

Withdrawal/Redaction Sheet

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. schedule	Schedule for Hillary Rodham Clinton, Draft #2 [partial] (3 pages)	2/28/94	b(7)(E), b(6)
002. schedule	Schedule for Hillary Rodham Clinton, Draft #1 [partial] (2 pages)	2/28/94	b(7)(E)
003. schedule	Schedule for Hillary Rodham Clinton, Draft #4 [partial] (3 pages)	2/28/94	b(7)(E), b(6)
004. memo	From: Kate Carr, Finance Director, To: Patti Solis, Re: February 28th Women's Council Event (3 pages)	2/24/94	Personal Misfile
005. fax	From: DSCC Women's Council (14 pages)	2/22/94	Personal Misfile
006. itinerary	Salute to Women Leading America (2 pages)	11/7/93	Personal Misfile
007. list	VIP Hillary Rodham Clinton Reception Attendees (4 pages)	11/7/93	Personal Misfile
008. fax	DSCC Women's Council 1994 Race Update (2 pages)	11/4/93	Personal Misfile
009. speech	Hillary Rodham Clinton, DSCC Women's Council (5 pages)	11/8/93	Personal Misfile
010. speech	Hillary Rodham Clinton DSCC Women's Council revised (4 pages)	11/8/93	Personal Misfile

COLLECTION:

Clinton Presidential Records
First Lady's Office
Liz Bowyer
OA/Box Number: 3980

FOLDER TITLE:

[HRC Background File] Monday, February 28 [1994]

2014-0483-S

sb397

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

- P1 National Security Classified Information [(a)(1) of the PRA]
- P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
- P3 Release would violate a Federal statute [(a)(3) of the PRA]
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C. Closed in accordance with restrictions contained in donor's deed of gift.

PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

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- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

#4

HRC Background files

April 23, 1993 - February 28, 1994

MONDAY, FEBRUARY 28

Talking Points
DSCC Womens's Council Events
February 28, 1994 New York, NY

Introduction

- We're here not just to give support to any woman candidate; rather, we're here to support Democratic women who are committed to values and issues we think will make a difference in this country.
- Women add important ingredients to political life. They add brains and energy and dedication. But even more important, they bring compassion and sensitivity borne of their own life experiences, and a unique perspective on government's role in helping people.
- More and more, women are being turned to for leadership because voters feel they can trust them to make non-political decisions and to think about our children and our nation's future.
- Across the Hudson at Rutgers University, the Eagleton Institute conducted a survey of state legislators to assess the "Impact of Women in Public Office." They have found that, compared to men, women are more likely to give priority to women's rights policies. They are more likely to bring citizens into the policy making process. And they are more likely to be responsive to groups that have previously been left out of policy making, such as the economically disadvantaged.
- And yet, despite the progress we have made, it is still too often an uphill battle for women to get elected to office. Surveys conducted at the Eagleton Institute have demonstrated that men are largely perceived as the "more winnable" candidates regardless of their party affiliations or stances on important issues.
- The DSCC's Women's Council is critical to ensuring that the distinct voice that women bring to policy-making is heard in the United States Senate.

Women in Politics

- Today, women hold 7 seats (5 D, 2 R) in the Senate (7%). and 47 voting seats (35 D, 12 R) in the House of Representatives (10.1%) (and one non-voting delegate, D). There are 4 women Governors (3 D, 1 R).

- The President is firmly committed to including women in the top levels of government. He is also pressing for changes that will enhance the lives of women. In the last year, the Administration has demonstrated this commitment through passage of the Family and Medical Leave Act, National Service, real deficit reduction, and plans for true reform of our nation's health care and welfare systems. The Earned Income Tax Credit is critical to helping parents in lower income brackets.
- The President's commitment is particularly evident in his political appointees. Women are now the top decision makers on a range of critical national issues: the economy, the environment, energy, health and human services, and law enforcement.
- For the first time ever, the top two officials at the Department of Justice are women.
- Recently, I attended a reception in honor of the top women appointees in the Clinton Administration. It was a particularly moving experience -- a beacon of the progress we have made. We can all remember a time when such a reception would have been inconceivable.
- The Clinton Administration's record on women appointees is historic. Today, 45% of the total Clinton appointees are women, and 30% of the top level, Senate-confirmed appointees are women.

Women and Health Care Reform

- As primary care givers in our society, women have tremendous contact with our health care system. Yet, they often are not the best served by it.
- Women make up a larger portion of the population holding part-time jobs and clerical or sales jobs -- jobs which usually do not offer health insurance to employees.
- Women tend to live longer and require more long-term and home health services that are often not available or affordable.
- Many women must rely on their spouses for health insurance and risk being dropped if they divorce or if they are widowed.

- From the beginning of the health reform process, responding to women's health and preventive care concerns has been a core goal. The President's proposal guarantees comprehensive benefits and emphasizes the kinds of care and research that protect women's health. The President envisions a reformed health care system with no limits on lifetime insurance, a true focus on primary and preventive care, and greater protections for children through immunizations and well-baby visits.
- As the health care reform debate ensues, we must never forget the real faces behind the statistics -- the real people who are counting on us. We hope that women in government will continue to bring citizens and the underserved into the policy making process.
- Just as we must continue to fight to put more women in office, we also must participate in the ongoing discussion about health care reform because of the stakes that we, as women, have in its outcome.

Withdrawal/Redaction Marker

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SCHEDULE FOR HILLARY RODHAM CLINTON
DATE: MONDAY, FEBRUARY 28, 1994
DRAFT: #2

WASHINGTON, DC/NEW YORK, NY/WASHINGTON, DC

Traveling Party: **HRC**
 Craighead **1-800SKYPAGE** **#207-4653**
 202-365-7717 **CELLULAR**
 Caputo **1-800SKYPAGE** **#883-5733**
 Verveer
 Sharon Farmer
 (b)(7)e 001

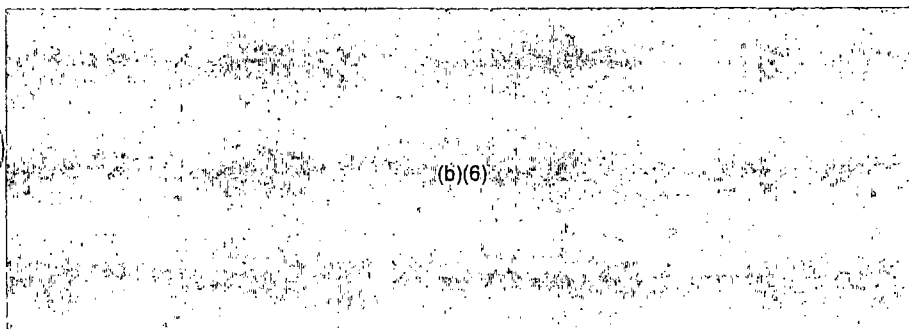
Lead Advance: **Kara McGuire**
 Sheraton New York & Towers Hotel
 811 7th Avenue & 53rd Street
 212-581-1000 **RM 4101**
 212-841-6730 **fax**
 1-800SKYPAGE **#883-5738**
 202-494-9730 **cellular**

Scheduling Desk: **Sara Grote**
 202-456-2922 **office**
 202-456-2317 **fax**
 202-483-7312 **home**
 1-800-528-7528 **WHCA #4363**

PREV RON **The White House**

8:00 am

Bill Lynch
212-572-8428 (w)
212-283-4808



001

8:40 am

DEPART White House South Portico
EN ROUTE Andrews Air Force Base

9:05 am

ARRIVE Andrews Air Force Base

NOTE: Sen. Daniel Patrick Moynihan, Sen. Diane Feinstein, Sen. Patty Murray, Sen. Carol Moseley-Braun, Sen. Barbara Mikulski & staff to meet up with traveling party at Andrews.

9:10 am

WHEELS UP Andrews Air Force Base

Flight Time: 50 HR.

SCHEDULE FOR HILLARY RODHAM CLINTON
MONDAY, FEBRUARY 28, 1994
PAGE 2

Manifest: HRC, CRAIGHEAD, CAPUTO, VERVEER, FARMER, SEN. DANIEL PATRICK MOYNIHAN, SEN. DIANE FEINSTEIN, SEN. PATTY MURRAY, SEN. CAROL MOSELEY-BRAUN, SEN. BARBARA MIKULSKI, LAWRENCE O'DONNELL [MOYNIHAN AA], FAY DRUMMOND [MOYNIHAN AA], BILL CHANDLER [FEINSTEIN AA], KAREN OLICK [BOXER AA], STEPHANIE FOSTER [MIKULSKI AA], MICHAEL TIMMENY [MURRAY AA], KATE CARR [DSCC],

(b)(7)e 001

Food: Breakfast

10:00 am

WHEELS DOWN New York, NY
LaGuardia Airport
FBO: Signature Flight Support
Phone: 718-476-5200
Fax:
CLOSED PRESS ARRIVAL

Greeters:

10:10 am

DEPART LaGuardia Airport
EN ROUTE Kings County Hospital

10:40 am

ARRIVE Kings County Hospital

10:40 am-
10:55 am

TOUR OF EMERGENCY ROOM
Kings County Hospital
CLOSED PRESS

Format:

Participants:

- HRC**
- Sen. Daniel Patrick Moynihan [D-NY]**
- Sen. Barbara Boxer [D-CA]**
- Sen. Diane Feinstein [D-CA]**
- Sen. Barbara Mikulski [D-MD]**
- Sen. Patty Murray [D-WA]**
- Sen. Carol Moseley-Braun [D-IL]**

Contact/Moynihan's Ofc: Rob Connor
202-224-2669
Ron Law
212-661-5150

Contact/Kings County Hosp:

XXX AM-
XXX AM

TOUR OF WARD
Rooms: TBA

**SCHEDULE FOR HILLARY RODHAM CLINTON
MONDAY, FEBRUARY 28, 1994
PAGE 3**

POOL PRESS

10:55 am-
11:25 am

MEETING

Room: TBA
Kings County Hospital
CLOSED PRESS

Participants:

-HRC
-Sen. Daniel Patrick Moynihan [D-NY]
-Sen. Barbara Boxer [D-CA]
-Sen. Diane Feinstein [D-CA]
-Sen. Barbara Mikulski [D-MD]
-Sen. Patty Murray [D-WA]
-Sen. Carol Moseley-Braun [D-IL]
-City Councilmen/State Reps???

Contact/Moynihan's Ofc: Rob Connor
224-2669

11:30 am

DEPART Kings County Hospital
EN ROUTE Morgan Stanley Offices, 1251 Avenue
of the Americas

11:50 am

ARRIVE Morgan Stanley Offices
1251 Avenue of the Americas
Holding Room: Office of Deborah Kushman
Phone: 212-703-4078
Fax: 212-703-4387
CLOSED PRESS ARRIVAL

Greeters: Dick Fisher, Chairman, Morgan Stanley
Deborah DeCotis, Managing Director, Morgan Stanley
Bill Harmon, Managing Director, Morgan Stanley

11:55 am-
12:00 pm

PRIVATE MEETING W/Dick Fisher, Chairman of
Morgan Stanley
Dick Fisher's Office, 30th Floor
Morgan Stanley Offices
1251 Avenue of the Americas
CLOSED PRESS

Participants:

-HRC
-Sen. Daniel Patrick Moynihan [D-NY]?
-Mrs. Moynihan?

*Peter Skahow →
"get Fisher bio
Morgan Stanley
article?"*

SCHEDULE FOR HILLARY RODHAM CLINTON
MONDAY, FEBRUARY 28, 1994
PAGE 4

- Sen. Barbara Boxer [D-CA]
- Sen. Diane Feinstein [D-CA]
- Sen. Barbara Mikulski [D-MD]
- Sen. Patty Murray [D-WA]
- Sen. Carol Moseley-Braun [D-IL]
- Dick Fisher, Chairman, Morgan Stanley
- Deborah DeCotis, Managing Director, Morgan Stanley
- Bill Harmon, Managing Director, Morgan Stanley

Contact: Kate Carr, Finance Director
202-485-3137

12:05 pm-
12:15 pm

OFFICIAL PHOTOS W/Host Committee
Dick Fisher's Office, 30th Floor
Morgan Stanley Offices
1251 Avenue of the Americas
CLOSED PRESS

Participants: Approx. 20 people. [See briefing for more info.]

Contact: Kate Carr, Finance Director
202-485-3137

12:15 pm-
1:45 pm

DSCC WOMEN'S COUNCIL LUNCHEON
Dining Room, 31st Floor
Morgan Stanley Offices
1251 Avenue of the Americas
CLOSED PRESS

NOTE: The luncheon will be videotaped by Morgan Stanley.

HRC's Table:

Program:

- HRC to be escorted into luncheon by Dick Fisher
- HRC will meet and greet with each of the 12 tables
- Deborah DeCotis, Managing Director, Morgan Stanley to escort HRC to table
- Deborah DeCotis welcomes guests & intros Sen. Barbara Mikulski
- Sen. Barbara Mikulski to deliver remarks and intros each Senator
- Sen. Barbara Boxer remarks

SCHEDULE FOR HILLARY RODHAM CLINTON
MONDAY, FEBRUARY 28, 1994
PAGE 5

- Sen. Patty Murray remarks
- Sen. Diane Feinstein remarks
- Sen. Carol Moseley-Braun remarks
- Sen. Barabara Mikulski to intro. HRC
- HRC to deliver 15 min. remarks
- HRC to take Q & A; Sen. Barbara Mikulski will act as moderator
- Sen. Mikulski to close program
- HRC is escorted out of room by Dick Fisher

Participants: Approx. 120 people to attend.
[See briefing for more info.]

Contact: Kate Carr, Finance Director
485-3137

1:50 pm **DEPART** Morgan Stanley Offices, 1251 Avenue of
the Americas
EN ROUTE Sheraton New York Hotel

1:55 pm **ARRIVE** Sheraton New York Hotel

Greeter:

2:00 pm-
2:30 pm

MEET & GREET/OFFICIAL PHOTO
Room: TBA
Sheraton New York Hotel
CLOSED PRESS

Format: Informal meet and greet/photo line.

Participants: Approx. 40 people to attend.
[See briefing for more info.]

Contact: Peter Shakow
456-6257

2:30 pm-
3:30 pm

MEDIA TIME

3:30 pm-
5:40 pm

DOWN TIME
Suite 4501
Sheraton New York Hotel
811 7th Avenue & 53rd Street
CLOSED PRESS

5:40 pm-
6:00 pm

MEET & GREET W/High Donors

**SCHEDULE FOR HILLARY RODHAM CLINTON
MONDAY, FEBRUARY 28, 1994
PAGE 6**

Princess Ballroom
Sheraton New York Hotel
811 7th Avenue & 53rd Street
CLOSED PRESS

Format: Receiving line.

Participants: Approx. 30 people to attend.
[See briefing for more info.]

Contact: Kate Carr, Finance Director
485-3137

6:00 pm-
6:05 pm

HOLD
Royal B

6:05 pm-
6:45 pm

DSCC WOMEN'S COUNCIL RECEPTION
Imperial Ballroom
Sheraton New York Hotel
811 7th Avenue & 53rd Street
OPEN PRESS

Format: Sen. Mosely-Braun to announce Sen.
Boxer & HRC onto stage Boxer to intro. HRC.
HRC to deliver ____ min. remarks. Work
ropeline?

Participants: Approx. 500 people to attend.
[See briefing for more info.]

Contact: Kate Carr, Finance Director
485-3137

7:10 pm-
7:15 pm

HOLD
Imer

7:15 pm-
8:15 pm

DSCC WOMEN'S COUNCIL DINNER
Royal Ballroom A
Sheraton New York Hotel
811 7th Avenue & 53rd Street
CLOSED PRESS

HRC's Table:

Program:

SCHEDULE FOR HILLARY RODHAM CLINTON
MONDAY, FEBRUARY 28, 1994
PAGE 7

- HRC to meet and greet with dinner guests upon arrival
- HRC to be seated at table [first course is pre-set]
- Sen. Barbara Boxer to intro. HRC
- HRC to deliver 15 min. remarks.
- HRC departs [dinner is served after HRC departs]

Participants: Approx. 150 people to attend.
[See briefing for more info.]

Contact: Kate Carr, Finance Director
485-3137

8:20 pm **DEPART** Sheraton New York Hotel
 EN ROUTE LaGuardia Airport

8:45 pm **ARRIVE** LaGuardia Airport

9:00 pm **WHEELS UP** New York, NY
 LaGuardia Airport
 FBO: Signature Flight Support
 Phone: 718-476-5200
 Fax:
 CLOSED PRESS DEPARTURE

Flight Time: 55 HR.

Manifest: HRC, CRAIGHEAD, CAPUTO, FARMER, (b)(7)e 001

9:55 pm **WHEELS DOWN** Andrews Air Force Base

10:00 pm **DEPART** Andrews Air Force Base
 EN ROUTE White House

10:25 pm **ARRIVE** White House South Portico

RON The White House

FORECAST FOR NEW YORK, NY:

-

February 27, 1994

VISIT TO THE KINGS COUNTY HOSPITAL

DATE: Monday, February 28
TIME: 10:40 am
LOCATION: Brooklyn, NY
FROM: Liz Bowyer

I. PURPOSE

To tour the Kings County Hospital with Senator Moynihan, visit the emergency room and meet with ??.

Need:

New Hospitals document from Chris/Lynn
New York and Health Care from Hart (also NY hospitalsdoc?)

II. BACKGROUND

The Kings County Hospital

History

For over three decades, the reconstruction of the Kings County Hospital has been an issue in central Brooklyn. There have been numerous plans set forth to redesign the 62-year old hospital, long recognized for its structural inadequacy in dealing with the needs of patients in central Brooklyn. The most recent plan, completed in 1986, redesigns the hospital into a 1.4-million square foot medical center with 1,220 beds and a full complement of specialized medical units.

In early February, however, Mayor Giuliani declared a moratorium on the reconstruction, contending that the current plan was designed to meet the needs of the hospital fifteen years ago, and no longer suits the needs of today's changing health care system. Officials say the project should be steered to primary care, with emphasis on prevention and outpatient treatment. The plan was drafted when the hospital was severely overcrowded with patients, but hospital records show that the occupancy rate of Kings County Hospital has steadily declined in last five years. (due to outpatient surgery, HIV care, etc...) They also say that many of the planned specialized units are already at the State University of New York's Health Sciences Center at Brooklyn.

Residents and political leaders in central Brooklyn are suspicious that the administration

just may be planning to kill the project all together -- the hospital is in a largely black neighborhood that supported Mayor Dinkins in the election. The project is already four years behind schedule, and xx million (43.6?) has already been spent. The community generally does not object to a new focus for the hospital but doesn't want any more delays. Some city officials says that the hospital should not be smaller, that Brooklyn should enjoy the same kind of full-service medical center that wealthier neighborhoods now enjoy. Guliani officials insist they plan to build the replacement hospital soon.

*The Health Systems Agency coordinates planning of new hospital operations in New York

*NYC's Health and Hospitals Corporation

*Kings County Hospital Advisory Board

Call Faye Drummond 224-4515

Background on the Hospital

It's 62 years old, serves xx, etc etc.

Moynihan

Why does he want to go to this hospital so much?

Other information on Moynihan:

He and his wife xx just returned from a week-long trip to India. Moynihan sent the President a letter about it.

Most interested in high rates of illegitimacy right now.

"Defining Deviancy Down"

Withdrawal/Redaction Marker

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First Lady's Office
Liz Bowyer
OA/Box Number: 3980

FOLDER TITLE:

[HRC Background File] Monday, February 28 [1994]

2014-0483-S

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DATE: MONDAY, FEBRUARY 28, 1994
DRAFT: #1

WASHINGTON, DC/NEW YORK, NY/WASHINGTON, DC

Traveling Party: HRC
Craighead 1-800SKYPAGE #207-4653
202-365-7717 CELLULAR
Caputo 1-800SKYPAGE #883-5733
Verveer
WH Photographer
(b)(7)e 002

Lead Advance: Kara McGuire
Sheraton New York & Towers Hotel
811 7th Avenue & 53rd Street
212-581-1000 RM
212-841-6730 fax
1-800SKYPAGE #883-5738

Scheduling Desk: Sara Grote
202-456-2922 office
202-456-2317 fax
202-483-7312 home
1-800-528-7528 WHCA #4363

PREV RON The White House

8:55 am **ARRIVE** Andrews Air Force Base

9:00 am **WHEELS UP** Andrews Air Force Base

Flight Time: 1 HR.
Manifest: HRC, CRAIGHEAD, CAPUTO, WH PHOTOG, (b)(7)e 002

10:00 am **WHEELS DOWN** New York, NY
LaGuardia Airport
FBO:
Phone:
Fax:
CLOSED PRESS ARRIVAL

Greeters:

10:10 am **DEPART** LaGuardia Airport
EN ROUTE Kings County Hospital

10:40 am **ARRIVE** Kings County Hospital

10:40 am-
10:55 am **TOUR OF EMERGENCY ROOM**

SCHEDULE FOR HILLARY RODHAM CLINTON
MONDAY, FEBRUARY 28, 1994
PAGE 2

Room: TBA
Kings County Hospital
POOL PRESS ?

Format:

Participants on tour:

-HRC
-Sen. Daniel Patrick Moynihan [D]
-Sen. Barbara Boxer [D-CA]
-Sen. Diane Feinstein [D-CA]
-Sen. Barbara Mikulski [D-MD]
-Sen. Patty Murray [D-WA]
-Sen. Carol Moseley-Braun [D-IL]

Contact/Moynihan's Ofc: Rod O'Connor
224-4451

10:55 am-
11:25 am

MEETING

Room: TBA
Kings County Hospital
CLOSED PRESS

Format:

Participants:

-HRC
-Sen. Daniel Patrick Moynihan [D]
-Sen. Barbara Boxer [D-CA]
-Sen. Diane Feinstein [D-CA]
-Sen. Barbara Mikulski [D-MD]
-Sen. Patty Murray [D-WA]
-Sen. Carol Moseley-Braun [D-IL]
-Assemblymen??

Contact/Moynihan's Ofc: Rod O'Connor
224-4451

11:30 am

DEPART Kings County Hospital
EN ROUTE Sheraton New York Hotel

11:50 am

ARRIVE Sheraton New York Hotel

Greeter:

11:55 am

PHOTOS

12:15 pm-

**PHOTOCOPY
PRESERVATION**

**SCHEDULE FOR HILLARY RODHAM CLINTON
MONDAY, FEBRUARY 28, 1994
PAGE 3**

1:45 pm

DSCC WOMEN'S COUNCIL LUNCHEON

Room: TBA
Sheraton New York Hotel
CLOSED PRESS

Format: Sen. Barabara Mikulski to intro. HRC.
HRC to deliver ___ min. remarks.

Participants: Approx. 120 people to attend.
[See briefing for more info.]

Contact: Kate Carr, Finance Director
485-3137

2:00 pm-
6:00 pm

DOWN TIME

Sheraton New York Hotel

6:00 pm-
6:45 pm

DSCC WOMEN'S COUNCIL RECEPTION

Room: TBA
Sheraton New York Hotel
OPEN PRESS

Format: Sen. Boxer to intro. HRC. HRC to
deliver ___ min. remarks. Work ropeline?

Participants: Approx. 500 people to attend.
[See briefing for more info.]

Contact: Kate Carr, Finance Director
485-3137

7:00 pm-
8:15 pm

DSCC WOMEN'S COUNCIL DINNER

Room: TBA
Sheraton New York Hotel
CLOSED PRESS

Program: Sen. Barbara Boxer to intro. HRC.
HRC to deliver ___ min. remarks.

Participants: Approx. 100 people to attend.
[See briefing for more info.]

Contact: Kate Carr, Finance Director
485-3137

8:20 pm

DEPART Sheraton New York

**PHOTOCOPY
PRESERVATION**

SCHEDULE FOR HILLARY RODHAM CLINTON
MONDAY, FEBRUARY 28, 1994
PAGE 4

EN ROUTE LaGuardia Airport

8:45 pm

ARRIVE LaGuardia Airport

9:00 pm

WHEELS UP New York, NY
LaGuardia Airport

NOTE: This is the last shuttle to Washington, DC.

Flight Time: 1 HR.

Manifest: HRC, CRAIGHEAD, CAPUTO, WH PHOTOG, (b)(7)e 062

10:00 pm

WHEELS DOWN Washington, DC
National Airport

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The White House

FORECAST FOR NEW YORK, NY:
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HHC →
Edna Wells Handa
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February 12, 1994, Saturday, Late Edition - Final

SECTION: Section 1; Page 21; Column 5; Metropolitan Desk; Second Front

LENGTH: 1287 words

HEADLINE: Manager Says New York Let Hospital Fail

BYLINE: By DAVID FIRESTONE

BODY:

The top executive of the company managing the billion-dollar project to rebuild Kings County Hospital said the city's Health and Hospitals Corporation -- and not his company -- was responsible for the project's troubles, and he presented a detailed list of what he called the city's mismanagement and delays.

The complaints came a day after Luis A. Miranda Jr., chairman of the Health and Hospitals Corporation, issued a scathing critique of the decadelong effort to rebuild the city's largest public medical center.

On Thursday Mr. Miranda said that the hospital corporation and the construction manager, Turner/Santa Fe Joint Venture, were responsible for fumbling that prevented the construction of a replacement for the obsolete hospital in central Brooklyn.

While Mr. Miranda placed much of the blame on his own agency, he singled out Turner/Santa Fe for criticism, questioning whether it was "up to the job" of replacing New York's largest public hospital.

But yesterday, Desmond Emanuel, the chief executive of Santa Fe Construction Inc., one of the partners in the joint venture, said it was the hospital agency that was not up to the job. Agency officials, he said, constantly altered the design of the new hospital and spent years checking the backgrounds of prospective contractors.

Company Won't Be Made Scapegoat

In an interview, he said he would not allow his company to be made the scapegoat, and said the hospital agency was so inexperienced that it should never have been allowed to handle the project.

"I don't know if H.H.C. is up to the task of building this hospital," said Mr. Emanuel. "I know that we are, because we just want to get this project built. But they have chosen to find a scapegoat and point the finger at us, when we have not delayed this project in any way."

Yesterday, a group of elected officials from central Brooklyn announced that they were forming a committee to monitor the city's progress in rebuilding the hospital, the only health-care provider for the largely impoverished residents of much of the city's most populous borough.

Assemblyman Clarence Norman Jr. said the group intended to pressure the city to lift the moratorium on the hospital's construction that was imposed last week by Mayor Rudolph W. Giuliani, and insisted the building must be completed by the year 2000.

"We don't want to have to fight the city on this, but this project has to move forward," said Mr. Norman, who is also the Brooklyn Democratic leader. "It is too important to the community to be delayed."

Mr. Norman, speaking for a group of City Council members and other elected representatives, said he agreed with Mr. Miranda's assessment that the hospital agency had fumbled the project in the past. But he said the agency must continue to manage the construction in order to avoid further delays.

Arrogance and Inexperience

Turner/Santa Fe, chosen in 1987 to be the construction manager for the hugerebuilding project, is a joint venture between Turner Construction Company, a giant national company based in New York that specializes in institutional work, and Santa Fe, a smaller minority-owned company also based here that has worked on several major projects for the city and state.

Mr. Emanuel said the two companies believed they were prepared for the regulatory and political challenges that usually accompany a huge public building project. But he said they did not expect the "arrogance and complete lack of experience" they faced at the hospital corporation, which had never before tried to build a hospital of this size.

Most of the design and architectural work on the 1,200-bed, 1.4-million-square-foot hospital had been completed by the time the agency selected Turner/Santa Fe to manage the work. But Mr. Emanuel said that shortly after his company began work, several top officials of the agency resigned to enter private industry, including the executive in charge of the Kings County project.

