

Dethroning the “Medical Clergy”
Yale-New Haven Hospital and the Community Health Movement in a Model City



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Cover Photo: Cushing/Whitney Medical Library. "Yale-New Haven Hospital and the Hospital of Saint Raphael, 1960s to the Present." Accessed January 11, 2013.
<http://info.med.yale.edu/library/news/exhibits/hospitals/1960s.html>.

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List of Abbreviations

ACS: American College of Surgeons
AMA: American Medical Association
CDA: City Demonstration Agency
CMHC: Connecticut Mental Health Center
CPI: Community Progress, Incorporated
HHC: Hill Health Center
HNC: Hill Neighborhood Corporation
HNU: Hill Neighborhood Union
HPA: Hill Parents Association
MCHR: Medical Committee for Human Rights

On August 29, 1969, Dr. Fritz Redlich, Dean of the Yale School of Medicine, held a meeting at the Connecticut Mental Health Center (CMHC) in The Hill neighborhood of New Haven for local residents, mostly black and Puerto Rican, to voice their frustrations and concerns with the Yale-New Haven Medical Center (Figure 2). A forum that allowed community participation in the affairs of the Medical Center would have been unheard of ten years earlier, but the civil rights movement of the 1960s had injected a concern for democratic involvement into the city's major institutions. According to Dr. Lowell Levin, who was present at the CMHC, it wasn't long before "the meeting got a little hot." One of the residents in attendance reportedly stood up, reached across the table, and grabbed Dr. Redlich by the neck.¹ The choking lasted only a few seconds before other doctors came to Redlich's aid, but the incident reflects two decades of growing tension between the Medical Center and The Hill.

Prior to a 1965 affiliation agreement that changed its name, the Yale-New Haven Hospital (which, together with the School of Medicine and School of Nursing formed the Yale-New Haven Medical Center) was called Grace-New Haven Community Hospital. How could a hospital whose very name implies community representation attract so much hostility from surrounding residents? This question invites investigation into the role that a community hospital like Yale-New Haven plays in a city's power structure and democratic culture. My examination approaches this topic from the perspectives of city officials, hospital administrators, and Hill residents. For instance, in what ways might city officials work through the hospital to shape the city—physically, socially, and politically—in the way it desires? Does the hospital, pursuing its own institutional agenda, wield considerable control over how the city is governed? And how important is health care and hospital policy to citizens' perceived level of representation and participation in city life and politics?

My goal in this essay is to show that the incident at the CMHC was rooted in the fundamentally conflicting visions for health care and democratic governance between city and hospital administrators and the residents of The Hill. In a sense, health care in the city was a microcosm of the broader civil rights movement; just as black and other minority residents of the city felt excluded from city politics, minority residents of The Hill believed that the

¹ Lowell Levin, Interview with author, 30 November 2012.

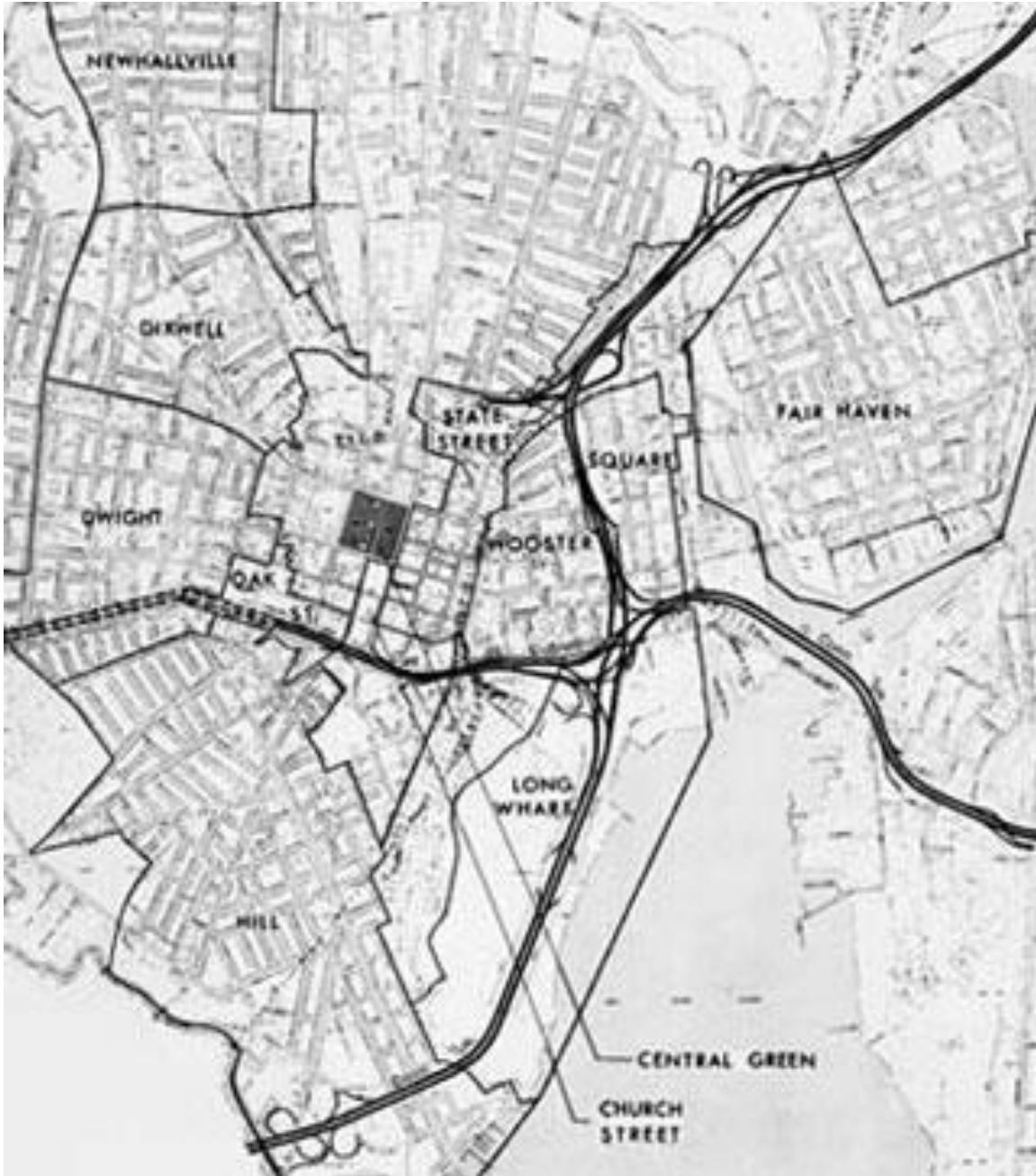


Figure 1: The Neighborhoods of New Haven. The Hill is New Haven's southwestern-most neighborhood, bounded by the Route 34 Oak Street Connector and Legion Avenue to the north and Long Wharf neighborhood to the east. This map was used to designate the various project areas for urban renewal, which sought to improve housing, commerce, and urban aesthetics. The New Haven Oral History Project. *Life in the Model City: Stories of Urban Renewal in New Haven*. 2004. Accessed October 10, 2012.
<http://www.yale.edu/nhohp/modelcity/>

hospital in their own neighborhood neither represented their interests nor granted them a voice in policymaking decisions. For instance, black physicians in the hospital were few and far between, and black laundry and dining workers were prohibited from unionizing to demand better wages and benefits. Black patients often could not afford health care, and when they were admitted to the hospital, they felt more like teaching material for Yale medical students than human beings in need of care. Meanwhile, the hospital worked in concert with the city's urban renewal programs to expand its physical plant. The expansion plans, designed without legitimate input from the neighborhood, often required demolition of Hill residents' homes and businesses. Thus, as residents of The Hill community organized to address civil rights violations and move for greater representation and control over the city, racial justice in the health care system was an essential part of their agenda. In this way, the community health movement, which culminated in the establishment of the Hill Health Center (HCC), represented not only a campaign to reform a malfunctioning health care system, but also a fight to establish democratic rule in a private industry that citizens conceptualized as a *public* institution.

Several decades ago, many sociologists and historians examined New Haven's urban renewal (spanning from the 1950s into the 1970s) to contemplate how the city was governed. For instance, Robert Dahl and G.W. Domhoff debated whether city politicians or business elites wielded most of the decision-making power in the city, but both authors overlooked the community health movement and the hospital as a political agent.² Conversely, authors primarily concerned with health care, such as Rosemary Stevens in her book *In Sickness and In Wealth*, overlooked the hospital's involvement in urban renewal and its importance to democratic culture.³ This essay seeks to show that the study of community health cannot be isolated from the history of urban renewal and the civil rights movement. Rather, health care and the institutions that provide it are wrapped up in broader conflicts over who is represented and able to participate in city governance. In New Haven, residents of The Hill regarded inequitable treatment both within and beyond the realm of health care as the result of their disenfranchisement and responded in a holistic way. The same grassroots neighborhood organization that sought improvements in housing, employment,

² Robert A. Dahl, *Who Governs?* New Haven and London: Yale University Press, 1961.

G. W. Domhoff. *Who Really Rules?* New Brunswick: Transaction Books, 1978.

³ Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century*. Baltimore And London: The Johns Hopkins University Press, 1999.

