urban League Collection, Bentley Library, Ann Arbor.

[353] Ibid.

[354] Thomas Sugrue, *Sweet Land of Liberty: The Forgotten Struggle for Civil Rights in the North*. (New York: Random House, 2008).

[355] Lear, "Negroes and Health Services," August 4, 1964. 55, Folder: Health and Welfare Department General File. Detroit Urban League Collection, Bentley Library, Ann Arbor.

this construction did not contribute to the overall improved health status of the city. Throughout the 1960s, the health of black Detroit residents declined while the health of white Detroit residents and those in the suburbs continued to improve. In the context of the "social health" understood by activist groups, the poor health of Detroit's black residents was caused by the poor housing and economic situation created by the construction of the DMC, while their poor health reinforced their poor economic circumstances.

This chapter argues that the city officials' decision to prioritize construction at the DMC while at the same time failing to address the declining status of Detroit Receiving contributed to the conditions that ultimately led to the Detroit Riots.[356] In particular, the focus on the DMC reflected city leaders' preference for its white middle- and upper-class residents at the expense of the city's black residents. City officials continually delayed improvements at Detroit Receiving, arguing that it was not a good use of funds for the city, while continuing to build and expand the DMC and University City, which did not provide services that directly benefitted Detroit's most vulnerable populations. The continued avoidance of Detroit's indigent population—comprised of mostly black folks

[356] Words matter. In the case of this event in Detroit—and several others across the country during the summers of the late 1960s—there is still a debate over exactly how to name this event. During the 50th Anniversary of the July 1967 incident, the Detroit Historical Society hosted an ambitious and provocative exhibit that lived online and in its physical museum in Midtown, located across the street from Wayne State and the DMC. Those who came into the museum were first asked a question before continuing through the exhibit: "What Do You Call It?" Consensus seems to be that "Riot" is the mainstream, or "white" way of referring to these events, while Detroit's black communities and those sympathetic to these causes tend to use words like "rebellion." I have chosen to use apolitical language to refer to the violence that occurred the nights of July 23-July 28, 1967, like "event," "occurrence," and "incident." I use Detroit Riots in this first instance, while addressing the historiography around this event, and in the title and first mention of the section dedicated to this narrative, since this is the way that this event is most commonly known in the traditional vernacular. While all of us come to these sorts of incidents with our own emotions and lenses (including recent events in places like Baltimore after the death of Freddie Grey, #NODAPL, or "celebrations" after World Series wins in places like San Francisco and Boston), using apolitical language allows us to fully contextualize and place the events and actions leading up to, and following, this watershed moment in Detroit's history.

due in part to the disproportional way that urban renewal policies negatively affected this population—meant that many of Detroit's black communities were relegated to a life of poverty and all the ills that came with it. Those who participated in the violent protests during July 1967 cited unequal treatment in housing and employment opportunities, and other events that doomed them to a life of poverty. Thus, the effects of the DMC development and its role in the decay of Detroit Receiving Hospital must be considered in an historical analysis of this event.

This chapter also attempts to parse out the difficult and complicated role that the DMC and Detroit Receiving played in the violence that occurred July 23-28, 1967 in Detroit. At once, these hospitals symbolized both the new Detroit and the one the city was choosing to leave behind, but this violence made city officials realize the necessity of an institution like Detroit Receiving. The aftermath of this event led to a newfound excitement from city officials like Mayor Cavanagh for Detroit Receiving to serve as a new trauma hospital within the confines of the DMC—whose previous political actions suggested a lack of support for such an institution. While city officials had spent the previous decade boosting the DMC Development, often to the detriment of Detroit Receiving, the violence in July was understood as a message—at least initially—about who actually lived in the city and utilized its resources. While the DMC was a symbol for city officials of what Detroit could be, Detroit Receiving was a symbol of what Detroit was at that moment. The central need of adequate trauma care during this event demonstrated that the offerings of Detroit Receiving were necessary not only for the indigent black patient community who frequented this hospital, but also for the success of

the whole city. While perhaps employing imperfect methods to do so, both city officials and black residents hoped the new trauma hospital would bring benefits to the health of the black community. These groups hoped that this hospital, Detroit Receiving, which had such meaning for black residents would be prioritized, updated, and have a physical presence finally reflective of its almost spiritual importance among this community.

The effects of the violence during the summer of 1967 were long lasting for the city but also within the DMC. The DMC development was the largest urban renewal project in the nation but is notably absent from the historiography of the Detroit Riots. This is despite historians noting that some of the effects of urban renewal, like housing displacement and subsequent economic disparities, were motivators for this event. This chapter seeks to correct that by acknowledging the role that Detroit Receiving played in the lives of Detroit's black communities. This chapter also recognizes the centrality of health activism among the city's black communities. Black activists often advocated for improvements in health provision concurrently to calls for improved economic conditions like housing and job opportunities. Many activists saw health advocacy as an entryway to further discussions of economic advocacy. In doing so, black activists highlighted the relationship between medical care, housing, jobs, and other markers of the lack of economic opportunity.

This chapter begins by exploring early black health activism, demonstrating that black activists often centered health in their activism as a means of advocating for overall improved living conditions. In Detroit, this activism continued throughout the twentieth century, carried out by groups already discussed in the first chapter, like the Detroit

Urban League, but also labor unions and the NAACP. In the case of the DMC, urban renewal development was at the intersection of health, housing, and jobs. Activism around this construction led to continued frustration with the city government and was a contributing factor to the conditions leading up to the incident in July 1967. The chapter will then explore the event that became known as the Detroit Riots, and chronicle both the national and local response that sought to address why this happened and determine how to never have an event like this again. Part of this response was the recognition of the importance of Detroit Receiving, which provided emergency and trauma care to black participants and city official's eventual decision to integrate Detroit Receiving into the DMC campus after decades of delay. This chapter will conclude by demonstrating that any understanding by city officials of the needs of Detroit's black community was fleeting. One of the more lasting effects of the inability of Detroit to confront its racial divisions was the failure of the city to deliver on its promise of a new Detroit Receiving Hospital.

Foundations of Black Health Activism

One of the earliest instances of formalized black health activism was Negro Health Week in the early twentieth century, largely motivated by the work of Booker T. Washington. Initially promoted and sponsored by the National Negro Business League, the impetus for the creation of Negro Health Week was twofold: to improve the overall health conditions of black Americans, and to increase the number of black Americans represented in the health care professions. Segregated medical education and training

resulted in drastic discrepancies in the number of trained black physicians in the United States.[357] In 1924, throughout the United States when segregation was not only common but often the law, there was only one black physician for every three thousand black patients, while there was one white physician for every white patient.[358] Negro Health Week focused on hygiene, with public health nurses and social workers providing education to black women about how to keep their home sanitary, and promoting the necessity of personal responsibility in advocating for individuals' improved health statuses for all members of black families.[359] Health demonstrations were a large part of the strategy of many public health workers during the Progressive Era, but these demonstrations were different in that they were developed for, and by, black populations.[360]

National Negro Health Week led to the establishment of the Office of Negro Health Work within the United States Public Health Service in 1932 as part of the New Deal.[361] Activists saw the establishment of this office as a victory, and, as a result, by the mid-twentieth century had begun taking a step back and broadening their definitions of "Negro health" improvement. In doing so, activists began taking what we today identify as a population health approach: working to improve job outlooks and providing education to black communities about how to navigate their local ordinances to demand

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[357] This is covered more in depth in Chapter 1, but you can also see Gamble, *Making a Place for Themselves* and Darlene Clark Hine, *Black Women in White: Racial Conflict and Cooperation in the Nursing Profession, 1890-1950* (Bloomington: Indiana University Press, 1989).

[358] Sandra Crouse Quinn and Stephen B. Thomas, "The National Negro Health Week, 1915-1951: A Descriptive Account." *Minority Health Today,* 2:3 (March/April 2001): 45-51.

[359] Ibid.

[360] Ibid.

[361] Angela Castellanos, "Federal Government and African-American Communities Identifying and Defining African-American Health Disparities Through Intervention: The National Negro Health Week Movement and the Office of Negro Health Work from 1915-1951." PhD Dissertation, Harvard Medical School, 2015.

better living conditions, in addition to still providing check-ups and vaccinations for communicable diseases.[362] In this way, black activists saw the clear, and unbreakable linkages between health and an improved standard of living for the broader black community.

In Detroit, this work on the national scale provided the background for groups like the Detroit Urban League to flourish. As we saw in the first chapter of this dissertation, the Detroit Urban League, an organization of middle-class black residents representing Detroit's black community by working for equal economic opportunities, worked toward a more inclusive medical center that would provide well-paying professional jobs to black Detroit residents. Even this activism demonstrates that medical center development was about so much more than just health—the urban revitalization plans included housing, transportation, employment, and changes to public safety in one of Detroit's neighborhood that had experienced historical disinvestment.

Black Health Activism in Detroit

By the 1950s, activism groups like the Detroit Urban League had made city officials and planners aware of the dual-system of care and opportunities for employment between black and white Detroiters. For example, activists organized studies, demonstrations, and testified before groups like City Council and the Detroit City Plan Commission presenting evidence of these disparities. In as early as 1948, the Admissions and Allocations Committee of the Greater Detroit Hospital Fund—a state-appointed and

[362] Susan L. Smith, *Sick and Tired of Being Sick and Tired: Black Women's Health Activism in America, 1890-1950.* (Philadelphia: University of Pennsylvania Press, 1995).

sponsored group of mostly white business men and philanthropists that provided advisement on how to prioritize hospital development in the Detroit area—noted that:

> "The problem of providing adequate hospital facilities for Negroes is more than a problem of construction of physical facilities. It is a problem of social policy. Negro citizens in Metropolitan Detroit need more adequate facilities because of a general long-standing community policy of segregating the sick Negro from our voluntary hospitals, he has been compelled to utilize inferior commercial hospitals. If he was fortunate enough to be admitted to one of our voluntary hospitals, he had to leave his Negro physician at the door of the hospital. Aside from a limited few, Negro physicians are not granted staff membership in our voluntary hospitals. Aside from an exceedingly limited number of isolated exceptions, young Negro physicians are not accepted as residents and interns in our voluntary hospitals. Advanced medical training and specialization is virtually impossible for the Negro physician in the Detroit area as long as he is unable to obtain staff privileges in high grade hospitals…The other half of the medical team, the trained nurse, has likewise not been given full opportunity to share the rich training experience our Detroit hospitals could offer…Negro women are generally unable to gain admittance to schools of nursing in the Detroit area…It is clear from the evidence that reasonably good hospitalization for Negroes and opportunities for training Negro physicians and nurses are exceedingly limited at the best and are largely non-existent in the Detroit area."[363]

As noted by this state board, the path for training black medical professionals was separated from "mainstream" white and publicly sponsored hospitals and training programs, even in northern cities like Detroit. This did not mean that there was a lack of interest or skill among black communities—quite the opposite. Historian Vanessa Northington Gamble has written that beginning in the late nineteenth century, black leaders began "making a place for themselves" by developing a black-controlled hospital systems in cities across the country, not only to ensure adequate treatment of black

[363] William H. Boone, "Resume of Efforts to Assess and Meet the Problem of Medical-Hospital Services for Negroes," *Review of Equal Opportunity in Eleven Detroit Area Voluntary Hospitals*, December, 1962. Box 64, Folder: Research Reports, 1962 Reports, Review of Equal Opportunity in Detroit Hospitals. Detroit Urban League Collection, Bentley Historical Library, Ann Arbor, Michigan.

patients, but also to provide training opportunities for black physicians and other medical professionals.[364] Detroit had one of the highest number of black hospitals in the country, and most of these hospitals were owned and operated completely by black residents.[365] However, due to the financial and other capacity limitations of the black hospital system in Detroit, groups like the Detroit Urban League continued to work for integration of medical education and employment at the city's white voluntary hospitals.

Also, in 1948, operating under the assumption that this group would be sympathetic to the health needs of black Detroiters, a group of citizens supported by the Detroit Urban League submitted a proposal to the Greater Detroit Hospital Fund for the development of a new interracial hospital. Although this was a philanthropic group, the Greater Detroit Hospital Fund wielded great political power in the city due to its role as an advisor to the mayor and other city officials on the prioritization of hospital construction, and thus was able to work in tandem with City Council. The organization decided not to recommend the inclusion of this project.[366] The Admissions Committee of the Greater Detroit Hospital Fund stated on November 26, 1948 that:

> "Thoughtful observers believe the inevitable trend of a so-called interracial hospital will be toward a segregated institution and low health standards; it permits the community to congratulate itself upon having solved a difficult social issue without in truth having made a basic attack upon the problem…Such a separate institution might well retard social progress toward the decent and democratic goal of integration. The issue before the Detroit community is clear. We can nurse our prejudices at a cost of an initial $4,000,000 initial investment, or we can work honestly toward integration of Negro personnel in our voluntary hospital system."[367]

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[364] Vanessa Northington Gamble. *Making a Place for Ourselves.*

[365] Valerie Gliem, "History of Detroit's Black Hospitals Detailed in Project," *The University Record,* November 6, 2000. http://ur.umich.edu/0001/Nov06_00/10.htm (accessed March 9, 2019).

[366] CIO, Resolution on Segregation and Discrimination in Hospitals, Undated (circa 1960). 75, Temporary Committee Hospital/Medical Services, 1951-1960. Detroit Urban League Collection, Bentley Library, Ann Arbor.

[367] Ibid.

For the Greater Detroit Hospital Fund, then, it made more sense to work on integrating the hospitals that already existed rather than build a brand new one with the explicitly stated goal of integration. Black Detroiters were skeptical that this would work, perhaps doubting the belief of the inevitability of integration that the Greater Detroit Hospital Fund seemed to purport since there were no other attempts to actively integrate, so they turned to their greatest source of political power: the unions.

Any political power that black Detroiters held in the 1950s was largely credited to their large numbers in the United Auto Workers [UAW] or Congress of Industrial Organizations [CIO] Unions. The CIO had been leading the fight for integration in labor settings—including hospitals that offered many service-level jobs for black employees. The CIO was involved because they had "always supported medical and hospital programs designed to bring professional training to all doctors, nurses, and medical technicians regardless of race, creed, or color."[368] The CIO made it known that while they believed the Greater Detroit Hospital Fund, saying that their statement was "abundantly clear" and would "inevitably result in a program of complete integration of all community hospitals at every level," they would also hold this group accountable to its promise to push for integration.[369]

The CIO issued a statement on hospital segregation and discrimination, stating that they had "repeatedly…sought to alert the American public, the United States Congress, and the organizations of professional people who have primary responsibilities

[368] Ibid.
[369] Ibid.

in the fields of health care to the scandalous failure to meet the needs of our nation's families."[370] The Wayne County CIO Council Delegates then, representing three-hundred thousand workers in Metro Detroit, urged the Metropolitan Detroit Building Fund to "use their good offices and work for an accelerated program designed to assist the citizens of Detroit in achieving the goals of complete integration in all of the hospital services in the community in a non-discriminatory and non-segregated basis."[371] Moreover, the CIO said none of their unionized workers would work to build or work in hospitals that were segregated.[372]

The Greater Detroit Hospital Fund determined that Parkside Hospital, the first and largest black hospital in the city, was the ideal hospital at which to work toward integration in the early 1950s. Black activists working for health integration in Detroit opposed the plan to integrate Parkside Hospital, however, believing that this would only result in continued "Jim-crow style hospitals." Instead, black activists argued that successful integration must happen from black patients being allowed in white hospitals—institutions that often had more capacity and funding—rather than expecting white patients to come to underfinanced and overburdened black hospitals.[373] These activists were disheartened at this half-hearted integration strategy at Parkland that they believed only paid lip service to equal opportunity.

In a joint address to make this frustration clear, the CIO and NAACP noted on November 16, 1953 that they "[were] against segregation in any form—whether in

[370] Ibid.
[371] Ibid.
[372] Ibid.
[373] Ibid.

hospitals, in schools, public transportation, public accommodations, or churches," making it clear that these activists were opposed to any expansion of a segregated hospital, and would instead continue to fight for integration throughout the city.[374] The CIO was no longer in support of the Greater Detroit Hospital Fund's plans for the future, and realized more grassroots activism would be necessary to create the changes in the city this union sought.

The activism from groups like the CIO, the NAACP, and the Detroit Urban League in the early 1950s to remove openly discriminatory policies at white-only hospitals did little to improve access at first, because there was no real way to police these policies. This was in line with other cities across the country, too. De facto segregation existed in nearly every city in the United States but was more prominently felt in places like Detroit where the black population was so prominent and concentrated.[375]

Beyond Access

Detroit's black activists knew, however, that the difficulties that black residents had in securing adequate medical care was more complicated than a lack of access. Harlan Randolph, an organizer with the Student Nonviolent Coordinating Committee [SNCC], was among the civil rights activists in the early 1960s who suggested that a lack of access was only one barrier of many that prevented black Americans from receiving

[374] Ibid.

[375] Lear, "Negroes and Health Services," August 4, 1964. 55, Folder: Health and Welfare Department General File. Detroit Urban League Collection, Bentley Library, Ann Arbor.

medical care. The bigger issue was that American medicine was a discriminatory system that prevented black patients from seeking health care and created issues preventing proper care utilization. He remarked:

> "Look at systems for the delivery of services in terms of the impact of different providers on different socio-economic groups. For example, in the treatment of venereal disease, the middle-class patient is treated by a private physician and no public record exists of this. The lower-class patient, in contrast, goes to a public clinic, where he is questioned extensively, and a public record is made. This kind of contact results in a negative psychological attitude toward receiving medical care."[376]

For Randolph, it was not enough to simply offer health care for all people regardless of their racial backgrounds or ability to pay; the care had to be of equal level and practitioners—and the systems in which they operated—needed to prioritize all patients' humanity and dignity regardless of racial background or ability to pay.

While of the things that DMC planners believed contributed to poor health for the bulk of the city's population—like a lack of physicians in the city's center and dilapidated buildings—certainly contributed to the poor health of Detroit's black residents, the real cause was hard-baked into the system itself. The explicit segregation—like excluding patients from white wards, denying black physicians admission privileges, and relegating black nurses to LPNs rather than achieving RN status—did result in a two-tiered system of health care in the city, and an inability of black city residents to find upwardly mobile employment within this growing industry. But the widespread, systemic segregation caused by more hidden transcripts, like denying patients based on their public

[376] Harlan Randolph, "Suggestions for Research on Civil Rights and Medical Care," undated (circa 1965). Box 56, Folder: Topical Files: Race Relations-Health 1987-2000. University of Michigan School of Public Health Collection, Bentley Historical Library, Ann Arbor.

insurance status or the way they received their injury, were more difficult to parse out. As Randolph noted, the perfectly legal, and unintentional segregation resulting from a black patient with a sexually transmitted infection going to a public clinic and therefore carrying a public record, were not factors taken into consideration by the DMC planners.

Social Determinants of Health in Detroit

As previously discussed in chapters one and two, Detroit had begun losing population shortly after World War II, seeing a proliferation of white suburbs and a core of mostly black urban residents. In Detroit, this resulted in a shrinking tax base, and a lower standard of living for the city's residents compared to their suburban counterparts. Detroiters, especially those living in the "inner city," experienced higher rates of unemployment, more difficulty finding safe and affordable housing, and other symptoms of increased poverty.

This was felt, perhaps more egregiously, because of the role that the medical center development played in increasing racial discrepancies in Detroit and making the social determinants of health even more severe. While a more thorough discussion is in earlier chapters, it is important to reiterate the housing crisis that this development helped to create.

The housing around the DMC required a "comfortable income." The Detroit Urban League pointed out this economic test excluded the black folks who had formerly lived in the neighborhood and instead privileged white-collar professionals.[377] The

[377] Minutes, Committee to Secure the Rights of Negro Business Concerns Located in the Proposed DMC Site, undated (circa June 1956). Box 42, Folder: Community Service Department—Topical File—Hospital and Medical

Detroit Housing Commission made their intention evident when they wrote that "the [ideal] Medical Center household is small, above average income, in a white-collar occupation, earning above average income." Again, the emphasis was on bringing people back to the city. From the same report:

> "The downtown image is in need of promotion to make it widely acceptable as a place to live. Only half of the people interested in downtown have ever seen any of the new housing built there. Concentrated efforts are therefore needed to reach and sell them…It is important to note that it is white-collar employment which holds the greatest promise for future economic growth in the Detroit area. The future of Detroit depends on utilizing this trend. Large shortages of residence for white-collar employees around the City's major white-collar employment centers could seriously impair future job expansion in the city."[378]

One-bedroom housing in this area before DMC Development cost an average of thirty dollars per month. After construction, planners estimated that similarly sized apartments would go as high as ninety-six dollars per month.[379] For context, the national average monthly rental in 1960 for a one-bedroom apartment was sixty-nine dollars.[380] The displacement that resulted from similar developments resulted in the growth of public housing—a project of urban renewal itself. While public housing was a solution for the lack of affordable housing, they quickly became centers of highly concentrated poverty, crime, and health troubles.[381] All the while, black Detroiters remained excluded

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Center Studies, undated [A6-22]. Detroit Urban League Collection, Bentley Historical Library, Ann Arbor, Michigan.

[378] Aaron J. Blumberg, Economic Consultant, "A Study Prepared for the Mayor's Committee on Community Renewal and the Detroit Housing Commission: A Community Renewal Program Study in Co-Operation with the Housing and Home Financing Agency." Box 84, Folder 8-Downtown Housing. Jerome P. Cavanagh Collection, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

[379] Ibid.

[380] Urban League Recommendations Respecting the Proposed Detroit Medical Center Development, June 23, 1957. Box 42, Folder: Community Service Department—Topical File—Hospital and Medical Center Studies, undated [A6-22]. Detroit Urban League Collection, Bentley Historical Library, Ann Arbor, Michigan.

[381] Other public housing projects were built as part of urban renewal in Detroit, the Brewster Douglass Housing Projects were initially built in the 1930s as part of the New Deal and were a big deal—Eleanor Roosevelt was there for the groundbreaking ceremony to start construction on the nation's first public housing project built

from both the care provided at the hospitals of the DMC and also the economic opportunities it afforded white residents.[382]

In Detroit, the mobilization around the problems of the DMC development and the neglect of Detroit Receiving fell primarily with the Detroit Urban League and the NAACP. Alondra Nelson has written how the Black Panther Party mobilized around these social determinants of health in other places around the nation, realizing that physical ailments and economic and social realities were inseparable among black residents. The Panthers offered free clinics with culturally competent care to impoverished black communities and ran campaigns to raise awareness about problems facing black communities like sickle cell anemia. At the same time, the Panthers demanded from white medical establishments and policymakers a greater understanding of biomedical issues facing black Americans and, in general, more equitable medical care.[383] In Detroit, however, while there was an active Black Panther Party, it focused primarily on self-defense against the police.[384] Its leaders focused on other forms of activism. Perhaps that is why the event in July 1967 was so violent and intense in this city.