Later, he said, an official of the agency decided to replace the original architects and planners and ordered the entire project redesigned.

The official decided to move various units of the hospital into different buildings, he said, and ordered the deletion of planned bridge between the new hospital and the State University Health Sciences Center across Clarkson Avenue from the hospital in East Flatbush.

"It was like throwing out two or three years of work," said Mr. Emanuel. He estimated that the resulting delay set back the project at least two years.

Agency officials were not at work yesterday because of Lincoln's Birthday and thus could not verify Mr. Emanuel's account of the changes to the project.

Contracts Had to Be Redrawn

As an example of the agency's inexperience, Mr. Emanuel said the hospital planners originally divided the project into only the four basic contracts required by state law: general contracting, plumbing, heating-air-conditioning, and electrical work.

But Turner/Santa Fe quickly realized that there were not enough contractors in the region large enough to qualify for such giant contracts, he said, resulting in a bid process that would not be competitive or economical for the city. In addition, he said, the large contracts meant that no minority firms would be able to participate, despite the insistence of neighborhood leaders that the construction provide an economic boost to the area.

At that point, he said, Turner/Santa Fe and the architects had to redraw the plans and rewrite the paperwork to subdivide the four large contracts into scores of smaller ones. The plumbing contract, he said, was divided to allow individual companies to handle only a few floors.

"That whole process probably added another year to the planning," Mr. Emanuel said.

City officials have cited the unusually large number of contracts for the project as one of the reasons for the moratorium called by the Mayor.

Excavation Held Up

Mr. Emanuel also recounted an almost comical series of events that held up the basic excavation work on the new hospital, necessary before any other construction work on the main building could begin.

In April 1992, he said, the agency awarded the excavation contract to the second-lowest bidder, ruling that the lowest bidder had not properly completed the necessary paperwork. The lowest bidder then sued the city, and was awarded the contract four months later after a court order.

But 10 months later, the lowest bid was thrown out after the agency discovered that it had failed to disclose a previous criminal record. It took another five months for the contract to be awarded to a third company, producing a total delay of 19 months. Even now, Mr. Emanuel said, the agency has still not completed background checks and approved the new company's subcontractors, meaning that no excavation work on the project can begin.

Turner/Santa Fe was criticized two years ago in an independent audit by the accounting firm of Coopers & Lybrand for experiencing "difficulty in adequately discharging its responsibilities." Mr. Miranda referred to the criticism on Thursday when chastizing the joint venture.

But Mr. Emanuel said his company's difficulties were solely the result of trying to respond to the slipups and constantly changing demands of the hospitals agency. Just two weeks ago, he said, the agency put out new bid specifications on part of the hospital construction and then had to pull them back after the agency's legal department decided it wasn't satisfied with the paperwork.

"It's unprecedented," he said. "I've never seen anything like it. They had no experience at this sort of thing, and they simply didn't rise to the challenge."

LANGUAGE: ENGLISH

LOAD-DATE-MDC: February 12, 1994

February 11, 1994, Friday, Late Edition - Final

SECTION: Section A; Page 1; Column 1; Metropolitan Desk

LENGTH: 1536 words

HEADLINE: New York Hospitals Chief Calls Brooklyn Plan a Giant Failure

BYLINE: By DAVID FIRESTONE

• Tahiriz / Harold
• Paul Kenny

BODY:

Charging a decade of mismanagement and incompetence, the new chairman of New York City's Health and Hospitals Corporation said yesterday that his agency had "completely screwed up" the planned billion-dollar reconstruction of Kings County Hospital, the city's largest public medical center.

In 1984 the agency embarked on what was then a \$550 million project to build a new 1.4 million-square-foot public hospital for the largely impoverished neighborhood in central Brooklyn. "Ten years later," said Luis A. Miranda Jr., chairman of the corporation's board, "after having spent \$119 million to date, we have only an administrative building, a food service building, a couple of holes in the ground, a few parking lots and some pictures of past mayors with hard hats claiming they have fulfilled a promise."

In addition, he said, "what we do have is an angry community and very little to show for it."

He laid the blame for the failure on his agency and its staff, the hospital's management and the project construction manager. "The absence of a team effort produced little or no project accountability, significant delays and a more costly project," Mr. Miranda said. "Because we have handled the management of the project so poorly, now it becomes everyone's and nobody's fault."

Following the lead of Mayor Rudolph W. Giuliani, who last week imposed a moratorium on the construction plan, Mr. Miranda called yesterday for a review of the project. That will mean yet another delay in the tortuous effort to replace a 62-year-old public hospital that is a virtual museum of an early-20th-century medical center. Almost all of its 1,200 beds are in large open wards, and the building makes do with balky window air-conditioners, broken elevators, frequent "brownouts" and an emergency room that cannot begin to meet the health needs of central Brooklyn's low-income residents.

An Angry Reaction

The announcement of the review yesterday infuriated community leaders in central Brooklyn, who have spent years demanding that the hospital be replaced. Elected leaders in the largely black area, already angry at Mayor Giuliani's moratorium, suggested that yesterday's action might be an attempt to scale down or even kill the project.

Mr. Miranda's sharp criticism of his own agency's work under the Dinkins and Koch administrations is supported by interviews over the past week with city and hospital officials, as well as community leaders, who described a decade of legal problems, bureaucratic infighting and political wrangling that has stymied the rebuilding efforts.

The starting date for construction, originally set for early 1992, has been postponed several times, most recently until last month. At the moment, no one involved with the project knows when construction will actually begin.

Several hospitals corporation officials said that the agency staggered under the weight of a project far larger than any it had ever completed and that the logistical difficulties of building a huge new hospital next to an existing one proved far more difficult than either the agency or the contractor ever expected.

Mr. Miranda, who was appointed by Mayor Giuliani, acknowledged in an interview yesterday that the project might have been too much for the hospitals corporation, saying it was possible that the new hospital might have to be built by another government agency and then turned over to the hospitals agency to run.

"If we don't know how to build a billion-dollar project, then we need to figure out and find out who can build it with us," he said. "Our commitment should be, let's build a hospital and let's not have any preconceived ideas that we have to do it this way or the way we have been doing it."

Mr. Miranda mentioned the possibility of future construction being handled by the State Facilities Development Corporation, which built Lincoln and Woodhull Hospitals for the city in the late 1970's. But Woodhull, in northern Brooklyn, opened a decade late and tens of millions of dollars over budget because of problems attributed to mismanagement.

The city agency's admission of mismanagement drew outraged protests from black political leaders in central Brooklyn, who suggested that Mr. Miranda made the admission to justify the moratorium and eventually end the reconstruction project.

"One of the best ways to kill a project is to stop it, let it lay dormant for a while, and then never start it again because it looks too expensive," said Assemblyman Clarence Norman Jr., who represents the area in the State Assembly and is the Brooklyn Democratic leader. "This statement sounds to me like nonsense, a subterfuge for what they really want to do, which is kill it."

Mr. Norman and several City Council members from the area accused Mr. Giuliani of trying to kill the new hospital because much of the largely black section of central Brooklyn voted for Mayor David N. Dinkins in the November mayoral election.

To Review the Project

But Mr. Miranda insisted yesterday that a new hospital would be built, though he declined to say whether it would be as large or fully equipped as residents have requested. He said the new hospitals corporation board would correct the management problems and proceed with the project, but he added that the construction manager, Turner/Santa Fe Joint Venture, might have to be replaced "if they are not up to the job." He appointed a senior director of the hospitals agency to review the project and recommend ways to get it started, and he said that from now on, the hospital would be the first item on the agenda of every meeting of the capital ommittee of the corporation's board.

Mr. Miranda did not specify the precise nature of the troubles afflicting the project, singling out only his agency and the staff of Turner/Santa Fe, which he criticized for not producing an independent audit of its work that was promised to the board 16 months ago. If the company does not produce the audit, he said, he "will ask the board to dump them."

Officials at Turner/Santa Fe, a joint venture of the Turner Construction Company and the Santa Fe Construction Company, did not return telephone messages yesterday.

But interviews with other city officials, as well as hospital and community leaders, described a decade of bureaucratic bungling and clashing political goals that virtually guaranteed the project would be delayed and over budget.

Two city officials who spoke on the condition of anonymity said that to begin with, the design of the project proved far more difficult than expected. The existing hospital buildings, most of which were completed in 1932, sit on an L-shaped 44-acre site at Clarkson and New York Avenues in Flatbush. Hospitals corporation planners and outside designers spent several years trying to find the right location for the new buildings, trying to work around ancient utility lines and support buildings.

Disputes Within Staff

The pre-construction stage, planned for two years, grew to five. As part of this phase, the contractors had to build new space for the hospital's administrative staff and the food service department so that their existing buildings could be demolished for more construction. Those buildings, completed in 1991, were not occupied until a year later because of disputes within the staff over who would move into them, officials said.

Just before the initial excavation for the main building was scheduled in the spring of 1992, a lengthy dispute broke out over awarding of a contract to an excavation company after a rejected company sued the city. As a result, excavation on the main building never began.

Problems involving the construction manager, Turner/Santa Fe, first came to light in March 1992 when Coopers & Lybrand, an independent auditing firm, wrote the hospitals corporation that the contractor was not properly discharging its responsibilities. But despite the audit report, which warned the agency that the project was in jeopardy, the agency's board approved Turner/Santa Fe's request for \$16 million on top of the \$19 million it bid to be construction manager for the project.

Mr. Miranda, the agency chairman, said yesterday that the joint venture had recently requested \$24 million more for the project, a request he said he did not intend to grant.

Several city officials said one reason for the delay and cost overruns was the area's insistence that much of the construction work go to small, minority-owned companies. Because many such companies were not large enough to be principal contractors in areas like air-conditioning, plumbing or electrical work for the entire building, the project was subdivided into scores of smaller jobs.

But hospital officials and community leaders said the additional contractors had nothing to do with the delays.

Councilwoman Una Clarke, who represents the hospital district, said residents had insisted on minority participation from the beginning.

"This is the first time in central Brooklyn that minority contractors have been able to help create some employment," she said. "The cost to the city will eventually be much higher if they can't create some economic stability in this area."

GRAPHIC: Photos: Ten years after the start of a \$550 million rebuilding of Kings County Hospital in Brooklyn, a new administration wants to review the delay-plagued project. Snow covered a construction site yesterday; "What we do have is an angry community and very little to show for it," Luis A. Miranda, new head of the Health and Hospitals Corporation, said of the

project. (Photographs by William E. Sauro/The New York Times)
(pg. B2)

LANGUAGE: ENGLISH

LOAD-DATE-MDC: February 11, 1994

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Newsday

February 18, 1994, Friday, CITY EDITION

SECTION: NEWS; Pg. 7

LENGTH: 1888 words

HEADLINE: Mismanaged Care; Kings County Hospital project a \$ 1-billion debacle

BYLINE: By Michael Moss and Gale Scott

BODY: The last time Art Granfar managed a million square feet of construction, the four-tower building went up in an astoundingly short time and won the developer much acclaim.

But while the fruit of that Zeckendorf job at Union Square bears an uncanny physical resemblance to the planned Kings County Hospital Center reconstruction, the likeness ends on the drawing board.

A review of documents and interviews with officials who involved themselves in the \$ 1 billion Kings County debacle reveals widespread concern that the project was archaic in design and sheer madness in method - some of which was expressed even before the first public dollar was spent.

Not only was the city Health and Hospitals Corp. incapable of directing a massive construction job that inevitably spun out of control, the structure itself was a throwback to the 1930s that bore no relevance to the health-care needs of Flatbush, HHC chiefs were told.

But they ignored the warnings issued internally and by overseers such as the city Office of Management and Budget. Then when things soured, they duped people who could have bailed them out, current and former city officials said.

"They kept saying everything was under control. At every meeting they kept saying that," said Rudolph Rinaldi, the former director of the city's Office of Construction, who monitored the project through much of its pre-construction phase.

Some people sensed disaster and tried to avert it. One former HHC manager, Elvia Fernandez, drove the contractors hard, while another, Anthony Japha, fought to turn the whole project over to the state Dormitory Authority.

Interviewed yesterday while on vacation in California, Japha, who now works for the state Metropolitan Transportation Authority, said that in hindsight he would have pushed harder. "To get that kind of thing done takes an enormous amount of attention at the highest levels," Japha said.

But Japha's 1989 memo to higher-ups as reported in New York Newsday yesterday, which cited "several hurdles" facing HHC, proved to be prescient.

While the Zeckendorf Towers went from a doodle on a napkin to condo sales in 36 months, nearly 10 years of work on Kings County, costing \$ 119 million so far, left the four-acre site still waiting for a shovel.

One building to be torn down is still stuffed with 5,000 square feet of medical records that a seemingly paralyzed HHC bureaucracy hasn't been able to move. A maze of tunnels needs far more repair than first thought. The need for a \$ 10 million pedestrian bridge is still in debate. And the first few thousand tons of customized steel is sitting in Sinking Springs, Pa., all dressed to arrive this week until the truckers were halted by a new city administration that has launched a crash effort to solve the mess by a self-imposed 60-day deadline.

"It's been beyond belief," says Granfar of Santa Fe Construction, which along with its partner, Turner Construction Co., has been blamed by HHC in turn for much of the trouble.

Hopeful Start

No one disputed the need for new facilities in one of the city's neighborhoods most desperate for health care.

The existing 1,210-bed Kings County hospital dates to the 1930s, and is gloomy and painfully inadequate.

There was a tent on the hospital lawn and a sense of hope in the air one crisp afternoon in the fall of 1989, when HHC president Dr. Jo Ivey Boufford presided at a ceremony to kick off long-awaited reconstruction.

"We all had high morale," Boufford said in an interview yesterday.

But starting in 1991, health-care experts began criticizing the idea of replacing Kings County with another 1,200-bed facility. Community activists persuaded state planners that because of the influence of the nearby SUNY Health Science Center, known as

Downstate, the design for Kings County had too much emphasis on acute care, and too little on primary care and clinics.

Downstate is a medical school and teaching hospital that provides doctors and supervises medical care at Kings County under an agreement known as an affiliation contract.

Divisions between Kings and Downstate figured in the costly design of the hospital, said Robert Gumbs, executive director of a health-planning group, The Health Systems Agency of New York City.

"They duplicate everything in the two hospitals, like labs, radiation therapy. They [still] need to decide whether it needs to be done at Kings County or University, or both," Gumbs said.

Others have said the project should be completely redone, breaking it into smaller facilities.

That's the view of Stanley Lowell, the former deputy mayor appointed to investigate quality of care at Kings County in the summer of 1991, following the death of Hasidic scholar Yankel Rosenbaum, who died of an untreated minor stab wound in the hospital emergency room.

In his report to the mayor in September, 1991, Lowell wrote, ". . . an over-1,000 bed hospital is, by virtue of its size alone, too large to operate efficiently. I recommend that HHC consider the possibility of splitting Kings County into three or four separate hospitals."

But HHC, which dismissed the idea out-of-hand, was having trouble rebuilding Kings County at any size.

'Conflicts and Inconsistencies'

HHC's prior experience was limited to structures 50 times smaller than Kings County, and city officials said they're now asking why they let HHC manage a \$ 1 billion job.

The city Office of Management and Budget questioned HHC's ability, but HHC officials convinced OMB they were up to the task, Japha said.

"We felt we had the capacity to do it," Boufford said.

Continuous offers from the state Dormitory Authority to take over all HHC construction were ignored, and in 1987, HHC hired the joint venture of Turner / Santa Fe to take over management of the Kings County project.

Mistakes are to be expected in a project this big, but the Kings County blunders alarmed HHC. In December, 1990, for example, contractors accidentally cut the hospital's telephone lines and fire alarms, and delayed telling anyone about difficulties they were having in anchoring foundation steel columns.

"I'm afraid that these occurrences signify a fundamental problem with the on-site supervision of the work," Japha wrote in a Dec. 10, 1990, memo to a Turner Construction Co. executive. "They are so serious that we need to reexamine the relationship between Turner / Santa Fe and the Corporation."

In a June 20, 1991, memo marked "confidential," HHC's Kings County project chief Elvia Fernandez implored staff to rethink that relationship. But a year later, Coopers & Lybrand, an auditor hired by HHC, wrote in a March 9, 1992, report that Turner / Santa Fe "appears to experience difficulty in adequately discharging its responsibilities."

Subsequent Coopers & Lybrand reports obtained yesterday by New York Newsday repeat the charge, as well as the auditor's criticism that HHC was not adequately riding herd on Turner / Santa Fe.

"Conflicts and inconsistencies abound," the auditor wrote in a July 29, 1993, letter to HHC.

Blaming the Bureaucracy

But Turner / Santa Fe is now firing its own salvos at HHC, blaming its bureaucracy for impeding progress.

The site was to be vacated in June, 1992, in what Granfar refers to as "decanting" - as in wine. "They kept coming up with excuses," Granfar said.

"There were two divisions at HHC involved, capital programs and hospital operations. And the two of them are talking, with us in the middle. This went on for eight months and as far as we know is still going on," said Granfar.

Santa Fe President Desmond Emanuel also complains that HHC did not include his firm in some important planning meetings, or fully share the project's budget. "They have kept us at bay from lots of events," Emanuel said.

There also were numerous changes to cope with in a project whose plans back in 1990 filled 15,000 pages in 30 books, with 750 drawings measuring 3 feet by 4 feet.

HHC added buildings for outpatients, support staff and a kitchen, while the number of beds in particular categories fluctuated wildly. Medical / surgery beds dropped from 488 to 288, while beds for prisoners rose from 88 to 208.

And then there was the \$ 10-million pedestrian bridge to Downstate, which was in, then out, then in the project.

There's also been a constant turnover of Kings County executives, and considerable turnover at HHC.

Too Many Cooks

Perhaps the greatest threat to the project's success is the army of contractors HHC decided to involve, some say.

Emanuel said he was prepared to proceed with 30 prime contracts, but political and community pressure, as well as HHC's own goals, pushed that number to as high as 220. It now hovers at about 110.

"The central Brooklyn community would not allow a \$ 600-million project to be built and not have local people be a part of that," said state Assemb. Clarence Norman (D-Brooklyn). "So the city did the responsible thing of involving the people of Brooklyn in this project."

But in an Aug. 16, 1991, letter to HHC raising what it called matters of "serious concern," the project architect, Hellmuth, Obata & Kassabaum, said that having so many "cooks" was unprecedented in the construction industry and raised huge organizational problems.

Emanuel and HHC officials jointly replied that increasing the number of contractors could save money by increasing competition, and that Turner / Santa Fe could manage the mass.

Emanuel, in interviews this week, said coordination would be increased by giving one contractor from each of the key trades the responsibility for getting the work started, but that has raised questions about Turner / Santa Fe's oversight role.

Since June, 1992, Turner / Santa Fe has had a contract amendment pending final approval by HHC that would award the firm an extra \$ 24.8 million to oversee the project, on top of its \$ 19 million original contract. The HHC board has balked at paying the additional funds until the auditors' concerns are addressed.

Current HHC Board Chairman Luis Miranda Jr. - a board member since 1990 - said the board was never told of problems until they were resolved. A review of board minutes confirms his assessment that staff did not alert the board as the project stumbled along from glitch to glitch.

City officials recall similar problems.

"What they [HHC] were doing was misrepresentation," charged Rinaldi, who has joined the state Dormitory Authority and is now talking to the Giuliani administration about involving the state in the project.

"We tried to put it back in line. We tried cutting the number of contractors. And strengthen the relationship with Turner. But we were working with top management whose agenda was different than the city's at one point, and they kept coming back with misinformation."

Fact and Figures

Kings County Hospital Center last year treated 334,450 inpatients, delivered 3,237 babies, saw patients in 626,911 clinic visits, and treated 143,565 patients in emergency services. Its 1,210-bed facility has a staff of 5,972. Before Mayor Rudolph Giuliani announced a moratorium on its construction, the hospital had received state Health Department approval to begin building the \$ 997-million project.

As approved, the project had 1,200 beds. (see microfilm for full text)

LANGUAGE: ENGLISH

LOAD-DATE-MDC: February 19, 1994

DANIEL P. MOYNIHAN
NEW YORK

United States Senate
WASHINGTON, DC 20510-3201

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I. KCHC HISTORY

Kings County Hospital Center (KCHC), a member institution of the New York City Health & Hospitals Corporation (HHC) is located in the heart of Brooklyn, and occupies 41 acres at the juncture of Crown Heights and East Flatbush. The hospital serves the Brooklyn community as both the family doctor and a major provider of a full spectrum of health care services. Throughout its history, the hospital has played a major role in meeting the health care needs of its surrounding population.

The roots of Kings County grew out of a program deeply embedded in public service and civic commitment. The town of Brooklyn, and the Hospital known as Kings County, have essentially remained one and the same since as far back as 1830 when our forefathers purchased 200 acres of land from the Martense family for the mere sum of \$3,000. Their purpose--to build a one room infirmary for publicly supported care of the sick.

Townpeople finally laid the cornerstone on July 9, 1831. By 1837, an increase in case numbers, to 719, required erection of a new building and construction of a medical center began to take shape. Growing rapidly, the institution soon became known around the country for treating difficult and unusual cases and by 1869 it became a resource center for the medical profession. Through the rest of the 1800's into the 1900's the people of Kings County Hospital continued to pioneer in the field of medicine, while expanding their center.

In the 1940's the institution expanded into its own independent village, and further witnessed the establishment of Kings County Hospital as a teaching institution. Continuing to pioneer and expand we are now the third largest hospital in the country. We treat over one million residents primarily of Central Brooklyn which includes the Bedford Stuyvesant, Crown Heights, East Flatbush, Flatbush, East New York and Brownsville communities.

The Hospital's inpatient capacity is 1,204 beds, with specialties in all fields of modern medicine, and 30 newborn bassinets. The Center also provides ambulatory care services in 113 clinics and a Level I trauma emergency room, with almost 200,000 visits in fiscal year 1990. ~~For information on the hospital's history, the following information is provided:~~
~~History of Kings County Hospital Center. KCHC is a back-up facility for other hospitals in the borough and is affiliated with State University of New York/Health Science Center at Brooklyn (HSCB).~~

In the past several years the city of New York and HHC have made a commitment to rebuild Kings County, and \$99 million dollars have been allocated for the reconstruction project. The resulting improvement in service will in essence ensure that Kings County continues growing under its founding principles--publicly supported, and embedded in public service and civic commitment.

92.4 million is the current project budget.

PROFILE: KINGS COUNTY HOSPITAL CENTER

Operated by the Health and Hospitals Corporation (HHC), Kings County Hospital Center is New York City's largest public hospital. Its 44-acre campus is located in central Brooklyn. A \$1 billion reconstruction and modernization project was recently put on hold by the Giuliani Administration; a smaller project is now contemplated.

Hospital Characteristics		Total Brooklyn
Facility beds:	1,260	9,423
Full-time equivalent employees:	6,715	4,193
Interns and residents:	465	2,425
ER visits:	168,856	815,277
Clinic visits:	351,211	1,937,646

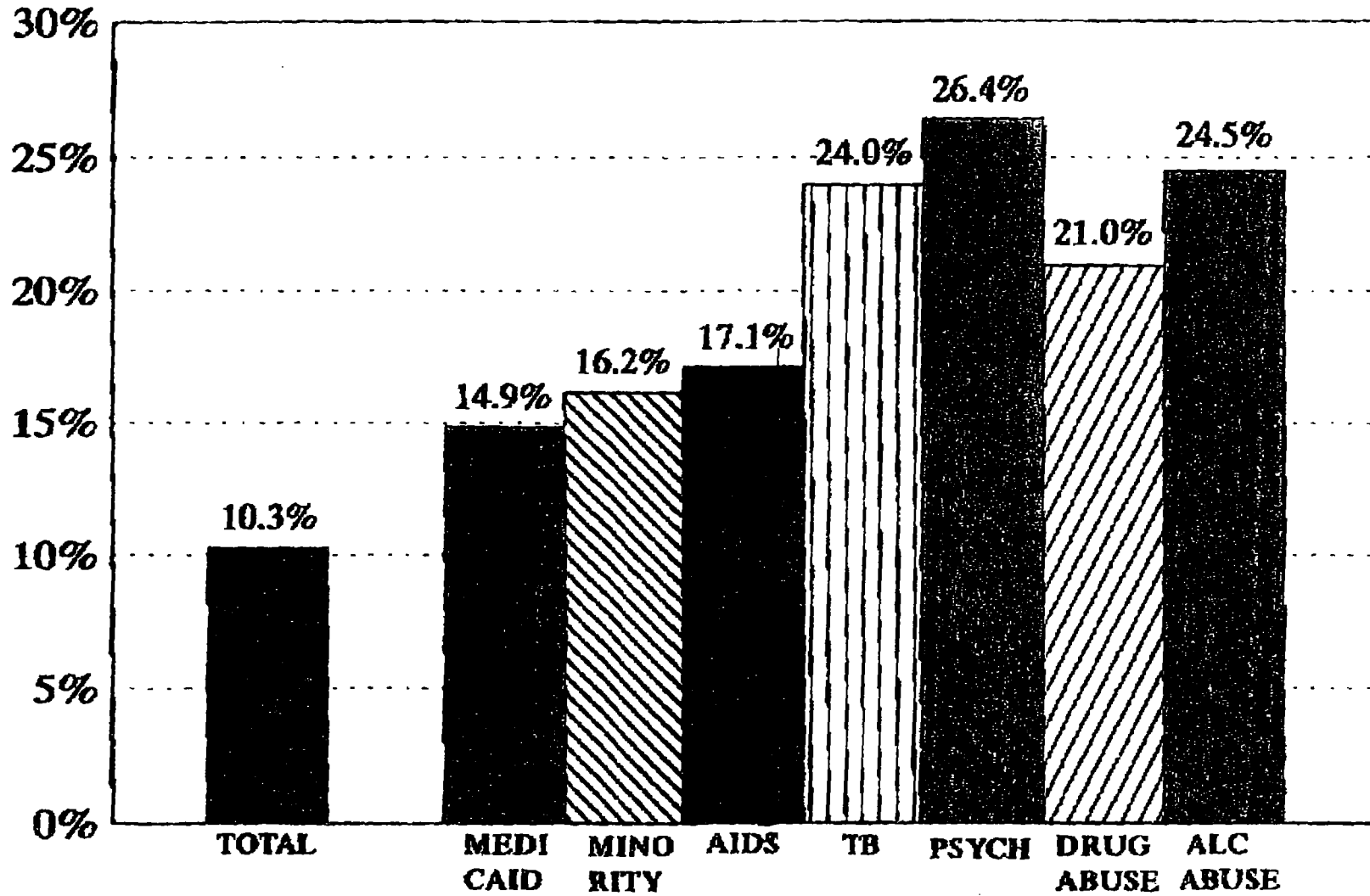
Kings County Inpatient Caseload		Total Brooklyn Caseload
Total cases:	29,767	289,840
Medicaid cases:	18,463	124,302
Minority patients:	28,848	178,634
AIDS cases:	920	5,372
Tuberculosis cases:	195	814
Psychiatry cases:	2,145	8,122
Drug abuse:	959	4,578
Alcohol abuse:	1,112	4,540

Kings County	(in Millions)
Total expenses	\$417
Total patient revenue	\$335
Loss	(\$82)
Loss after subsidy with other charges	(\$24)

