Worthy of Care? Medical Inclusion from the Watts Riots to the Building of King-Drew, Prisons, and Skid Row, 1965-1986

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Abstract

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Using historical and spatial methods to analyze a model academic medical center built after the 1965 Watts Riots -- King-Drew Medical Center in South Los Angeles – *Worthy of Care?* argues that multiculturalism was productive in dividing society between a *multicultural mainstream* and a *"permanent underclass."* Shaped by new possibilities for citizen inclusion, greater participation in mainstream society, and access to healthcare under President Johnson's landmark health and antipoverty laws, black medical professionals pioneered the design of the first federally-funded and black-led urban academic medical center attached to new cutting-edge health infrastructure - comprehensive health clinics, community mental health centers, and modern emergency rooms. It was important to black medical and political leaders that this new health system not only produce individual bodily health in black citizens but also fight the racial stigma of biological inferiority, poverty, and mental illness in black communities by producing heterosexuality, able-bodiedness, and employment as normal and natural to black health.

By the time King-Drew opened in 1972, however, medical and political leaders had to contend with the changing landscape of Los Angeles' globalizing economy. Sizable numbers of immigrants from Asia and Latin America and new social movements associated with welfare, disability, women's, and gay rights constitutive of these economic changes also began to impact the mission and function of the medical center. Faced with new phenomena such as "new homelessness," undocumented immigration, "working poverty," and gang and drug violence, the dissertation illustrates how medical infrastructure stigmatized urban residents of color for the ways they countered normative expectations of race and sexuality. The dissertation ultimately contends that, rather than eradicate poverty, the publicly funded medical center became productive for its capacity to contain and manage it by making working motherhood, racialized violence, and homeless health and mental health services profitable for a new enlarged free market healthcare and social service industry.

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Introduction
The Dawn of Multiculturalism

On the evening of August 11th, 1965, an act of police brutality on the corner of Avalon Boulevard and 116th Street in the predominantly black Los Angeles neighborhood of Watts suddenly and unexplainably sparked a riot that would last for a total of six days. By Friday, August 13th, the disorder had spread to adjoining areas to cover a total area of 46.5 square miles.[1] Only after it was clear that the deployment of local law enforcement officers and calls by civil rights leaders to end the rioting proved ineffective did California Governor Edmund "Pat" Brown finally act to stop the spread of violence by instituting a quarantine enforced by the National Guard.[2]

John McCone, official Chair of the Gubernatorial commission to investigate the riots and former CIA director, described the riots and the city as if it was a body caught with an infection in need of treatment by calling the riots "a symptom of a sickness in the center of our cities."[3] McCone used the language and imagery of contagion to explain how un-checked poverty in mid-twentieth century Americans cities did what epidemic outbreaks such as cholera and smallpox did to cities in the late-nineteenth century, setting off a chain reaction that led citizens to escape with their resources from being impacted or entrapped in what he called a "dull, devastating spiral of failure."[4]

National policy leaders and social scientists widely shared this spiral of failure narrative to account for the twin processes of downward economic mobility and urban blight of African American communities through culture of poverty theory, a theory popularized by Daniel Patrick Moynihan, Assistant Department of Labor Secretary, which blamed the economic immobility of urban blacks on the

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[1] John McCone. Violence in the City: An End or a Beginning? Los Angeles Riot Collection, Manuscript Collection 089, Box 1: Violence in the City (Special Collections, University of Southern California Archives) p. 1
[2] The California Hospital Association would later note that the boundaries of this quarantine zone roughly matched the boundaries of the Watts Health District. "Foreword" Special Study of South and Southeast Los Angeles Metropolitan Area Relating to Existing General Acute Hospital Facilities and Proposals for Acute Facilities Dec 14, 1965 Hospital Planning Association of Southern California Kenneth Hahn Collection Box 200, Folder 1 (Special Collections, Huntington Library)
[3] John McCone. Violence in the City: An End or a Beginning? Los Angeles Riot Collection, Manuscript Collection 089, Box 1: Violence in the City (Special Collections, University of Southern California Archives) p. 2
[4] John McCone. Violence in the City: An End or a Beginning? Los Angeles Riot Collection, Manuscript Collection 089, Box 1: Violence in the City (Special Collections, University of Southern California Archives) p. 5

dysfunction of female-headed households.[5] McCone believed failed home lives led to aimless and loitering youth, whom, he argued, eventually swelled "the ranks of the permanent jobless, illiterate and untrained, unemployed and unemployable."[6] He pointed to the movement of modern resources in Watts — good teachers, high-paying jobs, and quality healthcare services — to outlying suburbs as proof of the economic effects of a culture of poverty.

Local politicians, medical professionals, and activists saw an opportunity to combat culture of poverty in Watts by taking seriously McCone's recommendation "that immediate and favorable consideration…. be given to a new, comprehensively-equipped hospital" in the neighborhood.[7] McCone situated the building of a hospital within a suite of new social vehicles being created out of President Johnson's Great Society programs and President Kennedy's New Frontier to acculturate people of color into mainstream economic and political participation. In addition to new manpower training and education programs designed to train and employ men of color in white blue-collar jobs, new social change institutions flourished during the late 1960s, such as the non-profit organization and the ethnic studies in liberal universities, to achieve greater civic participation of marginalized groups.

The King-Drew project was unique in that it anchored manpower development and training programs in an expanding healthcare industry that could not be outsourced to new markets abroad. When the Los Angeles County Department of Health opened King-Drew Medical Center as its newest public hospital in March, 1972, $26 million dollars of county, state, and federal funds had been allocated to opening a 400-bed acute care King General Hospital tower and the new Drew Postgraduate Medical

[5] Daniel Patrick Moynihan. *The Black Family: The Case for National Action* (Washington, D.C., Office of Planning, Policy, and Research. United States Department of Labor, March, 1965)

[6] John McCone. Violence in the City: An End or a Beginning? Los Angeles Riot Collection, Manuscript Collection 089, Box 1: Violence in the City (Special Collections, University of Southern California Archives) p. 5

[7] "In light of the information presented to it, the Commission believes that immediate and favorable consideration should be given to a new, comprehensively-equipped hospital in this area, which is now under study by various public agencies. To that end we strongly urge that a broadly based committee (including citizens of the area and representatives of the Los Angeles County Department of Charities, Los Angeles County Medical Association, the California Medical Association, the State Department of Health, and medical and public health schools) be appointed to study where such a hospital should be located and to make recommendations upon various technical and administrative matters in connection with the hospital." John McCone. Violence in the City: An End or a Beginning? Los Angeles Riot Collection, Manuscript Collection 089, Box 1: Violence in the City (Special Collections, University of Southern California Archives) p. 73-74

School. These were the first set of buildings of a new, networked "medical complex," that would include a $36 million Psychiatric Research and Treatment Building and a $13 million ambulatory care clinic.

Whereas the county hospital was originally conceived in a time period focused on redefining the "ghetto" by employing black men in healthcare so that they could lead their own households out of poverty, its opening in 1972 launched it within a very different political landscape. A myriad of social movements that included welfare, women's, gay, disability, and civil rights had reshaped ideas about American citizenship that began to separate some minorities from an emerging "permanent underclass," a term popularized by Ken Auletta and supported by urban sociologists such as William Julius Wilson to describe the disorderly effects of homelessness, working poverty, and unemployment in urban cities.[8] On one hand, these social movements had won unprecedented social and economic mobility for a range of minorities that created robust black middle class neighborhoods, trendy gay neighborhoods, and revitalized districts like Little Tokyo in Los Angeles. Social scientists, however, began to observe that such social movements did very little to reverse the downward mobility of many residents in and around Watts and South Los Angeles.

Still committed to the ideals of civil rights that gave birth to the medical center, King-Drew's leaders adjusted the medical center's purpose and services to a new political landscape where citizens favored more public investment in prisons and policing and less into welfare and social service programs. In this dissertation, I argue that this process positioned the urban academic medical center as an institution sandwiched between a new "multicultural" mainstream society and an emerging multiracial "permanent underclass." As a result, by 1984, Los Angeles citizens could show off the city's thriving middle class ethnic and gay communities as proof of the benefits of fully embracing multiculturalism in city planning and politics as it hosted the Olympics in that year. It did so, however, by largely hiding sections of the city considered menacing for their reputation as havens for the poor, homeless, trans, drug using,

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[8] Ken Auletta first popularized the term in a 1981 New Yorker Article. He subsequently published it under other presses. Ken Auletta. *The Underclass*. The Overlook Press, New York 1999

loitering, and undocumented — areas of the city that also happen to be directly serviced by King-Drew Medical Center.

What accounts for this new process of race-making that made some minorities worthy of social and economic inclusion while demonizing others as worthy of exclusion and alienation? Is it evidence of civil rights progress "cut short" by a public unwilling to invest more resources into public health infrastructure? Or is it the unprecedented outlay of social and economic resources to the poor during the 1960s more proof that the social inclusion of the poor remains contingent on the cultural change of the poor rather than resource investment in their environments? If the latter, how might the inclusion of some minorities through the forced exclusion of an "irresponsible" underclass be productive for the political economy of "multiculturalism"? What are the possibilities and limits for universal healthcare in a healthcare system underpinned by racial capitalism?

The Role of Desire and Complicity in Multicultural Times

By keeping the tension between a civil rights project "cut short" and skepticism over the outcomes of universal resource investment in the poor taut, this dissertation leads an investigation into the role that desire and complicity play in shaping urban multicultural policy in the late twentieth century. King-Drew Medical Center was not a solution imposed on a poor black community but one that was proposed, planned, and implemented by black citizens, many of whom were poor, to lift a black neighborhood out of poverty. Scores of black politicians, medical professionals, and activists worked alongside white allies in government and medicine to contest negative associations of biological inferiority, disability, and sexual promiscuity with race by using the twin discourses of health and morality to redefine identifications with blackness as something normal, respectable, and even desirable. Under the leadership of the inaugural faculty of Drew Postgraduate Medical School -- Drs. Mitchell Spellman (Dean), M. Alfred Haynes (Chair of Community Medicine), and J. Alfred Cannon (Chair of Psychiatry) -- King-Drew played a significant role in African American and medical history because it was the first major academic medical school to be led by black faculty on the West Coast.

For King-Drew leaders and other black activists, western medicine was a compelling forum to gather deeply rooted beliefs that health and hygiene were not only important in representing the race to others as dignified and respectable but necessary for defending the survival of black culture and people under a violent racial regime of white supremacy and black genocide.[9] Greater access to healthcare was a strategy to combat the general devaluation of black life after the failure of Reconstruction and the rise of Jim Crow. For some, health and hygiene were smaller elements of a larger repertoire of race and self-making practices that also regulated ideas about conduct and behavior around sexuality, employment, and community participation. For others, access to healthcare served to fulfill a more immediate need as something to be used to simply survive urban life.

By the mid-1960s, access to healthcare unevenly distributed life chances amongst Americans by race and location that were appalling and disturbing in light of miraculous advances in biomedicine. Pinned to the free market, healthcare providers and institutions competed with each other almost exclusively over paying white middle class consumers and generally ignored poor inner-city and rural Americans.[10] While longer lifespans and the eradication of infectious disease in middle class America proved the effectiveness of health and hygiene services, statistical data continued to track high rates of

[9] For a summation of health traditions amongst black activists see: Alondra Nelson. *Body and Soul: The Black Panther Party and the Fight against Medical Discrimination*. (Minneapolis: University of Minnesota, 2011). In black civil society: Michele Mitchell. *Righteous Propagation: African Americans and the Politics of Racial Destiny after Reconstruction*. (Durham: University of North Carolina Press, 2004) Amongst Black Physicians: Vanessa Northington Gamble. *Making a Place for Ourselves: The Black Hospital Movement, 1920-1945* (New York: Oxford University Press, 1995). Amongst Black Nurses: Darlene Clark Hine. *Black Women in White: Racial Conflict and Cooperation in the Nursing Profession, 1890-1950* (Indiana University Press, 1989). Between Black Civic Leaders: Samuel K. Roberts, Jr.. *Infectious Fear: Politics, Disease, and the Health Effects of Segregation* (Chapel Hill: University of North Carolina Press, 2009) Amongst Black Women Activists: Susan L. Smith. *Sick and Tired of Being Sick and Tired: Black Women's Health Activism in America, 1890-1950.* (Philadelphia: University of Pennsylvania, 1995)

[10] According to Rosemary Stevens, "American hospitals" are "income-maximizing organizations" (6) that "are regarded, variously, as the best in the world, as myopically biased toward high-technology medicine, as riven with problems of costs and accessibility, and as mirroring the social divisions of contemporary America." (3) According to Jonathan Engel, "By 1965 the discrepancies were obvious and stark. While only 13 percent of households with an annual income of $5,000 or more lacked hospital insurance, almost 40 percent of households earning under $5,000 so lacked. And for children of the poor, the situation was worse. In a nation in which over 80 percent of the actively employed had hospital insurance by 1965, only 22 percent of children living in households with an annual income under $3,000 had the same." (5) See: Rosemary Stevens' Rosemary Stevens. *In Sickness and in Wealth: American Hospitals in the Twentieth Century* (New York: Basic Books, 1989) and Jonathan Engel. *Poor People's Medicine: Medicaid and American Charity Care since 1965* (Durham: Duke University, 2006)

infant mortality, preventable death, and shorter lifespans amongst America's racial and rural communities.[11]

By the mid-twentieth century, healthcare served as one of many social indices that told a larger story of a growing racial divide in the United States.[12] Frustrations over this divide increased as dissatisfaction over the pace of the civil rights movement turned into a rash of rioting in Northeastern cities in 1964 and in Los Angeles in 1965.[13] These riots, along with the McCone Commission's findings that connected racial violence and frustration to lack of medical access, provided proof to mainstream America of the continued costs of social and economic isolation of American resources.

Multiculturalism emerged in this milieu as an important language to describe civilized interaction over the topics of race and class that contrasted sharply with an older paradigm of defining American citizenship as white and middle class.[14] Civil rights activists and Cold War supporters were critical in arguing for an end to this older paradigm, citing the nation's founding principles of equality and brotherhood as mismatched with the nation's contemporary race relations.[15] Multiculturalism's capacity to bring contesting definitions of race, citizenship, and health brought white and black citizens into shared space that was ultimately productive in drawing citizens of all races into deeper support of democratic and capitalist solutions to crises at home and abroad.

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[11] Using data from 1965, M. Alfred Haynes, MD, of the NMA Foundation wrote that, "families with an income less than $2,000 per year have four times as many heart conditions, six times as much mental and nervous disorders, six times as much arthritis and rheumatism and almost eight times as many visual impairment as those in the highest income level." This was compounded by a large concentration of blacks in the poorest populations. He explained, "While carrying the fetus, the non-white mother has a risk of dying four times that of a white mother. For the non-white population the death rate for tuberculosis is four times greater and for influenza and pneumonia twice as great as that for the white population in the United States. M. Alfred Haynes. "The National Medical Association's Health Program for the Inner City" in the *Journal of the National Medical Association*, September 1968 (60) 5, p. 420-423.
[12] Housing and education are other compelling social indices.
[13] Riots shook Harlem, Philadelphia, Rochester, Chicago, Jersey City, Paterson, and Elizabeth in 1964.
[14] My arguments on this paradigmatic shift are indebted to Michael Omi and Howard Winant. *Racial Formation in the United States: From the 1960s to the 1990s* (New York: Routeledge, 1994)
[15] Scholarship has flourished on this topic after the publication of Mary Dudziak. *Cold War Civil Rights: Race and the Image of American Democracy* (Princeton: Princeton University Press, 2000). For narratives before and after the period covered by Dudziak, see: Glenda Gilmore. *Defying Dixie: The Radical Roots of Civil Rights, 1919-1950.* (New York: Norton and Company, 2008) and Jenna Loyd. *Health Rights are Civil Rights: Peace and Justice Activism in Los Angeles, 1963-1978* (Minneapolis: University of Minnesota Press, 2014)

For white citizens, multiculturalism provided a pathway to see affirmative resource distribution to the racialized poor as an effective policy to contain and eradicate racial violence and poverty at home. It also symbolized a new appropriate expression of American nationalism given the United States' new role in the global economy. Efforts to spread democracy and capitalism in South Vietnam, Latin America, and Africa demanded that the average American align their own racial attitudes towards minorities at home with America's diplomatic aims to spread democracy and free trade abroad.

Discussions over equitable distribution of healthcare services proved to be a flexible and inviting space for Americans to discuss racial and sexual difference over the course of the late 1960s and 1970s. Unlike the intrusive and authoritarian public health departments of the late-nineteenth and early twentieth centuries, access to the American Hospital came to be seen as human right that helped individual citizens secure and fashion an identity that was healthy, respectable and productive for society.[16] Women's, welfare, gay, disability and civil rights activists increasingly saw medical professionals as authorities by which they could negotiate the meanings of their racial and/or sexual difference that did not reify them as inferior, sick, and unhygienic.[17] Instead, their campaigns reveal that they were not *anti*-medicine but invested in using medicine to affirm their identities as normal, desirable, and productive for society.

Federal legislation in 1965 eased these demands by social movement activists because Medicare and Medicaid empowered the poor, women on welfare, the elderly, and disabled as consumers with rights

[16] The intrusiveness of American public health officers is legion and well documented. See: Howard Markel. *Quarantine! East European Jewish Immigrants and the New York City Epidemics of 1892* (Baltimore, Johns Hopkins University Press, 1997); John McKiernan-Gonzalez. *Fevered Measures: Public Health and Race at the Texas-Mexico Border, 1848-1942* (Durham: Duke University, 2012); Natalia Molina. *Fit to Be Citizens? Public Health and Race in Los Angeles, 1879-1939* (Berkeley: University of California Press, 2006); Nayan Shah. *Contagious Divides: Epidemics and Race in San Francisco's Chinatown* (Berkeley: University of California Press, 2001); Samuel K. Roberts, Jr. *Infectious Fear: Politics, Disease, and the Health Effects of Segregation* (Chapel Hill: University of North Carolina Press, 2009); Warwick Anderson. *Colonial Pathologies: American Tropical Medicine, Race, and Hygiene in the Philippines.* (Durham, Duke University Press, 2006)

[17] For women's health activism, see: Sandra Morgen. *Into Our Own Hands: The Women's Health Movement in the United States, 1969-1990*. (New Brunswick: Rutgers University Press, 2002). For welfare rights activism and general advocacy around ideas of health, see: Felicia Ann Kornbluh, *The Battle for Welfare Rights: Politics and Poverty in Modern America* (Philadelphia: University of Pennsylvania Press, 2007), Johnnie Tillmon, "Welfare Is a Women's Issue," *Ms. Magazine* 1 (1972), 111-16. See, also, http:// www.msmagazine.com/spring2002/tillmon.asp., Premilla Nadasen, *Welfare Warriors: The Welfare Rights Movement in the United States* (New York: Routledge, 2005). For disability rights activism, see: Kim E. Nielsen. *A Disability History of the United States* (Boston, Beacon Press, 2012). For civil rights activism, see: Alondra Nelson. *Body and Soul: The Black Panther Party and the Fight against Medical Discrimination*. (Minneapolis: University of Minnesota, 2011) and Steven Epstein. *Inclusion: The Politics of Difference in Medical Research* (Chicago: University of Chicago, 2007)

to seek care with providers of their choice in "mainstream" for-profit health institutions. President Johnson also instituted a slew of federal funding programs for medical school scholarships and academic medical centers to recruit more minorities into medicine. Instead of expanding the welfare state, these federal laws diversified the profile of the nation's patients and providers that actually strengthened and expanded "mainstream" free market medicine.

Thus, the combined effect of both law and social movement activities show that the measurement of health in the late 1960s and 1970s had less to do with seeing "sickness" and more to do with seeing "poverty." Whereas Nayan Shah notes that, "steadfast regulation of the body, conduct, and living environment became an increasingly crucial practice in guarding against the infiltration of disease" in a previous public health era dominated by contagious disease, my analysis demonstrates that the nation's top killers of cancer, heart disease, and stroke in the mid-1960s required patient's to expand their notions of hygienic practices to their status as citizen-consumers.[18] With an increasing number of diseases earning a reputation as "preventable," access and participation in mainstream medicine became desirable for its promise to progress treatment of more complex diseases that required larger amounts of capital for research. This desire to cure complex diseases made fashioning a consumer identity desirable not only to white middle class clientele but also to minority groups eager to assert their citizenship as worthy of the care and benefits of participating in cutting-edge medicine. As Nancy Tomes argues, the "consumer rights" movement of the 1970s and 1980s did not begin with white middle class consumers, but with women's, disability, and civil rights activists who promoted the idea as a way to signal their collective desire to participate in mainstream medicine while turning medical practitioners and institutions to focus on the unique needs of populations historically abused or ignored under medicine.[19]

Medicare and Medicaid were therefore seen by the leaders of King-Drew, the National Medical Society, and government leaders as a viable pathway to develop identification with consumer lifestyles

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[18] Nayan Shah. *Contagious Divides: Epidemics and Race in San Francisco's Chinatown* (Berkeley: University of California Press, 2001), p. 4

[19] Nancy Tomes. "Patients or Health-care Consumers? Why the History of Contested Terms Matters" in *History and Health Policy in the United States: Putting the Past Back In.* Rosemary Stevens, Charles Rosenberg, Lawton Burns (eds.) (New Brunswick: Rutgers, 2006) 83-112

within the poor that would, through accompanying anti-poverty funds and citizen participation policy, make greater wage participation as full consumers normal and desirable. King-Drew leaders helped invent and implement two new health institutions, the comprehensive health clinic and the community mental health clinic, as vehicles to transform poor residents into full citizens. Healthy and economically thriving black neighborhoods were assumed to be the ultimate product of efforts to recruit and prepare the poor for universal participation in wage labor and consumption in the free market through the deployment of health services. It was, therefore, important that direct intervention in King-Drew's anti-poverty scheme be calculated and strategic to maximize opportunities for indigenous community leaders to participate in this process. At first, local black community members were to be given provisional control and autonomy over the distribution of health services, and then, eventually and gradually, assume full control over services.

Additionally, to transition Watts from a neighborhood of poverty into a self-reliant neighborhood it was important for medical authorities to develop a repertoire of knowing and talking about "poverty" that was not abstract, but could be conveyed in scientific and objective terms. Medical professionals and voluntary healthcare organizations like the California Hospital Association, the John and Mary Markle Foundation, and the Commonwealth Foundation, mirrored strategies deployed by government officials and economists to seeing and alleviating poverty. They expanded medical knowledge to include the role of statistics, economic theory, and sociology that animated President Johnson's War on Poverty programs.[20] Like these programs, medical professionals developed their own "objective" and "scientific" versions of "poverty districts," called "ghetto health districts," Health Manpower Shortage Areas (HMSAs) and later, medically underserved areas (MUAs), to express the entwined problems of poverty and sickness. While these distinctions were first developed to send resources to statistically identifiable poor neighborhoods to augur the inclusion of their residents into mainstream society, they also

[20] For the proliferation of this way of seeing abroad and in the United States see: Timothy Mitchell, *Rule of Experts: Egypt, Techno-politics, Modernity* (Berkeley: University of California, 2002) and Alyosha Goldstein *Poverty in Common: The Politics of Community Action during the American Century.* Durham: Duke University, 2012

strengthened ideas around what constituted normal and deviant citizenship by creating a visual landscape that described how individuals consumed healthcare.

Instead of resolving the problem of poverty and unequal distribution of healthcare services, these strategies created more contestations over the role of social welfare in society as the American economy produced a smaller number of jobs than the total laboring population. Instead of producing citizens who identified themselves as full consumers, Medicare and Medicaid began to be associated with welfare benefits that were thought to produce and sustain female-headed households and a culture of poverty in racialized neighborhoods. This not only created a split amongst progressive white liberals but also created a split within the black community. While some leaders continued to see publicly-funded health benefits as way to integrate the poor into mainstream society, others advocated for the containment of costs and for new ways to make the poor productive that did not require them to be lifted out of poverty.

Racial Capitalism, Working Poverty, and a Permanent Underclass

The focus of this dissertation on King-Drew Medical Center spans the years between its inception in 1965 to the Emergency Medical Training and Labor Act (EMTALA), the first significant national legislation to define the role and identity of emergency rooms. During this time period, American medicine experienced an explosion of new health service delivery models: the academic medical center, the comprehensive health center, the community mental health clinic, and the emergency room. The flourishing of these new health institutions allows for an examination of how ideas of race were contested, re-defined, and transformed in politics, culture, and society by examining the redistribution of healthcare services to urban residents of color in Los Angeles. By tracking this process, this dissertation shows how health infrastructure and services supported and legitimated a new process of race-making that split society into two interrelated groups - a multicultural class and a permanent underclass - that did not collapse older notions of racial and sexual difference but built upon them to give new power and meaning behind race.

My analysis of race follows the work of scholars who look to the processes of racial capitalism to explain the continuing significance and force of "race" in society.[21] These scholars do not refute the idea that race is a social construct nor do they accept the idea that race is a biological fact. Instead, scholars of racial capitalism see race as a discursive force with material qualities that can be used by individuals and social groups as a tool to explain the inner workings of power. Within a dynamic landscape of multiple forces, race is not a stable force but one subject to changing meanings and purposes that come together and fall apart throughout time.[22]

I contend that multicultural projects like King-Drew emerged to solve a crisis of race relations that were manifested in the Watts Riots but also created the context for a new crisis between a multicultural mainstream and multiracial permanent underclass by the 1980s. Ruth Wilson Gilmore argues that, "crisis is not objectively bad or good" but rather, "signals systematic change whose outcome is determined through struggle."[23] Noting that struggle is "a politically neutral word" and "occurs at all levels of a society as people try to figure out, through trial and error" what to make of the problems set before them, Gilmore argues that solutions to crisis are never fully resolved but necessitate new responses to resolve

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[21] My conceptions of racial capitalism are indebted to the following work: Cedric Robinson. *Black Marxism: The Making of the Black Radical Tradition* (Chapel Hill, University of North Carolina, 1983); Clyde Woods. *Development Arrested: Race, Power and the Blues in the Mississippi Delta* (New York: Haymarket, 1998); Roderick Ferguson. *Aberrations in Black: Towards a Queer of Color Critique* (Minneapolis: University of Minnesota Press, 2004); Ruth Wilson Gilmore. *Golden Gulag: Prisons, Surplus, Crisis, and Opposition in Globalizing California.* (Berkeley: University of California, 2007); Robin D.G. Kelley. *Race Rebels: Culture, Politics, and the Black Working Class* (New York: Free Press, 1994); Robin D.G. Kelley. *Hammer and Hoe: Alabama Communists during the Great Depression* (Chapel Hill, University of North Carolina, 1990)

[22] I situate racial capitalism within the definitions of biopower, race, and space set forth by Michel Foucault and by Henri LeFebvre. According to Foucault, race is the "mechanism that allows biopower to work." Racism "is bound up with the workings of a State that is obliged to use race, the elimination of races and the purification of the race, to exercise its sovereign power." (258) It is not a stable and natural element — "the specificity of modern racism, or what gives it its specificity, is not bound up with mentalities, ideologies, or the lies of power. It is bound up with the technique of power, with the technology of power." (258) Michel Foucault. *"Society Must Be Defended:" Lectures at the College de France, 1975-1976*. (New York: Picador, 2003). Lefebvre argues that race, like any ideological social construct, "loses all force if it is treated as an abstract 'model.' If it cannot grasp the concrete, then its import is severely limited, amounting to no more than that of one ideological mediation among others." (40) Taking Foucault and Lefebvre together means that space becomes the terrain by which wars of race take place and meaning. As Lefebvre states, while "the lived, concrete, and perceived realms should be interconnected, so that the 'subject,' the individual member of a given social group, may move from one to another without confusion" is a racial ideal, "Whether [spatial realms] constitute a coherent whole is another matter." (40) Henri Lefebvre. *The Production of Space* (Malden: Blackwell, 1974)

[23] Ruth Wilson Gilmore. *Golden Gulag: Prisons, Surplus, Crisis, and Opposition in Globalizing California.* (Berkeley: University of California, 2007) p. 84

them. She argues that, "crisis means instability that can be fixed only through radical measures, which include developing new relationships and new or renovated institutions out of what already exists."[24]

Gilmore's scholarship on racial capitalism has helped focus attention on the role that prisons, homeless services, and low wage labor sectors have played in solving crises of the late 1960s and the early 1970s that created new crises in the late 1970s and 1980s.[25] Instead of seeing poverty and unemployment as signs of economic deterioration or something to eradicate, scholars of racial capitalism have begun to uncover how both are productive for and endemic to modern capitalism to function. Gilmore, for example, argues that prisons in the 1970s and 1980s grew in significance not for their role in making prisoners productive as laborers but for how their incarceration was made productive for others, particularly, real estate, prison, and policing interests in both metropolitan and rural economies.[26] I follow both Gilmore in her assertions that these economic arrangements required multicultural coalitions of leaders and citizens to support, account for, and manage phenomena like incarceration and unemployment rather than ameliorate or abolish them.

My project deploys the lens of racial capitalism to re-read canonical literature in urban sociology to account for the productive power of poverty. By using this lens, I refute the claim that the acknowledgement of race in contemporary politics perpetuates racism or replaces race with class. The idea that the use of race is detrimental to black progress was a popular interpretation of William Julius Wilson's canonical sociology text, *The Declining Significance of Race* (1978).[27] In it, Wilson argued that class, not race, in the late-1970s ought to be used as the most significant factor in shaping urban policy since black income distribution was beginning to match that of whites. Additionally, many interpreted

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[24] Ruth Wilson Gilmore. *Golden Gulag: Prisons, Surplus, Crisis, and Opposition in Globalizing California.* (Berkeley: University of California, 2007) p. 26.
[25] For work on prisons, see: Ruth Wilson Gilmore. *Golden Gulag: Prisons, Surplus, Crisis, and Opposition in Globalizing California.* (Berkeley: University of California, 2007) For recent work on homelessness and racial capitalism, see: Craig Willse. *The Value of Homelessness: Managing Surplus Life in the United States* (Minneapolis: University of Minnesota, 2015) and Alyosha Goldstein *Poverty in Common: The Politics of Community Action during the American Century.* Durham: Duke University, 2012. For work on working poverty, see: Clyde Woods. *Development Arrested: Race, Power and the Blues in the Mississippi Delta* (New York: Haymarket, 1998)
[26] Ruth Wilson Gilmore. *Golden Gulag: Prisons, Surplus, Crisis, and Opposition in Globalizing California.* (Berkeley: University of California, 2007)
[27] William Julius Wilson. *The Declining Significance of Race: Blacks and Changing American Institutions* (Chicago: University of Chicago, 1978)

Wilson's work as the perpetuation of culture of poverty theory, because it reinforced the idea that residents in Watts were not poor because they were black, but because they culturally lacked the social skills and resources to advance themselves.[28]

What emerged amongst sociologists engaging with *Declining Significance* was an assumption that the problem of poverty could be eradicated by finding the right social and economic factor(s) to "unlock" the mainstreaming of urban neighborhoods. Conservatives and even liberal supporters, for instance, appropriated Wilson's evidence of the advances of the black middle class as proof that race-based state interventions should be eliminated because society did not need to use them to distribute resources.[29] While Wilson himself did not directly argue for this, sociology of race scholars Michael Omi and Howard Winant believe that Wilson, "appears to believe that since the mid-1960s a genuine egalitarian racial state has existed in the US, and further, that supports for its policies is now a permanent feature of US politics."[30]

They argue that Wilson's trust in racial progress too easily betrays his own evidence that points to the persistence of a "black underclass." Wilson argued that no salient linkage of race tied the fortunes of the black middle class to the black underclass and that new state policies needed to address this.[31] Omi and Winant, however, interpreted the existence of this underclass as the product of a white backlash against state-sponsored racial progress initiatives that are disguised as color-blind policies and as efforts

[28] In fact, Moynihan and Wilson gave each other's work high praise. Moynihan's praise of Wilson's book, When Work Disappears: The World of the New Urban Poor is emblazoned on the front cover, stating: "Wilson's masterwork… the agenda for the nation in the generation ahead." When Moynihan passed away in 2003, Wilson returned praise for Moynihan's work, calling it "prophetic." William Julius Wilson. "Foreword: The Moynihan Report and Research on the Black Community" in *The Annals of the American Academy of Political and Social Science.* Vol. 621, Jan, 2009. P. 34-46.
[29] This assertion is made by Omi and Winant. "Conservative writers have appropriated Wilson's notion of a shift from racially based to class-based sources of black poverty to argue against egalitarian state interventionism itself." (27) Michael Omi and Howard Winant. *Racial Formation in the United States: From the 1960s to the 1990s* (New York: Routeledge, 1994). I make the observation that Moynihan, a well known liberal, also strongly appropriated the same arguments.
[30] Michael Omi and Howard Winant. *Racial Formation in the United States: From the 1960s to the 1990s* (New York: Routeledge, 1994), 28
[31] He argued for new social policy initiatives for poor blacks like child care centers to augur their inclusion into society. See William Julius Wilson. *The Declining Significance of Race: Blacks and Changing American Institutions* (Chicago: University of Chicago, 1978) p. 161

to normalize "reverse discrimination."[32] Although each strand of sociological inquiry proposed different pathways to equality, each ultimately believed that an appropriate formula of state distribution of resources could be developed within a capitalist economy to produce racial equality.

My project takes a different tact by joining scholars who show that white liberal, gay, and African-, Asian-, and Latino/a- American civic leaders and citizens in New York, San Francisco, Chicago, and Los Angeles joined in affirming their difference from a permanent underclass to assert that their citizenship in urban cities merited protection and investment from them.[33] The evidence of their participation, in what many other scholars describe as a white and conservative led movement against people of color, hides how people of color and other minority groups mobilized "culture of poverty" theory and the discourses of a "permanent underclass" against their neighbors and other people of color to confirm their status as part of a new mainstream multicultural society. My investment in this inquiry is not to vilify these activists of color or the manner in which they fought against white supremacy and racial genocide but to map alternatives to conceiving of social movement priorities that are careful of the violence they potentially authorize.

In addition, my contribution to studies of racial capitalism also connects the legacies of public health born in an earlier era with studies of globalization's effect on healthcare and the American economy in the 1970s and 80s. I develop this critique within the concept of the citizen-subject forwarded by Nayan Shah in his book, *Contagious Divides*.[34] Shah argues that public health regimes in the United

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[32] "One has only to consider electoral dynamics, or recent shifts in civil rights policy which legitimate the notion of 'reverse discrimination' (that is, the supposedly invidious effects on whites of affirmative action and similar policies), to recognize that the ongoing (post-1965) racial contestation for and within the state is far from over." Michael Omi and Howard Winant. *Racial Formation in the United States: From the 1960s to the 1990s* (New York: Routeledge, 1994), 28

[33] Christina Hanhardt. *Safe Space: Gay Neighborhood History and the Politics of Violence* (Durham: Duke University Press, 2013) Christina B. Hanhardt. "Broken Windows at Blue's: A Queer History of Gentrification and Policing" in *Policing the Planet: Why Policing Crisis Led to Black Lives Matter.* Jordan Camp and Christina Heather (eds.) (New York: Verso, 2016); Craig Willse. *The Value of Homelessness: Managing Surplus Life in the United States* (Minneapolis: University of Minnesota, 2015); Mike Davis. *City of Quartz.* (New York: Vintage, 1992); Christopher Lowen Agee. *The Streets of San Francisco: Policing and the Creation of a Cosmopolitan Liberal Politics, 1950-1972* (Chicago: University of Chicago Press, 2014); Clyde Woods. *Development Arrested: Race, Power and the Blues in the Mississippi Delta* (New York: Haymarket, 1998)

[34] Nayan Shah. *Contagious Divides: Epidemics and Race in San Francisco's Chinatown* (Berkeley: University of California Press, 2001)

States in the late nineteenth and early twentieth century crafted "a strategy of both state regulation and bourgeois self-regulation that linked the conduct and consciousness of the individual self with the vitality of society overall." Whereas this regime, at first, was created to define Chinese Americans living in San Francisco as outside of national belonging, he argues that its emphasis on "limited direct intervention in the lives of individual subjects…. fostered a range of practical strategies to shape, guide, manage, or regulate individual consciousness and conduct," that Chinese Americans used to demonstrate their "capacity to reason "correctly" and follow codes of "civilized" conduct.[35]

My interest in revisiting Shah's concept of the citizen-subject is concerned with how one's ability to perform proper citizenship in the 1970s and 1980s increasingly became contingent on one's ability to perform labor and produce oneself as a full consumer. The opportunities to meet the legacy of public health standards crafted earlier in the century became increasingly difficult towards the end of the century as new phenomena such as "new homelessness" and "working poverty" made it difficult for many to join the ranks of some middle class minorities who "made it" into the mainstream. "New homelessness" and "working poverty" both expressed a dramatic change in the American economy that shifted the nation's productive energy away from a manufacturing base to a new so-called service economy.

Sociologists understand new homelessness and working poverty as products of a larger process of global economic restructuring that produced some American cities as "global" cities.[36] As manufacturing industries absconded to markets abroad, American cities began to compete with each other for a limited number of high-end service workers in finance, real estate, and insurance industries that facilitated the transfer of capital and goods between the United States' regional markets and new international markets.[37] Geographers assert that the status of Los Angeles as a global city was not inevitable but required

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[35] Nayan Shah. *Contagious Divides: Epidemics and Race in San Francisco's Chinatown* (Berkeley: University of California Press, 2001), p. 7

[36] Saskia Sassen first popularized the term from research she performed throughout the 1980s. Saskia Sassen. *The Global City: New York, London, Tokyo*. (Princeton: Princeton University Press, 1991)

[37] I look to the following authors to account for this change: Jennifer Wolch. *The Shadow State: Government and Voluntary Sector in Transition*. (New York, The Foundation Center, 1990); Karl Polanyi. *The Great Transformation: The Political and Economic Origins of Our Time* (Boston: Massachusetts, 2001); Neil Smith. *The New Urban Frontier: Gentrification and the revanchist City.* (New York: Routeledge, 1996); Neil Smith. *Uneven Development: Nature, Capital, and the Production of Space* (Athens: University of Georgia, 1984); Sharon Zukin. *The Cultures of Cities* (New York: Wiley Press, 1997)

concerted and conscious effort by Los Angeles politicians and citizens to compete with other municipalities to attract high-end service workers by using public services and electoral power to affirm urban policies that aligned with the development of the city as a global center.[38]

King-Drew secured and produced two types of workers integral to global cities. First, it trained and produced cutting-edge medical research and practitioners who were key to attracting high-end service workers. They also provided high-quality emergency health services near the city's financial district. Second, King-Drew's health services attracted cheap labor to fuel productivity in the city's transformed low-skill service industries. As the demographic change of the King-Drew Health Service Area shows, Los Angeles was able to outcompete other cities for high-end financial sector workers by cutting costs around janitorial, domestic, and food service provisions increasingly filled by immigrant labor from Asia and Latin America. The county's expansion of health services allowed employers in these sectors to attract laborers to the region by providing healthcare without any extra cost to service industry employers.

The Re-terriorialization of Space

The hierarchy of Los Angeles' new global economy centered on an extremely small financial service sector (in finance, real estate, and insurance) that was, in turn, serviced by a tier of middle class professionals (doctors, lawyers, engineers, and artists) followed by a large tier of low-paid service sector workers (janitors, domestic, restaurant, and retail workers). This labor distribution did not absorb all laborers in the region's available labor pool but created a pattern of workers chronically out of work. Sociologists look to this process as creating a new phenomenon called "new homelessness" and a caste of

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[38] See: Mike Davis. *City of Quartz.* (New York: Vintage, 1992); Li Wei. "Los Angeles' Chinese Ethnoburb: From Ethnic Service Center to Global Economy Outpost" in *Urban Geography*, August 1998, Volume 19, Issue 6, pages 502-517; Ruth Milkman. *L.A. Story: Immigrant Workers and the Future of the U.S. Labor Movement*. (New York: Russell Sage Foundation, 2006); Ruth Milkman. *Organizing Immigrants: The Challenge for Unions in Contemporary California* (Ithaca: ILR Press, 2000); Pierrette Hondagneu-Sotelo. *Domestica: Immigrant Workers Cleaning and Caring in the Shadows of Affluence (*Berkeley: University of California Press, 2001); William B. Fulton. *The Reluctant Metropolis: The Politics of Urban Growth in Los Angeles*. (Baltimore, Johns Hopkins University Press, 2001)

workers consistently being paid under a living wage called the "working poor."[39] Similar to Gilmore's argument around the productive role of incarceration in global economies, I argue that King-Drew's construction is constitutive of new spatial arrangements in Los Angeles that included a newly re-designed skid row to address the city's homeless and mental health crisis and a new South Los Angeles to address the city's crisis of the working poor.

Despite attempts to attract more businesses to Watts to employ residents through other manpower development programs, King-Drew alone survived as the largest and longest lasting manpower program to emerge out of the Watts Riots. Still, with only 2,000 jobs to recruit for and a postgraduate medical program limited to degreed medical professionals and residents with high school diplomas, the medical center could do very little to change the fortunes of all 344,000 residents of Watts.[40] Those who could leave the neighborhood left the area while another third survived on welfare.[41] In turn, the spatial footprint of poverty grew as many became homeless, accepted lower wages in new service jobs, or entered into illicit economies to survive. In 1973, the County of Los Angeles expanded King-Drew's service boundaries to accommodate this growing amount of poverty.

Rather than treat prisons and the creation of a highly policed skid row as unrelated to healthcare, *Worthy of Care?* shows that King-Drew assisted in the re-terrioralization of space in the city. It helped craft and identify a dividing line within society between a cosmopolitan "multicultural" class and a permanent underclass by using its power of medical diagnosis and treatment to enter and exit individuals in and out of the South Los Angeles neighborhoods of Watts, Florence-Firestone, Willowbrook, and Compton. These realignments are vexing to account for two reasons. First, the expansion of poverty occurred unevenly, re-making once solidly white middle class neighborhoods into mixed income, mixed

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[39] For both these phenomenon, I look to: Michael Dear and Jennifer Wolch. *Malign Neglect: Homelessness in an American City.* (San Francisco: Jossey-Bass, 1994) and William Julius Wilson. *When Work Disappears: The World of the New Urban Poor* (New York: Vintage Books, 1996)

[40] The Drew Medical School limited its educational and training opportunities mainly to postgraduate medical doctors and had limited programs to train those with high school diplomas for physician assistants. In 1981, the school expanded its role to include medical students.

[41] This change has been well documented by Josh Sides. See: *L.A. City Limits: African American Los Angeles from the Great Depression to the Present* (Berkeley: University of California Press, 2003); Josh Sides. "Straight into Compton: American Dreams, Urban Nightmares, and the Metamorphosis of a Black Suburb" in *American Quarterly* (Vol. 56, 3) September, 2004. P. 583-605.

race neighborhoods that played host to rich and poor residents living right next to each other. Secondly, unlike older processes of spatial racialization, this process produced spaces of poverty such as skid row and South Los Angeles as more multiracial than monoracial than they had been previously.

This changing landscape produced dramatically different outcomes for some multiracial neighborhoods, casting some as "multicultural," productive, and safe spaces, while continuing to represent some neighborhoods, like Watts and Skid Row, as spaces of danger, criminality, and unemployment. This negative representation persisted even as Watts' demographic profile changed from a predominately black neighborhood to a predominately Latino/a neighborhood. By 1980, King-Drew was effectively a "black" hospital in a brown neighborhood, leading many Latino/a leaders to call for a shift in the medical center's identity, particularly around the racial background of its faculty, staff, and assumed patient base. By the mid-1990s, Gloria Molina, the prominent Los Angeles County Supervisor in the adjacent supervisorial district to King-Drew, attempted to exert her leadership by placing control over the hospital within Latino hands that were met with increasing hostility by black civic leaders and residents.[42]

Inside the medical center, the status of the medical center as a "black" institution was also challenged by the fact that foreign medical graduates from Asia, the Caribbean, Africa, and Latin America now constituted most of its physician staff (especially, its resident and intern physician staff). The composition of the center's medical staff challenged guiding assumptions that physicians and patients had to be both of the same racial and national background to be considered humane and competent caregivers. Both the global physician staff at King-Drew and the new surrounding Latino/a demographics are aspects of this dissertation that require deeper analysis and research.

These profound racial changes within Watts simultaneously take place alongside a demographic change within skid row, a neighborhood regularly associated with white transient men, that now saw an

[42] Molina's very public attempt to take over leadership of the medical center despite its location outside of her supervisorial district is the culmination of efforts by local Latino officials and activists to wrest control of the medical center away from black leadership over the course of the 1980s. This historical narrative is important and requires deeper research and analysis.

influx of homeless black, Latino/a, and Native American migrants. Instead of resolve the identity of Watts or Skid Row as a "black," "brown," or "white" neighborhood, my interest in this dissertation is to show how King-Drew's comprehensive health clinics encouraged black and brown mothers to rear their children in South Los Angeles and how the medical center's mental health infrastructure diagnosed and sent the homeless mentally ill to congregate in skid row. This movement illustrates how racial capitalism and new medical infrastructure colluded to draw some minorities into positions of relative privilege while cutting across racial and sexual communities to pull many individuals into deeper forms of economic precarity.

The lateral movement from a black to brown neighborhood in Watts and the downward movement of skid row into a "hyperghetto" therefore contrast with the development of some "ghettos" into "safe space."[43] Christina B. Hanhardt argues that, compared to black and brown neighborhoods in New York and San Francisco, "gay ghettos" earned a reputation as reputable places of urban life and work through gay rights activist efforts to defend their neighborhoods as vital centers of economic activity that needed greater police protection.[44] Hanhardt argues that this process was reinforced by successful campaigns by gay and homophile activists to de-pathologize homosexuality as a mental illness in 1973. She argues that, in turn, police regimes in post mid-1970s gay neighborhoods continued to police black and brown LGBT residents not on the basis of their homosexuality but because of their primary identification as part of a "permanent underclass."[45]

My contribution to this urban studies literature places healthcare at the center of this urban change by teasing out the differences between, and overlapping discourses of, community self-determination campaigns, gentrification, manpower development, and community development schemes. In particular, I show that the status of gay, black, and transient neighborhoods in Los Angeles changed dramatically after

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[43] For more on the hyperghetto, see: Eric Tang. *Unsettled: Cambodian Refugees in the NYC Hyperghetto*. (Philedelphia: Temple University Press, 2015)
[44] Christina Hanhardt. *Safe Space: Gay Neighborhood History and the Politics of Violence* (Durham: Duke University Press, 2013)
[45] Christina B. Hanhardt. "Broken Windows at Blue's: A Queer History of Gentrification and Policing" in *Policing the Planet: Why Policing Crisis Led to Black Lives Matter.* Jordan Camp and Christina Heather (eds.) (New York: Verso, 2016) 41-62

discourses of mental health and self-determination influenced the multicultural urban planning policy of African American mayor Thomas Bradley, who was first elected in 1973. Whereas each of the city's neighborhoods were afforded equal opportunity to access urban planning resources to affirm their racial or sexual identities in space, the outcomes of neighborhoods as havens for multiculturalism or as ghettos for the permanent underclass shows that this process of change developed unevenly for each community.

Whereas King-Drew's service boundaries were once conceived as tied to neatly defined "poverty districts," the medical center's identity was re-conceptualized in the 1980s as a "safety net" hospital that captured any and all indigent patients regardless of their location in a legally recognizable "poverty" district. This vexing spatial relationship to capture those accused of being a part of a permanent underclass within a "multicultural" society opens up questions over how a new complicated system of borders were invented, policed, and maintained in an economic system that privileges mobility and cultural expression.

Hanhardt's analysis shows that the border between multicultural society and a permanent underclass is porous and sometimes overlapping. It shares observations with Eyal Weizman that "against a geography of stable, static places, and the balance across linear and fixed sovereign borders," racial capitalism creates "frontiers [that] are deep, shifting, fragmented and elastic territories."[46] He argues that although "distinctions between the 'inside' and 'outside' cannot be clearly marked," state and voluntary organizations work together to build a system of "structured chaos."[47] Within such a schema, he argues, "the mundane elements of planning and architecture have become tactical tools and the means of dispossession."[48]

Here, the medical center's power to define health and service health needs for the poor constitutes a mundane element of planning and architecture that exists both in metaphysical and physical form. Through community development campaigns, some middle class gay and black neighborhoods in West Los Angeles were successful in proving the discursive force of health in the minds of other city residents

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[46] Eyal Weizman. *Hollow Land: Israel's Architecture of Occupation* (New York: Verso, 2007), 4
[47] Eyal Weizman. *Hollow Land: Israel's Architecture of Occupation* (New York: Verso, 2007) p. 4-5
[48] Eyal Weizman. *Hollow Land: Israel's Architecture of Occupation* (New York: Verso, 2007) p. 4-5

by highlighting the limited need of government and medicine to intervene in their lives to shape healthy lifestyles. By the 1980s, however, further intervention in the neighborhoods of skid row and South Los Angeles came to represent the opposite - that citizens trapped within a permanent underclass were unfit for mainstream participation based on their presumed unhealthy and dangerous lifestyles. In turn, strategic and animated public health funding over the course of the 1970s and 1980s to King-Drew transitioned its purpose as a social change vehicle to one that serviced the poor as part of the city's public safety policy. King-Drew's services aided in containing poverty and crime in South Los Angeles by playing upon resident's desires to maintain access to healthcare, prevent large outbreaks of diseases, and have life-saving emergency medical services near the city's critical financial and commercial districts.

Deviant Heterosexuality, Queer Domesticity, and Compulsory Able-bodiedness Revisited

Worthy of Care? further explores how discourses of health continue to intertwine the processes of race and sexuality through the discourse of disability. Gay and lesbian historians show that homophile, gay, and lesbian activists and medical professionals drew parallel discourses of racial equality, health, and morality from the civil rights movement to assert that gay and lesbian identifications were not signs of pathology and/or sickness but could be seen as natural, normal, and even desirable categories of identity. As Christina Hanhardt argues, many early assertions of gay and lesbian rights activists, particularly around police brutality, did not see racism and homophobia as two separate forces but intertwined processes of power that produced both as pathological.[49]

However, many scholars of sexuality have tracked the divergence of gay and lesbian discourse from race and disability after the de-pathologization of homosexuality in American Psychiatry in 1973 and the discovery of anti-retroviral drugs in the early 1990s.[50] Since then, gay and lesbian inclusion into

[49] Christina Hanhardt. *Safe Space: Gay Neighborhood History and the Politics of Violence* (Durham: Duke University Press, 2013)
[50] Annamarie Jagose. *Queer Theory: An Introduction* (New York: New York University Press, 1996); Chandan Reddy. *Freedom with Violence: Race, Sexuality, and the US State* (Durham: Duke University, 2011); David Eng, Judith Halberstam, and Jose Esteban Munoz. "Introduction: What's Queer About Queer Studies Now?," in *Social Text*, 2005, Volume 23, No. 3-4, pages 1-17; Jodi Melamed. *Represent and Destroy: Rationalizing Violence in the*

mainstream multicultural society mirrors the discursive patterns around middle class black respectability and racial liberalism, upholding tolerance of a mostly white gay and lesbian community as evidence of sexual progress and liberalism within multicultural society. The effect now conflates police brutality as a poor "black" issue while shores up police protection for gays and lesbians as a legal right.

My contribution to this literature demonstrates that the processes of racialization and sexualization that made it possible for some to gain inclusion into mainstream society also further excluded citizens by the sustained medical and social pathologization of their sexuality and disability. Race and homosexuality before 1965 were considered mental and biological afflictions that described the impossibility of health and sexual self-responsibility that required the citizen exclusion of all homosexuals and people of color. By the mid-1970s, however, gay and civil rights activists and their supporters appropriated these discourses of health and sexual self-responsibility to affirm that *some* racial and sexual identities were deserving of citizenship while others still remained unfit for social belonging. Their efforts normalized and naturalized their affirmed identities separately — affirming "black" as being properly heterosexual and employed and while affirming "gay" and "lesbian" as properly white and able-bodied.

Significantly, these efforts collectively did not support the de-pathologization of "gender dysphoria" associated with transgendered individuals. The combined effect made poor black and brown trans people especially prone to medical pathologization, police surveillance, and alienation from both black and mainstream gay communities in Los Angeles. The dissertation therefore accounts for the complicity of some gay and civil rights proponents in displacing and surveilling black and brown trans people into skid row by the 1980s. By investigating the implementation of skid row's "containment and mitigation policy" and the animated and strategic use of the police force, I show that the concentration of black and brown trans people in skid row is not out of coincidence.

My interest in following the lives of black and brown trans people is not to exceptionalize their experience but demonstrate how their location in society is co-constitutively produced with their

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New Racial Capitalism (Minneapolis: University of Minnesota Press, 2011); Grace Kyongwon Hong and Roderick Ferguson, eds. *Strange Affinities: The Gender and Sexual Politics of Comparative Racialization.* (Durham: Duke University, 2011)

heterosexual, gay, and lesbian *neighbors* in the permanent underclass as deviant, aberrant, and disabled. As King-Drew's medical professionals, researchers, and health planners pushed into the "ghetto" to service the city's poor urban residents, they also took time to carefully cultivate and disseminate new "knowledge" around the environmental aspects of urban life that played upon the body to produce sickness and poor health. In doing so, they standardized the norms of class crafted by the "discourses of respectability and middle-class tastes" and the norms of marital heterosexuality through "discourses of the nuclear family formation, adult male responsibility, and female domestic caretaking" as necessary for any curative or health regiment to be effective and long lasting.

These discourses were re-animated through culture of poverty theory and given new power through the marriage of medicine with social work management in King-Drew's comprehensive health clinics and community mental health clinics. White and black medical professionals and social workers translated culture of poverty theory into the mundane practices and architecture of medicine by normalizing middle class and nuclear family homes as the gold standard of healing and rehabilitative environments for disease. King-Drew's leaders developed and trained medical professionals and social workers to make a comprehensive assessment of a patient's domestic environment in order to assess what kinds of social service resources could be marshaled to approximate a stable home life for patient's to manage their conditions in.

The prevailing discourses of culture of poverty theory encouraged medical professionals and social workers to view not just the members of the ghetto who were homosexual as queer, but virtually every member of the ghetto as such. As Cathy Cohen argues in *Punks, Bulldaggers, and Welfare Queens*, culture of poverty theory's emphasis on female headed households produced women on welfare as not queer for their self-identification with homosexuality but for the way they are continually read as "heterosexuals on the (out)side of heteronormativity."[51] As Nayan Shah argues, this queering process for

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[51] Cathy J. Cohen. "Punks, Bulldaggers, and Welfare Queens: The Radical Potential of Queer Politics?" in *GLQ*, Vol. 3, p. 437-465.

deviant heterosexuals did not just queer individual subjects but also their domestic spaces.[52] Here, I use queer as both Cohen and Shah use it, "not as a synonym for homosexuality" but to "question the formation of exclusionary norms of respectable middle class, heterosexual marriage."[53]

Amongst medical practitioners and social epidemiologists, the queer domestic arrangements of female-headed households were understood to be the genus of a plethora of new queer domestic sites of urban living and work that included homeless shelters, brothels, bachelor apartments, crack dens, and gang homes. These sites were understood as natural breeding grounds for sexual promiscuity, violent behavior, and illicit underground economies tied to sex, welfare abuse, and drugs. Thus, in addition to the "welfare queen," the neighborhoods of skid row and South Los Angeles were presumed to be full of residents that included the overly fertile Latina mother, the absent father, the undocumented worker, the trans prostitute, the drug abuser, the alcoholic, the street hustler, the homeless, and the mentally ill.

The dissertation considers the production of these queer figures within racial capitalism by employing Robert McRuer's concept of "compulsory able-bodiedness" to view the status of residents in skid row and South Los Angeles through the lens of disability studies.[54] McRuer argues that the relationship between "ability" and "disability" is tied, since the advent of free labor, to the capitalist logics of biological reproduction and wage participation. Here, the forms of welfare subsistence, illicit work, and un- and under- employment stemming from new homelessness and working poverty curiously placed the residents of King-Drew's service area as, what McRuer terms, "crip," for the ways in which residents counter the normative expectations of child rearing and wage participation.[55]

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[52] Shah uses the term "queer domesticity" to describe this process. "The analysis of 'queer domesticity' emphasizes the variety of erotic ties and social affiliations that counters normative normative expectations." Nayan Shah. *Contagious Divides: Epidemics and Race in San Francisco's Chinatown* (Berkeley: University of California Press, 2001) p. 13-14

[53] Nayan Shah. *Contagious Divides: Epidemics and Race in San Francisco's Chinatown* (Berkeley: University of California Press, 2001) p. 13-14

[54] Robert McRuer defines compulsory able-bodiedness in "Compulsory Able-Bodiedness and Queer/Disabled Existence" In Lennard J. Davis, ed. *The Disability Studies Reader*. 2nd ed. (London: Routledge, 2006) p. 91. Adrienne Rich defines compulsory heterosexuality in "Compulsory Heterosexuality and Lesbian Experience" in *Signs: Journal of Women in Culture and Society,* 1980, Volume 5, Issue 4, pp. 631-660.

[55] For more on Crip theory, see: Robert McRuer. *Crip Theory: Cultural Signs of Queerness and Disability*. (New York: New York University Press, 2006)

American fascination with the permanent underclass helped mainstream multicultural citizens know and understand how to perform healthy lifestyles by being vigilant about their domestic space and their participation in for-profit healthcare. Additionally, mental health and medical professionals, through new medical theories like epidemiology of violence theory, pathologized that social violence of urban ghettos could be transmitted through exposure to violence. Through the discourses of the "welfare queen," "undocumented citizen," and "youth gang member," citizens learned that, in addition to accessing preventative and hospital care, strict upkeep of one's moral and physical safety required new consumer power to account for unforeseen "accidents" in emergency rooms and the need to defend one's neighborhood as safe through physical separation from "ghettos" and policing. These developments strengthened the difference between a new mainstream multicultural society and a new permanent underclass.

My dissertation relies extensively on historical sources taken from over 9 different local and national archives to answer how multiculturalism came to be a shared, but contested paradigm after 1965, and how it became produced and legitimated through new developments in American Medicine. In the first half specifically, I demonstrate how multiculturalism was produced and legitimated through the development of Health Districts (Chapter 1), Poverty Districts (Chapter 2), Public Hospital Referendums (Chapter 3), and the development of Drew Medical School (Chapter 4). In this first half, I argue that these objects, produced in the crucible of the civil rights movement and cold war, rallied both liberals and conservatives to produce liberal plural multiculturalism as a desirable objective for both public and private health institutions to maximize health and economic productivity in society.

These chapters demonstrate that for the leaders of King-Drew and the black medical community — Drs. Sol White, Mitchell Spellman, M. Alfred Haynes, and J. Alfred Cannon — it was important that black poverty be eradicated by using a medical center attached to a health and antipoverty district as an engine to employ and train black men in healthcare, to thwart the leadership of black female-headed

households, and to use its services and architecture to encourage black citizens to desire marriage and financially self-reliant homes as normal expressions of blackness.

Chapter 4 acts as the "hinge" between the first and second halves of the dissertation. This chapter, titled "Is Drew School a 'Black' School?" answers a question posed by the leadership of Drew's Postgraduate Medical School in their first recruitment brochure to prospective resident physicians. Instead of affirming the school's commitment to black people and medical education explicitly, I read how the school responded to its own question by explaining how its innovative curriculum strove to produce competent and qualified "multicultural" physicians attentive to the needs of the poor that did not stigmatize them as "ghetto" practitioners. The chapter accounts for how physicians, despite all their education and income earning potential, are also drawn into narratives of the permanent underclass through the accusation they are "slumlord" caregivers by virtue of their association with the poor.

The second half of the dissertation measures the discursive construction of multicultural citizen-consumers and physicians constructed in the first half of the dissertation against the material impact of economic globalization of Los Angeles after the 1960s. Despite expanded opportunities for advancement of some minorities, my analysis shows that the enlargement of low-paying service sector industries left a greater number of minorities with jobs that paid below the poverty line or no jobs at all. Recognizing by the mid-1970s that working poverty meant that male breadwinners in the community could not sustain wages large enough to purchase healthcare, I argue in Chapter Five that King-Drew leaders adjusted services in two comprehensive health clinics - Hubert Humphrey and Florence-Firestone - to combat the perceived social dangers of black and brown welfare dependency and over population by using its services to produce a policy of working motherhood that pushed women into the workforce in what sociologists term "the feminization of poverty."

In chapters Six and Seven, I argue that mental health professionals from gay and civil rights movements were selective in affirming racial and sexual identities as normal and healthy. I track the influence of multicultural theorizations of King-Drew's mental health leader, Dr. J. Alfred Cannon, on Mayor Tom Bradley and his coalition of Filipino American, gay, and urban planning activists. I argue that

the objectives of mental health infrastructure and urban planning developed certain middle class black and gay neighborhoods as healthy for the ways they conformed to new mental health affirmations of race and sexuality while further stigmatizing residents in South Los Angeles and skid row for their primary associations with crime, poverty, and transgressive sexual behavior.

Particularly in chapter seven, I explore Mayor Bradley's redesign of Skid Row as an "open-air mental health facility." Instead of seeing poverty and unemployment as signs of economic deterioration or something to eradicate, I argue along with scholars of racial capitalism, that city leaders came to see these phenomena as productive and necessary for Los Angeles' rise as a global city. In order to secure safer communities for low-income workers vital to sustaining Los Angeles' global economy in South Los Angeles and to redevelop areas like West Hollywood, it was necessary to draw the homeless, the mentally ill, and black and brown LGB and trans people into a new skid row by centralizing homeless and mental health services in it. Building upon Ruth Wilson Gilmore's argument around the productive role of incarceration in global economies, I argue that this new skid row and King-Drew's mental health services which encouraged migration to it, worked alongside prisons to constitute a suite of institutions to contain and manage what William Julius Wilson terms a permanent "underclass."

In chapter 8, I show that every day citizens along with city and private hospital leaders supported the funding of emergency rooms not for their role within a public health infrastructure but for their central role as part of a new public safety landscape of police and prisons. Here, King-Drew's trauma center played a central role in advertising the wonders of new emergency room technology through the treatment of black and brown youth impacted by street crime. I argue that county citizens continued to support King-Drew's trauma services even as they began to identify the rest of the medical center's services as welfare and as a drain on public resources.

I came to know and be familiar with King-Drew as a labor organizer assigned to work with resident physicians in combating the proposed services closures for its mother and baby services and emergency room services in the summer of 2005. The shuttering of these crucial programs eventually led to the

complete closure of the hospital in 2007. I gathered testimonies for what were called "Bielensen" hearings and, in the Conclusion of the dissertation, I share these testimonies in detail. My short time at King-Drew was complemented with an extended assignment working with the resident physicians of Highland Hospital (Alameda County Medical Center, a similar public hospital to King-Drew in Oakland) and an even longer period working with hospital, nursing home, and homecare workers throughout California's public and for-profit health systems.

To defend critical health services to the poor at King-Drew and Highland Hospital, the physicians and myself drew upon the language of multiculturalism and the permanent underclass by drawing attention to the economic role that public "safety net" hospitals played in servicing the most vulnerable *so that other hospitals could remain profitable and free of sick patients*. My experience working amongst caregivers, in both public and for-profit institutions, provided me a real sense of the difference between servicing indigent populations and private paying populations. The testimonies I gathered at King-Drew were inspiring for how the physicians genuinely cared for their poor patients but also equally haunting for how the defense of public health funding depended on the language of multiculturalism and a permanent underclass. That haunting informs the personal stakes of why I came to write this dissertation – to help build language and strategies that deeply consider an analysis of intersectionality and racial capitalism in contemporary efforts for universal healthcare.