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specifically for African Americans. Initially, admission to these housing projects was stringent—at least one adult in the household had to meet a minimum employment requirement. In the 1930s and 1940s when jobs were plentiful—even for black Detroiters—this was a relatively low bar. However, as competition over these jobs increased after World War II and black residents lost their housing, this requirement went away, resulting in the concentration of poverty within these residences. While a rich text, there seems to be no academic source on the history of this housing development, but podcasts from Michigan Public Radio can be accessed here: https://www.michiganradio.org/post/here-s-why-brewster-douglass-housing-projects-were-built-1930s

[382] The first two chapters of this dissertation provide more information on this topic.

[383] Alondra Nelson, *Body and Soul.*

[384] The Black Panther Party, Walter P. Reuther Library. https://reuther.wayne.edu/taxonomy/term/1476 (accessed on March 29, 2019).

The Detroit Riots

In the early morning of July 23, 1967, Detroit police officers raided an unlicensed, after-hours bar that was housed in the headquarters of a black civil rights group. The club was particularly busy that night, hosting parties for servicemen returning from Vietnam, and providing an air-conditioned respite from the thick humidity and oppressive heat outside. As police arrested the eighty-five black men inside the club, a group gathered on the street to observe. After about an hour, when the last person was arrested and taken away, hundreds of people had flooded the street, and the group that had gathered outside began throwing glass bottles. The police initially ignored this, but when a bottle crashed through a window of a police car, chaos erupted. The subsequent, three-day long violence would come to be known as The Detroit Riots, one of the deadliest and largest urban events during a decade that saw similar events around the nation. Fires had broken out by sunrise, and only hours later, every Detroit firefighter and policeman had been called into work, and violence continued to overwhelm the city.

Mayor Cavanagh requested that Governor George Romney send in State Troopers, and Governor Romney sent in the National Guard shortly thereafter. When the violence continued to grow, President Lyndon B. Johnson sent in two thousand Army paratroopers to patrol the streets in armored tanks. Over those three days, seven thousand people were arrested, forty-three people were killed, fourteen hundred buildings were burned resulting in nearly fifty million dollars in property damage, and five thousand people lost their homes.[385]

[385] "Uprising of 1967," *Encyclopedia of Detroit.* The Detroit Historical Society. https://detroithistorical.org/learn/encyclopedia-of-detroit/uprising-1967 (accessed March 20, 2019).

When the fires were put out and the damage was assessed, the questions that people across America could not stop asking were: "What happened? Why did it happen? What can be done to prevent it from happening again and again?"[386] This event, happening nearly in tandem with the less deadly incident in Newark, was directly responsible for President Johnson appointing an eleven-member National Advisory Commission on Civil Disorders only hours after the end of the violence in Detroit on July 28, 1967.[387] The Kerner Report, as it became more commonly known, stated that America was facing a "system of apartheid," and that the country was "moving toward two societies, one black, one white—separate and unequal."[388] The Kerner Commission acknowledged the way that racist and discriminatory policies kept black Americans "in the streets of the ghetto," and that this was the primary reason for these acts of violence by black communities across the nation. The report stated:

> "What white Americans have never fully understood—but what the Negro can never forget—is that white society is deeply implicated in the ghetto. White institutions created it, white institutions maintain it, and white society condones it."[389]

The eleven-person commission was a bi-partisan contingent of state and federal elected officials, business representatives, and the Police Chief of Atlanta, Georgia and the president of the NAACP. The commission suggested practical solutions including raising taxes to fund better inner city job opportunities, open housing opportunities in the suburbs, and create what housing advocates today called "scattered site housing," where

[386] The National Advisory Commission on Civil Disorders, *The Kerner Report.* (Princeton: Princeton University Press, 2016).
[387] Ibid.
[388] Ibid.
[389] Ibid.

affordable housing is spread throughout an area rather than concentrated in high rises in the projects or in slums.[390] The findings of this commission were largely ignored; shortly after the publication of these findings, the assassination of Martin Luther King Jr. was the catalyst for similar violent events across one-hundred American cities—the aftermath of which occupied the president's time.[391]

In Detroit, locals tried to assess on their own how their city could erupt with such violence, seemingly–at least according to journalists and those in white society—out of nowhere. About a month after the incident in late July, the *Detroit Free Press* ran a survey of four-hundred-thirty-seven black people involved in the event. Out of the twenty-three possible choices for the main cause of the event provided by the newspaper, police brutality, overcrowded living conditions, and poor housing were found to be the leading causes. Well over half of respondents identified these as having "a great deal" to do with the violence; frustrations around health and/or medical services were not options given by this newspaper.[392] Additionally, black participants noted that they felt treated unfairly by grocery stores, loan offices, real estate agents, banks, furniture stores, insurance brokers, automobile repair shops, and car dealers.[393]

These reasons for this violence were like the reasons that had motivated black activists decades earlier to work to improve health equity for black Americans. But instead of the more traditional routes of non-violent protest like public health

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[390] Ibid.

[391] Clay Risen, "King, Johnson, and the Terrible, Glorious Thirty-First Day of March," *A Nation on Fire: America in the Wake of the King Assassination*. (Hoboken, NJ: John Wiley & Sons, 2009).

[392] "How 23 Possible Riot Causes Were Ranked in Survey," *Detroit Free Press*, August 20, 1967. Box 56, Topical Files, Folder: Race Relations-Detroit Riots, 1967-1970. University of Michigan School of Public Health Collection. Bentley Historical Library, Ann Arbor, Michigan.

[393] Ibid.

demonstration projects, lobbying elected officials, and enacting research studies those involved in the event in July 1967 employed violent protest. In this way, this incident was the result of a population whose needs had been largely ignored—despite decades of non-violent protest—by their city's government. As Martin Luther King said, "A riot is the language of the unheard," and black Detroiters demanded to be heard.[394]

Speramus Meliora; Resurget Cineribus[395]

The violence in Detroit during late July 1967 has been well covered by historians, and anecdotes from that summer remain important for nearly all Detroiters today. But something that has received less attention is the peculiar place that the DMC and Detroit Receiving play in this narrative, and how city residents and officials placed newfound importance on the future of these institutions because of this event. The stories of many participants have largely been lost to history. However, the stories of the men and women who worked at the hospital that saw the bulk of the victims, Detroit Receiving, help to illustrate the important place that this hospital held was during the events in July.

Throughout the days of violence, the hospitals of the DMC and Detroit Receiving were heavily protected by Detroit Police, the National Guard, and active service troops sent in by President Johnson. Those injured in the event needed somewhere to go, and for that reason, these areas were given priority protection. However, the care received, even though the city had allegedly stopped segregating care in 1965, was segregated. Injured

[394] Lily Rothman, "What Martin Luther King Really Thought About Riots." *Time Magazine,* April 28, 2015. http://time.com/3838515/baltimore-riots-language-unheard-quote/ (Accessed May 22, 2019).

[395] The two mottos on the city flag of Detroit, adopted in 1907. Translated, they mean "We hope for better things; It will rise from the ashes."

black Detroiters were sent to Detroit Receiving, and white folks with private insurance were sent to the hospitals of the DMC and other private hospitals in the city, like Henry Ford Hospital.[396]

Already taxed and stressed out, this event required Detroit Receiving hospital staff to see even more trauma cases, testing the limits of both the physical structure and its personnel. Trauma surgeon John Crissman, who had just begun work at Detroit Receiving on July 1, 1967, remembers the "eerie calm" of the hospital during the event, especially in juxtaposition to the war happening outside its walls. Dr. Crissman said of the event that: "There was a paradox because the emergency room basically closed down, because there wasn't any of the routine, ambulatory emergency room patients coming in…The only things we saw were major trauma."[397] In addition to hallways flooded with patients and the "eerie" white noise of forty black patients on stomach pumping machines to heal from abdominal surgery to treat their stab and gunshot wounds, Crissman noted that he felt scared. He was worried that the animosity black participants showed in the streets toward white folks and white businesses would carry over to these patients in the hospital. But he reported he was surprised to find all his patients peaceful and "very grateful that someone was taking care of them."[398] While danger and destruction erupted outside of the walls of Detroit Receiving, the hospital was a haven of sorts where the racially charged violence stopped.

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[396] Ted Van Buren, interview by Alexis Draper. Detroit, MI, March 19, 2016. https://detroit1967.detroithistorical.org/items/show/251 (accessed September 12, 2018).

[397] John Crissman, interview by Hannah Sabal. Detroit, MI, July 11, 2016. https://detroit1967.detroithistorical.org/items/show/313 (accessed September 12, 2018).

[398] Ibid.

One medical resident, Dr. Carl Lauter, recounts the surprise he felt when he was called into the hospital. He was off, and was asked to come in, but not to drive because it might not be safe. He was further instructed that the bus would be even worse. His supervisor, Dr. Richard Bing, suggested that he call a "black cab" company to get to work. Dr. Lauter says of this transport:

> "I didn't know there was such a thing as a white cab company and a black cab company…apparently there were two black-owned cab companies in the city at the time and the police gave me their numbers, they know who they were."[399]

Tall, fair, and blond, Dr. Lauter was asked by his black cab driver to "scrunch down" in the back seat so to not draw attention to the cab and potentially welcome snipers' bullets.[400] Lauter didn't need to worry about his female nurse colleagues arriving safely to the hospital; in a gendered (and perhaps racially charged since many participating in the event were black men) practice to ensure the their safety, nurses were driven to the hospital via ambulance. This was possible since, despite the ever-growing violence creating a likely need for ambulances, they were not venturing out to find patients—patients came to the hospital mostly by police car.[401]

Lauter was at Detroit Receiving for seven days straight, and despite leaving his medical residency soon after to serve as a doctor in the military, he "never saw anything in the Air Force two years like [he] saw in that one week at Receiving Hospital as far as

[399] Carl Lauter, interview by Noah Levinson and Lillian Wilson. Royal Oak, MI, July 7, 2015. https://detroit1967.detroithistorical.org/items/show/48 (accessed September 12, 2018).

[400] Ibid.

[401] Muriel Smith, email to Detroit 67 Project. July 15, 2015. https://detroit1967.detroithistorical.org/items/show/29 (accessed September 5, 2018).

those type of injuries."[402] Because of the danger that came from getting to and from the hospital, most employees stayed there for the whole week, and from their sleeping room on the eighth floor, could see flames in all directions.[403]

The paranoia outside also brought in accident victims not injured in the violence per se; in fact, Detroit Receiving saw more accidental injuries during the riots than during a normal week. According to nurse Cheryl Pierce-Reidy, several people were actually "shooting themselves in the foot" because they were buying and working with firearms when they were not used to them.[404]

But just because the violence on the street was erupting, it did not mean that other medical issues and emergencies were not coming into the hospital. By the "third or fourth day" according to Dr. Lauter, he saw mostly "people like diabetics, who would run out of insulin and they couldn't get to the drugstore because everything was closed."[405]

The overflow of Medicaid and public patients made reimbursement more difficult than normal for the billing staff. Ultimately, the hospital was reimbursed at-cost for diagnosis and treatment of treating trauma injuries like gunshot and stab wounds, but many physician services were simply absorbed without reimbursement for the time of the hospital staff who treated and cared for all who arrived.[406]

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[402] Carl Lauter, interview by Noah Levinson and Lillian Wilson. Royal Oak, MI, July 7, 2015. https://detroit1967.detroithistorical.org/items/show/48 (accessed September 12, 2018).

[403] Ibid.

[404] Cheryl Pierce-Reid, interviewed by Lillian Wilson. Detroit, MI, July 25, 2015. https://detroit1967.detroithistorical.org/items/show/89 (accessed September 5, 2018).

[405] Carl Lauter, interview by Noah Levinson and Lillian Wilson. Royal Oak, MI, July 7, 2015. https://detroit1967.detroithistorical.org/items/show/48 (accessed September 12, 2018).

[406] Ibid.

Despite the peculiarities of working during this event, the physicians at Receiving were "mostly upbeat."[407] The hospital was protected with soldiers and military accompanying physicians on their medical rounds, and they were so busy they were largely unaware of the extent of what was happening on the outside of their so-called fortress.[408] Adding to the confusion was that virtually everyone who was coming into Receiving for trauma treatment was under arrest or a prisoner. As Dr. Lauter explained, "There were many, many, hundreds, maybe thousands of prisoners…[it was too confusing] so most were just released [after receiving care]."[409] In the accounts of the white medical staff about their time serving black Detroiters during this event, there was seemingly no concern over the continued policing of black bodies by locking these prisoners to their beds and pipes or fortifying the hospital despite it being an otherwise neutral zone.

After the flames subsided and the troops left the city, a fractured Detroit began to assess the damage. What was clear to all—residents, onlookers, and the city government itself—was the competency of staff at Detroit Receiving throughout the event. Praising the staff, representatives from Mayor Cavanagh's office wrote:

> "There is no question in my mind that had it not been for your most efficient handling of the many questions and requests that arose from the start of things, things would not have gone as smoothly as they did. I consider the City of Detroit exceedingly fortunate to have [a staff] of your dedication and ability serving its interests."[410]

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[407] Ibid.
[408] Ibid.
[409] Ibid.
[410] Letter from John Hanlon to Sidney Forst, August 18, 1967. Box 335, Folder 12--Board of Health. Jerome P. Cavanagh Collection, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

The Assistant Dean Walt of Wayne State University Medical School, who oversaw the workers at Detroit Receiving Hospital, received applause from Cavanagh's office for the way they worked during the "civil unrest."[411] Cavanagh's office wrote:

> "The manner in which you not only mobilized the professional staff, but perhaps more importantly, inspired them unquestionably played a major role in the amazingly effective manner in which the many problems were handled."[412]

More praise went to the administrator of Detroit Receiving Hospital, E.P. Henry. In speaking about the incident, Cavanagh stated:

> "I have bragged to so many people by now about the superb administration and activities of the Detroit [Receiving] Hospital during the course of that unfortunate week that I fear I overdo it. There is no question in my mind that the hospital would never have been able to perform in such an outstanding manner despite its excellent professional staff if you had not personally and consistently been at the helm from the very start to see that everything went properly."[413]

It was clear that despite the tragedy and uncertainty that befell the city during that event in July, city officials understood the central role that Detroit Receiving played in the continued operations of a functioning Detroit.

A New Receiving

As city leaders tried to make sense of why the events in July escalated so drastically, they sought to remedy ill will among the city's black communities and the

[411] Hanlon to Alexander Walt, Assistant Dean, August 15, 1967. Cavanagh Collection, Box 335, Folder 12--Board of Health. Jerome P. Cavanagh Collection, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

[412] Ibid.

[413] Letter from John Hanlon to E.P. Henry, August 15, 1967. Box 335, Folder 12--Board of Health. Jerome P. Cavanagh Collection, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

increasing feelings of separation of the remaining white population within the city.[414] One direct action was the development of the New Detroit Committee, founded in 1968 by Henry Ford II, J.L. Hudson, and Max Fisher—the three most prominent philanthropists in Detroit—to assist with Detroit's "rebuilding."[415] This ushered in a new era of even greater reliance on private funding for development in Detroit.

Federal funds for urban renewal had largely run out in Detroit by 1967, but by July 1968, the city unanimously endorsed the development of a new Detroit Receiving Hospital within the confines of the DMC.[416] This was due, largely, to the summer's previous violence giving the city the "proof" it needed to begin the reignited push for a new Detroit Receiving.[417] Mainstream organizations in Detroit, including New Detroit, partnered with "radical" black organizations in the first several months after the incident, working to include black voices in the future planning of the city.[418] The motivations of city officials and boosters to partner with black organizations are unclear. Perhaps they understood the need for inclusion from the findings from the Kerner Commission or perhaps they simply understood that the city's majority was changing and were concerned about the growing political power of the city's black residents. Regardless of their complex motivations, there were genuine attempts by city officials and boosters to prioritize the needs of this community in the aftermath of the summer of 1967. However,

[414] Fine, *Violence in the Model City*, p. 370.
[415] Fine, *Violence in the Model City*, p. 370-1.
[416] Medical Center Development Corporation Minutes, July 15, 1968. Box 6, Folder 6-13 Board of Trustees, Correspondence, Information, Bulletins, 1968. Hutzel Hospital Collection, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.
[417] Mozena, "The Detroit Medical Center," p. 89.
[418] Ibid.

like Mayor Cavanagh's initial courting of black Detroiters during his upset mayoral victory in 1961, these promises were short-lived.

The Medical Center Moves Forward

As the city announced its plans for a new Detroit Receiving within the DMC, the medical center development continued to flourish. In March 1967, the city broke ground on the first new hospital of the DMC: Children's Hospital. This month saw also the development of the Medical Court Apartments, a new apartment complex designed by the Detroit City Plan Commission for the largely white professionals who would work at the new Medical Center, as well as the establishment of the Coronary Center at Harper Hospital, which DMC developers hoped would become the "best in the nation."[419] These projects continued through summer 1968 when the city tried to finalize its plans for a new Receiving.

From the perspective of city planners and officials, the development of the DMC was working. From the start of the project in 1956 through December 1969, crime was reduced ninety percent, providing proof of a community transformed in the ways that would bring renewal to the city.[420] That said, the city's Thirteenth Precinct, which was the neighborhood immediately south of the newly developed DMC, still had the highest crime rate in the city.[421] The rest of the city was excluded from the progress made at this

[419] Professional Plaza Profiles, Volume 4, Number 1, March 1967. Box 4, Folder: Publications: DMC Professional Plaza Profiles 1967-1971 4-17. Grace Hospital Records, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

[420] Ibid.

[421] Ibid.

development—even the area directly neighboring the DMC. It was becoming increasingly clear that this development was isolated from the rest of the city; DMC officials did not see themselves as responsible for improving conditions outside of its own boundary walls.

This isolation from its surrounding community was not unique to DMC; there are many stories of academic health centers in urban centers struggling to reconcile their own economic progress with its economically depressed surrounding neighborhoods during the mid-twentieth century. One such incidence was the development of the Cleveland Clinic and its role in that city's violence in the summer of 1966. Like the DMC, the Cleveland Clinic developed in an impoverished part of the city. This institution did not include members of the surrounding neighborhoods in plans for its development and did not prioritize poor residents in its plans for care. Its leaders were caught by surprise when its surrounding neighborhood erupted in violence in the summer of 1966. But unlike in Detroit, Cleveland officials noted the disconnect between the Clinic's development and the state of its surrounding residents, noting that the renewal had "not paid off" for the most vulnerable of Cleveland's communities.[422] While similarly confused and scared like Detroit officials, Cleveland's city and county officials were able to implement meaningful change into future Cleveland Clinic development to work toward city-wide renewal through the development of satellite clinics serving indigent populations. While

[422] Thomas Hatch, "Notes on Urban Renewal," December 28, 1966, in Box 23, Folder 4, Gottron Papers; on the context of the Watts riot, see "Black Community Transformation in the 1960s and 1970s" in Josh Sides, *L.A. City Limits: African American Los Angeles From the Great Depression to the Present* (Berkeley, CA: University of California Press, 2003), 169–197, cited in Merlin Chowkwanyun, "Cleveland Versus the Clinic: The 1960s Riots and Community Health Reform," *American Journal of Public Health,* November 2018, Vol 108 (11), pp. 1494-1502.

it is fair question if these were tokenism it is important to note that the Cleveland Clinic enjoys the national reputation that the DMC hoped for during its planning throughout the mid-twentieth century.[423]

In Detroit, the DMC remained insular, and the involvement that city officials and powerful philanthropy groups like New Detroit initially sought from black residents was short-lived. This may be because this partnership between future planning in Detroit and vocal black activists was not politically advantageous in the suburbs during the aftermath of the violence in July 1967. Also short-lived was the commitment to rebuild a new Detroit Receiving within the confines of the DMC. While never outright denying this development, its commencement was indefinitely delayed without any progress until the mid-1970s due to a perpetual lack of funding.

Declining Health in Detroit

While people had begun leaving Detroit long before July 1967, the violent event that summer was enough to solidify Detroit's reputation as an unsafe and unwelcoming place for white folks. Homeownership rates declined, as did the city's tax base, and jobs became scarcer throughout the 1970s as manufacturing jobs moved south and overseas.[424]

The economic realities of life in Detroit meant that residents were more in need than ever of public services, but the city was not financially able to provide these. Because of declining city finances, Detroit ended its visiting nursing program, and queues

[423] Merlin Chowkwanyun, "Cleveland Versus the Clinic: The 1960s Riots and Community Health Reform," *American Journal of Public Health*, November 2018, Vol 108 (11), pp. 1494-1502.

[424] Sugrue, *On the Origins of the Urban Crisis.*

increased dramatically at public health clinics throughout the city.[425] In early 1974, a parent could schedule a pediatric appointment for her child at any of Detroit's clinics within about a week; by 1975, the wait time had increased to nearly three months.[426] Even though Detroit had a drug problem that had reached epidemic levels, the city-sponsored methadone clinic and drug abuse program were ended in 1975 due to a lack of funding.[427]

This strain on the city's health services was felt especially in the health status of Detroit's poor, black community. As in the previous decade, this decrease in health status was juxtaposed with continually improving health statistics in the outer city and the suburbs. Health disparities were so great in this area, in fact, that the Detroit Health Department branded the inner city as the "City Within the City."[428] By 1975, the "City Within" was home to half of all city residents.[429] The majority of these residents were black, and forty percent lived in substandard housing.[430] The "City Within" had higher rates of morbidity—twice the rates of pneumonia, cirrhosis, and infant mortality as compared to Detroit's suburbs, or even the "outer" city.[431]

The healthcare system that existed in the "City Within" was, according to a Detroit Receiving physician, "insufficient, discriminatory, fragmented, and burdened by

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[425] William M. Buckley, "Troubled City: How a Budget Pinch Diminishes Amenities a Depressed Detroit," *Wall Street Journal,* 7 Apr. 1975. Domestic Council Collection, Box Number 6, Folder-Detroit (1). Frederick Lynn May Domestic Council Collection, Gerald R. Ford Presidential Library, Ann Arbor, Michigan.

[426] Ibid.

[427] Letter from Richard Martin to Mark Greene, May 3, 1974. Box 4, Folder 4-73 Drug Treatment. Harper Hospital Collection, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

[428] Dolores Katz, "Health Care for Poor Impersonal, Inadequate," *Detroit Free Press,* 20 July 1975. Box 6, Folder 6-6 DMC Hospitals, News Clippings, 1972-1984. Grace Hospital Records, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

[429] Ibid.

[430] Ibid.

[431] Ibid.

red tape."[432] With few other choices, inner city residents continued to turn in droves to the emergency room at Detroit Receiving.[433] By this point in 1975, the hospital was losing nearly sixty thousand dollars a day, just shy of twenty-two million dollars annually due to the increasing visits from indigent patients.[434]

As the black population returned to being ignored by city government, their political power grew as the city demographics further shifted to a city that was increasingly black—forty-eight percent by 1970.[435] This led to the election of the city's first black mayor in 1972.