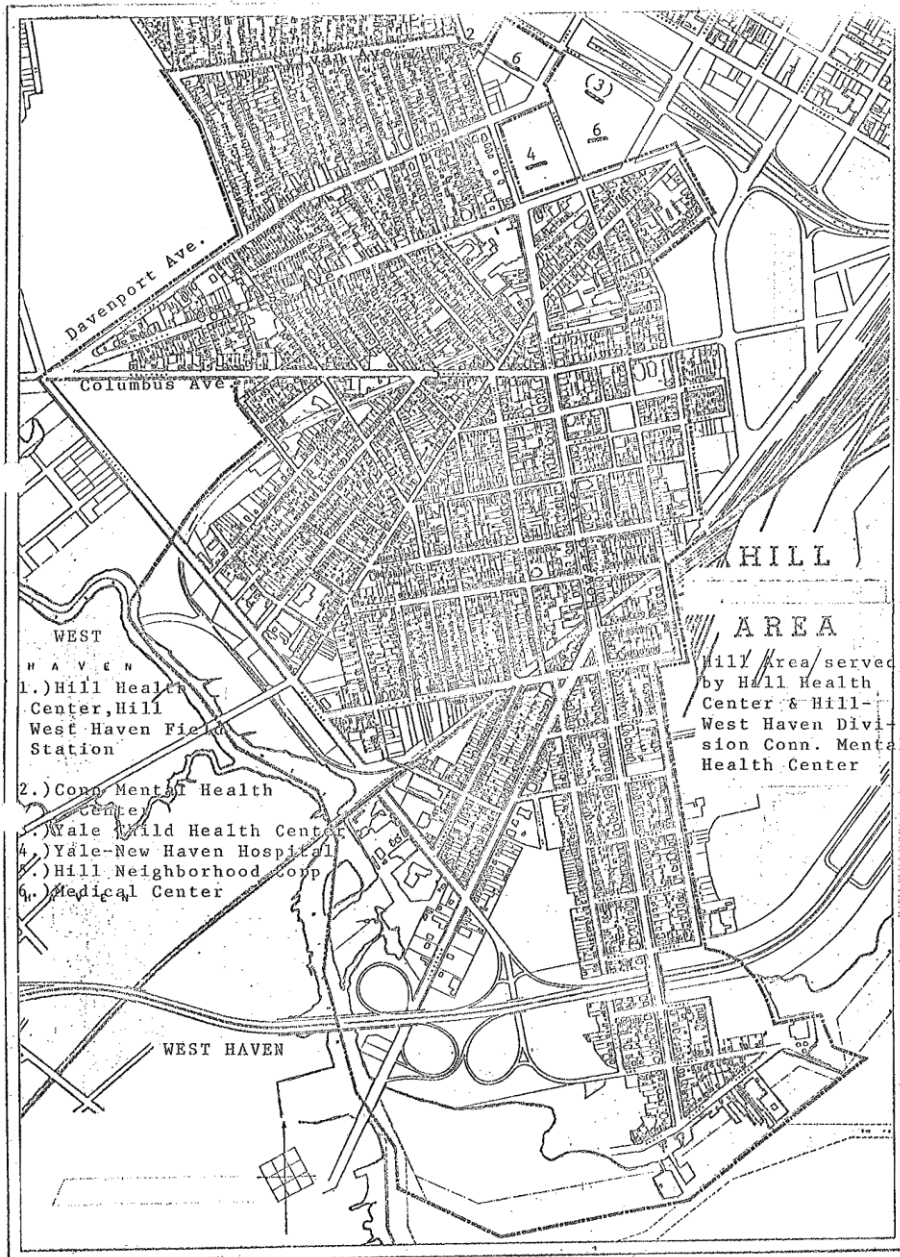


Figure 2: The Hill Neighborhood, 1969. Between 1950 and 1960, New Haven, like many northern cities, received an immense wave of black migrants from the South, arriving just as wartime manufacturing jobs disappeared. The Federal Housing Authority's policy of redlining, by which racial minority areas were denied favorable mortgage rates, allowed middle class whites to flee to the suburbs, concentrating the poor in inner city areas like The Hill. By 1969, The Hill neighborhood was highly segregated, with whites accounting for 49.9 percent of the population, blacks 42.5 percent, and Puerto Ricans 7.6 percent. The regions labeled 2, 4, and 6 were the grounds of Grace-New Haven Hospital and the Yale Medical Center. Statistics from Yohuru Williams's *Black Politics/White Power: Civil Rights, Black Power, and the Black Panthers in New Haven*. (St. James: Brandywine Press, 2000), 12. Map from "Application for Comprehensive Health Services," Box 46, Richard Weinerman Papers. Yale University Library.

and education also spearheaded the development of the Hill Health Center, which was owned and operated by local residents.

This essay adds to the dialogue on community health in New Haven that was initiated by Sarah Siegal, a history major who graduated from Yale in 2010. In “The Convergence of Civil Rights and Health Advocacy: The Establishment of New Haven’s Hill Health Center,” Siegal focuses on the work of the Medical Committee for Human Rights (MCHR), a group of white physicians at the Yale Medical Center that regarded health as a human right and worked with Hill residents to create the Hill Health Center. Siegal explained, “while the MCHR advocated for local involvement in health care, only Hill neighborhood residents understood the need for a facility of their own that was directly in their control.”⁴ Pursuing this notion, this essay shows *why* local involvement in health care was so essential by uncovering the points of conflict between residents and Yale-New Haven. Hospital–resident interaction stemmed not only from the hospital’s role as a health care provider, but also as a local employer and competitor for scarce real estate. As a private, non-profit teaching hospital (also known as a “voluntary” hospital) in a city that lacked a municipal hospital, Grace-New Haven encountered conflicts with the community as it balanced private interests with public responsibilities—for instance, conducting medical research and teaching as well as caring for patients, providing lucrative specialized services as well as free indigent care, and investing in physical expansion as well as fairly compensating employees. Setting the development of the Hill Health Center in this context adds an important new dimension to Siegal’s conclusion. The mission of the HHC was not solely to address the health disparities in The Hill, but to increase residents’ inclusion in the democratic culture of New Haven. As President Johnson’s Model Cities Program called for “maximum feasible participation” in urban antipoverty programs, Hill residents adopted a similar mantra in all areas of city life, including health care. “Everything they do,” said a member of The Hill Neighborhood Union, “we want to know, and we want to be a part of it. That’s number one.”⁵

In a letter from June 20 of 1963, Dr. Albert Snoke, the Executive Director of Grace-New Haven, wrote to Mayor Richard Lee to express his concern in three matters: urban

⁴ Sarah Siegal, “The Convergence of Civil Rights and Health Advocacy: The Establishment of New Haven’s Hill Health Center” (senior thesis, Yale College, 2010), 19.

⁵ Mandi I. Jackson, *Model City Blues: Urban Space and Organized Resistance in New Haven*. (Philadelphia: Temple University Press, 2008), 80

renewal in The Hill, black workers at Grace-New Haven, and charitable medical care.⁶ This essay addresses each of these topics in turn to reveal the competing ideas of health care and democratic participation between city and hospital administrators and Hill residents. The first section introduces Mayor Lee and illustrates the hospital's involvement in urban renewal plans, which excluded the participation of Hill residents. The second section introduces Fred Harris, a black resident of The Hill, and shows how community members organized to resist the top-down administration of urban renewal and hospital expansion. The third section tells the story of Grace-New Haven employees' (many of them Hill residents) effort to unionize and the hospital's exclusion of black physicians. Next, I address the struggle to provide charitable care to poor residents of The Hill and the discrimination that local patients encountered in the ward at Grace-New Haven. The essay then turns to the context of the Hill Health Center's founding, which rose out of The Hill community's effort to seize control of the city's antipoverty programs. In the penultimate section, I illustrate how the Hill Health Center was designed around the concept of community participation in health care to prevent the same civil rights abuses that Yale-New Haven committed. Lastly, I conclude with the impact the HHC's participatory system of health care had on residents' ideas of democratic culture and civil rights.

The Hospital as an Agent of Urban Renewal

The interests of Grace-New Haven Hospital were integral components of the city's urban renewal plans. Nonprofit hospitals like Grace-New Haven had various motivations behind their ambitious plans for expansion. More beds, new facilities, and the latest technology allowed the hospital to care for more patients, facilitated medical students' learning, and permitted medical school faculty to conduct cutting-edge research. Tearing down dilapidated housing to make way for hospital facilities also contributed to Mayor Lee's campaign to make New Haven a "slumless" city.⁷ However, the city and the hospital designed their construction plans without legitimate input from the citizens in the bulldozers' path. In the 1960s, The Hill community organized to obtain greater control over the physical landscape of the city, which meant confronting hospital administrators and Mayor Lee.

⁶ Albert W. Snoke letter to Richard C. Lee. June 20, 1963. Box 3, Correspondence between the city and the hospital. Yale-New Haven Hospital Records.

⁷ *Saturday Evening Post*, 1958, in *Life in the Model City*.

Mayor Lee had big plans for New Haven, rooted in the best of intentions. Born in a cold-water flat in New Haven to Irish Catholic parents, Lee possessed an inherent understanding of poverty and ethnic discrimination that shaped his liberal political career. In 1939, when he was just twenty-three years old, Lee was elected to the board of alderman and assigned to the City Plan Commission, where his interest in redevelopment began. In 1951, Lee visited the Oak Street slum, and was taken aback by what he experienced:

I came out from one of those homes on Oak Street, and I sat on the curb and I was just as sick as a puppy. Why, the smell of this building; it had no electricity, it had no gas, it had kerosene lamps, light had never seen those corridors in generations. The smells...it was just awful and I got sick. And there, there I really began...right there was when I began to tie in all these ideas we'd been practicing in city planning for years in terms of human benefits that a program like this could reap for a city...In the two-year period [before the 1954 election] I began to put it together with the practical application...And I began to realize that while we had lots of people interested in doing something for the city they were all working at cross purposes. There was no unity of approach.⁸

After being elected Mayor in 1954, Lee set out to establish his “unity of approach” in urban development. Thanks to federal urban renewal funds from the Housing Acts of 1949 and 1954, cities acquired and demolished slum properties, paving the way for private developers to build new homes and businesses. Mayor Lee turned New Haven into one of the most fascinating examples of urban renewal, attracting preeminent political scientists and civil engineers to New Haven and leveraging his close relationship with the Kennedy family to keep redevelopment funds flowing to the Elm City. However, in the opinion of many New Haven residents at the time, the structure of Lee’s Redevelopment Agency insulated the city’s political power structure from poor African-Americans.

Upon accepting the Democratic nomination for Mayor, Lee declared that he would appoint a committee of citizens within his first sixty days in office to study the city’s problems and work out possible solutions. It took nine months to pull together a group of 400 residents to form the Citizens Action Commission. The CAC weighed in on the building proposals of the Redevelopment Agency and provided a rubber stamp that signified democratic participation in urban renewal. However, membership in the CAC was severely unbalanced. Robert Dahl and many residents recognized that there were no members who lived in poverty or could be honestly classified as representatives of the poor. In fact, many

⁸ Fred Powledge. *Model City: a test of American liberalism: one town's efforts to rebuild itself*. (New York: Simon and Schuster, 1971), 29.

members of the CAC—as bankers, industrialists, and businessmen—stood to gain financially from redevelopment, creating a glaring conflict of interest.⁹ Still, at the outset of the city’s urban renewal campaign, the public trusted in their charismatic Mayor to transform downtown for the better. An article on Lee in the *Saturday Evening Post* went so far as to claim that he was “Saving a ‘Dead’ City” (Figure 3). However, public sentiment changed dramatically in the wake of the first, and most notorious, urban renewal project in the Oak Street neighborhood.

In 1950, the Oak Street neighborhood was widely considered New Haven’s worst “slum,” a term that historically connotes poverty, dilapidated infrastructure, and the presence of ethnic minorities. The Oak Street slum consisted mostly of Italian and Eastern European immigrants, as well as African-Americans.¹⁰ Thanks to the Federal Highway Act of 1956, the Redevelopment Agency planned to construct an expressway connecting western New Haven with the town of Derby, demolishing the Oak Street slum in the process. According to a report of the Yale-New Haven Joint Administrative Committee, the Oak Street Connector project was “instituted in part in response to urging from the Medical Center” to improve access to the hospital and expand the property of the School of Medicine.¹¹ Completed in 1959, the Route 34 Connector did not link New Haven with Derby as intended, but succeeded in obliterating Oak Street (Figure 4). Many residents from Oak Street found new homes in The Hill, which also received a number of African-Americans from subsequent urban renewal projects in Dixwell and other neighborhoods. Despite its crushing poverty, The Hill received comparatively little attention by city administrators in charge of urban renewal. The composition of the CAC and correspondence between Mayor Lee and Dr. Snoke suggest that the inattention toward and exclusion of minorities in The Hill during redevelopment decisions were not accidental. One topic of conversation outlined in Snoke’s letter to the Mayor in June of 1963 was “The Surrounding Neighborhood.”¹² Cryptically,

⁹ Robert A. Dahl, *Who Governs?*, 133.