This dissertation is thus, on one hand, an extended rumination on the creation of a "permanent underclass" and its discursive and material effects in an age of "multiculturalism." It is, however, as much a project with a deep longing to build a different health landscape. Rather than see the production of a population accused of being part of a "permanent underclass" as completely abject, I suggest throughout the dissertation, that my analysis opens up opportunities for transgender, welfare, immigrant, women's, disability and civil rights activists to join in political coalition with prison abolitionists, anti-police brutality, and undocumented rights organizers to mobilize queer as an analytic to imagine a different world based on the constraints of our time and our place. Additionally, by revealing how poverty is

productive for free market healthcare to operate, the dissertation joins social justice scholarship in asserting that free market solutions to healthcare like the Affordable Care Act and the recent American Health Care Act require the production of poverty to make healthcare profitable and desirable.

Chapter One
Doctoring Blackness: Black Middle Class Professionals and the Spaces of Integration and Black Power in 1965

In February, 1965, Dr. Sol White presented a petition on behalf of the Drew Medical Society to the Southern California Hospital Planning Association to create a new health district and hospital in South Los Angeles.[56] The Association was a voluntary regulatory body of private hospital owners that the Bureau of Hospitals had recently empowered to review hospital construction certifications on behalf of the State of California.[57] The Drew Medical Society proposed the certification of a new health district encompassing roughly 20-square miles and containing 344,000 residents.[58] (See Figure 1.1)With the northern border beginning at Jefferson Boulevard, the southern border at Artesia Boulevard, and the western and eastern edge bounded by Alameda and Broadway Boulevards, the proposed district was colloquially known to residents as "South Central," a reference to Central Avenue, the main thoroughfare running down the middle of the district, that was known for its Jazz clubs and black night life.

Hospital Planning Committee members, however, found White's proposal confusing. He was not seeking to meet the requirements of a "metropolitan" health district hospital but be granted the designation as a "rural" health district hospital. He reasoned that although the proposed hospital was to be situated in an urban dense neighborhood stretching from the southern edge of downtown Los Angeles to a section of the city called Watts, its predominantly black constituency was as financially poor and medically under-serviced as rural citizens living in the outreaches of the County of Los Angeles. By his

[56] "February 10, 1965 State Advisory Hospital Council Meeting Minutes." Kenneth Hahn Collection. Box 200, Folder 1 (Special Collections, Huntington Library)
[57] In 1963, the California Bureau of Hospitals required that any applicant seeking to receive Hill-Burton Hospital Construction funds from both the State of California and Federal Government first meet eligibility by gaining a construction certificate from the California Hospital Association. According to Gordon Cumming, Director of the California Bureau of Hospitals, this new program "would reduce the state's hospital building outlay from $1.5 Billion to $750 million between now (1960) and 1975" by placing "emphases 'on having the right hospital at the right time at the right place.'" See: "Overhaul of Hospital Funds Rules Proposed: Greater Voice Urged for Planning Councils in State and Federal Construction Grants" Dec. 7, 1962. *The Los Angeles Times*, p. A9
[58] "February 10, 1966 State Advisory Hospital Council Meeting Minutes." Kenneth Hahn Collection. Box 200, Folder 1 (Special Collections, Huntington Library)

account, White was the only pediatrician operating in the area despite the fact that 50% of the neighborhood was under the age of 15.[59]

White painted Watts as a medically under-served area of black residents as a strategy that highlighted himself and the nearly two dozen black physicians practicing in Watts as the rightful leaders to lead a hospital construction effort. The petition played upon the budding black power and self-help politics of the civil rights movement and the federal War on Poverty campaign by insisting that black physicians be the actors to address the absence of black health services and institutions in mainstream healthcare. As President of the Drew Medical Society, the local affiliate of the all black and male National Medical Association (NMA), White was the perfect advocate to attempt a scheme that lifted black residents out of poverty through the deployment of health services because the state already had one of the largest spatial concentrations of black physicians in the nation.[60]

The petition presented by him, however, only addressed the professional futures of less than a quarter the entire membership of the Drew Medical Society (according to him, roughly 25 physicians out of 150) despite the fact that the proposed district contained an urban dense population of 344,000 African Americans.[61] This meant that a majority of Drew Medical Society's members (roughly 125 of them) lived and worked in integrated middle class neighborhoods diffused with approximately 100,000-150,000 blacks that existed just outside the poorest black areas.[62] The profile of Sol White's group of petitioners did not relocate to these neighborhoods West of downtown but stayed in the thick of black poverty.

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[59] "As a pediatrician, Dr. Sol White boasts 10,000 patients in Watts, where 50 per cent of the residents are 15 years old or younger, talks about long hours in his clinic." Simeon Booker. "Watts Report: Doctor with 10,000 Patients / Called Odd ball Medic in Watts" April, 1966. *Jet* Magazine, pgs. 16-21

[60] According to a survey of the NMA, 574 black physicians resided in California. California had the highest numerical value of physicians in any state. M. Alfred Haynes. "The Distribution of Black Physicians in the United States, 1967" *Journal of the National Medical Association*. November, 1969. 61:6. pgs. 470-473

[61] "According to White's memory, there were only 25 doctors for the 200,000 residents of Watts and the surrounding areas" Daniel Simon. Dissertation. "The Creation of the King-Drew Medical Complex and the Politics of Public Memory" (University of Hawai'i at Manoa: Department of American Studies, 2014) p. 63. The original petition submitted by White for the health district verified that his proposed district contained closer to 344,000 residents, as opposed to Simon's quote of 200,000. See: "February 10, 1966 State Advisory Hospital Council Meeting Minutes." Kenneth Hahn Collection. Box 200, Folder 1 (Special Collections, Huntington Library)

[62] Estimates for the population of black citizens in Los Angeles in 1960 were at 500,000 people. Given that reports placed 344,000 of African Americans as living within the boundaries of the proposed health district, the author infers that the remaining 100,000-150,000 were distributed in census tracts outside of the district.

Rather than reflect a choice to live and practice in Watts, White migrated to Watts because, like his patients and neighbors, he was too poor and lacked the professional credentials held by other physicians to practice elsewhere.

I argue that Sol White's petition provides insight into how black middle class professionals produced difference amongst themselves that culturally divided them by their location in a "multicultural" integrated market or a "ghetto" mono-racial ethnic enclave. Despite this difference, black physicians shared a similar value system across this spatial difference and with their white counterparts, particularly in how they saw the twin discourses of morality and health as shaping their roles and mission as black leaders in society. Be it amongst white society or amongst an overwhelmingly poor black majority, it was important for black physicians to project themselves as strong, moral heads of their households and as respectable pillars of the black community. The constraints of medical education and temporally uneven access to advanced medical training and practice, however, deeply divided black physician mobility — allowing some to move out from the "ghetto" to new integrated middle class neighborhoods while leaving some to stay and make a living as lower middle class doctors working amongst the poor.

White's petition thus provides an opportunity to interrogate an under-analyzed stage of racial capitalism that countered normative expectations of what constituted a "ghetto" and a "suburb." Conventionally, there is a strong accepted belief that urban community formation is a process of racialized class formation that produces suburbs that are all white and spatially separated from deteriorating and poor non-white "ghettos."[63] Although more recent work has shown the existence of ethnic suburbs, or "ethno-burbs," these descriptions also tend to reify false spatial hierarchies by insisting that middle class ethnic enclaves are still spatially distinct from white suburbs and poorer racialized

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[63] As I discuss later, Mary Patillo argues that urban association with poverty has rendered black middle class communities and their families, "a hidden population in this country's urban fabric." She argues, "The black middle class and their residential enclaves are nearly invisible to the nonblack public because of the intense (and mostly negative) attention to poor urban ghettos." Mary Patillo. *Black Picket Fences: Privilege and Peril among the Black Middle Class* (Chicago: University of Chicago Press, 1999) pgs. 1 and 5.

ghettos.[64] Legally in California, racially mixed neighborhoods have also been conflated with poverty. The appearance of these neighborhoods coincide with the practice of "red lining," a real estate policy that assigned of lower appraisal values for homes in neighborhoods that lacked a unified racial character.[65] White's proposed health district, however, purposely excluded census tracts that were steadily gaining character as not black, white, brown, or Asian, but as racially mixed middle class neighborhoods.

White's proposed health district demonstrates that black physicians valorized racially integrated neighborhoods over mono-racial black neighborhoods in ways that divided the black physician community on the question of their role within a larger civil rights movement. While some celebrated the unprecedented economic and professional mobility of integrated neighborhoods as proof of civil rights and racial progress, others, like Dr. White, equated this migration outwards from traditional black communities as a form of race betrayal. White saw his health district plan as part of a larger movement to critique the civil rights movement's emphasis on integration by returning black professional energy to the "ghetto" and lifting the black masses out of poverty.

The reading practice I deploy in this chapter reads *against* and *with* the grain of this civil rights and black nationalist discourse to focus on the emergence of racially integrated medical markets and mono-racial medical markets as evidence of a stage in racial capitalism that sits between the turn from a postwar manufacturing economy to a so-called service based economy. From this vantage point, I see the activities of black physicians in both types of markets as two different pathways that black professionals took to exploit the health landscape to their advantage. Despite strong differences of opinion amongst each other, White's proposal provides an opportunity to examine the shared discourses of capitalism and health that black physicians used to take advantage of the uneven distributive processes of racial capitalism.

The genius of Sol White's strategy is that he foresaw the impact of new federal funding opportunities that did not require him to move out of his location to make new profits. Instead, he acted

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[64] Wei Li. "Anatonomy of New Ethnic Settlement: The Chinese Ethnoburb in Los Angeles" *Urban Studies*, 35:3 (1998)

[65] George Lipsitz. *How Racism Takes Place*. (Temple University Press: Philadelphia, 2011)

promptly to monopolize on the devaluation of a medical market that was soon to be lucrative by defending it from future claim jumpers. In the wake of the 1965 Civil Rights Act and War on Poverty legislations, President Johnson signed into law Medicare and Medicaid, (P.L. 89-97) two new healthcare benefits which empowered poor consumers to seek healthcare in "the mainstream," or, the free market, through third party reimbursement rendered through the federal government. In a sense, presented well in advance of the implementation of the federal laws in late 1965, White's petition could be interpreted as a twentieth century version of a gold rush claim. The care of patients once seen as untouchable and unprofitable would be, by the end of 1965, more desirable and valuable.

White's petition is also significant because it turned attention to the processes of stigmatization that labeled physicians as "ghetto" as the patients they lived next to and cared for. Instead of this process ending with 1965 legislation, as Dr. White had hoped, the stigma of living and working as a ghetto physician continued to prevail well after the 1970s into the 1980s. During President Nixon's administration, places similarly lacking in the amount of providers, institutions, and services per population were re-named "medically underserved areas" (MUAs), a term that highlighted the persistence of health deserts that Medicare and Medicaid were suppose to eliminate. Euphemistically, working within a MUA outside the context of medical education and training came to represent a physician's inability to produce oneself as qualified to work anywhere else. Interrogating the cultural factors that stigmatize health providers thus helps explain an important structural reason why physicians of any race continue to choose to practice outside of communities of color.

From, but Not of, The Civil Rights Movement

Dr. Sol White's rationale for proposing an all-black poor health district were clarified in an April 1966 article written by Simeon Booker in *Jet* Magazine. Written from the perspective of Dr. White, Booker exposed readers to a disturbing trend in Los Angeles' black medical landscape. Motivated by "wealthier customers and owning mansions," Booker wrote that most black doctors were turning away from serving poor black patients "toward[s catering to] a more middle class market - preferably

integrated."[66] While "many of the the Negro doctors have become richer, own $100,000 homes, [and] boast name clients," Booker asserted that the "prime target" of black doctors seemed to no longer be centered on helping the black community but "win[ning] privileges in white hospitals."

Booker juxtaposed the image of black middle class professionals living in mansions and catering to white patients with the cramped and challenging working conditions of Dr. Sol White. In an accompanying piece of photo journalism, readers were introduced to White with photos of him "taking a breather" from his client base of 10,000 patients, some of which appeared in a crowded line in his clinic examination area. (See Figure 1.2) Heralding him as a "Watts champion, an unsung hero, middle class and educated, but dedicated to helping the poor and unemployed in his community," the article heroized White's decision to leave his practice in a nearby integrated neighborhood to practice in Watts as a refreshing reversal in trend.[67] Booker used White's exemplary move from suburb to ghetto as a shining example of the types of new political commitments community activists were making to a new black nationalist movement arising out of the civil rights movement.

Booker's *Jet* article thus serviced a growing critique about the unforeseen ills of the civil rights movement, shining a light on the seemingly callous escape of black middle class professionals from black neighborhoods to integrated neighborhoods. It called the readers of the article to consider the turn amongst some civil rights activists away from the objectives of racial integration and towards black nationalist goals as a movement that could potentially win more health rights for blacks than the first. The article put forward a convincing argument that civil rights was actually hurting the most vulnerable population of the black community - the poor - by enticing black physicians to leave the community.

White's scheme appealed to citizens on the premise that blacks could build institutions equal to those in white neighborhoods, and that, because it would be owned by and for black people, it could anchor progress in the community rather than elsewhere. His scheme appealed to civil rights activists who

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[66] Simeon Booker. "Watts Report: Doctor with 10,000 Patients / Called 'Odd ball' Medic in Watts" April, 1966. *Jet* Magazine, p. 16
[67] Simeon Booker. "Watts Report: Doctor with 10,000 Patients / Called 'Odd ball' Medic in Watts" April, 1966. *Jet* Magazine, p. 18

were increasingly growing more concerned that the objective of racial integration would bring change too slowly or would never come. In the article, White firmly defended his plan under the growing belief that, "Negro leadership must embrace segregation 'for awhile' to solve problems in the ghetto."[68] Stating to readers that he saw "no permanent harm in all-Negro institutions, facilities, or endeavors," White insisted that more black physicians needed to, as he did, forego financial gain and focus on "their own kind" in order to "lead them out of this predicament." He insisted that Watts, only with black middle class leadership, "could be the community of tomorrow …once it has been de-ghettoized and rebuilt."

The *Jet* article helped outline for black readers a phenomenon of racial capitalism that was splitting the loyalties of the black professional class in two. By asking readers to weigh the merits of civil rights integration and black nationalist discourse, black readers were simultaneously asked to answer a question presumably presented before every black physicians after they graduated from medical school — should a black professional leave the black community to practice medicine in the name of racial integration? Or should he return to the black community to practice in the name of black nationalism?

The Intimacies of Race and Class

The article compellingy argued that the most pressing issue facing black physicians and other black professionals in the late 1960s was a simple choice of choosing where to live and work. The nuances of being a member of the black middle class and a black medical professional, however, produced pressures on them that stretched their commitments in opposite and sometimes contradictory directions that were not featured as tension points in the article. By flattening the nuances of black professional life, the article collapsed the ways in which black physicians were impacted by a range of influences well beyond their control. Rather than reify the simple choice presented by *Jet* magazine, scholarship on the black middle class shows that White's form of activism shared more in common with the black physicians that the article so damningly vilified.

[68] Simeon Booker. "Watts Report: Doctor with 10,000 Patients / Called 'Odd ball' Medic in Watts" April, 1966. *Jet* Magazine, p. 20

Scholars have argued that, while some progressive white liberals did see racially integrated neighborhoods as a sign of multicultural progress, a majority of whites continued to overwhelmingly regard the enlarged spatial imprint of integrated neighborhoods after WWII as proof of the spread of the ghetto. Mary Patillo argues that is this largely due to the fact that "the black middle class and their residential enclaves" continued to be "nearly invisible to the nonblack public because of the intense (and mostly negative) attention given to poor urban ghettos."[69] Likewise, Daniel Widener and Scott Kurashige argue that Southern California's regional white/non-white binary made the upward movement of other non-whites also invisible to whites living in Los Angeles for the same reason.[70]

Patillo argues that white racism forged an economic, social, and psychological bond between the racial classes through the economic market created by racialized poverty. She argues that the "new racial ghetto" formed between WWI and WWII in Chicago, for example, "formed the foundation upon which a new black middle class could flourish, one composed of 'ghetto entrepreneurs' [operating within an]''institutional ghetto' [that] provided a captive clientele for African American entrepreneurs and professionals."[71] The persistence of mainstream racism meant that members of the racialized middle class could not disregard the plight of the black masses because they were either directly socially impacted by racism directed at them and their lower class counterparts or indirectly materially impacted by their economic subordination.

Kurashige contends that this process of ethnic entrepreneurship-making in Los Angeles created a multiracial middle class from the regional segregationist practice of grouping non-whites (African-, Mexican-, Asian-, and Jewish Americans) in the same neighborhoods away from all-white neighborhoods.[72] Throughout the late 1940s and 1950s, he argues that it was a coalition between black

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[69] Mary Patillo. *Black Picket Fences: Privilege and Peril among the Black Middle Class* (Chicago: University of Chicago Press, 1999) p. 1

[70] See: Daniel Widener. *Black Arts West: Culture and Struggle in Postwar Los Angeles* (Durham: Duke University Press, 2010) and Scott Kurashige. *The Shifting Grounds of Race: Black and Japanese Americans in the Making of Multiethnic Los Angeles* (Princeton: Princeton University Press, 2008)

[71] Mary Patillo. *Black Picket Fences: Privilege and Peril among the Black Middle Class* (Chicago: University of Chicago Press, 1999), p. 17

[72] Scott Kurashige. *The Shifting Grounds of Race: Black and Japanese Americans in the Making of Multiethnic Los Angeles* (Princeton: Princeton University Press, 2008)

and Japanese American middle class neighbors that flexed their new postwar political muscle to "block bust" in surrounding neighborhoods, a process that enlarged the footprint of integrated residential housing. By the 1960s, this process created an economic landscape where some medical professionals could cater exclusively to other middle class professionals still operating businesses located in the older crowded ghetto while living on the edges of it.

Others argue that black middle class connectedness to poverty is perhaps more spiritually constructed than economically determined. For example, Michele Mitchell argues that an "aspiring" black middle class has existed because of and in spite of the unescapable intimacy of blackness with racialized poverty since the early twentieth century.[73] She argues that some contemporary middle class sensibilities can be traced to the social practices of African American reformers and activists who referred to themselves as either a "race woman" or "race man," "usually a self-made or high-achieving person who contributed to a local community and labored on behalf of the larger collective."[74] Here, her arguments center on a culture of respectability and morality developed by African Americans as a marker of middle class identity than the real or assumed possession of money.

She argues that reformers framed their actions within a prevailing belief that Jim Crow terror, high mortality rates, and extreme poverty amongst blacks were proof of an ongoing campaign of racial genocide. Black physicians, in particular, intimately understood these effects in both biomedical and environmental terms. The persistence of medically "preventable" diseases in black communities indexed not only the near absence of investment in mainstream medical providers, institutions, and services in black communities but the intractable domestic environment of poverty that bred disease and poor health. According to Mitchell, "reformers thus concentrated on more than the deleterious effects of racism — they sought to alter black self-perceptions, habits, and lives. [They also] wanted to reinforce black

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[73] Michele Mitchell. *Righteous Propagation: African Americans and the Politics of Racial Destiny after Reconstruction*. (Durham: University of North Carolina Press, 2004)
[74] Michele Mitchell. *Righteous Propagation: African Americans and the Politics of Racial Destiny after Reconstruction*. (Durham: University of North Carolina Press, 2004), p. xix

manhood, encourage women to be attentive mothers, and change both intraracial and interracial sexual conduct."[75]

Nayan Shah similarly argues that the twin discourses of "hygiene and social morality" in western medicine also offered a viable and flexible vehicle by which aspiring racial classes could appropriate mainstream discourses for their own means. He argues that medicine's underlying emphasis on bodily and spiritual control "offered overlapping repertoires and regimens designed to cultivate proper relations between the self and society in the modern world." In order for this "'civilized behavior' to thrive," he argues that it was important for "public health advocates [to insist upon] the 'monogamous morality' of respectable domesticity, with its regular households, Christian marriage and morality, and nuclear families."[76]

Black physicians took up this message in both the form and function of their professional organizations. From 1870 to the late 1960s, the NMA and local affiliates like the Drew Medical Society barred women physicians from membership and only allowed their participation in a Women's Auxiliary unit made up of the wives of physicians. Men participated in political rallies and lobbying efforts while women organized fundraisers, scholarships, and social gatherings.[77] The NMA advocated for this

[75] Michele Mitchell. *Righteous Propagation: African Americans and the Politics of Racial Destiny after Reconstruction*. (Durham: University of North Carolina Press, 2004), 12

[76] Nayan Shah. *Contagious Divides: Epidemics and Race in San Francisco's Chinatown* (Berkeley: University of California Press, 2001), 14

[77] An examination of the Drew Society events show that men were placed in a position of public leadership, representing the black community externally in their dealings with white mainstream medicine. For examples, see: "'Tokenism' Held Rap at Negro MDs: Hospitals Accused of Quota System for Medical Staff" Aug. 11, 1963. *Los Angeles Times* p. G7; "Charles R. Drew Society Society Pickets John Bicrher" (sic) Sep 26, 1963, *Los Angeles Sentinel*. p. A10; "Charles Drew Society Officers Installed" Dec 16, 1965 *Los Angeles Sentinel.* p. C6. Women's roles were relegated to a more intimate domestic sphere and focused on scholarships and staging fundraising balls. See: "The Women's Auxiliary of the N.M.A.," in the *Journal of the National Medical Association,* Vol. XXXIII, No. 6 (November, 1941) p. 273 and Mrs. Marcus O. Tucker "The Role of the Women's Auxiliary to the National Medical Association in the Talent Recruitment Program," in the *Journal of the National Medical Association*. Vol. 57, No. 6 (November, 1965) pp. 453-454. It's clear that the black community regarded the Drew Medical Society as paragons of society life and respectability. It's annual ball drew attention for its extravagance. A long list of wearers and dresses detailed the "original floor length gowns representing fashion houses both here and abroad." Activities before and after, who hosted them, and where were also important. Dr. Angela Clarke, significantly, hosted a pre-dance formal dinner, "at least one party ended with the home of actor Toni Franciosa," and "most of the guests proceeded to after-ball breakfasts where they dined and danced until dawn." "Local Physicians Club Stage Annual Ball" Jul 1, 1965 *Los Angeles Sentinel* p. C4.

patriarchal model because it informed its members of how healthcare expansion in black communities ought to unfold.

It was important for the NMA to support policies that respected the authority of black physicians to provide for their own households and to support the authority of male heads of households in the black community. The organization consistently rejected support for welfare programs and charity care because they were believed to encourage black women to live autonomously from the authority of black men.[78] The prevalence of charity hospitals in black communities also led to a common belief that black dependence on these institutions undercut the ability of black physicians to fairly compete against them. In short, the imposition of the government in aiding black families was generally believed to impede upon a black physician and father's ability to labor freely and with purpose.

In this respect, the NMA did not just appropriate mainstream discourses of morality but also the mainstream discourses of medical society. As many scholars of the NMA point out, this is surprising given the fact that the American Medical Association (AMA) had regularly rejected black physicians from membership on the basis of race since 1870.[79] Rather than encourage black physicians to create a separate standard, the AMA's rejection of black physicians from regular membership only made it a social and economic imperative for black physicians to culturally and socially authenticate themselves as legitimate physicians by continuing to abide by the AMA's governing rules and social mores.

As Douglas M. Haynes argues, although the AMA normalized and naturalized medical practice as a white and male endeavor based on its exclusion of blacks, women, and non-allopathic practitioners, the

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[78] The NMA made this position clear to their white counterparts in a speech delivered by the Director of the NMA Foundation, Dr. M. Alfred Haynes in 1965. Haynes took the opportunity to define the organization's primary goals in light of the fact that the AMA had formally desegregated its chapters after the Civil Rights Act of 1965. "Far from abolishing the National Medical Association, black physicians invite all physicians to join them in removing the barriers between government medicine and private medicine; in once and for all abolishing charity medicine; in bringing the poor into the mainstream of American medicine; and in helping every American, black or white, rich or poor, to enjoy the benefits of adequate health care." Haynes, M. Alfred. "Problems Facing the Negro in Medicine Today." in the *Journal of the American Medical Associatio*n, Vol 209, No. 7 (August, 1969) p. 1067-1069

[79] According to Robert Baker, the AMA achieved this by an 1870 decision led by Dr. Nathan Davis to give the right to determine membership locally to each chapter. As a result many local chapters, particularly in the South, adopted statutes limiting membership on the basis of race. As an issue of local rights, some black physicians were able to gain membership if, and only if, they migrated to states where membership was not contingent on race. See: Robert B. Baker. "The American Medical Association and Race" *American Medical Association Journal of Ethics.* June, 2014 16:6. pp. 479-488

AMA did provide a powerfully flexible code of social conduct through its Code of Ethics which "linked the rights and responsibilities of doctors in their patriarchal authority within the family."[80] Both the NMA and AMA translated this shared code of ethics as a high regard for the right of men to compete freely with each other for clients in order for them to provide for their families. In short, both organizations upheld the principles of free market healthcare by respecting the right of medical practitioners to compete with each other without the imposition of government.

Thus, there were many reasons why black physicians took flight from ghettos to racially integrated neighborhoods that were not considered a betrayal to the objectives of racial progress. In fact, the historical imperatives driving the motivations of the black middle class encouraged any form of mobility that re-defined blackness from being associated with being poor, promiscuous, and uncivilized to being productive, dignified, and moral. By taking on white patients and those of other racial backgrounds, black physicians combatted the general devaluation of black physicians as illegitimate and lesser physicians than white physicians. It also mattered that they continue to project an image of moral uprightness in integrated spaces by helping whites and others see black people as successful and civilized. Above all, they offered their success as proof to the black masses that a hygienic and moral life could pave a pathway out of poverty into health and wealth.

Essentially, black middle class professionals believed that their mobility into integrated health markets was an extension of their historical relationship with the black masses. From this vantage point, the fact that the *Jet* magazine framed the mobility of black physicians as a choice between a practice in the ghetto or an integrated neighborhood, illuminates the privilege of having spatial mobility that many in the black community did not have. Indeed, if anything, *Jet* reified the desirability of being a part of the black middle class by emphasizing that the strict adherence to the prevailing social discourses of respectable family, marriage, and free market capitalism meant more mobility for people of color rather than less.

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[80] Douglas Melvin Haynes. "Policing the Social Boundaries of the American Medical Association, 1847-70" in the Journal of History of Medicine and Allied Sciences, Vol. 60, 2, April 2005. P. 170-195

Being Black at the Right Time and Wrong Place or the Wrong Time and RightPlace

In arguing that black professionals be the agents to "de-ghettoize and rebuild" Watts, White revealed how he held a similar outlook on black poverty as other black professionals did. His profile, by most means, also matched the profile of most black physicians. He was raised in the South, went to medical school in the South, and migrated to new opportunities for black professionals in major cities outside of the South. His migration into Watts from a middle class neighborhood, however, points to the emergence of new constrictions of movement for black physicians in the early 1960s. Based on the narrow set of medical markets for black physicians to practice in and the contingency of their skills and talents given when they matriculated through medical education, it appears that White was more likely to have migrated because the integrated medical market he first attempted to infiltrate was already saturated with physicians who had come before him and had more marketable skills than he did.

In 1965, the NMA conducted a survey of its membership to assess the distribution of black physicians in the United States and to create a unified strategy for how the organization could take advantage of new laws dedicated to support black graduate medical education.[81] That survey revealed that black physicians comprised only two percent of all physicians in the nation. Despite the extremely small number of black physicians, the study found they were geographically concentrated in just two states, New York, California, and the District of Columbia; a fact that was striking given that a majority of black medical graduates had been trained and educated at only two Southern institutions, Meharry Medical College in Nashville and Howard University in Washington, D.C. (See Figure 1.3) Of the three destinations, California's was, by far, the most popular, with a nine-fold population growth of physicians since 1942. These facts suggest that while black physicians were still numerically disadvantaged in any medical market they migrated to, their visibility in some medical markets generally reflected the presence of black economic strength relative to other geographic contexts.

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[81] M. Alfred Haynes. "The Distribution of Black Physicians in the United States, 1967" *Journal of the National Medical Association*. November, 1969. 61:6. pgs. 470-473

This data supports two revelations around White's original practice in West Los Angeles. First it supports the idea that when he had completed his residency in 1957 at Los Angeles County General Hospital, he had opened his first physician practice in a medical market that was already full of competitors who were older and more experienced than him. Second, he also likely found that he had missed opportunities to gain an edge over his counterparts because he went to medical school at a less opportune time than them. White had attended Meharry Medical College when the institution was considered by many as financially weak.[82] Unlike Howard University's strong endowment fund, Meharry had barely begun its development campaign in 1952. Without the capital to build as an intensive surgical program and medical curriculum as other institutions, many Meharry graduates gained advanced medical skills during WWII in the military. Dr. Robert Pershing Foster of middle class Pasadena, for instance, graduated from Meharry within the institution's financially weak period but gained marketable skills after his for medical education as a surgeon for the United States military.[83] White's matriculation in the late 1950s, however, placed him well out of this window of opportunity.

White also found himself competing with Howard graduates who took advantage of a rigorous medical curriculum based on federal support and a large university endowment.[84] Howard had established a large endowment since 1928, which permitted medical school leaders there to stabilize a curriculum and keep up with innovations in medical specialties and sub-specialties at a comparable rate with many leading white medical institutions. Many of Howard's graduates took advantage of these innovations by moving to medical markets like New York. According to the NMA study, many Howard graduates

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[82] According to Axel Hansen, Meharry would not embark on a "development campaign" to establish a university endowment as Howard had until 1952, owing to the fact that the college was "plagued" from 1945-1950 "with financial problems" such that the college See: Axel Hansen. "Meharry Medical College in Retrospect" in the *Journal of the National Medical Association*. Vol 65, No. 4 (July, 1973) p 274 - 275, 287.

[83] Isabel Wilkerson. *The Warmth of Other Suns: The Epic Story of America's Great Migration* (New York: Vintage, 2010)

[84] According to Howard Epps, the support of the GEB catalyzed large-scale funding from other sources outside of the black community. By 1928, Howard had achieved and surpassed its goal of raising an endowment of $500,000, which enabled the institution to stabilize its curriculum and expand its plant premises in years to come. Significantly, while operating the Freedman's Hospital as its teaching hospital had its own complications, the leadership of Howard did receive a federal allotment for the operation and repair of the hospital, meaning the University could focus on its financial solvency as a medical school. Howard R. Epps, MD "The Howard University Medical Department in the Flexner Era: 1910-1929" in the *Journal of the National Medical Association*, Vol. 81, No. 8, 1989. Pages 885 - 911

preferred migration to New York while more Meharry graduates preferred migration to California. This pattern, however, did not deter Howard graduates from competing with Meharry graduates in Los Angeles. In fact, White had opened up his clinic in 1957 at the same exact time that the Julian W. Ross Medical Center was opening up two miles away. (See Figure 1.1) The Medical Center was the brainchild of Dr. Leroy Randolph Weekes, a Howard graduate who had organized other Howard alum to open up a 14-unit medical office building reflective the impressive array of specialist practices the university produced.[85]

The Ross Medical Center's group practice model represented an innovation in medical labor organization that allowed some black physicians to compete with stand alone physicians like White by appealing to consumers sense of convenience. Patients could easily see a range of specialists in one location in ways that made it easier for them to choose the physicians next door rather than run around town. While opening a stand alone clinic had been standard practice for black physicians, the effect of this new labor organization essentially made White's stand alone practice redundant and obsolete even before he had opened his clinic.

Mobilizing the Immobility of Poverty

As Booker's Jet article attests, White was just as critical of the movement of other black professionals out of the black community as black physicians. "[Dr. White] is particularly critical of Negro teachers," Booker explained, "who could do a tremendous job spurring underprivileged kids in Watts, but who would rather teach in predominantly white schools in Los Angeles County."[86] The effect of these statements amplified the idea that White's own decision to move from an integrated neighborhood in West Los Angeles to Watts was a choice rooted in his new political commitments to

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[85] According to Mayo Delilly, the Julian W. Ross Medical Center had practices catering to surgery, pediatrics, radiology, psychology, urology, dental science, ENT, pharmacy, bacteriology, and chemistry. Mayo R. DeLilly, MD. "The Julian W. Ross Medical Center" in the *Journal of the National Medical Association*. July, 1963, Vol. 55, 4. P. 261-167.
[86] Simeon Booker. "Watts Report: Doctor with 10,000 Patients / Called Odd ball Medic in Watts" April, 1966. *Jet* Magazine, p. 20.

black power. While it is true that White attested to this in the article, the presence of a saturated black physician market and innovations in labor organization such as the Julian W. Ross Medical Center indicate that White also felt pushed out of the market because he felt he could not comfortably compete there.

Instead, White seized upon an unprecedented window of opportunity afforded by new federal legislation that took the elements of his profile that were generally seen as immobilizing features of physician practice - his race, his training, and his location - and ventured to use them as professional assets. His petition played upon the feeling of being positioned at the borderlands of two distinct black spaces in the middle of a major metropolitan city - the integrated neighborhoods of Los Angeles and the agricultural regions of the rural South. In recounting his experience to Daniel Simon, White described the sensation of moving from West Los Angeles to Watts as "swamping," a term he used to describe the affective similarity of rural medical practice in the country to places like South Central Los Angeles.[87] The sensation affirmed his sense that black physician's tendencies migrated towards already established profit centers rather than towards areas of poverty as he had done.

While Watts *felt* like the rural South to White, White's petition reveals that he found it more preferable to work in Watts than in the South. Unlike the demographically spread out black residential patterns of the rural South, Watts' incredible density of black residential housing made Watts a potentially lucrative site of business given the foreseeable implementation of Medicare and Medicaid in late 1965. In this way, President Johnson's health initiatives opened up speculative energy to once risky medical markets by mobilizing urban density for free market health activity.

This overnight transformation of medical markets shaped opinions on the types of consumers and needs within them. Believed to be unaccustomed to regular care and unfamiliar with expert medical

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[87] Simon defines White's term swamping as "the amalgamating force of ghettoization in which different Southern cultures came together." Daniel Simon. Dissertation. "The Creation of the King-Drew Medical Complex and the Politics of Public Memory" (University of Hawai'i at Manoa: Department of American Studies, 2014) p. 63. I understand White's deployment as an epistemological orientation similar to Clyde Woods' concept of the "Blues." See: Clyde Woods. *Development Arrested: Race, Power and the Blues in the Mississippi Delta* (New York: Haymarket, 1998)

knowledge, White played up the belief that new medical markets needed primary care physicians over general practitioners. Here, White valorized a primary care specialist's extended training in lifestyle and preventative health guidance alongside their curative ability to treat health complications with biomedicine as more desirable than a general practitioner's shorter list of credentials. Additionally, the emphasis on needing a health counselor, rather than a health expert with rarefied knowledge on specific organs, body parts, or diseases contrasted the assumed health needs of the poor with the consumer patterns now appearing in American suburbs. As I argue later, these regions were beginning to focus on extremely expensive patterns of health consumption that favored physician sub-specialization that made primary care specialists redundant.

White's migration to Watts indicates that this pattern began to transform the role of primary care physicians working in integrated neighborhoods that emerged in White as a feeling of being disconnected from his sense of purpose and belonging in West Los Angeles. As he explained in an oral history with Daniel Simon, he moved his practice to the corner of Central Avenue and Imperial Highway in Watts with a fellow Meharry graduate, Dr. Philip M. Smith, in 1960. (See Figure 1.1) Although he revealed to Simon that most black physicians "were trying to get up and out" of Watts, he immediately felt more "in [his] element" and "needed" than he did before. Whereas he expressed he was not professionally satisfied in West Los Angeles, White "found satisfaction in his work despite the lower wages" in Watts because he found a population appreciative of his talents and skills that he likely did not encounter before.[88]

His movement from West Los Angeles to Watts to enter into group practice with another primary care physician also point to a general direction in strategy that other black physicians were employing to remain competitive in a medical landscape crowded with general practitioners and other stand alone primary care clinics. Since Smith was an obstetrician and gynecologist, their pairing in the same clinic heightened the likelihood that Smith's patients and newborns would become White's patients.

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[88] Daniel Simon. Dissertation. "The Creation of the King-Drew Medical Complex and the Politics of Public Memory" (University of Hawai'i at Manoa: Department of American Studies, 2014) p. 63-64.

Additionally, White was taking advantage of the fact that Watts was ten miles away in either north or south direction from the closest county hospital, or as others referred to it, the nearest "charity" hospital.

The effect made Watts an ideal location to situate a for-profit, independently run black hospital that could concentrate the talents of different black primary care practitioners (general surgeons, internal medicine physicians, pediatricians, psychiatrists, radiologists) while avoiding the trappings of working in a medical market where charity care limited profits. The lynchpin of the plan was Medicare's and Medicaid's legal function to transform eligible citizens into "consumers" with the ability to seek care at any participating provider in "mainstream" for profit hospitals rather than on charity institutions. In the eyes of White, the law provided a mechanism for his clinic to wry poor black patients away from county hospital care and into his privately run institution.

White was also hopeful that Medicare and Medicaid would amplify the effects of new manpower development programs under the newly created War on Poverty Programs of the Office of Equal Opportunity. White cited these programs as an accompanying revenue generating mechanism to account for the merits of his proposal before the California Hospital Commission.[89] In his mind, these programs would eventually replace citizen need for Medicare and Medicaid by employing male heads of households in the economy. These programs, more than any other programs, ensured that health development in Watts would progress in a manner consistent with the perspectives of the AMA and NMA.

Overall, his statements to "de-ghettoize and rebuild" the community show that he was inspired to make his practice as lucrative and as reputable as physicians in integrated health markets by using 1965 health and welfare law as the means to restore, for better or worse, his own status as a physician. In this regard, White's location in Watts appears to be not so much a choice but the result of the confluence of

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[89] White wrote that "proposed service area" was "a high unemployment rate area, a high welfare aid area, and is the recipient of funds from the Anti-poverty program, the Manpower Training Program, Urban renewal, etc.," as a motivating reason to support his plain. February 23, 1965 Letter From Dr. Sol White to Board of Supervisors. Kenneth Hahn Collection Box 213, Folder 8, "Martin Luther King Jr. Hospital" (Special Collections, Huntington Library)

the uneven opportunities for medical education, training, and advancement for black physicians in the 1960s.

The Rise and Fall of the "Ghetto" Physician

In effect, White made the move to Watts at first reluctantly, but soon found a way to redefine what it meant to be a "ghetto" physician by imagining the potential of new federal health and welfare legislations. In this regard, what is also significant about White's migration into Watts is that he was not, as many other black physicians were, a general practitioner, but a primary care specialist with a medical education background that many would find desirable. The fact that he found himself unable to be profitable in what many considered to be a lucrative medical market is indicative of the beginning of the general devaluation of primary care specialists in a medical landscape trending towards new medical sub-specialties.

As White's slide backwards towards low-income neighborhoods suggests, this trend had damning effects for black physicians. The NMA study of black physician distribution in the United States showed that black physicians tended to practice in stand alone clinics more than their white counterparts, who tended to practice in groups at a higher percentage and hold more lucrative certifications as sub-specialists.[90] He also found that "thirty nine per cent of black physicians" were general practitioners, a larger percentage than the number of general practitioners in the general physician population. Of those black physicians who specialized, a large majority of them were concentrated in primary care specialties, whose percentage in each of their specialties hovered at a dismal 1 or 2% of their respective specialties.[91]

While the data supported the belief that White's specialization placed him in better stead than his black colleagues in general practice, the data also painted a picture that the increasing trend towards

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[90] While "only two per cent of black physicians practiced in groups, only 9.5 per cent of all physicians practice in this way." M. Alfred Haynes. "The Distribution of Black Physicians in the United States, 1967" *Journal of the National Medical Association*. November, 1969. 61:6. pgs. 470-473

[91] "Internal Medicine - 540, General Surgery - 479 , Psychiatry - 275 , Ob/Gyn -425 , Pediatrics - 280, and Radiology - 109" M. Alfred Haynes. "The Distribution of Black Physicians in the United States, 1967" *Journal of the National Medical Association*. November, 1969. 61:6. pgs. 470-473

specialty and sub-specialty education in American medicine would soon eclipse the average black physician's credentials and education background. In this respect, the maneuver to enter group practice, as Weekes did with his fellow Howard colleagues in the Julian W. Ross Medical Center in 1957, and as White eventually did with his Meharry colleague Dr. Philip Smith in 1960, exemplify how black physicians innovated their labor practices to keep competitive and relevant.

According the Rosemary A. Stevens, "specialty education and certification were become normal practice in the United States by the early 1960s," such that, "every field of medicine was now a 'specialty.' Every doctor was a specialist."[92] She argues, however, that some fields of specialization emerged out of the "power of the cultural environment to influence organizational change" in ways that transformed some scopes of practice associated with general practitioners, such as Family Medicine, into bona fide specialties. She argues changed social consciousness around the lack of access to primary care accounted for the certification of Family Medicine as a specialty practice by the AMA's Advisory Board for Medical Specialties in 1969. As such, Family Medicine activists framed their movement as an appropriate professional response to rising concern about poverty, to the growing importance of specialization, and as a method "to set rigorous for certification and avoid identification with old-style general practice, which was looked down upon as relatively 'unscientific' in the leading medical schools."[93]

If creating a specialty to politically differentiate professional work from general practitioners was a tool deployed by some physicians in mainstream medical society to make their practices productive for them, then White's spatial differentiation of his work from the work of black physicians in integrated medical markets also appears to be an appropriate professional response by black physicians given their historic marginalization in the AMA. Thus, while Stevens argues that family practitioners used the "well-

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[92] Rosemary A. Stevens. "Medical Specialization as American Health Policy: Interweaving Public and Private Roles" in *History and Health Policy in the United States: Putting the Past Back In.* Rosemary Stevens, Charles Rosenberg, Lawton Burns (eds.) (New Brunswick: Rutgers, 2006), pp. 49-79

[93] Rosemary A. Stevens. "Medical Specialization as American Health Policy: Interweaving Public and Private Roles" in *History and Health Policy in the United States: Putting the Past Back In.* Rosemary Stevens, Charles Rosenberg, Lawton Burns (eds.) (New Brunswick: Rutgers, 2006), p. 67

established route of specialty credentials" in the AMA to self-designate themselves as specialists "given the evident success of other fields," White's petition points to a different route to arriving at a self-designation of significance within a spatial landscape crafted by racial capitalism.[94] Without the social and economic capital of mainstream white physicians, White attempted to make his spatial segregation from both the AMA and an integrated healthcare market productive by self-designating himself as a "ghetto" physician through a new health district.

By 1970, however, White's attempt to redefine black health care in urban poor neighborhoods through the potential usefulness of 1965 health and welfare laws to black physicians appears to be short-lived. In 1969, San Francisco's local NMA affiliate, the John Hale Medical Society, organized a conference along with the California Regional Medical Program to examine "Medicine in the Black Community."[95] Summary proceedings were published in the *California Journal of Medicine* by Drs. Oscar J. Jackson and Waldenese Nixon. Their profile of medicine in the black community identified all the actors that black physicians could now anticipate as being attracted to working in predominantly black mono-racial health markets.

The group identified three groups - "the dedicated ghetto physician, often black, who lives and works in the ghetto, frequently because has no alternative;" "a group of physicians that the black community calls claim-jumpers and parasites [who] are usually non-black physicians who are somewhat self-seeking;" and, "the county and charity facilities which are the traditional roots of care for blacks unable to afford private care."[96] Their description of the "dedicated ghetto physician" matched the working conditions described in White's 1966 *Jet* article, explaining that the ghetto physician "often carries a tremendous workload," is constantly "expected to be community leader," and often has a "crowded waiting room." The more revealing description that they have "no alternative" but to live and

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[94] Rosemary A. Stevens. "Medical Specialization as American Health Policy: Interweaving Public and Private Roles" in *History and Health Policy in the United States: Putting the Past Back In.* Rosemary Stevens, Charles Rosenberg, Lawton Burns (eds.) (New Brunswick: Rutgers, 2006), p. 67

[95] Jackson, Oscar J. and Waldenese Nixon. "Medicine in the Black Community." The Western Journal of Medicine. October, 1970. 114:4. p. 58

[96] Jackson, Oscar J. and Waldenese Nixon. "Medicine in the Black Community." The Western Journal of Medicine. October, 1970. 114:4. p. 58

work in the ghetto also indicates the crystallization of professional mobility that contrasts with the *Jet* article's descriptions of mobility in 1966.

Moreover, their detailing shows that very little changed in terms of the social and economic status of black physicians working in urban poor neighborhoods. In fact, the descriptions assigned to "claim jumpers" by Jackson and Nixon reveal that White's 1960 migration from integrated medical markets to the black community had been joined by other physicians who were also marginalized by mainstream and integrated medical markets. They argued that claim jumpers were "not qualified by modern standards," "have seen better days," and that "their quality of care would not be tolerated by white society." The irony of their indictments, however, failed to see these non-black physician's migration into a black medical market were a part of the same process of racial capitalism that had stigmatized them and black physicians as one class of "ghetto" physicians.

The existence of these new competitors did not signal the changing economic fortune of predominantly black communities but the persistence of and deeper asymmetries of power drawn by extreme poverty. To argue this point, Jackson and Nixon pointed to the overcrowded nature of services at county hospitals despite the fact that they "are often located some distance from the community" and that patients are "usually faced by an unsympathetic staff who cannot relate to the patient other than as a medical entity." The inconvenience and demoralizing experience of county care failed to make an appreciable impact on driving more business to black physicians through Medicare and Medicaid points to the stigmatizing power of working in low income neighborhoods assigned to physicians working in such contexts.

As the observation of Jackson and Nixon attests, the forces of racial capitalism did not just create a general devaluation of black physician labor but also the labor of other physicians of different racial backgrounds. In other words, the forces of competition drove physicians to compete for an increasingly finite amount of market space that was leading some to pool their resources increasingly into group practices and hospitals to drive out other competitors. While black physicians may not have found themselves able to compete in all-white middle class markets, the Julian W. Ross Medical Center shows,

by the late 1950s, this phenomenon drove black physicians to collectivizing their resources by experience and specialty to compete against *other* black physicians. By the 1970s, this trend continued well enough to account for the migration of some black physicians back to the ghetto like White and Smith and other physicians that Jackson and Nixon called "claim jumpers."

White's status as a primary care specialist also shows that this uneven distribution of health resources was beginning to impact physicians with more sophisticated types of medical education. While Stevens shows that some physicians organized their scopes of practices into new types of specialties, other primary care physicians choose to re-double their efforts to gain new certifications as sub-specialists. These new distinctions proved valuable in contexts where consumers desired to work directly with sub-specialists directly rather than work through a primary care provider. Given that the number of black primary care specialists represented 1-2% of their specialties, however, the likelihood of advancement for black physicians would require candidates to find themselves, as Foster did during wartime and Weekes did by choosing Howard, in the right time and right place.

Conclusion

Overall, the divide between the integrated and black medical market opens up a window to reconsider the prevailing wisdom over health manpower strategies, which is and has been to produce more physicians through the medical education pipeline with the expectation that the invisible hand of the free market will guide them to the appropriate specialization, sub-specialization, and geographic market. As the experience of White shows in navigating a very specific racial market in the 1950s and 1960s, physicians navigate medical education based on the promise that their skills will be matched properly with a specific geographic context established when they begin medical education. That White expected, at first, to find himself thriving in West Los Angeles as others had before him contrasts with his conflicted feelings about "swamping" in Watts. For him, black power became a viable vehicle for him to connect the spatial mismatch he felt between his education and place in the medical landscape. Of course,

he eventually embraced his location, albeit with some frustration, does indicate that he accepted a long and honorable commitment to black middle class traditions of serving the poor.

Other studies conducted in the early 1970s reveal that other physicians were not as committed. By 1971, President Nixon's administration was finding that previous campaigns to increase the number of students enrolled in medical school and the number of foreign medical graduates recruited to the United States to fill a health manpower shortage were actually exacerbating a new phenomenon they termed "physician maldistribution," the unequal distribution of physicians across space. Rather than migrate to new medical frontiers as expected, a health memorandum prepared for Nixon cited that "Physicians, like everyone else, have tended to migrate to areas where they can earn the highest income, enjoy the amenities of modern life, and relate to teaching institution." They argued that these trends reinforced an "acute shortage of practicing physicians in rural areas or urban ghettos" that was also being exacerbated by the trend "toward specialization and away from primary care" despite the fact that "it is the primary care physician who is most needed in under-served areas."[97]

By 1990, these conditions remained the same despite the meeting of an important mile marker. The Department of Health, Education, and Welfare triumphantly announced that indices created in 1965 to meet the physician manpower shortage "is expected to be more than adequate by 1990."[98] The celebration, however, was a pyrrhic victory. The Department added that, "in spite of the unprecedented increases in the total numbers of health professionals, indications are that shortages in many geographic areas and specialties, and uneven and inappropriate geographic and specialty distribution remain the most serious manpower problems." They also citied that, "in addition to the problem of geographic maldistribution, there are also substantial disparities in distribution by medical specialty, primarily reflecting an inadequate number of primary care physicians."

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[97] Health Program Memorandum 1971. RG 235 General Records of the Department of Health, Education and Welfare. Office of the Secretary. Box 14 Special Studies and Reports 1969-1970 (National Archives and Record Administration, College Park)

[98] Executive Summary 1990. RG 235 General Records of the Department of Health, Education and Welfare. Office of the Secretary. Box 14 Special Studies and Reports 1969-1970 (National Archives and Record Administration, College Park)

These facts point not only to a problem of healthcare economics but also a problem embedded in medical culture that stigmatizes certain healthcare specialities and geographic points of service as a signification of professional lack or failure. White's ambition and frustration reminds us that medical professionals balance their sense of self not just on the basis of race alone but on how they position themselves amongst their professional peers. Here, shame and fear serve as just as productive and profitable of feelings for racial capitalism as is desire and pride.

Ultimately, White's ascent as a primary care specialist and descent into Watts indexes how this process of stigmatization is racialized and classed. According to Daniel Simon, White described himself as one of the only specialists working in Watts when he first arrived in 1960 and he used this disclosure to affirm *Jet* magazine's lionized portrayal of his migration as using advanced medical education for the greater good, but it also reveals how White also navigated the process of stigmatization that was quickly making primary care specializations less appealing for physicians after the late 1960. His statements affirming his sense of professional superiority and difference from general practitioners reveals that he was anxious about his location at the borderlands between a new "multicultural" and cosmopolitan society associated with free market healthcare and what social science scholars would call a "new permanent underclass" associated with medically underserved communities.

His efforts to construct a health district in Watts to de-ghettoize and re-build the neighborhood as a mono-racial black middle class community show that he was fiercely concerned about his status as part of the latter rather than the first. In this sense, the Watts Riots that erupted in late 1965 — a full eight months after he first presented his petition to the California Hospital Commission — not only likely heightened his anxiety about his status as a physician working in a low income neighborhood but also helped him redouble his efforts to construct the hospital as an urban renewal engine. In this regard, the Riots did help other black physicians and local politicians rally to his plan and benefit from it.

By the time the *Jet* magazine published its feature article on White in 1966, White had capitulated to efforts to subsume the construction of the hospital as a new county hospital (to be named Martin Luther King, Jr. General Hospital) attached to a new medical school (named the Drew Medical School). He

would be appointed by Los Angeles County Supervisor Kenneth Hahn as an official member of a steering committee consisting of members from the Drew Medical Society, the Los Angeles County Department of Health, and the Medical Schools at USC and UCLA, for one year. Although the position paid him to be a part of the planning process, he described his participation as a "Promotion to a level of incompetence." He recalls, "they gave me a job with nothing to do in a trailer and no involvement at all in any of the politics or physical [development of the hospital."[99] Despite all his intellect and ambition, White's confession reveals how black middle class professionals are still stigmatized as "ghetto" as the neighbors and patients they serve.

[99] Daniel Simon. Dissertation. "The Creation of the King-Drew Medical Complex and the Politics of Public Memory" (University of Hawai'i at Manoa: Department of American Studies, 2014) p. 74

Figure 1.1 Dr. Sol White's Proposed Health Care District

Figure 1.1. Dr. Sol White's proposed health district is shaded in dark grey. White's original stand-alone practice in 1957 is located in the northwest corner of the map (*Dr. Sol White's West Los Angeles Clinic*), close to the Ross Medical Center. In 1960, Dr. Sol White moved practice to the middle of Watts (*Dr. Sol White's Watts Clinic*). Map made for author by Breanna Spears.

Figure 1.2 1965 *Jet* Magazine Article

WATTS REPORT: DOCTOR WITH 10,000 PATIENTS

CALLED 'ODD BALL,' MEDIC IN WATTS

By SIMEON BOOKER, JET Washington Bureau Chief

Frequently referred to as "an odd ball" in the 150-member Los Angeles Charles Drew Medical Society is 35-year-old Dr. Sol White Jr. Six years ago, unlike many of his colleagues, he opened offices in the virtually all-Negro Watts area and became the first specialist in the community. Most of the other medical men—with an eye toward wealthier customers and owning mansions—aimed toward a more middle-class market—preferably integrated.

Many of the Negro doctors have become richer, own $100,000 homes, boast name clients. A prime target of this group is to win privileges in white hospitals.

As a pediatrician, Dr. Sol White boasts 10,000 patients in Watts, where 50 per cent of the residents are 15 years old or younger, talks about long hours in his clinic, campaigns for a Watts hospital and has become a soul and heart of one of America's most publicized and combustible neighborhoods.

Sitting in his Watts office, Dr. White takes breather from arduous task of tending to cares of 10,000 patients.

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SHUNS MONEY TO HELP POOR

Children line his office and await turn for checkup as affable pediatrician checks boy's ear for possible infection.

Small patient doesn't care too much for physician's stethoscope —proceeds to loudly voice his displeasure. Doc weighs boy.

17

Aide administers hearing test to youth as Dr. White checks patient's medical history.

Waiting patients are appeased with toys and balloons that the doctor keeps on hand. Young girl appears amused.

19

Across street from his office, Dr. White stands on spot where store formerly stood before fiery Watts riots last year.

that a massive project will be undertaken to relieve the soaring unemployment. Despite the talk of neglect, middle-class Negroes have joined with Watts leaders to improve conditions. The NAACP activated its branch, the Urban League opened an office and business firms have begun to establish offices. A Negro dentist, Dr. Booker Tucker, is building a half-million-dollar medical center, one of the new show places of the area. There is throbbing interest in creation of more small businesses, credit unions and housing developments.

As to the future of Watts, the Texas-born medico feels that Negroes in the professional ranks (at present, only 25 doctors for an estimated 200,000 persons) must become involved along with lay people and encourage more colleagues to come into the neighborhood. He feels that there must be a blending of optimism along constructive lines to match the fury and militance of the masses. "This could be the community of tomorrow," said Dr. White, "once it has been de-ghettoized and rebuilt." As a middle-class Negro, Dr. White does his part to hasten the new era.

N. C. All-White Dental Group Must Admit Negroes

The all-white North Carolina Dental Society was ordered to lower all racial barriers and begin admitting qualified Negroes immediately.

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Figure 1.2. Simeon Booker. "Watts Report: Doctor with 10,000 Patients / Called 'Odd ball" Medic in Watts." April, 1966 *Jet* Magazine.

Figure 1.3 – The Distribution of Black Physicians in the United States

Table 1. Distribution of Black Physicians by School of Graduation, 1967.

School	*Total*	*Per cent*
Total Graduates	4,805	100.0
Howard University College of Medicine	2,186	45.5
Meharry Medical College	1,822	37.9
All other U.S. Schools	726	15.1
Canadian medical schools	19	0.4
Foreign medical schools	52	1.1

Table 2. Distribution of NMA Physicians by Region and State, 1967

Division State	Total NMA Members	Division State	Total NMA Members
	***Total Physicians* 4,805**		
New England	93	East South Central	275
Connecticut	41	Alabama	61
Maine	3	Kentucky	37
Massachusetts	43	Mississippi	44
New Hampshire	0	Tennessee	133
Rhode Island	6		
Vermont	0	West South Central	244
		Arkansas	17
Middle Atlantic	976	Louisiana	62
New Jersey	178	Oklahoma	30
New York	562	Texas	135
Pennsylvania	236		
		Mountain	29
East North Central	921	Arizona	12
Illinois	265	Colorado	8
Indiana	99	Idaho	0
Michigan	270	Montana	0
Ohio	256	Nevada	3
Wisconsin	31	New Mexico	5
		Utah	0
West North Central	197	Wyoming	1
Iowa	12		
Kansas	23	Pacific	598
Minnesota	19	Alaska	0
Missouri	135	California	574
Nebraska	7	Hawaii	4
North Dakota	1	Oregon	6
South Dakota	0	Washington	14
South Atlantic	1084	Possessions	22
Delaware	11	Puerto Rico	11
District of Columbia	417	Virgin Islands	11
Florida	82		
Georgia	86	Address Unknown	84
Maryland	163		
North Carolina	130	Overseas	262
South Carolina	45		
Virginia	138	Foreign Countries	20
West Virginia	12		

Source: M. Alfred Haynes. “The Distribution of Black Physicians in the United States” in the *Journal of the National Medical Association*, November 1969. Vol. 61 (6) p. 470-473

Chapter Two
Health as Urban Renewal: California Hospital Policy, Anti-poverty Programs, and "Ghetto" Health Districts

On January 29, 1966, Dr. Sol White and representatives of the all black and male Drew Medical Society found themselves outflanked and out organized by the leaders, activists, and members of over thirty community groups.[100] Led by Ted Watkins, the prominent leader of the Watts Community Action Labor Council, the meeting was convened in order to settle an urgent matter regarding the nature of a new proposed hospital and health district in the community. The idea for a new health district tied to the city's poorest black census tracts had been the original idea of Dr. Sol White, who envisioned the construction of a 200-bed for-profit hospital directed by him to service those within the district.[101]

Four months prior, the Watts Riots of 1965 heightened scrutiny of his original plan because the extent of riot damage shone a bright light on the scope of need for more health services and jobs in the community. It also drew attention to the potential profitability of the implementation of new Medicare and Medicaid laws in low income neighborhoods. The meeting demonstrated that, by late January, a slew of competitors had come forward to contest Drew Medical Society's original certification petition.[102] The most controversial of these was the bid placed forth by the Los Angeles County Department of Health, led by County Supervisor Kenneth Hahn, to maximize the state's allotment of beds in the district to construct a 735-bed county hospital. Their bid immediately ignited the ire of black community physicians and rose concern amongst representatives of the California Hospital Association, both of whom traditionally saw "charity" hospitals as competitors that undercut their ability to grow private physician practices and profits.

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[100] Eugene Purnell, Secretary, Laborers Local 300. Anti-poverty Committee. News Release "Community Organizations in Watts United for County Hospital" Jan. 30, 1966. Kenneth Hahn Collection. Box 200, Folder 14. Martin Luther King, Jr. Hospital, Hearing (Special Collections, Huntington Library)

[101] White originally presented a petition to build a 200-bed hospital to the California Hospital Association in early 1965 and then amended it to reflect 300-beds in December of 1966 "February 10, 1965 State Advisory Hospital Council Meeting Minutes." Kenneth Hahn Collection. Box 200, Folder 1 (Special Collections, Huntington Library)

[102] By February 1966, there were five petitioners: The Watts Community Hospital (White), South Los Angeles Community Hospital (Sweeney), Community Hospital for Watts (Burton), Jay Garland Memorial Hospital (Garland), City and County Plan (County of Los Angeles). Agenda. State Hospital Advisory Council Meeting Minutes. February 24, 1966. Kenneth Hahn Collection. Box 200, Folder 14. Martin Luther King, Jr. Hospital, Hearing (Special Collections, Huntington Library)

The town hall was called to settle the debate about who ought to take responsibility for the healthcare of Watts residents. The discussion centered around whether or not the new hospital should be privately-owned or publicly-funded. “After hearing speakers for a private hospital and a county hospital, [the room] voted overwhelmingly to adopt a resolution urging the board of supervisors to take immediate steps to build a County Hospital in Watts, whose doors would be open to private doctors and their patients.”[103] While the vote held no legal power, it amassed enough political clout to help sway the California Hospital Association, the official deciding body, to entertain the petition by the Los Angeles County Board of Supervisors more seriously than the original petition by Dr. Sol White.

Since 1963, the California Hospital Commission, a council of private hospital owners, held the decisive power to certify hospital construction in California. Made for and by private capitalists to progress their industry’s interests, these certification hearings were typically privately-held meetings where peers of hospital owners met to weigh the merits of new hospital construction permits based on their collective interests as capitalists. As such, the Association generally focused on the certification of privately-run hospitals rather than “charity” hospitals which undercut their collective profits. With the publicity around the riots, Sol White’s petition, the County’s petition, and the town hall, however, drew enough public scrutiny and attention on the Commission to make ruling against the creation of a new health district unlikely.

In this way, one of the most important products of the town hall was its power to pressure the California Hospital Association to agree to a new health district. It also helped Supervisor Hahn orchestrate a plan to subsume the desire of the Drew Society members to build their own independently-run private hospital under the County’s desire to quell resident dissatisfaction and frustration over being economically and socially isolated from mainstream society. Hahn hoped to modernize the role of the proposed county hospital by using new billing methods made possible through Medicare and Medicaid to cater to both private paying and welfare eligible patients. It was also imperative to him and the

[103] Eugene Purnell, Secretary, Laborers Local 300. Anti-poverty Committee. News Release “Community Organizations in Watts United for County Hospital” Jan. 30, 1966. Kenneth Hahn Collection. Box 200, Folder 14. Martin Luther King, Jr. Hospital, Hearing (Special Collections, Huntington Library)

Commission that any hospital certification or riot remediation program be led and owned by local residents, as opposed to "outsiders," because all new funding for health and anti-poverty programs under President Johnson's new initiatives required it.[104] As such, the Commission gave the certification to the County of Los Angeles with the full expectation that "community" members, the Drew Medical Society, and the local medical schools at UCLA and USC participate in its formation and operation.

I argue that the health district certified in 1966 became a new definitive spatial expression of state power for modern hospital health planning. Rather than drive health resources away from the "ghetto," the geographic boundaries of Watts' health district rendered a once purely discursive object — poverty — a visible and discrete problem for containment and eradication while normalizing and naturalizing free market health practices outside the area as part of a new multicultural mainstream. The spatial differentiation of Watts was not meant to arrest development in the area but track its eventual absorption with the rest of society. Significantly, the Watts Health District did not select out every community with black residents as part of the county's new health district but reserved the district's boundaries for black residents who regularly could not afford to pay for health services on their own.

The health district's significance lies with its exposure of metropolitan spaces that private hospitalists were, until 1965, unwilling to admit needed government intervention. The Watts Riots exposed a humanitarian crisis of extreme dense poverty that could not be fixed by the "invisible hand of the market," the belief that human needs can be efficiently met through private entrepreneurship.[105] To fix the crisis, the California Hospital Commission recruited legislation originally crafted for "rural" health districts to create a new designation - the poverty metropolitan district, or a "ghetto" health district. Unlike rural districts which were determined by the ratio of population to space, the main determinative

[104] I cover this policy of recruitment and implementation requiring the participation of the poor, known as "citizen participation" and/or "maximum feasible participation" later in the chapter.
[105] The phrase "invisible hand of the market" is generally attributed to Adam Smith's writings on laissez-faire economics in 18th Century Europe and popularized in his texts, The Theory of Moral Sentiments (1759) and The Wealth of Nations (1776). It usually refers to the idea that trade and market exchange automatically channel self-interests toward socially desirable ends.

eligibility for ghetto districts was the eligibility of petitioners and patients to qualify for federal health and anti-poverty assistance.