The Coleman Young Era

A suspected Communist who represented Detroit in the Michigan Senate, Coleman A. Young was elected on his platform of ending police brutality and promoting racial equity with over fifty-nine percent of the vote, indicative of the changing electorate within city limits.[436] Mayor Young immediately began working on his campaign promises but he also immediately became a controversial figure and an easy scapegoat for an increasingly tenuous relationship between the city and the suburbs. In his inaugural address, Young stated:

> "We can no longer afford the luxury of hatred and racial division. What is good for the black people of this city is good for the white people of this city. What is good for the rich people in this city is good for the poor

[432] Ibid.
[433] Ibid.
[434] "Facts about Detroit Medical Center," October 1977. Box 10, Folder 10-16 Detroit Medical Center Pamphlets. Harper Hospital Collection, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.
[435] Katz, "Health Care for Poor Impersonal, Inadequate," *Detroit Free Press*, 20 July 1975. 6, 6-6. Grace Hospital Records, Reuther Library, Detroit.
[436] Dale A. Berg, "The Election of Black Mayors, 1969 and 1973," *Annals of the Association of American Geographers* 67:2 (June 1977) pp. 2223-228.

> people in this city. What is good for those who live in the suburbs is good for those of us who live in the central city."

And then, previewing his ad lib styling that would become a hallmark of his tenure, Young closed with a warning:

> "I issue open warnings now to all dope pushers, to all rip-off artists, to all muggers: It's time to leave Detroit. Hit Eight Mile Road![437] And I don't give a damn if they're black or white, if they wear Superfly suits or blue uniforms with silver badges. Hit the road!"[438]

This began the mythos of Mayor Young as an executive who not only wanted white people to leave the city but encouraged the migration of "problem" residents to the suburbs. Both perceived suggestions made for a difficult relationship between city leadership and its surrounding suburbs in the years during the Young administration. In fact, city development plans became even more difficult as groups like the Greater Detroit Hospital Fund shifted focus from the city to the suburbs.[439] But Mayor Young believed that a new era of revitalization in the city center would bring about Detroit's renaissance. To that end, Mayor Young and his staff began developing a plan for their vision of Detroit and hoped to find funding through appeals directly to the President of the United States.

By Mayor Young's inauguration, the city faced a thirty-five million dollar budget deficit.[440] Mayor Young tried to remedy this by raising taxes on the remaining property

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[437] 8-Mile Road is the road that is the northern border of the city. This road has long held a place in Detroit's lexicon as the exit/entry to the city. This has been prevalent even in mainstream hip hop films including *Gridlock'd* and *8 Mile.*

[438] Bill McGraw, "Coleman Young: The 10 Greatest Myths," *The Detroit Free Press,* May 25, 2018. https://www.freep.com/story/opinion/2018/05/26/coleman-young-myths/638105002/ (accessed March 12, 2019).

[439] This will be covered in the next chapter.

[440] James Cannon, "Meeting to Listen to Presentation of 'Detroit Plan,'" April 30, 1975. Box 18, . Folder: Michigan – Detroit (2). Domestic Council Papers--James E. Falk Collection, Gerald R. Ford Presidential Library, Ann Arbor, Michigan.

owners in the city, but this did little to help—many of these tax bills went unpaid.[441] Knowing municipal funding would be necessary for any sort of renaissance or continued development in the city—which was still rehabilitating from the violence of July, 1967—Mayor Young reached out to the philanthropists of New Detroit (which had changed their name to Detroit Renaissance) and Governor William Milliken to develop a plan to approach the president directly.[442] It was the hope of this coalition that President Ford would be sympathetic to this cause as a Michigan native himself—and the chair of the Kerner Commission—and could thus sway Congress to approve special funding for the city.[443] Additionally, Mayor Young believed that the city was "owed" for damages from the federal government for what he called "Hurricane HUD"—a housing crisis caused by the Department of Housing and Urban Development [HUD]'s mismanagement of foreclosures in Detroit—in the same way that the federal government would help a city rebuild after an actual hurricane.[444]

After the July 1967 event, HUD "guidelines were purposely relaxed" to help rehome those who had lost theirs in both the event and subsequent economic decline, but "hindsight indicates the Department should not have been insuring" mortgages for some of these properties.[445] In addition to essentially providing subprime mortgages for Detroit residents and falsely inflating property values, opportunistic contractors "took advantage

[441] Ibid.

[442] Moving Detroit Forward: A Plan for Economic Revitalization, April 30, 1975. Box 18, Folder: Michigan – Detroit (2). Domestic Council Papers--James E. Falk Collection. Gerald R. Ford Presidential Library, Ann Arbor, Michigan.

[443] Ibid.

[444] Coleman Young to the Joint Economic Committee of the US Conference of Mayors, June 20, 1975. Box 18, Folder: Michigan – Detroit (2), Domestic Council Papers--James E. Falk Collection. Gerald R. Ford Presidential Library, Ann Arbor, Michigan.

[445] Ibid.

of the pressures and volume and were successful in 'ripping off' both HUD and unsophisticated buyers."[446] This left "drug dens and useless wreckage" in the city across its twelve thousand vacant homes.[447] By the mid-1970s, a third of all repossessions in the nation existed in Detroit due to the HUD crisis.[448] By 1974, HUD owned over sixteen thousand single-family homes in Detroit—twenty-one percent of the department's national inventory.[449] This catastrophe, created by the federal government and a key cause of the severity of Detroit's struggles, was another motivator for Mayor Young pleading to the president directly for funding for his jobs plan for the city.

The mayor realized that his city had become "the international symbol of the problems of big cities with its rates urban crime and unemployment," but he knew that it was "not ready to accept an epitaph."[450] Young saw in this crisis an opportunity, and in turn, this had implications for the city's health care institutions.

The Detroit Plan

In April 1975, Mayor Young presented "Moving Detroit Forward: A Plan for Economic Revitalization," to President Ford in April 1975. The Detroit Plan was an employment program for revitalization that emphasized immediate public service jobs to

[446] Tod Hulin, October 19, 1974. Central Name File: Coleman Young. Gerald R. Ford Presidential Library, Ann Arbor, Michigan.

[447] Ibid.

[448] Coleman Young to the Joint Economic Committee of the US Conference of Mayors, June 20, 1975. Box 18, Folder: Michigan – Detroit (2). Domestic Council Papers--James E. Falk Collection. Gerald R. Ford Presidential Library, Ann Arbor, Michigan.

[449] Tod Hulin, October 19, 1974. Central Name File: Coleman Young. Gerald R. Ford Presidential Library, Ann Arbor, Michigan.

[450] "Moving Detroit Forward: A Plan for Economic Revitalization," April 30, 1975. Box 18, Folder: Michigan – Detroit (2). Domestic Council Papers--James E. Falk Collection. Gerald R. Ford Presidential Library, Ann Arbor, Michigan.

restore activity within the city.[451] Central to the Detroit Plan were jobs in the medical industry. With a fifteen-million-dollar infusion from the federal government for this specific purpose, planners believed that they could add fifteen thousand jobs just in this industry. The Detroit Plan placed the DMC at its center. It conceded that development of a place like the DMC was "not traditionally seen as an industrial undertaking," but its importance in this venue could not be underestimated—by 1975, the DMC employed ninety-five hundred people and had an annual budget of one-hundred-eighty million dollars.[452]

To complete the DMC, Mayor Young and Detroit Renaissance petitioned the federal government for funding for a new Detroit Receiving Hospital at the center of the DMC. The Detroit Plan stated that this hospital's "rapid completion…[was] an integral part of the expansion of new industries in Detroit."[453] The city acknowledged that Detroit Receiving was "no longer economically efficient."[454] The construction of a new trauma hospital, however, in the DMC would mean that this hospital could be the flagship of one of the largest medical centers in the United States. Receiving would be "physically centered so patients could get specialized care from the most comprehensive array of services available anywhere."[455] In order to make this a reality, the city was asking for an interest-free federal loan. Eighty million dollars were needed for the construction of the

[451] Ibid.
[452] Ibid.
[453] Ibid.
[454] Ibid.
[455] Ibid.

new Detroit Receiving, which would result in one thousand short-term labor positions and fifteen hundred new permanent jobs.[456]

This plan also made suggestions for new federal legislation that would ease the troubles of Detroit and other cities like it, including tax credits and automatic funding for emergency feeding programs for cities with unemployment greater than nine percent, mass transit funding, and specialized housing funding for cities deemed "economically depressed."[457]

Before meeting with Mayor Young and Detroit Renaissance, the president and his staff knew they would not be approving this plan, and schemed how to "not raise false expectations."[458] The president's advisers stated that this proposal "ignored" several avenues for funding that Detroit was not currently pursuing, including the Comprehensive Employment and Training Act, the Work Incentive Program, the Economic Development Administration, the General Revenue Sharing fund, and its eligibility to receive about thirty-four million dollars from HUD as part of their Block Grant Program.[459] While acknowledging that Detroit's problems were "more severe than most cities," President Ford and his advisers understood that Detroit's difficulties reflected those experienced across other American cities at this time.[460]

Mayor Young felt optimistic after his meeting with the president, despite learning that it would be impossible for the federal government to provide the nearly 2.4 billion

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[456] Ibid.
[457] Ibid.
[458] James Cannon, "Meeting to Listen to Presentation of 'Detroit Plan,'" April 30, 1975. Box 18, Folder: Michigan – Detroit (2). Domestic Council Papers--James E. Falk Collection. Gerald R. Ford Presidential Library, Ann Arbor, Michigan.
[459] Ibid.
[460] Ibid.

dollars in funding required for what Mayor Young called a "Marshall Plan for urban depression."[461] President Ford told Mayor Young that he would prioritize Detroit on existing appropriations for mass transit and housing, and that the city should begin moving forward with some of the proposal "based on the assumption that the tax [credits discussed in the plan would] be approved."[462]

Receiving Hospital Within the DMC

Although the Detroit Plan did not receive the 2.4 billion dollars for which it asked, the federal government did give the city its eighty million dollar loan for a new Detroit Receiving Hospital.[463] The city was confident in its ability to turn around its unemployment in a short time and repay this loan using tax dollars from Mayor Young's increasing tax rates for city residents.[464]

The hospital construction itself cost only eighty million dollars, but another forty-five million was spent on its "cutting edge" concourse, award-winning architecture, and unique specialty care equipment.[465] This additional amount was not covered by their loan from the federal government, but the city believed it would make up this deficit through the economic transformation brought to this area.[466] "Rising like a beautiful phoenix from

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[461] John E. Peterson, "Young Optimistic Over Response: Ford Pledges Aid for 'Detroit Plan,'" *Detroit News,* May 1, 1975, Page 22A. Box 18, Folder: Michigan – Detroit (2). Domestic Council Papers--James E. Falk Collection. Gerald R. Ford Presidential Library, Ann Arbor, Michigan.

[462] Ibid.

[463] Detroit Receiving Hospital/University Center Pamphlet," undated (circa 1980). Box 10, Folder 10-16 Detroit Medical Center Pamphlets. Harper Hospital Collection, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

[464] Peterson, "Young Optimistic Over Response,'" *Detroit News,* May 1, 1975, 18, Michigan – Detroit (2). James E. Falk Collection. Ford Presidential Library, Ann Arbor.

[465] "Detroit Receiving Hospital/University Center Pamphlet," undated (circa 1980). 10, 10-16. Harper Hospital Collection, Reuther Library, Detroit.

[466] Ibid.

the ashes of its predecessors," it was hoped that this new structure would become the epitome of modern hospital architecture while simultaneously serving as a symbol of Detroit's renewal and the provider of health care to Detroit's neediest population.[467] Completed in late 1979, it won several national architecture awards.[468]

This excitement, however, was short-lived. After its completion, Mayor Young announced that the new, one-hundred-twenty-five million dollar structure would not open because the city could no longer finance its operations and debt service.[469] Adding to this crisis, the city could no longer support the old, outdated Receiving Hospital and so it too would be closed.[470]

News coverage of the planned closure made clear that the hospital's importance extended beyond the medical care it provided. An emergency room nurse was quoted in a newspaper article saying: "Here's a social problem: What do we do with the street people who live under Detroit Receiving's warm air vents when they turn the heat off?"[471] While city officials assured Detroiters that they would be able to receive care at the hospitals of the DMC, black residents maintained that Detroit Receiving was the only hospital that truly cared about the poor of Detroit—whether it was truly medical care they needed, or just basic human assistance.

Mayor Young and City Council felt like they were out of options; if the city was

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[467] Ibid.

[468] Ibid.

[469] Dolly Katz, "Gloom Settles in at Detroit General," *Detroit Free Press*, 19 Mar. 1980. Box 6, Folder 6-6 DMC Hospital News Clippings. Grace Hospital Records, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

[470] Ibid.

[471] Stephen Cain, "Hospital's Finale—Memories Linger." *Detroit News*, 16 June 1980. Box 6, Folder 6-6 DMC Hospital News Clippings. Grace Hospital Records, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

to have a Detroit Receiving Hospital, it could no longer belong to the city.[472] They began discussing selling the hospital to the Detroit Medical Center Corporation [DMCCo]—the nonprofit body that oversaw operations at the DMC.

One of the proposed solutions for Detroit Receiving's woes was floated in 1976 when Mayor Young and Governor William Milliken appointed a task force to discuss a potential state takeover of Detroit Receiving rather than place it into the DMC.[473] Mayor Young was never in favor of this, despite strong support from the DMCCo, business consultants, and DMC hospital trustees stating that the hospital must be "run by the city, for the people of the city."[474] The continued city ownership, however, made it difficult to run Detroit Receiving efficiently; its continued existence meant that the hospital had many masters within the city, including the health department, the mayor's office, city council, and voters, and this bureaucracy and lack of centralization and efficiency led to "chronic problems."[475]

Concerned Citizens for Detroit Receiving Hospital, a vocal community organization, rallied to prevent the sale.[476] They argued that turning Detroit Receiving Hospital into a "public benefit corporation" would make care more difficult to access for the medically indigent population in Detroit.[477] They argued that people who lacked

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[472] Memo from Bud Brooks to the Detroit Health Committee Re: Current Situation Regarding the Financing and Governance of Detroit General Hospital, 22 May 1977. Box 7, Folder-New Detroit Health Committee 1977. Solomon J. Axelrod Collection, Bentley Historical Library, Ann Arbor, Michigan.

[473] Mozena, "The Detroit Medical Center," p 125.

[474] Ibid.

[475] Ibid.

[476] Flyer, "Attention! People of Detroit! Stop the Take-Over of Detroit General!" undated, (circa 1979). Box 84, Folder 84-39 Detroit General Takeover, Concerned Citizens for Detroit Receiving Hospital. Detroit Commission on Community Relations/Human Rights Department Collection—Part 3, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

[477] Ibid.

insurance would be refused care at this new hospital, citing instances of difficulty in accessing care at Harper, Children's, or Hutzel, noting that if you had "no money or insurance (and sometimes even with Medicare and Medicaid) you could be turned away.[478]

Hospital employees also protested the sale, realizing that they would lose their status as city employees and therefore their union benefits with the sale to a public benefit corporation.[479] They argued that this sale would cut city jobs with no guarantee that current employees would be hired at the DMC. If they did find jobs at the new center, their new status as private employees would mean a pay cut and a drastic cut in fringe benefits.[480]

In the end, Mayor Young believed a private Detroit Receiving was better than none at all. The city sold the never used, one-hundred-twenty-five-million-dollar structure for twenty million dollars to the DMCCo in 1980, and the city was still responsible for the full repayment of the eighty million dollar loan from the federal government.[481]

Conclusion

Viewing the event commonly known as the Detroit Riots through the lens of Detroit Receiving Hospital reveals both the reasons leading to unrest within Detroit's

[478] Ibid.

[479] Flyer, "Save Detroit Jobs, Keep Hospital Union," undated (circa 1979). Box 84, Folder 84-39 Detroit General Takeover. Detroit Commission on Community Relations/Human Rights Department Collection—Part 3, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

[480] Ibid.

[481] Meeting of the Detroit Medical Center Corporation from Anthony M. Franco, 1980.Box 10, Folder 10-16. Harper Hospital Collection, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

black communities and the low-level of meaningful commitment that the city had to addressing the needs of these communities in the future. Even the election of Detroit's first black mayor could not fully address these seemingly intractable issues in housing, job opportunities, and health. Mayor Young and his predecessors understood that health care could be a new industry for the city and emphasized the development of the DMC, often at the neglect of Detroit Receiving. Historians miss a crucial part of this event if we do not seek to understand how the failure of the city to provide adequate health care services contributed to this violence. It is even more important to do so since the nature of the incident itself had revealed the need for competent trauma care and facilities with enough capacity to treat the influx of patients injured in any emergency during this event.

The violence that erupted in the city in July 1967 did not come from nowhere. It was a confluence of years of unheard activism from groups like the NAACP and the Detroit Urban League about the lack of employment, unsafe housing, and police brutality in the city of Detroit. This event led to long term effects in the city of Detroit that ultimately affected the DMC in both positive and negative ways. While this event has entered the mythos of the city as the initial point of Detroit's decline, historians like Thomas Sugrue have demonstrated that Detroit began losing economic power and population decades before.[482] Even contemporaneously, news media knew this was not true; in October 1961, *Time* Magazine ran a story titled "Decline in Detroit." This article noted that the wartime prosperity of the 1940s ended almost immediately, creating a recession in 1958 and resulting in a marked population loss. The article did speak,

[482] Sugrue, *Origins of the Urban Crisis.*

however, of the hopefulness of urban renewal projects like University City, and the eventual election of Jerome Cavanagh.[483] But that hopefulness and benefits of renewal were not shared with Detroit's black communities.

Despite the widespread acknowledgement from city officials and planners of the importance of Detroit Receiving following the violence of July 1967, the dedication to this hospital and Detroit's black communities soon became secondary to other concerns that officials were more important to the city's revival. Not until the election of Detroit's first black mayor, Coleman A. Young, did development of a new Detroit Receiving become a reality. And even then, poor choices made about its development undermined the economic viability of that important medical facility. By 1980, the new Detroit Receiving had been sold; it no longer belonged to the people of the city—despite costing them one-hundred-twenty-five million dollars to build. This, in turn, meant the health needs of Detroit's black residents remained unmet.

The next chapter explores the non-profit structure of the DMC more in-depth and seeks to understand why such a promising project resulted in so many issues for the city throughout its development.

[483] "Decline in Detroit," *Time Magazine*, October 27, 1961, p. 27.

Chapter 4

The Detroit Medical Center as an Academic Health Center: The Problems of Regionalism

In a retrospective celebration of the first twenty-five years of the Detroit Medical Center [DMC], George E. Cartmill, the president of Harper-Grace Hospital, noted that "without neighborhood revitalization" that came because of the urban renewal policies in the 1950s and 1960s, the "hospitals [of the DMC] would become simply community hospitals without teaching and research capabilities."[484] The "blighted" neighborhoods surrounding the Detroit Medical Center in the 1950s and 1960s had been razed and residents living within them displaced, making way for the wide streets, large green spaces, and reconstructed hospitals within the DMC. Boosters began to herald its development in the improved safety and reputation of the neighborhood—and some argued—the whole city. With those in control and power seemingly unaware of the population loss that began immediately after World War II and increasing racial tensions between white and black residents, the fallout of the event that came to be known as the Detroit Riots made for a long and difficult recovery.

The population within Detroit city limits continued to decline while the population of the surrounding suburban counties increased dramatically. Between 1960 and 1970, Detroit lost ten-and-a-half percent of its population while the surrounding

[484] George E. Cartmill, "The Dream Takes Shape: The First 25 Years of the Detroit Medical Center," undated (circa 1975-1980—"first twenty-five years" is unclear if it means from inception, from groundbreaking, from the development of the MCDC, etc.). Box 10, Folder 10-16. Harper Hospital Collection, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

communities of the metropolitan area had increased twelve percent.[485] The population changes became even more drastic over the next five years, 1970 to 1975 the city of Detroit lost an additional ten percent of its population, while northern Livingston and Macomb Counties increased in population by fifty-four percent; population in Oakland County increased too by thirty-one percent.[486] People were moving not only out of the city of Detroit, but also out of Wayne County, meaning that the tax bases of both municipalities declined significantly during this period.[487]

In addition to a loss in total population, these shifts resulted in areas of greater concentration of racial segregation. By 1970, seventy-seven percent of the state's black population lived in Southeastern Michigan, and over eighty percent of this population lived within Detroit's city limits. Detroit's unemployment at this time was also high at nearly fourteen percent, but 25.5 percent of these unemployed were black residents.[488] Over fifteen percent of all of Detroit's families were living in poverty in 1970.[489] These demographic and economic changes resulted in an ever-increasing population of indigent patients within the city of Detroit.

At the beginning of the 1970s, Detroit had begun recovering from the violence of 1967—although its tax base and population continued to decline. Part of that recovery was the continued development of the DMC, with plans for a new Detroit Receiving

[485] Mozena, "The Detroit Medical Center," p. 65.
[486] Ibid.
[487] John F. McDonald, "What Happened to and In Detroit?" CCIM Foundation (October 2013 Draft): 7. Accessed online at https://www.ccimef.org/pdf/ARES-2014-281-What-Happened-To-and-In-Detroit.pdf on December 31, 2018.
[488] Mozena, "The Detroit Medical Center," p 66.
[489] Ibid.

Hospital within the medical center. Continued development of the DMC was supported by state and federal policies that favored the development of academic health centers. These were centers organized around health professions education, health sciences research, and health care delivery through a central university, medical school, and at least one other professional schools such as nursing, pharmacy, or dentistry, and the university's teaching hospitals and clinics.[490] Planners of the DMC and city officials thought of themselves as a growing academic health center, but the continued focus on physician training at Wayne State and the hospitals of the DMC (with comparatively few resources paid to nursing and pharmacy education) resulted in this development functioning more like an academic medical center—one that centered the medical school, teaching hospitals, and medical staff.[491]

Federal health policies had contributed to the very existence of the DMC from its inception. Without urban renewal funds that became available after World War II, it would have been impossible for the City of Detroit or the State of Michigan to fund this institution. Hill-Burton, the federal program enacted in 1946 that provided funds for rural hospital construction, had evolved throughout the following three decades to also provide funds for urban hospital renovations. While the DMC greatly benefitted from Hill-Burton funding, the original and national focus of this program was the increased provision of outpatient care to help manage the rising costs of health care.[492] Later passage of other health care legislation like Medicare and Medicaid had lessened support for Hill-Burton

[490] Julie Fairman, *Making Room in the Clinic: Nurse Practitioners and the Evolution of Modern Health Care*, (New Brunswick, NJ: Rutgers University Press, 2009).

[491] Ibid.