KING COUNTY HOSPITAL COMPARED TO 'OTA , BROOKLYN

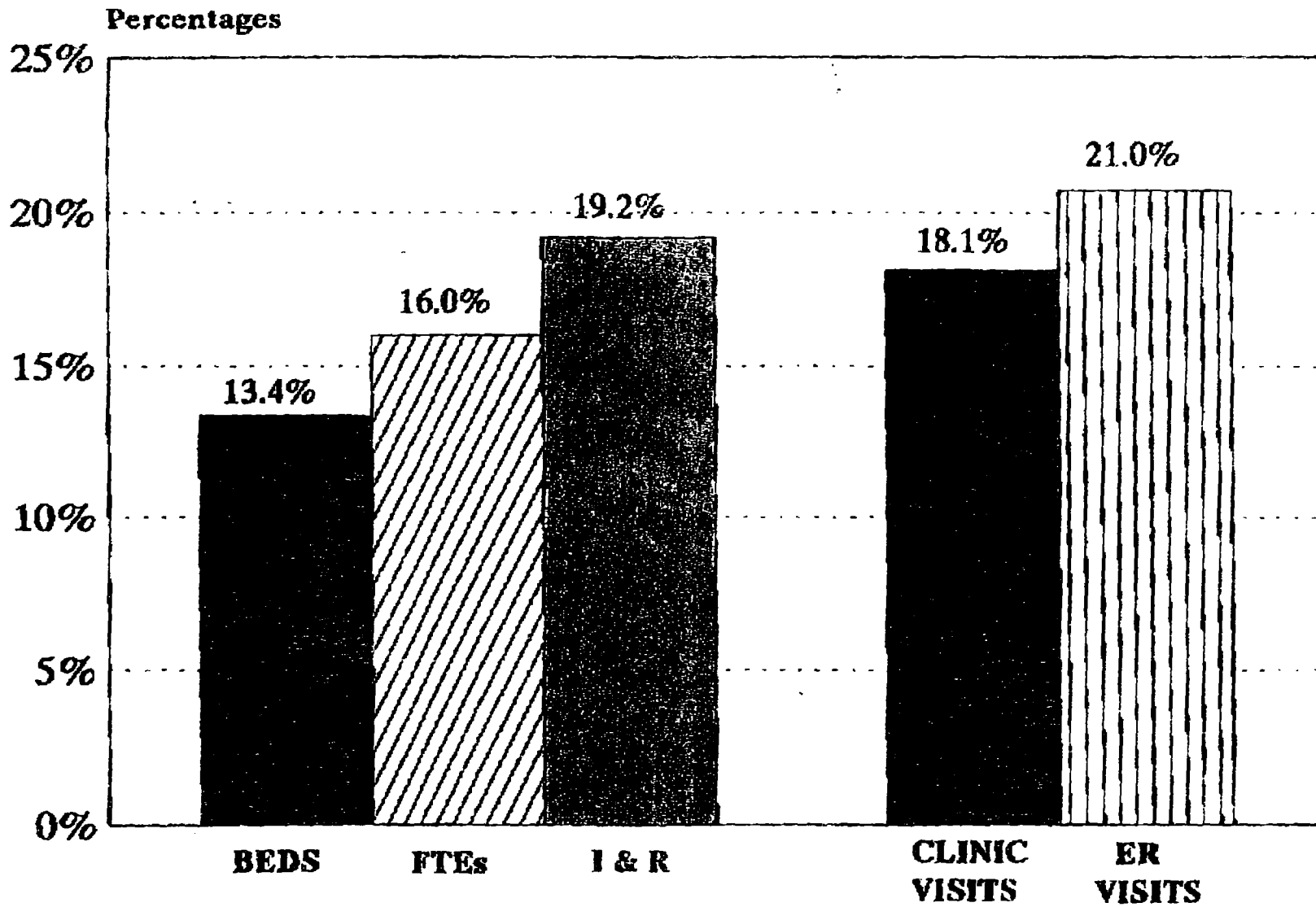
1992 CASE LOADS

Percentages



CASES

KIN... COUNTY HOSPITAL COM... ARE... TO... 'O' AL BROOK... YN
1992 STAFFING AND OUTPATIENT VISITS



STAFFING AND OUTPATIENT CASELOAD

Defining Deviancy Down

DANIEL PATRICK MOYNIHAN

IN ONE OF THE FOUNDING TEXTS OF SOCIOLOGY, *The Rules of Sociological Method* (1895), Emile Durkheim set it down that "crime is normal." "It is," he wrote, "completely impossible for any society entirely free of it to exist." By defining what is deviant, we are enabled to know what is not, and hence to live by shared standards. This aperçu appears in the chapter entitled "Rules for the Distinction of the Normal from the Pathological." Durkheim writes:

From this viewpoint the fundamental facts of criminology appear to us in an entirely new light. . . . [T]he criminal no longer appears as an utterly unsociable creature, a sort of parasitic element, a foreign, inassimilable body introduced into the bosom of society. He plays a normal role in social life. For its part, crime must no longer be conceived of as an evil which cannot be circumscribed closely enough. Far from there being cause for congratulation when it drops too noticeably below the normal level, this apparent progress assuredly coincides with and is linked to some social disturbance.

Durkheim suggests, for example, that "in times of scarcity" crimes of assault drop off. He does not imply that we ought to approve of crime—"[p]lain has likewise nothing desirable about it"—but we need to understand its function. He saw religion, in the sociologist Randall Collins's terms, as "fundamentally a set of ceremonial actions, assembling the group, heightening its emotions, and focusing its members on symbols of their common belongingness." In this context "a punishment ceremony creates social solidarity."

The matter was pretty much left at that until seventy years later when, in 1965, Kai T. Erikson published *Wayward Puritans*, a study of "crime rates" in the Massachusetts Bay Colony. The plan behind the book, as Erikson put it, was "to test [Durkheim's] notion that the number of deviant offenders a community can afford to recognize is likely to remain stable over time." The notion proved out very well indeed.

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Despite occasional crime waves, as when itinerant Quakers refused to take off their hats in the presence of magistrates, the amount of deviance in this corner of seventeenth-century New England fitted nicely with the supply of stocks and whipping posts. Erikson remarks:

It is one of the arguments of the study that the amount of deviation a community encounters is apt to remain fairly constant over time. To start at the beginning, it is a simple logistic fact that the number of deviancies which come to a community's attention are limited by the kinds of equipment it uses to detect and handle them, and to that extent the rate of deviation found in a community is at least in part a function of the size and complexity of its social control apparatus. A community's capacity for handling deviance, let us say, can be roughly estimated by counting its prison cells and hospital beds, its policemen and psychiatrists, its courts and clinics. Most communities, it would seem, operate with the expectation that a relatively constant number of control agents is necessary to cope with a relatively constant number of offenders. The amount of men, money, and material assigned by society to "do something" about deviant behavior does not vary appreciably over time, and the implicit logic which governs the community's efforts to man a police force or maintain suitable facilities for the mentally ill seems to be that there is a fairly stable quota of trouble which should be anticipated.

In this sense, the agencies of control often seem to define their job as that of keeping deviance within bounds rather than that of obliterating it altogether. Many judges, for example, assume that severe punishments are a greater deterrent to crime than moderate ones, and so it is important to note that many of them are apt to impose harder penalties when crime seems to be on the increase and more lenient ones when it does not, almost as if the power of the bench were being used to keep the crime rate from getting out of hand.

Erikson was taking issue with what he described as "a dominant strain in sociological thinking" that took for granted that a well-structured society "is somehow designed to prevent deviant behavior from occurring." In both authors, Durkheim and Erikson, there is an undertone that suggests that, with deviancy, as with most social goods, there is the continuing problem of demand exceeding supply. Durkheim invites us to

imagine a society of saints, a perfect cloister of exemplary individuals. Crimes, properly so called, will there be unknown; but faults which appear venial to the layman will create there the same scandal that the ordinary offense does in ordinary consciousness. If, then, this society has the power to judge and punish, it will define these acts as criminal and will treat them as such.

Recall Durkheim's comment that there need be no cause for congratulations should the amount of crime drop "too noticeably below the normal level." It would not appear that Durkheim anywhere contem-

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plates the possibility of too much crime. Clearly his theory would have required him to deplore such a development, but the possibility seems never to have occurred to him.

Erikson, writing much later in the twentieth century, contemplates both possibilities. "Deviant persons can be said to supply needed services to society." There is no doubt a tendency for the supply of any needed thing to run short. But he is consistent. There can, he believes, be *too much* of a good thing. Hence "the number of deviant offenders a community *can afford* to recognize is likely to remain stable over time." [My emphasis!]

Social scientists are said to be on the lookout for poor fellows getting a bum rap. But here is a theory that clearly implies that there are circumstances in which society will choose *not* to notice behavior that would be otherwise controlled, or disapproved, or even punished.

It appears to me that this is in fact what we in the United States have been doing of late. I proffer the thesis that, over the past generation, since the time Erikson wrote, the amount of deviant behavior in American society has increased beyond the levels the community can "afford to recognize" and that, accordingly, we have been re-defining deviancy so as to exempt much conduct previously stigmatized, and also quietly raising the "normal" level in categories where behavior is now abnormal by any earlier standard. This redefining has evoked fierce resistance from defenders of "old" standards, and accounts for much of the present "cultural war" such as proclaimed by many at the 1992 Republican National Convention.

Let me, then, offer three categories of redefinition in these regards: the *altruistic*, the *opportunistic*, and the *normalizing*.

The first category, the *altruistic*, may be illustrated by the deinstitutionalization movement within the mental health profession that appeared in the 1950s. The second category, the *opportunistic*, is seen in the interest group rewards derived from the acceptance of "alternative" family structures. The third category, the *normalizing*, is to be observed in the growing acceptance of unprecedented levels of violent crime.

II

It happens that I was present at the beginning of the deinstitutionalization movement. Early in 1955 Averell Harriman, then the new governor of New York, met with his new commissioner of mental hygiene, Dr. Paul Hoch, who described the development, at one of the state mental hospitals, of a tranquilizer derived from rauwolfia. The medication had been clinically tested and appeared to be an effective treatment for many severely psychotic patients, thus increasing the

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percentage of patients discharged. Dr. Hoch recommended that it be used systemwide; Harriman found the money. That same year Congress created a Joint Commission on Mental Health and Illness whose mission was to formulate "comprehensive and realistic recommendations" in this area, which was then a matter of considerable public concern. Year after year, the population of mental institutions grew. Year after year, new facilities had to be built. Never mind the complexities: population growth and such like matters. There was a general unease. Durkheim's constant continued to be exceeded. (In *Spanning the Century: The Life of W. Averell Harriman*, Rudy Abramson writes: "New York's mental hospitals in 1955 were overflowing warehouses, and new patients were being admitted faster than space could be found for them. When he was inaugurated, 94,000 New Yorkers were confined to state hospitals. Admissions were running at more than 2,500 a year and rising, making the Department of Mental Hygiene the fastest-growing, most-expensive, most-hopeless department of state government.")

The discovery of tranquilizers was adventitious. Physicians were seeking cures for disorders that were just beginning to be understood. Even a limited success made it possible to believe that the incidence of this particular range of disorders, which had seemingly required persons to be confined against their will or even awareness, could be greatly reduced. The Congressional Commission submitted its report in 1961; it proposed a nationwide program of deinstitutionalization.

Late in 1961, President Kennedy appointed an interagency committee to prepare legislative recommendations based upon the report. I represented Secretary of Labor Arthur J. Goldberg on this committee and drafted its final submission. This included the recommendation of the National Institute of Mental Health that 2,000 community mental health centers (one per 100,000 of population) be built by 1980. A buoyant Presidential Message to Congress followed early in 1963. "If we apply our medical knowledge and social insights fully," President Kennedy pronounced, "all but a small portion of the mentally ill can eventually achieve a wholesome and a constructive social adjustment." A "concerted national attack on mental disorders [was] now possible and practical." The President signed the Community Mental Health Centers Construction Act on October 31, 1963, his last public bill-signing ceremony. He gave me a pen.

The mental hospitals emptied out. At the time Governor Harriman met with Dr. Hoch in 1955, there were 93,314 adult residents of mental institutions maintained by New York State. As of August 1992, there were 11,363. This occurred across the nation. However, the number of community mental health centers never came near the goal of the 2,000 proposed community centers. Only some 482 received federal construc-

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tion funds between 1963 and 1980. The next year, 1981, the program was folded into the Alcohol and Other Drug Abuse block grant and disappeared from view. Even when centers were built, the results were hardly as hoped for. David F. Musto of Yale writes that the planners had bet on improving national mental health "by improving the quality of general community life through expert knowledge, not merely by more effective treatment of the already ill." There was no such knowledge.

However, worse luck, the belief that there *was* such knowledge took hold within sectors of the profession that saw institutionalization as an unacceptable mode of social control. These activists subscribed to a re-defining mode of their own. Mental patients were said to have been "labeled," and were not to be drugged. Musto says of the battles that followed that they were "so intense and dramatic precisely because both sides shared the fantasy of an omnipotent and omniscient mental health technology which could thoroughly reform society; the prize seemed eminently worth fighting for."

But even as the federal government turned to other matters, the mental institutions continued to release inmates. Professor Fred Siegel of Cooper Union observes: "In the great wave of moral deregulation that began in the mid-1960s, the poor and the insane were freed from the fetters of middle-class mores." They might henceforth sleep in doorways as often as they chose. The problem of the homeless appeared, characteristically defined as persons who lacked "affordable housing."

The *altruistic* mode of redefinition is just that. There is no reason to believe that there was any real increase in mental illness at the time deinstitutionalization began. Yet there was such a perception, and this enabled good people to try to do good, however unavailing in the end.

III

Our second, or *opportunistic* mode of re-definition, reveals at most a nominal intent to do good. The true object is to do well, a long-established motivation among mortals. In this pattern, a growth in deviancy makes possible a transfer of resources, including prestige, to those who control the deviant population. This control would be jeopardized if any serious effort were made to reduce the deviancy in question. This leads to assorted strategies for re-defining the behavior in question as not all that deviant, really.

In the years from 1963 to 1965, the Policy Planning Staff of the U.S. Department of Labor picked up the first tremors of what Samuel H. Preston, in the 1984 Presidential Address to the Population Association of America, would call "the earthquake that shuddered through the

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American family in the past twenty years." *The New York Times* recently provided a succinct accounting of Preston's point:

Thirty years ago, 1 in every 40 white children was born to an unmarried mother; today it is 1 in 5, according to Federal data. Among blacks, 2 of 3 children are born to an unmarried mother; 30 years ago the figure was 1 in 5.

In 1991, Paul Offner and I published longitudinal data showing that, of children born in the years 1967-69, some 22.1 percent were dependent on welfare—that is to say, Aid to Families with Dependent Children—before reaching age 18. This broke down as 15.7 percent for white children, 72.3 percent for black children. Projections for children born in 1980 gave rates of 22.2 percent and 82.9 percent respectively. A year later, a *New York Times* series on welfare and poverty called this a "startling finding . . . a symptom of vast social calamity."

And yet there is little evidence that these facts are regarded as a calamity in municipal government. To the contrary, there is general acceptance of the situation as normal. Political candidates raise the subject, often to the point of dwelling on it. But while there is a good deal of demand for symbolic change, there is none of the marshaling of resources that is associated with significant social action. Nor is there any lack of evidence that there is a serious social problem here.

Richard T. Gill writes of "an accumulation of data showing that intact biological parent families offer children very large advantages compared to any other family or non-family structure one can imagine." Correspondingly, the disadvantages associated with single-parent families spill over into other areas of social policy that now attract great public concern. Leroy L. Schwartz, M.D., and Mark W. Stanton argue that the real quest regarding a government-run health system such as that of Canada or Germany is whether it would work "in a country that has social problems that countries like Canada and Germany don't share to the same extent." Health problems reflect ways of living. The way of life associated with "such social pathologies as the breakdown of the family structure" lead to medical pathologies. Schwartz and Stanton conclude: "The United States is paying dearly for its social and behavioral problems," for they have now become medical problems as well.

To cite another example, there is at present no more vexing problem of social policy in the United States than that posed by education. A generation of ever-more ambitious statutes and reforms have produced weak responses at best and a fair amount of what could more simply be called dishonesty. ("Everyone knows that Head Start works." By the year 2000, American students will "be first in the world in science and mathematics.") None of this should surprise us. The 1966 report *Equal-*

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ity of Educational Opportunity by James S. Coleman and his associates established that the family background of students played a much stronger role in student achievement relative to variations in the ten (and still standard) measures of school quality.

In a 1992 study entitled *America's Smallest School: The Family*, Paul Barton came up with the elegant and persuasive concept of the parent-pupil ratio as a measure of school quality. Barton, who was on the policy planning staff in the Department of Labor in 1963, noted the great increase in the proportion of children living in single-parent families since then. He further noted that the proportion "varies widely among the states" and is related to "variation in achievement" among them. The correlation between the percentage of eighth graders living in two-parent families and average mathematics proficiency is a solid .74. North Dakota, highest on the math test, is second highest on the family compositions scale—that is, it is second in the percentage of kids coming from two-parent homes. The District of Columbia, lowest on the family scale, is second lowest in the test score.

A few months before Barton's study appeared, I published an article showing that the correlation between eighth-grade math scores and distance of state capitals from the Canadian border was .522, a respectable showing. By contrast, the correlation with per pupil expenditure was a derisory .203. I offered the policy proposal that states wishing to improve their schools should move closer to Canada. This would be difficult, of course, but so would it be to change the parent-pupil ratio. Indeed, the 1990 Census found that for the District of Columbia, apart from Ward 3 west of Rock Creek Park, the percentage of children living in single-parent families in the seven remaining wards ranged from a low of 63.6 percent to a high of 75.7. This being a one-time measurement, over time the proportions become asymptotic. And this in the nation's capital. No demand for change comes from that community—or as near to no demand as makes no matter. *For there is good money to be made out of bad schools.* This is a statement that will no doubt please many a hard heart, and displease many genuinely concerned to bring about change. To the latter, a group in which I would like to include myself, I would only say that we are obliged to ask why things do not change.

For a period there was some speculation that, if family structure got bad enough, this mode of deviancy would have less punishing effects on children. In 1991 Deborah A. Dawson, of the National Institutes of Health, examined the thesis that "the psychological effects of divorce and single parenthood on children were strongly influenced by a sense of shame in being 'different' from the norm." If this were so, the effect should have fallen off in the 1980s, when being from a single-parent home became much more common. It did not. "The problems associated

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with task overload among single parents are more constant in nature," Dawson wrote, adding that since the adverse effects had not diminished, they were "not based on stigmatization but rather on inherent problems in alternative family structures"—*alternative* here meaning other than two-parent families. We should take note of such candor. Writing in the *Journal of Marriage and the Family* in 1989, Sara McLanahan and Karen Booth noted: "Whereas a decade ago the prevailing view was that single motherhood had no harmful effects on children, recent research is less optimistic."

The year 1990 saw more of this lesson. In a paper prepared for the Progressive Policy Institute, Elaine Ciulla Kamarck and William A. Galston wrote that "if the economic effects of family breakdown are clear, the psychological effects are just now coming into focus." They cite Karl Zinsmeister:

There is a mountain of scientific evidence showing that when families disintegrate children often end up with intellectual, physical, and emotional scars that persist for life. . . . We talk about the drug crisis, the education crisis, and the problems of teen pregnancy and juvenile crime. But all these ills trace back predominantly to one source: broken families.

As for juvenile crime, they cite Douglas Smith and C. Roger Jarjoura: "Neighborhoods with larger percentages of youth (those aged 12 to 20) and areas with higher percentages of single-parent households also have higher rates of violent crime." They add: "The relationship is so strong that controlling for family configuration erases the relationship between race and crime and between low income and crime. This conclusion shows up time and time again in the literature; poverty is far from the sole determinant of crime." But the large point is avoided. In a 1992 essay "The Expert's Story of Marriage," Barbara Dafoe Whitehead examined "the story of marriage as it is conveyed in today's high school and college textbooks." Nothing amiss in this tale.

It goes like this:

The life course is full of exciting options. The lifestyle options available to individuals seeking a fulfilling personal relationship include living a heterosexual, homosexual, or bisexual single lifestyle; living in a commune; having a group marriage; being a single parent; or living together. Marriage is yet another lifestyle choice. However, before choosing marriage, individuals should weigh its costs and benefits against other lifestyle options and should consider what they want to get out of their intimate relationships. Even within marriage, different people want different things. For example, some people marry for companionship, some marry in order to have children, some marry for emotional and financial security. Though marriage can offer a rewarding path to personal growth, it is important to remember that it cannot provide a secure or permanent

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status. Many people will make the decision between marriage and singlehood many times throughout their life.

Divorce represents part of the normal family life cycle. It should not be viewed as either deviant or tragic, as it has been in the past. Rather, it establishes a process for "uncoupling" and thereby serves as the foundation for individual renewal and "new beginnings."

History commences to be rewritten. In 1992, the Select Committee on Children, Youth, and Families of the U.S. House of Representatives held a hearing on "Investing in Families: A Historical Perspective." A fact sheet prepared by committee staff began:

"INVESTING IN FAMILIES: A HISTORICAL PERSPECTIVE"

FACT SHEET

HISTORICAL SHIFTS IN FAMILY COMPOSITION CHALLENGING CONVENTIONAL WISDOM

While in modern times the percentage of children living with one parent has increased, more children lived with just one parent in Colonial America.

The fact sheet proceeded to list program on program for which federal funds were allegedly reduced in the 1980s. We then come to a summary.

Between 1970 and 1991, the value of AFDC (Aid to Families with Dependent Children) benefits decreased by 41%. In spite of proven success of Head Start, only 28% of eligible children are being served. As of 1990, more than \$18 billion in child support went uncollected. At the same time, the poverty rate among single-parent families with children under 18 was 44%. Between 1980 and 1990, the rate of growth in the total Federal budget was four times greater than the rate of growth in children's programs.

In other words, benefits paid to mothers and children have gone down steadily, as indeed they have done. But no proposal is made to restore benefits to an earlier level, or even to maintain their value, as is the case with other "indexed" Social Security programs. Instead we go directly to the subject of education spending.

Nothing new. In 1960, President Nixon proposed a guaranteed income, the Family Assistance Plan. This was described as an "income strategy" as against a "services strategy." It may or may not have been a good idea, but it was a clear one, and the resistance of service providers to it was equally clear. In the end it was defeated, to the huzzahs of the advocates of "welfare rights." What is going on here is simply that a large

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increase in what once was seen as deviancy has provided opportunity to a wide spectrum of interest groups that benefit from re-defining the problem as essentially normal and doing little to reduce it.

IV

Our *normalizing* category most directly corresponds to Erikson's proposition that "the number of deviant offenders a community can afford to recognize is likely to remain stable over time." Here we are dealing with the popular psychological notion of "denial." In 1965, having reached the conclusion that there would be a dramatic increase in single-parent families, I reached the further conclusion that this would in turn lead to a dramatic increase in crime. In an article in *America*, I wrote:

From the wild Irish slums of the 19th century Eastern seaboard to the riot-torn suburbs of Los Angeles, there is one unmistakable lesson in American history: a community that allows a large number of young men to grow up in broken families, dominated by women, never acquiring any stable relationship to male authority, never acquiring any set of rational expectations about the future—that community asks for and gets chaos. Crime, violence, unrest, unrestrained lashing out at the whole social structure—that is not only to be expected; it is very near to inevitable.

The inevitable, as we now know, has come to pass, but here again our response is curiously passive. Crime is a more or less continuous subject of political pronouncement, and from time to time it will be at or near the top of opinion polls as a matter of public concern. But it never gets much further than that. In the words spoken from the bench, Judge Edwin Torres of the New York State Supreme Court, Twelfth Judicial District, described how "the slaughter of the innocent marches unabated: subway riders, bodega owners, cab drivers, babies; in laundromats, at cash machines, on elevators, in hallways." In personal communication, he writes: "This numbness, this near narcoleptic state can diminish the human condition to the level of combat infantrymen, who, in protracted campaigns, can eat their battlefield rations seated on the bodies of the fallen, friend and foe alike. A society that loses its sense of outrage is doomed to extinction." There is no expectation that this will change, nor any efficacious public insistence that it do so. The crime level has been *normalized*.

Consider the St. Valentine's Day Massacre. In 1929 in Chicago during Prohibition, four gangsters killed seven gangsters on February 14. The nation was shocked. The event became legend. It merits not one but two entries in the *World Book Encyclopedia*. I leave it to others to

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judge, but it would appear that the society in the 1920s was simply not willing to put up with this degree of deviancy. In the end, the Constitution was amended, and Prohibition, which lay behind so much gangster violence, ended.

In recent years, again in the context of illegal traffic in controlled substances, this form of murder has returned. But it has done so at a level that induces denial. James Q. Wilson comments that Los Angeles has the equivalent of a St. Valentine's Day Massacre every weekend. Even the most ghastly re-enactments of such human slaughter produce only moderate responses. On the morning after the close of the Democratic National Convention in New York City in July, there was such an account in the second section of the *New York Times*. It was not a big story; bottom of the page, but with a headline that got your attention. "3 Slain in Bronx Apartment, but a Baby is Saved." A subhead continued: "A mother's last act was to hide her little girl under the bed." The article described a drug execution; the now-routine blindfolds made from duct tape; a man and a woman and a teenager involved. "Each had been shot once in the head." The police had found them a day later. They also found, under a bed, a three-month-old baby, dehydrated but alive. A lieutenant remarked of the mother, "In her last dying act she protected her baby. She probably knew she was going to die, so she stuffed the baby where she knew it would be safe." But the matter was left there. The police would do their best. But the event passed quickly; forgotten by the next day, it will never make *World Book*.

Nor is it likely that any great heed will be paid to an uncanny reenactment of the Prohibition drama a few months later, also in the Bronx. The *Times* story, page B3, reported:

*9 Men Posing as Police**Are Indicted in 3 Murders**Drug Dealers Were Kidnapped for Ransom*

The *Daily News* story, same day, page 17, made it four murders, adding nice details about torture techniques. The gang members posed as federal Drug Enforcement Administration agents, real badges and all. The victims were drug dealers, whose families were uneasy about calling the police. Ransom seems generally to have been set in the \$650,000 range. Some paid. Some got it in the back of the head. So it goes.

Yet, violent killings, often random, go on unabated. Peaks continue to attract some notice. But these are peaks above "average" levels that thirty years ago would have been thought epidemic.

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LOS ANGELES, AUG. 24. (Reuters) Twenty-two people were killed in Los Angeles over the weekend, the worst period of violence in the city since it was ravaged by riots earlier this year, the police said today.

Twenty-four others were wounded by gunfire or stabbings, including a 19-year old woman in a wheelchair who was shot in the back when she failed to respond to a motorist who asked for directions in south Los Angeles.

("The guy stuck a gun out of the window and just fired at her," said a police spokesman, Lieut. David Rock. The woman was later described as being in stable condition.

Among those who died was an off-duty officer, shot while investigating reports of a prowler in a neighbor's yard, and a Little League baseball coach who had argued with the father of a boy he was coaching.]

The police said at least nine of the deaths were gang-related, including that of a 14-year old girl killed in a fight between rival gangs.

Fifty-one people were killed in three days of rioting that started April 29 after the acquittal of four police officers in the beating of Rodney C. King.

Los Angeles usually has above-average violence during August, but the police were at a loss to explain the sudden rise. On an average weekend in August, 14 fatalities occur.

Not to be outdone, two days later the poor Bronx came up with a near record, as reported in *New York Newsday*:

Armed with 9-mm. pistols, shotguns and M-16 rifles, a group of masked men and women poured out of two vehicles in the South Bronx early yesterday and sprayed a stretch of Longwood Avenue with a fusillade of bullets, injuring 12 people.