¹⁰ The 1950 census recorded 859 Negro residents and 1,158 foreign born residents. 1950 Census of Population and Housing: Census Tracts, New Haven, CT. US Department of Commerce, 1952.

¹¹ “Report to The Joint Administrative Committee,” December 21, 1963. Box 1, Redevelopment. Yale-New Haven Hospital Records.

¹² Albert W. Snoke letter to Richard C. Lee. June 20, 1963. Yale-New Haven Hospital Records.



Mayor Richard Lee (left) and Edward Logue, Development Administrator. In background new construction rises on a former New Haven slum.

He is Saving a “Dead” City

Do old cities have to die? Consider how the young mayor of New Haven is bulldozing his “blight-ridden” town out of the stagnant past into a handsome new future.

By JOE ALEX MORRIS

The mayor with his wife and daughter. Lee, 42, has staked his career on redevelopment of his city.



As mayor of the Connecticut city of New Haven since 1954, Richard Charles Lee has assiduously devoted himself to violating certain fundamental rules for success in a political career. He embarrassed and angered many voters—including some prominent citizens and at least two red-faced city officials—by having the police tow away their automobiles for illegal parking. He made it impossible to “fix” a traffic ticket. He described New Haven as a decaying community and widely publicized the disgraceful fact that 10,000 disease-carrying rats infested a single street in the center of the city. He hounded wayward property owners into paying back taxes that had been

owing for as long as fifteen years. He fired city employees and a few appointed officials for loafing, and abolished patronage jobs with salaries totaling \$102,000 a year. Then he raised his own salary from \$10,000 to \$18,000 and boosted expenses of the mayor's office from \$20,000 to \$78,000 annually. On top of all this, he waged a running battle with the town's only newspaper owner, John Day Jackson, who has long been a powerful figure in local affairs.

That kind of politicking, as any party hack could—and did—tell Mayor Lee, is not recommended as the way to win a popularity contest at the ballot box.

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Figure 3: Article on Mayor Lee in *Saturday Evening Post*. In the top photo, Mayor Lee (left) and a reporter discuss the Oak Street Project in the background. The project sought to rid New Haven of its worst slum. *Saturday Evening Post*, 1958, in *Life in the Model City*.



Figure 4: The Oak Street and Hill neighborhoods, 1954 (top) and 1967 (bottom). The Route 34 Connector demolished the Oak Street neighborhood and improved access to Grace-New Haven Hospital, which is directly south of the connector at the base of College Street. “New Haven,” Price & Lee’s Official Arrow Street Guide, 1954 and 1967.

Dr. Snoke stated, “I believe we both are concerned about the area around the Hospital for very similar reasons.” The immediate segue into the next topic of the letter—redevelopment—suggests that the two items are closely related. Dr. Snoke mentioned the \$20,000,000 to \$40,000,000 proposal for expansion of Grace-New Haven, which would receive funding from the city’s urban renewal program. A look back to the long-range plan for the Medical Center crafted in 1960 by Perkins and Will architecture group shows the immense territory that the hospital sought to develop (Figure 5). The area of greatest interest to the hospital was the twenty-three acre plot directly south of the medical complex, designated as “Area A” in a subsequent report (Figure 6). Home to 432 families, Area A was “blighted,” and “the existence of a blighted area—with the kind of people it attracts—is no asset to the medical area.”

The kind of people that voluntary hospitals should attract, according to Rosemary Stevens, was “the very rich, who served on its boards and committees and who came into the hospital as the private patients of eminent physicians.”¹³ By contrast, the poor living in The Hill were not represented on Grace-New Haven’s board and often could not afford hospital care. John Wilhelm, a Yale graduate who worked on civil rights issues in The Hill during the 1960s, told Sara Siegal that the hospital’s “only relation with that community was physical takeover.”¹⁴ Hill residents felt that white politicians and hospital administrators like Lee and Snoke did not represent the interests of the poor in urban renewal. Many blacks in The Hill had been relocated there by renewal projects that catered to the white middle class: shopping malls, department stores, or parking lots.¹⁵ The prospect of losing their homes to a hospital in which they could not receive care was equally insulting. Frustrated by their exclusion from hospital and city decision-making and the takeover of downtown without their consent, Hill residents organized to demand equitable representation and participation in redevelopment. Perhaps the most important leadership trait of their champion, Fred Harris, was that he, too, was a Hill resident.

¹³ Rosemary Stevens, *In Sickness and in Wealth*, 236.

¹⁴ Sarah Siegal, “The Convergence of Civil Rights and Health Advocacy,” 20.

¹⁵ Fred Powledge, *Model City*, 151.

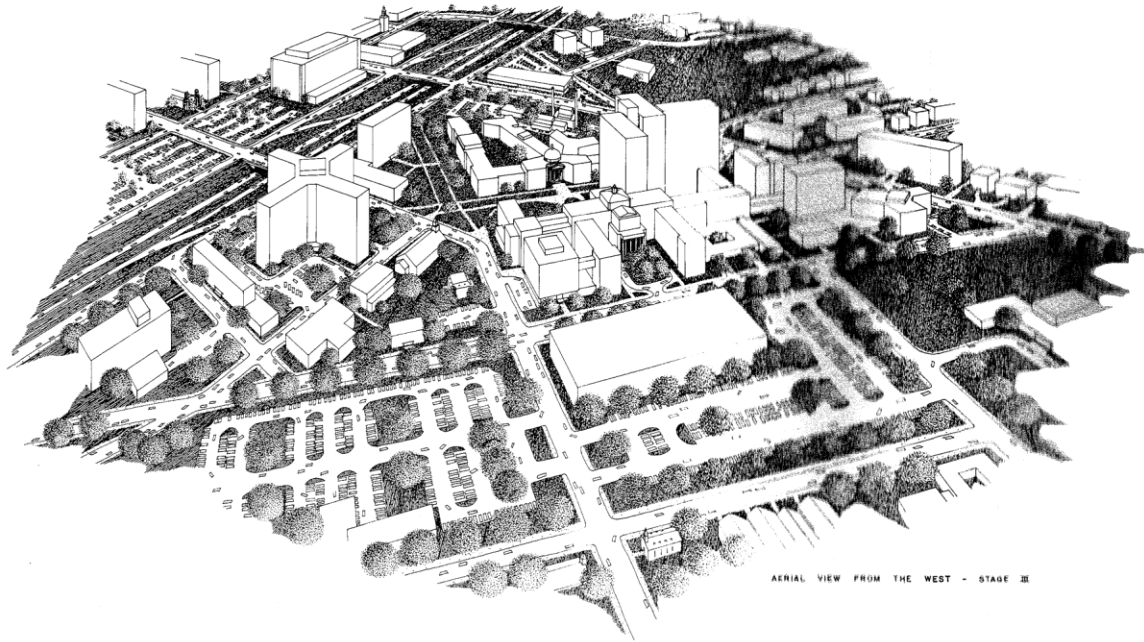


Figure 5: Long Range Plan for the Yale Medical Center, 1960. The hospital planned to relocate nearby residents in The Hill to build new facilities, dwellings for medical professionals, shopping centers, and parking lots. "Final Report: Long Range Plan for the Yale New Haven Medical Center," July 12, 1960. Box 1, Redevelopment. Yale-New Haven Hospital Records.

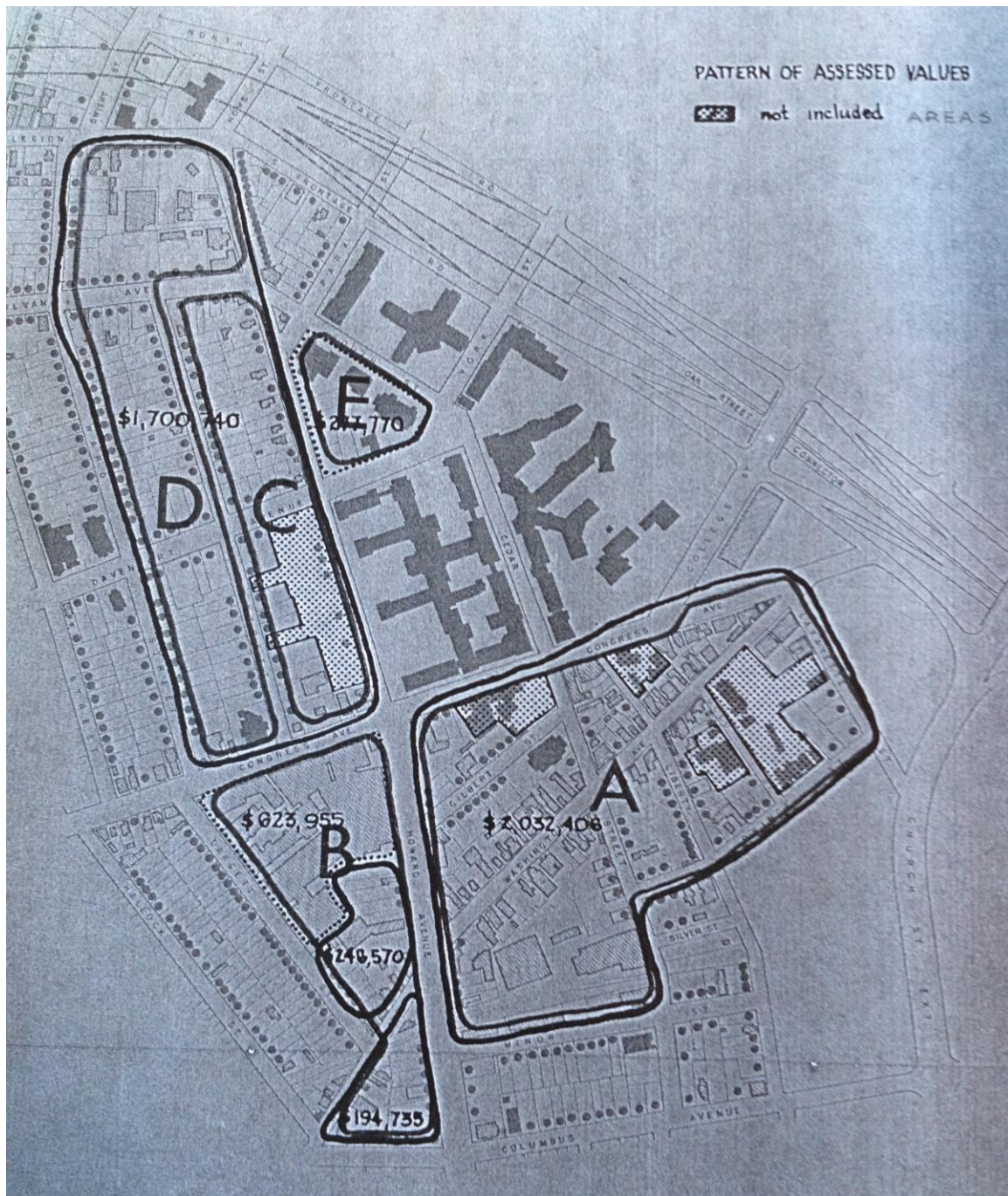


Figure 6: Redevelopment Plans for the Yale Medical Center, 1963. Hospital administrators planned to turn Areas C and D, home to 429 families, into parking lots. Area A would be transformed into 800 or more dwellings for “medical students, nurses, young staff members, and older people desiring to live near the medical facilities and Downtown.” “Medical Area,” July 3, 1963. Page 4. Box 1, Redevelopment. Yale-New Haven Hospital Records.