[492] Mozena, "The Detroit Medical Center," p. 67

generally, since they "heightened federal concern with the costs of hospital services." This led to President Nixon's veto of an extension of Hill-Burton in 1970.[493]

While the legislation—and therefore funding priorities—of the 1940s and 50s saw an emphasis on health planning through urban renewal, later legislation beginning in the 1960s focused on "regionalism" and the creation of academic health centers. Scholars have suggested that these policies were a natural extension of the "movement" since the late 1950s to "make widely available coordinated health facilities and services, especially hospitals" available to the wider citizenry.[494] But the new emphasis on academic health centers and medical regionalism in federal policies entering the 1970s brought with it both opportunities and challenges that the DMC had not yet encountered.

The Heart Disease, Cancer, and Stroke Amendments of 1965 was a "deceptive" title pulled from some of the most pressing chronic care issues of the era.[495] This legislation focused more on the "regionalization of the nation's health facilities and personnel" by granting more authority, and therefore more financial responsibility to regional health systems, while working to control the rising costs of medical care by encouraging shared planning—and therefore shared costs—of hospital care.[496] By establishing Regional Medical Programs, the act's purpose was to "encourage and assist in the establishment and maintenance of regional cooperative arrangements among

[493] Evan M. Melhado, "Health Planning in the United States and the Decline of Public-Interest Policymaking," *The Milbank Quarterly: A Multidisciplinary Journal of Population Health and Health Policy* 84:2 (June 2006): 359-440.

[494] Melhado, "Health Planning in the United States," pp. 359-440.

[495] Ibid.

[496] Carleton B. Chapman and John M. Talmadge, "Historical and Political Background of Federal Health Care Legislation," *Law & Contemporary* Problems 35:334 (1970): p 345.

medical schools, research institutions, and hospitals for research and training, including continuing education, and for related demonstration of patient care."[497] The establishment of fifty-six regions nationwide through this legislation allowed for smaller federal grants to be dispersed across the country, encouraging mutual cooperation and participation.[498] These policies were also enforced with the National Health Planning and Resources Development Act of 1974 which solidified the country's commitment to statewide, regional planning by consolidating the Hill-Burton and Regional Medical, and Comprehensive Health Planning programs—new programs aimed at treating the whole patient through integrated care teams rather than providing just medical care.[499]

Regional planning had become popular both because of its cost-containment effects, and the inherent support that regional medical planning fostered toward academic medicine.[500] Proponents of health regionalism believed that medical services were "best distributed through regional hierarchies descending from the urban center and its medical schools and teaching hospitals," with services and this knowledge dispersing from the city center to smaller communities across the country.[501] Health policy scholar and former Milbank Memorial Fund president Daniel M. Fox has named this mid-century focus on planning "hierarchical regionalism," citing the belief in medical science as these

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[497] Section 900, Public Law 89-239, cited in *The Regional Medical Programs Collection*, under "Brief History." NIH: U.S. National Library of Medicine, https://profiles.nlm.nih.gov/ps/retrieve/Narrative/RM/p-nid/94 (accessed December 15, 2018).

[498] Ibid.

[499] Walter J. McNerney, "Address to the Faculty and Students of the Program in Hospital Administration, School of Public Health, the University of Michigan, Ann Arbor: March 5, 1984," cited in Mozena, "The Detroit Medical Center," p. 72.

[500] Robin Kinslow-Evans, "Yesterday and Today: A Perspective on Changes in the Health Care Industry," *Alternative Delivery Systems News* 1:6 (November-December 1983)*:* p. 2.

[501] Melhado, "Health Planning in the United States."

policies' chief motivator.[502] Regional planning was premised on sharing costs among a network of laboratories, academic centers, and practitioners, which in turn, planners argued, would allow medical science to prosper, thereby increasing American's faith in personal medical care services and the importance of hospital centers.[503]

Congressional legislation also resulted in the proliferation of academic health centers during the second half of the twentieth century. The funding of medical education had become a national priority by the 1950s, with local spending on medical schools increasing more than four hundred percent between 1948 and 1958.[504] One reason for this was the conflation between offering more advanced medical education and the delivery of more technologically savvy medical services—the central ideology of the "medical center." Academic medicine grew virtually unchecked throughout the 1970s as the National Institutes of Health (NIH) increased its funding to academic research centers for biomedicine by fifty-five percent—up from six-hundred-three million dollars to two billion dollars from 1971 through 1981—providing proof of the "invulnerability of the medical school world."[505] This increase in funding from the federal source responsible for maintaining the country's place as a leader in research and development highlighted the social and cultural importance that the biomedical industry held in this country. This was only emphasized by the already-existing hospital proliferation that Hill-Burton funding brought.

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[502] Daniel M. Fox, *Health Policies, Health Politics: The British and American Experience, 1911-1965.* (Princeton: Princeton University Press, 1986).

[503] Ibid.

[504] Hugh Davis Graham and Nancy Diamond, *The Rise of American Research Universities: Elites and Challengers in the Postwar Era,* (Baltimore: Johns Hopkins University Press, 2004): p. 122.

[505] Ibid.

Entering the 1960s, "medical centers" had come to mean an institution that combined medical education, biomedical research, and employed the latest medical technology. However, soon, it became in fashion for hospitals affiliated with universities to distinguish themselves from "medical centers" by becoming "academic health centers," emphasizing the allied health professions like nursing and pharmacy in tandem to physician training and research.[506] Because national health funding priorities were focused on academic health centers, these institutions were centered in the national discussions on how to fund and deliver medical care at these sites.

For the DMC, the shift in funding and policy priorities presented another challenge. As the DMC endeavored to be southeastern Michigan's leading academic health center, the environment created by these policies that favored regionalism and the development of academic health centers increased competition between the individual hospitals of the DMC, delaying full integration and ultimately costing the DMC while these hospitals tried to act on its directive to consolidate and share costs.

At the DMC, planners worked toward full consolidation throughout its development, until full integration was reached in 1985. In this case, consolidation meant centrally organized and shared services, like janitorial, laundry, and communications. However, it also meant removing redundancies in the delivery of care. For example, rather than a cardiology department at each of the four hospitals of the DMC, cardiology would be serviced at Harper for the entire campus. All pediatric services would be

[506] Daniel M. Fox, "The Consequences of Consensus: American Health Policy in the Twentieth Century," *The Milbank Quarterly,* 64:1 (1986): p. 87.

offered at Childen's, all obstetrical services at Hutzel, and so on. This required the oversight of a central organizing body responsible for all actions throughout the DMC. This vision of full consolidation required complete trust and a cooperative spirit. However, the competitive environment that was created in part by changing federal legislation and funding priorities eroded trust and the "mutual accommodation" necessary for the development of a fully realized academic health center and regional health planning to work.[507]

This chapter argues that the focus in the 1970s on both the academic health center and regional health planning was a contributing factor in the inability of the hospitals of the DMC to enter enthusiastically into the nonprofit arrangement necessary for their survival in the 1980s; these policies ultimately bred competition rather than collaboration. The continued emphasis on advancing technology and biomedical research by the 1960s had solidified the ideology of large hospital systems built around teaching hospitals. However, by this point, the middle-class and private resources had already begun leaving inner cities, where many of these teaching hospitals—like the hospitals of the DMC—were located.[508] While proponents believed that these legislations would curb competing construction in the suburbs, hospitals away from city cores had an easier time finding support for their new developments.[509] This, paired with the continually rising costs of medical treatment and research created an environment where centers serving indigent populations were not likely to survive.

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[507] Fox, "The Consequences of Consensus: American Health Policy in the Twentieth Century," p. 93.

[508] Sallyanne Payton and Rhoda M. Powsner, "Regulation through the Looking Glass: Hospitals, Blue Cross, and Certificate-of-Need," *Michigan Law Review* 79:2 (December 1980): p. 208.

[509] Ibid.

As Detroit residents continued to face economic struggles and the percentage of people living in poverty grew, these hospitals faced greater challenges as they sought to meet this populations' needs. Most of this work fell to Detroit Receiving Hospital. Fulfilling this responsibility to this growing population further complicated Detroit Receiving's place within the DMC, even after city officials and DMC planners approved its incorporation, because of the negative stigma associated with public patients and the belief that this association with indigent patients would be bad for business. This increased competition among the DMC hospitals made it all but impossible for to build trust amongst each other. Any progress made toward consolidation was due, in large part, to the centrality of Wayne State University School of Medicine at the core of the DMC's plans for an academic health center.

The DMC as an Academic Health Center

The DMC defined its plan for an "academic health center" as "an integrated program of patient care, education, research, and community service in which each of the elements of the program is totally interdependent with all of the other elements…to provide a reasonably comprehensive health care program and to serve as a major education resource for southeastern Michigan."[510] This project "embodie[d]…imaginative and hard-headed planning…" among people from different fields, professions, and with different home institutions who were hopeful that it could

[510] Planning Report for The Detroit Medical Center Corporation, October 17, 1973. Box 105, Folder Greater Detroit Area Hospital Council, 1971-1973. University of Michigan School of Medicine Collection, Bentley Historical Library, Ann Arbor, Michigan.

have "many economic, social, and educational advantages for the people of southeastern Michigan."[511] This went along with planners' ultimate goals for consolidation at the DMC, where all of the individual member hospitals would share costs and services like laundry and phone services, and eventually phase out duplicative medical services at each institution. The intention was to have resources acquired by a specialty care service would spread be shared by all partners Wayne State University, the school that the DMC had partnered with to realize its goals of becoming an academic health center had schools of nursing and pharmacy and a physician assistant program—examples of some of the allied health professions in other academic health centers across the country.[512] But in all planning materials since the DMC's inception, the focus was always on medical education rather than the education of other health professionals.

The previously discussed regional health planning legislation was bolstered by an infusion of federal funds coming from bills aimed at increasing the number of doctors practicing in the United States. Congress, convinced by data indicating a serious physician shortage over the next two decades, enacted four pieces of legislation between 1963 and 1971 that provided taxpayer dollars to fund medical education. These legislators did so by providing funds "per head" of each medical student at each program to offset the institution's cost, in addition to the traditional means of support including construction grants, loans, and institutional support.[513] One of these, the Comprehensive Health Planning and Public Health Service Amendments of 1966, stated that "Congress

[511] Ibid.
[512] Ibid.
[513] Barbara J. Culliton, "Health Manpower: The Feds are Taking Over," *Science* 181:4225 (February 6, 1976): pp. 446-450.

finds…comprehensive health services [including] health manpower…essential at every level of government."[514]

In 1971, Congress passed the "landmark" Comprehensive Health Manpower Act of 1971, which authorized up to twenty-five hundred dollars per student in funding through July, 1974,[515] although the Institute of Medicine had estimated the average true cost of estimating a medical student to be more than 12,650 dollars (with about three thousand dollars annually going to support research at the student's institution).[516] Schools had been supported previously by "research grants…which everyone knew supported teaching but acknowledged as a way around American Medical Association opposition to overt federal support of medical education."[517] Total appropriations of this bill were approximately half a billion dollars per year.[518] At the same time, other federal programs like the Nurse Training Act of 1964 saw the development of advanced nursing programs at the baccalaureate, Masters, and doctoral levels, with the first nurse practitioner training program opening at the University of Colorado in 1965.[519] This helped in the professionalization of other allied health providers, and federal funding for the expansion of pharmacy programs, dental programs, and physical therapy programs had similar effects.[520] The undercurrent of this funding had two purposes: 1) to grow the

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[514] Steven Moscow, Ellen Z. Fifer, and Judith Guthman, "Changing State Laws Regulating Health Manpower," *American Journal of Public Health* 61:1, Number 37 (1971): pp. 37-39.

[515] Culliton, "Health Manpower," p. 447.

[516] Barbara J. Culliton, "Medical Education: Institute Puts a Price on Doctors' Heads," *Science* 183:4131 (March 29, 1974): pp. 1272-1274.

[517] Peter M. Milgrom, DDS, "Grants to Health Professions," *Change* 5:10 (Winter 1973/1974): p. 75.

[518] John Walsh, "Health Manpower Bill: Catch is Distribution of Doctors," *Science* 188:4186 (April 25, 1975): pp. 342-344.

[519] American Association of Nurse Practitioners, "Historical Timeline." https://www.aanp.org/about/about-the-american-association-of-nurse-practitioners-aanp/historical-timeline (accessed March 29, 2019).

[520] Barry L. Carter, "Evolution of Clinical Pharmacy in the US and Future Directions for Patient Care," *Drugs Aging*. 33:3 (March 2016): 169-177; Marilyn J. Field, Institute of Medicine Committee on the Future of Dental

health care industry to address potential future shortages, especially in primary care and in underserved communities and 2) to create adequate training institutions for these professions as biomedical research became more important in understanding the chronic illnesses facing Americans during the second half of the twentieth century.[521]

It is hard to deny the effectiveness of these policies—the 1970s saw a sixty percent increase in people employed in the health care industry due to the increased funding that went toward their education. By 1977, forty-three more medical schools had opened nationwide than existed in 1970.[522] This group included not only physicians but also members of the allied health professions like nurses, advanced practice providers, dentists, medical techs, and hospital employees, which became more necessary as these institutions grew to accommodate these growing industries. One of every seven new jobs created between 1970 and 1978 were in the health care field, and over half of these workers were in hospitals.[523]

Some critics believed that universities were prioritizing academic health centers to increase physician output only to increase the money their institutions were receiving from the federal government—not only from federal research funding, but also from federal reimbursement for medical services.[524] In addition to the increasing proportion of NIH funding that biomedical researchers received throughout the 1960s and 1970s, the

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Education, *Dental Education at the Crossroads, (*Washington, DC: National Academies Press, 1995); Margaret M Pack and Christopher K. Wong, "The Evolution of the Doctorate of Physical Therapy: Moving Beyond the Controversy." *Journal of Physical Therapy Education (*2002).

[521] Graham and Diamond, *The Rise of American Research Universities*, pp. 127-128.

[522] US Department of Health, Education, and Welfare, "Health in the United States 1979," https://www.cdc.gov/nchs/data/hus/hus79acc.pdf (accessed December 21, 2018).

[523] HEW, "Health in the United States 1979."

[524] Walsh, "Health Manpower Bill," p. 342.

rising costs of medical care helped to increase reimbursement at these institutions. The passage of Medicare and Medicaid resulted in reimbursement for services rather than a negotiated schedule, which in turn resulted in hospitals raising the costs for their services to pad their reimbursement.[525] Physicians employed at universities made money for these institutions. In many case, this led to "morale-threatening dimensions" between the salaries of the faculty of the medical school and other university faculty.[526] This was a contributing factor to issues not only between faculty between the Wayne State University School of Medicine and other departments across the university, but also to the increased competition among faculty at the hospitals of the DMC. This fee-for-service realm also led to a proliferation of specialty medicine as procedure-heavy specialties like cardiology and obstetrics brought in more funding (through higher reimbursement rates) for the DMC, while primary care and emergency faculty continued to cost the institution.[527]

While I have found no evidence stating that this increase in medical education funding was a direct motivator in encouraging the expansion of the DMC—or more pointedly, the audacious goal to make Wayne State University School of Medicine the largest medical campus in the nation—these intuitions were certainly taking advantage of these policies. In 1969, Harper Hospital received a 14.9 million dollar grant from the National Institutes of Health from the Health Manpower Act to build the Webber

[525] Graham and Diamond, *The Rise of American Research Universities*, p. 123.
[526] Ibid.
[527] Ibid.

Memorial Building addition to serve as a "teaching facility" within the DMC.[528] This addition was key in making the relationship with the hospitals of the DMC "more competitive" with Detroit Receiving for the allegiances of Wayne State University—a relationship crucial for the development of the DMC as an academic health center.[529]

While all the hospitals of the DMC had a relationship with Wayne State University School of Medicine, the strongest and longest-lasting relationship was with Detroit Receiving. While historians have argued that the increased funding available for regional medical education may have created increased competition between planned regions nationwide, this focus on the development of an academic health center also created increased competition among the DMC hospitals. This is because all these hospitals were all competing individually for the same federal health manpower funds. Because specialty care brought in more money for these hospitals, merging as an integrated DMC and applying for these funds as one institution was potentially detrimental for the hospitals like Harper and Hutzel that provided specialty care. This paired with the integration of Detroit Receiving into the DMC (and the negative stigma associated with this hospital because of the high number of indigent patients who frequented it) created an environment where the consolidation of the DMC was difficult. The next section will recount the attempts at this consolidation.

Attempts at Consolidation

[528] Corporate Records, Minutes of the Board of Trustees meeting, December 18, 1974, p. 5, cited in Mozena, "The Detroit Medical Center," p. 88.

[529] Mozena, "The Detroit Medical Center," p. 89.

Since its inception, the DMC had a central, guiding body overseeing and advising its development. This group underwent many changes—in name, purpose, and composition—since the establishment of the Medical Center Committee in 1955.[530] This group, formed at the discretion of then-Mayor Albert E. Cobo, was charged with presenting the first official DMC plan to City Council. To achieve this goal, Mayor Cobo assembled the director and two members of the board of trustees at each of the four medical center hospitals—Harper, Grace, Children's, and Hutzel—as well as the Dean of the School of Medicine at Wayne State University. The group was rounded out by the inclusion of Detroit city planners and architects.[531] It is important to reiterate that while the interwar plan for a new DMC was centralized around Detroit Receiving Hospital, by the 1950s, the city's municipal hospital was excluded from the new medical center plans.[532] By the time the proposal was completed in May 1956, the group had been renamed the Detroit Medical Center Committee [DMCC].[533]

The DMCC oversaw the early development of the DMC by working to make sure that the DMC was a positive for its community, including acting as the intermediary between City Council and the Detroit Urban League while that group organized its study demonstrating racial bias in hiring practices and patient treatment.[534] Another project that this group oversaw was the hiring of planning and design consulting firm Crane and

[530] Anthony Franco, "Detroit Medical Center Corporation," undated. Box 10, Folder 10-16 Detroit Medical Center Pamphlets. Harper Hospital Collection, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

[531] Crane and Gorwic Associates, Inc, "Detroit Medical Center Progress Report," 1966.

[532] For more information, see the first chapter of this dissertation.

[533] Detroit Medical Center Citizens' Committee, "A Proposal for a Detroit Medical Center," May 23, 1956. 75, Temporary Committee Hospital/Medical Services, 1951-1960. Detroit Urban League Collection, Bentley Library.

[534] For more information, see the first chapter of this dissertation.

Gorwic and the completion of what would become known as The Rourke Report. Dr. Anthony Rourke, the medical consultant at Crane and Gorwic, saw within the DMC the "rare opportunity…to take advantage of modern and complete planning of health facilities and programs…to establish a foundation for another hundred years of health care," and his report demonstrated the strategies by which he thought the DMC could make this happen.[535]

In March 1960, Dr. Rourke presented his report to the DMCC, where he made eighty-nine recommendations for the center's future. In addition to the physical changes in the area (the wider streets, the connected greenways, and the additions to the hospitals) the four hospitals of the proposed DMC would have to coordinate and consolidate their services to deliver on the promises of the potential of the new medical center. These recommendations included: arranging with the city for an "adequate and equitable basis of payment for indigent care services rendered" at the four hospitals of the medical center, centralized indigent care and pediatric services, relocation of the Wayne State School of Medicine to the DMC, and a relocation of "the city of Detroit's acute, general hospital in a new facility of approximately five hundred beds" to the new DMC, complete with a new outpatient clinic attached.[536] Dr. Rourke was explicit in the need for these hospitals to consolidate into one unified and integrated medical center, emphasizing his

[535] Anthony Rourke, "The Detroit Medical Center—Crane and Gorwic, Planning and Urban Design Consultants," 1960. Box 160, Folder 160-29 Detroit Medical Center. Jerome P. Cavanagh Collection, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

[536] Jacques Cousin, "Rourke Report on Proposed DMC," March 1960. Box 269, Folder 269-8 Mayor's Committee to Study Medical Care of the Indigent. Jerome P. Cavanagh Collection, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

belief that this would result in the most success for the DMC. In his report, Dr. Rourke wrote that:

> "Individual ingredients do not necessarily produce a prescription for excellence; neither does land area make a medical center; but rather it is the organization and coordination of a total program which produces a program of prominence."[537]

Dr. Rourke believed that "total program" would be most successful if anchored by a thriving medical school.

Dr. Rourke saw the true power in the DMC as a site of world-class medical education. He expressed concern that the city's plan, as written, would place the responsibility of caring for indigent patients onto Detroit Receiving which he feared would result in a less effective, less efficient DMC.[538] He emphasized that a coordination of these hospitals, and a plan for a new Detroit Receiving and outpatient clinic within the center, would result in the greatest likelihood of success. This would be, in part, because it would create fewer burdens on the medical school because of the inherent cost sharing practices that would come with this integration.[539] Additionally, by creating a more viable Receiving Hospital within the center, the city and medical school would be able to use resources elsewhere, enabling them to participate more fully in the growth of the DMC.

While the DMCC seemed to seriously consider the findings of The Rourke Report, conversations between this committee and city officials tended to be focused on the recommendations for development and construction rather than operations and

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[537] Rourke, "The Detroit Medical Center," 1960. 160, 160-29. Cavanagh Collection, Reuther Library.
[538] Ibid.
[539] Cousin, "Rourke Report on Proposed DMC," March 1960. 269, 269-8. Cavanagh Collection, Reuther Library.

coordination. It is important to remember, however, that in 1960, federal legislation rewarded urban development, and thus there was more funding and enthusiasm generally for construction and development. There were no federal funds at that time specifically for coordination and operation of health education and health care delivery. Perhaps seeking a second opinion, or perhaps unwilling (or unable) to abide by the findings from the Rourke Report, the DMCC hired a second consultant, Greenleigh Associates in 1964. Greenleigh was a management firm specializing in health and wellness issues, and their study focused primarily on the question of how to manage care for the poor in the new DMC since this patient population created the biggest burden on the city currently, and projections forecasted a growth in this community, creating larger strains on the medical school.

The Greenleigh Report had three recommendations: 1) that indigent care be concentrated under one single department across the four hospitals regardless of medical condition and overseen by one physician department and one administration department, 2) that Detroit Receiving Hospital should be closed and its physicians and staff absorbed by the four voluntary hospitals of the DMC, and finally, 3) if the hospitals of the DMC could not absorb Receiving's staff and physicians, Greenleigh suggested that a new Detroit Receiving Hospital be built, but not necessarily affiliated with the DMC.[540] The Greenleigh Report stressed that while the DMC and its leaders should be thinking about the medically indigent and the poor, the rumored changes to Title 18 and 19 of the Social

[540] John Hanlon, "Greenleigh Report," 1964. Box 269, Folder 269-8 Mayor's Committee to Study Medical Care of the Indigent. Jerome P. Cavanagh Collection, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

Security Act—that would become Medicare and Medicaid—meant that "in effect would result in there being no more 'charity' cases."[541] Presumably, each would be a paying patient and such, accepted in any facility in the community (although this should have already been the case both by accepting Hill-Burton funding and the passage of the Civil Rights Act in 1964; however, hospitals practiced dumping and other strategies to refuse care to indigent populations). The remaining question would be only whether there were enough beds in the combined facilities to provide for the anticipated increase in patients following passage of Medicare and Medicaid, or whether a new hospital for the indigent would be needed.[542]

The DMCC seemed to prefer the findings of the Greenleigh Report. City planners, and the hospitals, continued to place their faith in the ability to consolidate their institutions simply through the physical geography of the new DMC, and the promises of Medicare and Medicaid to address the city-wide financial problems with the growing number of indigent patients. While even the 1956 initial plan for the DMC spoke of intent to coordinate, there was very little—if any—action to move the DMC in this direction beyond its proximal built environment.