A Kai Erikson of the future will surely need to know that the Department of Justice in 1990 found that Americans reported only about 38 percent of all crimes and 48 percent of violent crimes. This, too, can be seen as a means of *normalizing* crime. In much the same way, the vocabulary of crime reporting can be seen to move toward the normal-seeming. A teacher is shot on her way to class. The *Times* subhead reads: "Struck in the Shoulder in the Year's First Shooting Inside a School." First of the season.

It is too early, however, to know how to regard the arrival of the doctors on the scene declaring crime a "public health emergency." The June 10, 1992, issue of the *Journal of the American Medical Association* was devoted entirely to papers on the subject of violence, principally violence associated with firearms. An editorial in the issue signed by former Surgeon General C. Everett Koop and Dr. George D. Lundberg is entitled: "Violence in America: A Public Health Emergency." Their proposition is admirably succinct.

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Regarding violence in our society as purely a sociological matter, or one of law enforcement, has led to unmitigated failure. It is time to test further whether violence can be amenable to medical/public health interventions.

We believe violence in America to be a public health emergency, largely unresponsive to methods thus far used in its control. The solutions are very complex, but possible.

The authors cited the relative success of epidemiologists in gaining some jurisdiction in the area of motor vehicle casualties by re-defining what had been seen as a law enforcement issue into a public health issue. Again, this process began during the Harriman administration in New York in the 1950s. In the 1960s the morbidity and mortality associated with automobile crashes was, it could be argued, a major public health problem; the public health strategy, it could also be argued, brought the problem under a measure of control. Not in "the 1970s and 1980s," as the *Journal of the American Medical Association* would have us think: the federal legislation involved was signed in 1963. Such a strategy would surely produce insights into the control of violence that elude law enforcement professionals, but whether it would change anything is another question.

For some years now I have had legislation in the Senate that would prohibit the manufacture of .25 and .32 caliber bullets. These are the two calibers most typically used with the guns known as Saturday Night Specials. "Guns don't kill people," I argue, "bullets do."

Moreover, we have a two-century supply of handguns but only a four-year supply of ammunition. A public health official would immediately see the logic of trying to control the supply of bullets rather than of guns.

Even so, now that the doctor has come, it is important that criminal violence not be defined down by epidemiologists. Doctors Koop and Lundberg note that in 1990 in the state of Texas "deaths from firearms, for the first time in many decades, surpassed deaths from motor vehicles, by 3,443 to 3,309." A good comparison. And yet keep in mind that the number of motor vehicle deaths, having leveled off since the 1960s, is now pretty well accepted as normal at somewhat less than 50,000 a year, which is somewhat less than the level of the 1960s—the "carnage," as it once was thought to be, is now accepted as normal. This is the price we pay for high-speed transportation: there is a benefit associated with it. But there is no benefit associated with homicide, and no good in getting used to it. Epidemiologists have powerful insights that can contribute to lessening the medical trauma, but they must be wary of normalizing the social pathology that leads to such trauma.

V

The hope—if there be such—of this essay has been twofold. It is, first, to suggest that the Durkheim constant, as I put it, is maintained by a

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dynamic process which adjusts upwards and *downwards*. Liberals have traditionally been alert for upward redefining that does injustice to individuals. Conservatives have been correspondingly sensitive to downward redefining that weakens societal standards. Might it not help if we could all agree that there is a dynamic at work here? It is not revealed truth, nor yet a scientifically derived formula. It is simply a pattern we observe in ourselves. Nor is it rigid. There may once have been an unchanging supply of jail cells which more or less determined the number of prisoners. No longer. We are building new prisons at a prodigious rate. Similarly, the executioner is back. There is something of a competition in Congress to think up new offenses for which the death penalty is seemed the only available deterrent. Possibly also modes of execution, as in "fry the kingpins." Even so, we are getting used to a lot of behavior that is not good for us.

As noted earlier, Durkheim states that there is "nothing desirable" about pain. Surely what he meant was that there is nothing pleasurable. Pain, even so, is an indispensable warning signal. But societies under stress, much like individuals, will turn to pain killers of various kinds that end up concealing real damage. There is surely nothing desirable about *this*. If our analysis wins general acceptance, if, for example, more of us came to share Judge Torres's genuine alarm at "the trivialization of the lunatic crime rate" in his city (and mine), we might surprise ourselves how well we respond to the manifest decline of the American civic order. Might.

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ASSISTANT SECRETARY FOR PLANNING AND EVALUATION
OFFICE OF HEALTH POLICY



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Veronica Nyham

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The Washington Post

A18 WEDNESDAY, JANUARY 5, 1994

The Value of Banning Bullets

Readers of Scott Shuger's excellent article "A Prescription for Ammo" [Outlook, Dec. 26] calling for prescription sale of bullets will be interested to know that this proposal was first made by Dr. J.H. Felts in an October 1975 editorial in the North Carolina Medical Journal. Suggesting the need for an epidemiological approach, Dr. Felts wrote:

"After all, it is not the firearm that we would be legislating against but the criminal user who loads it. Without the syringe and the needle, modern medicine would be paralyzed. It is who loads the syringe, what he puts in it, and how he uses it that counts. . . . Remember that in western movies and television serials the remedy to gunshot wounds, no matter their sites or seriousness, the approved and heroic therapy is 'get the bullet.' "

I have proposed taxing such rounds as the Black Talon principally because it is noticed when the chairman of the Finance Committee proposes a tax. My preferred tactic simply would be to ban the manufacture and sale of certain rounds (including the Black Talon, which no sportsman would ever use because it destroys game just as it does human tissue).

We did this with the cop-killer bullets capable of penetrating police body armor. Legislation banning armor-piercing ammunition was enacted in 1986 after a Senate vote of 97-1. The Senate approved by unanimous consent—in our version of the crime bill passed in November—an amendment to ban an insidious new class of cop-killer rounds such as the Swedish M39B.

Would it not also make sense to ban the sale of 9 mm ammunition to all but police departments? These seem to be the rounds that are so much involved in urban violence today—and which leave the police effectively outgunned.

DANIEL PATRICK MOYNIHAN

U.S. Senator (D-N.Y.)
Washington

THE NEW YORK TIMES **EDITORIALS/LETTERS** SUNDAY, AUGUST 29, 1993

Letter: On Gun Control

Seat Belts, Bullets and American Lives

To the Editor:

In a letter you published in 1960, I wrote to say that epidemiologists were trying to redefine automobile safety as a public health problem with greater attention to "passive" measures such as vehicle design.

Such views were then generally greeted with skepticism, if not derision, since conventional thinking then saw the problem as driver behavior and the solution as law enforcement. Yet by 1966 Congress had enacted legislation establishing the National Highway Safety Bureau, headed first by William Haddon Jr., M.D., who had begun his career in the New York State Department of Health. Automobile safety is now a recognized field of scientific research and technological innovation with results to show for it.

I relate this in the context of "What Can the Brady Bill Really Do? A Little Gun Control, a Lot of Guns" (The Week in Review, Aug. 15). You

note that since 1981, when James S. Brady, President Reagan's press secretary, was shot, "Americans have bought nearly 50 million new guns, including more than 20 million handguns." Americans may own some 200 million firearms. Would a waiting period for purchasing new weapons, which I surely support, even so make much of a difference?

You cite criminologists who are skeptical. And ought not they be? We have a two-century supply of handguns. These things last forever. Dr. Haddon used to say that when a car hit a tree nobody got hurt. It wasn't until the passenger hit the car that injury or death occurred. Therefore, think seat belts.

In the same analytic tradition can we not bring ourselves to see that guns don't kill people? Bullets do. And at most we have a four-year supply of ammunition, albeit some can be hoarded. Moreover, the Federal Gov-

ernment already controls, through licensing, the manufacture of bullets. Mind, the Bureau of Alcohol, Tobacco and Firearms, which issues the licenses (for derisory sums with no record keeping), isn't much interested. There is no reference to this responsibility in the bureau's job description in the Government Manual.

The publications of the National Safety Council in 1960 did not mention automobile design. But this can change. John D. Graham, who is director of the Injury Control Center at the Harvard School of Public Health, from which Dr. Haddon graduated, writes: "Bullet-related injury is barely a field of respectable scientific endeavor." But neither was vehicle design a third of a century ago.

DANIEL PATRICK MOYNIHAN
Pindars Corner, N.Y., Aug. 17, 1993
The writer is United States Senator from New York.

THE NEW YORK TIMES **EDITORIALS/LETTERS** SATURDAY, NOVEMBER 13, 1993

High-Tech Death From Winchester

America is already the most murderous nation in the industrialized world. The Olin Corporation's Winchester Ammunition Division has stepped up the slaughter by making a bullet equipped with claws. Imagine it: a razor-fingered bullet that grinds up internal organs and threatens the doctors who try to remove it. The victim dies a rapid, bloody death. The doctors risk getting AIDS from cuts on their hands.

This grotesquely destructive bullet — Winchester calls it the Black Talon — represents a particularly ugly brand of corporate irresponsibility. It's also a danger to public health. Winchester, if it has any decency at all, will withdraw it from production. Beyond that, Congress needs to ban such bullets from the market.

The Black Talon is a hollow-tipped bullet which unfurls sharp claws upon impact. As one doctor recently put it, "When you go in, the patient is bleeding from every major thing you can think of."

Doctors must probe with their fingers to find the bullet. Cuts will expose them to blood-borne infections carried by the victim, including hepatitis and H.I.V., the virus that causes AIDS. Trauma surgeons are already scarce. The American College

of Emergency Physicians has warned that many trauma surgeons will simply quit if the risk of AIDS becomes too great.

Some law-enforcement officials argue that the Black Talon and its cousins are perfect for the police because they cause bigger wounds, more bleeding and quicker incapacitation. Expanding bullets also remain within the target's body, unlike other bullets that pass through, wounding bystanders as well.

But criminals buy these deadly bullets too. Last July, when Gian Luigi Ferri killed eight people and wounded six others in a San Francisco high-rise, the bullets he used in his .45-caliber handgun were Black Talons. Similar bullets are made by other manufacturers, including the Eldorado Cartridge Company.

Representatives Charles Schumer of New York and Thomas Barrett of Wisconsin have introduced a bill that would ban the Black Talon and its cousins from the market. The bill deserves support. But the Olin Corporation, and others who make similar bullets, could make the legislation unnecessary by bowing to morality and common sense and withdrawing this grisly product from production.

A26 FRIDAY, NOVEMBER 5, 1993

The Washington Post

AN INDEPENDENT NEWSPAPER

A Bite on the Bullet

IF AMERICA already has a 200-year supply of guns, how do you ever curb the gunfire that is terrorizing neighborhoods across the country? You enact a huge federal tax increase on ammunition, because the country has only a four-year supply of that. After all, says New York's Sen. Daniel Patrick Moynihan, the tired cry of the gun lobbyists is only half right: "Guns don't kill people. Bullets do." That's what he told the Senate this week in advocating huge tax increases on handgun ammunition, which would price some of the most destructive bullets right out of the market. And because murder by handgun is a public health issue, Sen. Moynihan says he'll insist that President Clinton's health care plan include the ammunition tax proposal.

The measure would raise the current 11 percent tax on the wholesale price of handgun ammunition to 50 percent in most cases, but would not affect the tax on .22-caliber bullets used in target shooting. It also would raise the tax to 10,000 percent on the Winchester 9-millimeter hollow-tipped Black

Talon cartridge—an especially effective people-killer—raising the price of a single box to almost \$150,000. It would apply as well to all 50-caliber ammunition.

Needless to say, the gun lobby is not amused, even though the measure wouldn't do harm to the Second Amendment. The right to bear arms would remain intact, even though you'd be talking unloaded arms. And because Mr. Moynihan is chairman of the Finance Committee, one of the two Senate committees that have a predominant role in enacting the health care bill, the ammo-tax idea must be regarded as a serious proposal. The catch here is that just about the last thing the administration wants at this point is to add gun-lobby supporters to the ranks of critics of its health plan.

But if this really would threaten the health bill, here's an alternative: Add the proposal to the crime bill. As it stands, the best improvement to this bill would be its demise. Pump it with bullet taxes, and maybe it would take on a new and worthier life.

EDITORIALS of THE TIMES

Banning, Taxing Ammo: Can't Hurt

A gunshot wound often looks like a clean, tiny hole in the skin. But, as emergency room physicians know all too well, just below the surface the injury is likely to be anything but clean or tiny.

One appallingly common reason for the fractured bones, the torn arteries, the severed nerves, the shredded muscles inside the body is a perverse kind of bullet that is designed to disintegrate on impact. Because of the grievous injuries these bullets cause, and the skyrocketing cost of treating the victims, Sen. Daniel Patrick Moynihan is campaigning for a significant federal tax increase on this vile ammunition, plus a huge levy on those firms that manufacture or import it.

Among Moynihan's targets is the nine-millimeter Black Talon, touted by marketers for its "tissue-cutting" and "crushing" action. The New York Democrat wants to increase the cost of a box of these bullets from \$15 to \$1,500, in effect taxing the ammunition out of the market.

His proposals would also increase federal taxes (to 50% from 11%) on .25-caliber, .32-caliber and nine-millimeter bullets and impose a license fee of \$10,000 on manufacturers and importers of handgun ammunition (companies dealing with only police or other government agencies would be exempted). The legislation would raise a projected \$200 million a year.

Consider that the treatment of shooting victims in Los Angeles County hospitals alone in 1991 cost \$54 million. Local taxpayers paid most of the tab. On the national level, the public picked up 80% of the estimated annual expense related to gun violence—\$16 billion.

Treatment that once took days and cost a few thousand dollars can now last months or even years, with multiple specialist evaluations, repeated surgeries, extended rehabilitation and in many cases permanent long-term disability assistance. That can boost the total bill for a single patient to hundreds of thousands, even millions, of dollars. And that

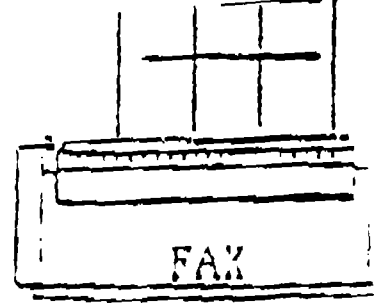
adds to everyone's health care costs.

No one is suggesting that taxes would pay for or solve the problem of gun violence. In fact *The Times*, in its series "Taming the Gun Monster," notes that it is the huge number of privately owned firearms in the United States—about 200 million—that drives the demand for ammunition. Thus we call for a complete federal ban on handguns and assault weapons except for law enforcement. Special, restrictive arrangements would be made for legitimate collectors. Hunters' rifles and shotguns would be separately licensed and regulated.

President Clinton has endorsed the ammunition tax in principle. Although he is concerned about tacking it onto the health care reform legislation, he is clearly warming to the issue. On Wednesday the President suggested that he might endorse an outright ban on the kinds of bullets Moynihan is upset about. Banning certain kinds of ammunition could prove to be an important if modest step in the right direction, too.

Telephone: (718) 245-3901

2



TELECOPIER TRANSMITTAL COVER SHEET
TELEFAX # (718) 953-1316

Date: 2-26-94
TO: Liz Boyes
FROM: Col Perkins

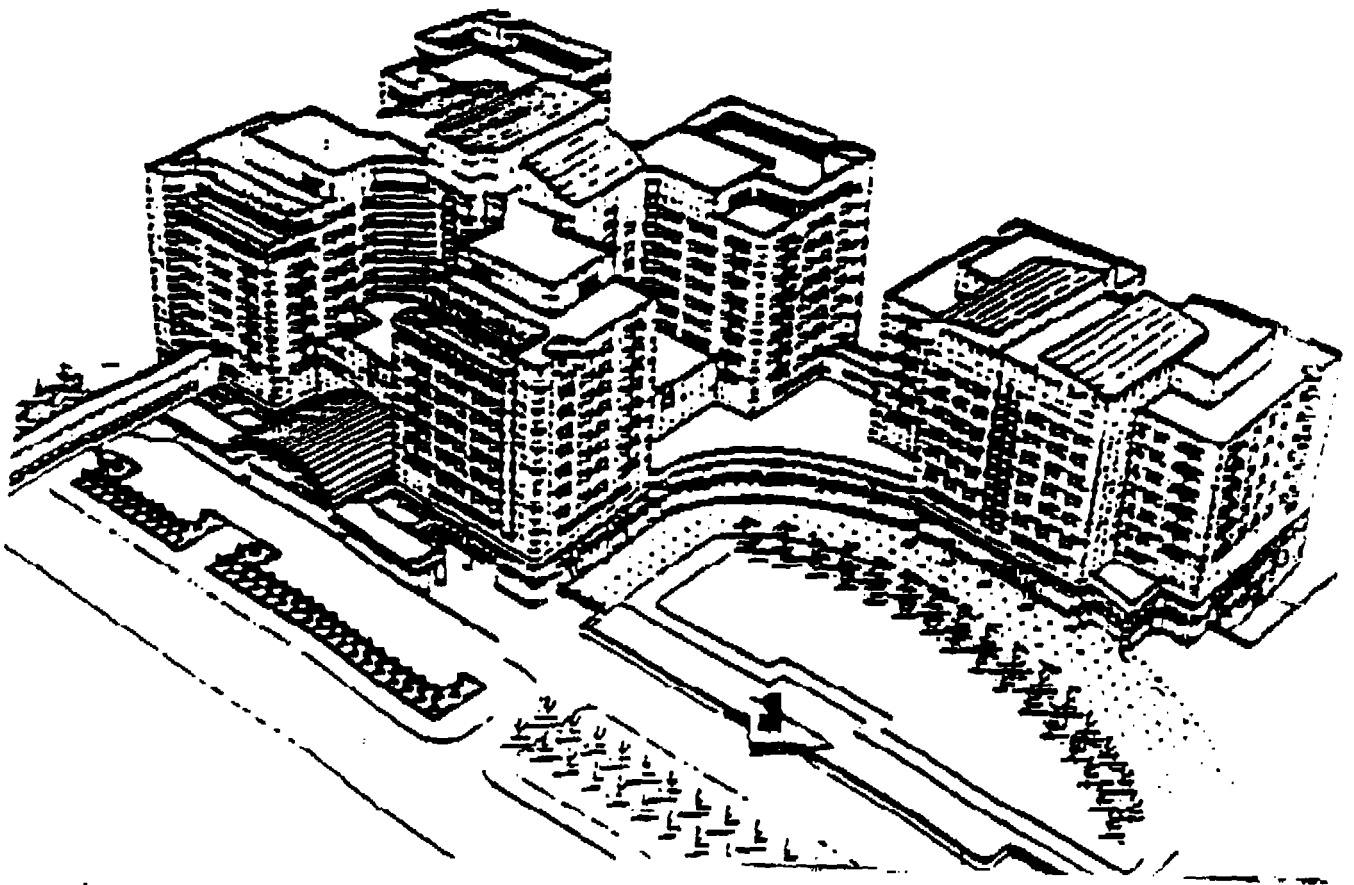
Number of Pages: This cover sheet + 4

ACTION TO BE TAKEN:

Deliver Immediately _____
As Requested _____
For Your Information _____
Please Review and Call Me _____
Please Approve _____
Return with Comments & Suggestions

COMMENTS:

*Welcome
To
Kings County Hospital Center*



*Architect's rendering of the new
Kings County Hospital Center*

Operated by the NYC Health and Hospitals Corporation, Kings County Hospital Center (KCHC), located in the heart of Brooklyn, New York is one of the largest acute-care hospitals in the country. Built in 1831, it has grown from a one room infirmary for publicly supported care of the sick, to its present 24 buildings on 44 acres.

Often referred to as Brooklyn's "Family Doctor", KCHC provides health care services to approximately 850,000 patients annually.

***AS WE WERE HERE
YESTERDAY
WE ARE HERE TODAY***

As we continue to serve an ever changing community, our programs and services have expanded to include:

- * One of the country's busiest Emergency Departments, with a world renowned Level One Trauma Unit, it is one of only two such units in the entire borough, serving 2.6 million residents. By contrast there are five such units serving 2.2 million residents in the borough of Manhattan.
- * Ambulatory care services with specialties in all fields of modern medicine, administered in 113 clinics with eight intensive care units.
- * Off-site health care facilities such as the Bedford Stuyvesant Alcoholism Treatment Center, a community based agency that provides a comprehensive network of services for the alcoholic and/or their families. Services consist of outpatient clinics, a residential halfway house and community education and outreach programs.
- * Back-up facility to the East New York Neighborhood Family Care Diagnostic and Treatment Center, as well as for other hospitals in the borough.
- * Complete computerization of the adult, pediatric and isolation dialysis units making these units among the very few such units in the United States. With this state-of-the-art system, featuring a complete and individualized patient

profile, treatment efficiency is significantly increased while reducing treatment time by at least one hour.

- * The expansion of services to the HIV/AIDS infected patient is designed to treat the unique needs of both the individual and their family. Services are offered in all age categories with an emphasis on clinical trials and research.

- * The Women's Health Services Department, one of the largest hospital based ambulatory services in the United States, treats over 50,000 patients in Obstetrics, Gynecology, Family Planning, GYN-Oncology, Colposcopy, Endocrinology, Post Abortal and Post Partum Clinics. In recognizing the special needs of our patient population, the Women's Health Services Department has incorporated a number of social services type programs to address the varied needs of women in all stages of maturation.

- * A beautifully renovated Child and Adolescent Psychiatry unit provides in-patient, therapeutic and educational facilities for children and adolescents. This unit provides an environment conducive to the child's effective participation in therapeutic programs.

***WE WILL BE HERE
TOMORROW***

In the midst of a major reconstruction project scheduled for completion in the year 2000, we are preparing to take KCHC into the 21st century of state-of-the-art health care:

- * In FY'85 the City of New York and HHC agreed to the reconstruction and renovation of KCHC. When completed, the new or renovated facilities will provide space totaling over 2 million square feet. As such, it will be the largest modernization/construction project of an acute care facility ever undertaken by HHC.
- * The main building will include general care and psychiatric in-patient services, diagnostic services and emergency services.
- * The new facility, with 1,260 beds will primarily be in two bed configurations, eliminating the 8 - 16 bed wards that presently exists.

* Ambulatory Care facilities will support over 260,000 ambulatory visits on-site and diagnostic out-patient clinical services.

* Completed construction and staff training of the new state-of-the-art Cook-Chill facility makes KCHC one of the few health care facilities in the country with such a high level of food preparation capabilities.

* Demolition to clear space for the new main acute-care facility was completed in the summer of 1993.

As KCHC moves forward in its commitment as a quality health care provider, its focus continues to expand. The resulting improvement in service will, in essence, ensure that Kings County Hospital Center continues growing under its founding principles - providing publicly supported health care that is embedded in public service and civic commitment.

**Kings County Hospital
Center**
*Always Here When You
Need Us.*

HOSPITAL PROFILE*

In-Patient Discharge

Adults/Children 31,782

Medical

(include ICU, Prison Med &
Alcohol Det.) 5,680
Surgical
(include ICU, Prison Surg.
& GYN) 8,180
OBS 4,788
Others (Psych., Alcohol Rehab,
phys. Rehab) 4,197

23,145

Pediatrics (incl. ICU)

Medical 3,919
Surgical 1,215

5,134

Newborn

Regular 2,709
Special Care 794

3,503

Out-Patient Visit 815,611 Services

Primary Care Center 339,739
Dermatology 8,820
Neurology 4,071
Women's Center 57,506
Psychiatry 52,475
Dental 21,895
Ophthalmology 13,291
Medicine 72,049
Pediatrics 39,160
Surgery 46,133
Orthopedics 2,918
Otolaryngology 5,784
Urology 2,195

Total service visits 666,036

Emergency Dept. Patient Visits

Peds ER 70,135
Psych. ER 5,304
Adult ER 74,106

Total ER visits 149,575

General Information

1,264 Beds

(Includes 50 bassinets)

6,376 Employees
467 Physicians
457 Housestaff

Admissions 31,770
Admissions thru ER 21,378
Pat. days care prov. 340,987
Average length of stay (days) ... 10.73
Average daily patient census 934
Occupancy 74
Births 4,829
Laboratory Room/Procedures . 2,970,957
Oper. Room Mins 701,955

Payers:

Blue Cross 4%
Medicaid 62%
Medicare 6%
Other 28%

Tests/Procedures

Ultrasound	33,162
X-ray	120,058
CAT Scan	6,701
Nuclear Medicine	1,961
Electrocardiology exams (EKG)	21,463
Physical therapy tm	66,921
Respiratory therapy treatments	181,193
Surgical procedures	5,013
EEG	1,008
Occupational therapy treatments	86,626

Kings County Hospital Center

451 Clarkson Avenue
 Brooklyn, NY 11203
 (718) 245 - 3131
 a member of the New York City
 Health and Hospitals
 Corporation

**Statistics are for FY 1993*

Clinical Departments

Medicine/Surgery/Obstetrics &
 Gynecology/Pediatrics/Psychiatry/Neurology/
 Neurosurgery/Urology/Dentistry/Ambulatory
 Care/Emergency Services/Radiation
 Oncology/Pathology/Anesthesiology/Ortho/
 Rehab Medicine/ Dermatology/ Ophthalmology

Affiliation

SUNY Health Science Center at Brooklyn

Communities Served

Flatbush/Bedford Stuyvesant/ East New
 York/
 East Flatbush/
 Crown Heights/Brownsville

Satellite Clinics

East New York Neighborhood
 Family Care Center
 Bedford Stuyvesant Alcoholism
 Treatment Center

Accreditation

The Joint Commission Accreditation of
 Health Care Organizations

Membership

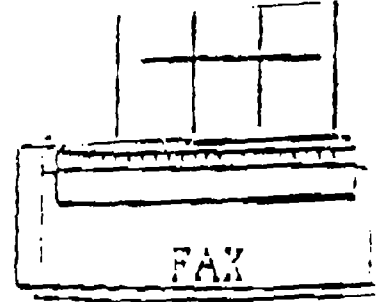
Teaching Hospitals of the Association of
 American Medical Colleges
 Hospital Association of New York State
 Greater New York Hospital Association

Licenses

New York State
 Department of Health

Telephone: (718) 245-3901

FAX #1



TELECOPIER TRANSMITTAL COVER SHEET
TELEFAX # (718) 953-1316

Date: 2-26-94

TO: Liz Boyer

FROM: Ed Jarkins

Number of Pages: This cover sheet + 3

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Return with Comments & Suggestions

COMMENTS:

KINGS COUNTY HOSPITAL CENTER

White Coat Program Fact Sheet

Operated by the NYC Health and Hospitals Corporation (HHC), Kings County Hospital Center (KCHC) located in heart of Brooklyn, has provided dedicated health care services to the Brooklyn and Staten Island Communities for 162 years. Built in 1831, Kings County has grown from a one room infirmary for publicly supported care of the sick, to its present 24 buildings on 44 acres.

KCHC:

- **One of the largest general acute-care hospitals in the country, is the largest municipal hospital in New York City.**
- **Has 1,210 beds (including 50 newborn bassinets).**
- **Employs over 6,000 persons (including housestaff), making it Brooklyn's largest employer.**
- **With specialties in all fields of modern medicine, the facility provides ambulatory care services in 113 clinics, with eight intensive care units.**
- **One of only two Level One Trauma Centers serving 2.6 million residents of Brooklyn and Staten Island, it operates one of the country's busiest emergency rooms. By contrast, five Trauma Centers serve the 2.2 million residents of the borough of Manhattan.**
- **The County is academically affiliated with the State University of New York/Health Science Center at Brooklyn (HSCB).**
- **In addition to its main campus, the County operates the Bedford Stuyvesant Alcoholism Treatment Center and serves as a back-up facility for the East New York Neighborhood Family Care Diagnostic and Treatment Center, as well as for other hospitals in the borough.**

In recognition of the investment needed to carry out KCHC's extraordinary mission, New York City and HHC have embarked upon an extensive program for the reconstruction and modernization of KCHC. \$920 million has been allocated for the total reconstruction of Kings County Hospital Center, which is currently scheduled for completion by the year 2000. The County's reconstruction is the largest hospital modernization/construction project in the history of the New York City Health and Hospitals Corporation. The project will provide new or renovated facilities totalling over 2 million square feet. The new state-of-the-art inpatient hospital to include general care and psychiatric inpatient services, diagnostic services, and emergency services, will contain 1,260 beds, primarily in two-bed room configurations where there are presently wards.