Ultimately, the County's objective was not to use these funds to undercut the profits of free market medicine but lubricate the transition of the community into healthcare standards held and determined elsewhere. Under President Johnson's citizen "participation mandate," the county's health-as-urban renewal program would be measured upon the degree by which it could recruit the poor to carry out their own anti-poverty programs. In short, the measurement of success would largely depend on the extent to which the poor recognized themselves as both the problem to be solved and solvers of the problem. The County and Drew Society members heralded this scheme as a way to strengthen the black community's commitment to universal labor participation and respectable marriage and family formation.

While the creation of the new health district rallied the County and black community to vanquish poverty and health inequality by maximizing the state's entire bed allocation of 735 beds, the Commission quietly debated the merits of granting so many beds to an operator where residents were still so poor and when the efficacy of antipoverty programs were so unproven. The ensuing bed debate between Drew, the County, and the Commission shows that keeping a reserve number of un-built beds was an important device for private hospital owners to exploit in order to keep their profits high. While the commission conceded to the creation of a new health district, their final recommendation to build a 438-bed hospital instead of a 735-bed hospital reveals that they believed that poverty determined profits not bed ratios.

Ultimately, the "ghetto" health district had a short-lived existence.[106] The hospital built and opened in 1972 based on the ghetto health districting plan, King-Drew Medical Center and the Watts-Willowbrook health district, would be re-termed by federal authorities and generally known to healthcare

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[106] In fact, the State Advisory Hospital Council Meeting in February of 1966 shows that the California Hospital Association was actively debating how bed allocations to "general hospitals" should be properly determined. The meeting minutes suggest that authorities were beginning to move away from geographically contiguous ideas of health markets to spatial areas that overlapped each other. In other words, private hospitals would decide their boundaries separately from general hospitals to catch different populations. "February 24, 1966 State Advisory Hospital Council Meeting Minutes." Kenneth Hahn Collection. Box 200, Folder 1 (Special Collections, Huntington Library)

administrators in 1973 as a medically underserved area/population (MUA/P), a distinction that named the persistent lack of health providers, institutions, and service in an area or amongst a specific social population based on several key indices of poverty. The "ghetto" health district thus exposes an incredibly short period where health planners deployed the term "ghetto" not as a diminutive term but as a term that captured how the ghetto and its meaning could be re-defined to signify something productive and non-threatening.

Seeing Like A State

The use of new geospatial units such as the "poverty district" and statistical combinations to make certain sub-populations "seeable" in the population were fundamental elements of President Johnson's War on Poverty programs in the mid-1960s. Although Dr. White had submitted his original petition to win designation for his proposed health district using the language of poverty districts in February 1965, the use of such distinctions were not commonplace knowledge or immediately recognizable to most local politicians and American businessmen outside of the District of Columbia. In the wake of the Watts riots, White's proposed district sent medical and political leaders on an educational journey to update themselves on the latest economic and social theory behind new state technologies around geospatial units. That education broadened the uses and applications of economic language previously and exclusively used by American diplomats, economists, and state bureaucrats in developing nations.

White's proposed outline of a twenty-square mile district containing a socio-economically uniform community across the indices of race, age, class, and space reveals that he was far ahead of most local politicians in understanding how to leverage new federal anti-poverty and healthcare reforms. His knowledge was a testament to the close relationship that had developed between President Johnson and the all-black and all-male National Medical Association (NMA) during the President's famous fallout

between his office and the more mainstream and white American Medical Association (AMA).[107] That relationship fast tracked knowledge about federal reforms directly to White through the NMA's annual leadership meetings. White had attended them as an activist, and later, as President of the Drew Medical Society, Los Angeles' local NMA chapter.[108]

When he crafted the district's boundary lines, White did not rely on sophisticated techniques of cartography and statistics but drew it based on his perceptions of where Los Angeles' poor black neighborhood of South Central ended and where new racially integrated middle class neighborhoods began. At the same time, White had also reached out to Kenneth Hahn and the Board of Supervisors in an attempt to curry favor for his health district to be designated as a rural, not metropolitan, district hospital. As I explore later, the designation would have provided him with construction and operating costs drawn from a district tax.

While both the Hospital Association and County knew there was a need for a hospital in the area, they separately tabled his petition because he did not present proof of ready capital and provided a rationale, at first, confusing to both of them. With a population in the district well over 100,000 people all living near or below the poverty line, both agencies did not know how to proceed given that it could not be designated as a rural district nor could it generate enough funds on its own to sustain itself as a metropolitan hospital. In fact, White presented evidence of the area's poverty by citing that the neighborhood was "a high unemployment rate area, a high welfare aid area, and is the recipient of funds from the Anti-poverty program, the Manpower Training Program, Urban renewal, etc."[109]

Hardly inclined to perceive how such poverty could be considered an asset, the Commission ruled that "although [it] agreed that the need was great," it tabled the matter and "expressed concern over the

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[107] According to Martha Derthick, the NMA essentially "represented the medical professional" between 1963 and 1965 since the AMA was "implacably hostile to government health insurance." *Policy Making for Social Security* (Washington, D.C.: Brookings Institute, 1979), page 96.
[108] According to Daniel Simon, White was actually on an extended trip back from the NMA's annual meeting in Cincinnati when the riots broke out in August. Daniel Simon. Dissertation. "The Creation of the King-Drew Medical Complex and the Politics of Public Memory" (University of Hawai'i at Manoa: Department of American Studies, 2014) p. 70
[109] February 23, 1965 Letter, Dr. Sol White to Los Angeles Board of Supervisors. Kenneth Hahn Collection Box 200, Folder 1 (Special Collections, Huntington Library)

ability of the requesting group to raise the necessary 1/3 funds for [federal and state hospital funds for] construction and expressed concern over the ability of the citizenry who would become patients in the facility to support annual operating cost requirements."[110] As I will show in the next section, the statements by both the Commission and the relative absence of activity by the County reveal that they had measured White's proposals on standards used by the industry and government for private hospital operators that existed prior to 1965. These show that both had not yet seriously considered the impact of new federal legislations on their activities in the wake of their implementation.

The Watts Riots served as the platform to prompt both agencies to re-consider White's proposal under the framework of the new health and anti-poverty programs as he had originally intended them to. After the riots had subsided in August, the Hospital Commission and Hahn followed the lead of the Governor Brown's official riot investigation panel, the McCone Commission, by assessing the needs of Watts' citizens and understand how existing state and private resources could meet the crisis unfolding in Watts. The California Hospital Commission commissioned its own study, the "Special Study of South and Southeast Los Angeles Metropolitan Area for Existing General Acute Hospital Facilities and Proposals of Acute Facilities," to determine how new health laws could dovetail with anti-poverty efforts.

The study confirmed that White had correctly identified a core district of poverty with virtually no hospitals in its boundaries. (See Figure 2.1) It also affirmed that not all census tracts containing black residents were poor and found that areas just outside of the proposed health district were dotted with hospitals, a majority of which were in danger of losing all or nearly all accredited beds in the wake of new Medicare and Medicaid requirements.[111] (See Figure 2.2) The findings unearthed a common pathology around rioting that believed that poverty painted the expected pathway of future and past social disorder. The study added to this pathology by suggesting that the spread of poverty might also place hospitals

[110] February 24, 1966 State Advisory Hospital Council Meeting Minutes. Kenneth Hahn Collection Box 200, Folder 4 (Special Collections, Huntington Library)

[111] The Agenda and Minutes of the State Advisory Hospital CounciL Meeting on Feb 10-11, 1965 in Los Angeles reflect that the entire 177 bed inventory in Watts in 1965 was deemed "nonconforming," meaning that a all of its bed stock would be unable to operate at industry standards when Medicare and Medicaid were implemented later that year. February 23, 1965 Letter, Dr. Sol White to Los Angeles Board of Supervisors. Kenneth Hahn Collection Box 200, Folder 1 (Special Collections, Huntington Library)

operating in adjacent neighborhoods in imminent financial danger. To convey this, the study team noted the district's bed needs would be entirely unfilled and drew "a grouping of population census tract areas around the periphery of Dr. White's geographical delineation, to reflect what appears to be an increase in high percentage Negro population with related socio-economic factors."[112]

Alyosha Goldstein argues that American anxieties about the spread of poverty on American soil reflected concern about social disorder and economic upheaval associated with the Cold War and global decolonization movements abroad. He argues that President Johnson's War on Poverty programs not only reflected this anxiety but refracted its programmatic agenda to mirror U.S. foreign policy initiatives for developing nations. He argues that, "in countries diagnosed as underdeveloped, economic growth ostensibly required industrialization fostered by (not altogether altruistic) direct foreign investment and the development of the labor force through investments in human capital."[113] According to him, this "gospel of growth was the core principle of US development and modernization initiatives, both abroad and at home."[114]

The authentication of Watts as a spatially distinct economic unit thus primed the neighborhood for political and economic intervention originally designed for underdeveloped nations. Timothy Mitchell argues that this shared way of seeing was the product of the "development of the economy as a discursive object" between economists and state technocrats between the 1930s and 1950s.[115] It provided a geospatial representation of the economy "in which the world was pictured in the form of separate nation-states, with each state marking the boundary of a distinct economy." It, more importantly, "provided a new, everyday political language in which the nation-state could speak of itself and imagine its existence as something natural, spatially bounded, and subject to political management."

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[112] "Foreword" Special Study of South and Southeast Los Angeles Metropolitan Area Relating to Existing General Acute Hospital Facilities and Proposals for Acute Facilities Dec 14, 1965 Hospital Planning Association of Southern California Kenneth Hahn Collection Box 200, Folder 1 (Special Collections, Huntington Library)

[113] Alyosha Goldstein *Poverty in Common: The Politics of Community Action during the American Century.* Durham: Duke University, 2012. p. 17

[114] Alyosha Goldstein *Poverty in Common: The Politics of Community Action during the American Century.* Durham: Duke University, 2012. p. 17

[115] Timothy Mitchell, "Origins and Limits of the Modern Idea of the Economy" (Paper presented at the Workshop on Positivism and Post-Positivism, University of Chicago, October 2001), 18-19, 20, 22. Also see: Timothy Mitchell, *Rule of Experts: Egypt, Techno-politics, Modernity* (Berkeley: University of California, 2002)

White's petition affirmed the power of this language by presenting himself as both the agent of and subject to political management. His petition demonstrated a willingness to see and understand spatially bounded poverty and economic stagnation as a problem in the same way that postwar global economists and government bureaucrats pushing for the "gospel of growth" outside the community did. White's distinctive identity as resident of Watts, however, ensured that the main agent of the President's policy of "the gospel of growth" would emanate from an embedded voice rather than a foreign one.

"The gospel of growth" did, however, require operatives at local levels to determine the pathway of development. The riots represented an opportunity for private hospital industrialists and local government leaders to consider local economic investment in new service industries like healthcare rather than old industries now being outsourced to new markets abroad. Likewise, instead of developing a labor force for a declining manufacturing economy, the new health district aligned Watts' manpower development programs to expand labor opportunities within healthcare. For local black leaders and for the Drew Medical Society, it was important that this manpower development program focus on recuperating black manhood from what they regarded as a dangerous pattern of state support for the autonomy of black women.

What is significant about the system of spatial differentiation employed in the 1960s is that it revived older spatial representations of racial settlement to much different ends. As scholars of quarantine and infectious disease management in the late 19th and early 20th century have shown, the construction of health districts were more frequently meant to limit investment of state resources in public health infrastructure and capitalist development within them in order to favor white settlement elsewhere in surrounding neighborhoods.[116] Whereas that body of scholarship uses the use of health districts to affirm

[116] Of the many great pieces of scholarship, I suggest: Howard Markel. *Quarantine! East European Jewish Immigrants and the New York City Epidemics of 1892* (Baltimore, Johns Hopkins University Press, 1997); John McKiernan-Gonzalez. *Fevered Measures: Public Health and Race at the Texas-Mexico Border, 1848-1942* (Durham: Duke University, 2012); Natalia Molina. *Fit to Be Citizens? Public Health and Race in Los Angeles, 1879-1939* (Berkeley: University of California Press, 2006); Nayan Shah. *Contagious Divides: Epidemics and Race in San Francisco's Chinatown* (Berkeley: University of California Press, 2001); Samuel K. Roberts, Jr.. *Infectious Fear: Politics, Disease, and the Health Effects of Segregation* (Chapel Hill: University of North Carolina Press, 2009); and, William Deverell. *Whitewashed Adobe: The Rise of Los Angeles and the Re-making of its Mexican Past* (Berkeley: University of California Press, 2004)

the existence of a racial state that defined national citizenship as white, the Watts health district worked towards opposite ends by representing itself as a technique of racial liberalism that supported a new multicultural state.

Settling Citizenship

In April 1966, the California Hospital Association approved plans to designate Watts as a poverty metropolitan district, a term others elsewhere referred to more colloquially and diminutively as a "ghetto" health district. The creation of this distinction indicates that private and government officials did not reverse their thinking around rural and metropolitan health districts but created an entirely new distinction for low income neighborhoods in urban settings. The new distinction represented how the medical community could use new health and anti-poverty funds to enter into new medical markets where health consumption countered normative expectations of utilization. In doing so, the distinction did not depart from a long history of California policy objectives that were designed to settle citizens into the region as free market consumers of western medicine.

As the absence of Los Angeles and California within the history of hospitals indicates, the region's overarching policy objective of migration and settlement of white anglos since California's statehood developed a larger public hospital system than most Eastern Atlantic states.[117] The California legislature framed the care of white men who migrated alone and fell sick as a pending moral and national crisis, mandating in 1855 that each county create provisions of care that many used to build a public hospital.[118]

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[117] The two most definitive monographs on the history of hospitals are Rosemary Stevens' *In Sickness and in Wealth: American Hospitals in the Twentieth Century* (New York: Basic Books, 1989) and Charles Rosenberg's *The Care of Strangers: The Rise of America's Hospital System* (Baltimore, Johns Hopkins University Press, 1987). Both rightly focus their attention on the rise of for-profit hospitals, which are the lionshare of the U.S. Hospital market. In doing so, they do not pay attention to California's hospital market until a robust private market emerges after WWI in the state.

[118] Without a strong economic base to support the building of private paying hospitals and an imbalance in the ratio of white men to white women, the California legislature passed the Pauper Act in 1855, which mandated the care of poor patients by each county government. The Daughters of Charity actually were motivated to migrate to Los Angeles in order to care for white male settlers and won the first contract from the County of Los Angeles to provide care for indigent settlers. As a 1885 *Los Angeles Times* article demonstrates in its description of an Independence Day event celebrating the lives of white patients at the county hospital, the hospital became an acceptable way to incarcerate indigent men as health hazards without invalidating their value as citizens or suffering their presence on

When White migration of families increased between the 1870 and the 1920s to California, the reputation of hospitals and medical professionals were changing for the better, such that California's vast public health infrastructure was looked upon as favorable amenity that anchored greater migration to the state than other locations.

By the end of WWII, California's large public hospital infrastructure and the settlement of veterans used to routine health checkups in the military into the region had produced a large population of consumers accustomed to hospital services and regular care. Continued national migration due to the war and the resettlement of whites within the county thus spurred private hospital construction in new white communities further from the nucleus of downtown Los Angeles. According to Margaret Taylor, however, some citizens in rapidly changing neighborhoods demanded a mechanism to secure hospital services in locations not yet recognized by private hospital industrialists or by public health officials as worthy of a hospital.[119] As she argues, citizens couched their demands for local hospitals within a broader desire for other public utilities such as water, sanitation, and energy services.

In 1945, the California legislature established "special districts" to address the crisis in matching the demand for public services and utilities with the explosive growth of California's population after World War II. According to Taylor, special districts were "created at the will of local residents to fulfill a particular need not being met by other governmental or private agencies."[120] The California legislature created stipulations for special districts specifically concerned with health by enacting the Local Hospital District Law (section 32000 et. seq. of the Health and Safety Code) to "give rural, low income areas without ready access to hospital facilities a source of tax dollars that could be used to construct and

the street. "At the County Hospital - A Large Attendance of Visitors and Credible Exercises," *Los Angeles Times* (Los Angeles, California, July 5, 1885), 6.

[119] Taylor, Margaret. California's Health Districts. White Paper prepared for the California Healthcare Foundation. April, 2006

[120] Taylor, Margaret. California's Health Districts. White Paper prepared for the California Healthcare Foundation. April, 2006. p 4.

operate community hospitals and health care institutions, and, in medically underserved areas, to recruit physicians and support their practices (e.g., subsidies, office space, equipment)."[121]

White sought the rural district designation in 1965 precisely because it did not call upon the county to build a new "charity" hospital in Watts but would have empowered him as the private agent to administer public health services on behalf of a fund drawn from local taxpayers. By law, citizens would have to vote for the tax and empower a council to draw up a contract of services and secure an agent either by creating its own service entity or subcontracting it out to an existing vendor. While these districts did have to agree to some contractual public health responsibilities, a lion share of their services would be based on fee payment schedules. As Taylor points out, many of these health district hospitals soon anchored more residential migration to their districts such that their designations as "rural" soon lost its meaning amongst a growing white metropolis of mostly independent hospital operators.[122]

By the 1960s, the tendency of hospitals to cluster close to each other prompted operators looking to defend the profitability of their hospitals with new competitors and state bureaucrats concerned with rising healthcare costs to initiate new policies to fight a new phenomenon called "overbedding."[123] Whereas citizens were once concerned with the lack of availability of hospital services in their neighborhoods, the concentration of hospital beds in some areas caused the California Hospital Association and the California State Bureau of Hospitals to band together to create a new distinction

[121] Taylor, Margaret. California's Health Districts. White Paper prepared for the California Healthcare Foundation. April, 2006. p 5

[122] Taylor shows that crowded competition has changed the nature and function of these districts. Since the implementation of the rural health district law, "close to a third of these districts have closed, leased, or sold their hospitals; some have declared bankruptcy; and many have changed and expanded their historic mission as providers of acute care to become funders of community health services. To a large extent, these changes in district functions have occurred in reaction to the evolving California health care environment, which has forced all hospitals, especially smaller facilities, to re-examine their reasons for continued existence." Taylor, Margaret. California's Health Districts. White Paper prepared for the California Healthcare Foundation. April, 2006. p 7

[123] James Schooler, chairman of the California Hospital Association's Southern California coast area hospital planning committee, first explained this phenomenon to readers of the Los Angeles Times in 1965. He stated, "when a community becomes over-bedded, the cost of maintaining such unoccupied beds is eventually borne by the 'consumer', the hospitalized patient." This "hidden h-tax" made healthcare costs unaffordable for a larger and larger pool of consumers. See: "Hospital Beds Pose Problems: West Side Paradox: Too Many Here and Too Few There" January 3, 1965 *The Los Angeles Times* p. WS1 and "Application for New Hospital Turned Down" August 11, 1964 *The Los Angeles Times*, p. A8

called the "metropolitan district," an entity devised not to encourage growth but to regulate it.[124] The central concern was that competition between operators were driving a surplus of beds that went unoccupied. Operators balanced the costs of labor staffed to unoccupied beds on the billing statements that they passed on to patients in occupied beds, raising the cost for all patients dramatically and unevenly.

Private operators voluntarily agreed to participate in metropolitan districting to keep costs down and to limit new competition to save the profitability of their ventures. In 1961, private hospitalists began to self organize themselves into metropolitan districts and agreed to a bed-to-population ratio set by the federal and state governments to determine the proper number of beds within a given district based on its population. In 1963, the California Bureau of Hospitals made it mandatory that any hospital seeking federal and state hospital construction assistance funds (otherwise known as Hill-Burton funds) for an area populated with more than 100,000 people obtain certification first with the California Hospital Association's new metropolitan district system. In theory, the system froze all new construction in "overbedded" districts and limited the size of hospitals to available bed surpluses in under-bedded districts.

The new criteria made it virtually impossible for White's proposed hospital to be eligible for state and federal assistance funds as a metropolitan district hospital. The new process universally assumed that any new hospital construction would come from entrepreneurs wealthy enough to enter the market with enough ready capital amounting to at least one-third of proposed construction costs and have enough

[124] The process to create metropolitan health districts first began as a joint venture between the California Bureau of Hospitals and the California Hospital Association at the private hospital's industry conference in 1960. According to Dr. John Smits, the California Hospital Association's President-Elect and regional director of Kaiser Foundation Hospitals, delegates approved a measure that would ensure that "no new hospitals or expansion of existing hospitals until the projects could be reviewed against a master plan." In 1963, the California Bureau of Hospitals required any applicant seeking to receive state construction funds meet eligibility through this new process. According to Gordon Cumming, Director of the California Bureau of Hospitals, the program "would reduce the state's hospital building outlay from $1.5 Billion to $750 million between now (1960) and 1975" by placing "emphases 'on having the right hospital at the right time at the right place.'" See: "Hospital Leaders Cite State Planning Needs" October 27, 1960 *Los Angeles Times* p. B8 and "Overhaul of Hospital Funds Rules Proposed: Greater Voice Urged for Planning Councils in State and Federal Construction Grants" Dec. 7, 1962 *Los Angeles Times* p. A9

costs to cover initial operating costs.[125] As a poor community physician from a resource deprived health market, White's financial profile could not win a construction permit based on the fact that he did not have the sufficient funds for both construction and operation.

His profile as an embedded agent and member of the Watts community, however, did make White eligible to receive state and federal assistance funding from a range of sources related to federal health manpower development programs, health service contracts, and anti-poverty programs. Under President Johnson's "citizen participation" mandate, any authority seeking these funds would have to demonstrate the successful recruitment of the poor into the planning and implementation of these programs and funds.[126] In short, the capital that White brought to the planning process was his not his meager and non-existent *financial* capital, but rather the *social* capital he brought in authenticating the project as an anti-poverty program through his identity as part of the "poor" class rather than as a part of a medical class.

The California Hospital Commission entertained the power of these anti-poverty programs because they promised to transform and eventually replace Medicare and Medicaid eligible consumers with free market consumers. The goal of anti-poverty programs was not to make individuals more dependent on government intervention, but more independently responsible through its main objective to push and arm laborers with new and locally relevant job skills. Conservatively, the Commission tied the eventual certification of "ghetto" health districts to the high probability that Medicare and Medicaid and some federal and state assistance programs would cover some of the operating costs of the proposed hospital. Be that as it may, it did not solve the problem of hospital construction costs.

Hahn's orchestration of a partnership between the County of Los Angeles and the Drew Medical Society paved a viable pathway that fused the County's identity as an agent with funds and Drew Society's identity as embedded "poor" leaders/subjects together. This partnership made it possible to win certification while amplifying the chances for more resources as an official anti-poverty program. More

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[125] The one-third construction costs would be matched by Hill-Burton funds drawn from the federal government and the California Bureau of Hospitals.
[126] For more on citizen participation, see: Alyosha Goldstein *Poverty in Common: The Politics of Community Action during the American Century.* Durham: Duke University, 2012

importantly, the plan signaled the transformation of “charity” care into something new and desirable for healthcare.

Whereas charity hospitals were seen as competitors that undercut the ability of surrounding hospitals to make profit, Medicare and Medicaid empowered traditional patients of charity hospitals to seek care in the “mainstream” of free market healthcare. Hahn’s scheme proposed to use the County’s ready cache of capital to transition Los Angeles County Hospitals into, essentially, free market competitors in low income communities that billed federally-eligible patients and fee-paying consumers as all providers theoretically could after 1965. Additionally, if Hahn’s vision worked, Drew Society’s members would eventually develop into the hospital’s legitimate leaders and tenants.

The participation of the Drew Medical Society therefore made the Watts health district a definitively unique project because it purposely crafted the hospital as the principle economic engine in the neighborhood. The creation of a health district in Watts did two things. First, the Commission, equally concerned about the spread of poverty towards neighboring hospitals just outside of Watts, saw the usefulness of creating an agent that took responsibility for its containment. Second, the identity of the district as a “ghetto” anti-poverty district armed it with additional tools to potentially transform it into a thriving free market district as metropolitan and rural district hospitals were in the rest of the county.

Profiting from the Unbuilt and the Under-serviced

The successful certification of a new type of health district — the “ghetto” health district — was heralded by the California Hospital Association, the California Bureau of Hospitals, the County of Los Angeles, and black community activists as the device to transition the community from relative social and economic isolation into a new multicultural society premised on private healthcare. For public bureaucrats, the district demonstrated how bed-to-patient ratios could be rationally met through the intensification of free market principles in metropolitan districts by relying on private actors to act in the best interests of all citizens. For private hospital operators, however, the district’s formation was more

important to them as a concession that won them the right to exit from the public stage and remove any potential public scrutiny of their unsavory internal practices.

By allowing this public-private relationship between the County and Drew to take center stage, the Association sought to prevent discovery of its internal practices over bed surplus allocations. Deeper interrogation of the Association show that private hospital operators were not interested in maximizing bed to population ratios to evenly distribute services and contain costs. Instead, their unwillingness to grant White's original petition reveals how they exploited their bed surpluses to maximize private profits.

In making Hill-Burton funds contingent on the certification process of the Association, the state had left the key elements of determining the size and membership of each metropolitan district to the hospital industry. In doing so, hospitalists organized smaller districts to keep competitors out of affluent markets and larger metropolitan districts for more socioeconomically diverse areas of the city. The effect created small profitable markets in the city's affluent regions that were difficult for new competitors to enter. It also furnished more middling hospitals in older regions of the city with a reserve surplus of unbuilt beds. Whereas some hospitalists formed metropolitan districts to maximize state bed ratios to keep out competitors, others preferred to form districts that kept and treated their reserve of surplus beds as private assets.

White had presented his petition in 1965 close enough to the creation of metropolitan districts in 1963 to reveal that the two districts that his proposed Watts District straddled, the Lynwood District (Area 819) and the Los Angeles Hospital District (Area 820) were both formed with a similar cushion of unbuilt beds allocated to each.[127] (See Figure 2.3) These districts differed from the wealthy Santa Monica-West district, which in 1964, turned down a proposal for a new 268-bed hospital because the "area [would] have sufficient hospital space because of expansion programs at existing hospitals."[128] What's surprising

[127] February 23, 1965 Letter, Dr. Sol White to Los Angeles Board of Supervisors. Kenneth Hahn Collection Box 200, Folder 1 (Special Collections, Huntington Library)
[128] "Application for New Hospital Turned Down" August 11, 1964 *Los Angeles Times* p. A8. This observation is supported by the Special Study conducted by the Association in December 1965, which named the solidly middle-class and professional neighborhoods of Burbank, Downey-Norwalk, Santa Monica, and Long Beach as fully bedded districts. Special Study of South and Southeast Los Angeles Metropolitan Area Relating to Existing General

is that while the more affluent Lynwood District held a population of 530,600 people, Los Angeles' Hospital District held a population more than twice that amount (1,198,000 residents).

The drastic difference in population numbers reveal that the Hospital Commission permitted hospitalist operators to organize districts in 1963 to seat and favor incumbent operators. The effect froze out new competitors of certain lucrative markets because district members had organized their districts to maximize bed ratios by the manipulation of the district's irregular size. By making bed surpluses a tool of power, competitors were forced to assess the meaning of a numerical surplus in a given hospital district. A new competitor looking to do business in the Los Angeles Hospital District, thus, might be dissuaded from entering the market if the surplus of beds was interpreted as a lack of confidence in what the actual market could bear or if it reflected a belief that the most lucrative patients were likely to remain loyal to a particular operator (and thus be unwilling to consider a competitor with newer and more modern beds.)

The similarity of surplus percentages of both Lynwood (16%) and Los Angeles District (12%) reflect a more plausible answer - that neighboring operators colluded with each other to give themselves a small enough surplus of beds that they could use at their discretion to build newer and more modern beds without having to interrupt the operation of its current bed usages. Here, Lynwood's smaller population size suggests an intense spatial concentration of wealth that was more diffuse in Los Angeles' hospital district. These irregular sizes could be exploited to concentrate beds in particularly rich sections of the district while relying on the numbers provided by poor residents in undeveloped sections of the district to their advantage.

This phenomenon reflects a racial and class divide in Lynwood's district. The creation of a Watts health district substantially decreased the size and population of the Lynwood District, splitting the district between a poor black and middle class white population. Lynwood's original census of 530,600 people with a bed ratio of 1,138 beds was cut roughly in half with the creation of the Watts district, to 244,000 people with a new bed ratio of 760 beds. (See Figure 2.3) The removal of half of Lynwood's

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Acute Hospital Facilities and Proposals for Acute Facilities Dec 14, 1965 Hospital Planning Association of Southern California Kenneth Hahn Collection Box 200, Folder 1 (Special Collections, Huntington Library)

spatial terrain and population reveals that its 960 beds were dedicated to an extremely small but wealthy clientele of 244,000 people located in the district's eastern edge. That a majority of people and space would be taken from it demonstrates that operators in the Lynwood District, particularly the Catholic-run 400-bed St. Francis Hospital, depended on Watts to furnish them with a surplus of beds that they did not intend to use unless for refurbishment or distribute to new competitors. The new Watts district entirely depleted Lynwood's bed surplus so much that the new adjusted district was now "over-bedded" with 960 beds of a 760-bed allocation.

In fact, the loss of their reserve surplus of beds explains why the Catholic Diocese refused Hahn's invitation to be the agent and vendor of health care services in Watts in the wake of the riots. During the month of December 1965, Hahn had invited nearby private operators outside of the Drew Medical Society, such as the St. Francis Hospital's Daughters of Charity and the Seventh Day Adventists, to take leadership of a Watts hospital.[129] Their refusal shows that they were concerned that beds in Watts would not be profitable and that the surplus of beds Watts' population gave to their current operations was not an asset they wanted to relinquish.[130] In contrast to Lynwood's newly adjusted "overbedded" district, the new Watts District was left with a bed inventory of 177 beds, of which all were set to lapse as operable beds with the implementation of Medicare and Medicaid. In other words, Watts was facing a possible bed inventory of no beds to service its population of 344,000 residents.

[129] In a Press Release dated December 23, 1965. Hahn notified the media that he was "contacting various religious organizations and the Ford Foundation to request their assistance in financing and opening 'this desperately needed facility.'" His actions are also reflected in a letter to Ford Foundation President, Henry T. Heald from Hahn, dated December 22, 1965. In it Hahn says State of California advisory council is favorable to awarding four million dollars under Hill-Harris funds but they still need an "additional one-third in matching funds so a hospital can be constructed by either a non-profit community group or a religious institution." All of this seems to prompted by advice by the State Council. In a December 15, 1965 Press Release, Hahn declared that the "Council should approve any reliable group of community doctors or religious group such as the Seventh-Day Adventists which could build such a non-profit hospital with Hill-Harris funds." Kenneth Hahn Collection Box 200, Folder 1 (Special Collections, Huntington Library)

[130] According to Dr. Sol White, St. Francis was known to regularly bar black physicians. Daniel Simon. Dissertation. "The Creation of the King-Drew Medical Complex and the Politics of Public Memory" (University of Hawai'i at Manoa: Department of American Studies, 2014) p. 65

Without a clear sense of these internal operator practices, Hahn initially led community activists to build the entire permissible state ratio of 735 beds for 344,000 people in the district.[131] At the community townhall and at the California Hospital Association hospital certification hearings, community members spoke eloquently and compellingly for a 735-bed hospital because they understood the state bed-to-population ratios as an ideal and democratic expression of equal distribution of health resources.[132] While White's original petition for a 200-bed hospital appeared to be a more conservative assessment of what a post-Medicare/Medicaid market might sustain, the state's ratio of beds-to-population made his proposal appear weak and ineffective in meeting the community's scope of need.

When the Commission finally ruled on the certification of the new health district and hospital, it did so privately in order to leave the fanfare and celebration to Hahn and the Drew Medical Society. Hahn and the Drew Medical Society used the occasion to announce an official campaign to raise public funds for a new county hospital through a referendum set to be on the ballot in Spring of 1966.[133] The press releases reveal that a compromise had been reach well away from the prying eyes of the public that arrived at a hospital of 438-beds, a number that was sufficiently large, but not as large as 735-beds, and not as small as 200-beds.

A Shared Space of Contested Meanings

This close inspection of the formation of a Watts Health District reveals that while the California Hospital Association, the County of Los Angeles, the Drew Medical Society, and Watts activists, residents, and community organizations were able to hold common cause in forming the district, their

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[131] Hahn worked fast to advertise the boundaries of a new health district despite the fact that the issue of bed size was unsettled. Nevertheless, he sent out a press release stating that, "Approval of boundaries for a 700-bed County hospital for the Watts-Willowbrook area was reported today by Supervisor Hahn." "Supervisor Hahn originally had worked to have a community group come forward to develop a hospital for this area with private financing. When no group of doctors or businessmen were approved by the State Advisory Council, Hahn moved to have the County provide the facility." Press Release. February 25, 1966. Kenneth Hahn Collection Box 200, Folder 1 (Special Collections, Huntington Library)

[132] Agenda. State Hospital Advisory Council Meeting Minutes. February 24, 1966. Kenneth Hahn Collection. Box 200, Folder 14. Martin Luther King, Jr. Hospital, Hearing (Special Collections, Huntington Library)

[133] The first of these was a Press Release sent on March 30, 1966. "Undersecretary of Commerce Leroy Collins has strongly endorsed a Los Angeles County bond issue to construct a 438-bed hospital in the Watts-Willowbrook area." Kenneth Hahn Collection Box 200, Folder 1 (Special Collections, Huntington Library)

shared agreement was shot through with a complex web of conflicting and opposing trajectories. Perhaps the greatest tension of these is the fact that the liberal democratic objective of politicians and community activists to eradicate under-bedded districts as a social good appeared to be in direct conflict with the capitalist imperative of hospital operators to defend the existence of a reserve surplus of beds as necessary for them to produce private profit. The County of Los Angeles thus took up the responsibility of the poor not just to service their healthcare needs but to act as the agent to push them into free enterprise healthcare. However, as some of the actions of private hospital owners show, the imperative to make profit pushes against this democratic ethos. Here, the fact that poverty emerges as just as productive of a force for capital as the desire for more health services is not a contradiction but two very important forces needed to sustain racial capitalism.

The sobering reality is that there is overwhelming evidence that demonstrates that the California Hospital Association and the County of Los Angeles were prepared to do nothing about the health crisis in Watts until the Watts Riots unfolded in August of 1965. It is also clear that the California Hospital Association only acted upon the health district because of the popular scrutiny and pressure applied onto them from community activists and organizers made them weary of a possible scandal over the exposure of their internal practices. The fact that community activists were able to win something they otherwise would not have won - a health district - is a victory balanced by another sobering defeat - that all those efforts fell short of building a hospital the size and scope of the community's need.

When the health district hospital, King-Drew Medical Center, was eventually erected and opened in 1972, the certification of fewer beds than needed ensured that the health district would still fit the rubric of a new federal designation for poverty health districts implemented by President Richard Nixon. In the early 1970s, President Nixon's administration saw that President Johnson's health and anti-poverty programs still had been unable to achieve the equitable distribution of health services and manpower in inner-city and rural areas. Nixon designated such areas as "medically underserved areas" (MUAs) under his Health Maintenance Organization (HMO) Act of 1973 (P.L. 93-222) which designated areas for new

federal health dollars for comprehensive health clinics (CHCs) through the use of poverty indices to map MUAs.

The County of Los Angeles would again find itself experimenting with CHCs as new types of health infrastructure and boundary-making that could extend the range of healthcare services for an even larger spatial footprint of poverty than the city's poorest black neighborhoods. In 1973, the County had divided up all of the county's regions in new "catchment" zones assigned to each of the county's main hospitals (Los Angeles County General-USC, Harbor-UCLA, Olive View, and King-Drew). They referred to these new boundaries as Health Service Areas (HSAs) and described King-Drew's HSA as an area encompassing "more than a million persons, with significant increase in the percentage of Mexican-Americans and whites, and a relative decline in the percentage of blacks."[134]

In doing so, the creation of a Watts health district and its evolution into a MUA and HSA did make the "ghetto" health district a new definitive spatial expression of state power in health planning but not in the way it was originally intended. The Watts health district drew a spatial unit that drew its borders contiguously with the borders of other health districts such that the map it drew appeared like a neatly ordered nation-state map. In this way, the 1960s health district map personified the ethos of racial liberalism, by mapping each district as if they were stable homogenous communities with an discrete economic profile as "rural," "metropolitan" or "ghetto."

The federal and county creation of MUAs and HSAs, however, re-drew health boundaries such that they overlapped with the imagined catchment boundaries of private hospitals sitting near to them. The new spatial reach of King-Drew's Health Service Area was not meant to express where their responsibility for healthcare ended and where a neighboring community's began. On the contrary, these new boundaries were meant to signify the willing responsibility of the County of Los Angeles to take responsibility for patients that for-profit hospitals chronically rejected from their service.

[134] The Master Plan Study, Summary Report, Section 1 of the Master Plan Vol. I. (The Drew School) Commonwealth Fund Series 18: Grants, Box 981, Folder 891. (Special Collections, Rockefeller Archives), p. 10

In other words, the creation of the “ghetto” health district eventually helped operators distinguish a society that divided itself by those receiving healthcare in a multicultural and cosmopolitan market of private hospitals and those who continued to depend on publicly-funded services rendered to a “permanent underclass” that increasingly became multiracial and poor in its own right. As the enlarged spatial footprint of need and shifting racial demographics show, the process of racial capitalism that was so clearly articulated as a problem of black poverty had, by 1973, shown its ability to draw much more than poor blacks into deeper poverty.

Figure 2.1 Map of Hospitals Included in the Special Study of South and Southeast Los Angeles Metropolitan Area

Figure 1.1 Figure 1.1

Source: Hospital Planning Association Report, December 14, 1965, Kenneth Hahn Collection Box 200, Folder 1 (Special Collections, Huntington Library). Map made for author by Breanna Spears.

Figure 2.2 Twenty Closest Selected Hospitals to Watts Health District, 1965

Twenty Closest Selected Hospitals to Watts Health District, 1965

Hospitals Inside Watts Health District			*Hospitals Outside Watts Health District*		
Name	Licensed Acute Beds	Accredited	Name	Licensed Acute Beds	Accredited
Avalon	22	No	Broadway	67	Yes
Oak Park	43	No	Suburban	39	No
Bon Air	42	No	Orthopedic	162	Yes
Gardena	75	No	John Wesley	259	Yes
Las Campanas	6	No	Doctor's	63	No
			Civic Center	36	No
			University	49	Yes
			South Hoover	32	No
			St. Francis	428	Yes
			Community of Huntington Park	77	Yes
			Soto	7	No
			Mission	129	Yes
			Morningside	86	Yes
			Community of Gardena	55	Yes

Source: Hospital Planning Association Report, December 14, 1965, Kenneth Hahn Collection Box 200, Folder 1 (Special Collections, Huntington Library)

Figure 2.3 State Plan Data for Proposed Watts Hospital Area

Priority Information 1964-1965 State Plan Data

Acute Short Term

	Existing Areas		Proposed Areas		
	Lynwood	Los Angeles	Lynwood	Watts	Los Angeles
Estimated Population July 1, 1963	530,600	1,198,000	244,000	344,000	1,140,600
Estimated Bed Need	1,138	4,696	760	735	4,696
Bed Inventory	1,088	5,475	911	177	5,475
Conforming	778	2,587	788	0	2,587
Nonconforming	310	2,888	133	177	2,888
Beds to be Added	50	0	--	588	0
Beds to be Modernized	310	2,109	--	177	2,109
Percent Need Met	82	86	100	12	86

Figure 2.3 The Agenda and Minutes of the State Advisory Hospital Council meeting provided a notation with this table that read: "The proposed areas meet the population requirements for metropolitan hospital service areas," meaning that all of the proposed districting populations exceeded 100,000 people.

Source: Agenda and Minutes – State Advisory Hospital Council Meeting, Feb 10-11, 1965 – Los Angeles, California. Kenneth Hahn Collection. Box 1, Folder 1 (Special Collections, Huntington Library)

Chapter Three
Propositions as Public Education: Multicultural Consensus on Racial Violence

Predictions of the demise of Los Angeles County's Proposition A at the June 7, 1966 election polls came long before the ballots were even counted. The ballot measure would have raised enough capital to construct and open a new branch hospital of the Los Angeles County Department of Health in the predominantly black neighborhood of Watts in the quickest and easiest way possible. Rioting that engulfed that community in August of 1965 had captured the attention of people not just in the United States but around the globe. The campaign to pass Proposition A was led by Kenneth Hahn, a liberal white County Supervisor whose district included Watts. He, along with proponents of the measure, had been skeptical throughout the duration of the campaign but remained hopeful of the chance it might pass.

Given Los Angeles County's overwhelmingly white electorate, a victory at the polls would have demonstrated the superior power of capitalism and democracy in mending racial tension and economic inequality to a national body torn apart by civil rights movement and a global landscape divided by the Cold War. Instead, the 62.5% of votes garnered for Proposition A fell just short of the required 66.6% support of the electorate to pass into law. Normally accustomed to seeing themselves as a progressive multiracial paradise, Los Angeles citizens interpreted the close but decisive defeat as evidence that California was sliding backwards into new and old forms of racial extremism.

Some white middle class voters turned to blame the narrow-mindedness and parochialism of their white working class counterparts. Tony Cimarusti, editor for the *Monrovia News Post*, for instance, blamed the Greater Los Angeles Citizens' Council, formerly the White Citizen's Council, for their active anti-Proposition A campaign and distribution of "Don't Reward Rioting" bumper stickers to white voters throughout the county.[135] Cimarusti pleaded with his white neighbors not to give in to the popular "bad

[135] Believing that citizens had unwittingly been led to support a white supremacist organization without knowing it, *Monrovia News Post* editor, Tony Cimarusti implored citizens who had seen the "Don't Reward Rioting" bumper stickers to "forget it." The Greater Los Angeles Citizen's Council, he argued, had just changed its name from the White Citizen's Council. By revealing to voters that, "it is a White supremacist organization," Cimarusti hoped to convince his neighbors that such an association with a racist organization would not be in keeping with supporting a hospital "open to persons of all races and creeds" and an issue aimed at bettering the "general health and welfare of

connotation[s]" of Watts by arguing that "many fine Negro families living in South-central LA deserve something better than to be tagged with the Watts label." He argued that it is for the "many fine Afro-American persons who own property in Southwest LA and who have seen their property values shattered by the riot and the resulting damage," and not the rioters, that "a hospital should - and must - be constructed."[136]

Some black leaders like the Reverend George Scott Jr., editor for the local black print magazine, the *United Pictoral Review,* turned to blame new black radicals who were now appearing regularly on the civil rights scene. Referring to them as "sophisticated new-comers," Scott cited the propensity of black radicals to "disagree with anything that eminates [sic] from the handiwork of the Caucasian" as a major obstacle to racial progress. In vilifying Hahn for his desire to help the black community, the reverend accused black radicals of "posses[sing] as much racial bigotry in their hearts in reverse as the Ku Klux Klan and the White Citizen's Councils which has spread around this nation of ours."[137] Lumped into a group of no-voters that included black middle class homeowners who were unwilling to part with money to help the poor, the reverend rated the black radicals as "the most dangerous" of those ready to vote no on the measure.

In this chapter, I argue that the 1966 Proposition A campaign was much more than a referendum about building a hospital, it was an arena of political education, teaching citizens what forms of language and attitude were acceptable in public discourse around the topics of race and poverty. While many opinions diverged on the role that the state should play in enforcing racial equality, popular support and opposition for the ballot both rallied their rationale against racial violence. As such, Republican and conservative leaders like John McCone, the Los Angeles Chambers of Commerce and the California Property Tax Association closed ranks with Democratic and liberal progressive organizations such the

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the county." Editorial, *Monrovia News Post,* June 7, 1966 Kenneth Hahn Collection, Box 201, Folder 34, "Editorials" (Special Collections, Huntington Library)
[136] Tony Cimarusti. "Reasons Hospital is Needed." May 19, 1966, Daily News Post. Kenneth Hahn Collection, Box 202, Folder 25 "Newspaper Clippings May 1966" (Special Collections, Huntington Library)
[137] Rev. George Scott, Jr. "Publisher's Reflections" United Pictoral Review, May, 1966. Box 202, Folder 24 "Newspaper Clippings May 1966" (Special Collections, Huntington Library)

Urban League, the NAACP, and the Watts Community Labor Council in supporting the measure as a solution to social disorder and economic instability. The endorsement of the referendum by such disparate political actors shows how multiculturalism had become a bi-partisan issue — crucial to the economy and public safety of citizens in Los Angeles.

Despite strong bi-partisan support, campaign leaders of Proposition A perceived that it might likely be a losing battle. The County Board of Supervisors initiated a series of actions to put in place a plan of action to build the hospital without referendum support as early as February of 1966 and authorized the County's Chief Administrative Officer to carry out those plans on the eve of the election.[138] While voters had affirmed similar construction projects for different neighborhoods of the county for nearly a century, Hahn and others privately worried that citizen support for large public works projects was contingent on public perceptions that such projects secured or would anchor greater white migration and labor participation in the region. Amidst a growing anti-tax sentiment amongst California homeowners, the referendum - temporally close to the riots and unavoidably associated with the blackness of Watts - was the first county measure that Los Angeles County voters encountered that did not assume a white citizen as its primary beneficiary.[139]

Early skepticism led Proposition A leaders to use the election primarily as a vehicle to center political discourse on multiculturalism. To do so, it was equally important for liberal progressives to use the election to build a new political machine capable of preserving the growth initiatives in the region to benefit the growing ranks of people of color in the city as part of a new multicultural mainstream. As

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[138] By as early as February 15, 1966, the Supervisors of Los Angeles County had authorized the Chief Administrative Officer and the Superintendent of Charity Hospitals to draft a report on constructing a County hospital. Hahn asked that, "sufficient funds to finance the hospital be included in the 1966-67 preliminary budget. He also instructed the Chief Administrative Officer to apply for matching federal and state funds (known as Hill-Harris Funds). Several days before the election, the Chief Administrative Officer provided a report, "Use of Public Authority and Non-Profit Corporation for Financing County Construction" on June 3, 1966 that empowered the Board of Supervisors to act in the event that the proposition would fail. See: "County Supervisor Kenneth Hahn Press Release February 15, 1966." Kenneth Hahn Collection, Box 200, Folder 3, "Press Releases;" and "L.S. Hollinger Memorandum to Board of Supervisors. June 3, 1966" Kenneth Hahn Collection, Box 200, Folder 14, "Miscellaneous" (Special Collections, Huntington Library)

[139] As I detail later, citizens certainly did consider race in previous ballot measures but unlike others, Proposition A explicitly used talk about race in its campaign materials. Ballot measures related to state referendum like Proposition 14 (1964) also dealt with race but these were state ballots not county measures.

Cimarusti's and Scott's criticism of two different forms of racial extremism attests, it was important that citizens understand how multicultural liberalism was a new expression of civic nationalism that was distinct and preferable to dangerous and de-stabilizing forms of racial nationalism.

It was therefore important for citizens to understand how a measure that created an explicitly black health district and hospital fit within a larger global schema of racial pluralism that pictured American citizenship as principally committed to racial and nation-state equality at home and abroad. Rather than see this liberal multiculturalism as inconsistent with the principles of white conservatism, my reading of election documents demonstrate how conservatives and liberals both appropriated the language of multiculturalism to form new political affinities based on public safety and global capitalism that differentiated themselves from older shared political affinities based on white nationalism and economic isolationism.

In this regard, Proposition A immediately built a durable political machine for Democrats that Republicans would soon emulate.[140] Hahn and his associates used the referendum to prepare for future electoral battles by using healthcare as the issue to galvanize new Democratic organizations embedded in ethnic communities. The Japanese American and Mexican American Committee for Proposition A, for example, developed a new cadre of once political outsiders into the fold of mainstream democratic participation. The goal of this new political machine would not be to thwart the city's white Republican bloc but the city's staunchly conservative Democratic leadership, led by "Dixiecrat" mayor Sam Yorty. By 1972, it would be the embedded ethnic organizations and the coalitions built from these 1966 efforts that would ultimately unseat Sam Yorty with the election of city's first black and "multicultural" mayor Tom Bradley.

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[140] According to Arlene Davila, the Republican party showed early interest in developing a new conservative voter base amongst Latinos by instituting the collection of census data on "hispanics" under Nixon. As Omi and Winant note the Republican party also began to recruit major black political figures like Ward Connerly and Clarence Thomas began to represent the interests of a growing number of black Republicans. Both concerted efforts were noticeable by the mid-1970s and 1980s. See: *Arlene Davila. Latino Spin: Public Image and The Whitewashing of Race* (New York: New York University, 2008) and Michael Omi and Howard Winant. *Racial Formation in the United States: From the 1960s to the 1990s* (New York: Routeledge, 1994).

Ultimately, the region's need to manage race brought liberals and conservatives together to defend the city's place within a new landscape of racial capitalism that made Los Angeles not only a conduit for capitalist enterprise between the United States and the Pacific Rim but also as the center for new types of labor arrangements that required economic peace and stability. It is therefore significant that shortly after the official announcement of defeat for Proposition A, the Board of Supervisors unanimously voted to draw funds to build the hospital directly from its general fund - an action they cited as a precedent upheld by its history of approving funds for other public safety infrastructure such as the county men's jail, courthouses, and juvenile hall.

Elections as an Arena of Public Education

According to sociology of race scholars, Michael Omi and Howard Winant, multiculturalism emerged as a paradigmatic way of seeing race relations in the United States in the late 1950s to 1960s.[141] Through the social movement activity of civil rights and black power activists, they argue that Americans began to shed attachments to an older racial paradigm they call a "racial dictatorship," which defined "'American' identity as white and as a negation of racial 'otherness'" associated with indigenous, African-, Latin- and Asian- Americans.[142] According to them, Americans replaced this model with a new liberal pluralist model of multiculturalism that assumes or strives for equal citizenship of society's members regardless of race in the 1960s.

Their reading of this shift valorizes civil rights and black power activists for their astute analysis of power, particularly in how they continued to critique the sustained uneven distribution of good schools, safe housing, and quality healthcare along racial lines. They argue that this unevenness persists despite the advent of multiculturalism because racists found a new rhetorical device to hide behind within racial liberalism's new political landscape. They point to *colorblindness,* an approach to race relations that sees

[141] Michael Omi and Howard Winant. *Racial Formation in the United States: From the 1960s to the 1990s* (New York: Routeledge, 1994)
[142] Michael Omi and Howard Winant. *Racial Formation in the United States: From the 1960s to the 1990s* (New York: Routeledge, 1994), p. 66

race, but does not use it to distribute state resources, as a new screen from which racist actors could mount a defense of older forms of racial dictatorship.[143]

In particular, their arguments attempt to un-mask the neo-conservative movement of the 1980s and its leader, President Ronald Reagan, as the re-articulation of older forms of racism. Omi and Winant take special offense to his appropriation of racially coded language and civil rights language and imagery in his election speeches to dismantle health and welfare programs that benefit people of color.[144] However, rather than see Reagan's articulations of race (or lack thereof) as partisan or as an unfaithful commitment to multiculturalism, his status as standard flag bearer of United States nationalism marks how the absence of overt white supremacy, in both rhetoric and law, demonstrates the degree to which multiculturalism governed public speech and acts across party lines.

In other words, Reagan's use of coded language and civil rights rhetoric to forward his political goals reveals how *color consciousness* and *color blindness* emerged as two valorized forms of public speaking that policed explicitly racist speech. Reagan's speeches and behavior reveal a profound commitment to the discursive parameters of multiculturalism that were uncommon amongst liberals and conservatives in previous racial paradigms. Here, my reading of Omi and Winant's critique is not as much interested in unmasking the true racism of neo-conservatives, but to understand how *color consciousness* and *color blindness* ascended as two discursive strategies of racial liberalism when ethnic studies and multicultural education was largely unavailable and virtually non-existent to most of mainstream society.

Reagan's status as the "great communicator" points to how elections and the field of politics helped shape the white electorate's ideas of how to speak and act about race and poverty that communicated their continuing commitments to American nationalism. Ballot measures like Proposition A in the mid-1960s helped citizens understand that appropriate forms of speech and acts were just as important as the ballot outcomes. Elections not only informed citizens about the proper relationships they ought to have with

[143] Michael Omi and Howard Winant. *Racial Formation in the United States: From the 1960s to the 1990s* (New York: Routeledge, 1994), p. 117-118
[144] Michael Omi and Howard Winant. *Racial Formation in the United States: From the 1960s to the 1990s* (New York: Routeledge, 1994), p. 132-136

their neighbors but also informed them of the potential impact their individual behaviors had on the country's national image on a world stage.

America's image as a nation of non-racists and enlightened thinkers was critical for local economies in Los Angeles and the United States to do more business with developing economies abroad and to attract global labor to migrate to fill the region's and nation's labor needs. Rebecca Schein argues that concern for America's reputation abroad was so critical to postwar diplomacy that state department leaders designed the Peace Corps recruitment and training program to produce a cadre of volunteers to combat the "American 'ugliness'" of overseas American diplomats.[145] She writes that "where 'ugly Americans' — racist, emasculated, provincial white men — were seen as emblems of an adulterated national character, [Peace Corps Director, Sargent] Shriver [could point] to benevolent, non racist, culturally sensitive white volunteers as proof of the persistence of the nation's founding ideals."[146]

For most Americans, however, the arena for multicultural education was not the Peace Corps or higher education but the discursive space of politics and elections. California's progressive era ballot initiative process and its place in the global economy made the state an early laboratory for racial liberalism, allowing politicians and activists an opportunity to experiment with strategies to educate citizens about new ways of seeing and talking about race that were critical to the region's postwar progress. Daniel HoSang argues that rather than see California's postwar ballot outcomes as evidence of racial progress or a slide backwards to racial dictatorship, they ought to be seen more appropriately as "a set of propositions about the meaning of race and racism."[147]

By seeing the definition and meaning of race as up for negotiation, citizens of color could see mainstream politics as a desirable space to negotiate their racial identity because it held out the possibility that old, damaging racial stigmas could be replaced with more positive ones. Ballot measures with the

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[145] Rebecca Schein. "Educating Americans for 'Overseasmanship': The Peace Corps and the Invention of Culture Shock" in *American Quarterly*, Vol. 67, No. 4, pp. 1109-1136
[146] Rebecca Schein. "Educating Americans for 'Overseasmanship': The Peace Corps and the Invention of Culture Shock" in *American Quarterly*, Vol. 67, No. 4, pp. 1109-1136
[147] Daniel Martinez HoSang. *Racial Propositions: Ballot Initiatives and the Making of Postwar California.* (Berkeley: University of California, 2010), p. 20

possibility of conferring new racial identities thus maximized citizen participation in mainstream democratic venues, helping people of color develop lines of debate that still conformed to the language and form of mainstream politics. In this system, speech and behavior from civil rights and black power activists were thus valorized for how they kept marginalized citizens engaged in the democratic process that overtly white supremacist speech and acts did not.

Furthermore, HoSang shows that *color blindness* is not just a device deployed by neo-conservatives, but one that both 1960s liberals and conservatives used to appeal to a white majority electorate. In 1964, for example, real estate interests organized California ballot measure Proposition 14 to repeal the Rumford Act of 1963, a law legislated by state lawmakers that made it unlawful for homeowners and real estate agents to discriminate against home buyers on account of their race. In doing so, the election debate failed to upend what he calls "political whiteness," a "political subjectivity rooted in white racial identity, a gaze on politics constituted by whiteness."[148]

He argues that political whiteness framed the debate around Proposition 14. The Citizens Against Proposition 14 campaign, for instance, purposely toned down "specific references to the existence or prevalence of racism" believing that it "would only hurt the campaign's fortunes among the white voters who dominated the electorate."[149] As such, the campaign, composed of civil rights leaders from all racial backgrounds, focused on reassuring white voters that the Rumford Act would do very little to change the composition of their neighborhoods and that voting against the Proposition represented a larger commitment to "human rights" than it did to racial progress. He shows that Proposition 14 supporters also steeped their arguments "in the rhetoric of egalitarianism and even *antiracism*," (italics his) using civil rights language and moral appeals to citizens that good, upstanding citizens could be counted on to do the morally right thing for people of color without the force of law.

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[148] Daniel Martinez HoSang. *Racial Propositions: Ballot Initiatives and the Making of Postwar California.* (Berkeley: University of California, 2010), p. 20
[149] Daniel Martinez HoSang. *Racial Propositions: Ballot Initiatives and the Making of Postwar California.* (Berkeley: University of California, 2010), 80

The most significant product of Proposition 14 is that it marked, for politicians and party strategists, the limits of where the majority white electorate was willing to have the state enforce multiculturalism. Although the proposition would not impact transactions where a state loan was involved (that is, a majority of home real estate transactions), the proposition was widely regarded as a measure that defended the right of private actors to discriminate in the private sphere. Thus, the measure came to be understood as a "white right to discriminate against and exclude people of color in general and Black people in particular."[150]

According to HoSang, 1964's Proposition 14 sent a political shockwave throughout California because it awakened the state's liberal progressives lawmakers to the presence of racism in the state. He explains that Lucien Haas, a key staff aide for Governor Brown, remembered California's political atmosphere before 1964 as a multiracial paradise. Up until 1964, Haas recalled that, "we had Mexicans, we had blacks, everything like that and we were all mixing it up and getting along fine." Proposition 14, however, "shattered [that myth] for me," as he came to the realization that, "My God, we're facing racism in the state of California."[151] In the eyes of progressive liberals like Haas, the measure aligned California voters more with white voters in the racist South than in the imagined ideals of a progressive West. In short, the proposition made ugly Americanism as real of a problem in one of its most so-called progressive Coastal states as it did in its most deeply Southern conservative states.

The End of the Growth Machine

Proposition 14 weighed heavily in Hahn's deliberations over how to message Proposition A to county voters but it was not the only political factor that influenced the direction of the campaign. In March 1966, Hahn pulled together an ad hoc committee that included members of his multiracial staff and the marketing firm of Winter, O'Dell, and Smith to craft a campaign strategy around the ballot measure

[150] Daniel Martinez HoSang. *Racial Propositions: Ballot Initiatives and the Making of Postwar California.* (Berkeley: University of California, 2010) pp. 66 and 70
[151] Daniel Martinez HoSang. *Racial Propositions: Ballot Initiatives and the Making of Postwar California.* (Berkeley: University of California, 2010)

for a new county hospital in Watts.[152] His March meeting not only discussed how Proposition 14 would likely impact the Watts Hospital bond but also how the measure would be read within a long history of county referendums related to public works construction.

Los Angeles county citizens had consistently funded public infrastructure to fund regional growth throughout the late 19th and first-half of the 20th Centuries but that trend of support had recently begun to wane. As Clarence Lo argues, an anti-tax movement led by citizen activists began to exert new pressure on local officials in the late 1950s and early 1960s, culminating in what William Fulton would term "the slow growth moment" of the 1970s and 1980s.[153] That movement would spillover and have national implications when, in 1977, California voters passed Proposition 13, an anti-tax initiative that inspired a nation-wide anti-tax movement. Fulton argues that citizen resentment over tax initiatives were primarily a reaction to what he calls the "growth machine," a combination of public and private investment initiatives that turned idyllic and sought after suburbs into another region of urban sprawl and chaos.[154]

Multiculturalism became an especially desirable tool for politicians to use because it helped craft public expectations that their vision of growth was aligned with city beautification and preservation objectives that was not actively leading the city to ugly urbanism. Since "virtually all of Los Angeles' politicians [from both Democratic and Republican parties] found themselves closely tied to the growth machine," both political parties were eager to use the language of multiculturalism to paint the patina of their growth plans as leading the city to become "a 'world-class' city — a center of commerce and culture equal to Tokyo, New York, Paris or London."[155] Such allusions of grandeur turned citizen attention to the more desirable aspects of cosmopolitan notoreiety rather than the gritty realities of globalization.

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[152] "Winter, O'Dell, and Smith Hospital Bond Issue Memo" Kenneth Hahn Collection, Box 200, Folder 4 "Memos" (Special Collections, Huntington Library)

[153] See: Clarence Lo. *Small Property Versus Big Government: Social Origins of the Property Tax Revolt*. (Berkeley: University of California Press, 1990) and William B. Fulton. *The Reluctant Metropolis: The Politics of Urban Growth in Los Angeles*. (Baltimore, Johns Hopkins University Press, 2001) p. 58

[154] William B. Fulton. *The Reluctant Metropolis: The Politics of Urban Growth in Los Angeles*. (Baltimore, Johns Hopkins University Press, 2001) p. 10

[155] William B. Fulton. *The Reluctant Metropolis: The Politics of Urban Growth in Los Angeles*. (Baltimore, Johns Hopkins University Press, 2001), p. 43, 47

The making of Los Angeles as a "global city," meant that politicians were equally invested in having their constituents understand that multiculturalism and its open stance towards foreign markets and laborers was likely to bring economic and demographic change. That change was dramatic. Once a city full of manufacturing companies, Los Angeles' landscape began to trade factories for immigrants to service a new service-based economy. Citizens unfavorably responded to the corresponding urbanization and racial demographic change of the city, seeing it as a threat to the comfort and racial homogeneity of white suburban living. Withholding public tax dollars for public works projects through referendums was the most available and effective method for citizens to voice their concerns about this kind of global change.

County voters, however, were not always so reluctant to give their taxes to city growth. County voters had a long history of supporting hospital construction and expansion campaigns since Los Angeles first began dispensing care to indigent patients in 1855. Over the course of the next century, County voters consistently voted to construct, transform, and expand an extensive network of County hospitals that included Los Angeles County General Hospital - USC (1878) in East Los Angeles, Olive View Hospital-UCLA (1920) in the San Fernando Valley, and Harbor General Hospital-UCLA (1946) in Torrance. In fact, voters carried affirmative votes for $69 Million in referendum money to all three facilities.[156] Voters in each of these campaigns responded to campaign messaging that emphasized the benefit of providing hospital care to the region's white migrants from the South and Midwest as they settled into the region's economy.

Evidence of waning support for county hospital facilities began to show when, in 1958, County voters rejected efforts to construct new medical facilities at Los Angeles County General Hospital-USC.[157] The messaging for 1958's Propositions C, D, E, and F for new medical facilities did not draw

[156] "Previous Bond Issues for Specific Hospitals in One Area which Have Been Approved by the Voters Throughout Los Angeles County" Kenneth Hahn Collection, Box 200, Folder 9 "Reports and Figures" (Special Collections, Huntington Library)
[157] According to the Los Angeles Times, "County Bond Propositions D, E, and F on the Nov. 4 ballot offer the means to an immediate cure" for an "ailing hospital." The ballot would have centralized the scattered outpatient

voter's attention to the county's need to accommodate growing migrant populations, who were increasingly black and Mexican, but instead emphasized the electorate's ability to save poor patients from the indignity of getting treatment in overcrowded and deteriorating county infrastructure.[158] Campaign material oddly focused citizens on not saving people but the crumbling buildings, some nearly a century old. All but one of the measures were successful.[159]

In 1960, the County re-attempted its efforts to build the facilities that previously failed by changing its campaign messaging. Instead of attempting to draw sympathy from voters on the plight of settling migrants or old buildings, the County's 1960 campaign drew voter's attention to the fact that poor conditions for patients translated into poor training conditions for the hospital's house staff and nursing corps. By sharing data that revealed that USC and UCLA's medical graduates accounted for an astonishing three-fourths of all the practicing physicians in Los Angeles, the campaign strategy appealed the voter's sensibilities about their own healthcare in the private healthcare market.[160] Fearing that poorly trained physicians in the county system would eventually mean poor care in their local private hospitals, the electorate responded by passing the hospital bonds as desired.