In the mid-1960s, as funding for the DMC began to change thanks in part to the new emphasis on regional health planning and manpower legislations, the DMC Citizens' Committee realized it would need to adapt to the new policy environment. By 1966, the United States spent fifteen billion dollars on hospital care alone, excluding funding for

[541] Ibid.
[542] Ibid.

research, construction, or administrative costs for insurance.[543] Exacerbating this need was that costs were even higher in hospitals that focused on specialty care—like the four hospitals of the DMC. Nationally, the per-bed cost in specialty hospitals was approximately thirty thousand dollars in 1965, or double what the per-bed cost was in community hospitals.[544] Further contributing to the cost issue was that in these specialty hospitals, even assuming that patients' insurance and other payments could cover their costs during their stay, the number of beds in these hospitals was shrinking; on average, beds occupied "less than twenty-five percent" of the space in specialty hospitals, with the rest of the space for expensive diagnostic and therapeutic equipment.[545] In addition to working to secure new opportunities for federal funding through the focus on consolidation and medical education, the DMCC worked toward other innovative structural changes.

The DMC as a Nonprofit

For the DMC, one solution to their increased funding troubles was to establish themselves as a nonprofit organization so that they would be able to collect philanthropic donations. Beginning in the early 1960s, health economists encouraged hospitals to establish themselves as nonprofits as a cost-saving measure. Because of the ability to accept philanthropic donations rather than continually fighting for limited public funding,

[543] H.M. Somers and A.R. Somers, "Medicare and the Hospitals*," The Brookings Institution,* Washington, 1967. Cited in Joseph P. Newhouse, "Toward a Theory of Nonprofit Institutions: An Economic Model of a Hospital," *The American Economic Review* 60:1 (1970): pp. 64-74.

[544] Edward L. Walls, Jr., "Hospital Dependency on Long-Term Debt," *Financial Management* 1:1 (Spring 1972): 42-47.

[545] Walls, Jr., "Hospital Dependency on Long-Term Debt," *Financial Management,* p. 44.

some economists argued that nonprofit hospitals, run by their central advisory board, would actually be able to offer higher quality, patient-centered care.[546] In 1963, The DMCC decided to pursue this option.

Following publication of the Flexner Report in 1910, private philanthropy, particularly from groups like the Rockefeller Foundation, had been a major source of funding for medical education and research.[547] After World War II, governmental organizations like the National Institutes of Health were outpacing private philanthropic foundations for education and research donations by almost three to one.[548] By the mid-1960s, hospital administrators realized that in a city like Detroit with a decreasing tax base and an increasing indigent population, it would be strategic to return to a private, philanthropic funding model.

In 1964, the DMC received its first financial contribution from the Detroit Building Fund, a local public organization formed in 1961 made of city planners and businessmen providing guidance on some of the city's larger urban renewal projects.[549] This gift provided the funds necessary for the DMCC to regroup and register as an official nonprofit thus avoiding taxes and able to accept charitable donations. To

[546] Newhouse, "Toward a Theory of Nonprofit Institutions," *The American Economic Review* 60:1 (1970): pp. 64-74.

[547] George Rosen, "Patterns of Health Research in the United States, 1900-1960," *The Bulletin on the History of Medicine* 39:201 (January 1, 1965).

[548] G. Terenzio, "A Survey of the History and Current Outlook of Philanthropy as a Source of Capital for the Needs of the Health Care Field," *Health Care Capital: Competition and Control* (New York: MacLeod & Perlaman, 1978): 239.

[549] Franco, "Detroit Medical Center Corporation," 10, 10-16. Harper Hospital Collection, Reuther Library.

publicize their new status, the group named itself the Medical Center Development Corporation [MCDC] in 1965.[550]

The development of the MCDC raised the profile of the DMC among some of the city's most charitable donors and was a major step forward for the hospitals of the DMC in coming together to form one institution. However, this new funding plan of relying on philanthropic donations did not address one of the most pressing issues facing the city in the mid-1960s: the issue of indigent care. Following the advice that the DMCC had received from Greenleigh Associates the previous year, the MCDC operated under the premise that Medicare and Medicaid would assist the hospitals of the DMC in covering the cost of indigent care. The hospitals of the DMC and Detroit Receiving billed all-inclusive daily rates for their care in compliance with reimbursement procedures from Wayne County and the local Blues insurance providers.[551] After the implementation of Medicare and Medicaid, however, this proved problematic; this per diem charge did not satisfy the documentation requirements for reimbursement from either Medicare or Medicaid, which provided reimbursement for "service rendered to covered patients on the basis of actual incurred costs," or what we understand now as "fee-for-service."[552] Compliance, the DMC and Detroit Receiving learned, would require a massive overhaul of their billing system; an undertaking of this size, the MCDC feared, was one with

[550] Cartmill, "The Dream Takes Shape," undated (circa 1975). 10, 10-16. Harper Hospital Collection, Reuther Library.

[551] Audit Report for Detroit General Hospital, Department of Health, December 31, 1967. Box 335, Folder 18--Board of Health. Jerome P. Cavanagh Collection, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

[552] Ibid.

which the hospital system would be "unable" to comply.[553] While perhaps more pronounced in the DMC's problems, adherence to new federal regulations proved burdensome for universities across the country, as compliance added to hospital operating costs—not only for reimbursement of Medicare and Medicaid, but also through the receipt of federal health manpower funds.[554]

Further contributing to these reimbursement woes were the state's rules regarding Medicaid reimbursement. In Michigan, only people below the age of twenty-one or over the age of sixty-five were eligible for Medicaid.[555] Additionally, Wayne County continued to refuse to reimburse the care for alcoholics, drug addicts, suicides, minors, prisoners, and those hospitalized for fewer than seventy-two hours—the majority of indigent patients fell into at least one of these groups.[556] In reality, since the county had lowered reimbursement amounts in the mid-1960s, this made little difference to hospitals within the city of Detroit who were struggling to get any sort of reimbursement for many of their patients.[557] While the MCDC had assumed passage of Medicaid and Medicare would reduce the number of patients receiving care without reimbursement, the state's restrictions on Medicaid and the county's limits on types of incidents it would reimburse meant that there remained large numbers of indigent patients unable to pay for their care. Inadequate preparation for Medicare and Medicaid policies' reimbursement structures left the hospitals of the DMC without a solution to its biggest financial strain: the

[553] Ibid.
[554] Graham and Diamond, *The Rise of American Research Universities*, p. 96-99.
[555] Audit Report, December 31, 1967. 335, 18. Cavanagh Collection, Reuther Library.
[556] Ibid.
[557] Ibid.

growing number of patients unable to pay for their treatment. Recognizing that their new organizational structure, and the newly enacted public health insurance programs would not address the deepest funding problems of the DMC, the MCDC worked to enact the recommendations from the 1960 Rourke Report, which understood that consolidation was an attainable cost-saving measure.

The Return of The Rourke Report

In November 1968, the MCDC added Fred Kaiser, a management consultant and trustee of Grace Hospital, to its organization.[558] The MCDC believed that a first, attainable step toward consolidation was to develop a plan to equally share amenities and services, including food preparation, phone services, and laundry. They believed that the management expertise of Fred Kaiser would help the MCDC achieve these goals.[559] In 1968, the MCDC received three million dollars from the Metropolitan Detroit Building Fund for this stated purpose, which paid for a consolidated laundry for the hospitals of the DMC, as well as the purchase of the land on which the facility was built, meaning that the laundry facility belonged to the MCDC, and not to the DMC or the city itself.[560]

The consolidated laundry facility was the only progress the MCDC was able to make on this front after two years. Hospital administrators expressed concern over a loss of autonomy at their institutions and worry that MCDC—a development organization—would be tasked with making clinical decisions at their respective institutions. However,

[558] Mozena, "The Detroit Medical Center," p. 66.
[559] Ibid.
[560] Stephen Cain, "Detroit Area to Get new Health Care Plan," *The Detroit News,* November 5, 1975. Cited in Mozena, "The Detroit Medical Center," p. 67.

the DMC hospitals did realize a financial incentive in consolidation after realizing that cost sharing a utility like laundry made a difference in the DMC's bottom line.[561]

By 1970, the MCDC had determined its stated objective was to provide collaboratively "the best possible care of the sick and disabled and preventative medicine for the healthy" while "complet[ing] training and education of all health personnel…[in the] pursuit of excellence in research and scientific development in the healing arts."[562] Additionally, it sought to become an "organized structure that will attract the finest minds and talents in the fields of health services and research so that its ultimate contributions will be of outstanding professional stature."[563] Perhaps most importantly, and heartened by its consolidated laundry program, the MCDC sought to develop "inter-institutional cooperation…allow[ing] the Center to operate as a cohesive whole with centralized planning and control under a single governing body while maintaining that degree of autonomy of the member institutions as required by the characteristics of each, leading to a complete merger of services, facilities, management, and in so far as legal possible, the physical plants and assets."[564]

Seeing that they were able to make some headway providing a plan for shared laundry but unable to work quickly toward progress in any other shared services, the

[561] Corporate Records, Minutes of the board of Trustees Meeting, November 17, 1976, p. 4, cited in Mozena, "The Detroit Medical Center," p. 68. As noted in the introduction, one of the challenges in this dissertation is the lack of concrete financial data in these discussions. Instead of providing charts and tables tracking the financial impact of integration, these arguments are mostly anecdotal and seem to be based on planners' perceptions.

[562] George E. Cartmill, "Purposes and Objectives of the Medical Center Development Corporation," 1970. Box 14, Folder: Hospitals and Organizations, Harper Hospital Correspondence 1966-1971. William T. Gossett Collection, Bentley Historical Library, Ann Arbor, Michigan.

[563] Ibid.

[564] Ibid.

MCDC again decided to hire Anthony Rourke in December 1970[565] to assist in deciding "whether [the MCDC] should also become a service organization through which almost all central activities flow," similar to the way they had handled the consolidation of laundry services.[566] Hiring Dr. Rourke again was done, in part, to allow Detroit Receiving, Wayne State, and the city to "engage in informed planning for their future facilities in the Medical Center" since these bodies had all expressed concern over losing their autonomy should consolidation fully be realized.[567] Rourke, in his completed report, indicated his continued support for the consolidation of all services at the DMC through a single provider—at this point, the MCDC—stating:

> "It is our opinion that the time has now arrived when there should be consolidation of the major gains made over the past several years. The recommendations provide for this organizational framework within which this can be done, and future progress can be made. This is particularly true because of the desire for inter-institutional cooperation which continues to flourish in the Detroit Medical Center."[568]

The 1970 Rourke Study repeated many of the recommendations from the initial 1960 report, but it also provided specific strategies for the consolidation of ambulatory care, medical records, admission and discharge, computer usage, the telephone system Centrex with physician registry and paging, security, bill collection, purchasing and stores, housekeeping, maintenance, grounds and landscaping, laundry, and nutritional

[565] Minutes of the Meeting of the Board of Trustees of Harper Hospital, December 22, 1970. Box 14, Folder Hospitals and Organizations, Harper Hospital Correspondence 1966-1971. William T. Gossett Collection, Bentley Historical Library, Ann Arbor, Michigan.

[566] Mozena, "The Detroit Medical Center," p. 69.

[567] Mozena, "The Detroit Medical Center," p. 70.

[568] Corporate Records, Minutes of the Executive Committee, November 3, 1975, pp. 3-4 cited in Mozena, p. 68.

services.[569] Additionally, and perhaps most importantly, Rourke's Report challenged the hospitals of the DMC to centralize their Board of Directors to "prevent unilateral action" and not take action on matters of development or operations before the centralized board had signed on.[570]

Wayne State University School of Medicine at the DMC

As previously discussed, Regional Medical Programs legislation was directed at developing comprehensive care coming from consolidated systems rather than fragmented programs, which was a significant backdrop to the continued attempts at consolidation of the DMC. In 1971, Marvin D. Meltzer, a trade unionist who served as a correspondent to the United Auto Workers' Social Security Department, wrote in an article about how the regional medical planning programs were affecting Wayne State by forcing the institution to think of itself as a leader in the region, able to address not only the city's pressing issues, but also the state's. While the hospitals of the DMC had begun attempts at consolidation before regional health planning legislation was in practice, Meltzer indicated that he viewed this legislations as a motivator for getting the DMC to think more creatively about what it could accomplish and challenged Wayne State to rise to the occasion. In it, he wrote that the issues of "highest priority" not only for Wayne State but the entire state were

[569] Medical Center Development Corporation, "Anthony JJ Rourke Inc Hospital Consultants of New Rochelle, New York, Recommendations," 1970. Box 6, Folder 6-21 Centralized Community Medical Center Development Corporation 1970. Grace Hospital Records, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

[570] Corporate Records, Detroit Medical Center Corporation, July 12, 1976; February 16, 1977 and Minutes of the Executive Committee July 12, 1976, p. 4 cited in Mozena, "The Detroit Medical Center," p. 69.

> "…in descending priority order: increasing the delivery of health care services, prevention of disease and is complications, and general professional continuing education to improve the quality of treatment services."[571]

The article went on to state that the intentionality with which Wayne State was working to partner with the hospitals of the DMC was an effect of the university recognizing that the:

> "medical consumer, particularly the low-income consumer, has found his voice with respect to the provision of health services. Access to comprehensive, high quality health care is no longer viewed as a matter of privilege but as a basic human right, and medical schools geographically located in the inner cities of large urban areas are affected with the necessity of coming to grips with the growing demands for service placed on them by the communities in which they reside."[572]

Continuing, he wrote of the importance of the DMC in this scenario, writing:

> "Of particular pertinence for us in that regard is the paradox we see in the Detroit Medical Center where we have the best care available in the area (and for which even greater concentrations of skill and technology are planned for the future), while within walking distance of it lives a large population whose medical care needs are the most severe…The task then is to develop health care delivery programs which can approximately accommodate the university's primary functions of teaching and research while simultaneously making available comprehensive, high quality care to the family in need of such care."[573]

While Meltzer saw the entire DMC as responsible for addressing these priorities, the bulk of the expectations to address the care of vulnerable populations fell to the responsibility of Detroit Receiving. Other hospitals within the DMC were not particularly interested in

[571] Marvin D. Meltzer, "The Role of Regional Medical Programs at Wayne State University, February 10, 1971. Box 22, Folder 22-6 Wayne State University Correspondence, 1971. Children's Hospital of Michigan Records, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

[572] Ibid.

[573] Ibid.

providing accessible care to the poor, which only contributed to continued struggle among the hospitals of the DMC as they worked to consolidate into one institution.

Detroit Receiving and the University Clinics Building

While the MCDC worked with Dr. Rourke to enact his recommendations on consolidation, they also resolved to work on two of the more audacious of the initial eighty-nine recommendations: building and integrating a new Detroit Receiving Hospital into the DMC and creating an adjoining outpatient clinic. The MCDC began serious discussions of this task in 1968—two years before the second Rourke Report—but the 1970 report accelerated these discussions.

This was a difficult task for the hospitals of the DMC. Chapter three provides more context for the peculiar place that the city's municipal hospital held in the hearts and minds of residents and city officials. Ultimately, DMC leaders feared the negative association with the (poor, indigent, sometimes criminal, sometimes violent) patients of Detroit Receiving would make the sought-after private paying suburban clientele much more difficult to court. However, as federal and state legislations changed operations and internal policies at the DMC, pressure was mounting from city officials and activists to develop a working relationship with Detroit Receiving. The major reason, beyond even patient care, was to preserve the budding medical education at the DMC, which relied on Detroit Receiving as the major site of all of its clinical education for both medical school students and residents—which Dr. Rourke identified in 1960 as the greatest potential for

success at the DMC.[574] City officials also realized that it had become more pressing to incorporate this hospital into the DMC; it was no longer able to finance this costly operation without help from the nonprofit structure set up in the DMC.

The first step in this process was a reorganization of the planning board, the MCDC. Because Detroit Receiving was still, in 1968 when these discussions began, run by the city, local officials petitioned to get representation from Detroit Receiving administration and from the Board of Health onto the MCDC.[575] This allowed the MCDC to "explore the role of the Detroit Medical Center Corporation in the planning of the new Detroit [Receiving] Hospital buildings in the Medical Center…" and minimize the risk of miscommunication with so many stakeholders involved.[576] By July 1968, the MCDC unanimously expressed their support for a new Detroit Receiving Hospital within the DMC, and added it to the third phase of DMC construction.[577] They understood that they would have to work to resolve issues such as Detroit Receiving's size, its management and organization, financing, and changing relationship with Wayne State as they moved forward with planning. This did not progress until Dr. Rourke provided the groundwork for this consolidation in his second report.[578] But in 1970, a decade after Dr. Rourke made his initial recommendation to do so, Detroit Receiving would finally become a part

[574] Jacques Cousin, "Rourke Report on Proposed DMC," March 1960. Box 269, Folder 269-8 Mayor's Committee to Study Medical Care of the Indigent. Jerome P. Cavanagh Collection, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

[575] Mozena, "The Detroit Medical Center," p. 77.

[576] Corporate Records, Minutes of the Nominating Committee meeting, January 15, 1975, cited in Mozena, p. 78.

[577]Medical Center Development Corporation Meeting Minutes, July 15, 1968. Box 6, Folder 6-13 Board of Trustees, Correspondence, Information, Bulletins, 1968. Hutzel Hospital Collection. Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

[578] Corporate Records, Minutes of the Nominating Committee meeting, January 15, 1975, cited in Mozena, p. 78.

of the DMC. As a new institution within the DMC, the MCDC agreed to operate—as it did for other DMC hospitals at this time as part of the consolidation plan—the hospital's parking, traffic control, and telephone and laundry.[579]

With their commitment to the incorporation of a new Detroit Receiving Hospital seemingly solidified, the MCDC and the city turned their attention to developing an outpatient clinic within the DMC—another recommendation from Rourke's 1970 Report.[580] The purpose of this clinic would be to attempt to relieve some of the demands of Detroit Receiving's emergency room by providing a site of primary care within the DMC, but also as an expansion for the medical school, providing direct clinical experience for Wayne State trainees. Wayne State funded, and led, this project.

By 1970, Wayne State was "interviewing a number of medical planning consultants to determine the selection of one of them to act as a consultant for the planning of the outpatient clinic building."[581] This project was owned by Wayne State University, but there was hope of collaboration with the DMC.[582] The impetus for this project was to provide Wayne State's growing number of trainees exposure to an outpatient population with "interdisciplinary care" as a focus so that trainees would learn how to provide care as part of an interprofessional health care team.[583]

Crucial to the planning, in the opinion city officials, was to have a physical connection between the new Detroit Receiving Hospital and this outpatient center, which

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[579] Ibid.
[580] Mozena, "The Detroit Medical Center," p. 77.
[581] Minutes of the Executive Committee meeting, May 13, 1974, cited in Mozena, "The Detroit Medical Center," p. 83.
[582] Mozena, "The Detroit Medical Center," p. 77.
[583] Minutes of the Board of Trustees meeting, July 17, 1974, cited in Mozena p. 84.

was to be called the University Clinics Building [UCB].[584] This physical connection was so important because it would provide an option for easier hospital admissions to Detroit Receiving Hospital—another way that the city was continuing to place responsibility for indigent care squarely on Detroit Receiving rather than throughout the hospitals of the DMC. Wayne State University School of Medicine faculty, however, was afraid that a physical connection from the UCB to the new Receiving would "carry the stigma attached to a city hospital, and thus not be able to attract [paying] patients."[585] The faculty saw the move to the DMC as a way to alter their national reputation, not only to attract more paying patients but also to attract more trainees.[586] The faculty was already concerned about the ability of Wayne State to attract as many medical students as this construction anticipated. This was concerning because a larger medical school without students and trainees would not only be a waste of money, but an embarrassment to planners. Because of the nature of its patient population, Detroit Receiving had garnered a national reputation as a place to see difficult cases (like tertiary syphilis and the end stages of a tuberculosis infection) that students and residents may not otherwise see in the United States. The medical school faculty were concerned, however, that Detroit Receiving also had a reputation of not preparing students for most other practice settings precisely because these cases were so different from those American physicians would typically see.[587]

[584] Mozena, "The Detroit Medical Center," p. 77.
[585] Mozena, "The Detroit Medical Center," p. 83.
[586] Mozena, "The Detroit Medical Center," p. 84.
[587] Letter from John R. Homminga to Jerome Cavanagh, February 27, 1964. Box 140, Folder 21 Feb Bd of Health. Jerome P. Cavanagh Collection, Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

Despite the faculty's concern about the stigma attached to being affiliated with Detroit Receiving—nothing different from other racially motivated concerns that had plagued the hospital for decades—new medical school Dean Robert Gregg also was adamant that the UCB should "serve all segments of society."[588] During these deliberations, however, the faculty and the MCDC did not discuss how the UCB would meet this charge, resulting in no solid plans to do so. Further confusing the main goals and vision of the UCB by Wayne State administration, Dean Gregg wrote to the board of the MCDC stating that in order to work, UCB would need to be primarily a service clinic—not one prioritizing education—and be staffed with "professionals," not students or residents, believing that making this a teaching institution would make it even more difficult to court private paying patients.[589] Regardless, the Board of Directors of the MCDC endorsed the development of the UCB, connected to the new Detroit Receiving Hospital, at their August 30, 1969 meeting. They also developed the Ad Hoc Ambulatory Care Committee for "identification of the concerns relating to the construction of Detroit [Receiving] and the University Clinics Building" hoping to address its negative reputation while working to serve the population that had grown accustomed to care at this hospital.[590]

Conflict at Wayne State University School of Medicine

[588] Corporate Records, appended to the Minutes of the Annual Meeting of Members and Trustees, April 28, 1976, pp. 3-5 cited in Mozena, The Detroit Medical Center," p. 82.

[589] Ibid.

[590] Corporate Records, Minutes of the Nominating Committee, May 18, 1977, appended to the minutes of the Board of Trustees meeting, May 18, 1977, cited in Mozena, "The Detroit Medical Center," p. 90.

The focus on expanding the medical school did not allow much attention to address the changing social dynamics at the medical school, including coordination among several strong personalities in order to form a central collaborative board to oversee operations at procedures at this medical center. Without an agreement to operate as a unit, the DMC's plans to become a consolidated academic health center would not work.