Included in the reconstruction are new Ambulatory Care facilities to support over 260,000 ambulatory visits on-site and over 100,000 primary care visits in community-based primary care centers. A Certificate of Need (CON) for the new Main Hospital was approved by the NYS Department of Health (DOH) in February 1992. Some swing space, including the new Support Office Building is completed and occupied. The new state-of-the-art Food Service Building (Cook-Chill) has also reached completion and received its Certificate of Occupancy (C of O) in early September 1992; full building food production began in early 1993. Renovations in buildings T, E, A, B, C and the Power Plant have either been completed or are nearing completion as part of the Make-Ready phase for construction of the new hospital. Program design modifications were also made during FY 92 to address deficiencies in the original design.

Project objectives also include innovative and path-breaking actions to maximize local and minority contractor and consultants and the employment of local workers and trades. Over 35% of all contracts awarded to date have been awarded to local, women-owned, and minority firms; over 50% of all workers on the project to date have been minorities and women.

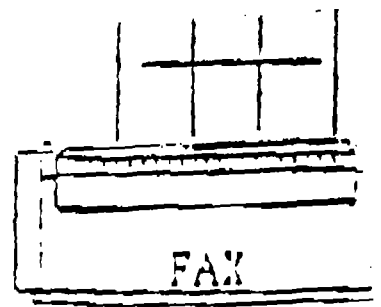
As the County moves forward in its commitment as a quality health care provider, its focus will expand to include a greater emphasis on health promotion and disease prevention programs and initiatives. The commitment involves expanding community-based primary care centers which are being developed with community input. Establishing processes for on-going community input and participation in the planning and development of new primary care facilities is an integral part of the restructuring of the Central Brooklyn health care delivery system, particularly as the implementation of Communicare and Managed care programs move forward.

The resulting improvement in service will, in essence, ensure that Kings County Hospital Center continues growing under its founding principles -- providing publicly supported health care that is embedded in public service and civic commitment.

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3

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Date: 2-26-94

TO: LIZ BOYER

FROM: ED LARKINS

Number of Pages: This cover sheet + 2

ACTION TO BE TAKEN:

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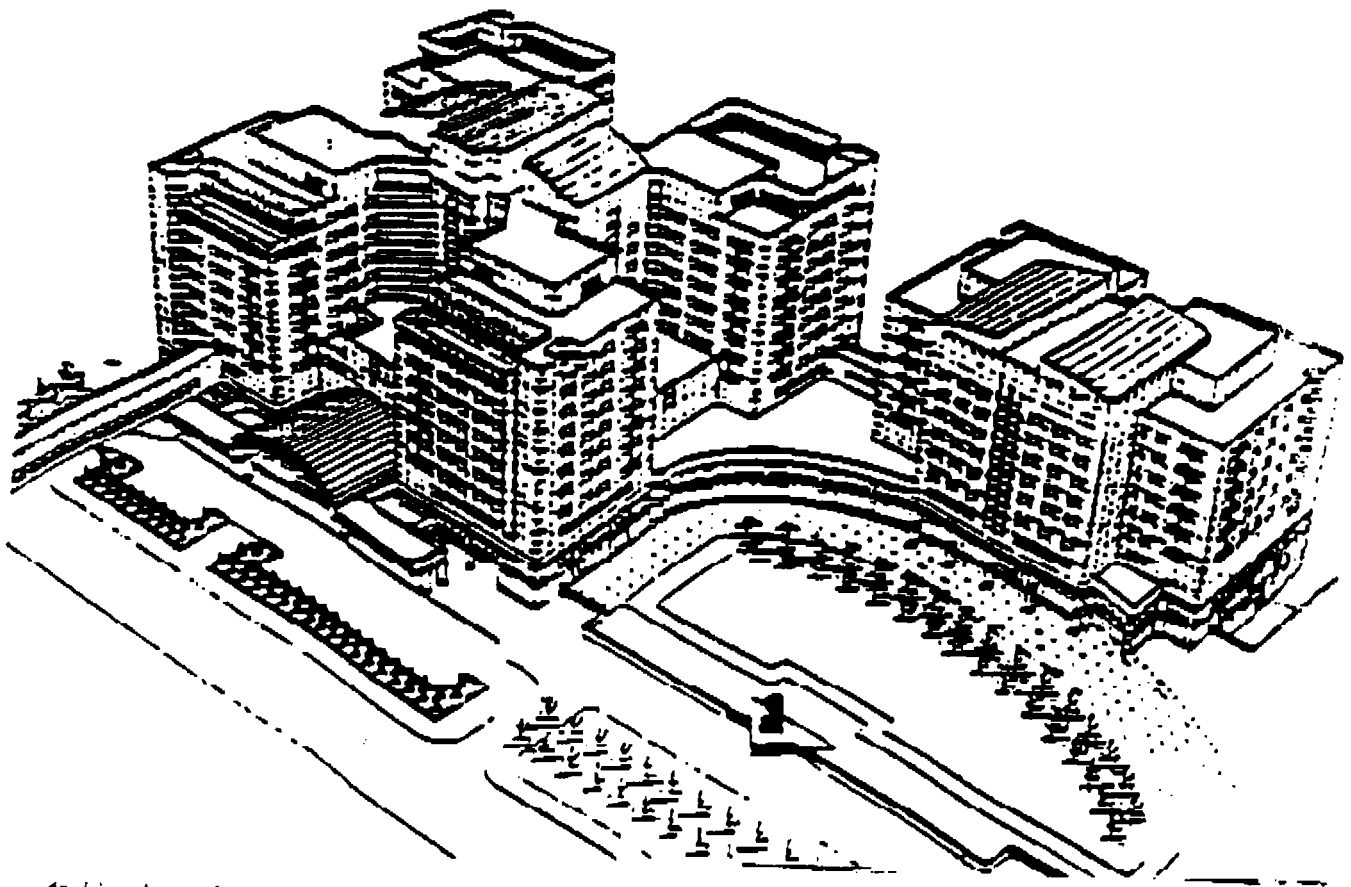
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Care/Emergency Services/Radiation
Oncology/Pathology/Anesthesiology/Ortho/
Rehab Medicine/ Dermatology/ Ophthalmology

Affiliation

SUNY Health Science Center at Brooklyn

Communities Served

Flatbush/Bedford Stuyvesant/ East New
York/
East Flatbush/
Crown Heights/Brownsville

Satellite Clinics

East New York Neighborhood
Family Care Center
Bedford Stuyvesant Alcoholism
Treatment Center

Accreditation

The Joint Commission Accreditation of
Health Care Organizations

Membership

Teaching Hospitals of the Association of
American Medical Colleges
Hospital Association of New York State
Greater New York Hospital Association

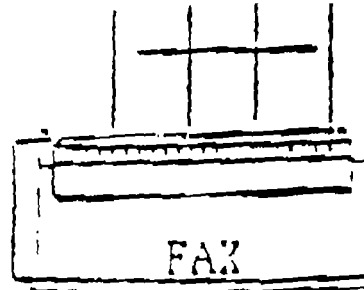
Licenses

New York State
Department of Health

Kings County Hospital Center

451 Clarkson Avenue
Brooklyn, NY 11203
(718) 245 - 3131
a member of the New York City
Health and Hospitals
Corporation

Telephone: (718) 245-3901



TELECOPIER TRANSMITTAL COVER SHEET
TELEFAX # (718) 953-1316

Date: 2-26-94
TO: Sgt. Boyer
FROM: Col. Jenkins

Number of Pages: This cover sheet + 3

ACTION TO BE TAKEN:

Deliver Immediately



As Requested

For Your Information

Please Review and Call Me

Please Approve

Return with Comments & Suggestions

COMMENTS:

SENT BY: KINGS COUNTY HOSPITAL : 2-26-94 : 1:26PM : EXEC DIRECTOR OFFICE-

KINGS COUNTY HOSPITAL CENTER

White Coat Program Fact Sheet

Operated by the NYC Health and Hospitals Corporation (HHC), Kings County Hospital Center (KCHC) located in heart of Brooklyn, has provided dedicated health care services to the Brooklyn and Staten Island Communities for 162 years. Built in 1831, Kings County has grown from a one room infirmary for publicly supported care of the sick, to its present 24 buildings on 44 acres.

KCHC:

- **One of the largest general acute-care hospitals in the country, is the largest municipal hospital in New York City.**
- **Has 1,210 beds (including 50 newborn bassinets).**
- **Employs over 6,000 persons (including housestaff), making it Brooklyn's largest employer.**
- **With specialties in all fields of modern medicine, the facility provides ambulatory care services in 113 clinics, with eight intensive care units.**
- **One of only two Level One Trauma Centers serving 2.6 million residents of Brooklyn and Staten Island, it operates one of the country's busiest emergency rooms. By contrast, five Trauma Centers serve the 2.2 million residents of the borough of Manhattan.**
- **The County is academically affiliated with the State University of New York/Health Science Center at Brooklyn (HSCB).**
- **In addition to its main campus, the County operates the Bedford Stuyvesant Alcoholism Treatment Center and serves as a back-up facility for the East New York Neighborhood Family Care Diagnostic and Treatment Center, as well as for other hospitals in the borough.**

In recognition of the investment needed to carry out KCHC's extraordinary mission, New York City and HHC have embarked upon an extensive program for the reconstruction and modernization of KCHC. \$920 million has been allocated for the total reconstruction of Kings County Hospital Center, which is currently scheduled for completion by the year 2000. The County's reconstruction is the largest hospital modernization/construction project in the history of the New York City Health and Hospitals Corporation. The project will provide new or renovated facilities totalling over 2 million square feet. The new state-of-the-art inpatient hospital to include general care and psychiatric inpatient services, diagnostic services, and emergency services, will contain 1,260 beds, primarily in two-bed room configurations where there are presently wards.

Included in the reconstruction are new Ambulatory Care facilities to support over 260,000 ambulatory visits on-site and over 100,000 primary care visits in community-based primary care centers. A Certificate of Need (CON) for the new Main Hospital was approved by the NYS Department of Health (DOH) in February 1992. Some swing space, including the new Support Office Building is completed and occupied. The new state-of-the-art Food Service Building (Cook-Chill) has also reached completion and received its Certificate of Occupancy (C of O) in early September 1992; full building food production began in early 1993. Renovations in buildings T, E, A, B, C and the Power Plant have either been completed or are nearing completion as part of the Make-Ready phase for construction of the new hospital. Program design modifications were also made during FY 92 to address deficiencies in the original design.

Project objectives also include innovative and path-breaking actions to maximize local and minority contractor and consultants and the employment of local workers and trades. Over 35% of all contracts awarded to date have been awarded to local, women-owned, and minority firms; over 50% of all workers on the project to date have been minorities and women.

As the County moves forward in its commitment as a quality health care provider, its focus will expand to include a greater emphasis on health promotion and disease prevention programs and initiatives. The commitment involves expanding community-based primary care centers which are being developed with community input. Establishing processes for on-going community input and participation in the planning and development of new primary care facilities is an integral part of the restructuring of the Central Brooklyn health care delivery system, particularly as the implementation of Communicare and Managed care programs move forward.

The resulting improvement in service will, in essence, ensure that Kings County Hospital Center continues growing under its founding principles -- providing publicly supported health care that is embedded in public service and civic commitment.



DANIEL P. MCYNIHAN
NEW YORK

United States Senator
WASHINGTON, DC 20510-3201

(202) 224-4451

TELECOPIER TRANSMITTAL SHEET

TO: Liz Bowyer

FROM: Roy Kienitz

SUBJECT: _____

COMMENT: _____

TOTAL PAGES INCLUDING COVER: 10

DATE: _____

TIME: _____

DRAFT**NEW YORK STATE HOSPITALS UNDER THE HEALTH SECURITY ACT**

	ALL HOSPITALS	TEACHING HOSPITALS
PATIENT CARE MARGINS TODAY	2.5%	4.3%
BASELINE GROWTH IN HOSPITAL COSTS *	9.3%	9.3%
COST GROWTH UNDER REFORM	6.6%	6.6%
REAL COST GROWTH UNDER REFORM	3.2%	3.2%

* Assumption from Health Care Association of New York State

DRAFT**HOSPITAL REVENUES, NEW YORK STATE, ALL HOSPITALS,
BEFORE AND AFTER THE HEALTH SECURITY ACT, BILLIONS OF DOLLARS**

	1993	1994	1995	1996	1997	1998	1999	2000
TOTAL	\$25.1	\$27.3	\$29.8	\$32.5	\$35.2	\$37.7	\$40.0	\$42.2
MEDICARE	\$8.2	\$8.9	\$9.7	\$9.9	\$9.8	\$10.7	\$11.6	\$12.5
MEDICAID	\$5.9	\$6.5	\$7.1	\$7.6	\$9.2	\$9.7	\$10.2	\$10.7
PRIVATE	\$9.4	\$10.3	\$11.2	\$12.3	\$11.6	\$12.1	\$12.6	\$13.1
PREVIOUSLY UNINSURED	\$1.6	\$1.6	\$1.8	\$2.0	\$4.0	\$4.2	\$4.3	\$4.5
ACADEMIC POOLS	—	—	—	\$0.5	\$0.6	\$0.9	\$1.2	\$1.2
VPA *	—	—	—	\$0.2	\$0.2	\$0.2	\$0.2	\$0.2

* Assumption from Health Care Association of New York State

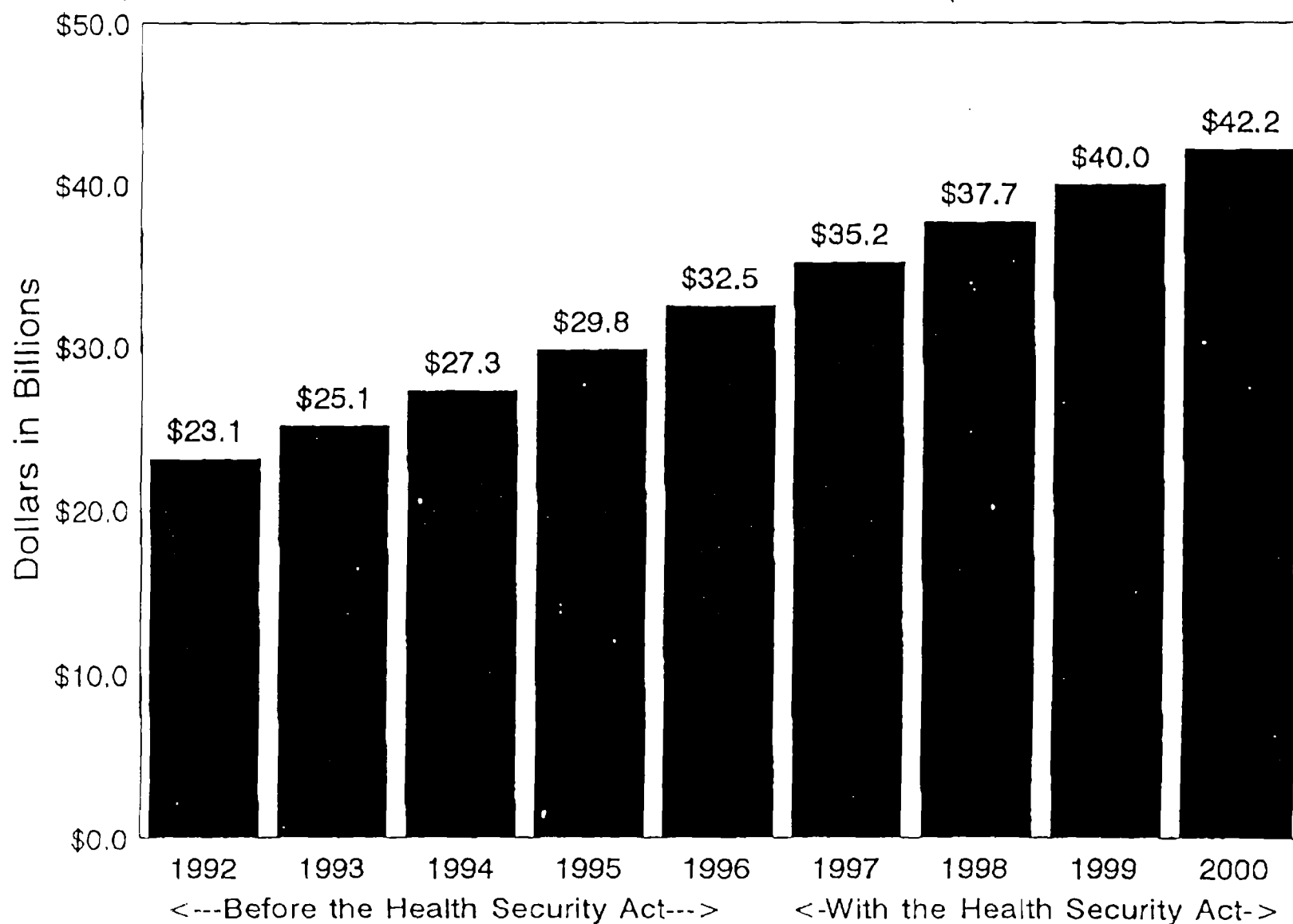
DRAFT**HOSPITAL REVENUES, NEW YORK STATE TEACHING HOSPITALS,
BEFORE AND AFTER THE HEALTH SECURITY ACT, BILLIONS OF DOLLARS**

	1993	1994	1995	1996	1997	1998	1999	2000
TOTAL	\$20.7	\$22.5	\$24.6	\$26.9	\$29.1	\$31.1	\$33.0	\$34.8
MEDICARE	\$6.5	\$7.0	\$7.6	\$7.5	\$7.6	\$8.2	\$8.8	\$9.5
MEDICAID	\$5.4	\$5.9	\$6.5	\$7.1	\$8.4	\$8.9	\$9.3	\$9.8
PRIVATE	\$7.3	\$8.0	\$8.7	\$9.5	\$8.9	\$9.3	\$9.7	\$10.1
PREVIOUSLY UNINSURED	\$1.6	\$1.6	\$1.8	\$2.0	\$3.5	\$3.7	\$3.9	\$4.0
ACADEMIC POOLS	—	—	—	\$0.5	\$0.6	\$0.9	\$1.2	\$1.2
VPA *	—	—	—	\$0.1	\$0.1	\$0.1	\$0.1	\$0.1

* Assumption from Health Care Association of New York State

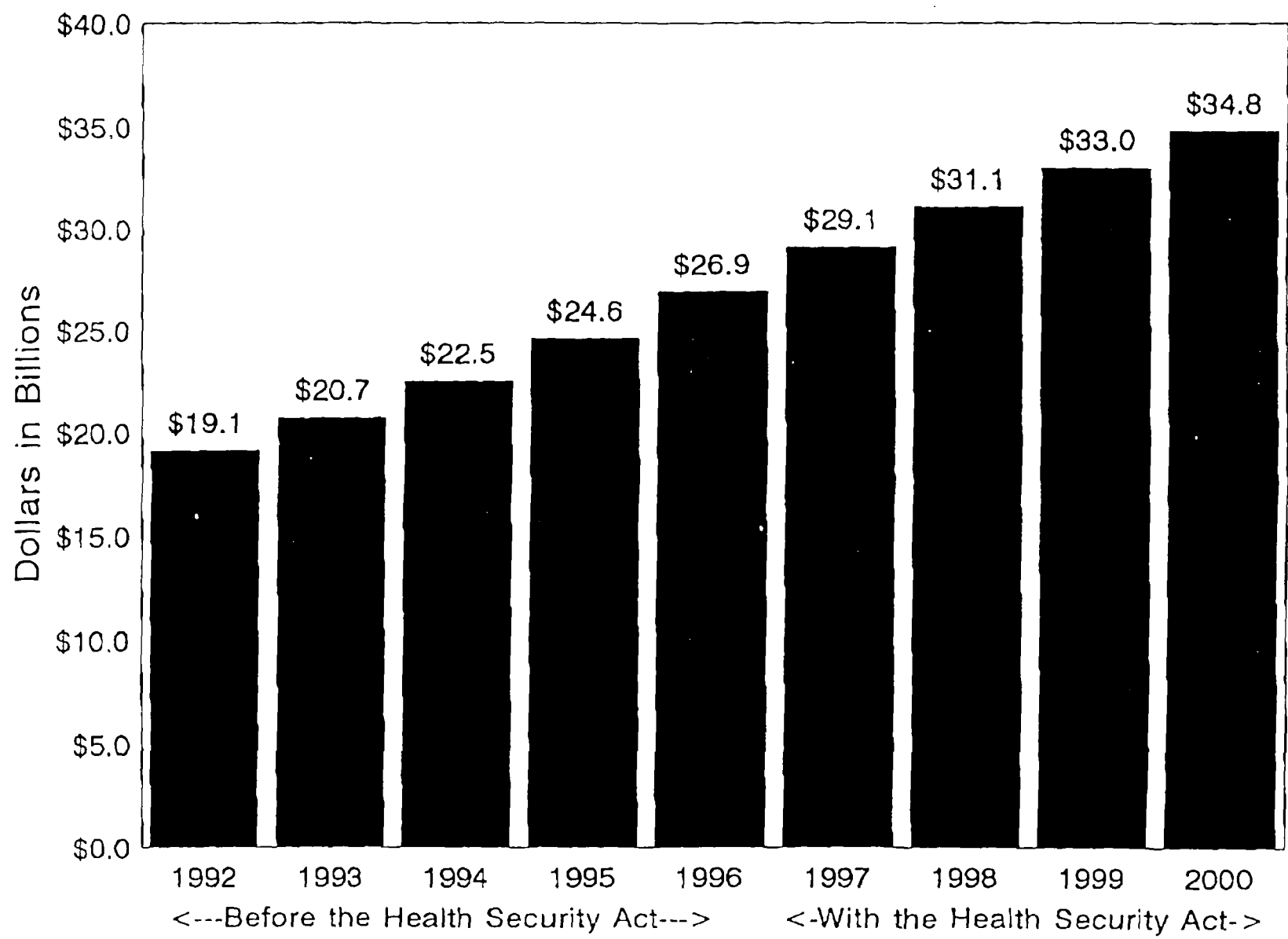
Hospital Revenues, New York State Hospitals

Before and After the Health Security Act



Hospital Revenues, New York State Teaching Hospitals

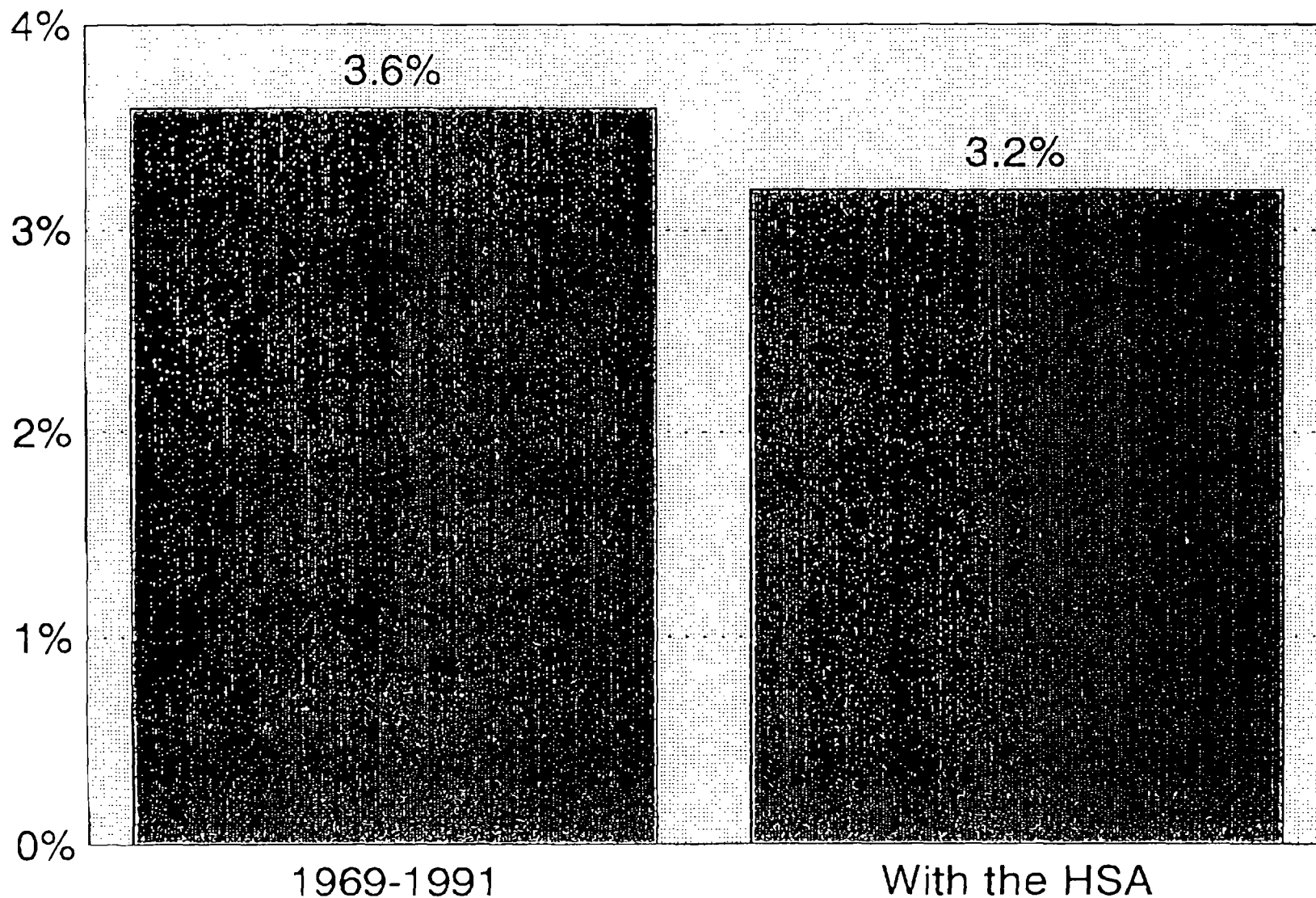
Before and After the Health Security Act