Hill Residents Participate in City Planning and Resist Hospital Expansion

Like Richard Lee, Fred Harris was born in a cold-water flat in New Haven and was committed to improving conditions in the city. However, his upbringing and experiences as a poor African-American man in The Hill inspired ideas of community participation and development that were very different from the Mayor's. "Citizen participation" to Fred Harris meant that "people should be allowed to determine their own destiny...And if people don't determine their own destiny, then they cannot be productive and cannot contribute anything to the city or the state or the country."¹⁶ Harris's introduction to community organizing came in 1965 when a group of black parents in The Hill neighborhood got together in outrage over the condition of Prince Street Elementary School. Children had no toilet paper and shared dilapidated books, and the school's white, alcoholic principal was in no hurry to make improvements.¹⁷ Black families worked with The Hill Neighborhood Union (HNU), a predominantly white organization established by Yale students, to make a list of demands: a black principal, more books, toilet paper, and paint to name a few. Then, led by Harris, they staged a march in front of the school. All of their demands were met soon after, and neighborhood blacks absorbed the HNU and rebranded it as the Hill Parents Association (HPA).

Taking on more issues that concerned its constituents, the HPA began to demand participation in the city's redevelopment decisions. The Redevelopment Agency's 1953 master plan proposed a six-lane "inner circumferential loop highway," or "Ring Road" as it would come to be called, encircling the downtown area and Yale University. The close relationship between the Grace-New Haven Hospital and the Redevelopment Agency is clear in the road's construction plans. The highway would effectively amputate the Dixwell, Dwight, and Hill neighborhoods from downtown, clearing large swathes of low-income neighborhoods while insulating Yale and the Medical Center from the rest of the city. Patients referred from outside New Haven would have swift access to the hospital without driving through the inner city, keeping the surrounding low-income community out of sight and out of mind. As Mani Isaacs Jackson recorded in her take on urban renewal in New Haven, the Redevelopment Agency "consistently denied the existence of plans for a Ring

¹⁶ Ibid., 152-3.

¹⁷ Richard Balzer, *Street Time: Text Based on Conversations with Fred Harris*. (New York: Grossman Publishers, 1972), 1.

Road.”¹⁸ However, a map from a Medical Center plan from May of 1965 clearly shows the proposed highway (Figure 7). In September of 1968, a coalition of community groups, including the Hill Parents Association, the Dwight Area Association, the New Haven Preservation Trust, the Save the (East Rock) Park Committee, and a number of state officials, met with Mayor Lee to discuss the Ring Road. The coalition testified in a number of hearings in opposition to the road over the next year, ultimately forcing the Redevelopment Agency to drop the plans.

According to Jackson, the difference between the Ring Road and the Oak Street Connector reflects the difference between the 1950s and the 1960s.¹⁹ In the 1950s, the city administration had free reign to mold the city as it pleased. Trained in disciplines such as sociology, political science, law, and architecture, these men claimed to hold the esoteric knowledge and skills necessary to rebuild cities.²⁰ In the 1960s, however, the civil rights movement had emboldened community groups like the HPA to demand a voice in urban renewal. Rather than yield to preconceived programs made by bureaucrats, The Hill resisted plans that would relocate their homes without benefiting the community. The Hill seemed to hold Grace-New Haven to a particularly high standard; as a community hospital, any claims to physical space in The Hill needed to have community consent. The democratic ethos of the civil rights movement also flowed into the hospital itself, where many Hill residents were employed.

¹⁸ Mandi I. Jackson, *Model City Blues*, 176.

¹⁹ *Ibid.*, 17.

²⁰ Officials in the Redevelopment Agency were pioneers of a field that *Time* magazine dubbed “urbanology.” Fred Powledge, *Model City*, 22.

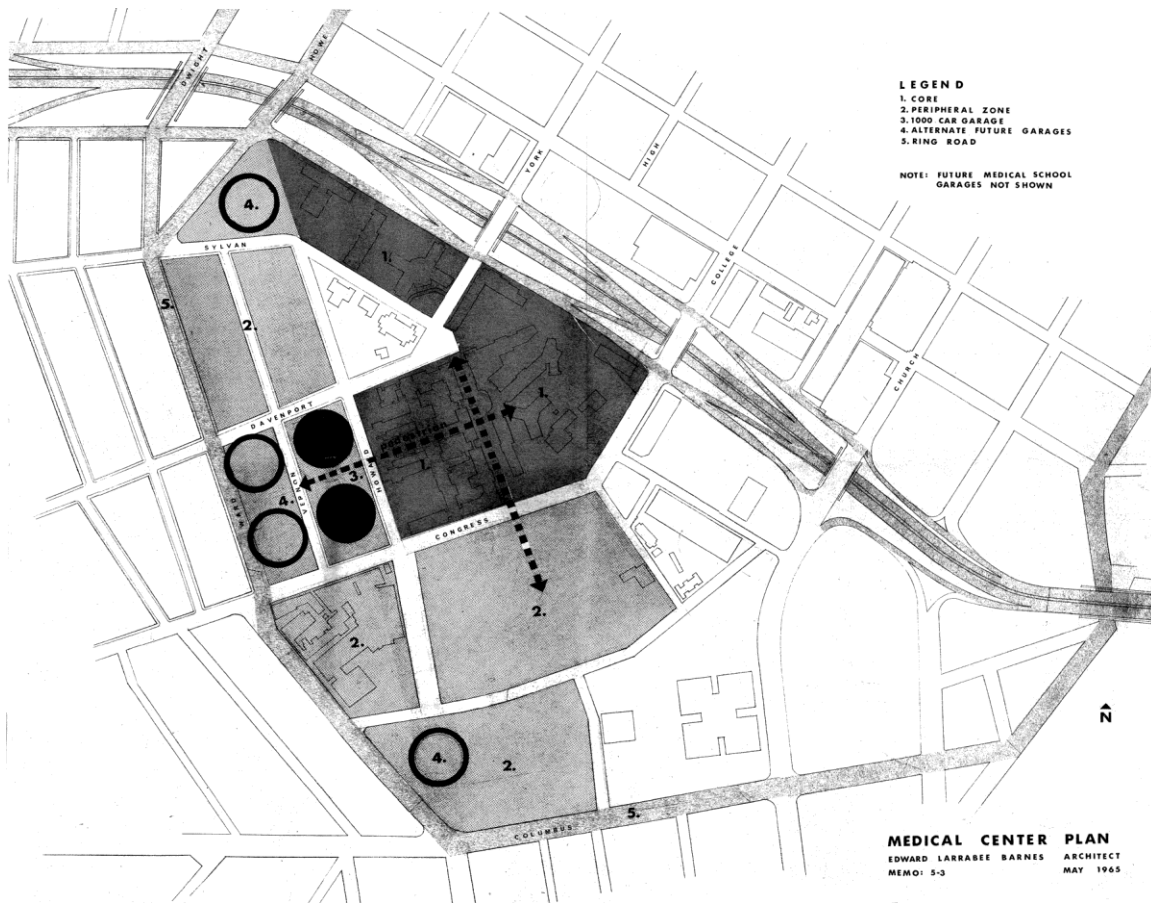


Figure 7: Medical Center Plan for the Ring Road. Item number five in the legend of the map reads “Ring Road,” which refers to the grey artery that runs around the medical center. Medical Center Plan, Edward Larrabee Barnes Architect, May 1965, Box 1, Yale-New Haven Hospital Records.

Discrimination in Employment at Grace-New Haven Community Hospital

The first and foremost item of concern in Dr. Snoke’s 1963 letter to the Mayor was “The Negro Problem.” According to Snoke, the hospital employed “2200 employees, and I am sure that we have the highest percentage of Negroes of any industry in New Haven.” The HPA was concerned about black employment at the hospital as well, but for a very different reason. Fred Powledge, author of a 1970 case study of New Haven’s urban renewal, reported that members of the HPA “were angered at the obvious lack of black faces on the Yale faculty—and, in fact, in most positions of employment except the menial ones.”²¹ As with all voluntary hospitals, Grace-New Haven was exempt from the National Labor Relations Act of 1935 and the Taft-Hartley Act of 1947, allowing it to ignore collective bargaining agents

²¹ Fred Powledge, *Model City*, 220.

and fire union sympathizers.²² While these legal protections theoretically were designed to protect patients (in the event a strike impeded normal hospital functions), some employees claimed the law stripped their power to demand fair compensation. Hill residents regarded the lack of bargaining power among black employees and the dearth of black physicians as yet another example of how Grace-New Haven did not represent its local community. In response, the community brought the civil rights movement into the hospital.

On the week of July 13, 1964, all department heads and supervisors at Grace-New Haven met with their employees to discuss the recent efforts of some workers to join an AFL-CIO union.²³ Not surprisingly, the meetings revealed that laundry and dietary workers had the most interest in unionization. As Patricia Sexton uncovered in the hospitals of her study, “both the kitchen and the laundry were described as ‘hell holes,’ and the workers in them as the most exploited and consequently the best organized groups.”²⁴ A report from the meeting between hospital management and dietary workers capture the workers’ bitterness: “In response to the question by Mr. Lawton of whether or not the employees feel that their individual dignity is maintained, [he] noticed one head shaking no.”²⁵ Wage caps, deductions for health insurance, and limitation of sick days were the primary topics of frustration. In any other industry, such conditions would undoubtedly precipitate a workers’ strike, but the hospital’s exemption from collective bargaining laws effectively handcuffed the workers at Grace-New Haven.

In response to workers’ interest in unionization, Vincent Sirabella, President of the Greater New Haven Central Labor Council, wrote to Dr. Snoke to alert him to the union drive. “We intend to conduct this organizing drive on a responsible and ethical level,” Sirabella reassured the Executive Director. “We have no intention of causing any work stoppages or incidents that would interfere in any way with patient service.”²⁶ The position of the Connecticut Hospital Association, however, held that “no matter how well intentioned a union may be, it cannot help but cause some measure of disruption in the

²² P. Preston Reynolds, “The Federal Government’s Use of Title VI and Medicare to Racially Integrate Hospitals in the United States, 1963 Through 1967.” *The American Journal of Public Health* 87, no. 11 (1997): 1854.