The Watts Hospital Bond Measure thus faced several problems based on race and geography. As support for the 1960 measure for County General Hospital attests, voters approved the measure based on its power to eventually improve private hospital care, a market that evidently had grown considerably larger in proportion to those using public healthcare by 1960. Here, the new Watts Hospital did not only

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facilities into a single "efficient" building, a nurse building, and an intern resident structure. "A Cure for the General Hospital" October 23, 1958. *Los Angeles Times* p. B-4

[158] The *Los Angeles Times*' article, "A Cure for the General Hospital" is telling. "Los Angeles County General Hospital, which annually provides treatment for nearly 900,000 patients, is itself suffering a painful ailment." The "First pangs of overcrowding at the hospital were eased by expanding the outpatient treatment program. The cure, however, led to complications and ultimately made the growing pains even worse. A total of 50 clinics scattered throughout the main hospital building are now needed to care for the 2000 outpatients given medical care each day." "These growing pains are now beyond temporary remedies. The only permanent cure is more buildings to relieve present overcrowding and to provide for greatly increased future needs."October 23, 1958. *Los Angeles Times* p. B-4

[159] The contagious disease ward was the only item that carried in the 1958 election.

[160] Under the article subsection titled "Training Stressed," *Los Angeles Times* author Louis Fleming directly quoted Dr. Thomas, the director of the hospital, who stated "the part of the story that is hard to tell is the effect on our training program of inadequate facilities. This can seriously handicap the learning of medicine."“Space Lack Prompts Hospital Bond Issue: More room needed for bed and clinic patients, doctors, interns and nurses" May 20, 1960. *Los Angeles Times*

suffer from its location in a black neighborhood but also from the strong likelihood that physicians trained there would also likely be black. For a white electorate, the hospital would thus appear racially partisan in respect to its geography and future contribution to society.

Using the track record regarding hospital referendums, the results of Proposition 14, and the "nationally publicized Watts revolt" as the "reference point[s]" for its recommendations, the marketing firm of Winter, O'Dell, and Smith ruled that "any attempt to disguise the geography of the subject hospital for the purpose of diversified newspaper publicity would, in our opinion, be futile."[161] Unlike the Proposition 14 campaign, which downplayed race and racism, the consultants determined that the campaign for a Watts hospital could not avoid it.[162] Proposition A materials would have to directly reform attitudes about race and poverty in order to win the referendum. As Winter, O'Dell, Smith phrased it: "recognizing that a large segment of the community is already prejudiced," based on the passage of Proposition 14, the "over-all value of the project to the entire community" would be a "hard sell."

In order to win, Proposition A would have to confront the white electorate's racism directly, asking them to consider the worthiness of public funds going to directly to benefit a community with a numerical minority in the city. In this regard, the ballot measure undoubtedly shone a bright light on the white electorate's decisive power to determine the welfare of its black citizens. More importantly, the ballot measure would also have to ask white citizens about the nature of their opinions on racism. The ballot measure's relationship to the Watts Riots, in particular, asked citizens to consider if the provision of public services was a preventative measure that spoke to the systematic nature of racism and poverty, or,

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[161] "Winter, O'Dell, and Smith Hospital Bond Issue Memo" Kenneth Hahn Collection, Box 200, Folder 4 "Memos" (Special Collections, Huntington Library)

[162] Proposition 14 amended and reinforced County leadership's understanding of the electorate. Fearing that white voters would interpret the Rumford Housing Act as preferential treatment for certain racial groups and locations, the Citizens Against Proposition 14 campaign toned down "specific references to the existence or prevalence of racism" believing that it "would only hurt the campaign's fortunes among the white voters who dominated the electorate." (HoSang, 80) The campaign focused, instead, on projecting the middle class home as a valued object that ought to be available to all and to show that Proposition 14 would unnecessarily stall the promise of property to an otherwise productive class of middle class people of color. More importantly, the campaign against Proposition 14 failed to articulate how the Rumford Act tied into a "broader vision that animated" the compendium of Federal and State policy commitments of the time, "which drew on shared aspirations for a society with greater possibilities and opportunities for all Californians." (HoSang, 86) Daniel Martinez HoSang. *Racial Propositions: Ballot Initiatives and the Making of Postwar California.* (Berkeley: University of California, 2010)

if it was simply rewarding naturally violent behavior. Put another way, white voters would have to determine their vote based on who they believed was responsible for the violence in Watts - was violence the result of white racism or was it a natural expression of blackness?

The Big Tent Politics of Multiculturalism

The assessment provided by Winter, O'Dell, and Smith gave Hahn and his office associates an honest prediction that the ballot measure for the Watts Hospital would likely lose but it also highlighted the need to build an effective long term solution that was proactive in setting and defending progressive political agendas. While the city's leadership was firmly in the hands of the Democratic party, its electoral base was largely dependent on a staunchly conservative white electorate. That conservative coalition of Democrats was led by Mayor Sam Yorty, a brash politician known to make disparaging remarks about African Americans and women. Thus, although the assessment of election consultants determined that the passage of Proposition A was unlikely, Hahn saw the election as an opportunity to advance a new liberal progressive coalition that could contest Yorty's conservative Demcratic bloc.

In essence, Hahn ventured to use the election as an opportunity to change the political paradigm by building a big political tent from which multicultural agendas could contain and eradicate old racist paradigms. Mayor Sam Yorty actively fought against the development of this contesting progressive bloc, going as far as organizing a revolt against federal Community Action Program (CAP) funding with the mayors of New York and Chicago through the U.S. Conference of Mayors.[163] The activism of Yorty ensured that Los Angeles' War on Poverty funds disbursed as little funds and as inefficiently as possible to black and Mexican American communities. As Charles Schultze, Director of the Federal Bureau of the Budget, described it to President Johnson, the stalling of local funds was clearly because "many mayors

[163] Richard M. Flanagan. Mayors and the Challenge of Urban Leadership (Lanham: University Press of America, 2004) p. 116-117

assert that the CAP is setting up a competing political organization in their own backyards."[164] (underline his)

Indeed, Hahn and other liberal progressive leaders including Tom Bradley and Augustus Hawkins sought to use Proposition A as a vehicle to activate new political leaders within the city's growing ethnic communities in South Los Angeles. The campaign would provide political neophytes with experience and skills to lead their communities to greater political participation within the Democratic party. As examples, Hahn appointed well-respected Japanese American residents Taul Watanabe, Kiyoshi Maruyama, and Gardena City Councilman Ken Nakaoka to sit on the Citizen's Steering Committee for Proposition A and to form a subsidiary Japanese American Committee for Proposition A.[165] Similarly, City of Los Angeles Mexican-American Affairs Coordinator Dr. R.J. Carreon and County Highway Safety Commissioner Alex Banuelos were also asked to served on the Citizen Steering Committee for Proposition A as representatives for Mexican Americans. They were joined by Lucy Baca and Joe Castillo to form a corollary Mexican American Committee for Proposition A.[166]

These efforts to transform underrepresented ethnic communities in South Los Angeles into strongholds for a progressive wing of the Democratic party were joined by actions to strengthen the voice of civil rights leaders over the black community. Weakened by the impression that civil rights leaders had lost control of the community during the Watts Riots, the ballot measure gave civil rights leaders, especially those within the all-black Drew Medical Society, the chance to offer the community and concerned citizens elsewhere a plan to combat racialized poverty concretely. Under the leadership of Dr. Henry Heins, the President of the Drew Medical Society and Dr. Julius W. Hill of the Los Angeles County Hospital Commission, the Drew Medical Society also raised $12,000 for the campaign and

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[164] "Sept 18, 196 Memo from Charles Schultze to President Johnson." Lyndon B. Johnson Collection Welfare 9 Box 26 Folder 8/1/65-9/21/65 (National Archives and Record Administration, Lyndon B. Johnson Library)

[165] "Leaders Pledge Support." *Gardena Valley News*, May 12. 1966." Kenneth Hahn Collection, Box 202, Folder 26 "Press Clippings" (Special Collections, Huntington Library)

[166] Baca served as the Chair of the Regional Planning Commission and Castillo as a Human Relations Commissioner. "Form Mexican-American Group for Proposition A" *East Los Angeles Tribune*. May 12, 1966. Kenneth Hahn Collection Box 202, Folder 26 "Press Clippings" (Special Collections, Huntington Library)

opened their own campaign headquarters on Crenshaw Boulevard to send out mailings and do campaigning.[167] (See Figure 3.1)

These relationships with African-, Latino-, and Asian- American communities ultimately formed a new political bloc with liberal progressive whites and Jewish Americans in the districts led by James Roosevelt, Charles Warren, and Edward Roybal. These progressive Democratic strongholds, stretching from Beverly Hills, Wilshire, Downtown and East Los Angeles joined the new liberal Democratic organizations built by Hahn, Bradley, and Hawkins in South Los Angeles. According to Raphael Sonenshein, these efforts in the wake of Proposition 14 helped solidify a "melting pot" that helped Tom Bradley ascend as mayor of the city in 1973.[168] Bradley's ascension was the first African American mayor of a majority-white electorate confirmed efforts to reconstitute the city's politics from its position as a "Dixiecrat" city to a multicultural one were successful.

As the final composition of the Citizen's Committee for Proposition A shows, however, Hahn's political efforts were not just successful in galvanizing a new liberal progressive coalition of leaders embedded in the city's various ethnic and racial communities. Hahn was also able to bring in a large cross-section of the city's *conservative* and *Republican* voters into his big tent of multiculturalism. Hahn, for instance, tapped John McCone, a conservative Republican industrialist who had also served as the Chair of the Governor's Commission on the Los Angeles Riots, as the honorary Chair of Citizen's Committee for Proposition A. McCone's credentials as a prominent businessman and former Director of the Central Intelligence Agency helped win the participation of the Los Angeles Chambers of Commerce, the Los Angeles City Council, the District Council of Laborers, the Catholic Archdiocese of Los Angeles, the Medical School Deans of UCLA and USC, and the County Board of Education.[169]

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[167] "Los Angeles Medics Cite Need for Hospital" May 12, 166. *Los Angeles Sentinel*. Kenneth Hahn Collection, Box 215, Folder 34, "Press Clippings" (Special Collections, Huntington Library)
[168] Raphael Sonenshein. *Politics in Black and White: Race and Power in Los Angeles* (Princeton: Princeton University, 1994) p. 70
[169] "Endorsements List" Kenneth Hahn Collection Box 201, Folder 19 "Endorsements" (Special Collections, Huntington Library)

These endorsements show that the effort to promote and defend multiculturalism in the city was not solely a liberal or Democratic objective but an agenda shared by political actors and affinity groups not normally credited with being supportive of multiculturalism. Their inclusion, leadership, and participation in the Proposition A campaign suggests that they came to support the ballot measure not out of *color blindness* but came to support multiculturalism and *color consciousness* as durable expressions of political whiteness as well. Here, what drew conservatives and Republicans to support Proposition A was not primarily its effect in helping African Americans or the Democratic party gain a new base of activists and supporters, but the potential effect it would have in maintaining economic stability and social order in the region's quest to become a global metropolis.

A deeper investigation to the types of messages that embedded liberal progressive leaders in ethnic communities used in their communications with their bases demonstrates a divide between the messages carried by proponents aiming their messages to the majority white electorate. Press releases made and sent by ethnic leaders emphasized that unity with African Americans meant progress and benefits for non-whites. Japanese American news statements, for instance, emphasized the "pride we feel when Americans, regardless of their origin, come to the aid of another."[170] Press releases for Mexican American outlets noted that the "Southeast, Watts-Willowbrook, Florence-Firestone" neighborhoods populated by "many Mexican American families" who live side-by-side with "Negroes, Orientals, and other ethnic groups" in the same "unhappy situation" stood to benefit from a new local county hospital.[171]

While these messages called attention to the shared experience of poverty in communities of color to see support for the ballot measure as a way to re-fashion the meaning of race, messages directed at the larger white electorate that focused on poverty and racism tended to reify old stereotypes of race that focused on people of color as diseased and violent. The most effective slogan to develop out of the

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[170] "Leaders Pledge Support." *Gardena Valley News*, May 12. 1966. Kenneth Hahn Collection, Box 202, Folder 26, "Press Clippings" (Special Collections, Huntington Library)

[171] "Support Hospital Bonds" Press Release. Kenneth Hahn Collection Box 201, Folder 16 "Press Clippings" (Special Collections, Huntington Library)

campaign was the motto “Disease Knows No Boundaries.”[172] Subsequent articles using the phraseology pointed to the fact that, without proper hospital facilities, poor blacks might easily infect others as they travel throughout the city for work. In other instances, the phrase equated Watts with Vietnam and the Congo*,* suggesting that, “if America can spend taxpayer’s money to build hospitals for African and Asian countries, and in Vietnam,” to quell violence, then “certainly we should take care of our own citizens first.”[173]

These messages were amplified by the fact that with such an extremely short timeline to the June election and with no money to properly mount a large marketing campaign, the Proposition A campaign relied heavily on donated time and editorial space. To maximize what little resources his office had, the campaign produced an 8-point "fact sheet" given out to endorsers and press outlets during a series of luncheons hosted by Hahn. (See Figure 3.2) Like a modern day social media “meme,” Hahn encouraged citizens to take and adjust, mix and rearrange the 8-point talking sheet to their local contexts.[174] The resulting mix of voter to voter tailored literature enabled the Yes on Proposition A campaign to popularize several slogans with the ability of authors to tailor their defense of such slogans based on who they believed their anticipated audience was, be they conservative or liberal.

Locally Safe, Globally Secure

The “disease knows no boundaries” slogan and its meaning quickly became the center point of discussion for supporters and opponents of the ballot measure. The phrase served as a flashpoint for public discussion because it invited citizens to comment on the possible new meanings of race and the implications of their vote beyond the building of a new county hospital in Watts. By asking white citizens to consider their relationship to inner cities and to far flung locations like the Congo and Vietnam,

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[172] “Fact Sheet - South Los Angeles County Hospital.” Kenneth Hahn Collection. Box 200, Folder 3 (Special Collections, Huntington Library)
[173] “Fact Sheet - South Los Angeles County Hospital.” Kenneth Hahn Collection. Box 200, Folder 3 (Special Collections, Huntington Library)
[174] The Oxford English Dictionary defines a meme as “a humorous image, video, piece of text, etc., that is copied (often with slight variations) and spread rapidly by internet users.

the slogan inspired the electorate to consider what forms of nationalism were appropriate given America's undeniable leadership role on the world stage. The Watts Riots had placed Los Angeles in the national spotlight and, by extension, had placed Los Angeles at the center of international attention.

According to Mary Dudziak, the pressure to keep open and friendly relationships with African, Asian, and Latin American nations became increasingly strained by racial conflict in the United States.[175] She argues that diplomatic and business interests abroad escalated pressure on U.S. diplomats and state leaders to accommodate civil rights demands of African Americans in order to pave an easier pathway to winning the Cold War. Proposition A landed Los Angeles citizens right in the middle of that conundrum, asking white citizens to consider American efforts to spread democracy and capitalism in the Congo and Vietnam as implicated and tied up with the status of citizenship for African Americans in Watts.

By doing so, the combination of the Cold War atmosphere and the Watts Riots intensified the white electorate's sense of safety and well-being by getting them to imagine the risks of their continued commitments to white nationalism and economic isolationism at home. While citizens had just affirmed their commitments to these principles through Proposition 14, Proposition A reminded them that such isolation could not possibly ignore the potential violence and economic disorder of deepening racial tension at home and abroad. Supporters of the ballot measure framed the election as an opportunity for white voters to reconsider their position on race by giving them the space to determine a new pathway before frustration with civil rights progress and the Cold War decided for them.

The Yes on Proposition A campaign was thus an open invite for members of the white electorate to arrive at, on their own terms, a stance that saw an open stance towards race and race relations as not only desirable and preferable but also mutually productive for whites and non-whites. Yes on Proposition A supporters presented the county hospital as the device to showcase the possibilities for new economic growth of President Johnson's anti-poverty programs. Proposition A promised a return to social order and

[175] Mary Dudziak. *Cold War Civil Rights: Race and the Image of American Democracy* (Princeton: Princeton University Press, 2011)

peace that replicated the social expectations of productivity and consumption of white mainstream society in communities of color.

The hospital was advertised as connected to the goal of convincing and trusting global citizens in the United States and around the world to join in the spread of capitalism and democracy. Building the hospital was billed as putting the economic and political responsibility of ghettos in the hands of its residents, in much the same way that federal support to South Vietnamese health and welfare programs was meant to ultimately end with efficient democratic and capitalist self-rule. As Hahn's fact sheet put it, "by building a quality hospital, jobs will be created, services will be rendered, lives will be saved, and the health of the community will be improved."[176]

Of course, as the support of former CIA director John McCone and the community of business interests suggests, the campaign's emphasis on multiculturalism also hid an ulterior motive to shift Los Angeles' regional economy to serve as a major conduit of trade and labor between Southern California and Pacific Rim nations. The hospital was critical to help augur this shift, as it could replace manufacturing jobs being sent to Latin America and Asia with new service jobs in healthcare. Quality hospital services, both public and private, would also be critical in attracting and securing other types of labor in the service industry needed for Los Angeles' global economy.

In effect, supporters and opponents of the ballot measure were drawn into the larger stakes of the ballot measure by asking them to comment on this new political and economic landscape through talk about the relationship of race to violence. It centered discussion on whether or not racial violence and social disorder could be prevented by the eradication of poverty at home and abroad or if violence was a racial trait inherent to black people. By framing the issue of racialized violence as unresolved, citizens felt welcomed to enter into the electoral arena to negotiate outcomes favorable to them.

For civil rights leaders and activists from different racialized communities, Proposition A provided a platform to educate whites on how poverty, not race, played the determinative factor in explaining

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[176] "Fact Sheet - South Los Angeles County Hospital." Kenneth Hahn Collection. Box 200, Folder 3 (Special Collections, Huntington Library)

violence in society. As an object that could be controlled and manipulated by the distribution of resources, civil rights activists were hopeful that whites and people of color could see the social affirmation of ethnic and racial identities as something desirable, non-threatening, and productive. In this regard, the nascent progressive Democratic organizations being developed through Proposition A in South Los Angeles allowed civil rights activists to point to their participation and leadership over recognizable local mainstream political organizations and over a new county hospital as proof of how their leadership aligned with the overall business growth agenda of the region.

For the majority white electorate, the question of violence allowed them to communicate their desire to sustain regional peace and social order to keep the region prosperous. For real estate, business interests, and politicians, the ability to advertise the city as a safe, orderly, and full of modern amenities was integral to attracting extremely lucrative global finance, real estate, and insurance workers and to keeping a standing pool of cheap labor to service a new so-called service economy. Framing the improvement of existing racial neighborhoods under the leadership of civil rights activists thus curiously assured white citizens that racial progress did not necessarily mean a dramatic change in the city's spatial dynamics and that their ability to have access to cheap labor for business ventures would remain unfettered.

While some members of the white electorate responded favorably to these messages, others did not. Less sympathetic opinions of Proposition A began to emerge in the final week of the election that painted the ballot measure as a form of electoral "blackmail." Hahn confirmed these opinions in his official autopsy of the ballot measure's failure. He cited that "tremendous racial tension," and what members of his office staff referred to as a "white backlash," began to emerge in light of the shooting death of James Meredith in Mississippi and the recent dismissal of a investigation over the death of Leonard Deadwyler, a black motorist killed by the Los Angeles Police on his way to delivering his pregnant laboring wife to a hospital.[177]

[177] Press Statement by Supervisor Kenneth Hahn. June 8, 1966. Kenneth Hahn Collection, Box 200, Folder 2 "Proposition A" (Special Collections, Huntington Library)

Hahn's team acted early on these events, calling together a press conference on June 1st to express fear of a "backlash."[178] A spokesman for the Citizens Committee for Proposition A told the Associated Press, that "we felt very optimistic about the bond issue before the reversal of Proposition 14 and the Leonard Deadwyler inquest, but these two things, happening so recently, are bound to cause some white backlash, so we are a little more concerned about it now." Newspapers picked up on renewed fear of racial rioting, reporting that white citizens might, as a response, "retaliate in the privacy of the voting booth and deny the hospital to southeast Los Angeles Negroes."[179] As the *San Gabriel Valley Tribune* reported it, "some backers have warned that new disorders in Watts could occur if the bond issue is not passed."[180]

By making and acknowledging renewed rioting as a realistic outcome of a failed ballot measure, liberals, not conservatives, had inadvertently gave opponents license to enter it into public discussions without appearing racist. Some newspapers, like the *South Bay Breeze,* attempted to spin this new messaging to "panicky" readers by insisting that "filling this need is not submitting to 'blackmail.'"[181] While it would not "remove the area's responsibility to strive for law and order, or lessen the resolve of enforcement agencies to maintain it," the newspaper affirmed that it was a "recognition of human suffering, and a realistic approach to easing it."[182] Other newspapers refused to spin this new piece of information so optimistically.

The *Los Angeles Herald Examiner* and the *San Gabriel Valley Tribune* wrote to readers to remind them that racial violence only seemed to be a black phenomenon that did not seem to come from other poor constituents in the county. The *San Gabriel Valley Tribune* argued that the ballot measure, "benefits only one area at the expense of the entire county" and "sets a bad precedent for other groups that may

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[178] "Watts Hospital Supporters Fear Backlash." *San Gabriel Valley Tribune*. June 1, 1966 Kenneth Hahn Collection, Box 215, Folder 34 "Press Clippings" (Special Collections, Huntington Library)
[179] "Watts Hospital Supporters Fear Backlash." *San Gabriel Valley Tribune*. June 1, 1966 Kenneth Hahn Collection, Box 215, Folder 34 "Press Clippings" (Special Collections, Huntington Library)
[180] June 5, 1966. *San Gabriel Valley Tribune*. Kenneth Hahn Collection, Box 215, Folder 34 "Press Clippings" (Special Collections, Huntington Library)
[181] April 24, 1966. *South Bay Daily Breeze*. Kenneth Hahn Collection, Box 201, Folder 4 "Press Clippings" (Special Collections, Huntington Library)
[182] April 24, 1966. *South Bay Daily Breeze*. Kenneth Hahn Collection, Box 201, Folder 4 "Press Clippings" (Special Collections, Huntington Library)

want special treatment." The *Los Angeles Herald Examiner* and *El Monte Herald* printed reader comments that affirmed that "there are poor people in Burbank, Glendale, Venice, Hawthorne, Pasadena and Monrovia, as well as Watts"[183] and that while "riot-torn Watts, may need [a] county hospital, […] so [too] does the San Gabriel Valley."[184]

These comments show that both arguments for and against supporting Proposition A grew increasingly contingent on the conflation of blackness with violence in the public's eye. In other words, yes-voters went to the polls to vote for the ballot measure in fear of racial violence, while others went to vote against the measure in spite of it. From this perspective, racism informed both supporters and opponents to vote at the polls in ways that made it difficult to claim that no-voters were racist in their motivations while yes-voters were not. Instead of demonstrate evidence of a white backlash, liberal acknowledgement of the violent black boogeyman shows that multicultural discourse itself depended on the conjuring of a new racial "other" to gain currency as a new racial paradigm.

The Power of the Racial Boogeyman

The debate in the week leading up to the election shows that efforts to teach the general public about the value of multiculturalism was co-constitutively produced through and with the close conflation of race and violence. As their reasoning for and against the Watts Hospital shows, racialized violence drew many conservatives and liberals, Democrats and Republicans, willingly together to multicultural discourse in order to fulfill their desires to fashion the local economy of Los Angeles to meet a new globalizing economy. Rather than resolve the relationship between race and violence, however, the ballot measure's outcome kept this tension in play in ways that were productive for differing political agendas.

Both liberals and conservatives agreed that a unified stance on racial violence was important but for different ends. Some liberals used the relationship to assert that racial violence could be contained and

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[183] June 18, 1966. *Los Angeles Herald Examiner.* Kenneth Hahn Collection, Box 215, Folder 34, "Press Clippings" (Special Collections, Huntington Library)
[184] May 12, 1966. *El Monte Herald*. Kenneth Hahn Collection, Box 215, Folder 34, "Press Clippings" (Special Collections, Huntington Library)

eradicated by new federal antipoverty programs that could use the twin processes of self-help and self-determination to recast race as a non-threatening category of difference. Contending voices, however, used the shared value on stamping out racial violence as a reason to police communities of color in ways that were more difficult to separate out who was "truly violent" from those that were "truly civilized."

As the debate around Proposition A shows, the outwardly and explicitly racist rhetoric of white supremacy did not actually play, or need to play, a large role in shaping public opinion. Liberals and conservatives both amplified the power and noise around racial violence without such explicitly racist expressions by drowning out and making explicitly white supremacist comments subordinate and needless given the new urgency and importance of race riots, violence, and anger. Here, white supremacist discussion could be re-coded within multicultural discussion in ways that took advantage of the unresolved search for where racial violence existed, if at all, in communities of color.

The product of this unresolved relationship produced some civil rights and black power leaders who appropriated mainstream discourses of civility, security, and economy as capable of governance over black community institutions in ways that further alienated black political voices that were angry and frustrated at both liberal and conservative traditions. Indeed, in addition to Dr. Sol White of the Drew Medical Society, the black medical leaders who eventually assumed leadership of the Watts Hospital — Dr. Mitchell Spellman, Dr. M. Alfred Haynes, and Dr. J. Alfred Cannon — serve as prime examples of civil rights and black power perspectives that appropriated mainstream discourses of law and order. Together with their white liberal and conservative counterparts, this multicultural class of leaders affirmed the righteousness of America's political and economic role at home and abroad.

In the end, Hahn used the ballot measure's outcome of 62.5% support as proof of a majority mandate, albeit an unlawful one, to authorize the use of funds to directly construct the hospital out of the county general funds. Hahn did not act unilaterally, but was joined by his conservative Democratic and Republican counterparts on the Board of Supervisors to unanimously vote to authorize immediately $12.5 million dollars to initiate plans to construct the hospital. Newspapers and Hahn's political team quickly

began reporting on alternative public mechanisms to fund the hospital following news of the ballot measure's failure. "We're going to build it," Hahn stated, "We'll find a way."[185]

In his official post-election press release, Hahn interpreted the ballot's majority outcome as an affirmation that multiculturalism was a new widely shared patriotic expression of American nationalism. His press release was crafted to reach local, national, and international audiences. He argued that the vote's "tremendous majority" stood as a "fine vote of brotherhood," an "outward sign" of an "inward attitude" that revealed that the "American citizen" was truly a "good Samaritan" that really "does care about someone else's misfortunes."[186] Citing that precincts far from the proposed hospital had supported the measure, Hahn stated that the vote "showed that the people in the remotest sections of the County are concerned with those who are less fortunate in the Watts-Willowbrook area."[187]

Behind the cloistered halls of government, however, Hahn's actions show that his discussions with other Board of Supervisors remained locally tied to concerns about regional stability. Using a report titled, "Projects included in failing bond proposals which were subsequently constructed by other means," the Board of Supervisors were alerted to a precedent of supporting capital construction projects from 1947 to 1965 that voters rejected but ultimately were built completely from county general funds. The report revealed that many of the county's law and order infrastructure - the Civic Center Superior Court, Downtown Juvenile Hall Center, County Courthouses, Men's Jail, and the San Fernando Valley Juvenile Hall — all were built without much criticism from voters.[188]

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[185] Tom Goff. "Watts Hospital Bonds Rejected: Other Issues Win" June 8, 1966. *Los Angeles Times*. Kenneth Hahn Collection, Box 215, Folder 34, "Press Clippings" (Special Collections, Huntington Library)
[186] Press Statement by Supervisor Kenneth Hahn. June 8, 1966. Kenneth Hahn Collection, Box 200, Folder 2 "Proposition A" (Special Collections, Huntington Library)
[187] Press Statement by Supervisor Kenneth Hahn. June 8, 1966. Kenneth Hahn Collection, Box 200, Folder 2 "Proposition A" (Special Collections, Huntington Library)
[188] While the cost of most these projects laid most of these projects laid from $2 -5 million, the Men's Jail, at a cost of $19 million had been financed through the Retirement Board. With the Retirement Board funds exhausted, the Board had no choice but to commit new hospital funds from the County General Fund.

Figure 3.1 – Drew Society Mailings and Press Clippings

L.A. Sentinel – June 2 - 1966

Vote YES for PROPOSITION "A" X

COMMUNITY HOSPITAL IN WATTS

Health Services For All — Protect Your Families Health

YOU MUST VOTE YES FOR PROP. "A"

YOU MUST VOTE YES FOR PROP. "A"

Photo by Josephite Harvest

YOU MUST VOTE YES FOR PROP. "A"

SPONSORED BY: CHARLES R. DREW PHYSICIANS FOR PROP. "A"

WHAT WILL PROPOSITION "A" PROVIDE?

1. THE NEED — The McCone Commission that investigated the August riots in Watts reported that hospitals in the area are "grossly inadequate in quality and number of beds." The Watts area has a higher incidence of every major disease than the average for the rest of Los Angeles. Approximately 50 percent of the patients in this area must now seek hospitalization at Los Angeles County General Hospital, contributing to the overcrowding at General Hospital. In addition, inadequate transportation between General Hospital and the Watts area presents a constant problem to patients.

2. THE PROJECT — A 438-bed acute hospital for short term care, and in addition a laundry, power plant and maintenance shops. The laundry will handle the requirements for El Cerrito and Long Beach General Hospital, now serviced by the overtaxed laundry at Harbor General Hospital. The number of beds was determined in accordance with State formulas to qualify for State financial aid.

3. THE COST — Estimated at $21,400,000, exclusive of site. The Board of Supervisors has ordered the sum of $100,000 included in the 1966-67 budget to buy the sub-standard 30-acre Palm Lane Housing project as a site for the hospital.

4. FINANCING — Net cost to the County is $12.3 billion, to be financed by bond issue. State and Federal aid under the Hill-Harris Act will produce $9,100,000. Interest and redemption on a 20-year bond issue would cost the owner of a home assessed at $5,000 less than 40 cents annually on his total tax bill.

5. ANTICIPATED REVENUES — Operating costs are expected to be offset by funds from Federal Medicare for the Aged, State Medicare, voluntary health insurance, fees from those who can pay, and County aid to low income persons not otherwise covered.

6. MEDICAL SERVICE — This hospital will operate as a teaching hospital to provide quality medical care to the citizens of the area. Post-graduate medical education will be emphasized through close affiliation with the Charles R. Drew Medical Society, the UCLA Medical School, and the USC Medical School. Local area physicians will participate, and the post-graduate education programs are also expected to attract physicians from other areas who will receive training to keep pace with medical advances.

7. CONCLUSION — The advent of Medicare is expected to tax severely the bed capacity of all hospitals, as well as impose heavy demands on hospital staffs. A 438-bed general acute hospital in Watts will do much to relieve the expected strain.

(Paid Political Adv.)

Figure 3.1 – Clockwise from Top Left: **Front and Back Mailers** sent from Drew Medical Society. **May 10 *Sentinel* Photo** of Dr. Clarence Littlejohn, Dr. Henry Heins, Mrs. Ralph Bledsoe, Dr. Mrs. Julius Hill, Mrs. Earl Claiborne, Col. Leon H. Washington, Jr. and Dr. Charles Brown. **May 26 *Sentinel* Photo** of Dr. Julius Hill, Mrs. Opal Gilliam, Mrs. Eva Bradford-Rock, Ted Watkins, and Dr. Geraldine Branch. May 18 South End Bee Photo of Dr. Henry Heins, Kenneth Hahn, and Lewis Roach. **May 10 *Southside Journal* Photo** of Dr. William R. Williams, Carey Jenkins, Kenneth Hahn, Dr. John F. Simmons, and Dr. Ross Miller

Figure 3.2 Fact Sheet – South Los Angeles County Hospital

To: Publishers and Editorial Directors March, 1966
From: Supervisor Kenneth Hahn

1. The Watts-Willowbrook area of Los Angeles County urgently needs a major hospital. The McCone Commission emphasized this need. The State Advisory Hospital Council has placed highest priority on development of this hospital.

2. The Board of Supervisors has acted boldly and wisely to immediately move to provide this badly needed hospital to serve a section of Los Angeles County which contains an estimated 350000 people. (Bounded by Alameda, Broadway, Jefferson, and Artesia.)

3. A 438-bed hospital will greatly relieve crowded conditions at all public hospitals in Los Angeles County, particularly Los Angeles County General Hospital. It takes two hours on public transportation to reach General Hospital from the Watts-Willowbrook area. Even so, fully 50 per cent of the patients from this general area now rely on County General Hospital and, on the average, there are more than 800 patients from this area in County General Hospital.

4. The hospital will cost $21.4 million. (Application has already been made for Hill-Harris Funds to provide $9.1 million.) The County's share, $12.3 million, will be submitted to the voters as a bond issue in June, 1966.

5. A bond issue is by far the most economical means to finance the County's share of this hospital. No other method of financing (competitive bids for a lease-back arrangement, negotiated lease, or general fund financing) can provide the hospital as economically as bond issue financing.

6. By building a quality hospital, jobs will be created, services will be rendered, lives will be saved, and the health of the community will be improved.

7. Disease knows no boundaries. If one portion of this great metropolitan area has substandard health and emergency care facilities, all other communities will be affected. Pain and illness, whether suffered in Los Angeles, in the Congo, or in Vietnam, have the same effect on human beings. If America can spend taxpayers' money to build hospitals for African and Asian countries, and in Vietnam, certainly we should take care of our own citizens first.

8. All citizens must have faith and hope for the future. We must re-build and restore confidences and good will in Los Angeles County. We must move forward to eliminate the real causes of poverty by getting at the roots of dissatisfaction, injustice, and discrimination in every aspect of life.

ALL RESIDENTS OF LOS ANGELES COUNTY SHOULD VOTE "YES" ON THE HOSPITAL BOND ISSUE

Source: Fact Sheet – South Los Angeles County Hospital. Kenneth Hahn Collection, Box 200, Folder 3 (Special Collections, Huntington Library)

Chapter Four
Is Drew School a "Black" School? Liberal Multiculturalism and Academic Medical Centers

On February 10, 1972, over six thousand people gathered on the front lawn of 12012 South Compton Avenue to dedicate Los Angeles County's newest public hospital, Martin Luther King, Jr. General Hospital.[189] The culmination of a seven year campaign, the King General hospital tower was a part of an entirely new federally-sponsored medical institution called the academic medical center (AMC), which combined the informal relationships between hospitals, physician practice groups, medical schools, and research institutions and formalized them into one unified medical complex of interlocking, mutually reinforcing missions. Renowned African American surgeon, Dr. Mitchell Spellman, served as the dual head of King Hospital and the new Drew Postgraduate Medical School (founded in 1966 and opened in 1972), the first medical school led by black faculty on the West Coast.[190]

By 1970, fifty four academic medical centers (AMCs) had been formed nationwide as Regional Medical Programs through partnerships of pre-existing hospitals, institutes and universities.[191] King-Drew, however, was the first to be constructed from the ground up as a "medical complex," and was also significant because it was known for its unique mission in combining the "arc of civil rights" and the "the arc of academic medicine" together into institution.[192] The *Journal of the National Medical Association,* heralded the 394-bed, six-story, $26.5 million acute care hospital tower "in the middle of a desert of deprivation" as a project "offering hope and light where there has been none, offering opportunities

[189] The dedication ceremony was covered extensively but its attendance was reported by Bill Robertson. "King Hospital Dedication A Success: 6,000 Persons Attend King Hospital Dedication Program," *Los Angeles Sentinel*, Feb. 10, 1972 page A1
[190] Until 1965, only two black medical schools existed. Howard University in Washington, D.C., and Meharry Medical College in Nashville, Tennessee.
[191] "Peak Years and Decline (November 1970 to November 1974)" Online Archive. The Regional Medical Programs Collection. (United States National Library of Medicine, Bethesda, MD) https://profiles.nlm.nih.gov/ps/retrieve/Narrative/RM/p-nid/99 Accessed March 5, 2017
[192] Remarks by President John J. DeGioia. Reflections on the Life and Career of Dr. Mitchell Spellman. Georgetown University. November 23, 2013. https://president.georgetown.edu/speeches/mitchell-spellman.html Accessed December 5, 2016.

heretofore unknown to the residents in this area, and offering medical services of a quality which would be desirable even in the most prosperous of communities."[193] (See Figure 4.1)

In reality, the hospital was far from finished. Cost overruns, work stoppages, delayed equipment delivery, and a nursing shortage had pushed back the opening of the hospital. A month and a half after the dedication, the hospital accepted its first patient, Robert L. Jamerson, on March 27th.[194] The delay revealed the extent to which expectations and reality of what the hospital could deliver continued to be mismatched. Despite reports that the hospital would employ a workforce of 2,000 to operate the 394-bed facility, the hospital had only hired 1,269 workers and had only made 72 beds operational on its opening date.[195] The hospital tower alone was so costly that hospital administrators reprioritized the opening of certain wards inside the tower and deferred the construction of outlying clinic and mental health facilities into a multi-phase plan that would be built over a period of ten years. Since the hospital's funds were drawn from external funds sourced from outside the community, the determination of which wards and services were to open were not determined by local citizens but by the requirements outlined by these external sources.

Conspicuously muffled in the celebration were the voices of the Drew Medical Society, an all-black and initially all-male medical society who had practiced in the community for decades. Their absence in the dedication ceremony program was especially curious given that they were primary stakeholders in the hospital planning process and, in some cases, were clinical lecturers affiliated at the Drew Medical School. As the name suggests, the school's naming practice reveals how the Drew Medical School was to serve both the needs of Society members while memorializing the legacy of its namesake, Dr. Charles R. Drew. In spite of all of the school's promising advantages, the muted voices of Drew Society members demonstrates that their participation had come to be strained by distrust and uneasiness.

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[193] Windsor, Charles A. "A Summary of the History and Plan for Development of the Los Angeles County Martin Luther King, Jr. General Hospital" *Journal of the National Medical Association*. November, 1972. Vol. 64, No. 6. Pages 544 - 547.
[194] "Dream Fulfilled: Martin Luther King Hospital Registers its First Patients" *Los Angeles Times*, March 27, 1972. Page 3.
[195] See: "Feb. 18, 1972 Memo to Kenneth Hahn from Lister Witherhill" Kenneth Hahn Collection Box 205, Folder 61; and, "March 23, 1972 Memo to Kenneth Hahn from Lister Witherhill," Box 206, Folder 69, (Special Collections, Huntington Library)

Drew Society members accused King-Drew leadership as being too focused on research and training of new physicians rather than serving the needs of the community and practicing physicians. In 1970, Drew Society member Dr. Hubert Hemsley wrote to readers of the local black press that the hospital was bound to "rob a person of dignity in the pursuit of esoteric goals," instead of making "the patient and community" its "major emphasis."[196] Such criticism had come to be shared by other community members by the hospital's opening. A leaflet distributed anonymously by "some dedicated people on the staff of King Hospital," charged that the "King Hospital is a Potential Death Trap," unprepared to safely handle patient care.[197] (See Figure 4.2) The unnamed protestors claimed that instead of making a hospital "responsive to the community," administrators had colluded with politicians to open a hospital with "second-rate services" and without emergency services.

These details show that King-Drew was not the ideal embodiment of community self-determination and quality healthcare that many ascribed to it on its arrival.[198] This chapter explores how federal antipoverty and health legislation gave leadership and funding *selectively* to members of the black community based on their ability to appropriate mainstream ideas of medicine and self-governance. King-Drew's planners manifested their commitments to these abstract concepts of medical leadership and autonomy in who they appointed as the medical school's leaders and the kinds of expectations they laid on the type of education that post-medical graduates would obtain. I argue King-Drew leaders aimed to produce a new type of physician, a "multicultural" physician, by absorbing the assumed patient-focused and humanistic aspects of local physician care and eradicating aspects of their practice associated with "slumlord care."

This maneuver to produce "multicultural" physicians rather than "black" physicians indicates a significant break from the assumption that the hospital would be staffed and operated by black medical

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[196] Charles Baireuther. "A Doctor's Opinion: MLK Hospital Will Fail Without Community Stress" *Los Angeles Sentinel*, April 23, 1970, page D2

[197] "Attention: The King Hospital is a Potential Death Trap" Kenneth Hahn Collection Box 206, Folder 69, (Special Collections, Huntington Library)

[198] Up until this moment, criticism of the hospital had been contained to the hospital's cost, especially since funds had been authorized from county general funds after voters failed to pass a referendum to fund it through a new county tax.

practitioners for black people. From the 1960s to the early 1970s, since Watts was, both in census numbers and in the imagination of city residents, a black community, the previous three chapters show that the creation of a public funding stream to combine a health district and poverty district was intended to benefit black residents in Los Angeles. By the 1970s, new statistical indices began to show that the community was far more impoverished than before and, more significantly, home to a growing number of Latin American immigrants. This chapter and those that follow assess the impact and consequences of this change and the challenge it presented to progressing a healthcare agenda centered on blackness.

King-Drew planners selectively appointed black medical men to leadership based on the probability that their medical training and expertise would not encourage medical standards separate from mainstream society (that is, "ghetto" standards separate from mainstream standards) but develop uniform standards that could apply across all racial and economic contexts. Drew leaders preemptively anticipated the concerns of prospective postgraduate medical applicants fearful of the stigmatization associated with practicing in low income communities by posing the question directly, "Is Drew School a 'Black' School?" in a brochure it sent widely out to medical schools in 1971.[199] (See Figure 4.3) To dispel damaging notions around race, the leadership of the Drew School emphasized that "we serve all persons - both those able to pay for their care and those who cannot" with a "single standard of health and medical services." It affirmed that Drew is "a multiracial, multiethnic institution, in the belief that single, racial, religious, or cultural organizations cannot sustain support or the strategy for lasting solutions to national health needs and issues."

These statements reveal that local black practitioners who had been practicing in and around Watts for generations had become a locus of concern for the Drew School that was both productive and threatening. On one hand, Drew School leaders wanted to laud local black physician participation in the school as an asset for medical education by giving new graduates a unique opportunity to learn interpersonal skills and culturally sensitive approaches to medicine assumed to be natural to local

[199] "Charles R. Drew Recruitment Brochure." Commonwealth Fund Series 18: Grants, Box: 97, Folder 889. (Special Collections, Rockefeller Archive Collection)

community physicians. On the other hand, they wanted these same long-time practicing physicians to become objects of medical education reform as well, updating their own professional education through the medical center's continuing education courses to fit the full expectations of modern medicine. The school summed it up in the following way: "The Drew School faculty believe those physician graduates seeking superior training in the specialties, *coupled with an outlook to serve people foremost*, will find the educational program at the King-Drew Medical Center appealing."[200] (Italics, mine)

Although the Drew School attempted to frame this relationship between the medical center and local community physicians as mutually beneficial, Drew Society members came to regard this relationship as extractive and exploitative of their labor. Instead of putting the needs of local community physicians first, the School appeared to privilege the production of new physicians who were being crafted to an abstract idea of multiculturalism and were being groomed to replace them in the medical market. Drew Society members were particularly incensed by the fact that the Drew School did not appoint an all black slate of medical faculty. Thus, Drew School's activities were not only seen as detrimental to local physicians because of the potential element of competition they brought to their practices but also for the fact that such competition could replace care provided by black physicians with those from outside of the community.

Capitalist Drive and Absorption of Critique

The creation of King-Drew Medical Center as a Regional Medical Program inspired a parallel conversation in California's second largest African American population in Northern California in early 1969. As I will explain in detail later, Regional Medical Programs (RMPs) were a new federal assistance program that sought to maximize the capacities of hospitals and medical schools to help lift the health standards of all Americans. In March 1969, the John Hale Medical Society, the all black medical society in Northern California, in conjunction with the California Regional Medical Programs - Area I, in San

[200] "Charles R. Drew Recruitment Brochure." Commonwealth Fund Series 18: Grants, Box: 97, Folder 889. (Special Collections, Rockefeller Archive Collection)

Francisco hosted a conference titled, "Medicine in the Black Community."[201] A report of the proceedings authored by two black physicians, Drs. Oscar Jackson and Waldense Nixon, provides an opportunity to assess black opinion on the healthcare landscape nearest to the opening of King-Drew.

Their summation emphasized that most hospitals in California's black neighborhoods did not regularly accept black physicians on their staffs or admit black patients to their care. According to them, "most community hospitals in the black patient's area tend to isolate themselves from the community and are often looked upon as well-armed fortresses, isolated by heavily armed guards."[202] For those black citizens able to find care, they observed that "the [black] patient is usually faced by an unsympathetic staff who cannot relate to the patient other than as a medical entity." Moreover, "the black patient greatly fears experimentation at the hands of the staff, since he never sees anyone who can afford other types of care or who goes to the clinic on a voluntary basis. He, therefore, feels isolated, and feels he is in a different medical class."[203]

In 1965, President Johnson passed the Heart Disease, Cancer, and Stroke Act, a law that created a new division in the Department of Health, Education, and Welfare called the Regional Medical Programs. The program was designed "to encourage and assist in the establishment of regional cooperative arrangements among medical schools, research institutions, and hospitals for research and training, including continuing education, and for related demonstration of patient care."[204] The spirit of the law was accompanied by other important legislations, including the 1965 Civil Rights Act, the Great Society programs, and the Social Security Amendments authorizing Medicare and Medicaid. The law was read widely by urban medical hospitals and universities as a mandate to reform their services, staffing, and service practices to be more multicultural in nature.

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[201] Jackson, Oscar J. and Waldenese Nixon. "Medicine in the Black Community." The Western Journal of Medicine. October, 1970. 114:4. p. 58
[202] Jackson, Oscar J. and Waldenese Nixon. "Medicine in the Black Community." The Western Journal of Medicine. October, 1970. 114:4. p. 58
[203] Jackson, Oscar J. and Waldenese Nixon. "Medicine in the Black Community." The Western Journal of Medicine. October, 1970. 114:4. p. 58
[204] Sec. 900, PL 89-239

According to Andrew T. Simpson, all these laws attempted to change the perceptions of academic medical centers as being "fortresses of health" by turning the energy and focus of medical care and medical training to the poor, particularly those of color.[205] He argues that mid-1960s represented a second "renaissance" for academic medicine that absorbed criticism of an earlier period that centered the healthcare industry's growth on white communities. Kenneth Ludmerer argues that, by the 1920s, "the medical school had become a factory, in the fullest sense of the term," and that, "like all basic industry, medical education had become capital and labor intensive, requiring laboratories, teaching hospitals, endowments, and a large full-time faculty."[206] As Jackson's and Nixon's accounts demonstrate, the focus on capital, medical research, and training had led hospitals and medical schools to focus their enterprises on a paying consumer based largely racialized as white and middle class to sustain business.

The emphasis on research and capital sometimes ran against the perception of openness that medical centers were trying to achieve. Guian McKee argues that academic medical center's drive to acquire more capital and build more sophisticated research and treatment facilities in urban centers have given them a reputation as "gentrifiers" by some residents, activists, and advocates of surrounding ethnic neighborhoods.[207] For example, McKee argues that despite the protests of Boston's South Cove Chinatown activists throughout the 1970s, Tufts University succeeded in demolishing tracts of land to build the Proger Health Services Building, Tufts Dental School, parking garages, and the rebuilding of the Pediatric Floating Hospital. Los Angeles County - USC Medical Center, likewise, had grown in size over its centennial history. From 1933 to 1972, the hospital campus had grown from one large 19-story 1,265,000 square foot medical and surgical tower to a campus of 79 acres that included a 400-bed osteopathic hospital, 166-bed psychiatric facility, a 170-bed contagious disease building, and an

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[205] Andrew T. Simpson. "Health and Renaissance: Academic Medicine and the Remaking of Modern Pittsburgh" in Journal of Urban History 2015, 41 (1) pages 19-27.
[206] Kenneth Ludmerer. *Learning to Heal: The Development of American Medical Education* (Baltimore: Johns Hopkins University, 1985)
p. 257
[207] Guian McKee. "The Hospital City in an Ethnic Enclave: Tufts-New England Medical Center, Boston's Chinatown, and the Urban Political Economy of Healthcare" in Journal of Urban History 2016, 42 (2), pages 259-283

outpatient building of 200,000 square feet that encroached upon the surrounding Mexican American neighborhoods.[208]

Simpson argues, however, that new federal programs in the 1960s and 1970s gave academic medical centers a chance to contest their reputations as fortresses of health by using federal money to play up their role as employers and trainers of medical personnel of color. He explains, "one of the most important ways that not-for-profit hospitals, medical schools, and universities reflected a new role as developers of human capital was by emerging as important sites for job training programs." As an example, Simpson argues that the University of Pittsburgh's Freedom House Ambulance Service, which ran from 1967 to 1975, "trained and employed African Americans from the city's Hill District who had incomplete or chaotic employment histories."[209]

Both Simpson and McKee argue that city officials in the late 1960s and early 1970s tended to favor academic health center construction. According to McKee, "choices about land use, and, particularly, about the removal of existing residential and commercial uses in service of the medical center's growth, demonstrated one of the core dilemmas posed by the emergence of the hospital as an urban anchor. Healthcare, medical education, and biomedical research clearly offered better future prospects for [cities] than garment manufacturing or low-cost retail."[210] Simpson added that, "the health professions, by virtue of the non-outsourceable nature of illness and the steady federal funding stream for health care as a consequence of Medicare and Medicaid, emerged as an important focus," of academic medical centers because they were seen to combat job loss experienced by deindustrialization. Since the 1970s, the "eds and meds" sector (the combined university and hospital industry) academic medical centers have become

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[208] Robert Tranquada and Robert Maronde. "The Hospital Within A Hospital: An Empirical Experiment in Healthcare in a Major Metropolitan Hospital" in the Bulletin of the New York Academy of Medicine. March, 1972 48:3, p. 560-561

[209] Andrew T. Simpson. "Health and Renaissance: Academic Medicine and the Remaking of Modern Pittsburgh" in Journal of Urban History 2015, 41 (1) p. 22

[210] Guian McKee. "The Hospital City in an Ethnic Enclave: Tufts-New England Medical Center, Boston's Chinatown, and the Urban Political Economy of Healthcare" in Journal of Urban History 2016, 42 (2), page 271

economic and political juggernauts as employers, providers of medical services, and as recipients of federally funded research grants, accounting for 34.7% of jobs in the nation's twenty largest cities.[211]

As Simpson points out, the steady federal funding stream of Medicare and Medicaid made it possible for urban academic medical centers to turn their exclusive attention from white and middle class clientele to make their patient base profiles more multiracial in nature. Academic medical centers' ability to recruit physicians of color to both their training programs, to their staffs, and to reflect curriculum that addressed the needs of poor patients and patients of diverse backgrounds was essential to maximizing new federal funding streams. In effect, academic medical centers invested in the rhetoric of "multiculturalism" and practices of minority hiring, admission, and service inclusion not only because it proved sound business practice but because it could also promise greater returns for institutions that could demonstrate fulfillment of the overarching objectives of President Johnson's Civil Rights and Great Society agenda.

As I will show, Medicare and Medicaid diversified the patient base profiles of hospitals while also intensifying market competition between hospitals. Institutions that could prove a history of servicing indigent patients, an open admissions policy for its medical staff and trainees, curriculum around patient-centeredness, and a good rapport with their surrounding communities of color stood to benefit from additional funds earmarked for Regional Medical Programs. At its height of funding in 1973, academic medical centers that received RMP designation were eligible to compete for $140 million dollars allocated for research and training grants that were separate from funds generated by Medicare and Medicaid.[212] In a highly competitive hospital market, these funds served as assets that could attract patients to choose to spend their consumer dollars at their hospitals over others.

Thus, for urban academic medical centers, "patient-centeredness" assumed the transition of institutional trajectories to shift their focus from exclusively white and middle class patients to include

[211] Guian McKee. "The Hospital City in an Ethnic Enclave: Tufts-New England Medical Center, Boston's Chinatown, and the Urban Political Economy of Healthcare" in Journal of Urban History 2016, 42 (2), page 260
[212] "Peak Years and Decline (November 1970 to November 1974)" Online Archive. The Regional Medical Programs Collection. (United States National Library of Medicine, Bethesda, MD) https://profiles.nlm.nih.gov/ps/retrieve/Narrative/RM/p-nid/99 Accessed March 5, 2017

poorer patients and those of color.[213] As other American and Ethnic Studies scholars have argued, this shift for greater inclusion of minority students and multicultural curriculum also took place in the 1960s and 1970s amongst liberal universities. The emergence of academic medical centers is thus an under-analyzed history of what many in the academy term "ethnic studies" and the various inter-disciplines of African American, Asian American, Chicano/a and Latino/a Studies, and Women's, Sexuality, and Gender Studies.

Here, both academic medical centers and liberal universities paused to absorb criticism of their role in producing American society as exclusionary and racist to reproduce themselves as "multicultural" spaces. American and Ethnic Studies scholar Roderick Ferguson argues that whereas American universities "once disciplined difference in the universalizing names of canonicity, nationality, or economy," widespread public protests in the 1960s re-shaped these institutions such that they began to see "minority difference and culture as positivities that could be a part of their own 'series of aims and objectives.'"[214] In other words, liberal universities became so adept, "alert and responsive" to absorbing criticism of racism and classism that they were capable of re-channeling that energy towards an "abstract - rather than a redistributive - valorization of minority difference and culture."[215]

King-Drew Medical Center's unprecedented capability to build a pedagogical project from the ground up allows us to see how health planners wrestled with criticism of academic medicine by using the key healthcare laws of Medicare, Medicaid, and President Johnson's Heart Disease, Cancer, and Stroke Act to contest the close association of medicine with whiteness. This trio of legislations forged new liberal multicultural institutions capable of ameliorating the racial antagonism between white communities and racialized communities they understood to be circulating and threatening to postwar order. They concretely saw these criticisms as targeting two different medical "types" - the arrogant

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[213] For a history of "Patient Centeredness" as a term see: Somnath Saha, Mary Chaterine Beach, and Lisa Cooper. "Patient Centeredness, Cultural Competence and Healthcare Quality" in the *Journal of the National Medical Association*. 2008, November, 100 (11): 1275-1285

[214] Roderick Ferguson. *The Reorder of Things: The University and its Pedagogies of Minority Difference.* (Minneapolis: University of Minnesota Press, 2012), p. 7

[215] Roderick Ferguson. *The Reorder of Things: The University and its Pedagogies of Minority Difference.* (Minneapolis: University of Minnesota Press, 2012), p. 8

physician walled behind the ivory tower of medical research and the friendly doctor with outdated knowledge as both equally dangerous to postwar progress.

Two Standards of Quality

Today, many regard the primary legislative acts that forged AMCs as laws that expanded the welfare state. This is especially true for Medicare and Medicaid (P.L. 89-97), two programs which have gained more recognition in recent times as so-called "entitlement" programs. Both, however, are crucial components of how AMCs function because they furnish the capital and diversity of patients that make capital-intensive medical research possible. These "big government" narratives tend to hide the role that Medicare and Medicaid played in enlarging free enterprise healthcare by focusing on how both led to the tiering of American medicine by race and class. This process obscures how many physicians of color and liberal progressives working in the 1960s saw the law as working to equalize and democratize healthcare rather than reify medical segregation and hides, more importantly, how the law achieves this through the free market means of consumer and provider choice.

The programs organize patients and providers into two pools: one pool of "consumers-citizens" eligible to enter the medical market place by their status – as seniors, the indigent/poor, or the disabled. It also created a second pool of medical providers who are certified to treat patients and seek reimbursement from the federal government for qualified medical services. President Johnson hoped that the size of this consumer pool would not only give citizen-consumers a wide marketplace of providers to choose from but also entice providers to enter into markets once considered risky.

Physicians, however, turned out to be less eager to meet the expectations of equitable access assumed be created as an important by-product of the law. Their practices tended to be more selective in their use of these programs. Many only opted to treat Medicare consumers, who were generally, but not exclusively, white and middle class, while refusing to treat consumers eligible for Medicaid, who tended

to be from more racially-diverse backgrounds.[216] The comparatively larger numbers of Medicare-only hospitals and physician practices, however, burdened a smaller amount of institutions participating in Medicaid who ended up taking on larger volumes of patients. This process racialized Medicare as both white and high quality while conflated Medicaid care with "slumlord" care, characterized by overcrowded facilities and poor quality care.[217] These cultural practices reinforced the belief that government has helped determine the quality of care that one receives by race and class.

This tiering effect has been met with a conservative call to eliminate this system for its perpetuation of racism, class hierarchy, and citizen dependency on "entitlements." Conservative black physicians like Ben Carson have forwarded this perspective believing that the elimination of such programs would result in lifting the stigma of poor care associated with black physicians and the stereotype of black patients as welfare recipients.[218] Yet, while Carson's advocacy today appears to some as being in conflict with the spirit of President Johnson's landmark health legislations, a closer examination of the activities of the all-black and initially all-male National Medical Association (NMA) in the 1960s reveals that Carson's perspectives historically aligned with black physicians' advocacy in Johnson's administration.

Black physicians in the 1960s viewed Medicare and Medicaid as *necessary* to end black dependency on welfare, anchor black health consumption in the free market, and to create mechanisms for black control of community institutions. They did not view the Medicare and Medicaid programs as enlarging the welfare state but rather as encouraging black physicians to "mainstream" black healthcare institutions by using federal laws around desegregation and funding to universalize a market-based medical service economy. They received an unprecedented opportunity to forward these policy positions when President Johnson assumed office in 1963 and the Democratic party won Senatorial and Congressional majorities in 1965. President Johnson turned to the NMA in his break with the

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[216] The process I described here in the paragraph has been analyzed by multiple authors including: Jena Loyd. *Health Rights are Civil Rights: Peace and Justice Activism in Los Angeles, 1963-1978* (Minneapolis: University of Minnesota Press, 2014); and, Jonathan Engel. *Poor People's Medicine: Medicaid and American Charity Care since 1965* (Durham: Duke University, 2006)

[217] This process of racialization of care is particularly pronounced amongst long-term care facilities. See: Jennifer P. Nazareno. Dissertation. *The Outsourced State*: *The Retraction of Public Caregiving in America.* UC San Francisco. 2015

[218] Ben Carson. *One Nation: What We Can All Do to Save America's Future* (New York: Sentinel, 2014)

conservative white-led American Medical Association in order to craft new healthcare laws that were consistent with his civil rights agenda.[219]

Medicare and Medicaid legislation ensured that the quality of medical care provided by a physician should not depend on the color of their skin or the location of their services but on the content of their training and education. Under Medicare and Medicaid law, providers gained their right to access Medicare and Medicaid consumers by giving up a certain amount of physician autonomy. Whereas physicians simply relied on their talents and abilities to attract consumers before Medicare and Medicaid, physicians who desired access to Medicare and Medicaid patients had to agree to physician standards set by the federal government.[220] Medicare and Medicaid thereby established a new national criteria by which a provider could be accredited as a "community" physician, which, in turn, certified them as qualified to care for America's most vulnerable populations.

What is also significant to NMA's view on 1960s health legislation is that they did not necessarily oppose the creation of two standards of care. They supported the legislative efforts of President Johnson, his main executive legislative aide, Wilbur Cohen, and renowned Baylor University heart surgeon Dr. Michael DeBakey to consolidate medical research into regional medical centers through the passage of the Heart Disease, Cancer, and Stroke Act. Programmatically implemented and supported as the Regional Medical Program (RMP) from 1965 to 1974, RMP created an elite set of anchor "academic health centers" distinctly held to a different standard than the field of "community" hospitals and physicians being normalized through Medicare and Medicaid.

Instead of representing a divide between "quality" and "poor" healthcare, advocates saw the difference between an RMP and a community hospital as a mutual partnership between innovators and

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[219] According to Martha Derthick, the NMA essentially "represented the medical professional" between 1963 and 1965 since the AMA was "implacably hostile to government health insurance." *Policy Making for Social Security* (Washington, D.C.: Brookings Institute, 1979), page 96.

[220] In order to be eligible for Medicare and Medicaid funding, institutions and providers had to voluntarily submit their businesses and credentials to external scrutiny in exchange for provider eligibility. For facilities, the law tied their eligibility to standards created jointly by the American Medical Association and the American Hospital Association called the Joint Accreditation Council of American Hospitals (JACHO) and tied provider eligibility to board certification with their specialties. Standards related to these are privately determined by professional organizations who work in the name of the public good.

practitioners. RMP Director Michael DeBakey anticipated that the standardization of medical practice through Medicare and Medicaid would stay stagnant without a mechanism to dynamically raise or change standards to reflect new knowledge and technology. The creation of RMPs solved this problem by linking hospitals to a regional academic health center that combined research, training, and service to innovate medical methods. As opposed to community hospitals, a RMP designation provided additional research and construction dollars exclusive to a particular region. In exchange for more federal research dollars, RMPs were mandated to share their knowledge with community hospitals in efforts to "speed the miracles of medical research from the laboratory to the bedside," and "speed communication between the researcher and the student and the practicing physician."[221]

RMPs were critical in that they not only accept their regional roles as anchor institutions for community hospitals operating in their local context but also that they share new knowledge with other academic health centers in other regions. Acting as medical flagships that distributed new medical knowledge and disseminated new methods of patient care delivery to community hospitals, these medical armadas were activated to meet the challenge of curing and treating America's top three most life threatening diseases - heart disease, cancer, and stroke. When programmatic support for RMPs declined, the institutions created from them became better known as Academic Medical Centers (AMCs).

For the NMA members, the possibility of creating a black-led AMC addressed a large gap in medical education for black physicians. Opportunities to receive a medical education for black citizens had been limited to two medical schools - Howard University and Meharry Medical College - and opportunities for research and administration were even rarer.[222] Having a black-led AMC would be an unprecedented commitment by the federal government to produce more black physicians and to invest in medical research that was germane to the black experience in America. More importantly, a black

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[221] Lyndon B. Johnson. "Remarks at the Signing of the Heart Disease, Cancer, and Stroke Amendements of 1965" October 6, 1965. Online by Gerhard Peters and John T. Woolley, The American Presidency Project. http://www.presidency.ucsb.edu/ws/?pid=27298.

[222] I extrapolate these points later in the chapter and discuss, at length, how black physicians navigated a segregated medical education and labor market in Chapter One. Can you provide citation of historical research that reinforces or qualifies this argument since there was limited desegregation of medical training up until 1960s

medical center attached to the nationwide network of academic medical centers had the potential to disseminate important information about providing quality patient care in urban and black neighborhoods.

NMA officials leveraged the need to provide quality patient care in poor populations with the challenges of combating high-fatality cancer, heart disease, and stroke that would not be possible without the greatest number of Americans possible participating in medical research. These diseases presented several challenges that were extremely different than the public health epidemics of an earlier epoch. First, unlike the episodic diseases like cholera, typhoid, and influenza, these "lifestyle" diseases required patients and research subjects to be engaged in a continuous relationship with medical professionals to monitor, counsel, and treat conditions that are more likely to be managed than eradicated.[223] Most American citizens had grown accustomed to going to a hospital only in an emergency and did not see it as a place to develop a lifelong relationship with.

Additionally, these diseases were not limited to one racial community or socioeconomic class but impacted each group similarly across such indices. In order for medical researchers make deep inroads to treat and cure complex, endemic diseases, the federal government invested capital in academic medical centers as research and treatments centers to motivate citizens to develop a recurrent, long-term relationship with a hospital that could ensure monitoring of diseases, develop effective care, and reach potential cures.