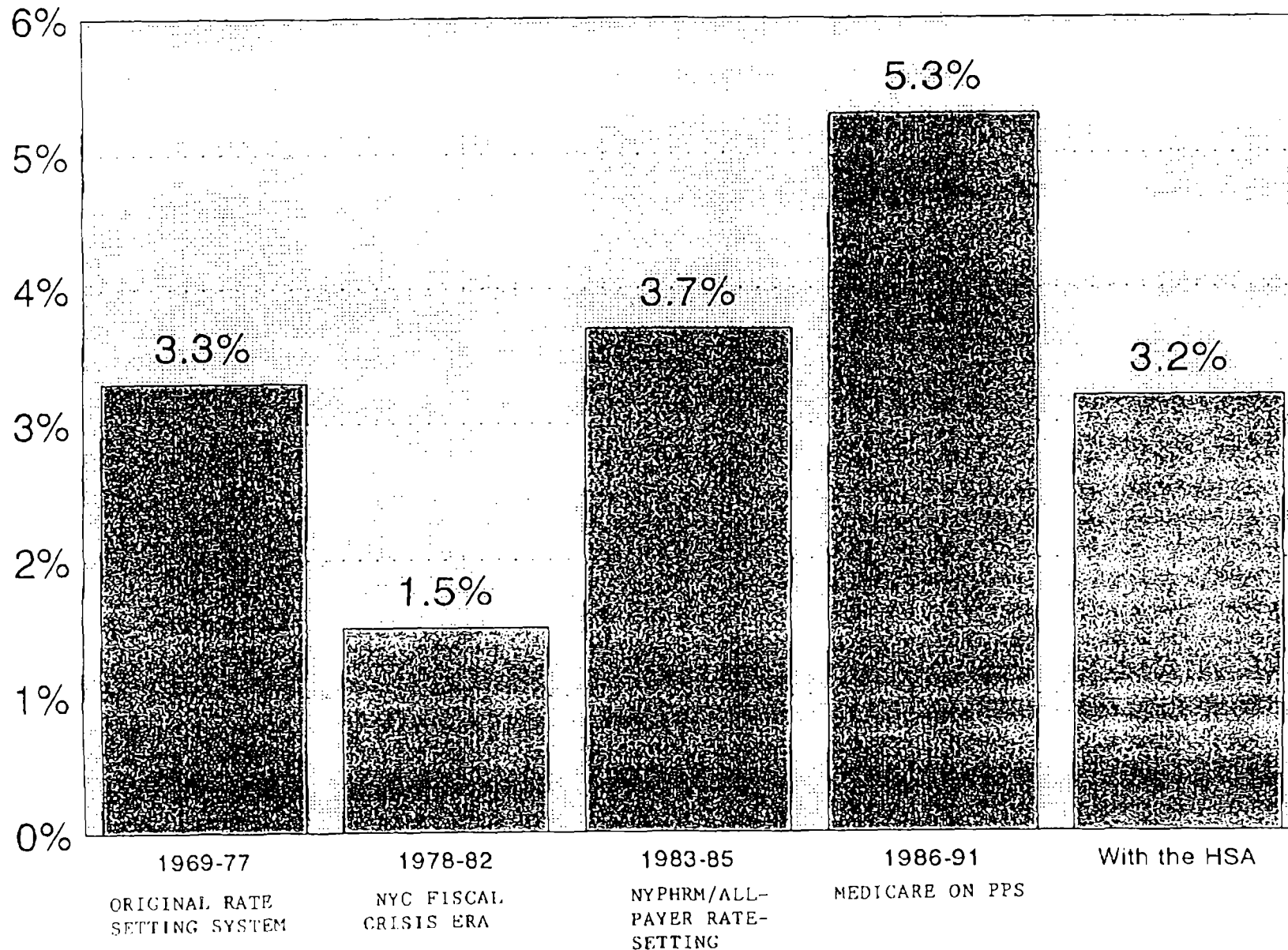
DRAFT

02/25/94 11:44 0202 401 7321 HHS ASPE/HP 011/013

Percent Increase in Real Costs, New York State Hospitals Before and After the HSA



Percent Increase in Real Costs, New York State Hospitals Before and After the HSA



SENATOR MOYNIHAN'S FIREARMS AND AMMUNITION CONTROL LEGISLATION

HISTORY

ARMOR-PIERCING BULLETS

- February 23, 1982: Senator Moynihan introduced S. 2128, the Law Enforcement Officers' Protection Act of 1982 to limit availability and use of handgun bullets capable of penetrating certain body armor. (97th Congress)
- February 22, 1983: Senator Moynihan introduced S. 2128 as S. 2128, the Law Enforcement Officers' Protection Act of 1983. (98th Congress)
- January 3, 1985: The Moynihan cop-killer bullet provision was introduced by Senator Thurmond as S. 104, a bill to amend the Omnibus Crime Control and Safe Streets Act of 1968. The bill made it unlawful for any person to manufacture or import armor-piercing ammunition. The language of S. 104 was included in Congressman Biaggi's H.R. 3121, the Law Enforcement Officers' Protection Act of 1985. It passed the Senate by a vote of 97-1 on March 6, 1986. President Reagan signed H.R. 3121 into law on August 8, 1986. (99th Congress)
- November 16, 1993: Senator Moynihan introduced S. 1659, the Law Enforcement Officers Protection Act of 1985, Amendment. The bill would amend the Law Enforcement Officers Protection Act of 1985 to include the M39B and similar armor-piercing rounds constructed with a thick steel jacket surrounding a lead core.
- November 19, 1993: Senator Moynihan offered an amendment to S. 1607, the Violent Crime Control and Law Enforcement Act of 1993, to update the definition of armor-piercing ammunition to include thick-steel jacketed ammunition, such as the Swedish M39B. The amendment was agreed to by unanimous consent, and the Senate passed S. 1607 on November 19, 1993. (S. 1609 is currently in conference.)

BULLET BAN

- October 16, 1986: Senator Moynihan introduced S. 2929, the Violent Crime Prevention Act to prohibit manufacture, transfer, and importation of .25 and .32 caliber bullets. (99th Congress)
- January 6, 1987: Senator Moynihan introduced the Violent Crime Prevention Act as S. 25. (100th Congress)
- January 25, 1989: Senator Moynihan introduced the Violent Crime Prevention Act as S. 229. (101st Congress)

- January 14, 1991: Senator Moynihan introduced S. 51, the Violent Crime Prevention Act to prohibit manufacture, transfer, and importation of .25, .32 and 9 mm bullets. (102nd Congress)
- January 21, 1993: Senator Moynihan introduced the Violent Crime Prevention Act as S. 178. (103rd Congress)

BULLET TAX

- October 8, 1992: Senator Moynihan introduced S. 3373 to tax .25, .32 and 9 mm bullets at 1,000 percent. (102nd Congress)
- January 21, 1993: Senator Moynihan introduced S. 179, the Real Cost of Ammunition Act, to tax .25, .32 and 9 mm bullets at 1,000 percent. (103rd Congress)
- November 3, 1993: Senator Moynihan introduced S. 1616, the Real Cost of Handgun Ammunition Act, to tax handgun ammunition, except for .22 caliber rim fire ammunition, at 50 percent. It would also impose a 10,000 percent tax on the Winchester 9-millimeter hollow tipped "Black Talon" bullet and all .50 caliber bullets and would impose a \$10,000 occupational tax on manufacturers and importers of handgun ammunition. (103rd Congress)
- November 22, 1993: Winchester Ammunition announced that it would withdraw the sale of Black Talon handgun ammunition to the general public.

FEDERAL FIREARMS LOOPHOLE

- May 23, 1991: Senator Moynihan introduced S. 1154 to require that persons comply with State and local firearms licensing laws before receiving a Federal license to deal in firearms. (102nd Congress)
- January 21, 1993: Senator Moynihan introduced S. 1154 as S. 113. (103rd Congress)

RECORD KEEPING

- November 25, 1991: Senator Moynihan introduced S. 2048 to require keeping of records with respect to the disposition of ammunition, and to require a study on the use and possible regulation of sales of ammunition. (102nd Congress)

- January 21, 1993: Senator Moynihan introduced S. 2048 as S. 109. (103rd Congress)

BULLET INFORMATION COLLECTION

- October 8, 1992: Senator Moynihan introduced S. 3373, the Bullet Death, Injury, and Family Dissolution Control Act to require HHS to collect and disseminate information on bullet-related violence; to tax at 1,000 percent 9 millimeter, .25, and .32 caliber bullets; and to develop recommendations to reduce and eliminate bullet-related violence. (102nd Congress)
- January 21, 1993: Senator Moynihan introduced S. 32, the Violent Crime Control Act to set up a Bullet Death and Injury Control Program within the Centers for Disease Control's National Center for Injury Prevention and Control; to tax at 1,000 percent 9 millimeter, .25, and .32 caliber bullets; to require record keeping with respect to the disposition of ammunition; and to require that persons comply with State and local firearms licensing laws before receiving a Federal license to deal in firearms. (103rd Congress)

SEMI-AUTOMATIC ASSAULT WEAPONS IMPORTATION

- April 7, 1989: Senator Moynihan introduced S. 733, the Assault Weapon Import Control Act of 1989 to prohibit the importation of semiautomatic assault weapons, large capacity ammunition feeding devices, and certain accessories. (101st Congress)
- April 9, 1991: Senator Moynihan introduced S. 733 as S. 789. (102nd Congress)
- January 21, 1993: Senator Moynihan introduced S. 789 as S. 108. (103rd Congress)

Guns Don't Kill People. Bullets Do.

By Daniel Patrick Moynihan

The suspect in the Long Island Rail Road shootings is said to have obtained the murder weapon, a 9-millimeter semiautomatic pistol, through a formal licensing process with a 15-day waiting period. That fails did nothing to prevent the slaughter should make us think.

As we do, it might help to go back to the early 60's, when we were trying to cope with what was then called the slaughter on the highways — the deaths and injuries from automobile crashes at a time when, rather suddenly, nearly everybody had a car.

No one knew how to think about the subject, save in terms of regulating and punishing the behavior of miscreants. On Dec. 20, 1960, The New York Times carried an editorial titled "Wild Men on the Roads." It began: "It is generally agreed that a lunatic fringe of dangerous drivers is responsible for the vast majority of traffic accidents. It is equally true that New York State's weak driver licensing

procedures make it almost impossible to keep these killer motorists off the road."

But in 1959 there had been 10.2 million automobile accidents, involving 18 million drivers. What was the use of calling them a "lunatic fringe"? Automobile collisions are a function of density — predictable events in a comprehensible system. The answer was to prevent crashes from having consequences, through passive measures like seat belts and highway dividers. And since we initiated this epidemiological approach, highway fatalities have gone down every year.

We need to approach handgun violence in the same way. This is not to deny that we are dealing, as the former Education Secretary William J. Bennett contends, with a crisis of values. But my business is government, and I don't know what government can do about values.

What I do know is that Police Commissioner Raymond Kelly estimates that there are as many as 1.7 million handguns in New York City (about the same as the number of automobiles). This is a two-century supply of handguns. By contrast, the city has no more than a three-year supply of ammunition.

"So far this year, 542 New Yorkers have been killed by stray bullets. And

in the past few days, two young women were shot in their pregnant bellies." A. M. Rosenthal wrote that on this page last Tuesday, the day of the Long Island shooting. By Thursday there were 11 more homicides. If we are to stop it, or come anywhere close, we have to get hold of the ammunition.

Tax ammunition until it's out of sight.

On Nov. 3, I introduced a bill that would levy a 10,000 percent tax on Winchester hollow-tipped "Black Talon" bullets, specifically designed to rip flesh. (Colin Ferguson, the suspect in the Long Island shootings, had some 40 of them.)

The tax would effectively raise the price of Black Talons from \$20 a box to \$2,000. On Nov. 22, 19 days after my bill was introduced, Winchester announced that it would cease sale of Black Talons to the public. Which suggests that the munitions manufacturers are more responsive than the

automobile companies were a generation ago. It is also important to note that in 1986 Congress banned the Telex-coated "cop killer" bullet, which penetrates police body armor. The Swedes are now making a new kind of armorpiercing round. We got that banned in the Senate version of this year's crime bill without a murmur.

It wasn't so long ago that the case for safety design in automobiles seemed hopeless. Bullet control has seemed equally quixotic, yet of a sudden the idea is getting through. The same may be said of the idea of licensing handgun ownership, suggested by President Clinton, Mayor-elect Giuliani and others. Drivers' licenses were a way of raising revenue in the first instance, but in time became a mode of instruction and regulation as well. Why not?

In the same way, the Federal Government needs to establish, and run, establish, a full-fledged regime of bullet control. This need be no threat to the sportsman; we are talking about handguns.

We need to ban some rounds, tax others, keep records, scrutinize licenses to manufacture. The Bureau of Alcohol, Tobacco and Firearms needs to come alive. The alternative is more death. Not just of pregnant young women, but, well, of our city. ¶

Daniel Patrick Moynihan, Democrat of New York, is chairman of the Senate Finance Committee.

ANNOUNCEMENT

February 1994

IMMEDIATE RELEASE

NEW EXECUTIVE DIRECTOR AT KINGS COUNTY HOSPITAL CENTER

Kings County Hospital Center in Brooklyn, New York, the largest municipal hospital in the New York City Health and Hospitals Corporation, and one of the busiest Level One Trauma Centers in the country, has a new Executive Director. Mr. Ed Larkins, moved into the position of Executive Director at the 1,210 bed hospital in September 1993. He joins Kings County Hospital Center after serving as the Chief Operating Officer at St. Louis Regional Medical Center, in St. Louis, Missouri.

A graduate of Wayne State University, and the University of Michigan where he earned his Masters in Business Administration and Masters in Hospital Administration respectively. With over 20 years of experience in health care, Mr. Larkins assumes his new position with a solid hospital administration background. He is a National Association of Public Hospitals Fellow, and maintains memberships in both the American College of Health Care Executives and the National Association of Health Care Executives.

Mr. Larkins takes the helm of this large institution as it is negotiating and finalizing a multi-million dollar affiliation agreement with its academic affiliate, State University of New York (SUNY) Health Science Center at Brooklyn, and undergoing an almost \$ONE BILLION reconstruction project to include the demolition, reconstruction and renovation of its 24 buildings and 44 acres of land, located in the heart of central Brooklyn.

Curriculum Vitae

Winter 1994

Edward Fishkin M.D.
176 Seeley St. Apt. 6B
Brooklyn, New York 11218

Telephone: Home: (718) 633-3038
Office: (718) 245-3980

BOARD CERTIFICATION:

American Board of Internal Medicine 1983 #81223

APPOINTMENTS

ACADEMIC:

1993-Present
Associate Professor of Medicine
SUNY Health Science Center at Brooklyn

HOSPITAL:

January 1992-Present
Associate Medical Director
Kings County Hospital Center, Brooklyn, New York

September 1989-December 1991
Chief, Dept. Emergency Medicine (acting)
Kings County Hospital Center, Brooklyn, New York

July 1987 - March 1991
Chief, Ambulatory Care
Kings County Hospital Center

June, 1984 - June, 1987
Director, Medical Clinic and Primary Care Services
Kings County Hospital Center

July, 1982 - May 1984
Associate Director, Medical Clinic
Kings County Hospital Center

EDUCATION:

SUNY Stony Brook, B.S. cum laude 1973

SUNY Downstate Medical Center, M.D. 1978

POSTGRADUATE

TRAINING:

July, 1978 - June, 1979 Internship in Internal Medicine
SUNY HSC Brooklyn, Kings County Hospital, Brooklyn V.A.

July, 1979 - June 1981 Residency in Internal Medicine
SUNY HSC Brooklyn, Kings County Hospital, Brooklyn V.A.

June, 1981 - May 1982 Chief Residency, Internal Medicine
SUNY HSC Brooklyn, Kings County Hospital Center

LICENSURE: State of New York, License Number: 149225

PROFESSIONAL American College of Physicians: 1983 - Present

MEMBERSHIPS:

Society of Urban Physicians: 1988 - 1992

Society of General Internal Medicine 1986 - Present

International Physicians for the Prevention of Nuclear War
1987 - present

COMMITTEE March 1992 - Present

MEMBERSHIPS: Quality Council: Chairman
Kings County Hospital

January 1992 - Present
Council to the President of the Medical Board
Kings County Hospital Center

1988 - Present
Medical Board
Kings County Hospital Center

April 1992 - Present
Medical School Admissions Committee
SUNY Health Science Center at Brooklyn

March 1992 - Present
Institutional Review Board
SUNY Health Science Center at Brooklyn

May 1991 - Present
Chairman, Health Site Committee
American Heart Association, N.Y.C. Affiliate

1990 - 1991
911 Committee of Emergency Medical Services

1989 - 1991

Vice President, Professional Staff
Kings County Hospital Center, Brooklyn, New York

1989-1992

Clinical Care Review Committee
Kings County Hospital Center

1989 - Present

Hospital Information System Task Force
New York City Health and Hospitals Corporation

1989 - 1991

AIDS Committee
Kings County Hospital Center

1988-1989

Chairman, Physician Assistants' Committee
Kings County Hospital Center, Brooklyn, New York

1988 - 1991

Chairman, Clinic Director's Committee
Kings County Hospital Center

1988-1991

Chairman, Ambulatory Care Committee
Kings County Hospital Center, Brooklyn, New York

1988 - 1989

Secretary/Treasurer
Society of Urban Physicians

1988 - 1989

Chairman, Task Force for a Smoke Free Kings County Hospital

1988 - 1991

Chairman, Asthma Committee
Kings County Hospital Center

1988 - 1991

Cancer Committee
Kings County Hospital Center

RESEARCH and PUBLICATIONS:

R. Sinert D.O., M. Akerman M.D., E. Fishkin M.D., Continuous Quality Improvement approach applied to Emergency Department care of asthma patients, submitted for publication, July, 1993

M. Akerman M.D., R. Sinert D.O., E. Fishkin M.D. Recurrent emergency room visits for asthma therapy reduced by steroid treatment. Abstract accepted for presentation, American College of Chest Physicians, Nov. 4 - 8, 1991

H. Lebovitz M.D., E. Fishkin M.D., E. Lewis, R.D.: Inner city populations and diabetes mellitus: the interface of society, culture and medicine; City Medicine, 2;(1):4-7, 1988.

Evaluation of the blood pressure response to exercise to predict future development of hypertension in normotensive teenagers at elevated risk: 1986 - 1990

Evaluation of the effects of aerobic fitness training on the control of hypertension and Type II diabetes mellitus: 1985 - 1990

Collaborator in a multi-center registry for the epidemiologic study of hypertension in diabetes mellitus: 1985 - 1988.

Effects of a Colon Cancer Screening program in a large, urban teaching hospital: Current

Effects of intensive interdisciplinary clinical care to prevent blindness and amputations in adult diabetics: 1988 - 1991

Atropine sulfate by inhalation in the treatment of asthma: 1982.

GRANTS AWARDED

Hypertension, Education and Management Program: by N.Y. State Department of Health, Bureau of Chronic Disease Prevention, 1983 - 1990. Total funding: \$300,000.

Diabetes Demonstration Project/Diabetes - Hypertension National Registry: National Centers for Disease Control, Atlanta, GA in collaboration with N.Y.S. Department of Health, 1983 - 1990. Total funding: \$150,000.

New Needs Grant for Outpatient Health Care Delivery: New York City Health and Hospitals Corporation, 1984. Total funding: \$203,000

Letters22.CV94.doc

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The New York Times

August 21, 1991, Wednesday, Late Edition - Final
Correction Appended

SECTION: Section B; Page 1; Column 5; Metropolitan Desk

LENGTH: 1714 words

HEADLINE: A Boy's Death Ignites Clashes in Crown Heights

BYLINE: By JOHN KIFNER

BODY:

Hasidim and blacks clashed in the Crown Heights section of Brooklyn through the day and into the night yesterday as the two communities, separately and bitterly, each mourned a member killed, one in a traffic accident on Monday night and the other stabbed in the racial melee that followed.

Bottles, rocks and ethnic slurs were hurled as hundreds of police officers struggled to separate the screaming, taunting groups near the headquarters of the Lubavitcher sect, at 770 Eastern Parkway.

As darkness fell, about 500 blacks, mostly young teen-agers, gathered at the intersection of President Street and Utica Avenue, where the accident had occurred and where the dead child had lived. They, set afire at least three vehicles, one a police car, hurled rocks at houses owned by Jews and looted a sneaker store. Five reporters and photographers were beaten, two by police officers and three by black protesters.

Collision and a Clash

The Dinkins administration voiced fears that the turmoil in a neighborhood where there has long been friction between blacks and the tightly-knit, Orthodox Lubavitcher community could worsen the city's already tense racial atmosphere.

The trouble began on Monday night when a car driven by a Hasidic man jumped a sidewalk and killed a 7-year-old black boy, Gavin Cato, and critically injured his cousin of the same age, Angela Cato. Word of the crash spread throughout the central Brooklyn neighborhood and brought out hundreds of blacks, mostly teen-agers, who surrounded the scene, some throwing bottles and jeering the police. As some angry youths roamed the neighborhood, a Jewish student from Australia, Yankel Rosenbaum, 29, was stabbed. He died in a hospital yesterday morning, and two teen-agers were arrested in the killing.

'Our Streets!'

The confrontations were fueled by rumors that the Hasidim involved in the car accident were given medical attention before the black children.

Last evening, the crowd of mostly young blacks at Utica Avenue and President Street were chanting, "Whose streets? Our streets!"

There were scattered clashes in the surrounding streets, with blacks and Hasidim throwing bottles and rocks at each other, and both sides tussling with the police. At the corner of Utica and President, black protesters surrounded an empty police car, stripped it and flipped it over.

Rocks Thrown at Homes

Young black men threw rocks at three homes along a block of President Street that black neighbors said belonged to Jews.

Gregory Seabrook, who lives next door to one of the houses, said the trouble had long been brewing, but "this is the worst I've seen.

"People are feeling that there is just no justice," he said. "They look to the St. John's rape case and they look to this."

A woman who answered the phone at one of the houses on President Street said her family was afraid to leave.

"They broke my windows and they are yelling," said the woman, who declined to be identified. "We are staying home and we don't go out. We hope it will be finished soon.

"The Jewish people are afraid to walk on the streets," added the woman, who said she had called the police to no avail. "Accidents happen and we are very sorry for the boy who died, but the whole community is not at fault."

In another of the houses, a man who answered the phone said: "We haven't gone out since last night.

"All you hear is shouting and screaming, thudding and glass breaking," the man said. "You hear the sirens, the police. It's pandemonium. It's very scary. Oh, I just heard some more glass breaking. What's going on? When's it going to end?"

Sneaker Store Looted

By around 9:30 P.M., many of the black youths had turned to looting. With at least 100 people looking on, a group of young men with pipes and sticks pried open the security gate

of the Sneaker King on Utica Avenue at Union Street. A cheer rose as they broke through the gates, entered the store and ran off with armfuls of sneakers and jogging suits.

A few blocks north, near Eastern Parkway, a fire broke out at about the sametime at the Utica Gold Exchange jewelry store. An ornate security gate had been pried open and looters began taking goods away. Dense smoke poured first from the store, then from the two stories above it.

Other stores along Utica were being hit and there were several fires. At onepoint a van in front of the victim's family's apartment house was torched and set the car next to it on fire. The police tried to hold a static position in the middle of Utica, but as they would march toward the crowd they would be met with flying bottles and bricks, driving them back in formation.

The police reported at least 14 arrests by 10 P.M. and said at least a dozenpolice had been injured by flying rocks or bottles. One officer was seen bleeding profusely after being struck in the face with a bottle.

By 12:30 A.M. today, the neighborhood was mostly quiet except for some"roving bands of looters," said Deputy Inspector Edward F. Loesch.

Earlier yesterday, uniformed city policemen in riot gear were seen beatingat least two news photographers as they attempted to photograph the clashes. One was identified as Viorel Florescu of New York Newsday; the second was Chris Griffith of the Amsterdam News, who was charged with assault. He was treated for minor injuries at Caledonian Hospital.

A black crowd chased two television journalists from WABC-TV down UticaAvenue, cornering them outside a store, where the crowd kicked and punched them.

Edward Keating, a photographer for The New York Times, was attacked by acrowd of youths and beaten. He was being treated at Kings County Hospital last night.

Mayor David N. Dinkins went to Crown Heights on Monday night and stayedseveral hours. His senior advisers said the violence had deeply upset him.

They viewed the case as especially troubling and dangerous in a neighborhoodwith a long history of black-Jewish feuding because it was the first involving deaths. If, as it appeared, the stabbing turned out to be retaliation for the car accident, officials worried that it could start a tit-for-tat cycle that would be difficult to break.

"We are in a tense situation," Mayor Dinkins told reporters at City Hall yesterday. "It's painful."

At Public School 167 on Eastern Parkway yesterday, Deputy Mayor Bill Lynchspent two and a half hours listening to complaints from about 60 residents of the community, most of them black but also including about a half dozen Hasidic Jews.

Much of the discussion was devoted to complaints from the blacks that the Hasidic community received preferential treatment from the police in the 71st Precinct. The complaints mirrored similar criticism in the Williamsburg section, where Hispanic residents have charged that the police have favored the Satmar Hasidic sect at the expense of Hispanic residents.

Returning From Cemetery

Police Commissioner Lee P. Brown, acknowledging that he was looking into complaints that Hasidic Jews were afforded preferential treatment in the two precincts, said that "I think that what you have here is years and years of tension in the area and there is still that mistrust that exists there."

Those tensions spilled over Monday night as the Lubavitcher Grand Rebbe Menachem Schneerson was returning from his regular weekly visit to the grave of his wife at Montefiore Cemetery, accompanied by the unmarked police car normally sent along with him as both a courtesy and a security measure.

Also accompanying the Rebbe was a dark blue station wagon driven by one of the Rebbe's followers, Yoseph Lisef, 22 years old. In the car, too, were twin brothers, Yakov and Levi Spielman, who were training Mr. Lisef in escort duty.

Children Pinned Against Grate

The station wagon fell behind the convoy and, according to witnesses, ran a red light at the corner of President Street and Utica Avenue and struck another car, sending it skidding onto the sidewalk about 8:20 P.M.

Playing there near their apartment at 1677 President Street were Gavin and Angela Cato. The station wagon plowed into them, pinning them against a steel grate, killing Gavin Cato, the police said. Angela Cato was taken to Kings County Hospital, where she was listed in serious condition.

Then, in what proved to be a critical turn, both a city Emergency Medical Service ambulance and a private ambulance operated by the Hasidim arrived on the scene as an angry crowd of blacks gathered from the busy intersection and nearby West Indian restaurants and pizza stands.

The police, the Hasidim and black witnesses all said that youths in the crowd attacked the driver of the station wagon and the crew of the Hasidic ambulance.

Police Commissioner Brown, reconstructing the incident for reporters yesterday, said that the police had told the Hasidic ambulance to get out "in the interests of preserving the peace there."

Passions in the crowd, now swollen by several hundred youths leaving anearby B. B. King concert, were further inflamed when they watched a police truck pull the wrecked station wagon away, leaving a pool of blood, said a black witness, Vaughn Stevens.

Floral Wreath and Bear

The bloodstain was marked yesterday by a floral wreath decorated with atiny blue teddy bear with a sign saying "hug me." A hand-lettered sign above it called for the "white Jew" involved in the accident to be brought to justice.

After the accident on Monday night, hundreds of black youths began runningthrough the streets, smashing windows, turning over at least one car, shouting "Jew! Jew!"

Racing along President Street, a group of black youths surrounded Mr.Rosenbaum, a visiting rabbinical students, and stabbed him at about 11:25 P.M., the police said. He died about an hour and a half later at Kings County Hospital. Commissioner Brown told reporters the death appeared to be in retaliation for the rumors on the street that the Hasidic ambulance had not tended the injured black children.

Arrested for the stabbing of Mr. Rosenbaum, but not yet charged thisevening, was Limerick Nelson, 16 years old, and a 15-year-old male who was not identified because of his age.

CORRECTION-DATE: August 27, 1991

CORRECTION:

Articles on Wednesday, Thursday and Friday about a traffic accident in Crown Heights, Brooklyn, in which a 7-year-old child was killed included an incorrect spelling of the driver's name supplied by the police. He is Yosef Lifsh.