²³ Management meeting, July 15, 1964. Box 1, Union. Yale-New Haven Hospital Records.

²⁴ Patricia Cayo Sexton, *The New Nightingales: Hospital Workers, Unions, and New Women's Issues*. (New York: Enquiry Press, 1981), 37.

²⁵ Notes on meeting of department of dietetics, July 20, 1964. Box 1, Union. Yale-New Haven Hospital Records.

²⁶ Vincent J. Sirabella letter to Albert W. Snoke, July 3, 1964. Box 1, Union. Yale-New Haven Hospital Records.

hospital's care of patients.”²⁷ From the outset of the meetings with their employees, the hospital management resolved, “even if 100% of the employees signed a union card, that does not necessarily mean that the hospital would recognize a union.”²⁸ The management denied Sirabella's request to attend these meetings in order to provide employees with the union perspective. Sirabella charged that the hospital had shirked the principles of “fair play and democratic procedure” in order to hold “a stacked meeting with a captive audience” to discourage dissent from the workers.²⁹ The wave of democratic empowerment in the 1960s, however, gave workers at Grace-New Haven the courage to demand that the hospital work for them as well.

Shortly after the close of management's meetings with employees, the newly formed Grace-New Haven Employees Organizing Committee circulated a flyer with the heading “Brainwash Operation Fails—Union Drive Picks Up Steam!!!”³⁰ In the flyer, the Committee informed workers about the administration's secret refusal to let Vincent Sirabella represent the union in meetings and encouraged workers to sign union cards. Although the hospital did not recognize a workers' union, the momentum generated by the Employees Organizing Committee pushed the administration to approve a wage increase, albeit a modest one. To justify the miniscule reparation, Dr. Snoke held that the drain on funds caused by charitable care made it difficult to fully meet employees' demands. In a letter to employees, Snoke reminded workers that free medical care for the poor in the previous year cost twice as much as the hospital's private income. He pleaded, “please remember that we do not pay wages and benefits from ‘hospital money.’ We pay you with ‘patients’ money.”³¹ The Employees Organizing Committee was less than pleased with the hospital's response. A letter circulated among workers shows the employees invoking rights claims inspired by President Johnson's War on Poverty:

Only a few weeks ago the hospital administration publicly stated that the hospital was running in the red and cried poverty. Now suddenly, it announced wage increases effective next October. Is this the token payment the hospital administration seeks to pay to avoid giving decent, living wages to us? Is this the 30 pieces of silver which the

²⁷ “Statement of Policy on Collective Bargaining,” October 20, 1964. Box 1, Union. Yale-New Haven Hospital Records.

²⁸ Management meeting, July 15, 1964. Box 1, Union. Yale-New Haven Hospital Records.

²⁹ Vincent J. Sirabella letter to William R. Wilson, July 13, 1964. Box 1, Union. Yale-New Haven Hospital Records.

³⁰ “Brainwash Operation Fails—Union Drive Picks Up Steam!!!” July 30, 1964. Box 1, Union. Yale-New Haven Hospital Records.

³¹ Albert W. Snoke letter to employees. July 8, 1964. Page 2. Box 1, Union. Yale-New Haven Hospital Records.

hospital administration wants to pay to prevent us from having job security, a grievance procedure, and the other benefits of a union contract? How can the hospital administration with such great to-do make the announcement of this increase when most of us will still be getting less than \$80.00 gross per week, or less than President Johnson says that a person needs to maintain himself above the poverty level?³²

Grace-New Haven employees picked up on the irony of the hospital's supposed financial difficulties and, simultaneously, the millions of dollars in federal money used for hospital expansion (the "hospital money" to which Snoke referred). In the same summer, Congress passed the Economic Opportunity Act, which required the "maximum feasible participation" of poor communities to frame and administer their own antipoverty programs. Grace-New Haven employees drew on this concept of empowerment to demand more representation in the place of their employment. The fact that employees regarded unionization as the vehicle for a better living supports Johnson's connection between economic opportunity and democratic participation. Hill residents wanted members of their community (in both literal and racial terms) to have a fair chance to succeed in hospital jobs, whether in the laundry or the operating room.

The sense of "community" that Grace-New Haven tried to represent failed in another vital area of hospital employment: the house staff of physicians. Dr. Gerard Burrow, author of *A History of Yale's School of Medicine*, remembers "only two or three African Americans" in his medical school class, and "that was reflected in the house staff."³³ In a 1959 study, Dr. Paul Cornely found that only 10% of the total number of hospitals surveyed in the North accepted African Americans as interns and residents, and only 20% had African-American physicians as members of the medical staff.³⁴ The American College of Surgeons (ACS), which gave hospitals the accreditation necessary for hospital insurance, required that physicians in the medical staff have good standing in a local medical society affiliated with the American Medical Association (AMA).³⁵ While the AMA admonished local medical society chapters for racial discrimination, it also asserted that "every component county medical society has the right of self government in local matters in membership," which

³² Did The Union Get The Wage Increases and Increase Benefits for Hospital Employees? Box 1, Union. Yale-New Haven Hospital Records.

³³ Gerard Burrow, Interview with author, January 15, 2013.

³⁴ P. Preston Reynolds, "The Federal Government's Use of Title VI and Medicare to Racially Integrate Hospitals in the United States," 1850.

³⁵ David Barton Smith, *Health Care Divided: Race and Healing a Nation*. (Ann Arbor: The University of Michigan Press, 1999), 44.

practically allowed local societies to exclude black physicians.³⁶ Due to the ACS requirements, exclusion from a medical society often meant exclusion from hospital employment.

As Leon Fink and Grain Greensburg described in their investigation of hospital labor movements, voluntary hospitals like Grace-New Haven were microcosms of the American social structure in the 1960s: “On one end were the twentieth century’s most upwardly mobile, successful, and esteemed professionals; on the other were the unskilled, unrecognized ranks of the working poor.”³⁷ These class divisions were inherently racial, as minorities were excluded from practicing health care and relegated to the lowest operational positions in the hospital. In her study of community health activists in the 1960s, Lily Hoffman found that the poor typically “were not interested in health care for its ‘intrinsic value,’ but that the health center had appeal as a ‘job center.’”³⁸ However, Hill residents were concerned with the *manner* in which Grace-New Haven provided health care. Doctor–patient relations in the hospital ward and the high price of health care also enforced class and racial divisions in the hospital and city as a whole.

The Struggle to Provide Indigent Care and Discrimination in the Hospital Ward

Another item of concern in Dr. Snoke’s 1963 letter to the Mayor regarded “the financial relationships between the two hospitals of the city and New Haven.”³⁹ Grace-New Haven reportedly experienced losses of hundreds of thousands of dollars due to the free or undercompensated care of poor patients, spurring an intense debate with the City Welfare Department over which institution bore financial responsibility for the city’s “medically indigent.” In the context of Grace-New Haven’s ambitious expansion, new medical technology, and clinical research, the hospital’s inability to provide charitable care was difficult for Hill residents to believe.⁴⁰ The apparent imbalance between the hospital’s private

³⁶ Robert B Baker, “African American Physicians and Organized Medicine, 1846-1968: Origins of a Racial Divide.” *Journal of the American Medical Association*, 300 no. 3(2008): 306.

³⁷ Leon Fink and Brian Greenberg. *Upheaval in the Quiet Zone*. (Urbana And Chicago: University of Illinois Press, 2009), 6.

³⁸ Lily M. Hoffman, *The Politics of Knowledge: Activists Movements in Medicine and Planning*. (State University of New York Press: 1989), 193.

³⁹ Albert W. Snoke letter to Richard C. Lee. June 20, 1963. Page 2. Box 3, Correspondence between the city and the hospital. Yale-New Haven Hospital Records.

⁴⁰ In 1959, the hospital sued the city for \$71,000 dollars in unpaid bills for indigent care. However, the hospital undertook \$16.6 million worth of expansion projects between 1952 and 1965. “City Disputes Big Hospital Bill.” *The New Haven Journal-Courier*. October 23, 1959.

interests and public service was emblematic of health care across the country. According to Rosemary Stevens, voluntary hospitals' "commitment to science and technology as an organizational ethos overshadowed any attempts to restructure the hospital as a community institution."⁴¹ Hill residents were unable to afford hospital care in most circumstances, but even when they did receive treatment, house physicians and Yale medical students regarded them as second-class citizens. Thus, Hill residents sought to establish a new form of community-based health care that was accessible to the poor and free from white paternalism.

Patients unable to pay for their medical expenses at Grace-New Haven theoretically had two options, depending on their level of poverty. The City Welfare Department supported the medical costs of the "indigent"—those who relied on public programs to meet their basic needs. The situation was more complicated for patients classified as "medically indigent" who were able to support their basic needs, but unable to pay for medical care. For starters, the hospital and the city disagreed on the definition of the term, or at what level of wealth a patient moved from absolute indigence to medical indigence. Patients denied by the city were supposed to receive care at the expense of the hospital's privately endowed "free bed funds." However, free bed funds had not been able to cover the costs of the medically indigent since 1946.⁴² The hospital resorted to inflating rates for paying patients in order to make up the losses from charitable care. In 1955, Dr. Snoke asserted that the cost of care for the individual who is medically indigent "should be met by gifts, grants, and endowments of the hospital to the limit of its resources, and then balanced by society in general."⁴³ By the 1960s, the hospital fervently pushed the city to assume more responsibility for the medically indigent. On October 1, 1962, the hospital "declined to admit as in-patients, or to treat in its clinics, any non-emergency patient referred for elective treatment or diagnosis unless payment for his care is covered in advance by insurance, cash, or formal acceptance of full financial responsibility by a local or State welfare department."⁴⁴

⁴¹ Rosemary Stevens, *In Sickness and in Wealth*, 235.

⁴² Care for the medically indigent in 1962 amounted to \$878,238, whereas the income for free bed funds of that year was \$115,843. "A report to the community on hospital care of the indigent," August 6, 1963. Box 3, Welfare Reimbursement. Yale-New Haven Hospital Records.

⁴³ Ibid.

⁴⁴ "The Position of the Grace-New Haven Community Hospital With Respect to the Care of the Indigent," March 11, 1961. Page 6. Box 4, Folder 101. Yale-New Haven Hospital Records.