Racial Pluralism as a Local Standard

The development of recurrent, long-term relationships with communities of color presented a challenge for academic medical centers unaccustomed to treating black patients as anything outside of medical material. As the statements by Dr. Jackson and Dr. Nixon attested, the belief that the black patient "greatly fears experimentation at the hands of the staff,"[224] was perceived as a major obstacle in

[223] Lifestyle Diseases is a term now popular amongst medical professionals to explain the origin of some diseases as rooted in the way people live their lives (particularly their habits around eating, sleeping, exercise, stress, etc.).
[224] Jackson, Oscar J. and Waldenese Nixon. "Medicine in the Black Community." The Western Journal of Medicine. October, 1970. 114:4. p. 58

gaining the participation of black patients in academic medical centers. Concerns about medical trust between medical practitioners and underprivileged groups became more inflamed over the course of the late 1960s and early 1970s as social movement campaigns around race, gender, sexuality, class, and disability justice gained momentum.[225]

For many, the July 1972 Associated Press exposé of the Tuskegee Syphilis Experiment, a 40-year study which knowingly left hundreds of southern black men untreated for syphilis, symbolized the callousness, racism, and classism of American medical research practices.[226] A closer examination of the Tuskegee Syphilis Study reveals that some of the black men in the study, however, did see themselves as the beneficiaries of caring attention, particularly by Eunice Rivers, the black nurse assigned to them during the multi-year study. Susan Reverby reveals that these black men saw the "care" they received by Rivers as compassionate given that most black Southerners were accustomed to receiving no care or attention at all from any trained medical professional.[227] As news reports drew attention to the fact that some were given a placebo (a drug with no effect) and were not informed of their use in advance of their participation, Reverby notes that many of the men continued to have a relationship with Rivers, seeing her as trustworthy and loving in contrast to their feelings of exploitation associated with the study overall.

Here, the context of care reverberated differently across different communities as the story took a life on its own.[228] The study prompted citizens within and outside medicine to demand greater community accountability for research and treatment practices in their own local contexts. It, for instance, inspired the

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[225] I mention many directly related to black health in the next few citations but readers may also see: Jenna Loyd. *Health Rights are Civil Rights: Peace and Justice Activism in Los Angeles, 1963-1978* (Minneapolis: University of Minnesota Press, 2014); Kim E. Nielsen. *A Disability History of the United States* (Boston, Beacon Press, 2012); Sandra Morgen. *Into Our Own Hands: The Women's Health Movement in the United States, 1969-1990*. (New Brunswick: Rutgers University Press, 2002); Steven Epstein. *Inclusion: The Politics of Difference in Medical Research* (Chicago: University of Chicago, 2007); Jael Silliman, Marlene Gerber Fried, Loretta Ross, and Elena R. Gutierrez. *Undivided Rights: Women of Color Organize for Reproductive Justice*. (Chicago: Haymarket, 2016)
[226] See: James H. Jones. *Bad Blood: The Tuskegee Syphilis Experiement* (New York: Free Press, 1981); Fred Gray. *The Tuskegee Syphilis Study* (Montgomery: New South, 1998); Susan Reverby, Editor. Tuskegee's Truths: Rethinking the Tuskegee Syphilis Study (Chapel Hill: University of North Carolina, 2000); Susan Reverby. *Examining Tuskegee: The Infamous Syphilis Study and its Legacy* (Chapel Hill: University of North Carolina, 2009)
[227] Susan Reverby. *Examining Tuskegee: The Infamous Syphilis Study and its Legacy* (Chapel Hill: University of North Carolina, 2009)
[228] See: Harriet Washington. *Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to Present* (New York: Harlem Moon, 2006) and Rebecca Skloot. *The Immortal Life of Henrietta Lacks* (New York: Broadway, 2010)

Black Panther Party to mount two campaigns from 1966 to 1974 focused on ensuring humane and dignified care for poor people of color. According to Alondra Nelson, their free standing clinics and patient advocate campaigns serve as examples of citizen campaigns which denounced the racism and classism of mainstream physicians and medical institutions but insisted that western medical practitioners could be made impartial, objective, and neutral.[229] In fact, Nelson and Keith Wailoo demonstrate that the findings inspired activists to call for more research funding to certain diseases like sickle cell anemia which disproportionately impacted black people.[230] Medical academicians used the criticism as an opportunity to re-asses their methods, instruments, measures, and approaches to research. As Steven Epstein demonstrates, the Tuskegee Study helped develop an entire field of biomedical ethics dedicated to topics such as informed consent, cultural competence, and racism in research design.[231]

For black physicians in the NMA and the Drew Medical Society, the study lifted up their assertion that only one solution could address medical distrust in black communities - more black academicians and black physician practitioners for black communities. Black physicians exploited the belief that race formed a shared common experience that mediated against the countervailing effects of class, gender, and sexuality to create a feeling of kinship that could overcome the traditional medical hierarchies of physician-patient and researcher-subject. This idea of race as a stable container of difference obscured a material relationship that mattered more deeply to black physicians, who often found it hard to develop sustainable medical practice from a poor and black patient base.

For Drew Society Members, the belief that only black patients could only be treated ethically by black physicians was rooted in the fact that most poor black patients in Los Angeles sought care in the white-led "charity" institutions of Los Angeles County General Hospital (affiliated with USC Medical School) and Harbor General Hospital (affiliated with UCLA Medical School). Drew members denounced

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[229] Alondra Nelson. *Body and Soul: The Black Panther Party and the Fight against Medical Discrimination*. (Minneapolis: University of Minnesota, 2011)
[230] Keith Wailoo. *Dying in the City of Blues: Sickle Cell Anemia and the Politics of Race and Health* (Chapel Hill: University of North Carolina, 2001)
[231] Steven Epstein. *Inclusion: The Politics of Difference in Medical Research* (Chicago: University of Chicago, 2007);

the use of black citizens for medical experimentation and practice at the hands of non-black researchers and resident physicians in these institutions as exploitative. Fearing the King-Drew would just become "another charity hospital," Drew Society President Hubert Hemsley argued, that "the charity hospital and clinic care, like most of our [black] institutions, was well intended, but it has failed. Rather than on center care on the needs of the patient foremost, he argued that, "in this system the highest priority is to teach interns and residents, secondarily to conduct research, and ultimately provide patient care."[232]

Hemsley's attitudes reflect the opinions of most black physicians in the nation, who felt shut out of hospital staffs and university hospitals. Despite strides in providing more opportunities for medical education, Dr. M. Alfred Haynes of the National Medical Association Foundation in 1969 argued that the greatest barrier for black physicians was that "some hospital boards still exclude black physicians more on the basis of race than on competence." He argued that "only too often, the black physician is assumed to be incompetent," particularly if he "practices in the ghetto." Haynes explained that most mainstream physicians would question why "a dedicated, competent physician [would] practice in the ghetto" because the expectations around physician competence were expected to match the patient profile of consumers accordingly.

The interest spurred by federal legislation thus gave black physicians a leverage point that countered mainstream medical practitioners and researchers' claims that they were not suited for medical practice. Society members had worked for decades in Watts and they viewed their survival in such poor settings as a testament to having loving and humane relationships they had developed with their patients. For a national policy agenda desperate to maximize citizen participation in mainstream medicine and, moreover, in medical research, the Drew Medical Society's mystical ability to develop trusting and mutually benefitting relationships with target underrepresented patient populations was seen as an asset worth federal investment in.

[232] Charles Baireuther. "A Doctor's Opinion: MLK Hospital Will Fail Without Community Stress" *Los Angeles Sentinel*, April 23, 1970, page D2

Taking the opportunity to implement the policy initiatives of the NMA, Dr. Sol White of the Drew Medical Society moved plans forward to build a black-owned Watts "community hospital," an exclusive for profit hospital that catered to private paying patients within a particular community.[233] Dr. White advocated the replacement of the region's charity hospitals with for-profit community hospitals would represent market freedom and access for for black people. They, as did other members in the NMA, upheld the exchange of payment for services found in community hospitals as cultural and economic transactions that insured against the coercive and exploitative aspects of research- and training-based care associated with charity hospitals. Instead of seeing Medicare and Medicaid as the continuation of "charity care," they viewed federal intervention as the creation of a new consumer class empowered with the means to make the medical market responsive to a more democratic and diversified medical market.

This view that Medicare and Medicaid would be used as an instrument to bring about the demise of charity care was widely shared. California State Director of Public Health, Dr. Lester Breslow, claimed that Medicare and Medicaid was bound to "replace the dual system of hospital care that prevailed in the past" and that it represented "a big step toward one standard of care for all."[234] Breslow, as did others, believed that new federal and state medical benefits would "no doubt promote more wholesome attitudes toward the poor on the part of medical and hospital administrators, teachers, and staff members," and that "no longer will a captive population exist as 'clinical material.'"[235] Some California counties, seeing that Medicare and Medicaid had shifted the responsibility for indigent care to the federal government and private market, shuttered their County Hospitals in the years between 1965 and 1985. Whereas 66 public hospitals were spread out over 49 of California's 58 counties by 1966, less than half of California's

[233] "February 10, 1965 State Advisory Hospital Council Meeting Minutes." Kenneth Hahn Collection Box 200, Folder 1, The Huntington Library, San Marino, California
[234] Lester Breslow. "New Partnerships in the Delivery of Services - A Public Health View of Need" in The American Journal of Public Health. July, 1967. Vol. 57, No. 7., p. 1096
[235] Lester Breslow. "New Partnerships in the Delivery of Services - A Public Health View of the Need" in *American Journal of Public Health.* July, 1967. 57 (7) 1096

counties operated a public hospital by 1985.[236] Others, like Los Angeles, converted their County Hospitals into "General" Hospitals which took in both paying consumers and patients eligible for indigent care.[237]

The issue at hand, however, was that most new federal legislation helped subsidized operating costs but did not account for new hospital construction funds.[238] Without enough capital construction funds of their own, Drew Society Members sought unsuccessfully to secure enough money to build their community hospital. Their fortune changed in late 1965 when the Watts Riots elevated their plan to an officially recommended riot remediation tactic in the McCone Commission report. As with most federal "citizen participation" policies of the time, the report's overall tone took the policy approach that aid and money be allocated to empower present community members to determine their own community development plans.

In that spirit, the Drew Medical Society accepted the recommendation of the McCone Commission that their plans be aided by the creation of a Watts Hospital Advisory Committee (hereafter, the Committee) consisting of them, the Los Angeles County Department of Hospitals, the Medical Schools of UCLA and USC, and representatives of the Watts community. The Committee members represented - community advocates for the equalization of health standards across the city and championed by Drew Society members in raising of health standards in Watts. Thus, even though each party was given equal voting power, the Drew Society faithfully trusted that they would be installed as leaders of the hospital at the end of the process. In early 1966, this Committee moved forward with a plan to raise hospital

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236 See: Robert Tranquada and Robert Maronde. "The Hospital Within A Hospital: An Empirical Experiment in Healthcare in a Major Metropolitan Hospital" in the Bulletin of the New York Academy of Medicine. March, 1972 48:3, p. 560-561; and, Elinor Blake and Thomas Bedenheimer, "Closing the Door on the Poor: The Dismantling of California's Public Hospitals," *Health Policy Advisory Center Report* 16 (1975): 230.

237 Lester Breslow. "New Partnerships in the Delivery of Services - A Public Health View of the Need" in *American Journal of Public Health.* July, 1967. 57 (7) 1094-1099: According to California Director of Public Health, Lester Breslow: "To equalize the [health landscape], the legislature also provided that counties could henceforth open their hospitals to any patients, not just the indigent. Hence, the way is now clear to the conversion of county hospitals in California into general hospitals for all persons and the establishment of a single network of hospitals servicing every segment of the community equally."

238 The exception to this rule is Hill-Burton Funds. To gain them, however, applicants had to demonstrate proof of a "local" match to engage a match by State and Federal Hill-Burton funds. The Drew Society could not meet this threshold.

construction funds through a county-wide referendum that would underwrite the creation of a new general hospital in Watts.

The conversion of charity hospitals into general hospitals ameliorated fears by the Drew Society that the proposed new county hospital represented the continuation of medical welfare. They also understood that plans to move forward with the hospital could not be conceived without them. Their participation fulfilled a unique prerequisite requirement for additional antipoverty funding that necessitated proof that local indigenous members of the community were involved in the planning and carrying out of poverty alleviation plans. In other words, Drew Society members welcomed the construction of a new county funded "General" Hospital believing that the prevailing ethos of self-determination, goodwill, and enterprise embedded in health and anti-poverty politics would eventually turn over the helm of the hospital to them. As a hospital more or less operated under their leadership, Drew Society members neither saw this new county hospital as a source of competition nor as an exploitative instrument in the community.

A Different Concept of Race

In late 1968, the Committee announced the appointment of Dr. Mitchell Spellman as the founding Dean of the Drew Postgraduate Medical School and head of King General Hospital. (See Figure 4.4) His impressive academic pedigree indicated a significant change in the vision to create a community hospital supported by Medicare and Medicaid to a hospital set to the standards of a full-blown academic medical center. In addition to being a trustee on the Board of the NMA and the NMA Foundation, its new research foundation, Spellman was also a member of the Society of Surgeons, the American Medical Association, and the American Federation for Clinical Research. Under a diversity scholarship grant awarded by the Commonwealth Foundation, he received his Ph.D. in Surgery at the University of Minnesota and earned a

highly coveted five-year Markle Foundation research grant to run clinical research at Howard University.[239]

Spellman's profile as a surgeon, researcher, and executor of grants indicated a new strategy to raise construction funds after the Committee failed to win the passage of the county-wide referendum it placed before voters in Spring of 1966. The local tax funds from this referendum would have created the most likely and expedient pathway to building a hospital that would have seated local Drew Medical Society members as hospital leadership. The crisis in funding in the aftermath of the failed referendum, however, shifted the fortunes of the Drew Medical Society as the reins of leadership were taken over by actors anchored elsewhere.

The most unlikely contenders for leadership appeared to come from the Drew Medical Society's own parent organization, the NMA. Seating Spellman, a physician closer with NMA leadership in Washington, D.C., as Dean of the Drew School signified how NMA leaders took advantage of the opening created by the referendum's failure by forwarding the national organization's goals over its local chapter. Unlike the immediate implementation of Medicare and Medicaid in 1965, RMPs underwent a period of planning and discussion until they were fully implemented in 1968. The scramble to locate new funding was looked upon as an opportunity to exert more direct national leadership to secure the Watts hospital as an RMP-eligible academic medical center. This desire, however, would run against the wishes of local Drew Society members who the saw the project as theirs to determine.

This fault line between the Drew Society and the NMA defined a different idea of proper medical trust between physicians and patients. Whereas Drew Society members encouraged Committee members to overlook their initial lack of pedigree, medical privilege, and research experience in favor of their interpersonal skills with poor patients, the NMA insisted that new generations of black physicians could not rely solely on interpersonal skills to be counted as qualified physicians. As Spellman's appointment suggests, the NMA position prevailed in defining physicians like him as a prototypical "multicultural"

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[239] "Spellman Heads New Drew Medical School" The Journal of the National Medical School January 1969 Vol. 61, No. 1, pages 90 - 91.

physician capable of sustaining the types of medical trust held between black physicians and black patients while also holding the qualities of rigor associated with white medical research institutions.

The standards used by the Committee to recruit the remaining department chairs demonstrates how the search criteria mediated the qualities seen as favorable in both urban and mainstream contexts. Recruitment documents show that, in addition to using membership in "leading academic and scientific societies," "experience, previous affiliations, and the traditional qualifications of degree and training" were considered "measurable as achievements" in discerning qualified applicants.[240] Technically, while the urban "experience" of Drew Medical Society physicians qualified them for consideration, the other criteria generally left them ineligible for final candidacy. (See Figure 4.5)

The NMA knew this because it had commissioned a diagnostic study of every NMA member in the nation in 1967.[241] The published study demonstrated that black physicians who met the criteria established by the Committee did exist but their numbers were few and far between. It revealed that black physicians were more likely to be general practitioners (38% of all black physicians), less likely to hold board certification (77.6% of all black physicians were not), and less likely to participate in teaching institutions and research (only 9%). The study's author, the then NMA Foundation Director, Dr. M. Alfred Haynes, interpreted the bleak data as evidence of historical segregation and the implicit burden placed on black-only medical schools to support black talent at each level of medical training. The data led NMA leadership to have a more muted voice on more black-only medical schools. Instead of being more vocal about more black medical schools, Haynes intensified the demand for historically white medical institutions to hasten medical school integration from the highest echelons of the academic medical ladder all the way down to their medical school admits.

The report indicates a shift in NMA opinion on black-only medical institutions. They demonstrated to NMA leaders in Washington, D.C. that expansion solely in the number of black-only medical schools

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[240] "Recruitment Guidelines. October 1, 1969" Commonwealth Fund Series 18: Grants, Box: 97, Folder 888. Rockefeller Archive Collection. Tarrytown, NY.
[241] M. Alfred Haynes, MD. "The Distribution of Black Physicians in the United States, 1967" The Journal of the National Medical Association. November, 1969, Vol. 61, No. 6. pages. 470 - 473

would not meet the scale of black physicians, researchers, and attending physicians needed to match the black population in a timely fashion. The NMA recognized that for many specialist categories such as Internal Medicine, General Surgery, Psychiatry, and Pediatrics, that only 1 or 2 percent of all specialists were black.[242] Finding a clinician with teaching and research out of such a small percentage meant that for some specializations, the criteria that the applicant be black had to be sacrificed for an abstract notion of "quality" that still accounted for the probability that such a candidate could inspire trust between himself and his patients.

The study also pointed to the probability that the search to appoint a "superb clinician" who was also "an excellent teacher and a competent researcher who has advanced knowledge," would prove challenging not only in respect to race but also in financing.[243] In 1969, USC and UCLA gifted a combined $202,235 in initial grant money from the California Committee on Regional Medical Programs to "underwrite recruitment of a full-time, clinically oriented faculty for the Drew School." By the end of the five-year RMP funding process, a total of $3 million dollars was set aside to recruit the entire Drew faculty. While a considerably smaller sum in comparison to the total cost of $26.5 million for the hospital, the grants were critical in establishing the Drew Medical School which, up until that point, only existed in concept and had no physical footprint.

The grant set off a series of financial crises that diminished the influence of the Drew Society, who had no financial strength to contribute any real money, and increased the voice of external funders who invested more capital to make the project a reality. The RMP money, for instance, not only held the hospital plan to RMP requirements that outlined the existence of ten specific capital-intensive and academically rigorous clinical departments but also demanded that each faculty member hold the

[242] M. Alfred Haynes, MD. "The Distribution of Black Physicians in the United States, 1967" The Journal of the National Medical Association. November, 1969, Vol. 61, No. 6. pages. 470 - 473
[243] This wording comes from "Recruitment Guidelines. October 1, 1969" Commonwealth Fund Series 18: Grants, Box: 97, Folder 888. Rockefeller Archive Collection. Tarrytown, NY.

"appropriate credentials for appointment in the affiliated University School of Medicine" sponsoring it.[244] The implicit veto power of UCLA and USC amplified after it was discovered that the initial RMP grant was "inadequate" in creating "academically competitive awards" to recruit desired faculty.[245] To compensate, UCLA and USC increased recruitment funds from their own budgets, the Committee projected needed RMP grant figures upwards, and the County adjusted its proposed salary scales.[246]

This financial instability also illuminates why Spellman's experience as a grant writer and winner was so critical to his appointment and those appointed after him. As the recruitment documents put it, "the capacities of a chairman to recruit skills and to build a department commensurate with the mandate and mission of the school" was "even more crucial for the Drew School than for established academic clinical entities" because it needed to rely on a greater share of private agency funds. By the time the hospital's opening, external observers would comment that an inordinate amount of everyday operations were tied to the needs outlined by the interest of external funds seeded from organizations like the Commonwealth Fund and the Markle Foundation.

Each of these financial contributions represented investment in defining a variant of the racial pluralism first proposed by the Drew Medical Society. Consistent with the idea that the school ought to be a black institution serving local black medical students and patients, the board prioritized race in the appointment of the Dean and the Departments of Community Medicine and Psychiatry.[247] In addition to Spellman, it seated NMA leader Dr. M. Alfred Haynes as the Chair of Community Medicine and UCLA Professor Dr. J. Alfred Cannon as the Chair of Psychiatry. Starting with the selection of Dr. Robert E. Greenberg, a physician of Jewish descent, as the Chair of the Department of Pediatrics in April 1970,

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[244] "Each Chairmen of a clinical department in the Drew School will occupy the chairmanship of the equivalent department in the King Hospital." "Recruitment Guidelines. October 1, 1969" Commonwealth Fund Series 18: Grants, Box: 97, Folder 888. Rockefeller Archive Collection. Tarrytown, NY.

[245] Costs escalated again in 1970 when RMPs revised its requirements for 2 more additional departments.

[246] The Committee devised a graduated pay scale that outlined "income ceilings" based on experience, service, and qualifications. Instead of being paid through one payroll, faculty members were paid through multiple payrolls to make their salaries "whole."

[247] "The Board has decided that the Dean of the Medical School should be a black physician, and that this should also obtain for the Departments of Community Medicine and Psychiatry. However, each of the other chairmanships will be filled without consideration of racial factors." "Discussion with Dr. Mitchell W. Spellman, Notes by Mr. Keenan of Commonwealth Fund 4/22/70" Commonwealth Fund Series 18: Grants, Box: 97, Folder 888 Rockefeller Archive Collection. Tarrytown, NY.

however, the committee decided that "each of the other chairmanships [would] be filled without consideration of racial factors."[248]

The abandonment of race as a determinative factor in the recruitment process produced a very different concept of race and medical trust between black patients and physicians. A survey of the remaining faculty chairs shows that instead of old notions of race and racial belonging, the Committee assessed the likelihood of a chair's commitment to diversity by highlighting their sustained and demonstrated clinical and research activities amongst poor and underrepresented communities. The vitae of the chairs emphasized a cosmopolitan approach to poverty that was very different from the shared experience of poverty that Drew Society physicians had with their patients. In contrast to Drew Society's understandings of race, the Committee construed research on and service to patients in both domestic and worldly sites of poverty in inner city Baltimore, Native American reservations in the Great Plains, Mexico, and India as alternative valorizations of multiculturalism. The Drew School highlighted service by newly appointed chairs in a series of press releases advertising their forays into these spaces as such.

The pattern of appointments reflect scholarly observations of citizen participation anti-poverty programs as they progressed from the late 1960s and into the early 1970s.[249] At first, self-help and self-determination policies sought to recruit any eligible member of the "poor" into the planning and carrying out of anti-poverty programs. By the 1970s, however, it became more critical for anti-poverty agencies to recruit citizen-activists who demonstrated a shared understanding of poverty as a discrete object of knowable dimensions. As an "encounter" with poverty rather than a shared lived experience, agencies like King-Drew valorized *encounters with* poverty in medical research and service as opposed to *living in* poverty because such intimacies approximated the empathy and kinship thought only possible between the poor themselves.

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[248] "Discussion with Dr. Mitchell W. Spellman, Notes by Mr. Keenan of Commonwealth Fund 4/22/70" Commonwealth Fund Series 18: Grants, Box: 97, Folder 888 Rockefeller Archive Collection. Tarrytown, NY.
[249] Alyosha Goldstein *Poverty in Common: The Politics of Community Action during the American Century.* Durham: Duke University, 2012

Slumlord Care

For some Drew Medical Society physicians, the appointment of white physicians was cause for war. In March and April of 1970, Dr. Hubert L. Hemsley aired Drew Society physicians' frustrations in both the *Los Angeles Sentinel* and the *Los Angeles Times* by accusing the hospital of being "one of the grandest schemes in medicine."[250] They used the appointment of white physicians as proof that the hospital was assuredly becoming "just another charity hospital controlled by medical schools outside Watts" that would undoubtedly "subject patient[s] to extremely long waits, impersonal service and contemptuous treatment." Hemsley warned that the hospital was bound to "become a beautiful White Ivory Tower Structure with speckled spots of Negro Visibility surrounded by a moat of social and medical ills unable to bridge the gap of distrust, envy, self-serving power, fear and misunderstanding that will surely develop," if the hospital did not take actions to demonstrate an "emphasis on community."[251]

What is clear from Hemsley's statements is that he wanted to assert that the new medical center would not be completely white, but be "speckled" with "spots of Negro Visibility." Here, he placed some black physicians within a new "multicultural" world of medicine that separated himself, other Drew Society members, and the poor patients of Watts as being further alienated by a "gap of distrust." What is significant is that he provided an analysis of the medical center that damned the entire institution, its research, and its educational trajectory despite the fact that the school was black led and committed to servicing the black community. His critique thus argued that the hospital may be led by black physicians but its "multicultural" objectives did not mean that its mission fulfilled the needs of the black community.

Not all Drew Medical Society physicians, however, held the same view. After a March 1970 meeting, Dr. M. Alfred Haynes assuaged fears that the hospital would not be a new competitor but be a

[250] Stanley Williford. "Doctors Fear King Hospital May Become Charity-Oriented" Los Angeles Times, March 2, 1970. Page A1

[251] The original sentence reads: "the King Hospital will become a beautiful White Ivory Tower Structure with speckled spots of Negro Visibility surrounded by a moat of social and medical ills unable to bridge this gap of distrust, envy, self-serving power, fear and misunderstanding, which will surely be developed." Charles Baireuther. "A Doctor's Opinion: MLK Hospital Will Fail Without Community Stress" *Los Angeles Sentinel*, April 23, 1970, page D2

partner in raising both community physicians and patients out of poverty.[252] King hospital administrator John O'Connor assured Drew Society physicians that "Private patients will be admitted and their doctors will be allowed to follow them through," meaning that physicians would have access to treat patients in the hospital and bill them accordingly.[253] These statements were also reinforced by King Hospital Director, Dr. Elmer Anderson, who stated that the participation of community physicians was crucial for the hospital to become a true "community hospital" that served both paying and poor patients. He feared, however, that low participation rates of community doctors would result in a system that reified the divide between charity care and private care rather than demolish it.

A joint federal study between the Department of Health, Education, and Welfare and the Commonwealth Foundation conducted in the first six months of operation found that Anderson's fears were becoming true. Titled the "Master Plan Report," the study assessed the school's success in recruiting and implementing its program to "raise the health standards of the community" with the participation of community physicians.[254] It reported that instead of pursuing active participation in the institution, many community physicians "have adopted, very much, a wait-and-see posture, which can be seen in their apparent lack of interest in joining the staff of the MLK hospital and in the long time it has taken to form the Attending Staff Association."[255]

Under Haynes' leadership, the Department of Community Medicine embarked on a mission to reform community physicians through continuing education programs that would raise their standards of practice out of poverty as determined by their specialty, Medicare, Medicaid, and RMPs. A task force gathered to discuss postgraduate medical training revealed that "doctors in the area do not as a rule pursue postgraduate training," "do not familiarize themselves with many of the newly developed medical

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[252] Meeting details and the following quotes in this paragraph can be found in: Stanley Williford. "Doctors Fear King Hospital May Become Charity-Oriented" Los Angeles Times, March 2, 1970. Page A1

[253] Stanley Williford. "Doctors Fear King Hospital May Become Charity-Oriented" Los Angeles Times, March 2, 1970. Page A1

[254] *Master Plan for the Drew Postgraduate Medical School, Los Angeles CA to the Bureau of Health Manpower Education, March 1973 Contract NIH 71-4149 Volume 2: Master Plan Report* Rockefeller Archives. Commonwealth Fund Series 18: Grants, Box: 98, Folder 888

[255] *Master Plan for the Drew Postgraduate Medical School, Los Angeles CA to the Bureau of Health Manpower Education, March 1973 Contract NIH 71-4149 Volume 2: Master Plan Report* Rockefeller Archives. Commonwealth Fund Series 18: Grants, Box: 98, Folder 888

techniques," and "do not have in-depth knowledge of many recently developed medications."[256] As such, they ruled that these factors "have a negative effect on the quality of service doctors offer their patients" since they "cannot pass on knowledge to their clients about the latest medical treatments and medications."[257]

These statements reveal that Drew School leadership had come to see the members of the Drew Medical Society as part of the health crisis in Watts rather than as partners in the alleviation of it. As a Medicare and Medicaid facility, physicians had to obtain board eligibility in their specialties in order to be appointed as faculty or be allowed to follow their patients through the medical center. For community physicians who met this criteria, the Drew School limited their participation in a separate faculty designation called a "clinical faculty appointment (CFA)."[258] Designed as "academic appointments without stipend or tenure," recruitment documents detail that they were made "available to community physicians, who, together with the full time faculty…undertake the obligations of both teachers and students."

As this description attests, community physicians who participated as faculty members were expected to be both open to extraction and to reform. The CFA designation was meant to exploit the dimensions of empathetic and sensitive bedside care that Drew Medical Society members had advertised as their expertise. Student observations of their practices were meant as practicums in applied medicine that modeled for students how to inhabit humane and ethical treatment in their own interactions with patients. Through the controlled space of King-Drew, these encounters with poverty were meant to prepare a new generation of multicultural physicians through a new canon of comprehensive liberal education.

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[256] Appendix, Section III of the Master Plan Vol. III (Postgraduate Health Professional Training), p. 26. Commonwealth Fund Series 18: Grants, Box 981, Folder 891. (Special Collections, Rockefeller Archives)
[257] Appendix, Section III of the Master Plan Vol. III (Postgraduate Health Professional Training), p. 26. Commonwealth Fund Series 18: Grants, Box 981, Folder 891. (Special Collections, Rockefeller Archives)
[258] "Recruitment Guidelines. October 1, 1969" Commonwealth Fund Series 18: Grants, Box: 97, Folder 888. Rockefeller Archive Collection. Tarrytown, NY.

At the same time, CFA designated physicians were also expected to be students themselves. The Department of Community Medicine designed a series of lectures and workshops to update the skills and knowledge bases of community physicians. Early task force reports mentioned the focus of these programs to teach community physicians about automated clinical laboratory equipment, artificial human organs, improved surgical techniques, and how to use computers to "assist in diagnosis."[259] While continuing education programs were being implemented much more widely across the nation, the context of such programs in Watts were read as patronizing to community physicians whose plight in practicing in low income neighborhoods were largely ignored until 1965.

As the joint federal study noted, community physicians mostly stayed away from participation as faculty members and in attending continuing education programs. While the study observers cited that "continuing professional education proved "particularly difficult to carry out among health professionals who are extremely overworked," they also admitted that Drew leadership failed to take "much of the initiative" in getting physicians to update and refresh their skills and knowledge as physicians. The joint federal study noted that the failure to appoint more community physicians to faculty remained a major miscalculation on part of the Drew leadership as "some elements in the community" felt that its faculty should be "from largely the same community."[260]

In the end, the divide between Drew School leadership and Drew Society members threatened to make "slumlord caregivers" out of the community physicians who refused to participate in continuing education courses and link their private practices to the new suite of services and range of technological advances now available in the medical center. Despite the study team's insistence that Drew focus on the continuing education of community physicians rather than open a post-undergraduate medical school for medical students, the inability to compel or inspire them to participate hastened the Drew school's steps

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[259] Appendix, Section III of the Master Plan Vol. III (Postgraduate Health Professional Training), p. 26. Commonwealth Fund Series 18: Grants, Box 981, Folder 891. (Special Collections, Rockefeller Archives)
[260] *Master Plan for the Drew Postgraduate Medical School, Los Angeles CA to the Bureau of Health Manpower Education, March 1973 Contract NIH 71-4149 Volume 2: Master Plan Report* Rockefeller Archives. Commonwealth Fund Series 18: Grants, Box: 98, Folder 888

to secure money to open an undergraduate medical school and expand the number of intern and resident spots to replace or outcompete the older generation of community physicians.

Is Drew School a "Black" School?

As opposed to seeing the mission of the school as muddled or racially confused, as the Drew Society members had come to see it, the definition of the Drew School as not any one race, any one organization, or any one culture produced a new definition of race. Here, the Drew School interpreted the "multi-ness" of academic medical centers, of its own complex relationships to USC and UCLA, and its multiracial faculty as unique assets in producing a new "multicultural" physician. To project what new multicultural physicians would look like, they offered the credentials and pedigree of its seated faculty members. The brochure detailed the rigorous process used to meet the qualifications set by the Drew School, King Hospital, and affiliating medical schools as indicators of what kinds of knowledges students were expected to gain while at King-Drew.

Interestingly, King-Drew's efforts to entice applicants to Drew by heralding the faculty they appointed as cosmopolitan, multicultural, and capable of seamlessly traversing across several types of medical encounters did eventually draw physicians who sought to be trained as such, but not in the way they had expected. The multi-fold brochure sent out in 1971 to prospective postgraduate students that described the King-Drew hospital district as "preponderantly black" and "an economically depressed area, lacking adequate social and health resources," did succeed in attracting black physicians to the Drew School but it also succeeded in attracting a large amount of foregin medical graduates and other non-white physicians.

A report provided by the Department of Surgery in 1977 noted that despite 8 out of its 10 surgical residents nominated for second, third, fourth, and fifth year levels for the academic year 1977-1978 were

black. Additionally, five of the seven incoming interns were also black.[261] These numbers attested to the fact that the mission of the school and its black leadership did manage to attract a majority of black students to its surgical program without having to name the school explicitly as black.

The emphasis on multiculturalism, however, did not mean that students hesitated to leverage blackness as a tool in asserting grievances with the school. Drew surgical interns were given internships with the expectations that fewer spots would be available to continue as residents.[262] The problem in 1976, however, was that only one of the four interns selected to continue as a second year surgical resident was black. While the other three residents were also minorities, the house staff union accused the the Department of Surgery of an unfair selection process, citing that the four unselected interns were all black.[263]

Issues like these continued to plague the Drew School as it struggled to not just attract black physicians but *any* physicians to fill its less popular primary care specialty programs. The school had begun to fill program slots with foreign medical graduates, who by 1980, constituted thirty to forty percent of all residents at King-Drew.[264] While foreign medical graduates could be found in all of Drew's programs, the foreign medical graduates applying for positions in primary care departments were regarded with higher amounts of skepticism than their American-educated counterparts.

Dr. Tureaud, Medical Director of King-Drew, explained his reluctance to appoint foreign medical graduates because those "with extensive experience" only sought acceptance as a resident as a route to fulfilling California's requirement of one year training experience to get a California license. He stated,

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[261] "April 5, 1977 Memo to Liston Witherhill from Leonard Turead Re: Appointment of Second Year Postgraduate Physicians in General Surgery Residency at King Hospital." Kenneth Hahn Collection Box 206, Folder 84 (Special Collections, Huntingon Library)

[262] This practice is common and expected in many surgical residencies. Interns are usually given notice with enough time for them to find a new internship or new life pathway.

[263] According to the memo, four physicians (Chat, Gardener, Azzam, and Razalan) were selected while five physicians were not (Smith, Nwokekeh, Valery, Udoh) "April 5, 1977 Memo to Liston Witherhill from Leonard Turead Re: Appointment of Second Year Postgraduate Physicians in General Surgery Residency at King Hospital." Kenneth Hahn Collection Box 206, Folder 84 (Special Collections, Huntingon Library)

[264] May 21, 1981 Letter from Leonard Tureaud, MD to Maybelline Griffin, Deputy to County Supervisor Hahn. Box 208 Folder 98 Huntington Library

"once they get their California license, they drop out of the program."[265] He explained that the impact caused "problems with providing patient care services and continued accreditation of the residency training programs."[266]

Whereas the Drew School in 1972 sought to attract physicians to serve and stay in these areas by drawing them into service via intern and resident training and education, the Drew School expanded their focus in 1981 by opening a medical degree program that sought to secure student's interest in serving medically underserved areas earlier and for longer periods of time. Dr. Haughton, the medical school director, explained that Drew students were to be groomed in hopes that they would "locate to some medically underserved area to practice, probably in one of the general specialties that fall under the loose category called 'primary care.'" Dr. Daniel Wooten, the Drew School's Associate Dean was careful to explain, however, that "we're not trying to put them into a contractual relationship. That is not what gets people to go places… the trick is trying to select the appropriate kind of people."[267]

Despite the steady production of minorities of color and foreign medical graduates, however, the King-Drew Service area continued to be assessed as a medically underserved area, showing that the production of multicultural physicians did prove productive for some physicians working as Drew School leaders but it did not ultimately translate into a material distribution of resources for communities of color. By 1990, The Department of Health, Education, and Welfare announced that "in spite of the unprecedented increases in the total numbers of health professionals, indications are that shortages in

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[265] These statements were directed towards explaining why Felicita Newmann (Philippines) would not be a good candidate to fill spots in the Community Medicine Department. The archive also reflects petitions to examine the credentials of Gilberto Ong (Philippines) and Ali Fouladi (Iran) Hahn. Box 208 Folder 98 Huntington Library

[266] May 21, 1981 Letter from Leonard Tureaud, MD to Maybelline Griffin, Deputy to County Supervisor Hahn. Box 208 Folder 98 Huntington Library

[267] *Los Angeles Times* writer, Allan Parachini described the first medical class as "a very nice mix:" "there are 13 blacks, five of whom are women; four whites, two of whom are female; two Latinos; one Native American and one student of Asian descent, who also is female." Allan Parachini. "First Class at Drew Medical School: Institution Readies Doctors to Aid the Medically Underserved" August 27, 1981. *The Los Angeles Times*. p. I1

many geographic areas and specialties, and uneven and inappropriate geographic and specialty distribution remain the most serious manpower problems."[268]

Ultimately, my analysis shows that while multiculturalism became desirable and productive for leaders of academic medical centers, its rhetorical use in appointing black physicians from the District of Columbia and white physicians to King-Drew leadership alienated and isolated the black community physicians from participating in the institution. Even after King-Drew began to produce the types of physicians it desired to have join the community physicians in Watts, national data shows that many went elsewhere after residency to develop their careers. The phenomena shows that while being trained in medically underserved areas can be desirable, the stigma of prolonged service in medically underserved areas continues to be a major obstacle to equal distribution of healthcare.

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[268] Executive Summary 1990. RG 235 General Records of the Department of Health, Education and Welfare. Office of the Secretary. Box 14 Special Studies and Reports 1969-1970 (National Archives and Record Administration, College Park)

Figure 4.1 – Carey Jenkins Sketch Renderings and Photo of King-Drew

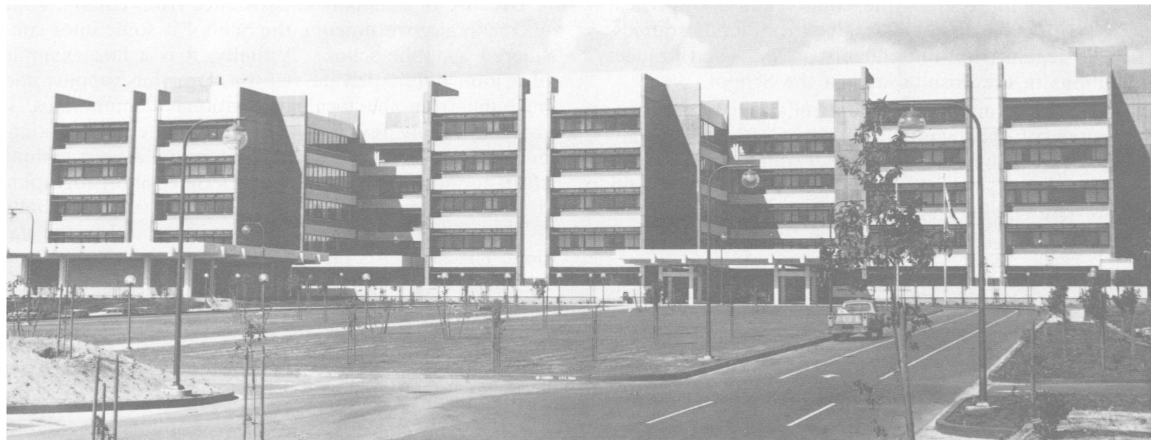
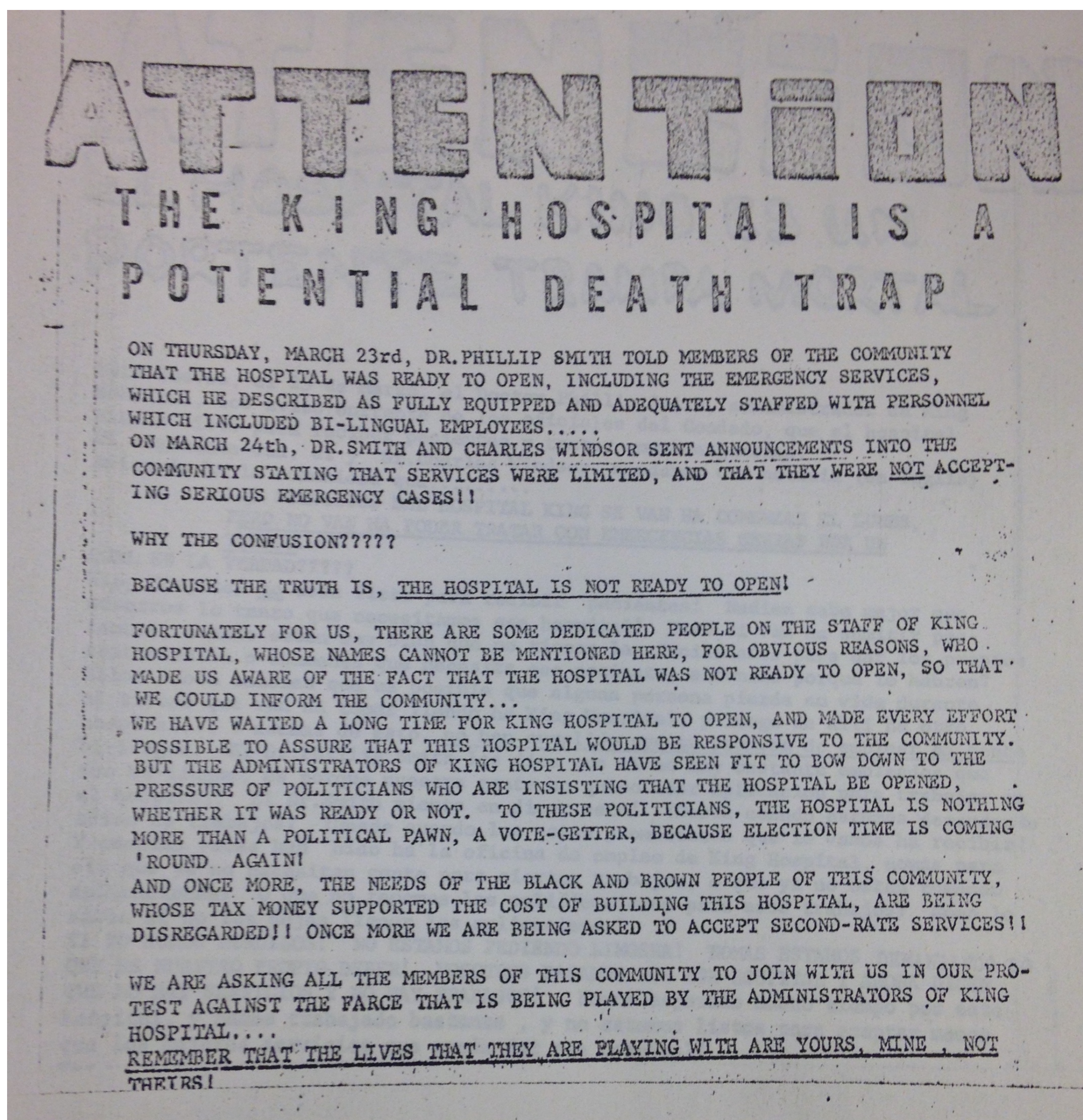


Figure 4.1. Top: Architectural Rendering of King, Jr. Hospital by Carey Jenkins, 1968. Below: Hospital photo on eve of its official opening in 1972.

Source: Architectural Floorplans. Kenneth Hahn Collection. Box 204, Folder 50 Health Services (Special Collections, Huntington Library)

Figure 4.2 – “Killer King”



ATTENTION

THE KING HOSPITAL IS A POTENTIAL DEATH TRAP

ON THURSDAY, MARCH 23rd, DR. PHILLIP SMITH TOLD MEMBERS OF THE COMMUNITY THAT THE HOSPITAL WAS READY TO OPEN, INCLUDING THE EMERGENCY SERVICES, WHICH HE DESCRIBED AS FULLY EQUIPPED AND ADEQUATELY STAFFED WITH PERSONNEL WHICH INCLUDED BI-LINGUAL EMPLOYEES.....

ON MARCH 24th, DR. SMITH AND CHARLES WINDSOR SENT ANNOUNCEMENTS INTO THE COMMUNITY STATING THAT SERVICES WERE LIMITED, AND THAT THEY WERE NOT ACCEPTING SERIOUS EMERGENCY CASES!!

WHY THE CONFUSION?????

BECAUSE THE TRUTH IS, THE HOSPITAL IS NOT READY TO OPEN!

FORTUNATELY FOR US, THERE ARE SOME DEDICATED PEOPLE ON THE STAFF OF KING HOSPITAL, WHOSE NAMES CANNOT BE MENTIONED HERE, FOR OBVIOUS REASONS, WHO MADE US AWARE OF THE FACT THAT THE HOSPITAL WAS NOT READY TO OPEN, SO THAT WE COULD INFORM THE COMMUNITY...

WE HAVE WAITED A LONG TIME FOR KING HOSPITAL TO OPEN, AND MADE EVERY EFFORT POSSIBLE TO ASSURE THAT THIS HOSPITAL WOULD BE RESPONSIVE TO THE COMMUNITY. BUT THE ADMINISTRATORS OF KING HOSPITAL HAVE SEEN FIT TO BOW DOWN TO THE PRESSURE OF POLITICIANS WHO ARE INSISTING THAT THE HOSPITAL BE OPENED, WHETHER IT WAS READY OR NOT. TO THESE POLITICIANS, THE HOSPITAL IS NOTHING MORE THAN A POLITICAL PAWN, A VOTE-GETTER, BECAUSE ELECTION TIME IS COMING 'ROUND AGAIN!

AND ONCE MORE, THE NEEDS OF THE BLACK AND BROWN PEOPLE OF THIS COMMUNITY, WHOSE TAX MONEY SUPPORTED THE COST OF BUILDING THIS HOSPITAL, ARE BEING DISREGARDED!! ONCE MORE WE ARE BEING ASKED TO ACCEPT SECOND-RATE SERVICES!!

WE ARE ASKING ALL THE MEMBERS OF THIS COMMUNITY TO JOIN WITH US IN OUR PROTEST AGAINST THE FARCE THAT IS BEING PLAYED BY THE ADMINISTRATORS OF KING HOSPITAL....

REMEMBER THAT THE LIVES THAT THEY ARE PLAYING WITH ARE YOURS, MINE , NOT THEIRS!

Figure 4.2 Distributed anonymously around the hospital’s opening in 1972, this leaflet contributed to locals referring to the hospital as “Killer King.” The distributors of the leaflet also took time to translate it into Spanish for the neighborhood’s now large Latino/a population.

Source: “Attention: King Hospital is a Potential Death Trap” Kenneth Hahn Collection. Box 206, Folder 69 (Special Collections, Huntington Library)

Figure 4.3 Drew Medical School Recruitment Material

Q WHAT IS THE CHARLES R. DREW POSTGRADUATE MEDICAL SCHOOL?

A. The Drew Postgraduate Medical School is the developing medical school which will provide professional training for graduate physicians and others, and provide patient care services at the Los Angeles County-Martin Luther King, Jr. General Hospital.

Q WHERE IS THE DREW SCHOOL LOCATED?

A. The Drew School and King Hospital are located in Willowbrook, in South Central Los Angeles, bounded by 120th Street, Wilmington and Compton Avenues — 2 miles east of the Harbor Freeway, 9 miles south of downtown Los Angeles.

Q WHO WILL BE SERVED BY THE KING-DREW MEDICAL CENTER?

A. The nearly 400,000 persons to be served live in the 40-square mile area surrounding the medical center. They are preponderantly black and reside in an economically depressed area, lacking adequate social and health resources.

The King Hospital, a Los Angeles County Department of Hospitals' facility, will serve all persons — both those able to pay for their care and those who cannot. Physicians are encouraged to hospitalize their private patients as well as those eligible for public-supported medical care. Among the benefits will be a single standard of health and medical services for all persons who live here.

Q IS DREW SCHOOL A "BLACK" SCHOOL?

A. The Drew School is a multiracial, multiethnic institution, in the belief that single, racial, religious, or cultural organizations cannot sustain support or the strategy for lasting solutions to national health needs and issues.

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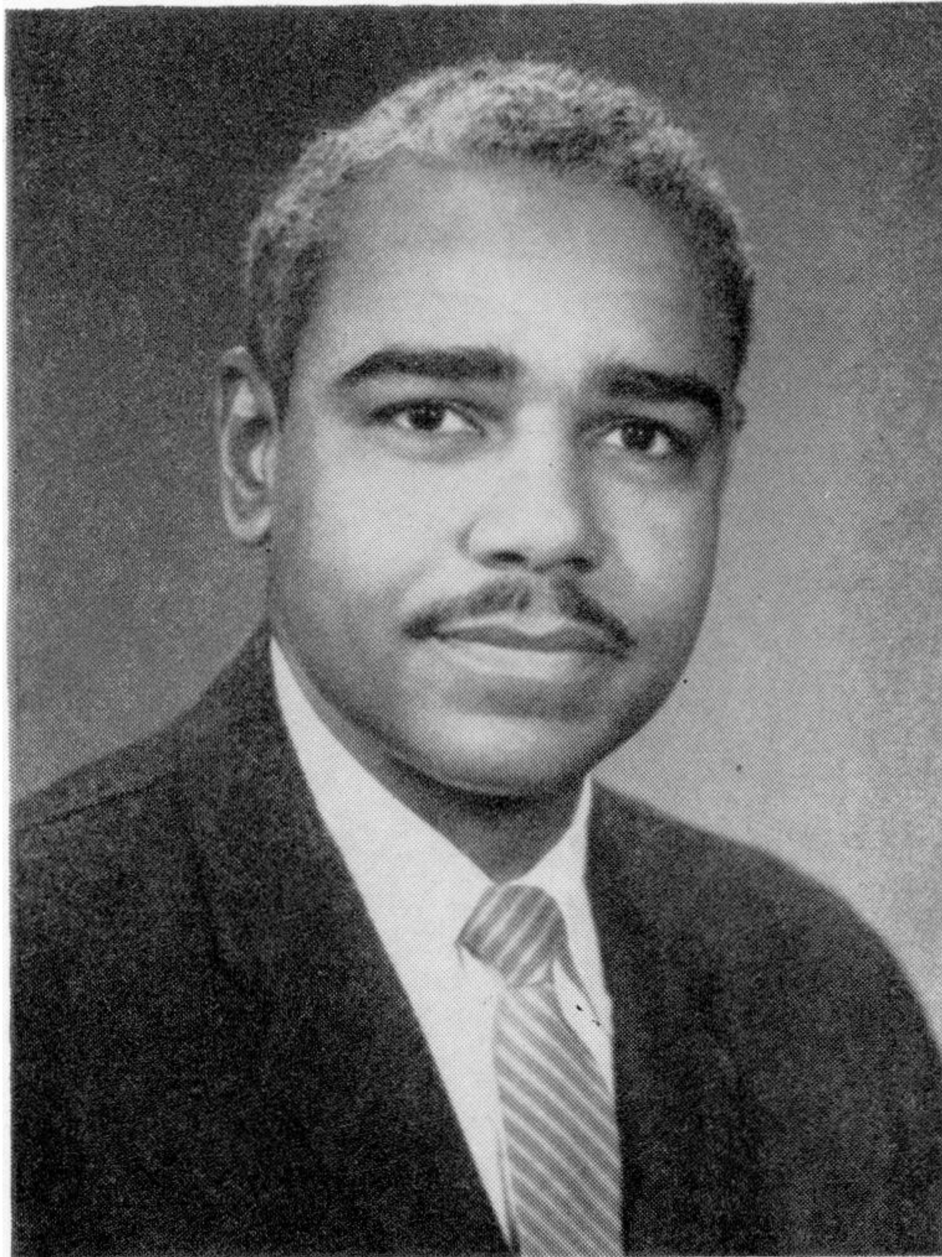
Source: Drew Postgraduate Medical School Brochure Bradley Administration Papers Box 857, Folder 2 (Special Collections, UCLA)

Figure 4.4 – Dean Mitchell Spellman, MD

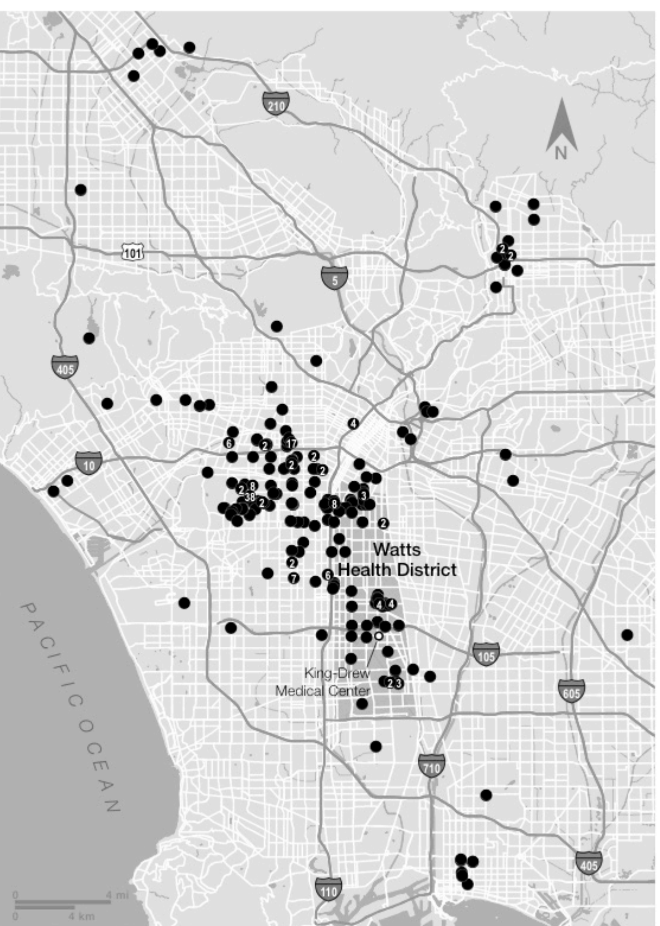


DR. MITCHELL W. SPELLMAN

Figure 4.4 - Dr. Mitchell Wright Spellman served as the inaugural Dean of the Drew Postgraduate Medical School from 1968 to 1975.

Source: "Spellman Heads New Medical School" in the *Journal of the National Medical Association*. Vol. 61, No. 1, January 1969. p. 90-91

Figure 4.5 Drew Medical Society 1971 Membership Map (Maps made for author by Breanna Spears.)



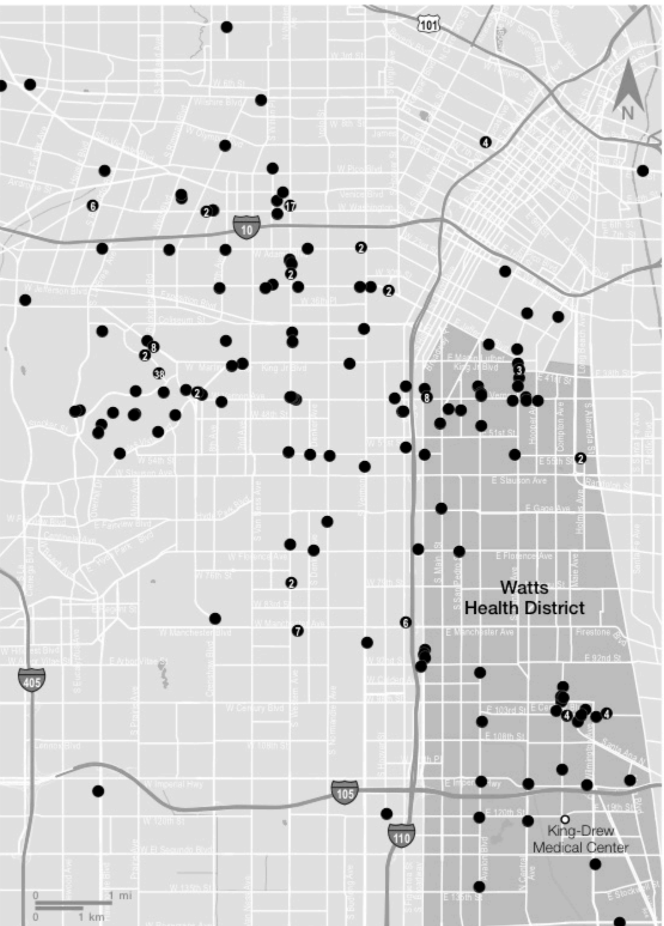


Figure 4.5 (Continued)

The Drew Medical Society provided a roster of all members in 1971 that reflected each member's self-identified specialty/specialties and whether or not they were board certified or board eligible as of 1968. With a total of 316 members, a majority of members resided in Los Angeles but members provided addresses in Orange County, Ventura, Riverside, and San Bernardino. Each black point represents a single stand alone practice, a black dot with a number within it represents a group practice; the number representing how many in that location. The left map provides an expanded view of the county while the right provides a more detailed map of the original Watts Health District. Approximately 68 (21%) physicians out of 316 practice within the original King Health District Boundaries.

Self-Identified Specialty	*Total*	*Certified*	*Eligible*	*Self-Identified Specialty*	*Total*	*Certified*	*Eligible*
ADM - Administration	2	--	--	NS - Neurosurgery	1	--	--
AM – (Unknown)	1	1	--	OBG – Obstetrics & Gynecology	35	8	8
ANES – Anesthesiology	8	2	1	OO - Retired	5	--	1
CEG – (Unknown)	2	--	--	OPH – Ophthalmology	3	2	--
D - Dermatology	3	1	1	OPH-OTO – Opth/Otolaryngology	3	--	1
GP – General Practitioner	100	1	1	ORS – Orthopedic Surgery	5	1	--
GP-GS - Gen. Practice/Gen. Surgery	2	--	--	P - Psychiatry	15	6	3
GP-OBG - Gen. Ob. & Gynecology	1	--	--	P-CHP – Child Psychiatry	3	1	1
GP-PD - Gen. Pediatrics	1	--	--	PATH - Pathology	2	--	--
GP-PUD – Gen. Pulmonary Disease	1	--	--	PD - Pediatrics	21	6	2
GS – General Surgery	31	13	3	PD-PDA – Pediatric Allergy	3	3	--
GS-TS- General Thoracic Surgery	1	1	--	PD-PDC – Pediatric Cardiology	2	2	--
GS-VS – General Surgery (Unknown)	2	2	--	PH – Public Health	4	--	--
IM – Internal Medicine	34	4	4	Podiatrist - Podiatry	1	--	--
IM-CD - Int. Med. Cardio. Disease	7	2	1	R - Radiology	7	1	--
IM-GE – Int. Med Gastroenterology	1	1	--	TS – Thoracic Surgery	1	1	--
N - Neurology	1	1	--	U - Urology	7	2	2

Total: 316 Total Board Certified: 62 Total Board Eligible: 29

Source: Drew Medical Society Roster 1971. Kenneth Hahn Collection, Box 205, Folder 64 Health Services (Special Collections, Huntington Library)

Chapter Five
The Authority to Care: Citizen Participation and the making of Working Motherhood and Absentee Fatherhood

On January 20th, 1975, Deputy Commissioner Dan Grindell wrote an update to Los Angeles County Supervisor Kenneth Hahn on efforts initiated by the County of Los Angeles to lift the health standards of poor residents in the city since the 1965 Watts riots. Grindell's memo focused on the Florence-Firestone Multipurpose Neighborhood Center two miles from the center of Watts. The center had just been converted into a Comprehensive Health Clinic (CHC), an innovative service model that melded antipoverty and welfare programs with County health services that were based on Neighborhood Health Centers originally funded by the Office of Equal Opportunity.[269] The County had transformed Florence-Firestone as a part of a county-wide initiative to base public access to county-funded health services in them. Florence-Firestone was a smaller version of the County's Hubert Humphrey CHC, a clinic built entirely from the ground up based on federal recommendations that was slated to open in 1976. This entire network of neighborhood centers eventually developed the funding criteria for federally-assisted community health centers that were widely expanded in the 1980s. (See Figure 5.1)

Grindell's eyewitness account reveals that in the decade since the riots, a profound racial and economic change had shifted the neighborhood from a predominantly black neighborhood to a majority immigrant and Latino neighborhood. He wrote, the "vast majority of patients [are] now Spanish-speaking" and "most patients (mainly women and children) cannot speak English."[270] Instead of seeing a model originally crafted to remedy a crisis around a black-white conflict as now suddenly useless, Grindell saw an opportunity to exploit the center's purposes to help acculturate another marginalized population. Fearful that this new immigrant population was being "deceived, cheated, and taken

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[269] Neighborhood Health Centers was the programmatic title given to clinics built and overseen by the Office of Equal Opportunity and Citizen Participation Programs from 1965 to 1972. Comprehensive Health Centers and Ambulatory Care Centers, although similar to the shape and character of OEO clinics, were administered and overseen directly by the Secretary of Health. For more on the history of Neighborhood Health Centers, see: H. Jack Geiger. "The First Community Health Center in Mississippi: Communities Empowering Themselves" in *The American Journal of Public Health*, October 2016, Vol. 106, No. 10, pages 11,738-11,740.

[270] January 20, 1975 Memo between Dan Grindell, Deputy and Philip M. Smith, MD, Acting Regional Director Florence-Firestone Educational Project. Kenneth Hahn Collection. Box 206, Folder 1.24.2.6.5.81 (Special Collections, Huntington Library)

advantaged of by landlords, merchants, etc. because they are unaware of legal rights [and are] not taking advantage of public education for their children and themselves," Grindell pointed to the center's flexible education program as the instrument that could govern disparate communities according to their local racial contexts.

He reasoned that the center's "education program" could be the device to turn a potential neighborhood full of people he called a "burden on society and to to the school system" into a population that would "seek further education, to help their children function in the schools, and to be responsible residents in their community." Not only would the center's education programs fight against the clientele's stated and observed biomedical afflictions of "rabies, lice, TB, ear-nose-throat infections, worms and parasites, and obesity" but through the two-three times daily offerings of 45-minute in-lobby courses on "family care", "family planning", "women's care" and "pediatric care," Grindell argued that this potentially burdensome community could be turned into a healthy community of participatory citizens.