GRAPHIC: Photos: A police officer scuffling with a Hasidic man yesterday on President Street in the Crown Heights section of Brooklyn at the scene of a fatal car accident. Scores of officers surrounded the area as clashes ensued between Hasidic Jews and blacks.; Police officers taking a black man into custody at the scene yesterday in Crown Heights. Word of the crash had brought out hundreds of blacks, mostly teen-agers, who surrounded the scene, some throwing bottles and jeering the police. (Photographs by Angel Franco/The New York Times) (pg. B1); Edward Keating, a freelance photographer who was working for The New York Times, was attacked by a crowd of youths in the Crown Heights section of Brooklyn. Transit Officers Robert Lewis, left, and Michael Mulvihill came to Mr. Keating's aid and took him to the hospital. (Keith Meyers/The New York Times); Hasidic Jews who demonstrated near accident site were surrounded by police officers. Later, Hasidic Jews and blacks clashed in the area. (Steve Hart for The New York Times); Police officers and blacks on the verge of confrontation yesterday in the Crown Heights section of Brooklyn. (Angel Franco/The New York Times) (pg. B4)

Table: "Crown Heights"

Kingston Avenue, just below Eastern Parkway: Blacks and Hasidim clash with bottle and

bricks.

Kingston Avenue and Union Street: where the police say two black youths fatally stabbed Yankel Rosenbaum at 11:25 P.M. Monday. Troy Avenue and Eastern Parkway: a police car was firebombed at 3:15 A.M. Monday. President Street between Schenectady and Utica: Rocks thrown at Jewish homes. Utica Avenue and President Street: where a child was hit by car driven by a Hasidic man Monday night. Focal point of black protesters. The Rev. Al Sharpton led a group of hundreds of demonstrators and called for the arrest of the driver. Utica Avenue between Eastern Parkway and President Street: A commercial street, where hundreds of blacks gathered. Some looting and burning occurred. (pg. B4)

Map of Crown Heights section of Brooklyn (pg. B4)

LANGUAGE: ENGLISH

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HEADLINE: Judge Blocks Bid to Release Crown Heights Testimony

BYLINE: By ANDREW L. YARROW

BODY:

A state judge yesterday rejected arguments by the Brooklyn District Attorney to have the minutes of a grand jury investigation into the death of 7-year-old Gavin Cato in Crown Heights released, saying to do so would not help ease racial tensions.

The judge, Theodore Jones of State Supreme Court in Brooklyn, added that the release of the minutes would also subject the grand jury to unnecessary second guessing.

In making his decision, Justice Jones rejected arguments by the District Attorney, Charles J. Hynes, and Mayor David N. Dinkins, who said that releasing the grand jury minutes would help ease racial tensions in Crown Heights, where a 29-year-old Hasidic student, Yankel Rosenbaum, was fatally stabbed, and several hundred blacks, Hasidic Jews and police officers were injured during several days of violence after Gavin Cato's death on Aug. 19.

"Instead of calming the community, the release of the minutes would inflame it while at the same time subjecting both the innocent accused and the grand jury to be 'second guessed,' " Justice Jones wrote in a six-page decision. "A grand jury's decision, taken after extensive deliberation, should not be the subject of a referendum."

Appeal Is Planned

Mr. Hynes, who said he was disappointed by the decision, said he planned to seek an appeal.

In his written decision, Justice Jones said that while there have been precedents for releasing grand jury minutes, Mr. Hynes had "not established a requisite compelling need to offset the obligation for the protection of an innocent accused."

Referring specifically to Crown Heights, he added said if the testimony were released, "each faction would, most likely, selectively interpret various items of testimony to support or disparage the vote of the grand jury not to indict."

Helman Brook, a deputy district attorney and one of three lawyers from Mr. Hynes's office handling the matter, said Mr. Hynes would still seek to have the 800-page transcript of the grand jury proceedings released. Mr. Brook argued that the roots of the racial tensions remained in Crown Heights, despite the passage of time.

Leaders of the Lubavitch Hasidic sect were also disappointed with the decision, saying that the release of the grand jury minutes would have convinced much of the public that the crash was an unintentional accident.

But Rabbi Shmuel Butman, a spokesman for the Crown Heights Jewish Community Council, said that while the Hasidim would have liked to have the testimony released, "we understand the judge's position for not releasing the minutes because this is clearly a question of safety for 33 witnesses and the grand jurors."

Mr. Hynes had called for release of the minutes on Sept. 5 after a grand jury found no basis for criminal charges against Yosef Lifsh, a Hasidic Jew whose car struck and killed Gavin Cato and injured his 7-year-old cousin, Angela. Mr. Hynes had contacted 32 of the 33 witnesses who testified before the grand jury to ask if they would agree to have their testimony released, and all but 7 were opposed to the idea.

Support for Secrecy

Among those opposed were 11 police officers. Their lawyer, Joseph M. Librie of the Patrolmen's Benevolent Association, asserted that secrecy and confidentiality in grand jury proceedings were "necessary to insure the independence of the grand jury system."

But Norman Siegel, executive director of the New York Civil Liberties Union, who had filed a brief in support of the District Attorney's efforts, said he would again file a friend-of-the-court brief.

"This is just round one in what could be a four-round dispute," he said, referring to the potential number of appeals that could be filed. "The public has the right to know, and this action will increase cynicism on the streets. Secrecy only breeds distrust of the system."

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HEADLINE: Attorney General Reno booed in New York

BYLINE: BY JOHN DeSANTIS

DATELINE: NEW YORK

BODY: Critics of Attorney General Janet Reno turned a Manhattan town hall meeting into a raucous crowd Monday night after the brother of a rabbinical student slain in the 1991 Crown Heights riots, said he was snubbed during the visit.

Norman Rosenbaum said he was not satisfied with Reno's investigation to determine whether federal civil rights charges should be filed in connection with the stabbing death of his brother, Yankel Rosenbaum in the Crown Heights incident.

Reno was invited by Rep. Carolyn Maloney, D-Manhattan, to the meeting at Congregation Kehilath Jeshurun, where members of the Jewish Actional Alliance hung a banner reading, "To Janet, our Valentine: Resign."

Reno drew applause while fielding questions about crime and violence. She called for support of the anti-crime legislation now in Congress and backed the idea of boot-camp style incarceration for first offenders.

But her call for a ban on assault weapons drew a ripple of boos from the 1,500 people in attendance.

The boos grew to a raucous chorus when the inflammatory subject of Crown Heights was raised.

Yehuda Kaploun, Yankel Rosenbaum's former roommate, asked whether former New York Mayor David Dinkins and federal drug czar Lee Brown -- police commissioner during the rioting -- would be investigated for their role in allowing the riots to continue for three days.

"It really is inappropriate for me to comment on a pending investigation," she said. Reno added, however, "If you would like to be a little bit quieter, I will invite you at the conclusion to meet with me."

Crown Heights was not the only thorny subject, as some activists also peppered her with demands for leniency toward Jonathan Pollard, jailed for selling U.S. military secrets to Israel.

"I am currently reviewing that matter now and trying to address every issue that has been raised," Reno said.

When one activist said White House ties to Dinkins and Brown made a special prosecutor necessary for the Crown Heights inquiry, Reno's rejection of the idea again spurred a raucous response.

At the end of the stormy two-hour session, federal agents hustled Reno out of the building.

Norman Rosenbaum said after the meeting that since Reno, who met with him Oct. 28, took the Crown Heights case she has ignored his requests for a second meeting.

"I was invited to attend (Monday) and she refused to speak with me. Snubbed would be an appropriate term," he said. "I have absolutely no faith whatsoever in the investigation of the pogrom that took my brother's life."

LANGUAGE: ENGLISH

LOAD-DATE-MDC: February 15, 1994



The Report of Stanley H. Lowell
Special Counsel to the
Health and Hospitals Corporation
of New York

New York, New York
November 1, 1991

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PRELIMINARY STATEMENT

On September 30, 1991, I was appointed Special Counsel to the Health and Hospitals Corporation at the request of the Mayor and by the authority of the Board. I was asked to make a Report to the Mayor and the Board within thirty days on certain questions concerning Kings County Hospital Center ("Kings County") and HHC that arose after the death of Yankel Rosenbaum at Kings County of August 20, 1991.

This is that Report. It is a pro bono effort by me and as such a labor of love -- for the City, its people, and Mayor David N. Dinkins, whose devotion to his responsibilities is without bounds.

I worked with a staff of four attorneys from the City Corporation Counsel's office, Marjorie Landa, Gail Rubin, Michael Aurette and Elizabeth Smith, all of us without any prior knowledge of the subject matter, without preconceived ideas, without any agenda and with open minds. We reached out and interviewed more than 50 individuals in the short period of time available to us. They came from the community which is served by Kings County, from the hospital itself, from the State University of New York Health Science Center at Brooklyn ("Downstate"), from the ranks of present and prior officials of HHC, and from top officials of the State Department of Health. We also spoke

in depth with knowledgeable individuals from the voluntary hospitals throughout the City.

Each person to whom we spoke sought to be helpful and informative, was open and frank, and gave unstintingly of his or her time.

We worked intensively to bring our Report in within the time limit set for us. Nevertheless, after ten days, it became apparent that the issues raised were broader than what may have occurred at Kings County. I advised the Mayor that he should appoint a blue ribbon panel which would be representative not only of the medical profession, but which would be truly representative of the total community. I hope that the Mayor's Panel will base its recommendations on a re-examination of health and hospital care in New York City, and will not be limited by present methods and past history.

Officially, I want to thank the four attorneys I mentioned above, as well as Christine Lupo and Rafael Rodriguez, each a dedicated employee of the City of New York, for their conscientious help and support in preparing this Report. I also express my appreciation to Regina Morris of the Mayor's Operations Office. It was a tough 30

days, including nights and weekends. Although the responsibility for the contents of the Report is solely mine, without each of them it could not have been done.

Dated: New York, New York
November 1, 1991

Respectfully submitted,

Stanley H. Lowell
Special Counsel to the
Health and Hospitals Corporation

INTRODUCTION

I have been asked to answer certain questions arising out of the death of Yankel Rosenbaum at Kings County on August 25, 1991 and to report back within 30 days. This is too short a time to answer completely all of the issues raised during my investigation. However, with the time constraints imposed on me, I have attempted to answer the questions asked and to highlight those areas which I believe warrant further inquiry.

I have recommended that the Mayor appoint a panel to conduct a full inquiry into these larger issues as they affect Kings County, the other MHC hospitals, and non-municipal hospitals in New York City as well. I hope that the Mayor's Panel will be able to address these broader health care issues which, by necessity, cannot be included in this Report.

The situation at Kings County cannot be understood without understanding the larger context of the provision of health care within the United States. Yankel Rosenbaum's care was affected not only by what occurred at Kings County, but by systemic problems in the delivery of health care in New York City and throughout the nation.

First and foremost is the inadequacy of the American health care system. Although it has been stated again and again, Washington has done nothing to ease the problem. Universal Health Care bills have been introduced

in the Congress for years, eleven or more are pending in this session, but the Administration has no health care policy and the Congress has not come to grips with the varying solutions that are presented. Sadly, health care is not considered a prime concern in the richest country in the world.

The growing population of uninsured and underinsured is a national problem of enormous proportions and is reflected in the burden the HHC must carry. Millions of poor and uninsured in New York City and across the country flood into emergency rooms like Kings County's to obtain essential, but not necessarily emergency care. However, primary care is not and should not be the responsibility of emergency rooms. They are not set up to provide basic health care and their efforts to do so divert much needed resources from true emergency care and reduce the quality of care provided.

Second, there is an inherent tension between the medical schools and voluntary medical centers which supply medical staff to hospitals and the hospitals themselves. Although they may overlap, the mission of the teaching institutions, to educate medical students and post-graduate trainees, is distinct from that of the hospitals, which are basically concerned with patient care. These tensions affect all hospitals, public or private, which have any relationship to medical schools or voluntary medical

centers. While I believe that these missions may be reconciled, I feel that the divergence between them is a reality that may affect patient care, unless resolved.

The issue is at what point should training of new doctors be subordinated to the needs of the patient? Should those who have just graduated from four years of medical school, but are still training as residents, provide unsupervised treatment of patients when they do not have the experience and "wisdom" of an attending physician? Are these residents functioning with the level of supervision required by the letter and the spirit of the New York State Department of Health regulations promulgated in Part 405 ("the 405 regulations")? Are resources being diverted from basic patient care into more esoteric equipment or procedures, because they provide a better training experience for the residents and medical students?

I believe that the problems faced by Kings County can be understood only when they are placed in the context of these broader health care issues. Notwithstanding this, I endeavor in this Report to provide useful analysis and recommendations covering some of the immediate problems facing the hospital.

These problems are not of recent vintage, however, but in fact are long-standing and have affected care over many years. After visiting Kings County and Downstate, and after speaking with many people from the various groups

concerned with the hospital, I have concluded that action is required immediately.

Notwithstanding the problems identified herein, I wish to acknowledge the talent and dedication of the individuals I met who work at Kings County. While this Report is often very critical of circumstances which exist at Kings County, it is not intended to censure the highly-motivated and exceptional work performed by individual doctors, nurses and administrators at the hospital. I commend them, at the same time that I recommend resolution of the long-standing systemic problems facing the hospital.

In addition, it is important to note that the people who staff the emergency room are no different from other human beings, and so are subject to human error. While all of us seek perfection in critical health situations, we cannot always expect it to occur. This statement is not intended to excuse any error which may have occurred in connection with the tragic death of Yankel Rosenbaum. However, the best we can do is seek to create institutions which minimize the chance of such human error. I hope this Report contributes to that effort.

**ACCOUNTABILITY AND RESPONSIBILITY
BETWEEN KINGS COUNTY AND DOWNSTATE**

Underlying all of the issues examined in this Report is the question of Kings County's relationship to Downstate. Many of the problems at Kings County stem from its ambiguous relationship to Downstate and the resulting problems of accountability. The ultimate responsibility for certain hospital functions is not clearly assigned within either institution and even where people do have clear responsibilities, they often lack the power or authority to control those functions.

For historic reasons, Kings County and Downstate have a uniquely minimal formal affiliation relationship with one another. Whereas other HHC hospitals have entered into broader contractual "affiliation" agreements with medical schools or medical centers in order to satisfy all their medical service needs, only three services at Kings County have formal affiliation agreements with Downstate: psychiatry, radiology and radiation therapy. Yet Downstate plays a major role in the functioning of Kings County's other departments as well, without the benefit of a comprehensive contract that defines and allocates responsibility. As best we can determine, the arrangement at Kings County in departments other than those three covered by affiliation agreements, is as follows:

When there is an academic department at Downstate that corresponds to a clinical department at Kings County -- such as the Department of Surgery or the Department of Medicine -- the Downstate academic department chair generally serves as the chief of the corresponding department at Kings County, and is placed on both the Downstate and Kings County payrolls as an employee of both institutions. Most of the chairs/chiefs physically spend the major part of their time at the medical school where they are provided with an office and support staff. The chair/chief may also be the director of the residency program for that particular department.

The directors of service, on the other hand, basically run the departments at the hospital and spend most of their time at Kings County, which provides them with an office and support staff. The directors of service also have academic appointments at Downstate and are placed on the payrolls of both institutions. The chairs/chiefs and the directors of service are recruited jointly for their positions at Kings County and Downstate.

In addition, there are attending physicians who have academic appointments at Downstate and receive two paychecks, one from Kings County and one from Downstate. These attendings care for patients and supervise residents at Kings County. They may also have a private practice across the street at Downstate. The compensation for these

doctors comes from both institutions in an effort to provide competitive salaries and attract highly qualified people to these positions.

In addition, there are other attending physicians at Kings County who are employed solely by Kings County. These doctors care for patients in departments that are headed by and partially staffed by dual Kings County and Downstate appointees. Their wages, hours and conditions of employment are negotiated with HHC by the Doctors Council, a union which represents attending physicians on the HHC payroll. Their base salaries are significantly lower than those of their counterparts on two payrolls.

Downstate also provides residents to Kings County who may rotate through other hospitals as well. Surgery residents, for example, rotate through five hospitals in all, with each hospital placing some of the surgery residents on its payroll. As a result, Kings County pays the salary of particular residents even when those residents are not physically on the premises of Kings County, and residents who are working at Kings County might well be paid by another of the five hospitals. The multiple sources of residents' pay causes major differences in salary and benefits among participants in the same residency program.

Some of the relationships between Kings County and its doctors appear subject to separately negotiated memoranda of understanding with Downstate; some appear

subject to individual contracts for services; some are subject to union agreements. It appears that some parts of these relationships are subject to no written agreements at all.

The difficulties with this crazy-quilt staffing should be obvious. The individuals who receive two paychecks work for two institutions whose interests are not always identical. Without a formal comprehensive agreement between the two, there are minimal means of communication and no clear allocation of responsibility. Conflicts are resolved on an ad hoc basis because no one individual is completely in control.

For example, although Downstate department chairs are responsible for allocating residents to Kings County to cover patient needs, Kings County can create obvious problems for a residency program by cutting a supervising attending slot for budgetary reasons. Or, for example, although HHC and the Kings County administration are responsible for improving the organization of the emergency room, the director of a residency program can cause major difficulties by threatening to pull his or her residents out of the hospital if he or she disagrees with the new organization. These preceding examples do not even account for the often conflicting interests represented by a "third force" in the hospital, the Doctors Council, which is

necessarily concerned with organizational, staffing and health care issues that affect its union members.

CONCLUSION

It is beyond dispute that the present relationship between Kings County and Downstate has to change in order for the accountability problems to be effectively addressed. Imposing accountability is imperative in order to improve the quality of medical care at the hospital. No system can be expected to function properly when no one is given full responsibility for its operation or the tools necessary to enable it to operate.

Given the range of choices presently available to Kings County, my tentative recommendation is for a full affiliation with Downstate. I make this recommendation based on the belief that an immediate, fundamental change in Kings County's relationship to Downstate is essential to addressing the problems which have long plagued the hospital, and that a properly drafted affiliation agreement is the best of several imperfect choices for achieving this goal.

I make this recommendation with full awareness that the present affiliation agreements appear to favor the medical schools, and, in any event, are not fully enforced by HHC. However, this fact does not necessarily reflect negatively on the concept of affiliation. HHC must take a

stronger approach with respect to an affiliation agreement between Kings County and Downstate.

Specifically, in order to be effective and to address the unique situation at Kings County, any affiliation agreement with Downstate must be designed to eliminate the administrative chaos which exists at Kings County and establish clear lines of authority, responsibility and accountability. Most important, however, any affiliation between Kings County and Downstate must reconcile the disparate service and teaching missions of the two institutions.

Kings County must enter into an agreement with Downstate which insures the provision of quality health care to community residents, regardless of their ability to pay. Accordingly, such an affiliation agreement should contain economic incentives for doctors to provide the same care at Kings County as they do at Downstate and to admit patients to both institutions without regard to their ability to pay, thereby helping to eliminate the perceived disparity in treatment received by patients at Kings County and Downstate's University hospital.

An affiliation agreement drafted along the lines described above would address many of the problems discussed in this report. For example, Kings County would have difficulty eliminating a supervising attending slot for budgetary reasons; instead, the staffing levels would be

negotiated and fixed as part of the affiliation agreement. Similarly, the medical school would not be able to hold its residency program hostage if it disagreed with organizational changes, because the residency program would be part of the comprehensive affiliation agreement. Affiliation would also allow the hospital to continue to enhance salary levels to attract high quality physicians.

Full affiliation, however, is not without its problems. We are aware that the Doctors Council opposes it, as do many groups and individuals in the community served by Kings County, based, in part, on their fundamental mistrust of Downstate's interest in serving the community's needs. We recognize this opposition, but have concluded that full affiliation along the lines described above presents the best of all the possible choices at this time.

Alternatives to full affiliation with Downstate may have merit and are clearly worth exploring. However, none appear to be immediately viable. For example, it has been suggested that HHC explore setting up a "professional corporation" at Kings County, as it has done at Coney Island Hospital and Woodhull Hospital. Due to changes that have occurred since the first affiliation arrangements were entered into, it appears that a pool of qualified doctors who are not connected with medical schools may be available to work in hospitals. However, it is not at all clear that the P.C. model would work at an institution the size of

THE EMERGENCY ROOM AT KINGS COUNTY

The adult emergency room at Kings County is one of the busiest in the country. During the 1990 fiscal year, approximately 227,000 patients visited the emergency room. By comparison, the Bellevue Hospital emergency room sees approximately 83,000 patients per year, and the Harlem Hospital emergency room receives approximately 100,000 visits.

Approximately ninety percent of Kings County's inpatients are admitted through the emergency room. Yet, the administrative structure of Kings County's adult emergency room' ("emergency room") is a microcosm of the administrative disorganization and lack of accountability in the hospital as a whole. Historically, multiple medical departments have staffed the emergency room and engaged in "turf battles" with one another over its operation. These battles have inevitably had an impact on patient care.

In 1988, the Department of Emergency Services was created to oversee the operation of the emergency room. It has no corresponding academic department at Downstate. The Kings County Department of Emergency Services is headed by a

¹Kings County actually has three separate emergency rooms: psychiatric, pediatric and adult. Our review is solely of the operation of the adult emergency room.

chief, assisted by two deputy directors, all of whom have dual appointments at Kings County and Downstate. The emergency room also has four associate medical directors solely employed by Kings County who report to the deputy directors and the chief. The associate medical directors have responsibility for general administration and oversight of patient care in the emergency room.

Direct patient care is provided in part by attending physicians, employed solely by Kings County, who are trained in internal medicine, OB/GYN, family medicine, surgery or emergency medicine. All of the attending physicians are members of the Doctors Council. In addition, residents training at Downstate in internal medicine and other areas provide direct patient care through rotations in the emergency room.

The Kings County emergency room, until recently, had been housed along a corridor of the hospital that was not originally designed to serve as an emergency room. By necessity, the emergency room was actually a conglomeration of different rooms: a treatment room for minor trauma; the OB/GYN room; the male and female rooms; the medical screening area for triage; and the critical care area (known as "C-1"). C-1 consisted of two rooms across a hall from one another, one for medical emergencies and the other for trauma. Each room could comfortably accommodate five to six beds, though there were often more beds crammed into the

rooms. Yankel Rosenbaum was treated in the trauma side of C-1.

There have been several problems with the Kings County emergency room that have resulted from its physical structure and departmental fragmentation. First, because the emergency room was housed in numerous separate rooms, different doctors were assigned to provide medical care in each. Therefore, if there were few patients in the asthma room, for example, but an overload of patients in the medicine side of C-1, it was difficult to shift around the medical staff because of the physical layout.

Second, it is unclear how well the C-1 trauma area was actually integrated into the Department of Emergency Services. The trauma side of C-1 was (and in its new location still is) staffed by a second year resident known as a "post-graduate year 2" or "PGY2" from the Department of Surgery. The Department of Surgery and the Department of Emergency Services appear to have differing views on who is "responsible" for the PGY2 in C-1. The Department of Surgery believes that the PGY2 is responsible to the Department of Emergency Services, most of whose attendings are trained in internal medicine. The Department of Emergency Services, however, views the trauma service as responsible for the PGY2 assigned to C-1 and itself merely as the "landlord" for the trauma service which operated out of C-1.

In practice, the surgical PGY2 assigned to C-1 appears to rely for help on the in-patient trauma team stationed in other parts of the hospital, as well as on additional back-up from the Department of Surgery, rather than on the attendings in the emergency room. Although the emergency room attendings who have received Advanced Trauma Life Support training would be competent to assist the PGY2 in the trauma area, it appears that as a practical matter, that rarely occurs.

A third problem in the emergency room is that patients sometimes experience difficulty getting admitted to a particular service in the hospital. One major reason for this problem is that the residents and attendings in the emergency room do not have "admitting privileges" to the hospital. This means that they cannot directly admit a patient into Kings County until the surgical, medical or another "in-patient" department allows them to be admitted.

Therefore, if, for example, a female patient enters the emergency room with severe abdominal pain, the emergency room attending might call a surgeon down, believing it to be appendicitis. The surgeon, however, may refuse to admit the patient, believing it to be a gynecological problem. The gynecologist might refuse to admit the patient believing it to be appendicitis. Since the emergency room attending cannot admit the patient on his or her own, the patient conceivably could wait in the

emergency room for hours until one department decides to take responsibility for the patient's care and authorize admission.

Kings County has been attempting to address these problems in a number of ways. First, in September, 1991, the emergency room was moved to a much improved physical location. C-1 now has a triage area, an isolation room, resuscitation rooms and space for 12 beds. The male/female rooms also have been integrated into a single space that allows for maximum physical flexibility for the beds as well as the staff.

Second, the Department of Emergency Services has been attempting to use the associate medical directors to settle disputes between services over which one should admit a patient. In addition, the hospital now has a Department of Medicine Treatment Team to ensure that admitted patients who must stay in the emergency room because of bed or staffing shortages get appropriate care.² There is also a

²Another reason the patient may sit in the emergency room for hours awaiting admission is if there is no available bed on a ward. Kings County operates under an archaic "ward" system with the majority of beds divided into surgical wards and medical wards. If the hypothetical stomach ailment patient above is diagnosed as having a medical condition, then the patient must be admitted to a medical ward. If there are no beds available in the medical ward, the patient must remain in the emergency room until one is free. This would be so even if there are available beds in the surgical wards.

program to decrease the patients' length of stay in the emergency room.

Third, Downstate and Kings County have agreed to establish an academic Department of Emergency Medicine at Downstate, and to reorganize the Kings County Department of Emergency Services into a Department of Emergency Medicine. The agreement envisions a residency program in emergency medicine which would train physicians to function across traditional departmental lines and stabilize all types of patients who come into the emergency room prior to their being treated in one of the hospital's in-patient departments. The agreement provides that the newly-appointed chair/chief of Emergency Medicine, who took charge of the emergency room on September 1, 1991, will recruit faculty and attending physicians trained in emergency medicine who will be able to supervise residents in the emergency room, including the trauma resident in C-1, and admit patients into any in-patient service at Kings County. That recruitment is underway. In the interim, the Department of Surgery has been offering Advanced Trauma Life Support training to attendings in the emergency room to enable them to function in a broader capacity. Fifty to sixty percent of the attendings have completed the course.

Fourth, approximately 18 months ago, Kings County opened an Urgent Care Center located approximately 200 feet from the emergency room, designed to treat patients who come

to the emergency room, but do not need emergency care in an acute setting. In the last year, the Urgent Care Center has treated approximately 60,000 patients, and reduced the number of visits to the emergency room by at least that amount. In addition, the Urgent Care Center has a program to redirect appropriate patients to neighborhood clinics and thereby further reduce the burden on the emergency room.

CONCLUSION

HHC and Kings County have taken steps in the right direction with the recent improvements in the physical and administrative structure of the emergency room. However, HHC and Kings County have been aware of the problems in the emergency room for years and it is disturbing that the problems remained unresolved for so long.

Kings County should continue its efforts to "decompress" the emergency room by encouraging use of the Urgent Care Center and the available Neighborhood Family Care Centers. I encourage HHC and Downstate to take a direct interest in expediting the establishment of the emergency medicine program and recruiting qualified staff. Only with full and strong support from HHC and Downstate will Kings County be able to effectively remedy the glaring problems in emergency care.

Finally, I note that Downstate's University Hospital does not presently have an emergency room of its own. While an emergency room at Downstate would help

alleviate the crush of emergency patients at Kings County, a solid commitment by Downstate to address the emergency room problems at Kings County might do just as well. The State Department of Health ("SDOH") should require Downstate to enhance its contribution to the Kings County emergency room or to open one of its own. The possibility of implementing a joint admissions program, whereby emergency room patients at Kings County would be admitted directly to University Hospital should also be explored.

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The New York Times

February 19, 1994, Saturday, Late Edition - Final

SECTION: Section 1; Page 1; Column 6; Metropolitan Desk

LENGTH: 1297 words

HEADLINE: REDESIGN PLANNED FOR CITY HOSPITAL SERVING BROOKLYN

BYLINE: By DAVID FIRESTONE

BODY:

Two weeks after Mayor Rudolph W. Giuliani declared a moratorium on the billion-dollar reconstruction of Kings County Hospital, his administration and state officials say they plan a thorough redesign of the project in order to produce a smaller, more efficient institution.