The origin of Grace-New Haven's financial woes lay in the immense changes in hospital medicine following World War II. Hospital care became increasingly expensive due to new medical technology, an increase in specialized services, and hospital expansion. By 1945, more than two-thirds of all deaths were attributed to chronic diseases such as heart disease, cancer, and stroke.⁴⁵ Rather than promote programs for community education and prevention, the American health care system responded with advancements in imaging, surgery, and intensive care. The fee-for-service model of reimbursement incentivized health professionals to over-prescribe lucrative tests and treatments. As Rosemary Stevens described, hospitals had a "clear incentive to build the demand for hospital service; that is, to behave as successful, competitive enterprises in which the goal was expansion of units sold, including surgical operations and filled private beds."⁴⁶ Thus, hospital expansion focused on building facilities to employ cutting-edge technology, and hospitals in close proximity often duplicated services due to their lack of regional planning.⁴⁷ The rise of third-party insurance companies like Blue Cross also contributed to inflation by removing considerations of cost constraints from hospital billings.⁴⁸

The design of the American health care system had important consequences to the voluntary hospital's image as a community institution. Grace-New Haven was one of the wealthiest hospitals in the country, yet health care was still out of reach to many residents of The Hill.⁴⁹ Health care in the US as a whole seemed to be designed to maximize industry profits rather than equitably distribute services to the public.⁵⁰ The cost of health care and the hospital's emphasis on specialized services repelled the poor, non-white citizens of The Hill and attracted preeminent physicians and paying patients. A growing portion of Grace-New Haven's income also came from research grants, which affected the balance of time

⁴⁵ Stevens, *In Sickness and in Wealth*, 203.

⁴⁶ Ibid., 33.

⁴⁷ Judith R. Lave and Lester B. Lave. *The Hospital Construction Act: An evaluation of the Hill-Burton Program, 1948-1973*. (Washington, American Enterprise Institute for Public Policy Research, 1974), 5.

⁴⁸ By 1960, Blue Cross paid for two-thirds of all nongovernmental expenditures on health care. Rosemary Stevens, *In Sickness and in Wealth*, 257.

⁴⁹ As of 1963, Grace-New Haven had 724 beds and 110 bassinets and was larger than 98% of all the general hospitals in the United States. "A report to the community on hospital care of the indigent," August 6, 1963. Box 3, Welfare Reimbursement. Yale-New Haven Hospital Records.

⁵⁰ Voluntary hospitals doubled their capital worth between 1947 and 1955 and again between 1955 and the early 1960s. Rosemary Stevens, *In Sickness and in Wealth*, 232.

that Yale faculty devoted to research versus patient care.⁵¹ In fact, clinical research served as another means by which the hospital created and enforced socioeconomic and racial divisions in the hospital and, by proxy, The Hill community.

Although most indigent patients received care at Grace-New Haven on an outpatient basis in the Emergency Department, some did receive inpatient care by means of “committee sponsorship.” In *Sickness and Society*, a provocative 1968 exposé of the Yale-New Haven Hospital, Raymond Duff and August B. Hollingshead described the experience of these patients from data and observations gathered over a three-year study. A Yale faculty member or house physician admitted such patients because they presented an interesting case study of pathology. The committee consisted of an ever-changing group of house staff and medical students with an interest in studying the patient’s disease and its treatment. One intern responded to the researchers’ questions quite frankly: “You’re interested in patients. I’m interested in the disease in the body in the bed.”⁵² Committee patients received care in the hospital ward, a building that “has been characterized by the hospital authorities as obsolete” and lacked any partitions between beds as in semi-private or private rooms.⁵³ *Sickness and Society* described the stigma associated with ward care and the effects on patients’ psyche:

Several patients told us: “Doctors have their secrets.” The patients were embarrassed by their ignorance and remained silent to avoid exposure. Thus, they failed to put their questions to the doctors although they asked such questions of family members, our data collectors, and sometimes the nurses if the latter would listen... They expected to be cared for by interns and medical students, yet they were resentful of being “pushed around” and ignored as individuals. Some realized that inconvenience, discomfort, and at times higher costs for decisions made in the interest of teaching and research, rather than in the interest of the patient, were necessary in order for them to get the benefits of service within the ward accommodations.⁵⁴

Patients in the ward lacked the medical understanding to speak the scientific language of Yale-New Haven physicians, and physicians typically did not translate their medical decisions into laymen’s terms. The gulf in knowledge between doctors and patients paralleled the one between bureaucrats of the Redevelopment Agency and New Haven

⁵¹ The Yale School of Medicine ended its direct subsidization of patient care in 1952, as the University chose to devote its funds only to activities tied to teaching and research. Gerard N Burrow, *A History of Yale’s School of Medicine: Passing Torches to Others*. (New Haven: Yale University Press, 2002), 185.

⁵² Raymond S Duff and August B Hollingshead, *Sickness and Society*. (New York: Harper and Row Publishers, 1968), 128.

⁵³ Raymond S Duff and August B Hollingshead, *Sickness and Society*, 37.

⁵⁴ *Ibid.*, 132.

citizens. In her study of activism in urban planning and medicine, Lily Hoffman argued, “medicine and planning created and fostered dependency among clients and helped maintain social control.”⁵⁵ Keeping citizens and patients in the dark about the rationale for redevelopment or medical treatment protected professionals’ higher authority and social status. As we can see from *Sickness and Society*, doctors’ objectification of ward patients as teaching and research material was eventually internalized by the patients themselves, which harmed the patients’ sense of agency within the hospital and perhaps even the community as a whole. In response to *Sickness and Society*, Dean Redlich expressed disappointment with how the authors depicted the Medical Center, but even greater disappointment in the reality of care at Yale-New Haven:

Many of the data and conclusions are correct: unfortunately it omits all positive statements which one could make about modern hospital care and gives a biased picture...Yet I cannot overlook the fact that psychological and social factors in diagnosis, etiology and therapy are neglected...the main message of the book is sound.⁵⁶

The study also omitted statements about race. Duff and Hollingshead only followed white patients in their study “because the races are unequally distributed in the accommodations the hospital provides inpatients.”⁵⁷ In other words, since the majority of black patients were treated in the ward, the researchers could not compare black patients’ experiences across private, semi-private, and ward accommodations. Thus, the socioeconomic segregation of patients served, to a large extent, as de facto racial segregation.

Hospital expansion also perpetuated racial segregation within the hospital. Like many voluntary hospitals, Yale-New Haven received federal loans from the Hill-Burton Act of 1946 to expand its campus. Although racial discrimination was prohibited in any hospital receiving construction funds, the law allowed “separate but equal” facilities.⁵⁸ The Supreme Court struck down the separate but equal clause in 1963, but the battle for racial integration of hospital facilities was far from over. In 1965, the Johnson Administration made receipt of Medicare funds dependent upon compliance with Title VI of the Civil Rights Act, which forbade racial discrimination in institutions receiving federal aid. As of April of 1966, three months before the start of Medicare, only 49 percent of hospitals met Title VI compliance

⁵⁵ Lily M. Hoffman, *The Politics of Knowledge*, 81.

⁵⁶ F.C. Redlich, Letter to Paul Beeson, May 15, 1968, Box 144, Folder 5, Kingman Brewster Papers.

⁵⁷ Raymond S Duff and August B Hollingshead, *Sickness and Society*, 15.

⁵⁸ Rosemary Stevens, *In Sickness and in Wealth*, 254.

standards.⁵⁹ With heavy pressure from the White House, 85 percent of hospitals were brought into compliance by June, but suits for racial discrimination in hospitals continued to be filed into the 1970s. Understandably, community activists in The Hill utilized the momentum of the civil rights movement to create a more participatory form of health care that protected their dignity as patients.

The Drive for Community Control of the Model Cities Program

The movement for community-involved health care in New Haven was a product of a broader concern for community participation in the development of the city. With the passage of the Model Cities Program in 1966, grassroots organizations like the Hill Parents Association gained the opportunity to design and implement antipoverty programs that were best suited for their communities. Since Yale-New Haven Hospital was a chief player in the physical and social design of the city, health care was an inherent component of Hill activists' antipoverty plans. Wresting control of antipoverty programs from the city was not an easy fight. The establishment of the Hill Neighborhood Corporation (HNC) to administer the Model Cities Program (which included the development of the Hill Health Center) came after a long battle between Hill residents and the city's antipoverty agency, Community Progress, Incorporated (CPI). Delving into the history of this conflict shows how the Hill Health Center arose from Hill residents' passionate campaign for democratic representation and participation in the city's economic development. Thus, I argue that participatory health care is an essential component to the formation of a city's democratic culture.

New Haven's many redevelopment projects brought the city and Mayor Lee into the national spotlight as a hopeful model for urban transformation. Yet, Mayor Lee soon realized that bulldozing slums was not enough to eradicate poverty. Writing in 1970, Fred Powledge recorded the city's shift from physical renewal to "human renewal" when the public's memory of the transition was still fresh. As he described, redevelopment "had exposed sights, smells, and frustrations that most white, middle-class observers had neglected to observe before. As the physical renewal program progressed, the need for

⁵⁹ P. Preston Reynolds, *The Federal Government's Use of Title VI and Medicare to Racially Integrate Hospitals in the United States*, 4.

‘people programs’ became increasingly apparent.”⁶⁰ In response, New Haven founded CPI to embark on a campaign of human renewal in seven of the city’s neighborhoods.⁶¹ Each neighborhood had an employment center to actively recruit applicants and develop jobs for them if available jobs were not suitable.⁶² The CPI model impressed the Johnson administration, which adopted the agency’s structure for the Community Action Agencies funded by the Economic Opportunity Act. However, the manner in which CPI developed and implemented its antipoverty programs committed the same mistake as the Citizens Action Committee: poor, minority residents were not represented in policy-making.

CPI’s founding document, “Opening Opportunities,” called for a “community seminar” made up of representatives of public and voluntary agencies, community leaders, as well as local, state and federal officials to assist the staff of CPI. However, the city’s poor residents were unrepresented in the selection process of CPI’s board.⁶³ Participation from the poor was intended to come via the CPI neighborhood outposts, but residents were reluctant to walk into unfamiliar offices and voice their concerns with strangers clearly of higher socioeconomic class. Furthermore, critics charged that CPI operated like “[the Mayor’s] own personal fiefdom, providing jobs for loyal voters and friends of friends when what were needed were people with a solid background in education and social work. Many complained as well that the men farthest removed from the blight of poverty were being employed to help its victims.”⁶⁴ Peter Almond, a young white employee of CPI, came to agree with Harris that the human renewal agency had failed the residents it intended to serve: “There was never, at least at any meeting I ever attended, any opening where the citizen’s word would have any kind of direct and obvious impact.”⁶⁵ According to Almond and Harris, CPI conceived programs behind closed doors, informed the citizens of their programs, and then forced them upon the community. “And that is where CPI and the city

⁶⁰ Fred Powledge, *Model City*, 51.

⁶¹ CPI created programs to improve education, employment, and other community services in seven neighborhoods: State Street, The Hill, Dwight, Wooster Square, Dixwell, Newhallville, and Fair Haven. The agency was funded by a \$2.5 million grant from the Ford Foundation. *Ibid.*, 55.

⁶² Some CPI programs included a Neighborhood Youth Corps out-of-school program to teach high school dropouts marketable skills, an adult worker training program, and on-the-job training programs in connection with about 300 local firms. *Ibid.*, 85.