Grindell's memo is astonishing for two reasons. First, his memo pinned the same fears around potential social disorder originally associated with single black mothers and wayward black youth on brown mothers he assumed to be monogamous and respectably married. Second and relatedly, the memo demonstrated the extent by which civic leaders were willing to invest in an alternative publicly-funded entry point to healthcare for a population it described elsewhere as "illegal" that was not the emergency room. As such, Grindell's eyewitness account served to cast both black and brown mothers as "unfit" for motherhood by underwriting the belief that black and brown fathers were virtually "absent" from the lives of their partners, kin, and community. In contrast to unpopular contemporary associations with undocumented immigrants and welfare recipients as burdens to public healthcare through emergency room (ER) utilization, CHCs continue to be popularly heralded by both liberal and conservative lawmakers as the solution to healthcare problems in urban communities.[271]

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[271] According to Lawrence D. Brown, "CHCs appeal as much to conservatives who fancy them an 'alternative to government' as to liberals who work to ease access to care for the disadvantaged. Although allegedly inclined to

I argue that Los Angeles County's shoring up of welfare services to mothers and children as a medical class protected through CHCs, regardless of race and citizenship status, also opens up an opportunity to assess the impact of culture of poverty theory on the racialization of black and brown men. Normally, culture of poverty theory is narrated as a problem of motherhood that disproportionately impacted the way society viewed women of color and their capacity to mother properly in ways that rendered narratives over personal responsibility popular by the 1980s. Peering over the balustrades into the history of CHCs, however, reveals a profound consolidation and concentration of welfare services into them that is considerably at odds with the disappearance of such services when peering outwards from the parapets of CHCs. CHCs thus preserve the welfare state whilst being attacked and diminished elsewhere throughout a period of late-deindustrialization that many scholars accept as the welfare state's decline, suggesting that CHCs also aided in strengthening narratives around personal responsibility with motherhood that appealed to more conservative regimes in the 1980s.

My analysis thus re-reads this history for the ways in which black and brown mothers and children served as the discursive material to build up CHC services and narratives around personal responsibility that fortified welfare services in their name whilst underwriting a general belief that men of color are "absent" as fathers and as participatory members of society. This process created the first policies of working motherhood, where the identity of mothers, not fathers, served as the primary target of wage earning and consumption in the family. This process marked a reversal in earlier iterations of federal policy that strove to achieve full health coverage of society through the universal creation of male breadwinners who were expected to direct care over their kin through their employers or employment. In fact, I show that plans to build Los Angeles' CHC networks were first conceived by Drs. Mitchell Spellman and M. Alfred Haynes to help fathers, not mothers, as the primary beneficiaries of the area's

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'starve the [governmental] beast,' the George W. Bush administration, impeccably conservative and Republican, has expanded funding for CHCs and - much more expensively and dramatically - presided over the enactment of long-deferred legislation introducing a prescription drug benefit in Medicare." (41) "The More Things Stay the Same the More They Change: The Odd Interplay between Government and Ideology in the Recent Political History of the US Healthcare System" in *History and Health Policy in the United States: Putting the Past Back In.* Rosemary Stevens, Charles Rosenberg, Lawton Burns (eds.) (New Brunswick: Rutgers, 2006), p. 32-48.

recently built health system, the King-Drew Medical Center. As Dean/Director and Chair of Community Medicine of King-Drew, Spellman and Haynes designed CHCs as a tool to anchor black male leadership over black families to win greater participation of the black community in society.

This original plan was supported by black civil rights leaders and politicians because it championed the idea that black health ought to be tied to individual participation and consumption in the free market economy. For them, black male employment was the answer to combatting the effects of white supremacy and poor health in the black community because it gave black men purpose and responsibility thought denied to them by a prior history of discriminatory federal job and welfare programs that were perceived to encourage black women to live autonomously from them. By pinning access to health service consumption to fee payment, Spellman and Haynes hoped to entice black women on welfare to enter into traditional forms of marriage and family by appealing to their desire to live healthy lifestyles. In short, Spellman and Haynes' original design conflated healthy lifestyles with heterosexual patriarchal marriage by associating living without a husband or without a family as a life doomed to poor health and poverty. Their sexual politics thus kept them in step with the moral and economic aims of the civil rights movement, mainstream white liberal society, and mainstream medicine of the 1950s and 1960s.

They were, however, increasingly more at odds with, on one hand, a growing welfare rights movement, and on another hand, a strong mostly white feminist liberation movement by the early 1970s. Ultimately, the way forward around urban healthcare was not so much decided by black physicians like Spellman and Haynes but by a technocratic federal government increasingly concerned about the plight of women and children in the settling of a new so-called service economy that sociologists termed the "feminization of poverty" and the emergence of "working poverty." Both were interchangeable terms used to describe the unprecedented shift in the employment base towards jobs associated with "feminine" labor that favored women as workers and made the status of racialized men in the labor pool redundant, temporary, or precarious. These movements shifted the assumption that participation of racialized men in society was necessary to secure postwar order and prosperity by entertaining the idea that other members of society could be the key to greater social participation in society.

Participation as Index for Postwar Progress

"Citizen Participation" arose as an important policy objective in the years after WWII as a way to manage contending demands on liberal democratic states by marginalized populations at home and abroad. The policy did not valorize all forms of participation in civic life but only those that strengthened investment in democratic and capitalist forms.[272] They therefore indexed a belief that non-participation, disengagement, and/or isolation from democratic spaces represented the possible influence of a contending state or ideology. As such, it was important that citizen participation encourage criticism over disengagement in the public sphere as well as foster ownership and responsibility over disavowal or passiveness in democratic processes. In this way, "participation" served as coded preservation policy for democratic and capitalist order despite the fact that the policy is popularly associated with the tumult, social conflict, and liberal support of leftist radicalism in the 1960s and 1970s.

President Johnson passed the most famous example of citizen participation policies in 1965. Otherwise known as "maximum feasible participation," President Johnson manifested this policy in his War on Poverty programs, particularly its Citizen Action Programs (CAP) administered through the Office of Equal Opportunity (OEO). President Johnson's War on Poverty funding played upon and continued a gendered division of labor enshrined in United States law since the New Deal. The New Deal worked to return the nation to economic health by fostering job opportunity programs centered on creating male breadwinners while crafting welfare programs to support the ability of widowed mothers to sustain a domestic home.[273] President Johnson's War on Poverty and Affirmative Action statutes were

[272] For more on citizen participation policy, see: Alyosha Goldstein *Poverty in Common: The Politics of Community Action during the American Century.* Durham: Duke University, 2012

[273] Margot Canaday argues that New Deal programs focused on manpower development and immigration indicate how American policy from the 1920s to the 1950s valorized white male heterosexual patriarchy while casting unemployment, homosexuality, and race as categories outside the bounds of citizenship. Similarly, Nancy Naples argues that citizen participation programs crafted for women carefully relegated their activities to the domestic sphere. See: Margot Canaday. *The Straight State: Sexuality and Citizenship in Twentieth Century America* (Princeton: Princeton University Press, 2009) and Nancy Naples. *Grassroots Warriors: Activist Mothering, Community Work, and the War on Poverty*. (New York: Routeledge, 1998)

seen as a delayed racial rejoinder to New Deal programs which had passed over black male laborers while giving black women new rights to welfare benefits.[274]

By the early 1970s, however, new social movements with divergent interests springing from the ethos of the policy attacked the heterosexuality and patriarchal assumptions underlying the policy and a patrilineal state. While some interests were directly born from citizen participation funding, others asserted new demands on the state based on the zeitgeist of self-determination/self-help politics embedded in the policy. Some of the strongest of these were feminist and welfare rights organizations which argued that new opportunities for women in education and employment meant that women did not need the care and authority of men to live full and active lives. In turn, they organized campaigns to craft new laws and state policies to redefine the role of women in society.[275]

Thus, the plans to build King-Drew Medical Center starting in 1965 and ending with its opening in 1972 are bookended by two different political perceptions around the economy of the household. Whereas plans began with the expectation that King-Drew's design augur the overall participation of the black community in society through black male participation in the economy, King-Drew's opening occurred at a moment when new feminist perspectives were being developed that believed that citizen participation might be best achieved through women's greater participation in the economy as wage laborers and consumers. These viewpoints collided over the direction of the hospital in a joint federal study conducted by the Bureau of Health Manpower and Education of the Department of Health, Education, and Welfare (DHEW) and the Commonwealth Foundation that ran from May 15, 1971 to August 15, 1972.

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[274] Ira Katznelson argues that President Johnson's programs attempted to rectify the shortcomings of New Deal programs which had passed over agricultural and domestic workers, two industries dominated by black laborers. See: Ira Katznelson. *When Affirmative Action was White: An Untold History of Racial Inequality in Twentieth-Century America*. (New York: Norton, 2005)

[275] Kristin Bumiller argues that feminist activists targeted the state as an object of reform that could redefine the citizenship of women as a category protectable by law and worthy of aid. She writes that anti-rape laws were exemplary of this agenda: "By focusing on law reform, mainstream [feminist] organizers promoted objectives consistent with the broad agenda of the women's movement. They called on the state to fulfill its obligations to protect all its citizens equally and identified the lack of enforcement of sexual crimes against women as a major obstacle to women's freedom within the public sphere." (2) Kristin Bumiller. *In an Abusive State*. (Durham: Duke, 2008)

Named the Master Plan Study (hereafter, referred to as "the study"), Spellman and Haynes opened up scrutiny of King-Drew to the DHEW and Commonwealth Foundation as a pathway to winning more grant money for the financially anemic Drew Medical School, the academic arm of King-Drew. In doing so, King-Drew leaders gave the DHEW the ability to evaluate their plans based on the agency's most pressing policy needs. In the thick of competing social movement demands by feminists, welfare rights activists, and black nationalists, the DHEW chose to evaluate King-Drew's plan on the following question: "Can an academic institution in an economically and socially disadvantaged area, with members of the community, collaborate together to raise the level of health in the community?"[276] In other words, the federal government desired to study how successful an institution crafted by civil rights leaders might manage the interests of new social movement actors in the community.

The federal government and Commonwealth Foundation empowered three research consulting firms - Lester Gorsline Associates, the Arthur D. Little Inc. and the Urban Workshop (hereafter, collectively referred to as the "study team" or the "consultants") - with conducting the study. The study was divided in two phases, with the first being an evaluation of King-Drew's ability to successfully incorporate all community interests into the planning process. The second phase judged King-Drew's ability to adjust to the study team's Phase I findings. This made the study team's Phase I conclusions essentially binding by requiring King-Drew to carry out its recommendations in Phase II.

The consultants reviewed a universe of individuals presently engaged by the hospital's planning process, including board members, politicians, health bureaucrats, medical educators, union leaders, doctors, and workers. These individuals were integrated into a massive and intricate web of planning and policy boards that culminated its power in the highest policy making body - a large executive board. This board was made up of members representing the County of Los Angeles, the Drew Medical Society, the community at-large, and the medical schools of UCLA, USC, and of Drew Medical School. While a cursory view of the board's composition gives the impression of an extremely open and plural democracy,

[276] The Master Plan Study, Summary Report, Section 2 of the Master Plan Vol. I. (The Study Plan) Commonwealth Fund Series 18: Grants, Box 981, Folder 891. (Special Collections, Rockefeller Archives), p. 3

a closer inspection reveals that membership was only limited to members of the community perceived to be a part of the community's "productive" and "laboring" classes.

This composition was curious because it appeared to have limited reach into a majority of the community. The planning bodies did not account for the staggering numbers of those in the community living under the poverty line (27%) and those under public assistance (29%).[277] Women, as opposed to men, made up a larger percentage of the health district (52.8%) and children between the ages of 5 and 19 made up more than a third of the community (35.5%) suggesting that women and children on welfare, although consisting of a large fraction of the neighborhood, had little involvement in the planning process. With an unemployment rate of 13% and an average income slightly above half of the median income of the County ($5,950 as opposed to $10,970), the study team also saw that the new demographic growth of Mexican Americans (16% in 1969) went unaccounted for in the board's make-up. In short, the medical center appeared to favor the engagement of the smaller and least neediest segment of the community over the larger and most neediest portion of the neighborhood.

Instead of being unreachable and unorganized, the study team found the unemployed and those on welfare considerably easy to reach and capable of being organized. They discovered this in a series of "neighborhood panels" it conducted in several different locations of the health district.[278] The panels stretched the universe of participation beyond the hospital's and tested general community members on how well they understood King-Drew's Master Plan. The consultants admittedly abandoned these panels "probably prematurely" after four meetings "largely out of disappointment over their apparent lack of success." They described these meetings as characterized by "an atmosphere of adversary confrontation" because community members had apparently mistook them for representing the leadership of King-Drew.

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[277] These statistics appear twice in the Master Plan Report. The Master Plan Study, Master Plan Report, Section I of the Master Plan Vol. II. (Historical Context) p. I-6 and in Appendix, Section III of the Master Plan Vol. III (Supporting Information for the Master Plan Study), p. 1-29. Commonwealth Fund Series 18: Grants, Box 981, Folder 891. (Special Collections, Rockefeller Archives)

[278] The Master Plan Study, Summary Report, Section 4 of the Master Plan Vol. I. (The Planning Process) Commonwealth Fund Series 18: Grants, Box 981, Folder 891. (Special Collections, Rockefeller Archives), p. 27

Despite being shakened, the consultants later admitted that, "in retrospect, it became clear that much had in fact been learned even in atmospheres that sometimes generated more heat than light."[279] Once they read past the anger of panel participants, the study team had come to see a sophisticated critique of the Master Plan that was likely developed from the feminist ideologies of the welfare rights movement. Although the National Welfare Rights Organization (NWRO) had dissipated nationally by 1972, Los Angeles activists and their chapters continued to play an important role in their own neighborhoods. Los Angeles' welfare rights organizations had sprung from citizen action programs and model cities program focused on housing rights in the city's public housing units.[280] These programs encouraged tenants to organize for better living conditions and services as a way to foster a stronger sense of dignity, consumership, and desire for ownership associated with middle class family life. By the early 1970s, these organizations had also developed new ideas about social productivity and value amongst women on welfare that were unanticipated.

According to Premilla Nadasen, black women on welfare articulated a brand of feminism that viewed welfare as the state's support for the productive labor of mothering.[281] They argued that, unlike the state's historic support to defend the place of white mothers in the home, black women had been denied this right by the unfair expectation that they mother while working as laborers/wage earners. The strategy to redefine black motherhood included tactics to win new, better, and more efficient welfare benefits from various welfare agencies. As these campaigns bore out, welfare mothers relied on highlighting the time, energy, and thrift needed to successfully rear children under welfare as a strategy to indicate the need for new welfare services or reform. In doing so, these narratives, in and of themselves, highlighted a model of social productivity - the mother capable of raising good children despite all odds - that was seen as a desirable form of motherhood. In other words, welfare rights activists articulated a

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[279] The study performed four community meetings. The first in Jordan Downs, a public housing complex in Watts; the predominantly poor Mexican-American neighborhood of Florence-Firestone; a meeting with representatives of the Council of Community Clubs and Community Services of Los Angeles; and a meeting held at the Urban Workshop's Watts headquarters.

[280] Kazuyo Tsuchiya. *Reinventing Citizenship: Black Los Angeles, Korean Kawasaki and Community Participation.* (Minneapolis: University of Minnesota, 2014)

[281] Premilla Nadasen, *Welfare Warriors: The Welfare Rights Movement in the United States* (New York: Routledge, 2005).

civic identity that was contrary to the narratives of idleness, excess, and sexual promiscuity that others had assigned to women on welfare by focusing on how the experience had the potential to transform them.

The short foray into the community through the neighborhood panels created a lasting impression on the study team. The meetings led them to re-think the merits of an economic development plan that solely rested community prosperity on the participation of men. In contrast to the view held by hospital leaders that Watts was a ghetto because of its rate of unemployment and dependency on welfare programs, the study team ruled that Los Angeles' residents "show a considerable level of sophistication in coping with the representatives of public agencies and private institutions" stemming from "a history of involvement in community action organizations including neighborhood councils, welfare rights organizations, civic clubs, churches, and fraternal and labor organizations."[282] These statements emphasized that while the hospital's plans to employ black men were heroic and admirable, they were completely ignoring a large constituency of active participatory citizens based on the fact that they were women and on welfare.

Developing Racial Manhood

King-Drew's Master Plan and the vision of health placed forward by black women on welfare drew battle lines between them that quite literally placed the biological reproduction of black citizens at the center of questions about racial progress. While both plans appeared as oppositional politics to the study team, Michele Mitchell argues that the desire to "reinforce black manhood, encourage women to be attentive mothers, and change [the perceived] sexual conduct" of black people has a unified history in African American communities that stretches back to Emancipation.[283] She writes that a "characteristic common to the overwhelming majority of the black aspiring class during the late nineteenth and early

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[282] The Master Plan Study, Master Plan Report, Section I of the Master Plan Vol. II. (Historical Context) Commonwealth Fund Series 18: Grants, Box 981, Folder 891. (Special Collections, Rockefeller Archives), p. I-7

[283] Michele Mitchell. *Righteous Propagation: African Americans and the Politics of Racial Destiny after Reconstruction*. (Durham: University of North Carolina Press, 2004), p. 12

twentieth centuries was an abiding concern with propriety - not to mention a belief that morality, thrift, and hard work were essential to black progress."[284] In other words, both King-Drew leaders and welfare rights activists both shared in redefining blackness as respectable albeit in two very different ways.

The study reveals that welfare rights activists were successful in convincing the study team to overlook their status as spouse-less mothers for their identity as hardworking mothers committed to rearing their children in safe and healthy neighborhoods. The study team's report, however, gestured to the fact that many within and outside the black community continued to regard them as an obstacle to black progress. In fact, despite the apparent lack of communication between medical center leadership and community, the study team remarked that many in the community knew full well that Drew's main purpose appeared to be "a provider of jobs and other economic services" for black males "rather than primarily of educational and health care services" for the majority of residents in the neighborhood.[285] So cut off were community members from the medical center that the study team ruled that the Drew Medical School which had crafted the mission of the hospital seemed to be "invisible."[286]

The primary brainchild of the original master plan was Dr. M. Alfred Haynes, King-Drew's Chair of Community Medicine, appointed in 1970 to develop the hospitals' overall strategy for raising the standard of healthcare in Watts. (See Figure 5.2) Haynes was a part of popular medical movement to authenticate Community Medicine as its own distinct medical specialty. Community Medicine proponents saw their main field of expertise as health planning, particularly in how to develop new medical markets that developed medical standards to match more established markets in rational increments while being sensitive to the local environment. For Haynes, it was also important that development of western medicine in these marginal communities encourage the development of consumer

[284] Michele Mitchell. *Righteous Propagation: African Americans and the Politics of Racial Destiny after Reconstruction*. (Durham: University of North Carolina Press, 2004), p. 10
[285] The Master Plan Study, Master Plan Report, Section VI of the Master Plan Vol. II. (The Planning Process) Commonwealth Fund Series 18: Grants, Box 981, Folder 891. (Special Collections, Rockefeller Archives), p. 6-3.
[286] The Master Plan Study, Master Plan Report, Section I of the Master Plan Vol. II. (Historical Context) Commonwealth Fund Series 18: Grants, Box 981, Folder 891. (Special Collections, Rockefeller Archives), p. I-9

tastes for western medicine born from community resourcefulness and participation rather than from dependency on "charity care."[287]

Haynes relied heavily on the use of statistics to identify the most pressing health problems in these communities and engaged community members to organize themselves to address those problems using the community's present resources. Haynes believed the social productivity in engaging impoverished community members in such a manner was important to developing a sense of community power while instilling ownership and value in western medical services that fed a desire for more. Ultimately, he believed that this process repeated over time would build a "comprehensive" health system that was locally determined by the community, its resourcefulness, and the timeliness of its actions. Haynes had honed this developmental theory as a doctor working as an Indian Health Service physician in Cheyenne, a rural physician in Vermont, an international medical researcher in India's Trivandrum Medical College, and in inner-city Baltimore as a professor before coming to Watts.[288]

Haynes defended this development scheme as saving patients from the shame and stigma of charity care while preserving local ways of life and identity. It also managed the expectations of what community members might expect of local services based on what community individuals could afford. Haynes theorized that this scheme could rationally determine what services the community was ready for, if such services were truly needed, and if they were economically sustainable. Instead of building a health

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[287] In his capacity as the Director of the National Medical Association Foundation, Haynes wrote to "invite all physicians to join [the National Medical Association] in removing barriers between government medicine and private medicine; in once and for all abolishing charity medicine; in bringing the poor into the mainstream of American medicine; and in helping every American, black or white, rich or poor, to enjoy the benefits of adequate health care." (1069) M. Alfred Haynes. "Problems Facing the Negro in Medicine Today," in the Journal of the American Medical Association, August 18, 1969, Vol. 209, No. 7, p. 1067-1069.

[288] From 1955-1959, Dr. M. Alfred Haynes developed a "health committee," comprised of local residents who worked alongside Indian Health Service staff to "solve" the local crisis of tuberculosis and high infant mortality. He then further developed the health committee concept was he taught Peace Corps medical interns to manage "rural 'primary health units,'" as a part of an assignment as a Visiting Professor at Trivandrum College in Kerala, India. When Haynes returned to Baltimore in 1966, he developed a "program for teachers of community medicine" that included "both American and foreign students" with the "objective" of encouraging students "to apply the principles of learning theory and curriculum planning to create a program of community medicine for their own countries." See: The Haynes Project. Website. "Life with Native Americans (1955-1959)" http://www.malfredhaynes.info/index.php?p=1_12_Life-with-Native-Americans; The Haynes Project. Website "The Hopkins Years (1964-1969)" http://www.malfredhaynes.info/index.php?p=1_14_Hopkins-Years; and The Haynes Project. Website "The Hopkins Years (1964-1969)" http://www.malfredhaynes.info/index.php?p=1_14_Hopkins-Years Accessed May 2, 2016

infrastructure from pure speculation, Haynes' community medicine plan proposed the incremental building of services from a core of essential services. As a "General Hospital" funded primarily through Medicare, Medicaid, and County funds, King-Drew's acute care tower only opened with the minimum number of services mandated by the federal government as necessary to perform care and research for the nation's top three killers - heart disease, cancer, and stroke.[289] Despite being the bare minimum, these services still constituted the most expensive services to be dispensed with public money.

Haynes ventured to safeguard the public's money by limiting the access to the acute care hospital through what he called an "ambulatory care center." Haynes proposed an off-site ambulatory care center located in the poorest section of Watts. The center would medically screen patients for a small fee in a facility operated by the privately-run medical school (Drew School) that would then refer citizens to the appropriate acute services in the county hospital (King General Hospital). The lower operating costs and relaxed atmosphere of ambulatory care center supposedly offered more time for physicians to consult with patients over different medical options for whatever ailment(s) they might have. This option-based approach emphasized having a sustained relationship with medical staff that built up a consumer orientation to health services. It also emphasized pursuing health as a lifestyle rather than as an intermittent episode fixable through expensive unplanned visits to the hospital.

The ambulatory care center, more importantly, controlled public access to the acute care hospital. Spellman and Haynes initially designed the medical center without an emergency room or outpatient clinic on the premises of the acute care tower. This meant that patients would not gain access to the most expensive publicly funded services without the referral power of physicians located in the fee-based ambulatory care center. As an intermediary between the community and tax supported services, Haynes' community medicine physicians would make the decisions about which cases were truly acute and which cases could be mitigated through lifestyle changes. As the new "front door" to the hospital, the ambulatory care center would also have the power to cull data to determine exactly what future priority

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[289] These mandated departments included: Pediatrics, Radiology, Ob-Gyn, Surgery, Anesthesiology, Medicine, and Pathology. The only two departments not mandated but included in the Master Plan were Community Medicine and Psychiatry, both of which were funded by alternative grants.

services were needed in the community. Cost overruns associated with the acute care tower, however, did not make it possible for the Drew School to open the ambulatory care center in time for the hospital's official opening in 1972. Without it, Spellman and Haynes authorized the operation of an emergency room on the weekends and an outpatient clinic operational only at night until money could be secured for an ambulatory care center.

Despite arguments that the fees charged at the ambulatory care center would be nominal, the fee drastically redefined what access to public hospitals could look like after Medicare and Medicaid. By 1972, President Nixon's administration had come to favor Medicare and Medicaid disbursement schemes that required citizens to pay a portion, albeit small, to access medical benefits.[290] As Haynes' design shows, the underlying opinion that such fees developed consumer profiles in citizens rather than dependency on state services was a shared value amongst conservative and liberal practitioners of medicine. The fee demanded that a wage earner be located in each household to take responsibility for the health of family.

In this regard, the ambulatory care center was meant to be complemented by the community's new Division of Allied Health Sciences, the official job creation and training arm of the Drew Medical School. Taking the statistics culled by the Department of Community Medicine and tracking the trends in new health professions, the school was meant to target the training of black men for training and employment in the local community and in other labor markets in need of new allied health workers. The school, for instance, focused its efforts on recruiting veterans returning from the Vietnam war for physician assistants.[291] Designed to work in tandem with the ambulatory care center, both institutions were envisioned as one big economic engine to transform the character of neighborhood.

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[290] Rosemary Stevens. *In Sickness and in Wealth: American Hospitals in the Twentieth Century* (New York: Basic Books, 1989), particularly her chapter "Pragmatism in the Marketplace: 1965-1980" pages 284-320

[291] According to a Brochure, "Twenty (20) former military corpsmen will be chosen through an intensive interview selection process" for King-Drew's MEDEX program. "All the participants will either have served on independent duty or will have received advanced training that will qualify them for independent duty." MEDEX brochure. Commonwealth Fund Series 18: Grants, Box 981, Folder 891. (Special Collections, Rockefeller Archives)

Spellman and Haynes defended their Master Plan as a more humane approach to medical care in poor neighborhoods because it provided a mechanism for the poor to reform themselves and meet standards of consumption and sexuality set by mainstream society and medicine. The fee-based ambulatory care center and the School for Allied Health Training were meant to arm black men with dignity and respect by giving them the authority and resources to care for their families. They assumed that this design would not only make marriage and family life desirable to black men but make conjugal and monogamous relationships with them desirable for black women. In this respect, the plan sought to further stigmatize and alienate black mothers who continued to live without husbands from the black community by reinforcing the belief that their sexual choices revealed their unfitness as mothers.

Working Motherhood as an Alternative Citizen Participation Approach

The Master Plan produced an image of black masculinity that drew attention to the unlocked potential of poor black men to be leaders at home and in the community. Unfortunately, while the plan served as a powerful critique of the historical impact of racism on black masculinity, it also reified mainstream patriarchy as the standard by which black men should be held to. In doing so, King-Drew's leadership had strengthened skepticism of their plan by highlighting the distance between the present state of black men in the community and their deviance from conventional roles of masculinity. Looking into evidence gathered by the study team to make its Phase I recommendations reveals how skeptical the consultants were in the ability of black men to make up the this distance.

The study team observed that the Master Plan targeted a segment of the community that was more difficult to organize because of their apparent aloofness from mainstream civic organizations. As manufacturing jobs absconded to further locations from the inner city, the unskilled, semi-skilled, and mostly male unionized workers who occupied such jobs grew more and more alienated from power in an enlarged non-union service sector labor market. Studies shared by the study team showed that despite the fact that both black and brown men in the neighborhood spent much of their time searching for work, the

work they found was often underpaid or temporary.[292] This unstable labor market looked more grim for younger generations. Whereas some older generations of high school educated black men could find work in the previous economy, the study team pointed out that the neighborhood's three high schools' average drop out rate of 39 to 43 percent annually meant that most of the community's men were ineligible for training and education at the Drew School.[293]

The perceived ungovernable nature of jobless men was exacerbated by the range of activities assumed to be taken up by idle men of color. The study team, for instance, associated "the high incidence of accidents and homicides" - the fourth and fifth leading causes of death in the community after cancer, heart disease, and stroke - with the high rate of "drug traffic that exists on the streets…housing projects and… schools."[294] Using data by gender on the number of court referrals related with drug law violations and heroin addiction, the appendix of the final report highlighted that the disproportionate share of court referrals and heroine addictions were related to black males.[295] The total effect made it appear as if unemployed men in the community were not just beyond the reach of the medical center's potential labor pool but also that of other governing civic institutions like the public school system and the police.

Although the stated mission of King-Drew was, as Lester Gorsline Associates paraphrased it, to "provide employment opportunities and professional growth for minorities," the study team ruled this mission was not "widely understood outside the school." They wrote that while being an "advocate of special concerns, a local action agency, or a source of jobs" may fall within the purview of an institution

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[292] The study team cited much of their material from a document titled, "Background Information: King-Drew Medical Center Service Area" assembled by the Department of Community Medicine. That document cited the Urban Employment Survey conducted by the US Department of Labor. "One out of every four who worked or looked for work in the the Urban Employment Survey areas was unemployed at some time during the 12 months per to the survey interview." Economic Characteristics. Department of Community Medicine. Background Information. Commonwealth Fund Series 18: Grants, Box 98, Folder 890. (Special Collections, Rockefeller Archives), p. 25.
[293] "The most recent [statistics on school dropout rates] (1965-1966) show that LA District High Schools located in the Hospital Service Area have experienced notably higher dropout rates than the average in the City School District. The estimate of dropouts in all senior high schools in the District was 21.5 percent. The equivalent figures for three of the senior high schools in the Service Area were 34.9% at Fremont, 42.4% at Jordan, and 43.6% at Jefferson." Education. Department of Community Medicine. Background Information. Commonwealth Fund Series 18: Grants, Box 98, Folder 890. (Special Collections, Rockefeller Archives), p. 36.
[294] The Master Plan Study, Master Plan Report, Section I of the Master Plan Vol. II. (Historical Context) Commonwealth Fund Series 18: Grants, Box 981, Folder 891. (Special Collections, Rockefeller Archives), p. I-6
[295] Appendix, Section III of the Master Plan Vol. III (Supporting Information for the Master Plan Study), p. 1-29. Commonwealth Fund Series 18: Grants, Box 981, Folder 891. (Special Collections, Rockefeller Archives)

in a community with "high rates of unemployment, low income, poor transportation, and depressing physical decay," they ruled that "Drew can make only limited responses" and provide "few solutions… for these global problems."[296] Ultimately, they decided that Drew's principal focus ought to be "on health" and should "not and cannot be principally a community action or economic development agency."

This did not mean that members of the study team withdrew interest from devising new avenues for greater citizen participation. In Phase II, study team members from the Urban Workshop shifted their focus to conduct a pilot study on the health of residents in the Jordan Downs public housing units near King-Drew. They were especially interested in the work of neighborhood councils and welfare rights organizations led by black mothers. These organizations appeared to have more viable vehicles for community participation for several significant reasons. First, unlike the unpredictable location of unemployed men in the neighborhood, the fixed location of women on welfare and their children in the city's housing projects and organizations made them easier to organize. These were strong durable organizations connected to municipal agencies that made them more efficient conduits of communication than labor organizations. Second, efforts here could uphold a complex but recognizable form of motherhood that stressed the responsibility of raising embryonic citizens and the state's need to assist women in keeping a respectable home. Third, and relatedly, the consultants saw an opportunity to exploit the social productivity that welfare rights leaders argued was endemic and necessary to survive on welfare.

Welfare rights activists argued that being on welfare required women to be smart, strong-willed, and persistent in order to navigate an inefficient, opaque, and openly racist bureaucracy of welfare agencies. By the 1970s, federal authorities viewed these by-products as valuable proof that women on welfare developed an aptitude for a new type of responsible mothering - working motherhood - that did not just come from job training programs but from the experience of being on welfare itself. The study thus attempted to resolve a continuing problem facing lawmakers since the 1960s to develop a unified

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[296] The Master Plan Study, Master Plan Report, Section II of the Master Plan Vol. II. (Mission and Strategies) Commonwealth Fund Series 18: Grants, Box 981, Folder 891. (Special Collections, Rockefeller Archives), p. 2-2

strategy to reduce welfare spending. While some conservatives were convinced that increased welfare spending could be reduced by cracking down on the number of women of color "abusing" the system, liberal lawmakers blamed increased welfare costs on government inefficiency.

After the Watts riots, Federal investigator William J. Page Jr. of the DHEW, for example, discovered that an ADC (Aid to Dependent Children) mother in Los Angeles seeking childcare while she attempts to find work was more than likely to use her time fighting the "fragmentation" and a "general absence of coordination" amongst federal, state, municipal, and charitable organizations to coordinate childcare so that she could find protected time for job searches.[297] Page concluded that not only was it well known that residents of "Watts and those of the Spanish-surname neighborhoods" had to confront racist agencies who were prone to being unhelpful but that the system did not even appear to work even for the most vigilant mother, regardless of race. Instead of blaming the poor, Page blamed "states and local committees" for their failure to design "intelligent utilization" and the "combinations of resources to accomplish program objectives." (underline in original)

The 1972 federal study gave authorities more evidence to act on these observations by adjusting the "ambulatory care center" concept to incorporate social workers and welfare agencies into the same building as healthcare services. This new "comprehensive care" concept created a context to coordinate more efficient services for mothers and babies that connected discourses of biomedical health with discourses of economic health. The connection treated poor health as symptomatic of a poor economic environment. CHCs thus brought clinicians and social workers into closer relationships with each other by encouraging each profession to see the achievement of health as the combined product of the successful mitigation of health problems and the stabilization of environmental factors such as food, shelter, and clothing.

The study team was encouraged to explore this reasoning because the Urban Workshop's pilot study favored this approach. Their consultations with young adult "community planners" from the public

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[297] September 17, 1965 Memo to The Undersecretary from William Page Jr. Subject: Los Angeles Task Force Work. RG 235 General Records of the Department of Health, Education and Welfare, Office of the Secretary Box 338, Folder: Los Angeles A - Z (National Archives and Records Administration, College Park, MD)

housing units were corroborated with health statistics developed from a local Model Cities Program. Both pieces of evidence formed the basis of study team's final recommendations to reorganize King-Drew's mission away from being an economic opportunity program to developing new public health services around maternal and infant care, hypertension, and drug and alcohol abuse. The Model Cities study summed up the connection between environment of health by stating that "poor health, mental and physical, lessens the ability of [neighborhood] children to perform well in school, hampers the adult resident's employment opportunities, and restricts the full enjoyment of leisure time for all" and that, likewise, "individual, family, community, and institutional factors still prevent many [neighborhood] residents from enjoying and benefitting from good health."[298]

King-Drew's Phase II plans prioritized the construction of ambulatory care center services with a "maternal and infant care" program complete with a child care center, comprehensive health and welfare services, and education programs with the following topics: "a family life education program" for with special emphasis on prevention and self-help, school health and learning disabilities, teenage health ("including but not exclusive to pregnancy"), and "gangs."[299] In 1973, the Los Angeles County announced that it would build a $7.2 million CHC based on these designs with DHEW money in a section of the city abutted by four different public housing units. Initial reports described the future facility as a "two-story building [that] will house comprehensive personal health care programs as well as community health and mental health care programs and services provided by the the Department of Social Services."

Dubbed the "Southeast Comprehensive Health Center" until it was re-named the Hubert H. Humphrey CHC in 1976, the center brought politicians from conservative and liberal wings of government into considerable agreement with each other. (See Figure 5.3) President Nixon's Department of Health, Education, and Welfare Secretary Casper Weinberger, nicknamed "Cap the Knife" for his

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[298] The Master Plan Study, Appendix, Section III of the Master Plan Vol. III. (Supporting Information to the Master Plan Study) Commonwealth Fund Series 18: Grants, Box 981, Folder 891. (Special Collections, Rockefeller Archives), p. 1

[299] The Master Plan Study, Appendix, Section II of the Master Plan Vol. III. (Reports of the Task Group on Maternal and Child Health Development) Commonwealth Fund Series 18: Grants, Box 981, Folder 891. (Special Collections, Rockefeller Archives), p. 1-3

notorious slashing of government spending, arrived in 1974 to be a part of the center's groundbreaking - announcing that "the center will be first county project of its kind where multiple health services will be provided in one facility."[300] Before the opening of the center, Lister Witherhill, Los Angeles County's Director of Health Services, made sure to also attribute the city's CHC system to the efforts of the staunchly liberal County Supervisor, Kenneth Hahn. Witherhill extolled to future patients that "these centers will be closely linked to specialized hospital services to provide for patients requiring hospital treatment" and that "the [County's] unification program will enable us to use our tax dollars more effectively by ending duplicated and fragmented services and decreasing costly hospitalizations."[301]

Weinberger's and Hahn's involvement in the center demonstrates that they both affirmed the CHC as a model institution for the future of welfare services, albeit for different ends. From Weinberger's point of view, government efficiency via CHCs helped re-cast welfare as a benefit given to mothers in a permanent state of widowed life, as it once was considered before, to a developmental/transitionary stage meant to develop the social productivity needed for the growing acceptance of working motherhood. On the same token, the consolidation and concentration of public services helped politicians like Hahn fortify relationships to an increasingly impoverished constituency that he could defend to weary taxpayers as a cost savings initiative. The CHC thus met the demands of better and more responsive welfare services while still upholding the ideals of personal responsibility.

Making Sense of Working Motherhood in an Age of White Feminism and Global Cities

While government bureaucrats and politicians responded to social movement claims in the making a policy of working motherhood, its ramifications demonstrate a strong disconnect between the social movement demands of poor people of color and its implementation. If anything, the policy of working motherhood appears to further the aims of white feminism and global capitalism while distorting the feminist ideology of welfare rights activists. Instead of focusing the public's attention on how racial

[300] "Ground Broken for Big Health Center" March 31, 1974. *The Los Angeles Times*. p. G23
[301] "Program Stresses County Health Care" March 6, 1975. *The Los Angeles Sentinel*. p. A3

capitalism had drawn and continued to bring more racialized laborers into more varied forms of poverty, white feminist rhetoric and talk of "global cities" in the hands of mainstream politicians appears to have helped reproduced racist notions about the racialized family that viewed women of color as unfit mothers and men of color as absent fathers.

White feminists in the 1970s heralded the unprecedented entrance of women into the workplace as an essential part of advancing reproductive "choice." As Jael Silliman argues, while reproductive choice "treats the individual's control over her body as central to liberty and freedom," this emphasis on "choice" "obscures the social context in which individuals make choices, and discounts the ways in which the state regulates populations, disciplines individual bodies, and exercises control over sexuality, gender, and reproduction."[302] Silliman and others use this critique to illuminate the historical use of sterilization and birth control by public health agencies to deny biological reproduction in communities of color.[303]

This critique also sheds light on welfare rights activist's unique perspective on the history of racial capitalism. Whereas pre-1965 job opportunity policies protected white motherhood in the home by securing the roles of white men as breadwinning heads of household, women of color were rarely afforded this opportunity until the expansion of the welfares state. In this regard, while white women celebrated the widespread entrance of women into workforce as a new symbol of feminist "choice," women of color saw such celebration as the normalization of their experience as working mothers. In fact, welfare rights activists often resented welfare-to-work programs that only seemed to move them from one form of poverty (under welfare) to another (as low-waged laborers).[304] Thus, instead of being new and liberating as white feminists claimed their entrance in the workforce to be, the policy appeared to mandate the compulsory participation of mothers of color in low wage labor pools while making those who stayed on welfare appear as lazy and abusers of public goodwill.

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[302] Jael Silliman. "Introduction" in *Policing the National Body*, ed. Jael Silliman and Anannya Bhattacharjee (Cambridge, MA: South End Press, 2002), x-xi.
[303] Jael Silliman, Marlene Gerber Fried, Loretta Ross, and Elena R. Gutierrez. *Undivided Rights: Women of Color Organize for Reproductive Justice*. (Chicago: Haymarket, 2016)
[304] See Premilla Nadasen's discussion of Work Incentive Programs (WIN) in her chapter on "Internal Tensions," pages 135-143. Premilla Nadasen, *Welfare Warriors: The Welfare Rights Movement in the United States* (New York: Routledge, 2005).

In this regard, the policy of working womanhood did not just index the limited economic mobility of women of color but also that of their male counterparts. As the study evidence attests, the new so-called service economy accompanying the "feminization of poverty" did not just distort the historical presence of women of color in the workforce but served to completely negate the role and power of racialized men in the family. In this regard, Spellman and Haynes' original plan to use the medical center as economic development engine was an honest reckoning of economic trends that attempted to channel black men into an ascending industry of the service sector at a moment where high paying, skilled, and irreplaceable service jobs were becoming more scarce.

The negation of Haynes' plan by the study team effectively left both inner-city men and women to compete for jobs in an economy changing in the tides of deindustrialization. To attract and keep a more select number of high-skilled and salaried jobs in finance, insurance, and real estate, many civic leaders in aspiring "global cities" supported measures to drive down the wages of many working class jobs.[305] Sociologists contrast cities like Detroit and St. Louis - which experienced an overall loss in population and gross domestic product - with new global cities like Los Angeles, New York, Houston, and Chicago whose building service and light industry capitalists drove wages below the prevailing wage market so that other high- and low-skilled service sector employers could benefit from lower overhead operating costs and continued profit margins.[306] As the changing demographics of South Los Angeles between 1960 and 1980 indicates, the sum of these efforts effectively pushed black laborers into a flexible labor market that was also being shaped by American economic and military intervention in Latin American nations that brought an unprecedented amount of refugee and asylum-seeking laborers to the same labor market.

As Grindell's testimony of the Florence-Firestone CHC attests, the new prevailing labor market of South Los Angeles reinforced the belief that black and brown men could not be depended on to

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[305] Saskia Sassen first popularized the term from research she performed throughout the 1980s. Saskia Sassen. *The Global City: New York, London, Tokyo*. (Princeton: Princeton University Press, 1991)

[306] See: Ruth Milkman. *L.A. Story: Immigrant Workers and the Future of the U.S. Labor Movement*. (New York: Russell Sage Foundation, 2006); Ruth Milkman. *Organizing Immigrants: The Challenge for Unions in Contemporary California* (Ithaca: ILR Press, 2000); Pierrette Hondagneu-Sotelo. *Domestica: Immigrant Workers Cleaning and Caring in the Shadows of Affluence (*Berkeley: University of California Press, 2001); William B. Fulton. *The Reluctant Metropolis: The Politics of Urban Growth in Los Angeles*. (Baltimore, Johns Hopkins University Press, 2001)

participate as meaningfully and conventionally in an economy that was shifting to accommodate more "feminized" forms of labor. In this regard, Grindell's memo demonstrates how the original plan's belief that a gainfully employed head of household did not necessarily equate to a breadwinner capable of having the resources and authority to direct healthcare for the family. In fact, the memo demonstrates that the County had taken the position that many residents in the city, regardless of their marriage and employment status, could not properly care for themselves without state assistance.

The throngs of Mexican and Central American immigrants seeking healthcare in Florence-Firestone's CHC served as evidence of a new workforce situated in the city's transformed low-paying service sector economy. More importantly, the willing investment into this community via CHC services reveals how County leaders had come to regard "working poverty" as not a problem to be eradicated completely but a valuable asset to political and economic leaders worried about securing the city's status as a "global city." So critical was this workforce to the future progress of the city that the County went to great lengths to secure public services to maintain the labor participation of the city's working poor. In other words, the city actively courted finicky global finance interests by using the city's public health services to keep a large and flexible pool of wage laborers paid below the poverty line.

In 1971, hoping to secure federal support for "alien services" rendered by Los Angeles County, James M. Pollard, legislative consultant to the Los Angeles County Board of Supervisors, explained to John Veneman, Undersecretary of the DHEW, that the County was prepared to spend "$22.4 million dollars in the 1972-1973 fiscal year….drawn exclusively from County funds" for health services rendered to residents with "alien status."[307] Pollard noted that the County was willing to dispense these funds even though the State legislature had reformed its subsidized Medicare program (MediCal) to retain coverage for single indigent adults (both men and women) but not those with alien status. He explained that the state's withdrawal of support meant that the County was prepared to sustain its services to undocumented

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[307] *Letter from Joseph M. Pollard, Legislative Consultant to the Los Angeles County Board of Supervisors to John G. Veneman, Under Secretary of Department of Health, Education, and Welfare, June 13, 1972.* National Archives Record Administration. RG 235 General Records of the Department of Health, Education, and Welfare, Office of the Secretary, Secretary's Subject Correspondence Box 405

immigrants through its own funds. It also intended to continue its historical use of "the question of residence or intended residence in the area" as the only "test" for those seeking care from the County.[308]

Although unsuccessful in winning federal support, Pollard's memo furnishes supporting evidence as to why King-Drew's study team ruled that the medical center should act as a more effective dispenser of healthcare services for unemployed and under-employed men than an employment machine. By absorbing healthcare costs previously shouldered by private employers, new industry configurations, like those occurring in the region's janitorial industry, were able to take advantage of paying workers less and without benefits. As labor scholars show, these janitorial jobs were formerly occupied by unionized black workers paid by property managers but, by the 1980s, these positions became increasingly outsourced to new janitorial companies that were non-union and staffed primarily by immigrant Latino workers. The location of Florence-Firestone at the crossroads of streets leading into the city's financial district and the city's garment and light manufacturing zones thus account for the profound demographic change in King-Drew's health service district from black to brown. (See Figure 5.1)

More than anything, the study team's findings paint a bleak and damning picture of racialized masculinity that, when viewed under the terms of prevailing conventions of heterosexual patriarchy, paint them as redundant even when employed. Here, the explicit naming of "mother and infant programs" in CHCs reveals how the state came to rely on mothers of color to stake a strategy to save the welfare state and to keep standards of motherhood uniform across race. At the same time, it also reveals the extent to which the federal and local government of Los Angeles withdrew considerable energy from plans to hold men of color to the same standards of domesticity as applied to white men. In a sense, the federal study ruled that poor men of color were "queer" for the ways in which they countered normative expectations of fatherhood, particularly for the perceived absence of their ability to provide for families even when their presence was seen as moral and monogamous.

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[308] The County continued funding undocumented immigrants until 1981. President Reagan granted asylum to all unauthorized immigrants in 1986.

Contesting Patriarchy

A study of the DHEW's activities after 1972 reveals that the King-Drew study helped to cement a policy movement to consolidate and concentrate welfare services for mothers and children in CHCs and neighborhood health centers throughout the nation. Federal grant and service contract funding from 1972 onwards tended to favor "multi-categorical grantee" projects that brought multiple agencies together who used statistics and patient tracking to furnish reliable health outcomes for a narrowly defined consumer population.[309] This criteria, in turn, favored state and municipal public health and welfare agencies eager to combine their resources into mother and baby programs to survive the gambit of anti-tax movements around the nation. The effect of this movement mark two significant developments that re-defined race and sexuality by the 1980s.

First, while the 1972 study marked a reversal of Haynes' and Spellman's original policy agenda for raising health standards in Watts, their principled belief that health and economic development in black communities ought to primarily empower black male heads of households still remained resonant amongst many prominent black community members. The divide produced a class of aspiring black citizens who saw their moral and health comportment as fundamentally different than that of those living in poverty or on welfare. Here, the ability to pay for healthcare without state aid worked to differentiate respectable forms of marriage and family from working poverty in creating one "multicultural class" separated by a "permanent underclass." In this sense, instead of transforming the public hospital into transformative machine to transition the poor from one category of race and sexuality to another, the public hospital served as border between the two.

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[309] This sentence is a cursory summation of federal research reports. From 1972 to 1974 the DHEW spent a considerable amount of research and development money in reviewing and evaluating Neighborhood Health Centers and Ambulatory Care Centers funded throughout the late 1960s and early 1970s. Some of these report titles include: *Feasibility Study of Neighborhood Health Centers (1972), Evaluation in Health: A Teaching and Research Program (1972), Ambulatory Health Care Information System: Overall System Description (March, 1972), Study to Evaluate the OEO Neighborhood Health Center Program at Selected Centers (1972), Strategies for Accommodating Ambulatory Care Projects Under Medicare and Medicaid (1973), Evaluation Manual for Comprehensive Health Services Projects (1973), Development of a Uniform Accounting System for Comprehensive Health Centers which are Funded by 314(e) Grants (1973), A Model for Analyzing Economic Impact of Comprehensive Health Service Projects (1974)a.* Special Studies and Reports 1969-1970. RG 235 General Records of the Department of Health, Education and Welfare, Office of the Secretary. Boxes 4 - 18 (National Archives and Records Administration, College Park, MD)

The federal study thus turned the mission of King-Drew Medical Center against Spellman and Haynes by serving as a damning repudiation of their leadership. It was the first step in a series of actions that would alienate and subordinate their leadership to the will of others. The study effectively shifted the reins of the operation of King-Drew medical center away from Spellman and Haynes and placed them firmly in the hands of the County of Los Angeles, whose public funds and existing operation of welfare programs ensured that any future government service contracts would favor them over Drew. Bound, however, to the federal recommendations in Phase II, Spellman and Haynes were tepidly trusted to carry out programmatic policies that were completely antithetical to their original design. Without hope to receive grant money from the federal government to keep Drew Medical School solvent, Spellman and Haynes entered into an agreement that would render their leadership at Drew increasingly impotent.

In October of 1973, with the assistance of California Senator Mervyn Dymally, Governor Ronald Reagan authorized a $1.8 Million assistance grant to Drew Medical School administered under the stewardship of UCLA Medical School to "support the programmatic efforts of Community Medicine."[310] The transaction secured the financial survival of the school while giving broad powers of UCLA over Drew Medical School to approve or veto the "a) selection of students b) the curriculum c) assignment of student rotations and d) the awarding of the MD degree."[311] Essentially, the agreement rendered the leadership of Drew Medical School as redundant and absent as the federal study had accused other men of color in the neighborhood to be.

The figure of the racialized absent father is, perhaps, the second most significant development of the 1972 study. Oddly, its power resides less in its hyper-visibility but in its power to frame, through silence and invisibility, the figure of the "welfare queen." Popularized by the coded language of President Reagan in the 1980s, the 1972 study shows us that the social production of the "welfare queen" was first

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[310] *UCLA - September 15, 1975 Letter to Dr. Charles E. Young, Chancellor of UCLA from M. Alfred Haynes, Acting Executive Dean of Drew* University Archives, Collection 255, UCLA Medical School, Papers of Jeanne Williams Box 2

[311] *UCLA - December 22, 1975 Letter to Dr. Charles E. Young, Chancellor of UCLA from Sherman Mellinkoff, Dean UCLA School of Medicine* University Archives, Collection 255, UCLA Medical School, Papers of Jeanne Williams Box 2

staged as a bipartisan compromise to survive and transform the welfare state during President Nixon's administration. By the 1980s, President Reagan's commentary struck a resonant chord with the public because of the extent to which CHCs gathered citizen opinions on the provision of public healthcare services that were increasing in costs for private consumers and the relative invisibility of black men in society due to higher incarceration rates. Thus, the social production and the cultural power of the "Cadillac" welfare mother is therefore made possible by the haunting social acceptance of black and brown absentee fatherhood.

It is this context of attack on black and brown women and men that inspired a range of black feminist and women of color activists to reassess the impact of civil rights, welfare rights, and white feminist movements on poor communities of color. The 1980s demonstrated that the responses to the historical imbalance of justice between the races and between the sexes never veered far from conventional notions of kinship, patriarchy, and heterosexuality. The vision of justice offered by Spellman and Haynes only offered black mothers continued oppression as women, while the vision of welfare rights activists left little room to comment - for or against - the position of men in communities. Still too, the vision of feminist rights offered by white feminists offered men of color no place of meaning in a system of racial capitalism. In each of these perspectives, the promise of community offered men of color three impossible modes of participation: oppressive power, silence, and denial.

There is room, however, for possibility. Seeing a dark road for racial futures, black feminists in the 1980s took up the question of racial masculinity in a feminist future very seriously, offering imagined possibilities that, for those involved in the 1972 study, might have drawn a different purpose for CHCS. For Black feminists like bell hooks, for example, it is important to recognize that black men are capable of nurturing and developing community *alongside* women regardless of their presence in the home.[312] She argues that "fathers who are not present all the time can still be a loving presence" and that, "the presence of biological fathers matters less than the presence of loving black male parental caregivers." More recently, queer scholars have considered that an ethic of seeing black and brown men as capable of being

[312] bell hooks. *We Real Cool: Black Men and Masculinity* (New York: Routeledge, 2004)

feminist must begin with seeing them as capable of loving and being loved in return. In taking up Marlon Riggs' powerful assertion that, "Black men loving black men is the revolutionary act," E. Patrick Johnson argues that contending with the cultural denigration of black men must begin with valuing racialized men alongside women and queers of color in society.[313] These perspectives open up rather than limit the number of possible responses to raising health and well being that rely less on gender and sexual roles and more on the meaning that individuals take on in creating community.

[313] E. Patrick Johnson. *Teaching Blackness: Marlon Riggs' Place in Black (Gay) History* http://newsreel.org/guides/Riggs-Guide/Teaching-Blackness-by-E-Patrick-Johnson.pdf

Figure 5.1 Map of King-Drew Comprehensive Healthcare Clinics

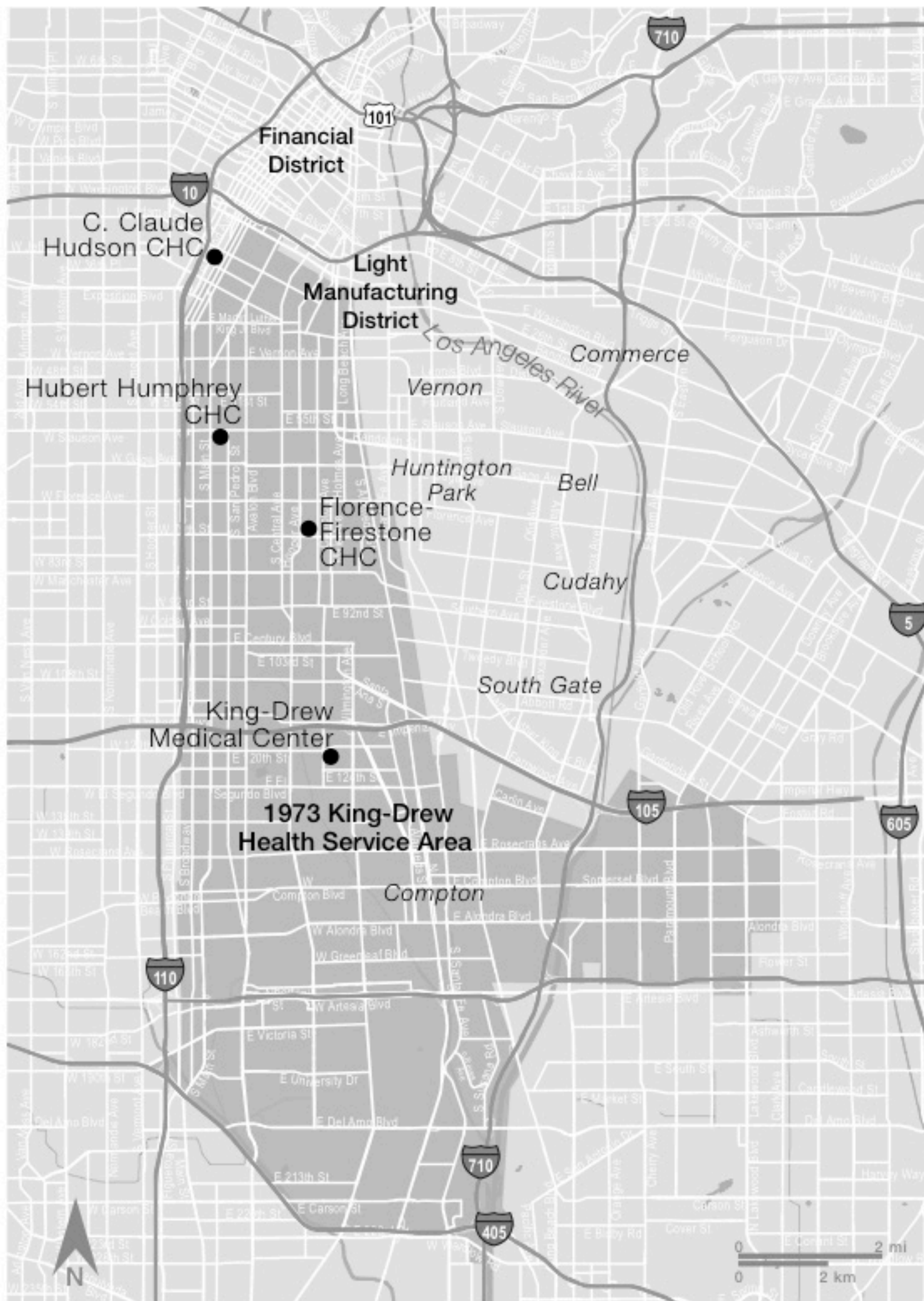

Figure 5.1 The Florence Firestone CHC, C. Claude Hudson CHC, and Hubert Humphrey CHC all sat north of the King-Drew Medical Center campus. As the map reveals, the neighborhoods in which they are placed all have easy access to downtown and to the light manufacturing districts to the North and East and the "Hub Cities" of Vernon, Huntington Park, Commerce, Bell, Cudahy, and South Gate. The Health Service Area reflected here reflects the boundaries of King-Drew's Regional Medical Program boundaries. In 1973, the County expanded the boundaries to an area now known as Service Planning Area-6 (SPA-6). Map made for author by Breanna Spears.

Figure 5.2 - M. Alfred Haynes, MD

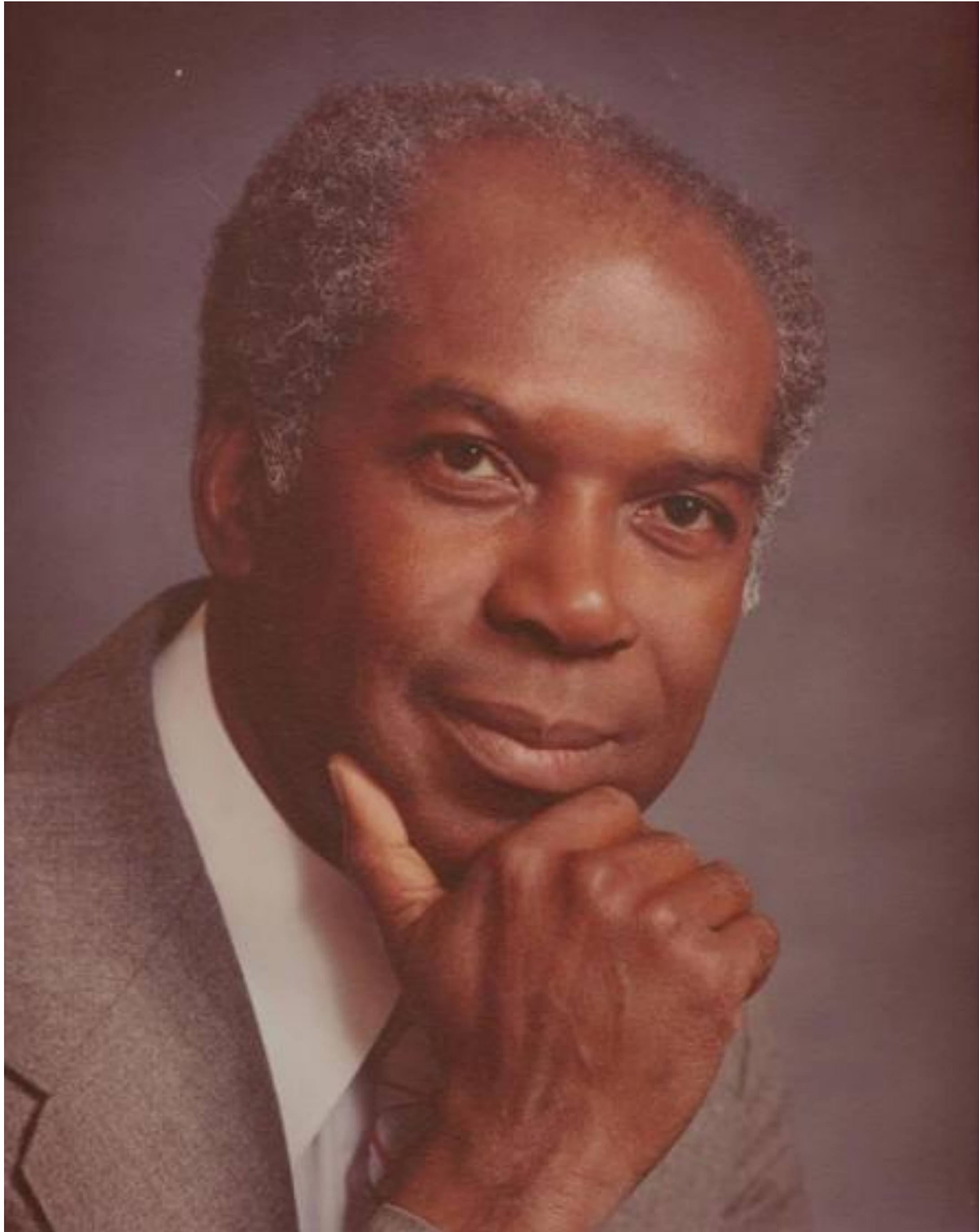

Figure 5.2 Inaugural Chair of the Department of Community Medicine, Dr. M. Alfred Haynes. He served as Chair of Community Medicine until 1976 and returned in 1979 as the Dean of the Drew Medical School. He served as the Dean until 1986.

(Source: The Haynes Project http://www.malfredhaynes.info/ accessed: March 19, 2017)

Figure 5.3 Hubert Humphrey CHC

Figure 5.3 Top: Architectural rendering of Hubert Humphrey Comprehensive Health Center, originally known as the Southeast Comprehensive Health Center, or the "Slauson and Main" clinic (after the major cross streets located nearby). Below: Completed Center, photo date unknown.

Source: Hubert Humphrey Comprehensive Health Center 1974-1981. Kenneth Hahn Collection. Box 194, Folder 1 Health Centers/Trauma Centers (Special Collections, Huntington Library) and Jenkins/Gale and Martinez, Inc. (http://www.jgminc.com/medical.html)

Chapter Six
Building Black Mental Wellness from the Outside In: Dr. J. Alfred Cannon, Community Mental Health Clinics, and Therapeutic Publics

On June 4, 1974, Founder and Executive Vice President of the Central City Community Mental Health Center, Dr. J. Alfred Cannon ordered Dr. Hiawatha Harris to terminate a recently hired consultant named Dr. Dimitrios Gourgouris.[314] Cannon had reason to believe that his hire represented a serious overreach of the Mayor's office into the affairs of a local non-profit mental health center. Tom Bradley, the newly elected African American mayor of Los Angeles, had dispersed funds to Central City Community Mental Health Center (hereafter, Central City) earmarked for "youth programming," a new programmatic initiative centered on gang and drug prevention. The funds preserved operational budgets for inner-city community mental health centers that, elsewhere, were being attacked by politicians and other mental health professionals as redundant and ineffective. Cannon, however, did not read Gourgouris' consultation services as an attack on the mission of the center but as an attack on his personal leadership of it. He speculated that the "virtually invisible" consultant and his failure to share investigative findings with the Center's board of directors hid an ulterior motive to uncover Cannon's leadership as the root of "internal problems" plaguing the center and several other city-funded projects.

Central City's new funding stream uncovers a very different narrative about deinstitutionalization. Most historians of psychiatry regard deinstitutionalization, or as it is otherwise known, the community mental health movement, as a declining or failed movement by the mid-1970s. Movement proponents held an ambitious vision to treat every diagnosed mentally ill person in non-restrictive settings. Instead of achieving a significant release of diagnosed mentally ill people from asylums, deinstitutionalization is generally remembered as exacerbating the effects of deindustrialization. The selective release of some chronically mentally ill patients from custodial care joined prevailing economic patterns that were eroding

[314] Cannon's direct statement: "I believe at the time Mr. Gourouris was hired you mentioned it had been at the suggestion of the Mayor's office (strongly inferring that pressure had occurred, i.e., that his hiring was in direct relation to the receipt of funds to Central City CMHS ostensibly for 'youth programming')." June 24, 1974. Confidential Memo from Dr. J. Alfred Cannon to Dr. Hiawatha Harris. Collection 293 Thomas Bradley Collection, Box 3863, Folder 10 Bill Elkins, Central City Mental Health Facility 1974-1975 (Young Research Library, UCLA)

once stable post war labor markets to create one expanding mass of homeless, under- and un-employed laborers that sociologists and news outlets began to term "new homelessness" and a "permanent underclass."[315] Widespread reporting of "street people," crime, and social disorder in early 1970s is thus used to mark the end of deinstitutionalization and the de-funding of mental health programs for other non-medical solutions such as policing and prisons by a panicked citizenry.