One of the major challenges brought by these new social dynamics were the difficult issues between Wayne State's School of Medicine and the broader university's administration. As the medical school became more important to the university's survival as it became the best-funded arm on campus, leadership at the medical school and at the university administration butted heads; leadership at the medical school wanted more of a say within broader university happenings. While discord had simmered for half a decade, this conflict came to a head in 1969 as the university began to work on the expansion of health professional schools. This conflict was primarily between the Medical School Dean Ernest Gardner and University President William Keast.[591] A local newspaper analyzed this issue as being a disagreement between "medical care" and "health care," or, physicians and allied health professionals.[592] Dean Gardner was allegedly leery of "…letting other professionals such as nurses and pharmacists take on new roles and creating new types of organizations such as group practice, Medicare, and national health insurance," while President Keast saw the expansion and investment in these professions

[591] Mozena, "The Detroit Medical Center," p. 73.
[592] Ibid.

as a way to continue Wayne State's quest to become a national leader.[593] However, those within the medical school instead saw the controversy as centered on President Keast's concern that the medical school and its dean had become too powerful.[594]

University administrators' concern about the power of medical schools was a national trend in response to the massive funding these schools received. Because of the disproportional increase of National Institutes of Health funding received by biomedical researchers compared to the other research and development areas, medical faculty got paid much higher salaries than did their non-medical colleagues.[595] In some cases, this affected morale as medical faculty perceived this ability to bring in more funding translated to an increase in importance and prominence.[596] Regardless of actual cause of this conflict, the controversy ended in Dean Gardner's resignation from the School of Medicine.[597]

Dean Gardner's anxieties over what he viewed as the erosion of the status of physicians was not necessarily unique. Physicians had enjoyed increasing cultural influence and importance since the early 1900s. As biomedical research and medical technology continued to provide more favorable outcomes for more patients by the mid-twentieth century, physicians seemed to be able to maintain professional autonomy and a sovereignty unlike any other American profession.[598] This was amplified by the American Medical Association, which took a strong position against any proposed

[593] Stephen Cain, "A Hospital Fights to Survive," *The Detroit News,* January 11, 1976, p. 1.
[594] Ibid.
[595] Graham and Diamond, *The Rise of American Research Universities,* pp 127-128.
[596] Mozena, "The Detroit Medical Center," p. 74., *The Rise of American Research Universities,* 127-128.
[597] Mozena, "The Detroit Medical Center," p. 74
[598] Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1984).

legislation or regulation that threatened this autonomy.[599] However, coinciding with the development of academic health centers, allied medical professions began to grow in cultural importance, potentially threatening the unchecked power enjoyed by physicians for so long.[600] On the other hand, President Keast's concern about the medical school overshadowing the rest of the university was also a legitimate concern; in large part because of emphasis on biomedical sciences and regional medical planning by the middle of the twentieth century, the School of Medicine received significantly greater federal funding than any other unit in the university.[601]

This conflict and its subsequent outcome influenced the continued development of the DMC, since a stated goal was to expand the School of Medicine campus to accommodate the large influx of expected students. President Keast reported to the MCDC Executive Committee on April 7, 1970 that while the "ultimate goals for the enlargement of the Medical School enrollment, the construction of the planned buildings in the Medical Center complex, the relationship with the individual hospitals, and with the Medical Center Development Corporation" remain unchanged, the "time table for the implementation" was changed, citing a delay caused by Dean Gardner's resignation and an uncertain future for the leadership of the School of Medicine. President Keast's plan, then, was to establish a medical school task force to establish priorities and review schedules so that the "ultimate goal" was still achievable.[602]

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[599] Ibid.

[600] Fairman, *Making Room in the Clinic.*

[601] Graham and Diamond, *The Rise of American Research Universities,* p. 131.

[602] Corporate Records, Detroit Medical Center Corporation, Jacques Cousin memo to the Executive Committee and Alan Schwartz, March 30, 1976, appended to the Minutes of the Executive Committee meeting, April 5, 1976, cited in Mozena, "The Detroit Medical Center," p. 92.

The Blue Book

By 1971, with plans for incorporation of all the buildings that would form the consolidated DMC—and construction on the new campus of Wayne State University School of Medicine on the medical center campus—the guiding body of the DMC again evolved to achieve the consolidation recommended by Anthony Rourke. In 1971, the MCDC changed its name to the DMC Corporation [DMCCo].[603] Inaugural President George E. Cartmill—who had served as the director and president of Harper Hospital for nearly three decades—said that the purpose of renaming this body was to "accelerate and strengthen the inter-institutional cooperation which would allow the center to operate as a cohesive whole with centralized planning and coordination under a single body" in line with regional health planning trends.[604] Still able to accept philanthropic donations, the name change signified a philosophical change from development to delivery. With its last construction projects underway, the organization needed to dedicate its full attention to the consolidation of one cohesive DMC, with the DMCCo serving as the unifying, and decision-making body—a corporation—acting on behalf of the hospitals.[605] In order to work toward making this a reality, the DMCCo began to work with Anthony Rourke on developing a unifying document that would provide guidelines and strategies for the consolidation of the DMC.

[603] Cartmill, "The Dream Takes Shape," 10, 10-16, Harper Hospital Collection, Reuther Library.
[604] Ibid.
[605] Mozena, "The Detroit Medical Center," p. 89.

By 1972, the DMCCo, comprised of representation from the original four hospitals of the DMC, a new Rehabilitation Institute, Wayne State School of Medicine, Detroit Receiving, and the planned UCB, developed the DMC's Program Utilization Forecast, known as "The Blue Book."[606] The Blue Book laid out the objectives of all included institutions in the DMC, divided into three categories: health care, staffing, and fiscal. The objectives stated that these institutions would share all burdens and profits of treating the patients of all hospitals within the medical center.[607] This would be

[606] Mozena, "The Detroit Medical Center," p 90. [you seem to be changing fonts here]

[607] Corporate Records, minutes of the Executive Committee meeting, July 21, 1976, cited in Mozena, "The Detroit Medical Center," p. 92. Objectives stated here: {This might be better in an appendix.]

A. Health Care Objectives

1. To provide the highest quality health services to all persons needing them, within the present and future capabilities of the Medical Center institutions, regardless of any person's religious, racial or ethnic identification, or economic status.
2. To engage in joint planning efforts utilizing the best available skills and information in the design of an overall service program for the entire Medical Center.
3. To concentrate like services; to avoid unnecessary duplication of facilities and personnel; and to maximize utilization of available resource.
4. To coordinate the planning of the service capabilities of the Medical Center institutions with the service capabilities of other intuitions outside the Medical Center in cooperation with appropriate public and private health planning agencies. To be entirely aware of and committed to the concept that the Medical Center shall become a center of coordinated health care system which includes specialized, primary and preventative health services through which the health care needs of all in the Greater Detroit area will be met.
5. Within the framework of this coordinated program, and to the limit of their capabilities,
    a. To continue to provide specialized and primary health services.
    b. To continue to serve the teaching and research needs of Wayne State University, and
    c. In addition, to focus on the primary health needs of appropriately specified geographic areas.
6. To vigorously support other agencies to obtain similar commitments from other Detroit area hospitals so that high quality health services will be accessible and available to all persons, irrespective of their religious, racial or ethnic identification, or their economic status.

B. Staffing Objectives:

1. Recognizing the legal responsibility of hospital trustees to maintain a balanced staff of well qualified physicians to assure the quality of care provided to patients utilizing their institutions,
    a. It is the objective of the Detroit Medical Center hospitals to provide equal opportunity, commensurate with the physicians' abilities, to staff privileges for al qualified physicians…subject to the conditions and obligations which accompany such privileges, regardless of religious, racial, or ethnic identification.
    b. To develop a mechanism by which the medical staffs of each of the Medical Center hospitals will be afforded appropriate privileges enabling them to follow their referred patients into other Medical Center Hospitals.

C. Fiscal Objectives:

accomplished by the DMCC acting as the fiduciary body of the DMC, responsible for patient billing, insurance negotiations, service contracts, and funding application on behalf of all the institutions within the DMC. This was in preparation of not only cost sharing for this organization, but also profit sharing.[608] This plan was, however, controversial. Representatives from the hospitals within the DMC argued against cost and profit sharing and sought to retain the fiscal autonomy of each individual hospital. The ensuing discussions among hospital representatives on the DMCCo resulted in a delay of full consolidation of the DMC until 1985.[609]

Members of the DMCCo Executive Committee, who were mostly comprised of representation from the four original DMC hospitals, said that the Blue Book was incomplete and not forward-thinking, with the DMCCo Executives stating that the integration of services it called for—save for the inclusion of Detroit Receiving and UCB—had already been done.[610] With such animosity brewing over what full consolidation would mean, the Blue Book ended up being a convenient scapegoat for physicians and administrators who were looking to leave the DMC, with DMCCo Executive Robert Mack stating:

> "The Blue Book was used as an excuse by people who left to practice in greener pastures in the suburbs. It was a façade used by those wanting to escape whatever unfavorable circumstance was already in place."[611]

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1. To utilize joint planning in such a manner as will minimize the costs of providing health services without sacrificing quality care.

The Medical Center institutions recognize that these Health Care Objectives cannot be fully met unless full cost reimbursement for the services is obtained, and agree to work to accomplish this end."

[608] Mozena, "The Detroit Medical Center," p 90.

[609] David Barkholz, "Five Detroit Hospitals Form System, Aim to Improve Competition Stance," *Modern Healthcare*, 15 (September 27, 1985): p. 46.

[610] Mozena, "The Detroit Medical Center," p. 95.

[611] Corporate Records, Minutes of the Board of Trustees Meeting, March 15, 1978, cited in Mozena, "The Detroit Medical Center, p. 95.

Clinical Consolidation of the DMC

Another important aspect of consolidation, which was formalized in the Blue Book, was the elimination of all trauma and emergency care—except for pediatric emergencies to be treated at Children's and obstetrical emergencies to be treated at Hutzel—at the original four hospitals of the DMC. Instead, Detroit Receiving, which was soon-to-be incorporated into the DMC, would provide all trauma and emergency care within the medical center.[612] The hospitals of the DMC had not yet reconciled themselves to Detroit Receiving's reputation, including ongoing accreditation issues, which included a final citation in 1975 about overcrowding and fire safety in the hospital that was not remedied until 1978.[613] Both its reputation and accreditation issues "cast doubt in some minds on the future of the new Detroit [Receiving] then under construction in the DMC."[614]

There was disagreement among the institutions of the DMC as to what constituted an "emergency." One of the growing pains of joining these hospitals together was that each hospital used different terminology and different clinical criteria to define emergency care.[615] For example, Detroit Receiving staff actively treated patients using

[612] Ibid.

[613] Dolly Katz, "Hospital Demerits Explained," *Detroit Free Press*, Sunday, November 11, 1978. .Box 6, Folder 6-3 News Clippings 1976-1979, Grace Hospital Records. Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

[614] Mozena, "The Detroit Medical Center," p. 124.

[615] Ibid.

the emergency room for their primary care, while it would not be unusual for other hospitals of the DMC to turn such a patient away.[616]

The DMCCo Medical Advisory Committee was concerned that Detroit Receiving as the only site of emergency care in the DMC, may not allow "assurances of an acceptable standard of health care delivery" because of the inability of private physicians to "follow private patients."[617] Additionally, critics believed that there were not "adequate standards in the operation of the [Detroit Receiving] emergency room."[618] Furthermore, the advisory committee worried that medical staff would not apply to work at Detroit Receiving until they were assured it was a place where private patients could receive the type of care in the type of facility at which they had grown accustomed.[619] The fears of the DMCC may have been unfounded, however. By 1976, seventy-five percent of admissions to the DMC came from "areas that [were] declining in population," like Detroit's inner city, while the vast majority of patients still came from a five-mile radius.[620] The only areas "declining in population" by 1976 in Metropolitan Detroit were in the city proper; the DMCCo was still trying to make concessions for suburban patients while city residents continued to be the main patient population at the hospitals of the DMC.

Contributing to the struggles of consolidation, the administrators of Hutzel and Harper hospitals were concerned about losing the revenue generated by emergency care

[616] Ibid.
[617] Ibid.
[618] Ibid.
[619] Mozena, "The Detroit Medical Center," p. 130-132.
[620] Ibid.

once Detroit Receiving became the primary site of emergency care.[621] The admission of patients following evaluation in the emergency room was an important source of revenue at these hospitals. Once Detroit Receiving became the only site of emergency care, the administrators at Hutzel and Harper, feared that emergency patients requiring admission would stay at Detroit Receiving instead of getting admitted to Harper, Grace, or Hutzel.[622] This very argument demonstrates not only the hospitals of the DMC's unwillingness to fully join together as one institution, but also a grave misunderstanding of what the DMCC was attempting to accomplish through its shared financial responsibilities and profits. Rather than recognizing that business at Detroit Receiving would improve the financial earnings of the entire DMC once these institutions were fully integrated, these hospitals still competed, and acted as though they were all responsible for their own earnings. This economic anxiety was exacerbated by the "obvious reluctance of private physicians to have their [emergency] patients enter the DMC system through the Detroit [Receiving] emergency room," echoing the long-held racist and classist perceptions of Detroit Receiving and its patient population.[623]

Ultimately, these fears proved determinative. Rather than pursuing full consolidation, the DMCCo allowed both Harper-Grace and Hutzel to keep their emergency departments, which they called the Ambulatory Reception Center so as to distinguish them from the emergency room at the Detroit Receiving Hospital.[624] This action by the DMCC undermined Detroit Receiving's ability to succeed and kept the dual

[621] Ibid.
[622] Ibid.
[623] Mozena, "The Detroit Medical Center," p. 127.
[624] Ibid.

system of care within the DMC. The de facto experience, then, was that the emergency department at Detroit Receiving remained the indigent hospital, "seriously affecting Receiving's financial viability," and helped to "perpetuate the perception of Detroit Receiving as a hospital for the poor."[625]

These concerns carried over to the new UCB building "being identified with the indigent image of Detroit [Receiving] Hospital."[626] The administrators of Hutzel, Grace, Harper, and Children's hospitals instead thought it would be better to plan for private outpatient services at their own individual hospitals rather than to have this service be centralized at UCB, essentially nullifying its purpose.[627] City officials, Wayne State administrators, and the board at Detroit Receiving opposed this plan, stating that it would be another decision that yet again perpetuated Detroit's "two-door system" of care, and worrying that only indigent patients would be served at UCB.[628] Toby Citrin, a board member at Detroit Receiving, continued to emphasize that the new Detroit Receiving Hospital was not being planned as an indigent hospital—and in fact, the first Detroit Receiving was not intended to serve only this population—since all hospitals of the DMC should be taking indigent patients.[629] No compromise on this plan was reached (each hospital continued taking its own outpatients), but the DMCCo believed it saw a victory when an agreement was reached for all three DMC emergency departments—at Harper,

[625] Ibid.
[626] Ibid.
[627] Mozena, "The Detroit Medical Center," p. 85.
[628] Mozena, "The Detroit Medical Center," p. 86
[629] Corporate Records, Minutes of the Nominating Committee, May 18, 1977, appended to the minutes of the Board of Trustees meeting, may 18, 1977, cited in Mozena, "The Detroit Medical Center," p. 79.

Grace, and Receiving—were staffed by the same professional association, sharing physicians, nurses, and other providers.[630]

All these attempts at consolidation, however, did little to ease the contentious relationship of DMC hospitals with Wayne State University. Medical school faculty had to fight to be given hospital appointments at Harper, Grace, Hutzel, and Children's in addition to their traditional appointments at Detroit Receiving because there was still a concern over any affiliation with Detroit Receiving decreasing a hospital's reputation.[631] The centralization of the DMC staff, however, was a crucial part of the consolidation of the medical center as purported by The Blue Book. Managing the staff through the DMCCo and allowing physician and staff privileges across all the hospitals would equalize care and provide greater employment opportunities for support staff.[632]

While infighting occurred at the DMCCo level, physicians at each hospital expressed great concern over this potential arrangement, noting that they had a "comfortable situation [and didn't] want to see it disturbed."[633] Those who were in favor of moving toward a centralized staff realized that it would "aid in the development of overall medical leadership and provide the impetus to develop clinical programs which are reasonably non-competitive within the DMC, while being competitive with programs outside of the DMC."[634] What's more, it was crucial to fulfilling the aims of The Blue Book, and the DMCCo more broadly. DMCCo member Robert Black noted that

[630] Ibid.
[631] Ibid.
[632] Ibid.
[633] Mozena, "The Detroit Medical Center," p. 121.
[634] Mozena, "The Detroit Medical Center," p. 123.

physicians "typically hate[d] change of the status quo…fearing loss of control and loss of income."[635] At the same time, he believed that a centralized staff would allow physicians more autonomy and control at the DMC, "deter[ing] the boards and administrators from retaining too much self-interest in their institutions."[636]

By spring 1977, full consolidation of the hospitals within the DMC had failed. As DMCCo board members continued to contest the adoption of the policies within the Blue Book, the DMCCo decided that the best course of action was to return to each individual's home institution and work on Rourke's suggestions internally, undermining the very intent of the Blue Book.[637]

The DMCCo continued to struggle with consolidation for the rest of the decade, especially regarding Detroit Receiving and the UCB, which provided the anchor for Wayne State's teaching program. In 1979, the Michigan State Legislature passed a statute reaffirming the purpose of both the UCB and Detroit Receiving and finalizing their operations by the DMCCo.[638] This transfer placed the full control of Detroit Receiving and UCB in the hands of the Detroit Medical Center Corporation. This authorized the DMCCo to appoint Detroit Receiving's hospital board and CEO, with the UCB supervised by Detroit Receiving.[639]

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[635] Ibid.
[636] Mozena, "The Detroit Medical Center," p. 121.
[637] Ibid.

[638] Michigan Legislature, *Act 217 of 1979,* "Transfer of Clinics Building and Detroit Receiving Hospital," January 15, 1980.

[639] Ibid.

Conclusion

The increasingly competitive environment created by regional medical programs and the centralizing of the academic health center served only to create skepticism and distrust among the hospitals of the DMC, making the integration necessary for its success virtually impossible. These hospitals had identified indigent care as a major source of financial turmoil at Detroit Receiving, but an inability to share the responsibility of this growing burden within the DMC due to racist and classist fears about these patients ruining the reputation of this medical center further contributed to its failure. Difficulties with Medicaid and county reimbursements made it impossible for Detroit Receiving to recuperate funding for the bulk of its patient population. The continued economic struggles of Detroit Receiving as it worked to meet the needs of Detroit's population further contributed to its "bad" reputation among the hospitals of the DMC, and thus, this hospital continued to be a liability rather than an asset for the medical center. This resulted in a reluctant partnership. The contentious relationships of the institutions of the DMC paired with regional medical planning policies which economists and scholars have identified as increasing costs by concentrating hospital services and emphasizing biomedical research was a significant factor that contributed to the failure of the DMC to thrive, and therefore, impeding the renaissance of the city of Detroit more broadly.

Whatever strides the DMCCo made during the 1970s and 1980s, it was not as consolidated as it outwardly claimed to be. While the DMC faced "many obstacles from geography to racism to mundane bureaucratic wrangling," coordination and consolidation

represented the DMC's biggest challenge.[640] Critics had identified that the "key to all of its possibilities is a cooperative venture among the hospitals, concentrating individual specialties, such a pediatrics, in individual hospitals, and sharing services, such as radiology, that all hospitals use."[641] The "byzantine arrangement" of the separate hospitals with separate administrations, with "independent doctors who don't quite trust each other" belied the very concept of a centralized medical center.[642] Trust was absent to the point that hospital administrations had to be "force[d]…to do anything…all agreements have to be worked out by mutual consent."[643] And while this distrust came from many sources, a contributing factor was the backdrop created by regional medical program legislation by the 1970s.

The policy and funding focus on regionalism and academic health centers increased competition between the hospitals of the DMC itself, making the hospitals within the DMC more concerned for their own survival rather than for the whole of the DMC. In Metropolitan Detroit, this was felt even more strongly as the separation between the suburbs and the city continued to grow. From the beginning, DMC planners intended the DMC to attract increasing numbers of paying patients from the suburbs. However, the growing numbers of suburban patients imagined by the planners never materialized. Despite multiple advertising attempts to reach this community, private patients from the suburbs never came. The image of the city grew worse throughout the 1970s and 1980s, prompting one medical center official to sum it up, stating: "I wish it weren't so, but

[640] Mozena, "The Detroit Medical Center," p. 80.
[641] Ibid.
[642] Ibid.
[643] Mozena, "The Detroit Medical Center," p. 81.

frankly, how many Oakland County housewives do you know who are willing to drive thirty minutes or more to get to the medical center and then have to sit in a waiting room full of welfare mothers?"[644]

Once the anchor of the Southeastern Michigan region, Detroit was no longer able to attract white suburbanites to visit, live, or receive health care. But throughout its entire development, the DMC continued to try to court these individuals. The DMC did consolidate fully under the DMCCo in 1985, but that is far from the end of the story. The DMC continued to struggle over the next thirty years, often due to many of the same factors it has been unable to face since the 1950s.

[644] Edwin Chen, "Detroit Medical Center—Urban Renewal Success," *The Detroit News*, September 9, 1977. Box 6, Folder 6-3 News Clippings 1976-1979, Grace Hospital Records. Walter P. Reuther Library of Labor and Urban Affairs, Detroit, Michigan.

"As I witness and participate in our visionary efforts to revitalize Detroit and contrast them with the multi-billion dollars' worth of megaprojects advanced by politicians and developed that involved casinos, giant stadiums, gentrification, and the Super Bowl, I am saddened by their shortsightedness. At the same time, I rejoice in the energy being unleashed in the community by our human-scale programs that involve bringing the country back into the city and removing the walls between schools and communities, between generations, between ethnic groups. And I am confident just as in the early twentieth century people came from around the world to marvel at the mass production lines pioneered by Henry Ford, in the twenty-first century they will be coming to marvel at the thriving neighborhoods that are the fruit of our visionary programs."—Grace Lee Boggs[645]

Conclusion

The story of the Detroit Medical Center does not end in 1985. Once fully integrated, the hospitals of the DMC turned their energy to emphasizing the full range specialty care and biomedical research on their campus, even hosting Michigan's

Figure 4: Governor Blanchard touring the new Damon Clinical Laboratories at the newly consolidated DMC in 1985. Photograph from Box 189, Folder Photographs: Detroit Medical Center. JJ Blanchard Collection, Bentley Historical Library, Ann Arbor, Michigan.