⁶³ The board of CPI was appointed by Mayor Lee and members of the Board of Education, the Redevelopment Agency, the Citizens Action Commission, the United Fund, the Community Council of Greater New Haven, and Yale. Fred Powledge, *Model City*, 55.

⁶⁴ Yohuru Williams, *Black Politics/White Power*, 59.

⁶⁵ *Ibid.*, 159.

and the Mayor all failed, as far as I'm concerned," Almond said, "failed in the sense that they simply could not tolerate, or understand, or accept the implications and the fact that a neighborhood group could devise and plan and opt to run its own program."⁶⁶

Following a highly publicized strike at the State welfare office in Hartford, Harris and the HPA were riding a crest of local support. In the late spring of 1967, Fred Harris approached Community Progress, Inc. with a \$34,000 proposal to operate three programs in The Hill during the summer: a day camp and educational program, a recreation and playground project, and Operation Breakthrough, which "had as its aim the development of jobs for the 'hard-core' unemployed."⁶⁷ CPI agreed to provide the funds, but with strings attached. Fred Harris later recalled the meeting with the Mayor:

It seems that some of the CPI offices had been firebombed the previous night...[The Mayor] told us he'd found the \$34,000 for us. He said that in return for it we should make sure there was no trouble this summer. I know it sounds crazy, but that is what the man said. We weren't going to tell him we didn't control people in the entire city and didn't even control people in the Hill. I don't know what he thought. So we told him we didn't think there was going to be trouble.⁶⁸

While Harris sought to make the HPA as representative of The Hill as possible, Mayor Lee held the organization accountable for every incident in the neighborhood. These unrealistic expectations allowed the Mayor's office to undermine the HPA whenever conflict arose, especially after the riot in August of 1967. Compared to the riots that swept other American urban centers in the mid-1960s, New Haven's riot (sparked by a shooting in The Hill) was less violent and destructive. Still, New Haven could no longer identify itself as the nation's poster child for urban renewal. The disturbance brought attention to the abysmal living conditions and clear discrimination in The Hill that the Redevelopment Agency and CPI had not alleviated.⁶⁹ Rather than consider how the city's approach to urban renewal may have contributed to the riot, Mayor Lee used the HPA as his scapegoat. According to Harris, Lee told the HPA, "you guys didn't keep your bargain."⁷⁰ CPI and Mayor Lee believed the riot "reflected more of a thirst for revelry than a social protest," as Harris's followers were

⁶⁶ Fred Powledge, *Model City*, 159.

⁶⁷ Ibid., 162.

⁶⁸ Richard Balzer, *Street Time*, 16-7.

⁶⁹ In 1967, fifteen percent of the city's total housing was in The Hill, yet the neighborhood accounted for more than twenty percent of the city's substandard housing. The Hill represented only 2.5 percent of the population in the jurisdiction of the New Haven State Jail, but 12 percent of the jail's inmates came from the neighborhood. Fred Powledge, *Model City*, 162.

⁷⁰ Richard Balzer, *Street Time*, 21.

“too young to know about the progress that’s been made—or too burned up to care...Few if any of the incidents of the four days bespoke any widespread discontent.”⁷¹ Thus, Lee considered the riot supporting evidence of the HPA’s futile attempt to democratically involve the black community in its own economic and social development: “Fred Harris is not a leader in the real sense. They’ve tried to *make* him a leader. It’s hard to single out what the Negro table of organization is. No one really knows, and no one who is white really knows it, no matter what anybody tells you.”⁷²

Despite Lee’s attempt to point the finger at the HPA, CPI came under intense scrutiny from its funding body, the Ford Foundation, after the riot. In a 1968 investigation, the Ford Foundation linked CPI’s failures to its lack of community representation. The final report found that CPI “has made no significant impact on the fundamental problems of employment, housing, and education in their community...because residents are not consulted and do not participate meaningfully in program development and implementation.”⁷³ The report went on to call CPI’s Residents Advisory Committee, which consisted of three residents from each of the seven neighborhoods, a meaningless “rubber stamp” without adequate power to influence program design. Rather than capitalize on the potential of community-led antipoverty programs, CPI treated groups like the HPA “as conduits, antennae, and supporters, rather than as social action organizations” because such organizations “posed threats to the [CPI] coalition.” The stage was set for a grassroots movement for community control of the city’s war on poverty.

The Demonstration Cities and Metropolitan Development Act of 1966, better known as the Model Cities Program, gave America’s urban poor a second chance to participate in economic development. The law provided funding for new antipoverty programs that could be administered by community organizations rather than municipal government. In 1967, the city formed the City Demonstration Agency (CDA) to design antipoverty programs for The Hill, which was chosen as New Haven’s Model Neighborhood. Initially, the Board of Alderman proposed that five of the fifteen members of the CDA be from The Hill. A quickly organized group calling itself The Hill Ad Hoc Model Cities Steering Committee agitated for greater Hill representation in the CDA, which the Board of Alderman eventually

⁷¹ Fred Powledge, *Model City*, 171.

⁷² *Ibid.*, 176.

⁷³ *Ibid.*, 138.

accepted. In April of 1968, the Ad Hoc Committee rebranded itself the Hill Neighborhood Corporation (HNC) and was allowed to select eleven of the twenty-one CDA members. Willie Counsel, vice president of the Hill Parents Association, was elected chairman of the HNC. Counsel felt that “Model Cities should be *our* baby, and we should have a chance to prove to the nation that Model Cities can be a concept that works.”⁷⁴ For the first time, city planning bypassed City Hall, and The Hill had representative input in program design. Given the neighborhood’s past experiences with Yale-New Haven Hospital, community-based health care was a chief component of the HNC’s plan for the Model Neighborhood.

The Hill Health Center and Community Participation in Health Care

Now with control over the Model Neighborhood program, the HNC needed to prove that community-led development was possible. Just as Mayor Lee demeaned Fred Harris’s abilities as a leader, officials from CPI hoped that HNC’s “coup on City Hall” would only prove “to everybody who could see or was interested...that they could not run a goddamned thing.”⁷⁵ One key area in which the HNC sought to enshrine citizens’ self-determination was health care. The Hill’s turbulent relationship with Yale-New Haven Hospital—as an agent of urban renewal, a major employer, and provider of charitable care—inspired the HNC to create a health center of its own that responded to the hospital’s past abuses. For instance, local residents selected the physical location of the Hill Health Center, worked in the center and chose its physicians, and participated in their treatment decisions. The HNC believed that community involvement in the HHC not only improved health care for local residents, but also addressed the root cause of poverty by empowering individuals with a democratic voice.

Beginning in the spring of 1966, Hill residents involved in the HPA began to organize the Hill Health Council, which moved under the umbrella of the Hill Neighborhood Corporation in 1967. With technical assistance from a psychiatrist and social worker from the Connecticut Mental Health Center, the HNC negotiated with the Yale School of Medicine’s Department of Pediatrics to devise a system of health care for children in The Hill. The School of Medicine proposed a facility that would provide free comprehensive care to eight-thousand children, provide jobs and training to residents of the area on a

⁷⁴ Fred Powledge, *Model City*, 294.

⁷⁵ *Ibid.*, 292.

preferential basis, and operate all aspects of the center with community participation, as defined by Hill residents. Unlike Yale-New Haven's "physical takeover" of the neighborhood, the HNC required local participation in choosing the location of the Hill Health Center. The Hill Health Council appointed the Site Selection Committee (made up of black, white, and Spanish-speaking Hill residents), which received community consent to build the health center at 400 Columbus Avenue. The HHC got off the ground with financial support from the School of Medicine, but became an independent nonprofit in 1971. In the 1970s, the Hill Health Center expanded its services to adults and received a substantial portion of its funding from the Office of Economic Opportunity as part of the Hill's Model Neighborhood program.⁷⁶

In light of discrimination in employment and the prohibition of unionization at Yale-New Haven, community representation in employment at the health center was a high priority for the HNC. The Hill Health Council selected a Personnel Committee (consisting of two white, two Puerto Rican, and five black Hill residents) to screen every individual that applied to work at the HHC.⁷⁷ The Personnel Committee gave Hill residents preference for all positions in the center, reviewed all terminations of staff, and ensured that all employees received a living wage. Although the HHC did employ professionals that were not from The Hill, such applicants had to pass the scrutiny of the Personnel Committee. In an article celebrating the HHC's focus on community involvement, Rudolph Sellers shared some of the pointed questions the Committee asked during job interviews, such as, "What do you know about black or Spanish-speaking people?" and "What would your reaction be if you were called a white racist or an Uncle Tom by a Hill resident?"⁷⁸ The Committee's intention was to weed out any applicants who "view ghetto people as universally 'bad' people." Hill residents had had enough with condescending and paternalistic staff at Yale-New Haven. The Hill Health Center ensured that its employees, whether operational staff or health care providers, possessed the compassion and cultural competency to serve Hill residents. Furthermore, the HHC's black community health workers broke the mold of traditional health care provision, creating a more holistic system of disease prevention and treatment that involved the participation of local residents.

⁷⁶ Gregory R. Huth, "The Hill Health Center: Two Decades—And Growing," *Yale Medicine*, Summer 1989, 4.

⁷⁷ Rudolph V. Sellers, "The Black Health Worker and the Black Health Consumer—New Roles for Both," *American Journal of Public Health* 60, no. 11 (1970), 2159.

⁷⁸ *Ibid.*, 2160.

As tension between the Yale Medical Center and The Hill grew in the 1960s, Dean Redlich sought an avenue for diplomatic relations between the two groups and selected Dr. Lowell Levin as a liaison, or “cultural translator,” to the local community. Levin transmitted community sentiments to hospital administrators and medical faculty that many had never considered. Although The Hill faced grave public health disparities, Levin found that residents’ most salient concerns regarding health had to do with their lack of agency in the health care system:⁷⁹

They wanted to learn how to protect themselves from disease, deal with health information that was often complicated and conflicting, and benefit from options available to them without jumping through hoops. They wanted to develop a “self-care” orientation, learn what the root causes of many of their health problems were, and what they could do as a community without benefit of the “medical clergy.”⁸⁰

The Hill Health Center made this self-care model a reality. Black community health workers at the HHC were trained not only in basic health services, but also community organization, social work, and health education. Thus, the health workers could provide patients with the knowledge they needed to make medical decisions as well as help patients navigate any obstacles to medical care and healthy living, such as, “transportation, baby-sitting needs, broken promises of agencies, unemployment, and poor and inadequate housing.”⁸¹ As Sellers described, the HHC intended “to provide Hill residents with a mechanism through which they, as consumers, can become the planners and the managers of their own health programs, using the skills of trained health workers to assist them toward that end.”⁸² In doing so, the HHC knocked the “medical clergy” from their elite pedestal. Unlike the paternalistic treatment ward patients encountered at Yale-New Haven, HHC patients possessed the agency to decide what was best for their health.