The call for a redesign of the city's largest public hospital, coming after a decade generally acknowledged to have been wasted on delay, mismanagement and poor planning, is certain to postpone the long-awaited project in East Flatbush even further.

Political and neighborhood leaders in central Brooklyn, who have pleaded for a new hospital through more than three decades and five different mayors and who sharply criticized Mr. Giuliani when he imposed the moratorium, say the new delay is unconscionable.

"It's outrageous that they've spent all this money to have an expert design it, and now they say it won't meet the needs of the next century," said Waldaba Stewart, an economist living in Crown Heights who is a member of the Kings County Hospital Community Advisory Board. "How long is it going to take for them to come up with the right hospital?" So far, \$43.6 million has been spent on planning and design.

A Design Too Old?

But the swift changes transforming the country's health care system have already eclipsed the mid-1980's design for a sprawling, 1,200-bed campus that New York City's Health and Hospitals Corporation has struggled for years to build, state and city health officials say.

Whatever hospital finally emerges will have fewer beds and be more tightly focused on primary care, with emphasis on prevention and outpatient treatment,

rather than expensive specialties, they say.

"The project was not headed in the right direction," said Dr. Bruce Siegel, who began work this week as the new president of the hospitals agency, appointed by Mr. Giuliani. "All over America hospitals are redesigning to cut out expensive inpatient beds and expand their primary-care networks. It's not a good idea to just bulldoze ahead with a 15-year-old project that may not be what Brooklyn needs in the year 2000."

Mayor Concurs

Karen Crowe, a spokeswoman for Mr. Giuliani, said the Mayor concurred with Dr. Siegel's desire to steer the project toward more primary care for the community. She said the two men would meet soon to discuss the precise size of the new hospital.

Residents and political leaders in central Brooklyn said they were suspicious of the administration's intentions in redesigning the project, expressing concern that the current moratorium is a prelude to simply killing the project in a largely black neighborhood that supported Mr. Giuliani's opponent. But Giuliani administration officials insisted they plan to build a replacement hospital with a minimum of delay.

There have been numerous master plans and designs for a replacement of the 62-year-old hospital, but the current plan, completed in 1986, calls for a 1.4-million-square-foot medical center with 1,220 beds and a full complement of specialized medical units, like a burn center and a radiation therapy clinic. The size of the new hospital was determined at a time when the existing building was so desperately overcrowded with patients that its ancient wards were jammed with makeshift beds and emergency cases could barely fit into overstuffed elevators.

But hospital records show that the occupancy rate of Kings County Hospital has steadily declined in the last five years from more than 100 percent to 75.4 percent in 1993, a trend matched by surrounding medical centers. Hospital officials say the construction throughout central Brooklyn of several primary-care centers, which practice preventive medicine and treat illnesses before they require hospitalization, has reduced the demand at Kings County, as have limits on Federal payments that result in shorter patient stays.

"What's happening at Kings County is part of a nationwide trend," said Robert D. Gumbs, executive director of the Health Systems Agency of New York City, which coordinates planning of new hospital operations in the city for the state. "Occupancy has dropped because of things like outpatient surgery and a better ability to manage H.I.V. and substance abuse. You don't need these mammoth structures anymore; the hospital will wind up being less important as the focal point of health care delivery."

As the Kings County Hospital plans are re-evaluated, Mr. Gumbs said, his agency would require the new hospital to have "significantly fewer" inpatient beds. He did

not specify how many, but other city and state officials predicted that the new plan would include somewhere between 600 and 800 beds.

"There are a lot of people who think the optimal-size hospital is under 600 beds," said Dr. Siegel. "I want to look at this in the perspective of what is the size that the people of Brooklyn need. What does the community need?"

Duplication Cited

A top official with the State Health Department said the moratorium was also an appropriate time to trim a large number of planned specialized units that are duplicated at the State University of New York's Health Sciences Center at Brooklyn, a 300-bed teaching hospital directly across Clarkson Avenue from Kings County. Edward J. Dowling, associate director of the Health Department's Division of Health Facility Planning, said there was no need to have two complete medical laboratories, radiation therapy units and obstetrics and pediatric units on both sides of the same street.

"This may be an opportunity to look at the scope of the project," said Mr. Dowling, who has been a critic of the project's size for many years. "I think there are several things that could be changed without adding another 10 years to planning it. And you don't want to walk away from the \$119 million they've already spent."

Despite the concerns of some Brooklyn residents, Dr. Siegel said a replacement hospital for Kings County would definitely be built, and he predicted that the additional delays would be minor in comparison with the delays in the current project, which is about four years behind its original schedule.

Sidique A. Wai, president of the New York City Health Crisis Coalition, an umbrella organization of 15 community groups that has pressed for the new hospital, said he believed the neighborhood would not object to shifting the hospital's focus toward more primary care, but he insisted that the city provide a firm date when new construction would begin.

Councilman Objects

Enoch Williams, a Brooklyn Councilman who is chairman of the Council's Health Committee, objected to the decision to reduce the hospital's size, saying residents of the area have the right to the same kind of full-service medical center that wealthier neighborhoods now enjoy.

"Those primary-care clinics are no panacea," said Mr. Williams. "We have a lot of health needs in central Brooklyn, and for them all of a sudden to turn everything around on this hospital just doesn't make sense. We can't stand any more stops on this."

Health and Hospitals officials say they have begun preliminary discussions with the state Dormitory Authority over whether that state agency might construct the new hospital and then turn it over to the city. Such a move, combined with the reduced scale of the hospital, could mean fewer construction jobs and fewer of the minority contractors that political leaders have requested, but Dr. Siegel said the agency's new highest priority was making the project manageable.

"I understand the symbolism of the project, and I understand the employment concerns," said Dr. Siegel. "But you have to remember that this is a health care project, and it should be designed to provide health care first and foremost."

LANGUAGE: ENGLISH

LOAD-DATE-MDC: February 19, 1994

Withdrawal/Redaction Marker

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
003. schedule	Schedule for Hillary Rodham Clinton, Draft #4 [partial] (3 pages)	2/28/94	b(7)(E), b(6)

COLLECTION:

Clinton Presidential Records
First Lady's Office
Liz Bowyer
OA/Box Number: 3980

FOLDER TITLE:

[HRC Background File] Monday, February 28 [1994]

2014-0483-S

sb397

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

- P1 National Security Classified Information [(a)(1) of the PRA]
- P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
- P3 Release would violate a Federal statute [(a)(3) of the PRA]
- P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
- P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]
- P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.

PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

- b(1) National security classified information [(b)(1) of the FOIA]
- b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
- b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
- b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
- b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
- b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
- b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

SCHEDULE FOR HILLARY RODHAM CLINTON
DATE: MONDAY, FEBRUARY 28, 1994
DRAFT: #4

WASHINGTON, DC/NEW YORK, NY/WASHINGTON, DC

Kara
(List)

Traveling Party: HRC
Craighead 1-800SKYPAGE #207-4653
202-365-7717 CELLULAR
Caputo 1-800SKYPAGE #883-5733
Verveer
Marshall
Jordan
Jennings
Thorpe
Sharon Farmer
(b)(7)e 003

Members of Congress: Sen. Daniel Patrick Moynihan [D-NY]
Sen. Diane Feinstein [D-CA]
Sen. Barbara Mikulski [D-MD]
Sen. Carol Moseley-Braun [D-IL]

Congressional & DSCC Staff: Lawrence O'Donnell [Moynihan]
Fay Drummond [Moynihan]
Bill Chandler [Feinstein]
Stephanie Foster [Mikulski]
Karen Olick [Boxer]
Kate Carr [DSCC]

Dr. Bayle

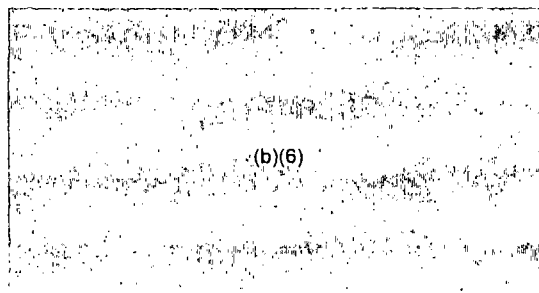
Lead Advance: Kara McGuire
Sheraton New York & Towers Hotel
811 7th Avenue & 53rd Street
212-581-1000 RM 4101
212-262-4410 fax
1-800SKYPAGE #883-5738
202-494-9730 cellular

Scheduling Desk: Sara Grote
202-456-2922 office
202-456-2317 fax
202-483-7312 home
1-800-528-7528 WHCA #4363

PREV RON

The White House

7:30 am



003

**SCHEDULE FOR HILLARY RODHAM CLINTON
MONDAY, FEBRUARY 28, 1994
PAGE 2**

202-966-4600 [o]

8:10 am **DEPART White House South Portico
EN ROUTE Andrews Air Force Base**

MOTORCADE MANIFEST:

HRC's Limo: HRC

**Staff Van: CRAIGHEAD, CAPUTO, VERVEER, MARSHALL, JORDAN,
JENNINGS, THORPE, FARMER**

8:35 am **ARRIVE Andrews Air Force Base**

NOTE: Sen. Daniel Patrick Moynihan, Sen. Diane Feinstein, Sen. Carol Moseley-Braun, Sen. Barbara Mikulski & staff to meet up with traveling party at Andrews.

8:45 am **WHEELS UP Andrews Air Force Base**

NOTE: ABC crew will shoot departure from Andrews.

Flight Time: 50 HR.

Manifest: HRC, CRAIGHEAD, CAPUTO, VERVEER, MARSHALL, ANN JORDAN, JENNINGS, THORPE, FARMER, SEN. DANIEL PATRICK MOYNIHAN, SEN. DIANE FEINSTEIN, SEN. CAROL MOSELEY-BRAUN, SEN. BARBARA MIKULSKI, LAWRENCE O'DONNELL [MOYNIHAN STAFFER], FAY DRUMMOND [MOYNIHAN STAFFER], BILL CHANDLER [FEINSTEIN STAFFER], KAREN OLICK [BOXER STAFFER], STEPHANIE FOSTER [MIKULSKI STAFFER], KATE CARR [DSCC],

(b)(7)e 003
Food: BREAKFAST

9:35 am **WHEELS DOWN New York, NY
LaGuardia Airport
FBO: Signature Flight Support
Phone: 718-476-5200
Fax: 718-476-5239
CLOSED PRESS ARRIVAL**

9:45 am **DEPART LaGuardia Airport
EN ROUTE Kings County Hospital
[drive time: 40 min]**

NOTE: Capricia Marshall and Ann Jordan to break from traveling party at this point.

MOTORCADE MANIFEST:

HRC's Limo: HRC & SEN. DANIEL PATRICK MOYNIHAN

Staff Van 1: CRAIGHEAD, CAPUTO, VERVEER, JENNINGS, THORPE, FARMER

**SCHEDULE FOR HILLARY RODHAM CLINTON
MONDAY, FEBRUARY 28, 1994
PAGE 3**

*SCALEA saved a police officer with
ORTIZ
new procedure for removing the bullets*

**Staff Van 2: O'DONNELL, DRUMMOND, CHANDLER, FOSTER, CARR
Guest Van: SEN. DIANE, FEINSTEIN, SEN. CAROL MOSELEY-BRAUN, SEN.
BARBARA MIKULSKI**

**10:25 am ARRIVE Kings County Hospital
OPEN PRESS ARRIVAL**

Greeters: Ed Larkins, Exec. Dir.
Dr. Ed Fishkin, Assoc. Medical Dir.
Cong. Major Owens
Cong. Ed Towns
Councilman Clarence Norman
Assemblymember Enoch Williams
Nancy Oswald, Dir. of Inter-gov't affairs, AGC Corp.
Dennis Rivera, President, Union 1199 Drug, Hospital &
Health Care Employees Union
Stanley Hill, Exec. Dir., District Council 37, AFSCME

10:30 am PROCEED TO TOUR OF Kings County Hospital

Participants on tour:

- HRC
- Sen. Daniel Patrick Moynihan [D-NY]
- Sen. Diane Feinstein [D-CA]
- Sen. Carol Moseley-Braun [D-IL]
- Sen. Barbara Mikulski [D-MD]
- Ed Larkins, Exec. Dir.
- Dr. Ed Fishkin, Assoc. Medical Dir.
- Cong. Major Owens
- Cong. Ed Towns
- Councilman Clarence Norman
- Assemblymember Enoch Williams
- Dennis Rivera, President, Union 1199 Drug,
Hospital & Health Care
Employees Union
- Stanley Hill, Exec. Dir., District Council
37, AFSCME

**10:30 am-
10:40 am**

TOUR OF EMERGENCY ROOM

Holding Room:
Phone:
Fax:
Kings County Hospital
451 Clarkson Ave
Brooklyn, NY
CLOSED PRESS

SCHEDULE FOR HILLARY RODHAM CLINTON
MONDAY, FEBRUARY 28, 1994
PAGE 4

NOTE: Dr. Tom Scalea, Chief of Emergency Services and Dr. Phillip Rice, Emergency Services to greet HRC at entrance to ER.

Format: HRC to tour emergency room and observe patients.

Participants: Approx. ____ patients.

Contact/Moynihan's Ofc: Rob Connor
202-224-2669/4515
Ron Law
212-661-5150

Contact/Hospital: Mr. Ed Larkins, Exec. Dir.
718-245-3901

10:45 am-
10:55 am

TOUR OF NEO-NATAL UNIT
Room C 61, 6th Floor
CLOSED PRESS

NOTE: All tour participants will need to wash hands and don hospital gowns before entering neo-natal unit.

Format: Only HRC and Sen. Daniel Patrick Moynihan will enter this room to observe babies.

Participants: Approx. ____ babies.

Contact/Moynihan's Ofc: Rob Connor
202-224-2669/4515
Ron Law
212-661-5150

Contact/Hospital: Mr. Ed Larkins, Exec. Dir.
718-245-3901

10:55 am-
11:00 am

TOUR OF WARD
A 12
POOL PRESS

NOTE: Corridor approach to ward will be pool press as well.

Format: HRC to meet and greet with patients.

Participants: Approx. 10 patients

*NO pre-natal cases
② many mothers on drug
don't have bc
no pre-natal case
① 1000 dollars per baby*

*have have health insurance
demonstrating lack of privacy*

*① John Levitt
Howard Goldberg
Rep.*

SCHEDULE FOR HILLARY RODHAM CLINTON
MONDAY, FEBRUARY 28, 1994
PAGE 5

Contact/Moynihan's Ofc: Rob Connor
202-224-2669/4515
Ron Law
212-661-5150

Contact/Hospital: Mr. Ed Larkins, Exec. Dir.
718-245-3901

11:00 am-

11:15 am

MEETING

Board Room
Kings County Hospital
CLOSED PRESS

Format: Informal meeting.

Participants: Approx. 22 people to attend.
[See briefing for more info.]

Contact/Moynihan's Ofc: Rob Connor
202-224-2669/4515
Ron Law
212-661-5150

Contact/Hospital: Mr. Ed Larkin, Exec. Dir.
718-245-3901

11:20 am

DEPART Kings County Hospital
EN ROUTE Morgan Stanley Offices, 1251 Avenue
of the Americas
OPEN PRESS DEPARTURE
[drive time: 40 min.]

NOTE: Enid Ford, President, Advisory Board & Marge Matthews, Co-Chair, Advisory Board to greet HRC upon departure.

MOTORCADE MANIFEST:

HRC's Limo: HRC & SEN. DANIEL PATRICK MOYNIHAN

Staff Van 1: CRAIGHEAD, CAPUTO, VERVEER, JENNINGS, THORPE, FARMER

Staff Van 2: O'DONNELL, DRUMMOND, CHANDLER, FOSTER, CARR

Guest Van: SEN. DIANE, FEINSTEIN, SEN. CAROL MOSELEY-BRAUN, SEN. BARBARA MIKULSKI

12:00 pm

ARRIVE Morgan Stanley Offices
1251 Avenue of the Americas
Holding Room: Office of Deborah Kushman
Phone: 212-703-4078
Fax: 212-703-4387
CLOSED PRESS ARRIVAL

SCHEDULE FOR HILLARY RODHAM CLINTON
MONDAY, FEBRUARY 28, 1994
PAGE 6

Greeters: Dick Fisher, Chairman, Morgan Stanley
Deborah DeCotis, Managing Director, Morgan Stanley
Bill Harmon, Managing Director, Morgan Stanley

12:00 pm-
12:05 pm

PRIVATE MEETING W/Dick Fisher, Chairman of
Morgan Stanley
Dick Fisher's Office, 30th Floor
Morgan Stanley Offices
1251 Avenue of the Americas
CLOSED PRESS

Participants:

-HRC
-Sen. Daniel Patrick Moynihan [D-NY]
-Sen. Barbara Boxer [D-CA]
-Sen. Diane Feinstein [D-CA]
-Sen. Barbara Mikulski [D-MD]
-Sen. Patty Murray [D-WA]
-Sen. Carol Moseley-Braun [D-IL]
-Dick Fisher, Chairman, Morgan Stanley
-Deborah DeCotis, Managing Director, Morgan Stanley
-Bill Harmon, Managing Director, Morgan Stanley

Contact: Kate Carr, Finance Director
202-485-3137

12:05 pm-
12:10 pm

OFFICIAL PHOTOS W/Host Committee
Dick Fisher's Office, 30th Floor
Morgan Stanley Offices
1251 Avenue of the Americas
CLOSED PRESS

Participants: Approx. 20 people. [See briefing for more info.]

Contact: Kate Carr, Finance Director
202-485-3137

12:15 pm-
1:45 pm

DSCC WOMEN'S COUNCIL LUNCHEON
Dining Room, 31st Floor
Morgan Stanley Offices
1251 Avenue of the Americas

SCHEDULE FOR HILLARY RODHAM CLINTON
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CLOSED PRESS

NOTE: The luncheon will be videotaped by Morgan Stanley.

HRC's Table:

- Deborah DeCotis, Managing Director, Morgan Stanley
- Richard Fisher, CEO, Morgan Stanley
- William Harman, Dir. of Gov't Affairs, Morgan Stanley
- Sister Marilyn Fisher, Chair, Board of Stewards, Franciscan Sisters of the Poor Health Systems
- Melanne Verveer
- Eileen Winterble, White House
- Sister Nora Marie Walsh, Incarnate Word Health Systems
- Irene Miller, Exec. Vice-Pres., Barnes and Noble
- Linda Knight, Treasurer, FHMA
- Martha Marsh, CEO, Matthew Thorton Health Plan
- Mary Ann Keller, Assistant General Council, Sallie Mae

Senators will be seated at different tables.

Program:

- HRC to be escorted into luncheon by Dick Fisher
- HRC will meet and greet with each of the 12 tables
- Deborah DeCotis, Managing Director, Morgan Stanley to escort HRC to table
- Deborah DeCotis welcomes guests & intros Sen. Barbara Mikulski
- Sen. Barbara Mikulski to deliver remarks and intro each Senator
- Sen. Barbara Boxer remarks
- Sen. Patty Murray remarks
- Sen. Diane Feinstein remarks
- Sen. Carol Moseley-Braun remarks??
- Sen. Barbara Mikulski to intro. HRC
- HRC to deliver 15 min. remarks
- HRC to take Q & A; Sen. Barbara Mikulski will act as moderator
- Sen. Mikulski to close program
- HRC is escorted out of room by Dick Fisher

Participants: Approx. 120 people to attend.
[See briefing for more info.]

Contact: Kate Carr, Finance Director
202-485-3137

1:50 pm

DEPART Morgan Stanley Offices, 1251 Avenue of the Americas
EN ROUTE Sheraton New York Hotel

SCHEDULE FOR HILLARY RODHAM CLINTON
MONDAY, FEBRUARY 28, 1994
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NOTE: Sen. Daniel Patrick Moynihan & staff will break from traveling party at this point.

MOTORCADE MANIFEST:

HRC's Limo: HRC & SEN. DANIEL PATRICK MOYNIHAN

Staff Van 1: CRAIGHEAD, CAPUTO, VERVEER, JENNINGS, THORPE, FARMER

Staff Van 2: O'DONNELL, DRUMMOND, CHANDLER, FOSTER, CARR

Guest Van: SEN. DIANE, FEINSTEIN, SEN. CAROL MOSELEY-BRAUN, SEN. BARBARA MIKULSKI

1:55 pm **ARRIVE** Sheraton New York Hotel

Greeter:

2:00 pm-

2:30 pm

MEET & GREET/OFFICIAL PHOTO

Princess Ballroom

Sheraton New York Hotel

CLOSED PRESS

Format: Informal meet and greet/photo line.

Participants: Approx. 40 people to attend.

[See briefing for more info.]

Contact: Peter Shakow

456-6257

2:45 pm-

3:05 pm

INTERVIEW W/Cindy Adams, New York Post

Suite

Sheraton New York Hotel

ON THE RECORD-TBA

3:15 pm-

3:45 pm

TEA W/Cindy Adams, New York Post, Liz Smith

Newsday, Jeannie Williams, USA Today, Linda

Stassi, New York Daily News

Suite

Sheraton New York Hotel

ON THE RECORD-TBA

3:45 pm-

5:35 pm

DOWN TIME

Suite 4501

Sheraton New York Hotel

811 7th Avenue & 53rd Street

CLOSED PRESS

SCHEDULE FOR HILLARY RODHAM CLINTON
MONDAY, FEBRUARY 28, 1994
PAGE 9

NOTE: Capricia Marshall will meet up with traveling party at some point during this hold.

5:40 pm-
6:00 pm

MEET & GREET W/High Donors
Princess Ballroom
Sheraton New York Hotel
811 7th Avenue & 53rd Street
CLOSED PRESS

Format: Receiving line.

Participants: Approx. 30 people to attend.
[See briefing for more info.]

Contact: Kate Carr, Finance Director
202-485-3137

6:00 pm-
6:05 pm

HOLD
Royal B

6:05 pm-
6:45 pm

DSCC WOMEN'S COUNCIL RECEPTION
Imperial Ballroom
Sheraton New York Hotel
811 7th Avenue & 53rd Street
OPEN PRESS

Format: Sen. Carol Moseley-Braun to announce Sen. Barbara Boxer & HRC onto stage. Sen. Barbara Boxer to intro. HRC. HRC to deliver 15 min. remarks. Work ropeline.

Participants: Approx. 300 people to attend.
[See briefing for more info.]

Contact: Kate Carr, Finance Director
202-485-3137

7:10 pm-
7:15 pm

HOLD
Royal B

7:15 pm-
8:15 pm

DSCC WOMEN'S COUNCIL DINNER
Royal Ballroom A
Sheraton New York Hotel
811 7th Avenue & 53rd Street

**SCHEDULE FOR HILLARY RODHAM CLINTON
MONDAY, FEBRUARY 28, 1994
PAGE 10**

CLOSED PRESS

HRC's Table:

- Barbaralee Diamonstein
- Maggie Cole
- Alice Ilchman
- Edith Everett
- Debbie Farar
- Frayda Feldman
- Susan Jonal McCone
- Kathie Berlin
- Janice Spalla

Program:

- HRC to meet and greet with each of the ____ tables
- HRC to be seated at table [first course is pre-set]
- Sen. Barbara Boxer to intro. HRC
- HRC to deliver 15 min. remarks.
- HRC departs [dinner is served after HRC departs]

Participants: Approx. 150 people to attend.
[See briefing for more info.]

Contact: Kate Carr, Finance Director
202-485-3137

8:20 pm	DEPART Sheraton New York Hotel EN ROUTE LaGuardia Airport
8:45 pm	ARRIVE LaGuardia Airport
9:00 pm	WHEELS UP New York, NY LaGuardia Airport FBO: Signature Flight Support Phone: 718-476-5200 Fax: 718-476-5239 CLOSED PRESS DEPARTURE.

Flight Time: 55 HR.

Manifest: HRC, CRAIGHEAD, CAPUTO, VERVEER, MARSHALL, FARMER, SEN. DANIEL PATRICK MOYNIHAN [tentative], O'DONNELL [tentative], DRUMMOND [tentative], (b)(7)e 003

9:55 pm	WHEELS DOWN Andrews Air Force Base
10:00 pm	DEPART Andrews Air Force Base

SCHEDULE FOR HILLARY RODHAM CLINTON
MONDAY, FEBRUARY 28, 1994
PAGE 11

EN ROUTE White House

10:25 pm

ARRIVE White House South Portico

RON

The White House

FORECAST FOR NEW YORK, NY:

-

Withdrawal/Redaction Marker

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
004. memo	From: Kate Carr, Finance Director, To: Patti Solis, Re: February 28th Women's Council Event (3 pages)	2/24/94	Personal Misfile

COLLECTION:

Clinton Presidential Records
First Lady's Office
Liz Bowyer
OA/Box Number: 3980

FOLDER TITLE:

[HRC Background File] Monday, February 28 [1994]

2014-0483-S

sb397

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

- P1 National Security Classified Information [(a)(1) of the PRA]
- P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
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C. Closed in accordance with restrictions contained in donor's deed of gift.

PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

- b(1) National security classified information [(b)(1) of the FOIA]
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- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

Withdrawal/Redaction Marker

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
005. fax	From: DSCC Women's Council (14 pages)	2/22/94	Personal Misfile

COLLECTION:

Clinton Presidential Records
First Lady's Office
Liz Bowyer
OA/Box Number: 3980

FOLDER TITLE:

[HRC Background File] Monday, February 28 [1994]

2014-0483-S

sb397

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

- P1 National Security Classified Information [(a)(1) of the PRA]
- P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
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Withdrawal/Redaction Marker

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
006. itinerary	Salute to Women Leading America (2 pages)	11/7/93	Personal Misfile

COLLECTION:

Clinton Presidential Records
First Lady's Office
Liz Bowyer
OA/Box Number: 3980

FOLDER TITLE:

[HRC Background File] Monday, February 28 [1994]

2014-0483-S

sb397

RESTRICTION CODES

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Withdrawal/Redaction Marker

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
007. list	VIP Hillary Rodham Clinton Reception Attendees (4 pages)	11/7/93	Personal Misfile

COLLECTION:

Clinton Presidential Records
First Lady's Office
Liz Bowyer
OA/Box Number: 3980

FOLDER TITLE:

[HRC Background File] Monday, February 28 [1994]

2014-0483-S

sb397

RESTRICTION CODES

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Withdrawal/Redaction Marker

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
008. fax	DSCC Women's Council 1994 Race Update (2 pages)	11/4/93	Personal Misfile

COLLECTION:

Clinton Presidential Records
First Lady's Office
Liz Bowyer
OA/Box Number: 3980

FOLDER TITLE:

[HRC Background File] Monday, February 28 [1994]

2014-0483-S

sb397

RESTRICTION CODES

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Withdrawal/Redaction Marker

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
009. speech	Hillary Rodham Clinton, DSCC Women's Council (5 pages)	11/8/93	Personal Misfile

COLLECTION:

Clinton Presidential Records
First Lady's Office
Liz Bowyer
OA/Box Number: 3980

FOLDER TITLE:

[HRC Background File] Monday, February 28 [1994]

2014-0483-S

sb397

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Withdrawal/Redaction Marker

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
010. speech	Hillary Rodham Clinton DSCC Women's Council revised (4 pages)	11/8/93	Personal Misfile

COLLECTION:

Clinton Presidential Records
First Lady's Office
Liz Bowyer
OA/Box Number: 3980

FOLDER TITLE:

[HRC Background File] Monday, February 28 [1994]

2014-0483-S

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