[645] Grace Lee Boggs, *The Next American Revolution: Sustainable Activism for the Twenty-First Century*. (Berkeley: University of California Press, 2011).

governor, James Blanchard, to tour the labs and see the new equipment that was offered at what the city hoped would be one of the premier medical campuses in the country. By the late 1980s, this center had grown to eight institutions: the original four DMC hospitals, Detroit Receiving, the UCB Outpatient Center, the DMC Rehabilitation Institute of Michigan for long-term and step-down rehabilitation, and DMC Sinai-Grace Hospital. But the full incorporation of this medical center under the nonprofit DMCCo did little to help stem ongoing problems. Officials' desire to be a world-class medical center was in constant struggle with the reputation of both the city and the DMC itself. It became increasingly more difficult for the city to maintain adequate standards at the hospitals of the DMC.

These problems were exacerbated by the increasing costs of health care leading up to the DMC's consolidation in 1985. In Michigan, these health care costs were eight percent higher than the national average.[646] From 1976-1981, health care costs in Michigan doubled, with the state paying eleven billion dollars annually, spending nearly half this on hospital care.[647] The Michigan Republican Caucus urged in the beginning of the 1980s for the legislature to "divert…attention from short-term treatment and solutions and toward long-range prevention strategies," citing that prevention only accounted for six percent of the budget went toward prevention and health education was less than one percent; less than two-tenths of one percent went toward research.[648] Future Michigan Governor John Engler urged his colleagues in the early 1980s to focus on prevention as a

[646] John Engler, "Speech to Michigan GOP Caucus," undated circa 1982. Box 10, Folder: "Health Care," John Engler Collection. Bentley Historical Library, Ann Arbor, Michigan.
[647] Ibid.
[648] Ibid.

cost-saving measure at hospitals across the state, since this problem was not going away. Engler stated:

> "What legislators and health professionals have not yet accepted is that—to some extent—rising health care costs are a product of our era and will always be with us. Science and technology have created advancements, which for all purposes but the practice, are positive…even the major health insurance companies, so often seen as a bottomless pit of funds, are running out of money."[649]

These rising costs were not helped by local policies that made care for the patient populations at the hospitals of the DMC even more difficult.

In 1985, the same year that the DMC incorporated under its nonprofit, Wayne County expanded the criteria for indigent care, allowing a patient to register as "indigent" if their income level did not allow them to pay the hospital their full bill within six months.[650] This expansion, however, did not assist the DMC; Wayne County continued to not service any patient, or any institution, within the city of Detroit well into the 1990s.[651] In the same year, Wayne County rethought its emergency care requirements, stating that treatment for emergencies require the patient to be in danger of "immediate…of life or other endangerment."[652] Wayne County determined, then, that if the patient was not in danger or dying, and was indigent, they would be transferred to "community based hospital" like Detroit Receiving or Harper at the DMC.[653] Presumably, this policy

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[649] Ibid.

[650] Wayne County Department of Health, "Indigent Eligibility Criteria," May 1985. Box 57, Folder: State Detroit Wayne County Health Department. University of Michigan School of Public Health Collection. Bentley Historical Library, Ann Arbor, Michigan.

[651] Vernice Davis-Anthony, Health Officer, "Wayne County Department of Health: Health Centers Service Guide," 1995. Box 57, Folder: State Detroit Wayne County Health Department, University of Michigan School of Public Health Collection. Bentley Historical Library, Ann Arbor, Michigan.

[652] Wayne County Department of Health, "Indigent Eligibility Criteria," May 1985. 57, State Detroit Wayne County Health Department. University of Michigan School of Public Health Collection. Bentley Library.

[653] Ibid.

continued even once Congress passed the Emergency Medical Treatment and Labor Act in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act [COBRA], which required emergency departments to provide assessment and care to any Medicare patients.[654] This remains an unfunded mandate, and so while people have the right to access this care, hospitals do not have to provide it.[655] Thus, transferring patients to the hospitals of the DMC if they were not in immediate need of lifesaving care was completely legal.

Problems at the DMC continued in tandem with continued economic decline and demographic shifts within the city of Detroit. Between 1970 and 1980, there was a 29.6 percent decline in employed residents in the city of Detroit; at the same time, there was a 27.6 percent increase in employed residents in the city's surrounding suburbs.[656] This decline continued, but stabilized a bit, when between 1980 and 1990, the decline in employed residents was 14.9 percent. During this same period, the population of employed residents in the Detroit suburbs increased 14.5 percent. Not only was Detroit's decline continuing, but the disparities between the suburbs and the city were continuing to grow—even once the decline slowed. At the same time, the racial demographics of the city of Detroit and its surrounding communities continued to shift. While the overall population of Detroit was declining, it was growing less diverse. Between 1980 and 1990, the white population of Detroit decreased from 33.4 percent to 20.7 percent, and the

[654] US Code 42 § 1395dd, "Examination and Treatment for Emergency Medical Conditions and Women in Labor." https://www.law.cornell.edu/uscode/text/42/1395dd (accessed April 1, 2019).

[655] Beatrix Hoffman, *Health Care for Some.*

[656] Department of Housing and Urban Development, State of the Cities Data Systems (SOCDS). https://socds.huduser.gov/CEnsus/totalemploy.odb?msacitylist=2160.0*2600022000*1.0&metro=msa (accessed April 4, 2019).

black population increased from 62.7 percent to 75.5 percent.[657] The suburbs were still overwhelmingly white, although it was slowly diversifying; in 1980, the white population of the suburbs was ninety-four percent, and by 1990 it had dropped slowly to 92.4 percent.[658] The decades of policies that favored white homeownership, and urban developments like the DMC that displaced black residents and destroyed black-owned businesses had resulted in areas of in the surrounding suburbs that were essentially solidly white.

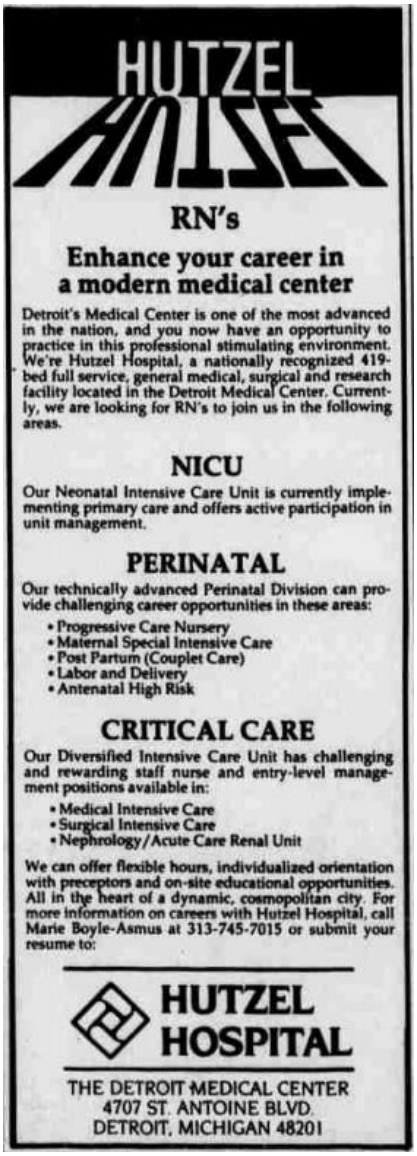

Figure 5: Nursing ad from the *Minneapolis Star and Tribune*, August 3, 1986.

The development of the DMC did little, if anything, to improve the economic conditions of the city. As this dissertation has shown, three solid decades of resources poured into the hospitals that would become the DMC likely was a contributing factor to the city's economic decline. Adding insult to injury, the DMC had not succeeded in any of its planners' initial goals—to transform the Detroit economy, to provide additional white-collar labor for Detroit residents, or to improve the health of the city and its residents.

As the city continued to struggle, so did the DMC. Set against the backdrop of the declining city, the medical campus struggled to overcome the negative image of the

[657] Ibid.
[658] Ibid.

city to hire an adequate number of physicians, nurses, and staff. Ads ran in newspapers all around the Midwest trying to encourage folks to move to Detroit and work for the DMC, emphasizing not only the benefits of employment, but also the opportunity to live within a "dynamic, cosmopolitan city."[659] But the city was not the only problem for the DMC. Because of the economic and staffing troubles, care itself also suffered. Dangerous cases of negligence at the DMC began to make national news, like a four-year legal case ending in 1989 when the DMC settled for an undisclosed amount over the "improper care" of a man who died after maggots nested in his tracheotomy hole.[660]

By the late 1980s, scholars were beginning to look for links between the bad economy and health. In 1989, the University of Michigan published The Detroit Area Study, which incorporated tools from a "new field within public health," which had begun because researchers, teachers, government workers, and health providers determined that studying the socioeconomic status of people was crucial to understanding the full effects of epidemiological issues and disease.[661] This study found that "no progress [was made] toward racial equality in the 1980s" in Metropolitan Detroit.[662] The report found that thirty-seven percent of black Detroiters lived in households with an income of below ten thousand dollars, and the median income of black Detroiters was only sixteen thousand dollars—it was 32,500 dollars for white Detroiters.[663] Of the

[659] Hutzel Hospital Nursing Ad, *Minneapolis Star and Tribune,* August 3, 1986, p. 124.

[660] Chuck Shepherd, "News of the Weird," Distributed by Universal Press Syndicate and Published in *Minneapolis Star and Tribune,* September 17, 1989: 78.

[661] Deborah Shelton, "The Great Divide," March 10, 1995. Box 4, Folder 1995, "Study of Health and Social Attitudes." University of Michigan Detroit Area Study Collection, Bentley Historical Library, Ann Arbor, Michigan.

[662] James Tobin, "U-M Study: Race Still Splits Area." *The Detroit News,* December 10, 1989. Box 1, Folder: Newspaper Articles 1981-1990. University of Michigan Detroit Area Study Collection Bentley Historical Library, Ann Arbor.

[663] Ibid.

findings, Detroit NAACP President Arthur Johnson said: "It is a system which…works to continue the exploitation of black [people], and in that sense, we have our own form of apartheid."[664] This echoed the conclusions published in the Kerner Report two decades earlier in response to the violence in American cities. This Detroit Study also found that there remained marked differences in the health of black and white residents due to these differences in living conditions, including in infant mortality.[665]

The United States Surgeon General had a goal of lowering infant mortality to nine per one thousand by 1990, and Michigan had met that goal—for white infants. The rates of black infant deaths were still high—23.5 deaths per one thousand births in 1984—with the trend worsening rather than improving.[666] In one year, from 1985 to 1986, black infant mortality for the state of Michigan increased by 2.2 percent, while white infant mortality decreased 3.2 percent during the same period.[667] In Detroit, this difference was even more prominent: black infant mortality increased by 8.5 percent, and white infant mortality declined by 24 percent.[668] "The gap between black and white infant death rates is a tragedy—an indictment against our society," remarked Gloria Smith, the director of the Michigan Department of Public Health in 1987.[669] By 1987, only nine states and the District of Columbia had higher overall infant mortality rates than Michigan, and only the District of Columbia had a worse infant mortality rate than the city of Detroit, where

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[664] Ibid.

[665] Ibid.

[666] Babies at Risk, Table in the *Ann Arbor News* from the Michigan Department of Health. May 18, 1990. Box 57, Folder: Topical Files: Race Relations-Health 1987-2000. University of Michigan School of Public Health Collection, Bentley Historical Library, Ann Arbor.

[667] Ibid.

[668] Ibid.

[669] Peter Luke, "Black Infant Mortality increasing in Michigan," November 2, 1987. Box 57, Folder: Topical Files: Race Relations-Health 1987-2000. University of Michigan School of Public Health Collection, Bentley Historical Library, Ann Arbor, Michigan.

twenty-one of every one thousand infants born did not live to see their first birthday in 1990.[670]

A task force assembled by the Michigan Department of Public Health in response to the Detroit Area Study determined that the root causes of the increasing mortality rates among black infants were poverty, inadequate medical services, and malnutrition.[671] Other cited causes included low birth weight (black babies born under 5.5 pounds increased almost ten percent from 1985 to 1986), increasing number of teen births in the black population, and increasing number of births to mothers with less than a twelfth grade education.[672] This task force recommended an expenditure of thirty-one million dollars throughout the state to increase health care access, Medicaid expansion, and community education programs in the counties with the highest amount of infant mortality.[673] The state had already approved an expenditure of seventeen million dollars in 1987.[674]

By 1992, infant mortality rates had dropped overall in Michigan and within the city of Detroit, but the infant mortality rates of black babies in Detroit remained double

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[670] Ibid.

[671] Ibid.

[672] Several factors contribute to low birth rate, including malnutrition, a lack of prenatal care, lead exposure, and substance abuse. The mid to late 1980s saw the rise of the "crack epidemic" due to the newly available free-base cocaine being available for as little as $2.50 per dose. By 1988, crack had replaced heroin as the most abused drug in the city of Detroit, and its cheapness and easy availability resulted in its widespread usage. More information see the Drug Enforcement Administration's History from 1985-1990 available at https://www.dea.gov/sites/default/files/2018-07/1985-1990%20p%2058-67.pdf. Accessed on April 4, 2019. See also: Luke, "Black Infant Mortality Increasing in Michigan," *Ann Arbor News*, November 2, 1987. 57, Folder: Race Relations-Health 1987-2000. University of Michigan School of Public Health Collection, Bentley Library.

[673] Babies at Risk, *Ann Arbor News*. May 18, 1990. 57, Race Relations-Health 1987-2000. University of Michigan School of Public Health Collection, Bentley Library.

[674] Luke, "Black Infant Mortality Increasing in Michigan," *Ann Arbor News*, November 2, 1987. 57, Folder: Race Relations-Health 1987-2000. University of Michigan School of Public Health Collection, Bentley Library.

that of white babies.[675] The overall drop in infant mortality rates was largely credited by both the Detroit and Michigan Departments of Health to the outreach programs which sought to increase the number of women receiving prenatal care, but in reality the overall percentage of women receiving prenatal care had remained the same—around seventy-one percent.[676]

These gaps between the health of white and black residents in Detroit extended beyond infant mortality; the morbidity rate gaps between white and black people were the largest in the United States.[677] The gaps were most pronounced in heart disease.[678] In Michigan, the death rate for heart disease among black residents was three percent higher than it was for white residents, but by 1985, it was twenty-seven percent higher.[679] These rates were quickly increasing—in 1975, the death rate for black Michigan residents was thirty-eight percent higher than it was for white Michigan residents; by 1985, that had increased to forty-eight percent.[680] Homicide, however, remained the leading cause of death for black male Michigan residents between the ages of fifteen and thirty-four.[681]

These studies cited poor access to care as factors, and a misunderstanding of what sorts of health care could help decrease the rates of these illnesses.[682] Harold Johnson,

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[675] Kenneth Cole, "City, State Infant Mortality Rates Drop." *The Detroit News*, January 9, 1992. Box 57, Folder: Topical Files: Race Relations-Health 1987-2000. University of Michigan School of Public Health Collection, Bentley Historical Library, Ann Arbor, Michigan.

[676] Ibid.

[677] Luke, "Black Infant Mortality Increasing in Michigan," *Ann Arbor News*, November 2, 1987. 57, Folder: Race Relations-Health 1987-2000. University of Michigan School of Public Health Collection, Bentley Library.

[678] Tobin, "U-M Study: Race Still Splits Area." *The Detroit News*, December 10, 1989. 1, Newspaper Articles 1981-1990. University of Michigan Detroit Area Study Collection. Bentley Library.

[679] Peter Luke, "Black-white Health Gap Grows," *Ann Arbor News*, April 14, 1988. Box 57, Folder: Topical Files: Race Relations-Health 1987-2000. University of Michigan School of Public Health Collection, Bentley Historical Library, Ann Arbor, Michigan.

[680] Ibid.

[681] Ibid.

[682] Tobin, "U-M Study: Race Still Splits Area." *The Detroit News*, December 10, 1989. 1, Newspaper Articles 1981-1990. University of Michigan Detroit Area Study Collection. Bentley Library.

dean of the University of Michigan's School of Social Work and a task force member with the state of Michigan wrote:

> "Even though Michigan spends $1.5 billion annually for health care for the poor, there are people who are not receiving adequate health care, particularly in the area of prevention, which we all know is critical for good health."

He highlighted his assertion that it would be less costly in the long run for the state to focus on preventative and primary care.[683] Johnson also cited the greater likelihood that black residents had lower wage jobs without included health care benefits, making it less likely that this population of people would seek medical care early.[684] Former head of the Detroit Board of Health, Jay Waller, summed it up succinctly: "Being poor is hazardous to your health."[685]

Despite scholars citing a lack of access for the poor health of black residents, medical and public health students in Southeastern Michigan were being taught that addressing these health care inequalities would be more difficult than simply improving access. Some in public health taught the long history of racial inequalities in medical care, citing the many ways that racially motivated practices affected the ways that black patients interacted with the medical profession, including Dr. Marion Sims's gynecological experiments on slaves, medical textbooks instructing X-ray technicians to give black patients larger "X-ray doses" because of their "thicker skins" and "denser bones," segregated blood donation, and the inequalities of treatment for black and white

[683] Ibid.
[684] Ibid.
[685] Ibid.

patients with the same condition in the same hospitals.[686] Even the concept of "flesh colored bandages" only matching the flesh of one race contributed to the continuation of racist practices in medicine.[687]

By the late 1980s, some public health scholars began blaming "the major source of these disparities" on "the fact that we live in a racist society," and saw the true reason for the health gaps between white and black residents being the cutback in programs that provided assistance to historically underserved populations.[688]

For these scholars, racism was described as not necessarily as the conscious discrimination present in pre-Jim Crow United States policy, but instead the "structures of society which support the dominant position of whites and the subjugation of people of color."[689] Even so, one professor conceded, similar to the civil rights activists before him, that:

> "We are not likely to do very much about change in our economic and health care systems by focusing efforts of change at benefitting the Black population or other subordinate groups, Rather, social progress is more likely to come about by action which emphasizes benefitting the population at large. This means supporting programs like social security and national health insurance or a national health service—which can be used by the entire population—rather than programs aimed at racial minorities, or even the poor more generally."[690]

In Detroit, the actions of city officials and planners of the DMC certainly contributed to the racist society that supported the continued subpar living experiences

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[686] Anonymous, "Minor Changes in my Lecture on 'Race, Health, & Public Policy," Health & Public Policy: Ethnic Minorities. January 1989. Box 57, Folder: Topical Files: Race Relations-Health 1987-2000. University of Michigan School of Public Health Collection, Bentley Historical Library, Ann Arbor, Michigan.

[687] Ibid.

[688] Ibid.

[689] Ibid.

[690] Ibid.

for black residents. The slum clearance that led to the initial construction of the DMC displaced thousands of black residents and shuttered hundreds of black-owned businesses, stunting the economic growth of this community. While the Detroit Urban League tried to work with the city to ensure that the jobs that this development would create would also benefit Detroit's black residents, this community was ultimately excluded from the DMC's progress—even the middle-class black professionals on whom the majority of the Detroit Urban League's activism was focused. Black residents were underrepresented on staff, in leadership positions at the hospitals, and in advisory positions with the city. And over the course of its development, black patients faced discrimination and were unable to receive adequate care at the hospitals of the DMC, often transferred and dumped to overcrowded and substandard Detroit Receiving.

The construction of the DMC perpetuated the dual system of care within the city of Detroit, contributing to the continued poor health of Detroit's black communities. By not providing adequate health provision for this population, the city all but ensured its continued economic decline; health must be present for an individual to be a contributing member of his or her neighborhood and city. If a community is perpetually unhealthy, there is little energy or additional funds for community members to participate in their city's "renewal." And, the city's renewal will be delayed as more resources are needed to care for this sick community. The United States never signed onto either the 1948 or 1966 United Nations' treaties that identified several basic needs as human rights, including access to clean water, sanitation, nutrition, and health care.[691] This means that

[691] Hoffman, *Health Care for Some.*

not Detroit, or any other municipality, is obligated to provide health care to its residents. But the case of the DMC should perhaps make municipalities contemplate doing so.

The University of Michigan published a study in 2000 in the *New York Academy of Sciences* that found that the differences in death rates between white and black Michigan residents were at the same rates as they were in 1950, citing this outcome as the result of deliberate actions that continued to keep black residents a perpetual underclass.[692] Senior research scientist David R. Williams wrote:

> "This is not an act of God. Neither does it simply reflect racial differences in individual behavior or biology. Instead, considerable evidence suggests that these striking racial differences in health and their persistence over time reflect, in large part, policies and practices that are linked to the historical legacy of racism, and that have created adverse living conditions that are pathogenic for minority populations…For both Blacks [sic] and whites [sic], men and women with higher household incomes have better health than those with lower incomes. Moreover, the differences in health between high income and low-income persons of each races are often larger than the overall differences between Blacks [sic] and whites [sic]...Racism can affect health indirectly through institutional policies that reduce employment and educational opportunities for minorities. In addition, racism also can affect health directly in multiple ways. Residence in poor neighborhoods, racial biases in medical care, and the stress of experiencing discrimination can all have negative effects on health."[693]

Historians like Thomas Sugrue, David M.P. Freund, and Sidney Fine have identified several reasons for Detroit's economic decline, including a lack of a diversified economy (focusing primarily on the auto industry), no public transit, shortcomings of leadership, and of course, racial tensions and the racist policies that were the outcome of

[692] Diane Swanbrow, "Black-white Health Gap is as Large as it Was in 1950, New U-M Study Says," *The University Record.* March 13, 2000. University of Michigan School of Public Health Collection, Folder: Topical Files: Race Relations-Health 1987-2000. Bentley Historical Library, Ann Arbor.

[693] Diane Swanbrow, "Black-white Health Gap is as Large as it Was in 1950, New U-M Study Says," *The University Record.* March 13, 2000. University of Michigan School of Public Health Collection, Folder: Topical Files: Race Relations-Health 1987-2000. Bentley Historical Library, Ann Arbor.

these tensions.[694] But the examination of how health provision, or the lack thereof, contributed to its decline has thus far been absent in the historiography. A careful analysis of how Detroit officials created policies and set funding priorities that did not improve health provision for Detroit residents, ultimately leading to the failure of Detroit's largest urban renewal project, is an important factor in understanding the decline of Detroit.

What's more, in our own field—the history of medicine—scholarship that examines health in American cities after World War II is lacking, generally. The works that do exist in this area have done admirable work in weaving examinations of how local and federal policies affect health access for different urban populations based on their racial or class identities.[695] This dissertation adds to this historiography by providing a case study of a large urban renewal project in a city whose economic decline has been more pronounced than any other large American city in the late twentieth century. In addition, it furthers the arguments put forth by historians by demonstrating that local planners and officials can further contribute to policies that do not provide adequate "safety-net" health care services by setting funding priorities intended to benefit white, middle-class residents and city visitors.