Central City's "youth programming" funds demonstrate, however, that local politicians continued to fund the community mental health movement for communities of color under new programmatic means that actually capitalized on citizen desire for public safety, prisons, and policing. As Cannon's initial acceptance of youth program funding tied to gang, crime, and drug abuse prevention attests, mental health professionals were, for the most part, complicit with the terms of this new political and financial arrangement. In this chapter, I argue that local politicians in Los Angeles influenced by mental health theories based on the civil rights movement continued to invest in mental health resources for neighborhoods of color well into the 1980s through community mental health centers (CMHCs) turned non-profit community-based service organizations (CBOs). As they did, some mental health professionals wrestled with the tendency of new mental health directions to incriminate those they were drawn into help in the first place.

Some continued on under these new terms while others left entirely. Writing in 1977, Cannon argued that "the [mental health] system is so brutal, that instead of a rehabilitative experience the net effect [of mental health services] is a re-criminalizing one."[316] Sobered to the reality that "Black males are being institutionalized at an alarming rate and are presently, as environmentalists might say, an endangered species," Cannon sent himself into exile by working for the Government of Zimbabwe in 1983. When he passed away in 1988, his obituary in the *Los Angeles Times* revealed a once deep

[315] For an overview of new homelessness literature, see: Peter H. Rossi (1990). "The old homeless and the new homelessness in historical perspective." *American Psychologist, 45*(8), 954-959. The term "permanent underclass" was popularized in American lexicon by Ken Auletta's 1982 *New Yorke*r article published later as *The Underclass*. The Overlook Press, New York 1999. Sociologists generally attribute Gunnar Myrdal's work as first developing the concept. See: Gunnar Myrdal. *An American Dilemma: The Negro Problem and Modern Democracy* (New York: Harper and Row, 1962) and *Challenge to Affluence* (New York: Pantheon, 1963).
[316] J. Alfred Cannon. "Re-Africanization: The Last Alternative for Black America" in *Phylon*. Volume 38, No. 2 (Second Quarter, 1977) p. 203-210

relationship to Los Angeles' elite class of African American politicians. Joined by Representatives Melvyn Dymally and Augustus Hawkins in mourning, Mayor Bradley memorialized him by saying, "[Cannon] leaves a legacy for those he sought to serve."[317]

That legacy was indeed long lasting and far reaching. In addition to Central City, the infrastructure Cannon built included medical facilities dedicated to African American health such as the Drew Medical School, Kedren Community Mental Health, the Psychiatric Department at King Hospital, the Franz Fanon Research and Development Center, and the Frederick Douglass Child Development Center. (See Figure 6.1) Along with his influential leadership over UCLA's Program in Social and Community Psychiatry from 1963-1971, Cannon's theories on race and his innovative black mental health service models formed the evidentiary basis that many Asian/Pacific Islander American and Latino American mental health professionals used to create their own mental health programs.[318] Significantly under-appreciated and under-analyzed, however, is Cannon's involvement in building several cultural institutions as integral components of his clinical work. Cannon created the Inner City Cultural Center (ICCC) and the Mafundi Institute, a multicultural arts theater and a black arts center that received funding from the same federal and municipal sources as his mental health programs.

That the same granting institutions entrusted Cannon with so many projects and so much money illustrates that politicians did not only underwrite his projects with money but also supported the theoretical framework that connected the medical with non-medical aspects of his work. This latter point suggests that a framework of race and mental health can be used to understand how politicians saw themselves as accomplices in forwarding the deinstitutionalization movement under the banner of the civil rights and community self-determination. It demonstrates that Cannon and Bradley both shared the opinion that law and medicine could empower people of color to reshape space and racial meaning

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[317] George Ramos. "Had Apparent Heart Attack in Zimbabwe: Dr. J. Alfred Cannon; Health Crusader" *Los Angeles Times*. March 11, 1988. http://articles.latimes.com/1988-03-11/news/mn-1168_1_heart-attack accessed December 9, 2016

[318] "The training program had been largely constructed from the experience of J. Alfred Cannon, MD, literally the first Fellow in Social and Community Psychiatry at UCLA." "Dr. Cannon helped plan the formal training program funded by the NIMH and was for some years its Assistant Director." Marvin Karno. "A Career in Social Psychiatry." Collection 444 Marvin Karno Professional Papers, Box 1, Master of Social Psychiatry Degree Program Revival, 1986-1988, #1 (Darling Biomedical Library, UCLA)

powerfully enough to de-stigmatize race from mental illness and develop new associations with race that were positive, beautiful, and desirable.

As such, space served as just as important of a field of intervention for both mental health therapists and politicians as the psyche. To re-define race, Cannon and Bradley ventured to re-make built space by building what I am calling a *multicultural therapeutic public* which affirmed some representations of race as healthy and desirable. Their strategy involved convincing others to recognize that some forms of racial difference could be used to encourage patients of color to lead modern lifestyles. They affirmed certain racial identities based on representations of respectable marriage, family, and employment as natural manifestations of racial psyches while continued to pathologize sexual promiscuity, homosexuality, abusive behavior, criminality and chronic unemployment as evidence of mental illness. Clinicians referred to this pathology in racial terms not unlike the colloquial terms used by anti-colonial activists, using terms like “ghetto” mentality, colonial mentality, and internal colonialism to name mental states within people of color as the natural product of living under the strain of white supremacy and as abnormal manifestations of authentic racial identities.

Capitalizing on the momentum of psychotherapeutic movement, Cannon developed a variant of psychotherapy that specifically addressed racial difference. He also believed that therapy tailored to one’s “ancestral core” could maximize the benefits of mental health services. He believed that a new racial ethos of cultural pluralism needed to restructure American society outside the clinic in order for any clinical intervention to be truly effective. As opposed to a “mainstream” world built primarily for white citizenship, Cannon used deinstitutionalization to further the aims of citizen participation and community self-determination policies to build a multicultural landscape where each racial community was empowered to plan and carry out the construction of their own versions of mainstream white institutions. The effect of the mutually reinforcing image of “blackness” produced by black psychiatrists and a black public was meant to conjure a black patient who desired mental wellness enough to pursue and self-fashion a healthy lifestyle based on their ancestral core. This pattern repeated for each race formed a new

multicultural society which recognized and managed racial difference through an individual's desire to pursue a "healthy" lifestyle defined by their ancestry and heritage.

The power of therapeutic publics was that it produced, essentially, a "non-pathological" or "normal" person of color, that did not necessarily require the intervention of a mental health professional. A multicultural public lifted the "strain of race" from the psyche of people of color by furnishing them with a world that represented race as having a place in society instead of being in a world where people of color existed but did not belong. Such a feeling of being in but not of the world was thought to create a psychic split that manifested in poor behavior. Thus, the main benefit to investment in infrastructure for otherwise healthy people of color is that it demonstrated that if people of color were simply allowed to self-fashion their own identities and develop their own neighborhoods that it would prove that people of color were not, as previously thought in psychiatry, void of an inner psyche and incapable of membership in civil society.

As Cannon's self-exile in Zimbabwe suggests, the multicultural world-making that Cannon, Bradley, and others embarked upon in the 1960s came to a crossroads after the political atmosphere of the mid-1970s shifted the responsibility of the community mental health movement to local politicians, youth program coordinators, and the police. Instead of the broad reach of multicultural institutions as imagined in the 1960s, community mental health proponents redirected mental health and community development funds into new projects - gang prevention programs housed in CBOs - that took advantage of the public's panic over racialized street gangs and drugs. Rather than work to de-stigmatize race as an inherently healthy psychic state, these service organizations depended on funding that awarded operational funds based on the close pathology of race to criminality and mental illness.

A Distorted View

The mission to de-pathologize race from mental illness at Central City shows that CMHC staffers never intended to treat the most acute and chronically mentally ill. Instead, most CMHCs were focused on the prevention and identification of individuals who demonstrated high risk factors for future mental

illness. CMHC leaders held up a preventative approach that appealed to citizen's productive desires to live a healthy lifestyle as a liberal alternative to the prevailing interventionist approaches which brought citizens into contact with mental health providers only after a traumatic episode. The narratives of morality underlying this view were particularly attractive to traditions within communities of color that conflated health with respectable marriage and family.[319] They believed that their advocacy in producing vigilant and responsible individuals was a more effective strategy than interventionist approaches even though it could not produce a direct, observable, or quantifiable measure of reducing state hospitalization rates as other methods could.

The historiographic consensus on CMHCs shows that many in the psychiatric community interpreted this shortcoming of preventative methods as proof that CMHCs contributed very little to deinstitutionalization efforts. According to Gerald Grob, while every mental health institution can be blamed for their part in the "wholesale neglect of the mentally ill, especially the chronic patient and the de-institutionalized," the abandonment of the most vulnerable mentally ill populations by CMHCs appeared to be especially egregious.[320] The National Institute on Mental Health (NIMH), for instance, reported that there was "little evidence" to support the claim that CMHCs were reducing state hospitalization rates.[321] Instead of achieving the "substitution of one service [in the state hospital] for another [in the community]," as was expected of CMHCs, they proved more successful in recruiting "new clientele" that were less chronic and less acute than those moving from asylum to community settings.

The perception that CMHCs ought to have shouldered the responsibility for the most acute, chronic, and poorest of the mentally ill is one example of how accepted narratives distort how CMHC leaders saw themselves, spoke about their services, and viewed their patients. Prevention served as an

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[319] For other examples over this conflation between health and morality, see: Nayan Shah. *Contagious Divides: Epidemics and Race in San Francisco's Chinatown* (Berkeley: University of California Press, 2001) and his discussion of morality and medicine on pages 14, and 105-107. Within African American traditions, these ideas of morality and hygiene were tied to strong beliefs in combating racial genocide. See: Michele Mitchell. *Righteous Propagation: African Americans and the Politics of Racial Destiny after Reconstruction*. (Durham: University of North Carolina Press, 2004) pages 141-172 and pages 218-240.
[320] Gerald Grob. *From Asylum to Community: Mental Health Policy in Modern America* (Princeton: Princeton University, 1991) p. 257
[321] Grob, p. 255

important shared goal amongst all deinstitutionalization proponents but its urgency wained as lay citizens began to connect the appearance of "street people" with deinstitutionalization. Citizen fury led some working from larger and more well-funded mental health institutions in state and general hospitals to blame CMHCs for the crisis. They argued that CMHCs ought to change their services to accommodate the growing number of chronic and acute patients released into the community at large. CMHCs were easy targets given that some diagnostic categories, like schizophrenia, increased in number for poor and black men.[322] Despite the fact that state and general hospitals were the main agents in diagnosing black men as schizophrenic, it was these same institutions which absolved themselves of their care.[323] These diagnose-and-release practices assumed that care for these populations would be provided by providers of color out in the community.

The continued valorization of the highest functioning citizens by CMHC staffs thus cultivated the idea that their priorities were misplaced, misguided, and unresponsive to the crisis. Dr. Donald G. Langsley, the President of the American Psychiatry Association, attacked CMHCs for using treatment regimens that had "not yet been proven successful" and for carrying out services that were more custodial than research-based in nature.[324] By focusing on "counseling and crisis intervention" for "predictable problems of living," Langsley joined a chorus of local mental health researchers who pushed to divert the dwindling amount of mental health funding from CMHCs to more capital intensive research based in neuropsychiatry and the development of psychotropic drugs. The most vocal proponent of this view in Los Angeles was Dr. Louis Joylon West, Director of UCLA's Neuropsychiatric Institute and Department of Psychiatry, who used his leadership and resources to de-fund CMHCs.

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[322] This phenomenon is compellingly argued by Jonathan M. Metzl. *The Protest Psychosis: How Schizophrenia Became a Black Disease* (Boston, Beacon Press, 2009)

[323] This phenomenon was observed by the Los Angeles County Department of Mental Health in 1967. According to County researchers, Arleta Crowell and Roger Rice, a one month study of Los Angeles General Hospital's emergency psychiatric admissions revealed that its most common diagnosis was schizophrenia (62% of all cases and 50% of all admissions). Crowell and Rice observed, however, that "even if a Negro or Mexican American is diagnosed as schizophrenic, he has less chance of being admitted to the emergency service. While 65% of the white schizophrenics were admitted only 55% of the Negros and 41% of the Mexican Americans were admitted." Study on Inpatients. Collection 0423 Los Angeles County Department of Mental Health records, California Social Welfare Archives, Box 2, Folder 9 (Special Collections, University of Southern California)

[324] Donald G. Langsley. "The Community Mental Health Center: Does It Treat Patients?" *Hospital and Community Psychiatry*, 31 (1980). pages 815-19.

West argued that "major government emphasis on — and investment in — mental health service delivery systems emphasizing comprehensive CMHCs, [was] seemingly (if not truly) [coming] at the expense of fundamental psychiatric education and research."[325] For him, the stakes of continued funding to CMHCs were high in two respects. First, West believed that the authority of psychiatrists as researchers and medical experts were being undermined by providing operating and training funds to "mental health paraprofessionals" (a diminutive term he used for psychiatric social workers, psychologists, social behavioralists, and community health workers). Secondly, he feared that CMHC activists were doing too good of a job of re-defining mental illness. He believed that their tendency, along with other mental disability activists, to argue that those labeled mentally disabled were "not really mentally ill at all" would soon have people believe that "the nature of mental illness is not that closely related to medical care and therefore shouldn't be closely related to medical costs."[326] CMHCs thus, posed a threat to psychiatrists because they not only divided mental health funds for medical research but helped politicians and the public question the effectiveness of funding psychiatry as a science at all.

These comments would have people believe that Cannon and other psychiatrists of color who helmed CMHCs did not fashion themselves as innovators but as practitioners or as custodians of the mentally ill. By the 1970s, the closer relationship between government funding and psychiatric research was seen as a more progressive relationship than the prior defining relationship between state funding and asylum care. By painting Cannon as the latter, West implied that Cannon was performing asylum-like services in community settings that amounted to little nothing more than welfare. In contrast, West painted his research on neuroscience, epigenetic trauma, and psychotropic drugs as more progressive because its proprietary implications anchored psychiatry and its uses in the free market. West thus framed

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[325] Changing Concepts of Psychiatry. Collection 590 Louis Joylon West Papers, Box 12, Folder 2 (Darling Biomedical Library, UCLA)

[326] Full Quote: "Different solutions have been offered recently through redefinitions of the problem. One way of redefining the problem is by looking at a goodly number of these four million [diagnosed mentally ill] people and saying, well, they're not really mentally ill at all, and therefore we don't have to say that the nature of mental illness is not that closely related to medical care, and therefore shouldn't that be closely related to medical costs." New Trends of Psychiatry in the Community Setting. Proceedings of the Kittay Scientific Foundations 4th Annual International Symposium. Cambridge Mass. Ballinger 1977. Mental Health – LJW on Community Psychiatry, 1977. West, LJ. Setting the problem. In G Serban (Ed.) Collection 590 Louis Joylon West Papers Box 139, Folder 13 (Darling Biomedical Library, UCLA)

the future of mental health funding as a decision between fostering new forms dependency on mental health services or developing deeper consumer choice, freedom, and responsibility within individuals.

A closer look at Cannon reveals him to be as much an innovator than his critic West would have people believe. Cannon's primary innovation was the development of a new service model which combined mental health services with other needed social services around child care, housing, etc., for targeted poor populations. The construction of these centers formed the overall programmatic agenda of the newly formed Los Angeles Department of Mental Health Services in 1959. It's Director, Dr. Harry Brickman, explained that the department's strategic vision was to create a network of community based organizations "'riding on the shoulders' of established community caretakers," a term he used for mental health professionals of color (psychiatrists, psychologists, and social workers) working in their own communities.[327] By "enrich[ing] their capacity to deal with mental health programs of their essentially non-mental health caseloads," Brickman argued that department resources would not only help them "deal directly and more effectively with the emotional problems of their welfare recipients, probationers, students, etc.," but empower them to refer a client to "definitive mental health professionals in the community" for treatment and research.

This flexibility solved two problems related to mental health research. Psychiatrists supported deinstitutionalization because their professional association with asylums compromised their credibility as medical researchers and as arbiters of impartial and unbiased medical "science." Whereas other medical physicians could rely on the seeming objectiveness of their specialties, psychiatrists suffered from the stigma that their practices were subjective, racist, and coercive. While psychotherapy had made inroads to gain the trust of a mostly white middle class population, CMHCs helped bridge the relationship between psychiatry and populations that had come to distrust mental health professionals. In short, CMHCs were seen as critical for gaining research access to vulnerable populations by producing consumers who sought them out willingly and under consent.

[327] Harry R. Brickman, M.D., Ph.D, Interviewed by Frances Lomas Feldman in Dr. Brickman's Office July 9, 1999. Oral History Transcripts (Special Collections, University of Southern California)

As the inaugural Fellow in the Program in Social and Community Psychiatry at UCLA Medical School, Cannon opened the Central City Community Mental Health Center as the first CMHC in Los Angeles in 1961. A recent graduate of Columbia University, Cannon replicated the mental health model piloted at the LaFargue mental health clinic of Harlem by providing psychotherapeutic sessions in a local black church funded initially by patient and community donations.[328] Unlike the LaFargue, Cannon had raised $900,000 in demonstration grant funding from the NIMH to formalize its services in 1966 and won a much larger $3.7 million seed grant from the federal government, State of California, and the County of Los Angeles to expand it in 1968.

The center won attention from newspaper readers across the nation who were eager to see what innovative services President Johnson's community mental health amendments were developing. A 1968 *Austin American Statesmen* article described Central City as facility with two doors - one to "deal with the mental ills found in city slums," and another marked "Community Service Center" which oversaw the carrying out of a hodgepodge of activities related to "controlling alcoholism, rescue missions, language classes, seminars for the retired, and occupational therapy."[329] It's hallmark programs, however, were a "Teen-Queen" club for black girls and a karate class for black boys. "In all of these," Cannon claimed, "we have found we can reach the young and the old who need help but just won't come to a mental health center." According to clinic administrator Richard Sanville, the solution to solving a mental health crisis for poor local residents was as simple as, literally and figuratively, a "walk … through [the] corridors to our consultation rooms" from the community service center to the mental health center.

The newspaper neglected to mention that few mental health services existed in the predominantly black South Central neighborhood of Watts outside of those offered in Central City. This meant that the focus of Central City necessarily remained limited to mild forms of mental health intervention. Any

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[328] A spate of scholarship focuses on the work of the Lafargue and its Director, Wertham has just become available. See: Dennis Doyle. Psychiatry and Racial Liberalism, 1936-1968 (Rochester: University of Rochester, 2016) and Gabriel Mendes. *Under the Strain of Color: Harlem's Lafargue Clinic and the Promise of an Anti-racist Psychiatry* (Ithaca: Cornell University Press, 2015)
[329] "Down-to-Earth Psychiatry Helps in Los Angeles Slums." *The Austin American Statesmen* October 10, 1968; B. 1

serious case of mental illness still required the referral of patients to psychiatric wards at Los Angeles County General Hospital and Harbor General Hospital (both ten miles away from Watts). More importantly, these referrals transferred patients out of community control and into the hands of predominantly white psychiatric researchers. This reality placed Central City staffers in a predicament because referral risked jeopardizing the trust developed between them and local residents. The effect necessarily left staffers to focus on prevention rather than rehabilitation.

The need for a psychiatric ward sensitive to the experience of people of color prompted County Supervisor Kenneth Hahn, Congressman Augustus Hawkins, and then Councilman Thomas Bradley to devise plans to add an acute psychiatric ward to the plans of King-Drew Medical Center in 1969. To chair the design of this new facility, Dr. Mitchell Spellman, Dean of the newly formed Drew Medical School and de facto leader of the planned King General Hospital, appointed Cannon as the Chair and Director of the Psychiatric Department in 1971. His appointment was an unprecedented commitment by local politicians and medical officials to create a comprehensive mental health network that did not require referral of black patients outside of the black community. From a patient's perspective, this meant that every aspect of psychiatric care - service from a provider, the referral of care between providers, the training of providers, and the research performed by providers - were all conducted by black physicians.

Theorizing Multiculturalism

Matching physicians to patients by race clearly differentiated CMHC activism from other deinstitutionalization supporters. CMHC proponents polarized mental health practitioners by troubling those committed to civil rights on their opinions regarding black nationalism. Critics regarded this separate racial universe as antithetical to the racial integration aims of early civil rights efforts and asserted that compassion and skill in serving the poor ought to be seen as moral qualifications that trumped racial belonging. CMHC activists, however, viewed structural racism as an enduring impediment to mental wellness in people of color and regarded the determinant of race to be an imperative for ethical and humane care. As such, CMHC proponents argued that treatment and, more importantly, research

performed on people of color ought to be performed by those who shared the same structural experience. In contrast to their detractors, they did not see this approach as a disavowal of a cultural pluralism but saw protected interactions between co-ethnics as socially necessary for meaningful participation by people of color in a new multicultural society.

As deinstitutionalization progressed, however, critics used the close relationship of CMHCs to cultural nationalist organizations such as the Black Panther Party and the *US* organization as proof that they were more interested in political work than in the work of progressing medicine and science.[330] As a mostly white profession, some white psychiatrists resented the protectionist claims of CMHC leaders over patients of color because it left many without access to clinically accessible populations. For example, the right to research patients of color defined an unsuccessful attempt by Dr. West to build a "Violence Center" at UCLA with state money in the early 1970s. The center would have had access to experiment on predominantly black and brown patients in several state prisons and youth detention camps but was stopped by organized activism by the Coalition Against Psychosurgery, the Black Panthers, and others. West interpreted the successful de-funding campaign as an obstacle to scientific progress and denounced its critics as an "ignorant" group of outside agitators who were trying to "manipulate the black community" into supporting efforts that ran against the interests of their community.[331]

Cannon's statements on the controversy reveal that he did not oppose research over violence outright but asserted that West's study design "may have the wrong direction or the wrong form."[332] He elaborated further that West's approach "seems to be concerned more with the symptoms than the causes." A fellow black graduate of UCLA's program of Social and Community Psychiatry and then Associated Dean of Harvard Medical School, Dr. Alvin Poussaint furthered Cannon's point by stating:

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[330] "Some community mental health centers were also caught up in the social and political conflicts of the 1960s and early 1970s, thus further vitiating their already marginal involvement with the severely mentally ill." Gerald Grob. *From Asylum to Community: Mental Health Policy in Modern America* (Princeton: Princeton University, 1991) p. 254

[331] Stanley Williford. "Blacks Figure in Struggle Over UCLA Center" *Los Angeles Sentinel* August 2, 1973 p. A9

[332] Stanley Williford. "Blacks Figure in Struggle Over UCLA Center" *Los Angeles Sentinel* August 2, 1973 p. A9

"violence has to be studied but I think people are too quick to study minority groups."[333] He added, that "institutionally sanctioned violence" needed to be studied just as much as individual violence, arguing that "if they are going to study the violence of prisoners they should study the violence of prison guards."[334] These statements point to how CMHC leaders understood racism as a root cause to violence.

Invoking the community of mental health professionals anchored at King-Drew Medical Center, Cannon differentiated his research from West by stating that "we here [at King-Drew] feel a study of violence in our community might be best done by ourselves." In a bold pre-emptive move, Cannon announced that "we have formed a violence center which will focus on what are the institutions and what are the elements in American life that produce and encourage violence."[335] Admitting that this center was "still in the planning stages," Cannon's statements gestured to a body of knowledge around structural racism that he and others had been developing since he first opened Central City in 1961. As his statements on violence indicate, Cannon held a more expansive understanding of mental wellness that considered treatment beyond the narrow set of interventions possible between a provider and patient.

Beyond constructing a "comprehensive," linked, and locally accessible mental health universe of acute, rehabilitative, and preventative services, Cannon sought to construct a broader range of social institutions that helped people of color produce one's own sense of identity, one's universe, and one's relationship between identity and universe. The problem, as Cannon and other mental health professionals of color saw it, was that white supremacy denied people of color access to their ancestral pasts, and by extension, their rightful identities. They saw this denial not just in terms of history and culture but in the lack of institutional representation of people of color in everyday civic life. They developed a critique based on the findings of pre-eminent black urban sociologists like E. Franklin Frazier who studied the continued denial of access to an ancestral past in the face of legal freedom in Great Migration cities like Chicago.

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[333] For more on Poussaint, see: Kevin Mumford. (2012) "The Moynihan Report and Homosexual Damage, 1965-1975." *Journal of Policy History* 24:1, 53-73

[334] Stanley Williford. "Blacks Figure in Struggle Over UCLA Center" *Los Angeles Sentinel* August 2, 1973 p. A9

[335] Cannon started the Franz Fanon Research and Development Center as the Chair of Psychiatry at King-Drew Medical Center in 1975. It published a journal, *Fanon Center Journal*.

Sociology and Psychiatry shared in the challenge of addressing segments of the community which were labeled "social problems" such as unwed mothers, wayward youth, prostitutes, drug addicts, homosexuals, criminals, and the homeless. Frazier proposed that these types were a distortion of natural black values and could be accounted for by slavery's historical impact in shattering traditional kinship patterns and a connection to an ancestral past that could provide "resources, traditions, and techniques" to draw from. He argued that "restricted [from] the communication of ideas, the social organization of Negro life and its dominant values act as a social prism through which ideas, patterns of behavior, and values current in the larger American community are refracted and distorted."[336] In other words, he argued that slavery dissolved marriage as a guiding institution and its disappearance was sustained by relief and charity programs that dis-incentivized black male participation in family formation and that left female-headed households prone to being "ground down by poverty" and its children "scattered" and "likely to become delinquent."[337]

Cannon and others linked the effects of ghetto segregation as observed by Frazier as being similar to critiques lodged at asylums. In his first journal article published in 1964, Cannon described "The Psycho-social Effects of Segregation" in similar terms to the way that Erving Goffman described the behavior of patients incarcerated in asylums.[338] Cannon argued that instead of living under the rules of a truly free society, the constraints of living under the rules of a "dominant" white society, led black people to behave according to a white cosmology rather than a black cosmology. He ruled that the resulting psychic split manifested in a "masculine protest" in black males that manifested in "the form of [family and community] desertion, chronic hostility toward female[s], multiple affairs and [the] use of sexuality as a sword and a shield."[339] He concluded that the same psychic split in black women led them to "resent the 'weak' Negro male," be "dominant," displace their "anger upon [their] children," and engage in non-

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[336] E. Franklin Frazier. *The New Negro in the United States* (New York: Macmillan, 1949), p. 8
[337] E. Franklin Frazier. "The Impact of Urban Civilization Upon Negro Family Life" in *American Sociological Review*, Vol. 2, No. 5, Oct, (1937) p. 618
[338] Erving Goffman's *Asylum* (1962) popularized the idea that asylums served as a "total institution" in which "guards" (his term for institutional psychiatrists) acculturated "captives" (his term for patients) not to the social mores of outside society but to a culture of survival dictated by those in charge of the closed institution. See: Erving Goffman. *Asylums: Essays on the Social Situation of Mental Patients and other Inmates.* Chicago: Aldine, 1962
[339] It's clear here that Cannon is working within a Freudian tradition advocated by Alfred Adler.

conjugal relationships with “a series of male figures in the home.”[340] With “no suitable identification” for black children to emulate, Cannon argued that such tension and socially disruptive behavior would be bound to be repeated in children’s adulthood or end in mental illness if left untreated.

These ideas reveal that the “youth programming” in Central City’s services that were described as ancillary to psychiatric intervention were, in fact, a central component to therapy. While Cannon relied on psycho-analytic theory and practices to constitute his methods, the programmatic activities at Central City demonstrate that he also depended on forms of behavioral therapy to condition black citizens to see respectable marriage and family as normal expressions of blackness. It was especially important that black children manifest a healthy desire for blackness in themselves and in their future partners by choosing black lovers. Cannon remarked, for instance, that Central City’s “Teen-Queen” girls club was “based on the idea that black is beautiful.” It’s “stress [on] Afro-American standards of beauty, grooming, and conduct” were meant to “help the young Negro girl build an image of herself that relates to her environment.” Cannon also defended the instruction of boys in karate as “virile sport” that conveyed ideas of “discipline and proper diet” to young black men.[341] Here, both activities staged expectations of desire that youth were expected to fulfill as heterosexuals in their adult life.

To his detriment, Cannon’s overwhelming emphasis on a social world limited to co-ethnics certainly did lead many to mis-read him as a radical racial separatist. These claims, however obfuscate how Cannon considered a solid sense of one’s past and a desire for co-ethnic communion as necessary component features of a new multicultural society. Cannon interpreted the integration of Japanese and Jewish Americans into American society in the 1960s as proof of the benefits of what he called the development and enhancement of an “ancestral core.” He theorized the need for a black process of “re-Africanization” by noting that Japanese and Jewish Americans had achieved their own “comprehensive recognition of the essentiality of ‘core identity’ enhancement” through their efforts to re-build a strong

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[340] Cannon, J. Alfred “The Psycho-Social Aspects of Segregation” in the Journal of the National Medication Association 1964, 56:2 p. 160

[341] Down-to-Earth Psychiatry Helps in Los Angeles Slums. *The Austin American Statesmen* October 10, 1968; B. 1

Japanese and Jewish State after WWII and their considerable investment in cultural preservation schools for their children in the United States.

Unlike African Americans, Cannon argued that they were "not only surviving, but prospering" in a multicultural society because they were able to navigate racial difference by recognizing the stability of their own ancestral cores and that of others. Cannon defined an "ancestral core" as one's "cosmic relation to a people and land,"[342] and believed they were flexible and durable enough to create "the necessary continuity to antiquity and to racial 'beginnings,'" while still enabling individual's to connect one's current space and time with "the mythic and mystical identification with [an] ancestral 'place.'" The overall effect allowed individuals to "relate to [a] racial mission and purpose, frequently in cosmic terms," that did not need a western referent to constitute its power and could be drawn upon by individuals in a diasporic context.

In short, a person connected to his or her ancestral core could feel at peace regardless of the racial contexts in which one lived and worked. Such peace afforded citizens of color not only the clarity to take advantage of new economic opportunities made possible by civil rights and affirmative action statutes but also connected their accomplishments to a racial destiny. Cannon wrote that only "Diasporans" deeply connected with their racial cores have the "spiritual-cultural and racial [context… that] provides for or at least facilitates balance and harmony between one's *eigenwelt*, *mitwelt*, and *umwelt*," Freudian psychoanalytic terms that referred to the seamless connection between one's awareness of the world and their identity, one's cultural environment, and a world centered on self.

Multicultural World-Making

This view that psychiatrists had a role to play outside the clinic as well as inside of it played well into the hands of critics who played up CMHC involvement in community activism as an improper use of public money for political ends. As mental health funding became more compromised with these

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[342] J. Alfred Cannon. "Re-Africanization: The Last Alternative for Black America" in *Phylon*. Volume 38, No. 2 (Second Quarter, 1977) p. 203-210

accusations, Cannon dedicated more and more time to asserting his authority over the institutions not dependent on mental health funding. He had built several of these institutions with anti-poverty program money with the intention that they forwarded the aims of his "Re-Africanization" campaign. He explained that, in order for "blacks to understand, relate to and accept their ancestral 'core,' "close cultural, educational, economic, spiritual and political interaction with their ancestral land base, Africa," needed to be facilitated through institutions locally situated in African American neighborhoods.[343] As such, he argued that the work of mental health professionals needed to go "beyond the narrow confines of psychiatry and other health disciplines" to recruit other disciplines into the work of building a therapeutic public. Looking to the advancement of Jewish Americans and Japanese Americans in architecture, finance, engineering, etc., Cannon argued that "identity enhancement or African 'core' clarification and construction efforts must be joined by historians, archeologists, economists, artists, architects, business experts, spiritualists, educators, behaviorists and health workers."

This perspective explains why Cannon turned to building two cultural arts institutions with anti-poverty funding in the mid-to-late 1960s. In 1965, along with fellow UCLA academic C. Bernard Jackson, Cannon won $300,000 from the Rockefeller foundation to found the Inner City Cultural Center (ICCC), the nation's first multicultural theater center.[344] Then, together with C. Bernard Jackson and Ron Karenga, Cannon founded the black arts-focused Mafundi Institute in 1967. In ensuing years, both centers would continue to operationally sustain themselves under grants from funders such as the National Endowment for the Arts and Model Cities Funding. The programmatic aims of the ICCC and the Mafundi illustrate how Cannon did not conceive of cultural nationalism and multiculturalism as antagonistic to each other but extremely necessary for each to survive.[345]

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[343] J. Alfred Cannon. "Re-Africanization: The Last Alternative for Black America" in *Phylon*. Volume 38, No. 2 (Second Quarter, 1977) p. 203-210

[344] "$300,000 Grant for Inner City Center" *Los Angeles Times,* May 29, 1968 C1. In this article, Cannon states: "Art is the recognized statement of the truth of a people" and theater is the most revelatory of the arts in the "statement of being." It has the ability to speak directly to "the real innards of the people."

[345] For more on the Black Arts Movement and federal funding of urban art programs, see: Daniel Widener. *Black Arts West: Culture and Struggle in Postwar Los Angeles* (Durham: Duke University Press, 2010)

As arts organizations located near to and connected to Hollywood, Cannon ventured to broadcast respectable and dignified representations of people of color at a scale large enough to reach every person of color who owned a television set. Each center acted as a proving ground for talent - acting as a conduit between producers and executives from Hollywood looking to fill casts with people of color and as an job creation engine for citizens from different communities of color. The centers also became well known for showcasing theatrical works for, about, and by people of color with the intention of being picked up in larger more established venues. The Mafundi, in particular, housed youth art programs in "art, drama, music, dance, film making, fencing, and modeling," that exposed black children to African aesthetics and political art.[346]

Through the ICCC and with places like the Mafundi Institute, other racial and ethnic groups replicated their own theater companies, including Teatro Campesino, the East-West Players, and the Bilingual Foundation of the Arts. As the successful careers of George Takei, Louis Gossett, Jr., and Roger E. Mosley demonstrate, the mission of all these centers focused on producing artists who shared in the civil rights and race-affirming messages conveyed in the characters and screenplays that they acted out. It was imperative that multicultural plays of the ICCC demonstrate how a knowing sense of self and ancestry left audiences with a sense of how recognizing and respecting racial difference could help in producing social harmony. To this end, Mafundi plays like Jean Genet's *The Blacks* (1970) and Julius Johnson's *Grits and Guts and Grandpersons* (1972) were meant to move black audiences to action by drawing attention to the injustices of racism or by creating favorable associations with black protagonists who fit the mold of black respectability and desirability. The entire effect of these centers was to create a therapeutic public that mutually reinforced the counseling of therapists of color inside and outside the clinic office.

Ironically, the success of all of Cannon's activities around multiculturalism and community self-determination helped usher in the election of Thomas Bradley as the first African American mayor of Los

[346] This listing appears in an article advertising a fundraiser for the center. "Stars Plan Gala Night to Benefit Mafundi" *Los Angeles Sentinel* December 25, 1969. C2

Angeles while hasten his own fallout with local black leadership. As a councilman, Bradley's mostly black constituent base was less likely to scrutinize his support of Cannon's projects but his election in late 1973 meant that he would be facing conservative and tax payer scrutiny from new constituents outside his council district. Cannon's reputation as a radical black nationalist served as a liability and he was becoming more, not less, vocal about his brand of racial nationalism. As responses to attacks on CMHCs, NIMH began to shift CMHC funding towards drug and alcohol rehabilitation and away from psychotherapeutic programming. Combined with Hollywood's turn towards negative depictions of black life in "blaxploitation" films, this general movement away from re-Africanization led Cannon to re-double his black nationalist efforts.

His black nationalist identity became noticeably more radical by late 1972. According to Mafundi's legal counsel, John Raiford, "a whole new personality came over Cannon."[347] Hazel Stewart, a white Mafundi board member, recalled that, "for some reason, Dr. Cannon began to disassociate himself from the white members of the Board and other members that didn't agree with him."[348] The resulting implosion between Mafundi board members and Cannon resulted in the effective dissolution of the black arts center in 1973. Seeing Cannon's racial separatism and new demeanor as too radical and unpalatable for a general electorate to defend, Bradley withdrew his support of Cannon but maintained fiscal support for the programs constructed by him. By 1975, the "massive deterioration of staff moral, the continuing resignation and exodus of key staff, the demoralization of the Board of Directors, and the pervasive influence [of] Al Cannon" prompted Bradley's staff to devise an action plan to "save the program" by "eradicating the pervasive grip that Al Cannon has on the Board and on that facility."[349] In a memo

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[347] The entire controversy was detailed in the black press. Leanna Ford. "Mafundi Institute Mired in Turmoil: Dr. Cannon 'Acting Like a Dictator'" *Los Angeles Sentinel*. August 9, 1973. A1

[348] Cannon had also just experienced a tremendous loss of control in planning King-Drew's acute psychiatric unit. A funding crisis at Drew led to an incredible infusion of state money in 1972/1973 that was managed by the leadership of UCLA's Medical School. The infusion effectively placed leadership of Drew's capital projects and admission selection process to leadership of UCLA. In effect, Louis Joylon West (Chair of Psychiatry at UCLA) was given final decision making over matters relating to Drew's Psychiatry Department. By this time, West had already been a vocal critic of CMHCs and was already mired in the controversy over the Violence Center.

[349] "Bill Elkins Memo to Mayor Tom Bradley via Emma McFarlin. Subject: Central City Mental Health Facility." Collection 293 Thomas Bradley Collection, Box 3863, Folder 10 Bill Elkins, Central City Mental Health Facility 1974-1975 (Young Research Library, UCLA)

suggesting that the Mayor had directly meddled in the affairs of the Mafundi Institute, Deputy Mayor Emma McFarlin suggested to Mayoral Advisor Bill Elkins and Mayor Tom Bradley that "the same process advised for Mafundi [could] be utilized" for solving the problems at Central City.[350]

Disillusionment

Newspapers noted that Cannon left for Harare, Zimbabwe, in 1983 to "assist in developing a health care system for the new, Black-led government."[351] The country's independence in 1979 coincides with with his change from being the Chair of Psychiatry at Drew Medical School to being the new Chair of International Medicine.[352] These actions indicate that Cannon had felt disillusioned enough by the civil rights and community mental health movement to slowly disown and disassociate himself from it. He had remained in Los Angeles just long enough to see the opening of the Augustus Hawkins Comprehensive Community Mental Health Center at King-Drew Medical Center. (See Figure 6.2) Opened in 1981, the naming of the facility as a "community mental health center" suggests that he was a major architect despite the fact that he was not. Instead of being committed to the community mental health ethos of involuntary commitment, the facility was essentially a facsimile of other acute psychiatric lock down facilities that had persisted after deinstitutionaliztion.

This movement away from the principles of community mental health appears to manifest in all the infrastructure that Cannon had built in the previous decades. Central City had been replaced with a new facility, Kedren Mental Health Center, a facility that more closely matched federal funding initiatives around drug and alcohol abusers and violent offenders. The location of services that had been offered under Central City had also been altered. Under Bradley's leadership those services were now funded by the city as "gang prevention" programs housed in non-profit community based organizations (CBOs). As

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[350] "Bill Elkins Memo to Mayor Tom Bradley via Emma McFarlin. Subject: Central City Mental Health Facility." Collection 293 Thomas Bradley Collection, Box 3863, Folder 10 Bill Elkins, Central City Mental Health Facility 1974-1975 (Young Research Library, UCLA)

[351] F. Finley McRae. Heart Attack Claims Cannon in Zimbabwe. Los Angeles Sentinel March 17, 1988 p. A10

[352] Cannon was replaced by Frank W. Hayes in 1979. Jeanne Spurlock. *Black Psychiatrists and American Psychiatry* (Arlington: American Psychiatric Association, 1999). p. 13

opposed to community mental health's emphasis on prevention, the apparatus of the movement had been altered to focus on mental health intervention in individuals only after trauma had manifested in a violent act or episode.

Throughout the 1970s and 1980s, NIMH funding of CMHCs declined but did not cease. Instead, mental health funding became more selective and more narrowly tailored to special interests. Cannon's disillusionment over CMHCs was therefore not over their disappearance but over the fact that they seemed to be thriving and prospering under new terms that he did not agree with. To those who accepted these new terms, however, the new funding streams stood as a testament to their resolute activism and their ability to maintain a broad mental health coalition that stretched beyond the psychiatric community. In fact, while some funding continued under the auspices of the NIMH, a bulk of new CMHC funding became available through the ascension of new mainstream multicultural politicians who worked on their behalf to keep them operationally alive.

In this regard, its easy to see why critics held such vitriol over the close relationship that CMHCs had to controversial organizations such as the Black Panthers but also to new mainstream multicultural politicians such as Tom Bradley. When Bradley ascended into the Mayor's Office in the mid-1970s, his coalition of community activists included many disciples developed under Cannon and his leadership of Los Angeles' community mental health movement. In the same way that Cannon's activities at the ICCC and the Mafundi Institute empowered many more arts leaders to develop their own cultural spaces, so too did other mental health professionals of color take up Cannon's theorizations of race to apply them within their own community contexts. Cannon did directly propagate his theories and encourage mental health professionals of Latino, Asian, and Pacific Islander descent to build their own mental health infrastructure and therapeutic publics as the program head for UCLA's Program in Social and Community Psychiatry. As the 1960s progressed into the 1970s, these Asian American, Pacific Islander, and Latino mental health

professionals increasingly benefitted from the influx of Asian, Pacific, and Latino immigrants now living streaming into the city.[353]

Despite having reservations about the efficacy of CMHCs, the virtual absence of mental health infrastructure in new immigrant neighborhoods of the 1970s convinced enough leaders in the NIMH to continue CMHC funding to immigrant neighborhoods exclusively. In 1972, the NIMH seeded the infrastructure to reproduce Central City's "community service center" model under the auspices of the Mental Health Task Force on Asian Americans and Pacific Islanders and the Mental Health Task Force on Spanish-Speaking Americans.[354] As Cannon did, these Task Forces affirmed certain racial identities centered on respectable marriage and family and productive participation in the economy as true expressions of race while regarded sexual promiscuity, homelessness, criminal behavior, drug abuse, and violence as evidence of pathology. They did not regard this pathology as biologically determined but instead referred to its manifestation as evidence of the role that white supremacy played on producing a "ghetto/colonial/ barrio" mentality or as "internal colonialism."[355] Using the "community service center" model piloted at Central City, each task force focused on the increased recruitment of mental health professionals within their communities and the development of a suite of CMHC-like institutions.

The Asian American and Pacific Islander Task Force, for example, implemented the Asian American Mental Health Training Center (AAMHTC) in Los Angeles under the direction of Filipino American Licensed Clinical Social Worker, Royal "Uncle Roy" Morales which ran from July 1972 to

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[353] Mae Ngai details the various routes (1965 Immigration Act, Refugee Status, and Unauthorized Entry) by which this new immigration pattern from Asia and Latin America was constructed. See: Mae Ngai. *Impossible Subjects: Illegal Aliens and the Making of Modern America* (Princeton: Princeton University Press, 2004)

[354] See: Proceedings, First National Conference on Asian American Mental Health, San Francisco, April 27-19, 1972; and, Spanish-Speaking Conference on Mental Health, Chicago, June 8-10, 1972. Royal F. Morales Collection Subject File "A," Folder 1: Asian American Community Mental Health Training Center - Conferences, Box 3 (Asian Reading Room, Library of Congress)

[355] Drawing from E. Franklin Frazier, Abram Kardiner, Bertram Karon, and Thomas Pettigrew, mental health workers of color produced several different terms to describe psychic states related to racism. Psychiatrists Cannon and Pouissant favored "black psyche" while Social Workers like Filipina American Juanita Tamayo Lott ("Migration of a Mentality," *Social Casework,* 1976) and the The Black Task Force of the Council on Social Work Education (1972) preferred the terms "internal colonialism." The term "ghetto mentality" was first applied to Jewish and Catholic communities prior to the 1950s and continued to have currency in popular discussions around poor behavior.

June 1982.[356] Unlike Central City, the goal of AAMHTC was to act as a resource for Asian American and Pacific Islander mental health professionals to develop new talent and to place them in existing CBOs. The placement of trained mental health professionals in existing CBOs such as Search to Involve Pilipino Americans (SIPA), the Chinatown Service Center, United Cambodian Community, Korean Youth Center, and the Japanese Pioneer Center essentially re-made each community organization into a CMHC. The AAMHTC also fulfilled the vision of Department of Mental Health Director Harry Brickman to enrich the capacity of community organizations while identifying and referring new mental health cases to the appropriate service. For the Asian American community, in particular, the AAMHTC allowed different ethnic groups to develop their own distinct ethnic identities while constructing a "Pan-ethnic" Asian identity that mirrored broader multicultural paradigms.

Many CBOs, including the CBO that Morales oversaw himself, SIPA, directly borrowed from Central City's programming. Morales described SIPA as a "Youth Diversion Model" that utilized a mix of "counseling services, job development projects, recreational activities, a summer employment program and a summer recreation program," to encourage Filipino American youth away from gang related activity.[357] The CBO achieved youth participation by developing a repertoire that upheld knowing one's ancestral past and good citizenship as desirable modes of citizenship by mixing workshops on cultural dance, music, theater, language, craft-making, and history with activities centered on do-gooding such as neighborhood clean-up days, graffiti removal sweeps, and soup kitchen service.

By 1982, however, resumed attacks on NIMH funding to CMHCs ceased funding to the AAMHTC. By then, however, the power of Bradley's mayoral administration had grown and stabilized precisely because of the deepening relationship between CMHC infrastructure and his office. Many of these CBOs served as extensions of the mayoral office, consolidating the liberal progressive multicultural agenda in ways that complemented Bradley's Democratic coalition. Faced with the possible dissolution of

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[356] My descriptions of the AAMHTC come from the Asian American Mental Health Training Center Final Report July 1972 - June 1978. Royal F. Morales Collection Subject File "A," Folder 5 Asian American Mental Health Training Center Box 2 (Asian Reading Room, Library of Congress)
[357] SIPA, Inc. Fall 1984 Pamphlet. Royal F. Morales Subject File "S", Papers Box 15, Search to Involve Pilipino Americans (Asian Reading Room, Library of Congress)

this embedded political infrastructure, Bradley acted quickly to assemble temporary funding solutions in order to buy time to secure a more insulated funding stream. As indications of these streams, SIPA won two consecutive operational grants from 1982-1983, a "Community Services Grant" and "Community Development Grant" totaling $100,000 from the City of Los Angeles in 1982 and a "County Justice System Program" from the County of Los Angeles in 1983. Both programmatic agendas capitalized on taxpayer support for policing and prisons by converting the language of mental health prevention into anti-economic deterioration and youth delinquency programs. Despite the fact that these allocations paled in comparison to prison and policing budgets, Bradley and CBO leaders defended these programs as liberal alternatives to aggressive disciplinary policing approaches.

Fearful that conservative critics would eventually attack these programs as ineffective anti-crime programs and play up their effectiveness in lubricating the Democratic political machine, Mayor Bradley engineered a new method to fund CMHCs disguised as CBOs. In exchange for tax breaks to transnational corporations looking to do business in Los Angeles like the Shuwa Corporation (then owners of ARCO and the Bank of America Tower), Bradley instructed corporate owners to make a large donation to the United Way as part of the city's "corporate accountability" campaign.[358] Bradley then used the infusion of capital into the United Way as leverage to change the internal governance structure of the United Way. By mirroring the multicultural governance model of the city, Bradley effectively engineered the funneling of corporate money to CMHCs cast as non-profit CBOs. In 1985, the United Way's new multicultural

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[358] "On July 29th, Shuwa Corporation sponsored a luncheon honoring Mayor Bradley. Mayor Bradley called for the Japanese businessmen and companies operating in the United States to be good corporate citizens by participating in the local activities such as the United Way. He explained that the U.S., state, county, and city governments can do just so much to assist those citizens in need of assistance. In order to achieve political, social, and economic stability, businesses and citizens who can help should aid the citizens, businessmen and companies to operate in a stable political, social, and economic environment. Major upheavals and riots in the political, social, and economic areas mean less profit for the business because energy that could be spent productively towards making a profit will be directed towards resolving and stabilizing the upheavals and riots. Mayor Bradley asked Jeff Matsui, Senior Deputy to the Mayor, to assist the United Way in getting the overseas copanies doing business in Los Angeles to participate in and assist the United Way" Memorandum From Frank Watase to United Way Asian Pacific Research and Development Council Members August 10, 1987. Royal F. Morales Papers, Subject File "U", Box 1, United Way (Asian Reading Room, Library of Congress)

model effectively sustained the operations of gang prevention programs under CBOs such as the Filipino American-based SIPA and the African American-based Esquire Boy's Club.[359]

Certainly by Cannon's departure in 1983, the die had already been cast in terms of the direction of CMHCs. While the programmatic aims of CMHCs-turned-CBOs preserved many of the practices that Cannon supported, the ideological underpinnings of its new funding streams depended on the continued valuation of youth crime as a racial problem. In other words, in order to preserve themselves as institutions in the community, CBOs had to continue to depend on the wider social perception that youth of color were inherently inclined to pathology. It was necessary for programs like SIPA to claim that the youth participating in their programs were already delinquents who needed the custodial care of the program to rehabilitate them from criminal activity whether it was real or imagined. The ethical quandary underlying this orientation explains, in part, why Cannon had become so disillusioned by the comprehensive mental health network he had built.

Reconsidering the Contributions of Community Mental Health Centers

The United Way's support of CMHCs-turned-CBOs who fulfilled the public policy craze over gang prevention programs demonstrates that funding of community mental health practices continued well beyond the 1980s. This fact points to a greater need to re-conceptualize and re-think the periodization of the community mental health movement. Certainly, this shift does indicate the rise and decline of psychiatrists involved in the community mental health movement and their eventual replacement by unexpected actors. In the case of Los Angeles, neuroscience and psychotropic drug research appears to have drawn the psychiatric community away from the community mental health movement while anchoring the disciplines of psychology, social work, and behavioral therapy deeper in its methods. Another unexpected outcome was the absolute leadership of politicians of color who worked tirelessly to

[359] Allocations '86: Highlights of United Way's 1986-87 Allocations Process. Royal F. Morales Papers, Subject File "U", Box 1, United Way (Asian Reading Room, Library of Congress)

apply its theory and sustain its organizational vehicles despite a considerable amount of dissent within the psychiatric community.

Cannon's self-exile also leaves us with a more sobering assessment of the movement. Whereas the movement began brimming with the possibility of abolishing one long-standing coercive and inhumane institution - the asylum - the movement's transformation during the 1970s and 1980s adapts to the rising strength of an equally damaging institution - the prison. Here, the desire to prevent the incarceration of people of color in the asylum ends with a range of mental health services that appear complicit with the incarceration of people of color in penal institutions. This phenomenon in and of itself does not appear to be antithetical to the theorizations of race propagated by CMHC activists. By normalizing *some* racial identities based on respectable marriage and family as natural expressions of race, Cannon's theorizations shared in condemning racial identities that countered these expectations as pathological.

It's here where community mental health's biggest contribution to social conceptions of mental wellness lay. Although, certainly, some may see the persistence of biological racism at work in counting the failures of the community mental health movement, the community mental health movement was successful in producing a new way of looking at race. Cannon and others helped construct the belief that some citizens of color could be counted as mentally well for their membership as part of a "multicultural" and cosmopolitan class while others could be simply counted as mentally ill members of a "permanent underclass." Thus, the new social policy terms of the 1980s such as "new homelessness," "working poor," and "immigrant isolation" can be read as new articulations of where those living outside of a "multicultural" society were presumed to be contained.

This interpretative framework explains how Los Angeles' first African American and longest presiding mayor oversaw the largest unprecedented growth of prisons and policing in a city that Cannon himself stated had "one of the more 'enlightened' systems" of justice.[360] In the terms cast by Cannon, Bradley simply saw his policies as upholding the rights of citizens he considered "truly black" and "truly

[360] J. Alfred Cannon. "Re-Africanization: The Last Alternative for Black America" in *Phylon*. Volume 38, No. 2 (Second Quarter, 1977) p. 203-210

multicultural" from those he considered "truly criminal." Still, Cannon's polemical assessment that opens up this article, that, "Black males are being institutionalized at an alarming rate and are presently, as environmentalists might say, an endangered species," gives pause to consider how he was troubled by the contradictions of racial liberalism that he himself had helped promote.

Here, Cannon reveals an optimist view of mental illness that cannot be reconciled with a more pessimistic view. From the perspective of Cannon, his therapeutic vision held the visionary possibility that every black soul and psyche could be reformed through a hygienic public that produced every citizen as non-violent. From the perspective of Bradley, however, a more pessimistic view emerges - that the law can and should protect those who demonstrate themselves as such while work to contain those who demonstrate themselves to be otherwise.

Figure 6.1 J. Alfred Cannon, MD

Figure 6.1 Inaugural Chair of Psychiatry, Dr. J. Alfred Cannon. This portrait, painted in 1972 by Lyle Suter hung in the lobby of the Central Community Mental Health Center.

Source: Lyle Suter website (http://www.lylesuter.com/central-city-community-mental-health-center/)

Figure 6.2 Augustus Hawkins Community Mental Health Center

Figure 6.2 Augustus Hawkins Community Mental Health Center was opened in 1981. The final design was rendered and constructed by Carey Jenkins, the same architect who designed King-Drew and the Hubert Humphrey Comprehensive Health Clinic.

Source: Jenkins/Gale and Martinez, Inc. (http://www.jgminc.com/medical.html)

Chapter Seven
Poor Influences and Criminal Locations: Los Angeles' Skid Row, Multicultural Identities, and Normal Homosexuality

On July 22, 1984, *Los Angeles Herald Examiner* reporter, Tony Castro re-introduced Los Angeles residents to a new skid row through the lives of a group of Lesbian, Gay, Bisexual, and Transgendered (LGBT) Black and Latino women and trans people that the Los Angeles Police Department (LAPD) referred to as "the Dragons."[361] Emerging nightly in droves on Sixth Street between San Pedro and Central Avenues at 2 am, Castro described the "tall, leggy" Dragons as "a different type of prostitute," one that was "on the increase" in Los Angeles. He wrote, "they are not women but male transvestites - drag queens" and that, "while there are real women prostitutes in the area," the Dragons both outnumber them and are "moving in on" the prostitutes who work along Seventh Street. Most notably, the newspaper and the police both linked the "Dragons" to drug dealing, particularly heroin, which the police claimed, "invariably…lead[s] to violence in the area." As Detective William Adrian put it, "almost every other murder down here is alcohol and drug related."

The article was meant to familiarize citizens with "new homelessness" and a "permanent underclass," two interrelated phenomena that named residents like loiterers, rowdy teenagers, drunks, prostitutes, and the mentally disturbed as destabilizing and violent forces that required new "broken windows" policing to contain and eradicate social disorder.[362] Castro mentioned that such efforts to police the "Dragons" were particularly important given the city's upcoming role as host to the 1984 Olympic Games. As other cities had in gearing up for the international sporting event, citizens had tacitly given city officials license to forcefully remove or displace the city's undesirables.[363] Police overfilled city and

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[361] Tony Castro. "Prostitutes take refuge in the shadows of skid row: Poor urban slum becomes city's newest hotbed of vice." *Los Angeles Herald Examiner*, Sunday, July 22, 1983. Bunker Hill Redevelopment Project Records, Collection no. 0226, Regional History Collection. Box 6, Folder 1, "Skid Row Press Clippings" (Special Collections, University of Southern California) Page 2-3

[362] This article and the phrasing I use here is heavily indebted to discussions and conversations between the author and Christina Handhardt, particularly over Handhardt's "Broken Windows at Blue's: A Queer History of Gentrification and Policing" in *Policing the Planet: Why Policing Crisis Led to Black Lives Matter.* Jordan Camp and Christina Heatherton (eds.) (New York: Verso, 2016)

[363] For a comprehensive and detailed analysis of gentrification in Olympic cities, see: Centre on Housing Rights and Evictions (COHRE). "Fair Play for Housing Rights: Mega-events, Olympic Games and Housing Rights,

county jails with known alcoholics, the homeless, and suspected criminals immediately before and throughout the entire duration of the games.[364]

As Castro's article strove to illustrate, the policing of black and brown LGB and trans people from the city's nightlife corridors outside of skid row only seemed to work to deposit them inside the neighborhood. What Castro failed to mention in his article was the City's new special policy around Skid Row/City Central East that accounted for the limited economic development and restrained use of law enforcement in the neighborhood.[365] This policy, known in 1984 as the containment and mitigation policy, brokered a "peaceful coexistence" between the city's outlying multicultural, cosmopolitan, and family-oriented neighborhoods and a skid row designed for a permanent underclass that could not be immediately absorbed into prisons or state hospitals.[366] As opposed to the policy, Castro's article focused on a flustered LAPD, whose patrolmen stated that the crafty ability of the "Dragons" "to disappear into hotel doorways at the sight of a 'suspicious' car," and their own inability "to get a male police officer to dress up in women's clothes" as the main reasons why solicitation crack downs elsewhere were not as successful in skid row.

As Castro's account attests, broken windows policing brought together the economic processes of gentrification, policing, and prisons right up to the perimeters of skid row, but inside the neighborhood, the City guided its urban policy from a very different economic process - mental health

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Opportunities for the Olympic Movement and Others" (Geneva: COHRE, 2007), and; Dave Zirin. "Want to Understand the 1992 LA Riots? Start with the 1984 LA Olympics" in *The Nation*. April 30, 2012. https://www.thenation.com/article/want-understand-1992-la-riots-start-1984-la-olympics/ accessed December 28, 2016.

[364] Kevin Roderick of the *Los Angeles Times* detailed the effects of police sweeps leading up to and during the games. See: "Los Angeles Polishing Its Image for Olympic Visitors: Horse Patrols Ride Herd on Transients." *The Los Angeles Times*. July 21, 1984, p. 8, and, "Derelicts Lose the Precious Little in Sweep by City Crew", *The Los Angeles Times.* August 2, 1984, p. 3.

[365] The City officially referred to the section of the city as City Center East but also referred to the neighborhood by its more common name, skid row.

[366] In 1991, the City summed up the "Policy Objectives" of the containment and mitigation policy as such: 1. "To maintain and preserve the existing housing stock [of] Single Room Occupancy (SRO) Hotels … [for] the very low income and nearly homeless population." 2. "The stabilization of the residential community and the provision of social services for the local population." 3. "Maintaining a 'peaceful' coexistence between the residential and the commercial business communities." Central City East - Central Business District Redevelopment Project. Briefing Report. May 1991 Bunker Hill Redevelopment Project Records, Collection no. 0226, Regional History Collections. Box 5, Folder 12. (Special Collections, University of Southern California) p I-2 - I-3

deinstitutionalization. Generally, deinstitutionalization, the psychiatric movement to abolish involuntary commitment of the diagnosed mentally ill in asylums has been accepted as a process that exacerbated the effects of deindustrialization, the shift from a manufacturing economy to a new so-called "service" economy that resulted in high un- and under-employment, crime, and "street people." My chapter re-reads de-institutionalization from the viewpoint of civil rights and gay rights activists who saw the movement as working towards the opposite effect. Instead of leading to new homelessness, they saw deinstitutionalization as its other name – the community mental health movement - as both a social movement and as an economic development program capable of combating poverty and mental illness while auguring those formerly outcast by race and sexuality into the promise of democratic and capitalist progress. It was necessary to demonstrate these values not just in rhetoric but in space by building healthy black and gay communities that could lift the stigma of mental illness from them.

I argue the development of a containment and mitigation policy around skid row illustrates the dark consequences of the racial liberalism forwarded by some civil rights and gay rights activists after they assumed greater leadership of city resources and community development plans starting in 1973 with Tom Bradley's election as the first African American mayor of Los Angeles. Inspired by mental health theories developed in the 1960s that affirmed certain representations of black and homosexual identity as "healthy" and "respectable" while diagnosing certain modes of racial and sexual expression as "sick" and "undesirable," the economic development policies implemented by these activists supported the ostracization of queer people within black communities and gay communities into skid row.

Here, I use the term "queer" as Cathy J. Cohen does, as an umbrella term to name a range of identities that counter normative expectations. In this respect, skid row's geographic space permits a reading of figures normally read for their hyper- and hetero-masculinity - the absent and unemployed father, the homeless drunk, and the gang member - as objects of the same queering effect that Cohen argues queers black and brown welfare mothers and those living with AIDS.[367] In short, I am interested in

[367] Cohen has two significant works that discuss this queering effect. She discusses "cross-cutting" explicitly on pages 13 and 14 of *Boundaries of Blackness: AIDS and the Breakdown of Black Politics* (Chicago: University of

how deinstitutionalization's focus on "compulsory heterosexuality" and "compulsory able-bodiedness" aimed to define mental "wellness" as productive citizenship via respectable marriage and family and wage labor participation in the formal economy over the no work or illicit work of places like skid row.[368] In this way, deemed unable to biologically reproduce, rear ideal citizen-subjects, or labor in socially acceptable ways, the residents in skid row were not just queer but, as Robert McRuer would argue, also "crip" for the ways they failed to fit within a prevailing moral and economic system of ability.[369]

The momentary capture of "the Dragons" in skid row thus brings two prominent fields of queer studies - queer of color critique and crip theory - into deeper conversation with each other to demonstrate how power is routed through race, sexuality, class, and disability to constitute each other.[370] That is, rather than reify the normalizing processes that produce race, sexuality, and disability as discrete and distinct from each other, the hyper-visible rendering of "the Dragons" in marginal spaces like skid row accounts for the entanglement of all three processes. As C. Riley Snorton argues, "part of what informs media representation of [black sexuality] is an assumption - a popular, long-held myth - that both the truth of race and the truth of sex are obvious, transparent, and written on the body."[371] Here, the myth that all blacks are properly heterosexual, that all gays are white, and most of both are able, makes the "Dragons"

Chicago, 1999) and as a condition for alternative forms of coalition in "Punks, Bulldaggers, and Welfare Queens: The Radical Potential of Queer Politics?" in *GLQ*, Vol. 3, p. 437-465.

[368] Robert McRuer defines compulsory able-bodiedness in "Compulsory Able-Bodiedness and Queer/Disabled Existence" In Lennard J. Davis, ed. *The Disability Studies Reader*. 2nd ed. (London: Routledge, 2006) p. 91. Adrienne Rich defines compulsory heterosexuality in "Compulsory Heterosexuality and Lesbian Experience" in *Signs: Journal of Women in Culture and Society,* 1980, Volume 5, Issue 4, pp. 631-660.

[369] For more on Crip theory, see: Robert McRuer. *Crip Theory: Cultural Signs of Queerness and Disability*. (New York: New York University Press, 2006)

[370] For more work on queer of color critique, see: Grace Kyongwon Hong and Roderick Ferguson, eds. *Strange Affinities: The Gender and Sexual Politics of Comparative Racialization*. (Durham: Duke University, 2011); Chandan Reddy. *Freedom with Violence: Race, Sexuality, and the US State* (Durham: Duke University, 2011); Jodi Melamed. *Represent and Destroy: Rationalizing Violence in the New Racial Capitalism* (Minneapolis: University of Minnesota Press, 2011); Nayan Shah. *Stranger Intimacy: Contesting Race, Sexuality, and the Law in the North American West* (Berkeley: University of California Press, 2012); and Siobhan Somerville. *Queering the Color Line: Race and the Invention of Homosexuality in American Culture* (Durham, Duke University Press, 2000). For work that informs my use of crip theory, see: Robert McRuer. *Crip Theory: Cultural Signs of Queerness and Disability*. (New York: New York University Press, 2006); Rosemarie Garland-Thomson. "Misfits: A Feminist Materialist Disability Concept" in *Hypatia*. Vol. 26, No. 3 (Summer, 2011); Nirmala Erevelles. "Disability and the Dialectics of Differences." in *Disability and Society* 11.4 (1996); Julie Livingston. "Insights from an African History of Disability" in *Radical History Review*. Issue 94 (Winter, 2006) 111-26.