The establishment of the Hill Health Center would not have been possible without the support of some progressive physicians from the Yale Medical Center, particularly Dr. Richard Weinerman. Weinerman was a prominent member of the Medical Committee for Human Rights (MCHR), which was concerned about racism in health care and inequitable access to medicine in the United States. In many northern cities, MCHR chapters helped

⁷⁹ In 1967, the infant mortality rate in The Hill was 35.5 per 1,000, the highest in the city. The accidental death rate was 69.2 per 100,000, as compared to 39 in the city as a whole. Tuberculosis and venereal disease prevalence were also higher than city averages. Fred Powledge, *Model City*, 162.

⁸⁰ Lowell Levin, Interview with author, November 30, 2012.

⁸¹ Rudolph V. Sellers, “The Black Health Worker and the Black Health Consumer,” 2162.

⁸² *Ibid.*, 2161.

establish community health centers based on the model created by Dr. H. Jack Geiger, a civil rights activist who helped found the Congress of Racial Equality (CORE).⁸³ Not surprisingly, the HHC adopted many elements of Geiger's model, such as local community health workers, an emphasis on preventive medicine, and democratic control of medical policy. However, whereas the New Haven MCHR advocated for greater community representation on the Yale Medical Center board, the HNC insisted on creating a health center of its own.⁸⁴ Although Dr. Weinerman's expertise was invaluable in organizing the HHC, the most important aspect of the health center and the community health movement as a whole was local residents' leadership and control over a new form of health care. The HNC believed that community ownership of health care could not only improve residents' health, but also raise their political and socioeconomic status.

The HNC recognized that Yale-New Haven Hospital constructed and enforced class and racial divisions that deprived poor, minority residents of The Hill of equal representation in the city. Thus, health care was an essential component of the HNC's plan for social transformation of The Hill, which was spelled out clearly in the HHC's federal funding application:

Residents of low income communities are often described in psychological terms as distrustful, apathetic, alienated, hopeless, hostile, dependent, and having low self-esteem and a feeling of worthlessness...Those characteristics are associated with inadequate housing, unemployment, low income and the demoralizing and demeaning influence of overt and covert racial and economic discrimination...The tendency of professional agencies to be paternalistic in their planning for communities inadvertently foster this alienation and apathy. However, we contend this process is a reversible one if meaningful participation can be evolved through increased autonomy.⁸⁵

In addition to housing, employment, and education, it seemed that the HNC identified health care as an essential good that enabled citizens to succeed. Health care not only protected individuals' economic productivity, but also shaped citizens' conception of their self-worth. Certain services were beyond the financial reach of the poor, which implicitly assigned a lower value to their lives. Yale-New Haven's disregard of Hill residents' property, discrimination against nonwhite employees, and objectification of minority patients also demeaned poor citizens' autonomy, which the HNC believed to be the root cause of

⁸³ Sarah Siegal, "The Convergence of Civil Rights and Health Advocacy," 4.

⁸⁴ *Ibid.*, 18.

⁸⁵ Application for Comprehensive Health Services, Box 46, Richard Weinerman Papers.

poverty. By giving Hill residents democratic control over all aspects of health care, the HHC claimed to function as an antipoverty agency in its own right.

Health Care and Democratic Culture in an American City

Having organized a public forum for Hill residents at the CMHC, Dean Redlich surely felt that he had tried to include local residents in the medical center's decisions. In the minds of Hill residents, though, community participation in health care took more than just meetings with hospital administrators; it required a new type of health system altogether. The system envisioned by Dr. Redlich, Dr. Snoke, and Mayor Lee consisted of a professional class, or "medical clergy," delivering services to laymen within a voluntary hospital. Although Yale-New Haven partnered with city government and purported to be a "community hospital," the hospital used its private status to avoid public accountability. The medical clergy formed hospital policies—where to expand, whom to employ, and how to provide care—without input from Hill residents. The HNC and supporters like Dr. Weinerman had an alternate vision for health care that paralleled the democratic movement sweeping other aspects of city policy.

Mandi Isaacs Jackson held that the citizen response to urban renewal and the birth of the civil rights movement was a battle to determine whether cities would "be something that could be 'managed,' like a corporation ... or governed, designed, and sustained by the people who lived and worked there."⁸⁶ Choosing the latter option, the HNC fought for democratic involvement of Hill residents in decisions that shaped the physical, economic, or social fabric of the city. Community control of health care was especially important to the democratic culture of the city. The Yale-New Haven Hospital had threatened to box Hill residents into dilapidated areas, suppressed their bargaining power as employees, and deprived them of human dignity as patients. By designing and implementing their own system of health care, Hill residents freed themselves from the paternalism of the medical clergy.

Herein lies the most important nuance between my interpretation of the community health movement and Sarah Siegal's. Siegal contended that the chief goal of the Hill Health Center was to address the health disparities in the neighborhood, which "required local

⁸⁶ Mandi I. Jackson, *Model City Blues*, 116.

participation to ensure that services provided reflected community needs.”⁸⁷ However, I believe that community participation in the health center was part of a broader effort to increase Hill residents’ autonomy. The HNC understood that residents’ lack of representation in the city’s major institutions, such as Yale-New Haven, perpetuated poverty in The Hill. In my opinion, the services that patients received at the HHC were not as important as the respect and empowerment conferred by the participatory health system. The HNC hoped that this social transformation within health care could help increase Hill residents’ agency in the city. With a stronger democratic voice, residents could shape New Haven in ways that could raise them out of poverty and improve their health. As Dr. Levin put it, “health is a product of social development.”⁸⁸ That is, if an individual is socially empowered, then physical health is sure to come.

Whether or not the word “community” was included in their hospital’s name, Hill residents expected the hospital located in their neighborhood to serve their interests first and foremost. Despite Yale-New Haven’s private identity, the community regarded the hospital as a public institution that should treat everyone equally and reflect the values of democratic participation at every level of its organization. The hospital’s failure in those areas spurned The Hill to adopt a social justice approach to medical care that pursued a new definition of “health”—one that demanded self-determination, freedom from oppression, and respect from others. Thus, health represented not only a physical state, but also the exercise of one’s civil rights.

⁸⁷ Sarah Siegal, “The Convergence of Civil Rights and Health Advocacy,” 4.

⁸⁸ Lowell Levin, Interview with author, 30 November 2012.

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Bibliographic Essay

Urban renewal and the community health movement in New Haven proved to be an incredibly deep research topic. Because my topic was local and relatively recent, I had access to a wealth of primary documents and key individuals who were involved in the events of my study. Thus, while secondary sources were useful in constructing the national context of urban renewal and health care policy, I could piece together the narrative about Yale-New Haven Hospital and The Hill using primary documents and personal interviews.

Yale University Manuscripts and Archives contained collections of primary documents from key people and institutions in my study. The “Redevelopment” boxes of the Yale-New Haven Hospital Records provided detailed plans for hospital expansion, complete with the dates, budgets, and maps that I used to show the course of the hospital’s redevelopment. The Records also yielded correspondence between Dr. Snoke and Mayor Lee, which gave me a window into the close relationship between the two as well as their attitudes toward the local community. This is where my interest in this topic began, as I could clearly see the physical conflict between the hospital and the surrounding community. I also found multiple folders of materials on the hospital’s union drive and struggle to provide charitable care. Slowly, a complete picture of the hospital’s many facets emerged.

Next I searched the papers of Richard Weinerman, which alerted me to the movement for an alternate form of health care underway in The Hill. The Weinerman papers were invaluable to understanding the motivations behind the development of the Hill Health Center. The funding application for the health center showed the Hill Neighborhood Corporation’s philosophy of community empowerment as a means to combat poverty. I also consulted the papers of Kingman Brewster, the President of Yale in the 1960s, and found Dean Redlich’s response to *Sickness and Society* as well as a memo about some sort of incident at the Connecticut Mental Health Center. From there, I checked out *Sickness and Society*, which provided a damning picture of the patient experience in Yale-New Haven’s ward.

Desiring an account of the interactions between the major players that I had found, I read through Dr. Gerard Burrow’s *A History of Yale’s School of Medicine*, which contained the timeline of the Hill Health Center’s founding and described Grace-New Haven’s competing interests of charitable care, teaching, and research. I also conducted an interview with Dr. Burrow to get his take on what it was like to work in Grace-New Haven during the social

upheaval of the 1960s. Dr. Burrow suggested that I interview Dr. Lowell Leven as well. I owe the title of my essay as well as a more complete understanding of The Hill's perspective on community health to Dr. Levin. Still, I wanted the perspective of Fred Harris to understand community organizing in The Hill. Luckily, I found Richard Balzar's interviews with Fred Harris in *Street Time* archived in the Beineke Library. Harris's descriptions of meetings with the Mayor were not only hilarious, but also showed how the community's effort to represent itself was constantly undermined by the Mayor.

I also consulted a number of secondary sources for general information about urban renewal and health care policy across the United States and in New Haven. Fred Powledge's *Model City* and Mandi I. Jackson's *Model City Blues* both provided excellent histories of urban renewal, CPI, and the Model Cities Program in New Haven. Their work showed me how the Hill Neighborhood Corporation grew out of an intense battle to establish community participation in antipoverty programs. Patricia Sexton's *The New Nightingales* and Leon Fink and Brian Greenberg's *Upheaval in the Quiet Zone* provided the broader context on hospital labor movements. After reading their work, I had a better of what employment at Grace-New Haven was like. My background knowledge of American health policy in the 1950s and 1960s came from a number of books. David Smith's *Health Care Divided* and Rosemary Stevens's *In Sickness and in Wealth* both showed how voluntary hospitals enforced socioeconomic and racial divisions in society. Stevens also detailed how voluntary hospitals became one of the most profitable industries in the country at the expense of serving the public health needs of their local communities. *The Politics of Knowledge* by Lily Hoffman provided an interesting perspective on city planning, medicine, and democratic culture. After reading her book, I better understood why Hill residents desired training to provide basic health services as a means to increase their autonomy. And of course, Sarah Siegal's thesis opened my mind to alternative deductions that could be made from the community health movement in New Haven, providing me with a launching pad for my essay.

My research is limited by the lack of doctors' or patients' first-hand experiences with the hospital and The Hill community. Even if some individuals were still alive and available, some of their accounts could be protected by doctor-patient confidentiality. It is also important to note that while I uncovered multiple hospital expansion plans from the 1960s, the salience of hospital construction to Hill residents at that time was undoubtedly much lower as compared to the height of hospital construction during the 1970s and 1980s.

Because Mayor Lee was rather unique in his degree of political power and New Haven was rather small, comparing the community health movement in New Haven to another, larger American city would be useful to drawing national inferences. This essay would also benefit from a contemporary update on the Hill Health Center and Yale-New Haven Hospital to see how the community health movement shaped their trajectories over the past forty years and what, if anything, The Hill neighborhood has gained from the journey.