This dissertation informs both urban historiography and the historiography of medicine by examining how the federal urban renewal project of the DMC, a hospital campus that could have provided medical care to the increasing indigent population of Detroit, became an albatross. Driven by racism and classism, city officials did not

[694] Sugrue, *On the Origins of the Urban Crisis.;* Freund, *Colored Property*; Fine, *Violence in the Model City.*
[695] Wailoo, *Dying in the City of the Blues;* Colgrove, *Epidemic City;* Hoffman, *Health Care for Some.*

develop resources for the city that existed, instead developing what planners hoped would be a draw for people to come back to the city. In doing so, city planners and officials drained Detroit of its resources and did little to contribute to the wellbeing of its citizens—arguably, this development made health worse. Contemporary planners and policymakers should consider this history when working on urban renewal today. Poor health—and racism—is costly, and it cost Detroit its renaissance.

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The DMC Today

The DMC is continually expanding, now affiliated with institutions all over Metro Detroit.[696] But it is still recovering from its past. Today, the DMC's very existence is in jeopardy.

The DMC never resolved its financial troubles. From 1998-2003 alone, the DMC lost three-hundred-sixty million dollars, or seventy-two million dollars annually.[697] The DMCCo planned to layoff one thousand employees, but an aid plan from the state, county, and city of fifty million dollars to the hospitals most in need—Detroit Receiving and Hutzel—prevented those layoffs in 2003.[698]

From 2003 to 2010, the DMC continued to grow and work to address its financial issues that still existed from the large numbers of indigent patients that the DMC treated. It operated without an annual deficit during these seven years, but this was not enough to

[696] Detroit Medical Center, "Our Locations," https://www.dmc.org/our-locations accessed April 1, 2019.
[697] Associated Press, "Midwest," *The New York Times*, July 22, 2003; A15.
[698] Ibid.

make up for its years of debt and deficit.[699] Reusing its old strategy to save money on the salaries of physicians at their hospitals, the DMC added seventy-nine new residency slots in affiliation with Wayne State in 2010. In addition to the cost-saving, a spokesperson for the DMC hoped that the addition of residents would "continue to impact the underserved needs of our community while providing world class healthcare." These residents would be located primarily at Detroit Receiving, Hutzel, and Harper hospitals, spread out among various specialties like emergency medicine, surgery, cardiology, and obstetrics and gynecology.[700]

But despite the strides that the DMCCo made in those seven years, their historic debt was too great a burden to bear. In June 2010, the DMCCo signed a deal with the for-profit, Nashville-based health system, Vanguard Health Systems Inc. to turn over ownership for 417 million dollars.[701] Through the agreement, Vanguard also agreed to cover the DMC's still-outstanding 147 million dollars in debt, forgave the DMC's additional 450 million dollars in bond debt, protected the DMC's 189 million dollars in pension contributions, and still provided an additional 350 million dollars for "ongoing capital needs."[702] Vanguard also promised 500 million dollars in additional in capital investment funds in the first five years of its ownership.[703] Despite the move to a for-profit model of health care delivery, DMC Board Chairman Steve D'Arcy noted that this

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[699] Patricia Ansett, "What Does This Mean for DMC's Future?" *The Detroit Free Press,* Saturday, March 20, 2010; 12A.

[700] Andrea Pec, "Detroit Medical Center to add 79 New Residency Slots," *The News Herald,* January 7, 2019 http://www.thenewsherald.com/news/state/detroit-medical-center-to-add-new-residency-slots/article_98e330f9-d708-52e7-9c96-76e2abff038c.html, accessed April 2, 2019.

[701] Amy Lane, "For-profit Vanguard Signs Deal to Buy Nonprofit Detroit Medical Center." *Crains Detroit Business,* June 10, 2010. Accessed online at https://www.crainsdetroit.com/article/20100611/FREE/100619971/for-profit-vanguard-signs-deal-to-buy-nonprofit-detroit-medical, accessed April 5, 2019.

[702] Ibid.

[703] Ibid.

sale "represents a new model for health care delivery," and would be "the catalyst to creating world-class health excellence in Detroit."[704]

The Vanguard sale provided DMC and city leaders with hope. DMCCo Board Member Roger Penske said that this sale would bring "a Christmas tree of opportunity" to the city by providing five thousand construction jobs and more staff once the developments were completed. City officials also believed that this sale would create a boon for the surrounding neighborhood, and "lure patients back from suburban hospitals."[705] This was almost identical language that city planners and DMC boosters used in 1956. By this point, the suburban competition was intense. Then-DMCCo CEO Mike Duggan said that the DMCCo Board and the City of Detroit has "had to sit by and watch while West Bloomfield and Novi and Ann Arbor make huge investments in modern new hospitals and we've been frustrated we can't do the same [here]," alluding to the massive growth that places like the University of Michigan Medical Center saw over the past thirty years.[706] But, this time, planners believed they found the right infusion of funds and right leadership to meet the goals of the DMC, even though its buyer, Vanguard, was already 1.8 billion dollars in debt.[707]

Members of the surrounding community expressed concern over the sale of the DMC, which ran all the hospitals in the city of Detroit by this point. Community members feared that a move to a for-profit institution meant that the DMC would no

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[704] Ibid.

[705] Patricia Ansett, "DMC Leaders See Rosier Future with Investment." *The Detroit Free Press,* Saturday, March 20, 2010; 12A.

[706] Ibid.

[707] Katherine Yung, "Analyst: Buyer 'Lives on the Edge." *The Detroit Free Press,* Saturday, March 20, 2010; 12A.

longer provide treatment for its indigent patients.[708] In response to this, CEO Duggan added a provision to the sale that Vanguard would promise to provide indigent care and "charity medicine" for the next ten years while the city worked to develop alternate plans.[709]

In 2013, due to its own financial problems, Vanguard was no longer able to operate the DMC, or several of its other acquisitions. In 2013, Dallas-based Tenet Healthcare purchased Vanguard for 1.8 billion dollars and assumed its two-and-a-half billion dollars in debt.[710]

The optimism that DMC and city leaders expressed after the Vanguard sale was absent once their ownership was transferred to Tenet. However, Tenet largely delivered on the promises that Vanguard made in its sale, including the provision of 850 million dollars in capital investments at the DMC over the five years after purchase; the last project of that investment, an addition at Children's Hospital, was completed in summer 2017.[711] But this came at a cost, most notably, the DMC's commitment to its community's care.

In March 2018, the State of Michigan found that spending at the DMC for "charity care" cases had been reduced by ninety-eight percent since its Tenet purchase, spending just four-hundred-seventy thousand dollars on "charity care" in the DMC

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[708] Ansett, "DMC Leaders See Rosier Future with Investment." *The Detroit Free Press,* March 20, 2010; 12A.

[709] Ibid.

[710] JC Reindl, "DMC's For-Profit Owner Keeps $850M Promise, Including Redone Children's Hospital," *the Detroit Free Press.* July 12, 2017. https://www.freep.com/story/money/2017/07/12/dmcs-profit-owner-keeps-850-m-promise-including-redone-childrens-hospital/473577001/ (accessed April 7, 2019).

[711] Ibid.

hospitals in 2016.[712] In contrast, local competing health care systems Beaumont spent twenty-six million dollars on "charity care," and Henry Ford spent nineteen million.[713] In 2013, before the Tenet sale, the DMC was spending close to twenty-two million dollars on care for this population.[714]

Labor groups like the Michigan Nurses Association [MNA] noted that this decision to "abandon its legal commitment" to indigent patients could have "grave consequences" for the 7.4 percent of Detroit residents, or fifty thousand people, who had no health insurance.[715] The MNA noted that the ninety-eight percent reduction in charity care at the Tenet DMC outpaced the sixty-six percent reduction in uninsured Detroit residents that came as a result of the Affordable Care Act and Michigan's Medicaid Expansion.[716] The MNA were not sure where these patients in need were receiving the care they needed—if they were at all.[717]

Hospital Name	2013 Charity Care Spending	2016 Charity Care Spending
DMC Sinai-Grace Hospital	$8,311,306	$225,206
DMC Harper University Hospital	$2,756,203	$56,952
DMC Detroit Receiving Hospital	$11,099,494	$151,799

Table 1: Charity Care Spending amounts at select DMC hospitals from 2013 to 2016. Data from Michigan Nurses Association, "Broken Promises at Tenet DMC."

[712] Michigan Nurses Association, "Broken Promises at Tenet DMC: How a Dallas-based Company Abandoned its Commitment to Charity Health Care in Detroit," March 2018. https://www.insidedmc.org/uploads/7/7/1/1/7711851/tenet_dmc_charity_care_report.pdf (accessed April 7, 2019).

[713] Ibid.

[714] Ibid.

[715] Ibid.

[716] Ibid.

[717] Ibid.

This revelation came at the same time as Wayne State University School of Medicine made its grievances with Tenet known. The school was not used to contracting with a for-profit institution, which resulted in conflicts. Wayne State wanted long-term commitments so it could promise its trainees viability, while Tenet only provided six-month commitments.[718] Because of this strife, Tenet announced its plans to dissolve its affiliation with Wayne State University School of Medicine in May 2018. Wayne State doctors represented twenty-five percent of all physicians that worked in the DMC, with two hundred physicians working across the hospitals' intensive care, neonatal, and trauma care units.[719]

For the University Physicians Group, the professional organization responsible for the employment of Wayne State physicians, this dissolution was detrimental. In November 2018, this group filed for Chapter 11 bankruptcy, although this group emphasized that this was a "restructuring" rather than a closure or liquidation.[720] This group also noted that it intended to still pay its workers their 1.6 million dollars in salaries. During this time, many physicians left this group due to the "period of instability."[721]

However, the lack of affiliation with the DMC was short-lived. In September, the DMC and University Physicians entered into five-year partnership.[722] At this time, the

[718] JC Reindl, "DMC to Sever Century-old Ties with Wayne State University," *The Detroit Free Press.* May 2, 2018. https://www.freep.com/story/money/2018/05/02/dmc-sever-ties-wayne-state-university-detroit-medical-center/574966002/ (accessed April 2, 2019).

[719] Ibid.

[720] Karen Bouffard, "University Physician Group Files for Bankruptcy Reorganization," *The Detroit News,* November 8, 2018. https://www.detroitnews.com/story/business/2018/11/08/university-physician-group-files-bankruptcy-reorganization/1930225002/. (accessed April 2, 2019).

[721] Ibid.

[722] Ibid.

CEO of the DMCCo reaffirmed the DMC's commitment to collaboration with Wayne State University and the University Physicians Group, and reiterated that the DMC valued "the access, expertise, and specialized care that these physicians provide to our patients," continuing that they "shared a longstanding history and mission of serving the health care needs of the Detroit community" and would continue doing so.[723] Wayne State was not enthused about the continued partnership, but spokespeople from the school noted that they would "try to make the best of a bad situation," fearful that the DMC would still only be "interested in limited contracts for teaching and clinical administrative services."[724]

The uncertainty between Wayne State and Tenet left the DMC short-staffed. Even once the affiliation was reaffirmed, the loss of physicians that summer created serious issues for the DMC. One way the DMC sought to operate in these shortages was that Detroit Receiving and Harper Hospitals stopped monitoring surgical site infections.[725] This resulted in a failed inspection from the Centers of Medicare and Medicaid Services in late 2018 when they discovered dirty surgical instruments and flying insects in the Intensive Care Units at these two hospitals.[726] This was the second time in only two years where the DMC was in jeopardy of losing its Medicare contract.[727] Hopeful that their medical center would be able to overcome this, the DMC issued a statement, reading that:

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[723] Ibid.

[724] Ibid.

[725] Karen Bouffard, *The Detroit News* "Dirty instruments cause second DMC hospital to fail federal inspection." November 28, 2018. https://www.detroitnews.com/story/business/2018/11/28/dirty-instruments-cause-second-dmc-hospital-fail-federal-inspection/2123582002/ (accessed April 2, 2019).

[726] Ibid.

[727] Bouffard, "University Physician Group Files for Bankruptcy Reorganization," *The Detroit News,* https://www.detroitnews.com/story/business/2018/11/08/university-physician-group-files-bankruptcy-reorganization/1930225002/. Accessed on April 2, 2019.

"The DMC remains committed to providing residents of Detroit with safe, accessible, quality care. This commitment is central to our mission and everything we stand for."[728] Although this problem was remedied in the Spring of 2019, the problems that have plagued the DMC since its beginning continue to exist. And its continued inability to comply with regulations puts its very existence at risk

The DMC is still home to most of the city's hospitals and physicians; if this institution closes, there will be irreparable damage to Detroit's residents and economy. But this reality is the result of decades of negligence toward the community that needs care from the DMC the most. It is my hope that the case of the DMC serves as a cautionary tale—for cities across the country but also Detroit itself—highlighting the necessity to provide care for a community's most vulnerable residents. Beyond a moral imperative, this dissertation demonstrates that there is also an economic imperative.

[728] Ibid.

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Appendix

I.

A Proposal for a Detroit Medical Center
Submitted to the Detroit City Plan Commission, on May 23, 1956, by the Detroit Medical Center Committee

On behalf of the trustees of all the hospitals involved here today, I want to thank the Commission for the opportunity you have given us to present a program which is of vital importance to every man, woman, and child in our community.

During the past year, a special committee of trustees of Children's, Woman's, the Grace and Harper hospitals, has investigated the possibilities for developing the area in which these hospitals are located into an integrated medical center.

It is my privilege today, as chairman of this committee, to place before you, for your official consideration, our conclusions and proposals regarding the development of this area as a great medical center.

The boundaries of the area examined by the committee are as follows: Woodward Avenues on the west, Hasting on the east, Mack Avenue on the south, and, on the north, Warren to St. Antoine, St. Antoine to Ferry, and Ferry to Hastings again. These boundaries were more or less predetermined by the locations of the hospitals and the problems related to their locations.

This small segment of our City plays a very important dual and contradictory role in the matter of our health. The four hospitals located here accounted, last year, for one-twentieth of the total number of patients admitted to all of Michigan's more than 200 general hospitals. Every twentieth hospital admission in the whole State took place in this area. And this is the contradiction. The four hospitals doing this tremendous job are hemmed in by the words and the most unhealthy slums in Detroit.

Operating these hospitals has become increasingly difficult amidst the blight which surrounds them. This is their common and urgent problem which led to the appointment of the committee. I know that it is not necessary for me to tell the City Plan Commission about the terrible slums around our hospitals. A number of the blighted areas have been marked for top priority in the redevelopment program worked out by the City Plan Commission. The urgent objective of our committee is to try to get this neighborhood redeveloped in the shortest possible time.

There is also another objective. We want to see the neighborhood developed in such a way as will allow Detroit to realize the full potential of the excellent resources for health care and medical education that are presently in existence. We want to see this area developed as a fully integrated medical center.

By the term "integrated medical center" we do not mean simply a harmonious grouping of structures, all in one way or another serving the purpose of health care. We mean something much more specific and much more important in terms of an active relationship. I should like to take a minute to clarify this point, for this goes to the heart of the proposed program.

Few lay people realize the intricate and continuous relationship that exists between medical practice and medical education. I was not aware of it until after I had been a hospital trustee for some time. It takes a great deal of teaching and training to develop the knowledge and skills of the practicing physician or surgeon. These highly developed skills would die if we did not provide the facilities and the opportunities for students and residents to acquire them in turn. We have a cyclical pattern to consider. Education, training, clinical practice, education, training, over and over again. This cyclical process of education, training, clinical practice, as it also involves research and experimentation, is most productive when we have an integrated relationship between a medical school and teaching hospitals to carry it on. This is what we have in mind when we speak of developing an integrated medical center.

The Wayne State University College of Medicine is one of the finest in the country. Its present affiliations are sufficient to meet its undergraduate teaching needs. But it does not have the integrated teaching arrangement with large hospitals that could provide the full scope of practice necessary to meet its postgraduate requirements. This is a real handicap. It concerns all of us in these days of serious shortages of every kind of doctor. A medical school with a well-established and rounded postgraduate program will prove more attractive to students than one that has no such program, or only the rudiments of such a program. In addition, hospitals having an integrated relationship with medical schools are the ones that hold the greatest attraction for medical internes [sic] and residents.

The Wayne State University College of Medicine is not located in the immediate area we are discussing. However, with modern transportation and the expressways, the very short distance involved presents no problem.

The four hospitals represented here have everything necessary with which the Wayne Medical School could build a rounded and systematic postgraduate program.

Let us take a quick inventory of what these hospitals have to offer:

1. These four hospitals have a total complement of 1,648 bds and 272 basinets. [This is more than] The famous Columbia-Presbyterian Medical Center. We do not have to add a single hospital bed to become a great medical center.
2. During the year ending September 30, 1955, these hospitals handled 50,000 in-patient admissions, excluding admissions for births. The patients were provided with a total of 440,000 days of hospital care, covering every conceivable type of illness and accident. In addition 9,000 babies were born in them and they received 53,000 days of care. These hospitals, during the calendar year 1955, provided nearly 250,000 out-patient and emergency services. This gives us some idea of the unmatched opportunities these hospitals offer for postgraduate work.
3. About 35% of all the physicians listed by the Wayne County Medical Society hold staff membership in one or more of these hospitals.
4. These hospitals have organized medical staffs who are working under integrated conditions that have been developed over a span of from two to three generations of continuous experience.

5. The Grace and Harper hospitals have Schools of Nursing. Children's Hospital maintains an affiliating arrangement with nearly a dozen schools who send their student nurses there for Pediatrics instruction.
6. All of the facilities we have already mentioned will shortly be increased with the opening of the Rehabilitation Institute of Metropolitan Detroit, which adjoins Harper Hospital.

We have all of this to offer as the core around which to develop the medical center.

What does the University think of the program? I should like to read the following letter from
Dr. Gordon H. Scott, Dean of the College of Medicine.

WAYNE STATE UNIVERSITY

College of Medicine
College of the Dean

May 14, 1956

Mr. Ray R. Eppert
6701 Second
Detroit, Michigan

Dear Mr. Eppert:

The Wayne State University College is greatly interested in the plans of Harper, Grace, Woman's and Children's Hospitals to rehabilitate the area in their vicinity. In the past two years we have made every effort to aid in the formulation of these plans to help in their activation. It is our deep concern that these hospitals not only continue their present high standards, but that they expand their efforts in new directions so that, with the cooperation of the College of Medicine, their facilities may become the proving ground for even finer teaching, research and service.

When we became a state university, we assumed new obligations. We believe that the State of Michigan intends that its newly acquired College of Medicine develop its resources in all directions so that it will be second to none. We firmly believe that one of the first and more important steps in this direction is the working out of definite plans for collaborative use of facilities and staff with those private hospitals which are geographically and structurally suited to our needs. Since we will increase the size of our classes in the near future, these working arrangements must contemplate teaching at all levels. We are certain that this can be done when the Boards of Trustees of the hospitals understand and appreciate our problems. A working arrangement which will be truly cooperative will furnish the teaching, research and service facilities essential to the development of a great medical center and the University need not find itself in the position of having to build a competitive hospital system to fulfill its function.

It follows that the things which affect the midtown hospital group and the Detroit Receiving Hospital have a direct bearing on our future planning. The welfare of the

hospitals will in no small way determine the future of what must become a great medical teaching, research and service center. We believe that any steps which are taken to conserve and increase their usefulness will be richly rewarding to the University and the State which it serves.

Sincerely,
Gordon H. Scott
Dean

OBSTACLES THAT MUST BE OVERCOME

What is it that has stood in the way so far, and still stands in the way, of the necessary integration?

Here are the facts:

1. Badly needed help in general, and desirable categories of employees, in particular, have revealed an increasing reluctance to take employment with these hospitals because of the slums which surround them.
2. The professional and skilled employees of these hospitals have been gradually moving away from the area. Such a trend is invariably accompanied by an inclination on the part of these employees to consider employment in hospitals nearer home, or in hospitals located in more attractive surroundings.
3. Employees cannot find real relief even by moving out of the area. Two shifts of predominantly female employees must come into the area, or leave it, during the hours of darkness. Despite the best efforts of the Detroit Police Department, it cannot be said that the area is safe for female employees during these hours.
4. The hospitals cannot hope to find relief by means of possible housing programs for their employees because patients, too, are revealing increasing reluctance, and even resistance, to being hospitalized in this area.
5. The patients who do come to these hospitals are worried about their visitors who have to come into the area, or leave it, after dark.
6. The heavy flow of traffic past these hospitals has added another source of dissatisfaction and danger. The congestion and lack of sufficient parking space are other handicaps.

Because of these problems, the hospitals have found themselves, for years, on the horns of a dilemma. What should they do? They have asked themselves this question year after year. If they remain where they are, and nothing is done, their future is not a bright one. Such a negative development would be disastrous to the community. These hospitals have a book value of $27,000,000.

Let us suppose that these hospitals considered moving to more attractive areas. It is estimated that it would cost more than $50,000,000 to replace these hospitals with new structures. The cost is obviously prohibitive. This is an alternative which must be rejected, not simply because of its prohibitive cost, but because it is contrary to the interests of the community.

The need for the program we are discussing today is urgent and we hope the City Plan Commission will carefully consider the following recommendations:

1. The area in which the hospitals are located, and the adjacent areas, should be made available for development as a medical center with appropriate residential and community facilities.
2. Parts of the area should be set aside for residential purposes, and should include medium-cost apartments for the 3,600 employees of the four hospitals and their families. There should be housing facilities for professional people and others of the comfortable income groups who may be interested in living quarters that are near the hospitals or the other institutions in the medical center.
3. Provisions should be made for schools, a shopping center, parking and recreational facilities in the residential area.

We hope that the City Plan Commission will help us to get the project down to a definitive proposal. And finally, after we have worked this out together, that the Commission's recommendations to the City Council will be affirmative.

We believe that a tremendous opportunity exists to create in Detroit one of the world's great medical centers. The value of such a center is to all the citizens of Detroit and the entire State is, we are certain, obvious to everyone.

Adequate medical teaching, research, and practice is vital to both the physical and economic health of our community.

The medical profession has been making rapid and remarkable strides in researching and developing "less depreciation" and "longer life" in that most important product—people. We are on the verge of a break-through in many facets of the health problem, which when accomplished will open up new vistas of opportunity for further achievement and success.

Medical brains alone will not do the job. We must provide the tools, the weapons, the facilities, the environment to permit the most efficient and effective prosecution of this all-out war against disease.

The proposed medical center would place Detroit in the front lines in this battle and would assure for our community the maximum benefits for our citizens. Likewise, its potential contribution for better health to our entire country, and, in fact, to the whole world is an important and compelling reason for quick affirmative action.

Respectfully Submitted,

The Detroit Medical Center Committee

Harper Hospital:	Ray R. Eppert, Chairman Richard H. Webber George E. Cartmill, Director
The Grace Hospital:	John N. Lord Arthur W. Winter Roger W. Debusk, MD, Director
Children's Hospital:	Jerome H. Remick, Jr.

	Mrs. Gerard R. Slattery Miss Mildred Riese, RN, Administrator
Women's Hospital:	Mrs. John N. Failing, Jr Mrs. Benjamin E. Young Miss Catherine Maloy, RN, Administrator