[371] C. Riley Snorton. *Nobody is Supposed to Know: Black Sexuality on the Down Low* (Minneapolis: University of Minnesota Press, 2014) p. 12

appear as queer for the ways that they continue to counter normative expectations of affirmed categories of difference. More importantly, by tracing how actors colluded to use politics and medicine to craft what others have termed the "hyperghetto" its possible to imagine new ways of organizing new political coalitions to create and imagine a different space entirely.[372]

The Containment and Mitigation Policy as Identity Politics

As a social movement, deinstitutionalization reached its apex in California with the passage of the Lanterman-Petris-Short Act (LPS) in 1967 (Cal. Welfare & Inst. Code, sec. 5000 et. seq.), which mandated the closure of its state hospital system and full replacement of care by County and private operators by 1973.[373] Capturing the zeitgeist of health rights as integral to civil rights and women's rights, mental disability activists championed LPS as legislation that transformed "patients" under the authority of the state and of physicians into "consumers" empowered by choice and the free market.[374] Unless observed to be imminently harmful to oneself or to others, clinicians were legally required under LPS to release patients into a less- or non-restrictive treatment setting of their choosing. Patients could thus refuse care and ask for unsupervised release into the community as a legal option without recourse.

As an economic process, deinstitutionalization's diagnose-and-release mechanism was meant to jump start new careers and profit centers focused on mental health because it assumed that rational patients and their families would seek, demand, and pay for help to treat their illnesses.[375] De-industrialization mixed with de-institutionalization's legal onus to make mental health treatment the

[372] For more on the hyperghetto, see: Eric Tang. *Unsettled: Cambodian Refugees in the NYC Hyperghetto*. (Philedelphia: Temple University Press, 2015) and Loïc J.D. Wacquant. "Deadly Symbiosis: When Ghetto and Prison Meet and Mesh." *Punishment and Society*, no. 1 (2001): 95-133; From Slavery to Mass Incarceration." *New Left Review* 13 (January-February 2002): 41-60; and, *Punishing the Poor: The Neoliberal Government of Social Insecurity*. (Durham, NC: Duke University Press, 2009)
[373] The law was unsuccessful in reaching its mandate to close all state hospitals. State hospitals were kept open but were considerably altered to treat only the most severe research cases of mental illness.
[374] As Nancy Tomes shows, this demand to see people as consumers rather than patients was a shared perspective amongst civil rights activists. See: "Patients or Health-care Consumers? Why the History of Contested Terms Matters" in *History and Health Policy in the United States: Putting the Past Back In.* Rosemary Stevens, Charles Rosenberg, Lawton Burns (eds.) (New Brunswick: Rutgers, 2006) 83-112
[375] For an analysis of deinstitutionalization as economic process see: Joseph P. Morrissey, Howard H. Goldman, and Lorraine Klerman. "Cycles of Institutional Reform" in *Mental Health Care and Social Policy.* Phil Brown, ed. (New York: Routeledge, 1985) p. 70-98

responsibility of the mentally diagnosed, however, created a new range of liabilities for the poor individual, especially those of color, who lacked the resources to manage such diagnoses on their own. It also created a new context for liability for the families of the diagnosed, who now had to choose between managing the diagnosis of a loved one with scant resources or accept the responsibility of allowing a family member diagnosed with a potentially violent illness to remain in the household.

Widespread perceptions that city leadership was doing a poor job in responding to the crisis of mentally disturbed "street people" created new opportunities that new political coalitions exploited. In late 1973, Los Angeles citizens rejected incumbent conservative Democrat Sam Yorty for a new liberal progressive mayor, Tom Bradley. Bradley would govern the city for an unprecedented 5 terms from 1973 to 1992. Citizens were initially attracted to his profile as a former LAPD patrolman and his experience in dealing with mental health issues as a popular City Councilman. Instead of depending solely on the disciplinary tactics of the police to create safe and healthy neighborhoods, Bradley's methods also heavily relied on exploiting citizens' desire to produce city space that affirmed their presence in the metropolis.

Solving the city's homeless and mental health crisis was thus critical not only to white middle class constituents who voted in hopes that Bradley could fix the crisis but was also important to civil and gay rights leaders who were eager to progress the development of their own neighborhoods in the city. Strangled, however, by taxpayer resentment for public services and by LPS' mandate, Mayor Bradley devised a solution that did not require the building of new and expensive city-supported mental health and homelessness services. In 1976, Bradley formalized a policy to re-design skid row as a destination for the diagnosed mentally ill, unemployed, and homeless to live freely and away from society *by their own choosing*. The policy essentially accepted and enhanced the character of skid row as a proper place for the homeless, loiterers, and the mentally ill so that areas outside of skid row could economically develop unobstructed. Skid row had long been a neighborhood for transient laborers and wayfarers since the late nineteenth century because of its high density infrastructure of Single Residency Occupancy (SRO) hotels and the new policy worked to keep it that way.

The City had halted demolition of SRO housing in 1967 to conduct a series of social science investigations to determine a new appropriate policy that did not encourage the dispersal of the homeless into newly gentrified areas of the city.[376] By the time Bradley assumed office, these reports had helped city planners understand that deinstitutionalization was not the only phenomenon at work in creating homelessness. The city noticed that the increased number of mentally ill residents in skid row were also matched by an increased number of people they described as substance abusers, ex-felons, and women living alone. The City used these observations as evidence that the neighborhood was being used as a "half-way" home for those unwanted in formal custodial institutions (state hospitals, jails, and other detention centers) and in their own "home" communities.[377] Essentially, the City interpreted the increased number of chronic mentally ill, workers chronically unable to find stable work, and the working poor as proof that skid row was growing not only because of deinstitutionalization but also because of the effects deindustrialization.

Bradley used these reports to craft what the City initially referred to as the rehabilitation and mitigation policy which accelerated the preservation of SRO and homeless shelter infrastructure and encouraged the development and concentration of indigent services in skid row. City technocrats characterized the City's position as an enlightened alternative to past policies. "Slums were things to be 'cleared' … [but] today, this approach is generally considered short-sighted, and inhumane" since it

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[376] Several of these reports, including: Social Impact Evaluation – Central City East (1976); The Changing Face of Misery (1988); To Build a Community (1988); Briefing Report - Central City East (1991) can be found at the Bunker Hill Redevelopment Project Records, Collection no. 0226, Regional History Collections. Box 5 and 6 (Special Collections, University of Southern California). The city's initial reports conducted in 1969 by Robert Vander Koi of the University of Illinois and by Dr. Blumberg of Philadelphia were not saved but summarized in its 1978 Social Impact Evaluation Report.
[377] Leaning on reports conducted in 1969 by Robert Vander Koi, the City saw that "the streets of Central City East could serve as a 'half-way' community for the indigent residents of the central city." (p 5) This idea was evidently spurned from direct observation of the rise of neighborhood's black men: "In 1969 approximately 23% of the men observed in Central City East were black (cf. Both the national Census and the Vander Koi survey research work). In the current population 30-35% of the men are black, many of whom are younger, and are not in Skid Row for traditional reasons. Often, they are not dependent on casual labor opportunities but rather using the area as a 'half-way community' between prison and their home neighborhood." (p 7) Bunker Hill Redevelopment Project Records, Collection no. 0226, Regional History Collection. Box 5, Folder 16, "Social Impact Evaluation of Central City East: Study of the Central Division Facility Police Building Impacts on the Skid Row Community 1978" (Special Collections, University of Southern California)

would leave no viable housing option for the "adult Los Angeles resident who will either be *forced to* or *prefer to* live in what most of the citizenry would regard as unacceptable conditions." (emphasis mine)

What is significant about the policy is that Bradley's administration defended the concentration of the homeless in skid row as a method to enhance the rights of the homeless as a protected citizen class. In fact, the City argued that, "a policy focused solely on making a geographic area like Skid Row the site of more prosperous and economically productive activity *undervalues the social productivity involved in preserving and improving the living places* of very poor people, many of whom are also afflicted by a host of other debilitating problems."[378] (emphasis mine) Here, the city encouraged citizens living in skid row to identify, desire, and self-fashion an identity as "homeless" and "debilitated" in order that they might socially produce advocacy mechanisms and services that could recognize their needs as such.

These statements reveal that Bradley's administration actually conceived of its policy as a community development scheme that upheld the rights of homeless citizens that also developed the economic interests of a new homelessness industry made up of mental health service providers, social workers, SRO owners, shelter operators, and soup kitchens that attended to homeless lifestyles. In exchange for subsidies and grant assistance programs, the city encouraged homeless businesses to relocate and ring the perimeter of a new modern skid row. In place of walls or restraining straps, the city capitalized on the wide latitude taxpayers gave the city to increase the city's police squad. In 1975, the City built a new police sub-station at the northwestern end of skid row and staffed up its policing squads to contain residents in a 50-block area between the police station and the Los Angeles River to the east.[379] (See Figure 7.1)

The City knew these policies would increase both the number of homeless in the neighborhood and the rate of violence in it. From 1970 to 1986 skid row's nighttime population had doubled from ~6,000 residents to 11-12,000 residents. As expected, business owners not protected as part of the homelessness

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[378] Bunker Hill Redevelopment Project Records, Collection no. 0226, Regional History Collection. Box 5, Folder 14, "Changing Face of Misery" (Special Collections, USC Libraries, University of Southern California) p. 51
[379] Bunker Hill Redevelopment Project Records, Collection no. 0226, Regional History Collection. Box 5, Folder 16, "Social Impact Evaluation of Central City East: Study of the Central Division Facility Police Building Impacts on the Skid Row Community 1978" (Special Collections, University of Southern California)

industry complained bitterly about their safety and ability to conduct business. Paul Huh, general manager of the Pacific American Fish Company, for instance, complained to Castro that "Mayor (Tom Bradley) and the city have tried cleaning up the city and cracking down on prostitution but I think all they may have succeeded in doing is driving it down here." Huh later revealed that even sophisticated organized efforts by non-homeless industry businesses had done nothing to turn the City away from its policy, showing that the City was committed to making the district a homeless "outdoor detention camp."[380]

Castro's article, however, did highlight a troubling pattern that prompted city officials to clarify their policy in 1984. Huh's business sat a block away from Para Los Niños, "a day-care center for neglected and abused children and youths."[381] The center catered to a rapidly increasing number of Central and South American families now living in the cramp quarters of SRO housing. Declaring that "Skid Row is no place for children," the City renamed its policy the containment and mitigation policy to highlight the intended character of the neighborhood as a place for single unattached adults.[382] In an unprecedented move to service a population that city officials suspected or knew outright was largely undocumented, the City authorized new funding initiatives to relocate immigrant families outside of the district into areas deemed more suitable for children.[383]

The containment and mitigation policy illustrates the extent to which the City went to consciously enforce skid row as a queer space for citizens that Treva Ellison has termed "serviceable but unprotectable."[384] In this regard, the City's efforts to police in black and brown LGB and trans people and ferret out immigrant families to other areas of the city point to a curious spatial logic of consolidating a

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[380] Michael Dear and Jennifer Wolch. *Malign Neglect: Homelessness in an American City.* (San Francisco: Jossey-Bass, 1994)

[381] Tony Castro. "Prostitutes take refuge in the shadows of skid row: Poor urban slum becomes city's newest hotbed of vice." *Los Angeles Herald Examiner*, Sunday, July 22, 1983. Bunker Hill Redevelopment Project Records, Collection no. 0226, Regional History Collection. Box 6, Folder 1, "Skid Row Press Clippings" (Special Collections, University of Southern California) Page 2-3

[382] Bunker Hill Redevelopment Project Records, Collection no. 0226, Regional History Collection. Box 5, Folder 14, "Changing Face of Misery" (Special Collections, USC Libraries, University of Southern California) p. 54

[383] Cindy I-Fen Cheng. Paper Presentation. "From Sanctuary to Skid Row: Governmentally and the Resettlement of Central Americans in Los Angeles" University of Southern California Center for Transpacific Studies Lecture. November 18, 2014, Los Angeles, California.

[384] Treva Ellison. Paper Presentation. "In the Business of Misery: Race, Policing, and Making 'Gay LA,'" The American Studies Association Meeting, October 8-11, 2015. Toronto, Canada

range of queer figures that countered normative expectations around kinship and wage labor into one district while protecting space elsewhere for families and productive wage earners. As the city's caution against undervaluing the social productivity of this underclass shows, the city strategically placed mental health and social services around them to a accentuate their identity as a class of "street people" that, under any other spatial context, would have little protection.

The Hidden History of Community Mental Health

The containment and mitigation strategy borrowed from and altered a pattern of concentrating mental health and social service programs that had been developed by community mental health activists in the 1960s. A a rule, scholars use the appearance of homelessness in unexpected neighborhoods and its increase in places like skid row in the late-1970s as a historical point to mark the end of the community mental health movement. Many, including those in the mental health universe, attributed the rise in homelessness to the entire mental health industry's "wholesale neglect of the mentally ill, especially the chronic patient and the de-institutionalized.[385] Tom Bradley's use of community mental health logics to create skid row, however, suggests that the base of the movement shifted away from a formal mental health world of research and clinics into a realm governed by the logics of urban planning and political economy.[386]

The prevailing narrative of the movement's death also occludes how shame around homelessness turned mainstream psychiatry against community mental health activists and the main locus of their work, community mental health centers (CMHCs). These centers first appeared as a result of National Institute of Mental Health (NIMH) funding after President Johnson passed his 1965 amendments to the Community Mental Health Center Act of 1963 (PL 88-164). Shortly after the 1965 Watts Riots, Dr. J.

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[385] Gerald Grob. *From Asylum to Community: Mental Health Policy in Modern America* (Princeton: Princeton University, 1991) p. 257

[386] Scholars in the History of Psychiatry will recognize this pattern amongst many other institutions that exist beyond the reach of mental health governance but are known or suspected to house a great number of the mentally ill such as the modern day nursing home, boarding care center, and the prison. See Phil Brown, ed. *Mental Health Care and Social Policy*. (Boston: Routledge, 1985)

Alfred Cannon of UCLA's Program in Social and Community Psychiatry was awarded a demonstration grant to expand the Central Community Mental Health Center as the first federally assisted CMHC in the nation.[387]

A 1968 *Austin American Statesmen* article described Central City as a facility with two doors - one to "deal with the mental ills found in city slums," and another marked "Community Service Center" which oversaw several other social service programs funded by anti-poverty and welfare agencies.[388] It's hallmark programs, however, were a "Teen-Queen" club for black girls and a karate class for black boys. The center's two-door approach allowed mental health professionals and social workers to shuttle citizens normally fearful of seeing a mental health professional and being stigmatized as "crazy" from one side of the center to the other. Essentially, the center served to bring together the federal government's anti-poverty programs with local social work programs under the same roof as mental health services.

According to the Director of Los Angeles County Department of Mental Health, Dr. Harry Brickman, the CMHC formed the bedrock strategy to increase utilization of the County's mental health system by the city's growing multiracial neighborhoods. He explained that his strategic vision was to create a network of community based organizations "'riding on the shoulders' of established community caretakers" - a term he used for mental health professionals (psychiatrists, psychologists, and social workers) - working in their own communities.[389] By "enrich[ing] their capacity to deal with mental health programs of their essentially non-mental health caseloads," Brickman argued that department resources would not only help them "deal directly and more effectively with the emotional problems of their welfare recipients, probationers, students, etc.," but empower them to refer a client to "definitive mental health professionals in the community" for treatment and research.

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[387] Central City was not the first CMHC in the nation. Cannon had founded the center in the basement of a church in 1961. In doing so, he had replicated the service model of the LaFargue Clinic of Harlem which had just closed in 1957. See: Dennis Doyle. Psychiatry and Racial Liberalism, 1936-1968 (Rochester: University of Rochester, 2016) and Gabriel Mendes. *Under the Strain of Color: Harlem's Lafargue Clinic and the Promise of an Anti-racist Psychiatry* (Ithaca: Cornell University Press, 2015)

[388] "Down-to-Earth Psychiatry Helps in Los Angeles Slums." *The Austin American Statesmen* October 10, 1968; B. 1

[389] Evelyn Hooker. Audio Recording. Dr. Evelyn Hooker Lecture on the Task Force on Homosexuality, Los Angeles 1971, ONE Program #157. Feb. 7, 1971. (ONE Archive, University of Southern California Libraries)

The model solved multiple problems facing psychiatry and community activism in the 1960s. For community mental health professionals working in urban clinics, CMHCs created a mechanism that equipped them with the power to assist citizens suffering from mild forms of stress and depression primarily resulting from poverty. The ability to coordinate cases amongst welfare programs saved the poor from the accusation that their stress was evidence of mental illness while still empowering CMHC staff to refer citizens displaying more complex symptoms to more specialized researchers and clinicians. The CMHC served to centralize community activist space by giving a space and a profession to activists trained with mental health knowledge. At the time, "definitive mental health professionals" favored these activists-turned-mental health paraprofessionals because they help create a willing and consenting patient pool that contrasted with coercive and authoritarian practices associated with asylum practices.

For civil rights and gay rights activists, the CMHC helped prove a larger social movement goal. It helped bolster the idea that if people stigmatized as mentally ill were simply allowed to govern themselves and self-fashion their own neighborhoods that they could be shown to be inherently capable and mentally well. In this sense, community mental health activists counted two victories as a result of their work. First, they regarded federal anti-poverty funding in the forms of Citizen Action Programs and Model Cities funding as mental health funds just as much as those dispersed through the NIMH, and second, they celebrated the removal of homosexuality as a mental illness in Psychiatry's official Diagnostic and Statistical Manual of Mental Disorders (DSM-II) in 1974 as proof of the effectiveness of their message.

The NIMH played a vital role in both victories. By 1975, the NIMH had awarded Central City with multiple awards and had initiated special demonstration grant programs specifically for the development of Asian American and Spanish-Speaking CMHCs.[390] The NIMH had financed, for instance, the Asian American Mental Health Training Center in Los Angeles led by Filipino American Licensed Clinical

[390] See: Proceedings, First National Conference on Asian American Mental Health, San Francisco, April 27-19, 1972; and, Spanish-Speaking Conference on Mental Health, Chicago, June 8-10, 1972. Royal F. Morales Collection Subject File "A," Folder 1: Asian American Community Mental Health Training Center - Conferences, Box 3 (Asian Reading Room, Library of Congress)

Social Worker Royal F. Morales to transform existing Asian American community-based organizations (CBOs) into de facto CMHCs.[391] While the NIMH did not finance gay and lesbian CMHCs prior to 1974, it did finance all the research used to de-pathologize it. In particular, it financed the studies arguing for the existence of a "normal homosexual" by Dr. Evelyn Hooker of UCLA.[392] (See Figure 7.2)

After 1975, however, the homelessness crisis had completely turned mainstream psychiatry away from supporting community mental health objectives. Psychiatrists in more well-funded and established institutions such as state hospitals, research institutes, and general hospital psychiatry wards attacked the funding of CMHCs by undermining its theories as ineffective, its methods as unproven, and its priorities as misguided. Psychiatrists in these institutions had expected CMHC practitioners to relieve them of the burden of caring for chronic and severely mentally ill patients. Instead of achieving the "substitution of one service [in the state hospital] for another [in the community]," as they had expected of CMHCs, community practitioners proved more successful in recruiting "new clientele" that were less chronic and less acute than those moving from asylum to community settings.[393]

Mainstream psychiatrists also argued that CMHCs failed to shift their services to care for the growing number of chronic and acute patients released into the community at large. CMHCs were easy targets given that some diagnostic categories, like schizophrenia, increased in number for poor and black men.[394] The perceived stubbornness of CMHCs led many, such as Dr. Donald G. Langsley, the President of the American Psychiatry Association, to attack them for using methods that had "not yet been proven

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[391] The final report of the Asian American Community Mental Health Training Center (AACMHTC) listed 48 "field instructions sites" including the Asian American Drug Abuse Program, Carson Community Center, Chinatown Service Center, Japanese Pioneer Center, Korean Youth Center, Little Tokyo Service Center, the Indochinese Refugee Forum, Omai Fa'atasi, Samoan Service Center, and Search to Involve Pilipino Americans. Royal F. Morales Collection Subject File "A," Folder 5 Asian American Mental Health Training Center Box 2. "Asian American Mental Health Training Center Final Report July 1972 - June 1978." (Asian Reading Room, Library of Congress)

[392] Her most famous NIMH-sponsored study was "The Adjustment of the Male Overt Homosexual" J*ournal of Projective Techniques,* (1957) 21:1, 18-31

[393] Grob, p. 255

[394] This phenomenon is compellingly argued by Jonathan M. Metzl. *The Protest Psychosis: How Schizophrenia Became a Black Disease* (Boston, Beacon Press, 2009)

successful" and for carrying out services that were more political than research-based in nature.[395] These claims eventually turned the National Institute on Mental Health (NIMH) against CMHCs, which had found "little evidence" to support the claim that CMHCs were reducing state hospitalization rates by the 1980s.[396] Opponents argued that CMHC funding ought to be diverted to more objectively scientific projects such as research on neuroscience, drug development, and epigenetics.

As their regard for anti-poverty programs and the depathologization of homosexuality reveal, community mental health activists never intended to take on the treatment of the deinstitutionalized, the chronic, and the severely mentally ill. Instead, clinicians such as Cannon and Hooker spent a considerable amount of time and energy on proving that most of the people in their research and treatment populations were "normal." Thus, they worked against the grain of most psychiatric findings that found minorities as incapable of healthy pathologies by arguing that healthy identifications of "blackness" and "homosexuality" did exist.

They, however, did believe that deviation from the racial and sexual types they affirmed could be read as either (in the case of race) "internal colonialism" or (in the case of homosexuality) "self-hate." Cannon, for instance, argued that the symptoms of sexual promiscuity, aggression, and violence found in such "ghetto" figures like absent fathers, homosexuals, drug and alcohol abusers, wild youth, and prostitutes were the unhealthy manifestations of a psycho-analytic split caused by white supremacy on the racial mind.[397] To correct it, Cannon advocated for therapy tailored to re-suturing the patient to a proper "ancestral home," in his case, to cultural identifications with Africa and the construction of a black nationalist public that naturalized behaviors associated with respectable marriage and family as black or "African."[398] Cannon's work thus normalized heterosexuality and adherence to a patriarchal economy as signs of healthy black identity formation and posed female-headed households and homes on welfare as

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[395] Donald G. Langsley. "The Community Mental Health Center: Does It Treat Patients?" *Hospital and Community Psychiatry*, 31 (1980). pages 815-19.
[396] Grob, p. 255
[397] Cannon, J. Alfred "The Psycho-Social Aspects of Segregation" in the *Journal of the National Medication Association* 1964, 56:2 160-163
[398] J. Alfred Cannon. "Re-Africanization: The Last Alternative for Black America" in *Phylon*. Volume 38, No. 2 (Second Quarter, 1977) p. 203-210

prone to pathology. His findings supported the idea that some people of color could be counted as black and African American while some could just be simply counted as "ghetto."

Likewise, Hooker's research on gay white men who publicly frequented gay establishments like bars and bathhouses and who led productive lives at work and at home revealed to her that individuals who accepted their homosexuality in public life could be considered as having "no impaired identity."[399] While she affirmed some forms of homosexuality based on community productivity and safety, she continued to advocate for the prevention of some forms of homosexuality she considered "destructive."[400] She was particularly antagonistic to sexual activity and gender expressions attached to street life that indicated sexual ambivalence or confusion (such as cruising, prostitution, hustling, and living in secret) that denied the existence of a stable sexual core of homosexual or heterosexual. As such, the de-classification of homosexuality campaign supported by homophile activists within and outside psychiatry purposely did not declassify "gender dysphoria" or distress with one's gender identity in order to discourage the criminal behaviors associated with homosexual crime and street life.

While Cannon clearly departed from Hooker on the existence of a "normal" black homosexual, their research both shared a new way of looking at race and sexuality. The location of black and brown LGB and trans people in the concentrated space of skid row with the homeless, mentally disturbed, working poor, and the formerly incarcerated by 1984 demonstrates the power of this new race-making process. The multiracial poverty of skid row serves to show how Cannon and Hooker conceived of the development of a new multicultural mainstream set apart from a "permanent underclass" that departed from a previous landscape divided between a white heterosexual mainstream and segregated ghettos. Here, both Cannon's and Hooker's affirmations of health black and gay identities mirror the work of activists and sociologists detailed in the work of Christina Handhardt and Roderick Ferguson who set out

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[399] Evelyn Hooker (1957) "The Adjustment of the Male Overt Homosexual" J*ournal of Projective Techniques*, 21:1, 18-31

[400] Evelyn Hooker. Audio Recording. Dr. Evelyn Hooker Lecture on the Task Force on Homosexuality, Los Angeles 1971, ONE Program #157. Feb. 7, 1971. (ONE Archive, University of Southern California Libraries)

to define black and gay communities as healthy "neighborhoods" rather than backwards "ghettos" by purging queer figures from their communities.[401]

It Takes A Village

The belief held by community mental health practitioners that most people of color and homosexuals did not need clinical treatment as much as they needed access to education, jobs, housing, and businesses in their own communities immensely appealed to urban activists, politicians, and planners. Indeed, Cannon and Hooker believed that more, not less, public investment in gay and racialized communities would be needed to build a therapeutic public on a scale large enough to maximize mental wellness in minority neighborhoods. While Cannon and Hooker regarded these investments as clinical or therapeutic, others in psychiatry and conservative circles began to see such a close relationship between clinicians and the community as too political.

Cannon and Hooker were both very vocal about connecting their patients with organizations and activities that shared in affirming their conceptions of healthy racial and sexual pathologies. Cannon took a very direct role in the community. For example, in addition to his use of psychotherapy at Central City, Cannon relied on cultural heritage programming as a form of behavioral therapy that developed respectable heterosexual identities in black youth. As he explained, Central City's "stress [on] Afro-American standards of beauty, grooming, and conduct" in its "Teen-Queen" girls club's were meant to "help the young Negro girl build an image of herself that relates to her environment," in the same way that the "virile sport" of karate was meant to convey ideas of "discipline and proper diet" in young black men.[402] Here, both activities staged expectations of desire that youth were expected to fulfill as heterosexuals in their adult life.

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[401] See: Christina Hanhardt. *Safe Space: Gay Neighborhood History and the Politics of Violence* (Durham: Duke University Press, 2013), and; Roderick Ferguson. *Aberrations in Black: Towards a Queer of Color Critique* (Minneapolis: University of Minnesota Press, 2004)
[402] Down-to-Earth Psychiatry Helps in Los Angeles Slums. *The Austin American Statesmen* October 10, 1968; B. 1

Cannon also built infrastructure that operated outside the formal bounds of psychiatry which complimented his vision of black mental wellness in popular culture. Along with C. Bernard Jackson, Cannon founded the first multicultural arts center in the nation, the Inner City Cultural Center (ICCC) and, with Jackson and Ron Karenga, founded a black arts center called the Mafundi Institute.[403] Both spaces incubated scripts and multicultural actors for Hollywood productions as an attempt to model scenes of multiculturalism and to broadcast more respectable representations of race on a grand scale. The intent was to develop through television, film, and other popular culture mediums a desiring subject around an affirmed identity of race that did not need the direct intervention of a mental health professional. Cannon referred to all his activities as "'core' clarification and construction efforts" that built a multicultural public that was comprised of multiple cultural nationalist publics.[404]

In this regard, Hooker shared with Cannon's statements that, in order to make these multicultural publics effective, community mental health efforts must be "joined by historians, archeologists, economists, artists, architects, business experts, spiritualists, educators, behaviorists and health workers."[405] While Hooker was less involved with gay rights activism at a grassroots level, her research recommendations pointed to the need for greater education and training amongst "professionals" such as teachers, lawyers, and social workers about the truth of homosexuality. In a speech to her colleagues in 1971, Hooker spoke about the need for "special training for all law enforcement personnel who come in contact with homosexual issues or problems" and her desire to be invited by LAPD Chief Davis to form a training program to help patrolmen understand the difference between normal and abnormal forms of homosexuality.[406]

The research of both Cannon and Hooker were extremely popular with activists working within the vein of "self determination" and civil rights politics. Their theories reverberated through both radical and

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[403] Daniel Widener. *Black Arts West: Culture and Struggle in Postwar Los Angeles* (Durham: Duke University Press, 2010)

[404] J. Alfred Cannon. "Re-Africanization: The Last Alternative for Black America" in *Phylon*. Volume 38, No. 2 (Second Quarter, 1977) p. 203-210

[405] J. Alfred Cannon. "Re-Africanization: The Last Alternative for Black America" in *Phylon*. Volume 38, No. 2 (Second Quarter, 1977) p. 203-210

[406] Evelyn Hooker. Audio Recording. Dr. Evelyn Hooker Lecture on the Task Force on Homosexuality, Los Angeles 1971, ONE Program #157. Feb. 7, 1971. (ONE Archive, University of Southern California Libraries)

more conservative wings of the black nationalist and gay rights movements including organizations such as the *US* Organization, the Black Panther Party, the Gay Liberation Front, and the more measured organizations such as the Municipal Municipal Elections Committee of Los Angeles (MECLA). Most notably, their theories were palatable to new mainstream multicultural politicians eager to use modern psychiatric research to underwrite their community development schemes for neighborhoods once neglected by older governing regimes.

Both Cannon and Hooker were influential in shaping Tom Bradley's urban policies and his new cross cultural coalition when he assumed mayoral office in 1973. By then, Bradley had supported Cannon's four biggest projects - Central City, the Inner City Cultural Center, the Mafundi Institute, and King-Drew's Psychiatry Department -through city funds.[407] Bradley's close relationship with David Mixner, his 1973 mayoral campaign manager, also led him to be one of the first big city mayors to openly support gay rights. When Mixner started MECLA as a gay rights lobby in 1975, Bradley headlined its black tie dinners to raise money to defeat anti-gay candidates and ballot initiatives.

Bradley supported CMHCs and CBOs like Central City and the Gay Community Service Center (later known as the Los Angeles Gay and Lesbian Center) because they not only fit into Bradley's community development program for the city's multicultural neighborhoods but also because they assisted in building a stronger liberal base for his new multicultural political coalition. Once in office, Bradley consolidated the power of CMHCs, CBOs, and community mental health practitioners initially through Model Cities Funding and then through new grants he named as "city community development" and "community service" grants. When conservatives attacked his close relationship with CMHCs and CBOs and when mainstream psychiatrists had achieved the defunding of them by the NIMH in the early 1980s, Bradley went to far lengths to engineer a new funding mechanism through the non-profit foundation, the United Way.

[407] All except King-Drew's Psychiatry department were funded as Model Cities initiatives. Bradley assisted in the creation of King-Drew Medical Center through a Joint-Powers Authority agreement between the City and the County that permitted the medical center and the Psychiatry Department within it to exist.

In exchange for tax breaks to transnational corporations looking to do business in Los Angeles like the Shuwa Corporation (then owners of ARCO and the Bank of America Tower), Bradley instructed corporate owners to make a large donation to the United Way as part of the city's "corporate accountability" campaign.[408] Bradley then used the infusion of capital into the United Way as leverage to change the internal governance structure of the United Way. By mirroring the multicultural governance model of the city, Bradley effectively engineered the funneling of corporate money to CMHCs cast as non-profit CBOs. In 1985, the United Way's new multicultural model effectively sustained the operations of CBOs developed out of the CMHC model.[409]

Bradley not only supported CMHCs and CBOs working within the community mental health tradition but translated the theory into official city planning policies. Cannon's and Hooker's ideas gave city planners a role to play by affirming identities deemed productive for democracy and capitalism by privileging those expressions in built space. In 1974, shortly after taking office, Bradley engineered the adoption of the Skid Row containment plan and followed it with the establishment of the Central Business District Redevelopment project in July 1975 through the Community Redevelopment Agency (CRA), the city's official public-private downtown redevelopment agency. According to CRA's executive summary statements, these legislative ordinances and their background studies aimed to achieve gentrification in downtown first by resolving the "human problems" associated with skid row's

[408] "On July 29th, Shuwa Corporation sponsored a luncheon honoring Mayor Bradley. Mayor Bradley called for the Japanese businessmen and companies operating in the United States to be good corporate citizens by participating in the local activities such as the United Way. He explained that the U.S., state, county, and city governments can do just so much to assist those citizens in need of assistance. In order to achieve political, social, and economic stability, businesses and citizens who can help should aid the citizens, businessmen and companies to operate in a stable political, social, and economic environment. Major upheavals and riots in the political, social, and economic areas mean less profit for the business because energy that could be spent productively towards making a profit will be directed towards resolving and stabilizing the upheavals and riots. Mayor Bradley asked Jeff Matsui, Senior Deputy to the Mayor, to assist the United Way in getting the overseas copanies doing business in Los Angeles to participate in and assist the United Way" Memorandum From Frank Watase to United Way Asian Pacific Research and Development Council Members August 10, 1987. Royal F. Morales Papers, Subject File "U", Box 1, United Way (Asian Reading Room, Library of Congress)

[409] In 1986, five of the six newly funded Asian American United Way agencies were former AACMHTC recipients: the Asian American Drug Abuse Program, Japanese Community Pioneer Center, Korean Youth Center, and Search to Involve Pilipino Americans. Other allocations by racial groups went to: the National Center for Immigrant Rights, El Centro Human Services, La Clinica del Barrio, Su Casa Family Crisis Center for Hispanic communities and the Equire Boys Club, Youth Action Center for Positive Change for black communities. See: Allocations '86: Highlights of United Way's 1986-87 Allocations Process. Royal F. Morales Papers, Subject File "U", Box 1, United Way (Asian Reading Room, Library of Congress)

residents.[410] Rather than rely completely on policing, Bradley crafted a “humane” multicultural redevelopment scheme from lessons learned from the productive power of psychiatry, particularly the power of affirmed “identity” in stabilizing ideas of “community” found in the work of therapists like Cannon and Hooker.

Key to the city’s redevelopment scheme was enhancing the social environment of a district towards healthy affirmed identity formations. As such, the Central Business District Redevelopment project divided downtown into seven zones each based on their apparent strength to carve out an economic niche and neighborhood identity. (See Figure 7.1) Rather than erasing the historical heritage of these neighborhoods, the CRA’s guiding policy preserved and enhanced distinctive characteristics and a sense of neighborhood “identity” to drive new economic development. The promotion of the immigrant character of Little Tokyo and the loft space in the Arts District, for instance, were meant to not only draw tourists and buyers of art to elements already present in these communities but to also attract new capital from individuals seeking the global or artistic lifestyles that were assumed to come with life in these neighborhoods.

Bradley’s broad political coalition of white liberals and leaders of color supported this multicultural urban development scheme for its promise to support new municipal infrastructure in areas formerly neglected and made unsafe by segregation from white mainstream neighborhoods. For the city’s black leaders, Bradley’s containment and mitigation policy permitted them to focus their efforts on making Watts (ten miles south from skid row) and other areas of South Los Angeles model neighborhoods for black identity. (See Figure 7.3) On the same token, the same policy allowed gay rights activists to settle community development efforts on West Hollywood, an unincorporated section of the County surrounded by other municipalities (ten miles northwest of skid row), as the neighborhood to project a healthy image of homosexuality to other city residents. These affirmations of “healthy” multicultural identities stand in

[410] Box 5, Folder 12. “Central City East - Central Business District Redevelopment Project. Briefing Report. May 1991” Bunker Hill Redevelopment Project Records, Collection no. 0226, Regional History Collections, Special Collections, USC Libraries, University of Southern California. p I-1

stark contrast to the affirmations of "transient" and "mentally disabled" being ascribed and reinforced in skid row.

Significantly, Castro's exposé was careful to differentiate the homosexuality of skid row's residents from the developments being staked out in West Hollywood. He wrote, "although [the Dragons] are selling sex to other men, both police and gay rights activists hesitate to describe it as 'homosexual prostitution.'"[411] This statement was surprising because Castro's article appeared in the thick of a concerted effort by the mostly white and initially all gay MECLA to win protection for LGBT people by incorporating West Hollywood as a municipality and by electing the nation's first all-gay city council in 1984. The disavowal of homosexuality in skid row by some gay activists was even more surprising given that the police helped to construct the difference between West Hollywood's homosexuality and Skid Row's homosexuality despite the fact that the LAPD was notoriously homophobic.

The broad agreement between West Hollywood activists and the LAPD reveals how deeply Evelyn Hooker's mental health theorization of homosexuality shaped protection for some forms of homosexuality while permitting violence on others. Here, it is clear how gay rights campaigns after the late 1960s primarily benefitted white gay men at the expense of other homosexual people posed as mentally disabled and troublesome, not for their sexual identity, but for their primary association with a "permanent underclass." On the same token, the policing of black and brown LGBT and trans people into a concentrated population within skid row also points to their unwelcomed presence in the city's historically black and brown neighborhoods.

Violent Identities

Castro's article shows that, despite being envisioned as a liberal alternative to policing, community mental health theory ended up informing the logic of LAPD's activities in its displacement activities

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[411] Tony Castro. "Prostitutes take refuge in the shadows of skid row: Poor urban slum becomes city's newest hotbed of vice." *Los Angeles Herald Examiner*, Sunday, July 22, 1983. Bunker Hill Redevelopment Project Records, Collection no. 0226, Regional History Collection. Box 6, Folder 1, "Skid Row Press Clippings" (Special Collections, University of Southern California) Page 2-3

leading up to the 1984 Olympic Games.[412] The use of the police signifies not a change in the city's multiculturalism policy but instead indicates a shift in prevailing mental health theory in the 1970s. 1960s multiculturalism shifted the parameters of race and sexuality such that they no longer were as durable of expressions for mental illness and social disorder. While Bradley saw his multicultural policies based on psychotherapeutic ideas of identity as a liberal counterpoint to policing power that empowered gays and people of color to draw on their productive desires to create safe and productive neighborhoods the same racially liberal framework drew ideas of violence and social disruption more tightly around an "underclass." As the residents who populate skid row show, these ideas of who constituted an "underclass" did not completely suspend the use of race and sexuality. Therefore, although originally conceived as a more humane approach to urban development, the theoretical underpinnings of community mental health eventually heightened concern over a multiracial "underclass" that required a pathology to account for them as "violent people."

UCLA's Departments of Psychiatry and Psychology both served as crucial spaces to incubate Cannon's and Hooker's ideas of multiculturalism and social disorder throughout the 1960s and it would produce a new pathology around violence in the 1970s to amend these theories. This new "colorblind" theory was coined and promoted under the auspices of Dr. Louis Joylon "Jolly" West, the Department Chair of Psychiatry and Director of UCLA's Neuropsychiatric Institute. (See Figure 7.2) Appointed in 1970, West was appointed on the basis of a new promising theory he termed, "Epidemiology of Violence Theory," which argued that exposure to violence at a young age caused adults to be more prone to perpetuating violence as an adult. To study this hypothesis, West gathered violent offenders across racial and class backgrounds to identify the social factors that account for the perpetuation of violence. Coming

[412] For more on liberal approaches to policing in this period, see: Christopher Lowen Agee. *The Streets of San Francisco: Policing and the Creation of a Cosmopolitan Liberal Politics, 1950-1972* (Chicago: University of Chicago Press, 2014)

from “all walks of life,” West’s studies honed in on the fact that all violent offenders in his study appeared to be “the victims of violence in childhood themselves.”[413]

The theory thus evolved the culture of poverty theory underwritten by community mental health experts that pinned violence to queer domestic arrangements by insisting that untreated exposure to violence at a young age led individuals to become violent perpetrators as adults. The theory shored up the political projects of racial elites who pointed to the theory to explain how the backwards poor and their queer domestic arrangements - mired with financial tension, family conflict, and urban violence - continued to pose problems for urban revitalization in communities of color. The theory likewise was used by gay elites to explain how some forms of homosexuality associated with street life, crime, and shame such as cruising, prostitution, and transgendered identities, were not true homosexuals but confused individuals who continued to cause, as Hooker reasoned, “endless agony and suffering” to themselves and to society.[414]

Epidemiology of violence theory, however, significantly diverged from community mental health theory on the vector by which violent behavior was transmitted. Whereas Cannon and Hooker believed violent behavior was passed onto individuals through a purely developmental model, West assumed that one’s social environment triggered an underlying *genetic* predisposition that could be organically located in the brain. In other words, West’s epigenetic theory proposed that the transmission of violence was not class-bound as Hooker and Cannon reasoned but could also be used to account for violence in affluent persons exposed to an act of violence or trauma.

In 1972, West proposed and successfully won money through the State of California to construct a “violence center” to locate the genetic predisposition of “violent individuals” in the brain by examining “child abuse, sexual offenses, neighborhood violence, suicides amongst young people, murder, alcohol

[413] Box 2, Folder 3 Violence Lectures. Sanity in the Sierra Madre: The Tarahumara Indians Louis Joylon West Papers (Collection 590). UCLA Library Special Collections, Charles E. Young Research Library, UCLA
[414] Evelyn Hooker. Audio Recording. Dr. Evelyn Hooker Lecture on the Task Force on Homosexuality, Los Angeles 1971, ONE Program #157. Feb. 7, 1971. (ONE Archive, University of Southern California Libraries)

and drug-related violence."[415] While West believed that "early diagnosis" of a violent predisposition would inspire citizens to treat and prevent violence as they would any other disease, activists publicly took issue with the fact that he proposed to experiment on "mental institution inmates, delinquents, and prisoners," particularly black and brown youth at two camps associated with the California Youth Authority, convicted "violent sex offenders" at Atascadero State Hospital, and released ex-prisoners. Widespread protests by community activists ended its construction by pressuring the State of California to withdraw funds for the center in 1974.[416]

Although West was unsuccessful in creating a violence center, his theory bolstered middle class desire to guard against potential exposure to violence in their own homes and neighborhoods. Epidemiology of violence theory, for instance, was used to underwrite an uptick of child abuse and domestic abuse laws and expanded prison infrastructure. Feminist scholars have since argued that these laws have resulted in reducing welfare services such as foster care and rehabilitation programs for greater rates of adoption and incarceration in the mid-1970s to 1980s.[417] Urban historians have also observed that the 1970s account for new widespread privatized measures for safeguarding middle class neighborhoods such as gated neighborhoods.

Beginning in 1987 LAPD Police Chief Daryl Gates revived and regularized police sweeps through black and brown neighborhoods that he had instituted in the weeks leading up to the Olympics. Naming his activities, Operation Hammer, Gates conducted an extreme form of broken windows policing - searching for and arresting any citizen suspected of being involved in gang and drug activity for questioning.[418] Instead of meeting outright condemnation, Gates' efforts to rid black and brown

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[415] "UCLA Institute Plans Violence Study Center: State-Funded Project, First of its Kind in Nation, to Research Numerous Fields" *Los Angeles Times*. May 23, 1973. P. A22

[416] West kept record of most of the events of its demise. See: Box 6, Folder 18 "Who Killed the Violence Center?" Louis Joylon West Papers (Collection 590). UCLA Library Special Collections, Charles E. Young Research Library, UCLA.

[417] See: Bumiller, Kristin. *In an Abusive State*. (Durham: Duke, 2008); Briggs, Laura. *Somebody's Children*. (Durham: Duke, 2012); Gilmore, Ruth Wilson. *Golden Gulag: Prisons, Surplus, Crisis, and Opposition in Globalizing California.* Berkeley: University of California (2007)

[418] Mike Davis. "Fortress LA" and "The Hammer and the Rock" in *City of Quartz.* (New York: Vintage, 1992)

neighborhoods were met with praise by many of the city's black politicians who were growing frustrated with the rate of community progress in black and brown neighborhoods.

It's here where the policing sweeps of 1984 are the most informative in drawing the lives of LGBT people together with the hyper- and hetero-masculine image predominantly associated with male gang youth. Castro's article noted that the first raid on black and brown LGB and trans people had begun in 1983 with a "female impersonators' club where prostitution was rampant" in the San Fernando Valley's Ventura Boulevard. The raid resulted in the forced closure of the club and continued sweeps along the city's main nightlife corridors along Sunset, Melrose, and Santa Monica Boulevards until "the Dragons" appeared in skid row. These sweeps, a year in advance of the Olympics and three years in advance of Operation Hammer suggest that the police had begun to stage broken windows policing first with black and brown LGB and trans people and then to others deemed a part of the same "underclass." Here, the figures of "the Dragons," the homeless, the working poor, and gang members are drawn as queer for the shared prevailing assumption of their sexual relationships were non-conjugal and non-monogamous and that their participation in the economy was either illicit or non-existent in spite of their own stated identifications.

The Urgency of Space

Overall, community mental health theory not only accounts for the physical creation of skid row but also flexibly accounts for why residents in it could neither be counted as multicultural and/or gay citizens by the city's activists, politicians, and urban planners. Instead, a reading of the space they inhabit tells us a great degree about how they have been viewed as aberrant, potentially dangerous, and disabled to a larger society. On one hand, this history demonstrates how broken windows policing is informed by mental health theory and racial liberalism as opposed to being in contradiction with it. This is a sobering reality that contrasts with the seductive social benefits and economically productive aspects of multiculturalism. Not only were the 1984 Olympic games the first modern olympic games to make profit but its worldwide television broadcasts of Los Angeles' ethnic citizens and their visibly themed

neighborhoods served as advertisements to the benefits of embracing multiculturalism and culturally affirming redevelopment policies.

On the other hand, this history demonstrates how the projection of a desirable multicultural city required the production of hidden deteriorating spaces like skid row. Instead of seeing this process as inevitable or as a historical dead end, queer of color critique and crip theory furnishes us a way of seeing that allows us to consider new ways of creating new unexpected political coalitions between the homeless, the unemployed, the disabled, and queer and trans people. In doing so, there is ample room to re-think how categories like race, homosexuality, and disability have been re-shaped by law and social movements and how new political coalitions can produce an alternative reality.

In the meantime, Los Angeles' skid row continues to be a productive site for the city to narrate who is and is not protectable. Over thirty years after, skid row still conjures many of the figures outlined as residents of Skid Row by Tony Castro. According to contemporary scholarship, the neighborhood's police force has the largest dedicated "peace time" police force outside of American-occupied Baghdad.[419] As George Lipsitz observes, six million dollars annually is spent on the neighborhood's special force of fifty police officers and twenty-five narcotics officers.[420] In this regard, the legacy of Bradley's multicultural redevelopment strategy still reverberates in skid row's footprint despite its smaller square footage.

According to Robin Kelley, Skid row has been made smaller by the rise of incarceration and development, with its's former 50-block radius whittled down to 15-20 blocks by competing real estate interests in Little Tokyo and the Artist District to colonize the northern and eastern ranges of skid row block-by-block.[421] Rather than suggest that things are getting better for black and brown LGB and trans people and for other residents of skid row, the shrinking neighborhood reveals to us that there is perhaps

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[419] Heatherton, Christina. *Skid Row Reader.* Los Angeles: Freedom Now, 2011. p. 4

[420] George Lipsitz. "Policing Place and Taxing Time on Skid Row" in *Policing the Planet: Why Policing Crisis Led to Black Lives Matter.* Jordan Camp and Christina Heather (eds.) (New York: Verso, 2016) p. 124

[421] Robin Kelley. "Ground Zero" in *Skid Row Reader.* Christina Heatherton, ed. (Los Angeles: Freedom Now, 2011). p. 8

less, rather than more, space for queer people to congregate and exist than before. If this is so, we must re-assess the urgency of space and how we move through it.

Figure 7.1 Map of Skid Row

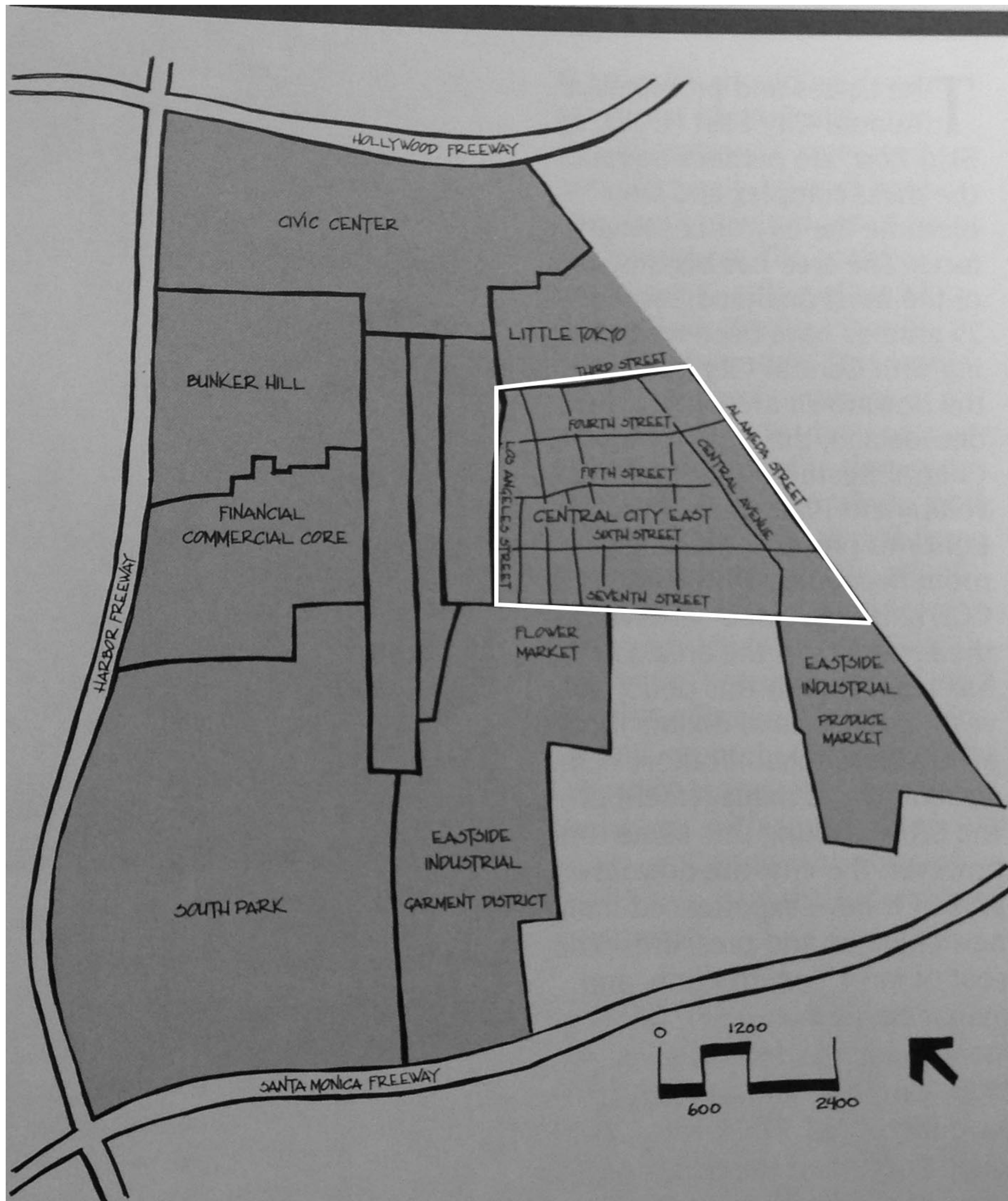

Figure 7.1 The City re-termed Skid Row "City Center East" in its planning documents. This map also details the re-development profiles of the city's other downtown neighborhoods.

Source: The Changing Face of Misery. Bunker Hill Redevelopment Records, Collection no. 0226, Regional History Collection. Box 5, Folder 14. (Special Collections, USC Libraries, University of Southern California.)

Figure 7.2 Key Community Mental Health Players

Figure 7.3 Key Community Mental Health Players from Top Left Clockwise: Dr. J. Alfred Cannon; Dr. Evelyn Hooker; Mayor Bradley (seated in middle, surrounded by his mayoral staff in 1989); and Dr. Louis Joylon West.

Figure 7.3 Community Development and Mental Health in Los Angeles

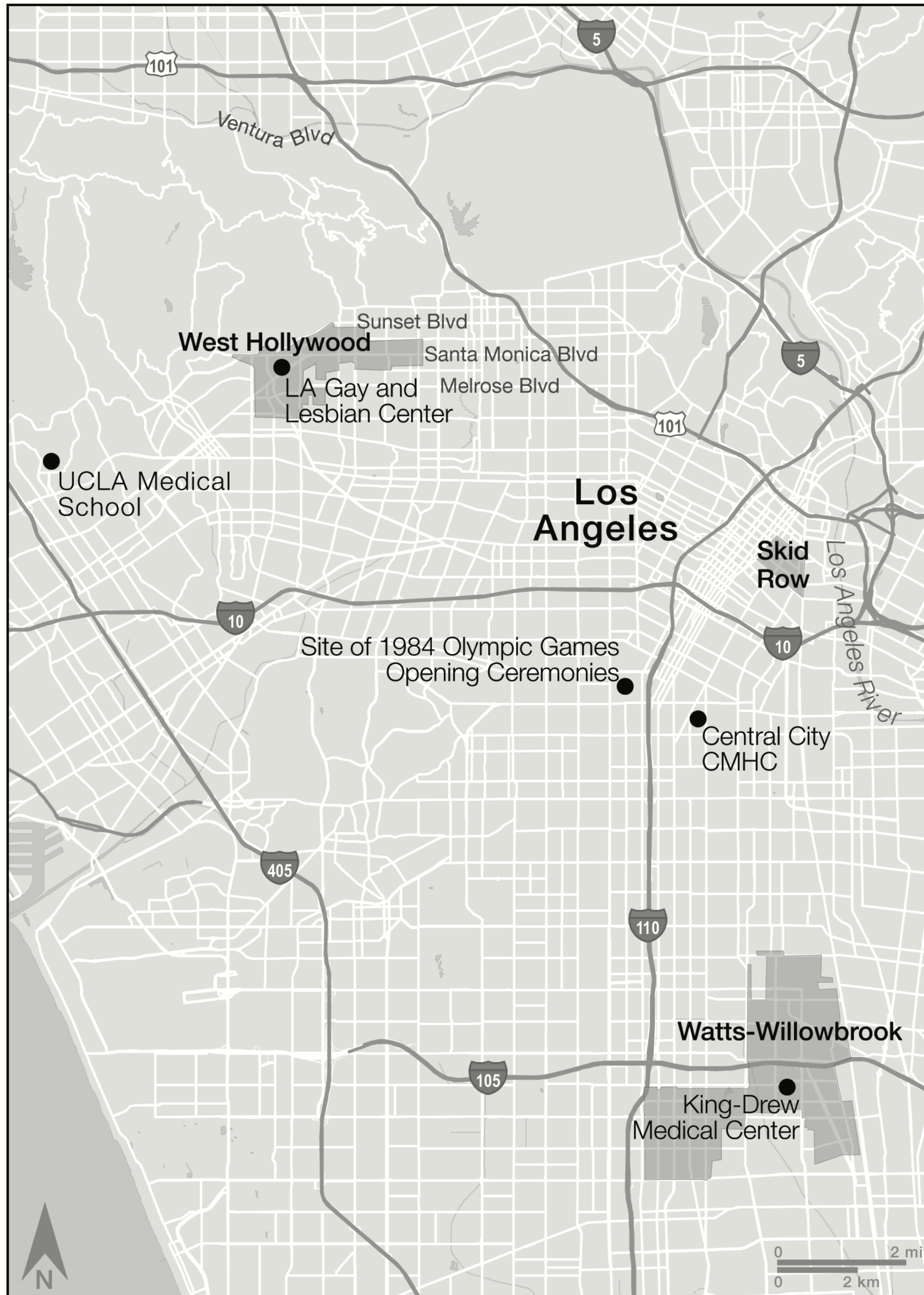

Figure 7.3 ***Relationship of Skid Row to Watts/Willowbrook Neighborhoods and the City of West Hollywood.*** Central City CMHC served as a satellite mental health clinic within King-Drew Medical Center's Health Service District. The city's major LGBT nightlife corridors (Sunset, Santa Monica, and Melrose) run from West Hollywood to Los Angeles' downtown. Map made for author by Breanna Spears.

Chapter Eight
Displacement without Disavowal: Emergency Medical Systems, Public Health Clinics, and the Production of a Permanent Underclass

On November 6, 1986, President Reagan signed into law the Simpson-Mazzoli Act, formally known as the Immigration Reform and Control Act (IRCA), P.L. 99-603 of 1986. More well known to Americans as "amnesty," the landmark immigration bill provided a pathway to legal citizenship for a portion of the estimated 2 to 3.5 million undocumented immigrants living in the United States who could prove that they had resided continuously in the United States since January 1, 1982, and were not likely to "become a public charge."[422] By all accounts, the measure favored individuals who could prove they had been stably employed, did not have a criminal record, and were able to continue to work. With an estimated 32 percent of all the nation's undocumented immigrants living within Los Angeles County, the bill quickly turned national attention to the city to see how politicians would absorb, as Catholic Archbishop Roger Mahoney phrased it, the "shadow society" of "people who have lived among us for many years but without the benefit of fully participating in the American community."[423]

Mahoney's hopeful description of moving some segments of society from the shadows into light illuminated a larger phenomenon dividing American society that went beyond the single issue of undocumented immigration. Amnesty's legal process of selecting out individuals to join a mainstream multicultural society of responsible, hardworking, able, and healthy individuals only worked to highlight the deeper political, economic, and spatial alienation of a growing "permanent underclass," a term popularly deployed to describe social disorder associated with chronic unemployment, crime, welfare dependency, undocumented immigration, and disability found in deteriorating inner-cities.[424] According

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[422] According to David Holley of the *Los Angeles Times*, "the bill offers legal residency to illegal aliens who can prove they have been in the country since or before Jan. 1, 1982. Those deemed likely to become a 'public charge' may be disqualified. Estimates vary on how many people will meet these requirements." David Holley. "Counties, Concerned Over Amnesty Issue, Study Added Costs Southern California Weighs Impact of Alien Bill" October 18, 1986. *The Los Angeles Times*, p. 10.

[423] Marita Hernandez. "Mahony to Establish Alien Amnesty Centers" October 20, 1986. *The Los Angeles Times*. p. B1

[424] Ken Auletta first popularized this term in a New Yorker articled titled "The Underclass." Auletta then published the work separately under a different press. Ken Auletta. The Underclass. (New York, The Overlook Press, 1999).

to Immigration and Naturalization Service (INS) estimates, roughly half of the United States of America's undocumented citizens would be eligible for amnesty, meaning the other half would be left with the stigma of crime, poverty, and charity long associated with urban poverty.[425]

For County Supervisor Peter Schabarum, amnesty was framed by an earlier piece of legislation passed by President Reagan, the Emergency Medical Treatment and Labor Act (EMTALA) P.L. 99-272 of 1986, which mandated that hospitals must give "an appropriate medical screening examination within the capability of [a] hospital's emergency department [to any citizen seeking emergency medical help]… to determine whether or not an emergency medical condition… exists."[426] The bill ensured that citizens could get stabilized for a medical condition they deemed an emergency but did not provide for any follow up care unless a patient had the ability to pay.[427] Despite that amnesty would provide a windfall of $144 million dollars of federal money to the County to assist with the local integration of newly anointed legal residents, Schabarum was concerned that the law would generate $190 million in annual county costs related to new health and human services expenses incurred by soon-to-be legalized residents that would not be covered with federal assistance money and require unknown costs for the provision of emergency care.[428]

The term also became popular amongst sociologists who used the term to discuss working poverty. See: William Julius Wilson. *When Work Disappears: The World of the New Urban Poor* (New York: Vintage Books, 1996)

[425] According to William Branigin of the *Washington Post,* "the INS says nearly 4 million aliens may apply for amnesty under the various provisions of the new law and about half will be eligible." William Branigin. "US Migrant Falls Hard on Jobless in Central Mexico: Mexicans Returning from US Jobs as Migrant Law Begins to Have Impact." March 3, 1987. *Washington Post*. p. A1.

[426] EMTALA Fact Sheet. American College of Emergency Physicians (ACEP) Website. https://www.acep.org/news-media-top-banner/emtala/ (Accessed February 4, 2017)

[427] As I will show later, the law preserved a practice that the County implemented in 1981 called DHS Policy No. 516, which limited all healthcare services to undocumented immigrants and uninsured Americans to the emergency room.

[428] According to David Holley of the *Los Angeles Times*, Peter Schabarum, Chairman of the Los Angeles County Board of Supervisors said, "From the point of view of local government, this bill probably has compounded our problem rather than solving it." Holley explained further that, "Schabarum said he believes that most of the projected $190 million in annual county costs will not be reimbursed by the federal government, despite a provision setting aside $4 billion to reimburse state and local expenses. That's because aliens who gain legal status will become eligible for federal- and state-funded health care programs such as MediCal and Supplemental Security Income payments for the aged, blind, and disabled. Los Angeles County projects that the state will face annual expenses in the county of $149 million and that the federal share will be $144 million." David Holley. "Counties, Concerned Over Amnesty Issue, Study Added Costs Southern California Weighs Impact of Alien Bill" October 18, 1986. *The Los Angeles Times*, p. 10.

Schabarum's response that "this bill probably has compounded our problem rather than solving it" reveals that he believed that immigrants would be a financial burden to the County regardless of their legal or undocumented status. Schabarum alluded that amnesty would not relieve the county of a much larger problem of "working poverty."[429] Along with high unemployment, working poverty described the expansion of new wage practices that paid workers below the poverty line without benefits and employment protections that made large pools of uninsured individuals dependent on county hospital services. In his eyes, amnesty and EMTALA required the County to pay for expanded comprehensive health services for those considered by the federal government as worthy of legal citizenship while mandating more costly healthcare for those that the federal government did not deem worthy of it. Individuals granted amnesty would thus receive services that the county had designed primarily for welfare eligible mothers and children while the remaining undocumented immigrants would join a growing pool of indigent and uninsured receiving care in the emergency room.

Amnesty split undocumented immigrants and blended the terms of this divide into a language of welfare services that had been locally defined as a problem of black poverty. After the 1965 Watts Riots, the County of Los Angeles embarked on a mission to create a rational system of delivering care to the city's mostly poor black neighborhoods through the construction of a new public hospital, King-Drew Medical Center, connected to a suite of comprehensive health clinics (CHCs) focused on preventative healthcare. At the same time, the County had also begun to develop a sophisticated emergency medical system (EMS) that connected ambulance services to public emergency rooms (ERs). The deepening rate of unemployment, working poverty, and welfare in black neighborhoods, inflation in medical costs, and anti-tax movements, however, made the dual investment in both preventative and emergency medical services untenable for the County of Los Angeles by 1981. This crisis was exacerbated by the rapidly changing racial demographics of the neighborhood - as more and more immigrants fleeing violence and

[429] Working Poverty is a term popularized by William Julius Wilson. *When Work Disappears: The World of the New Urban Poor* (New York: Vintage Books, 1996)

civil war from countries like Mexico, Guatemala, and El Salvador came to settle in Watts and surrounding neighborhoods.

Instead of continued investment in both preventative and emergency medical infrastructure, I argue that amnesty and EMTALA hastened efforts to starve public preventative health infrastructure of resources in favor of more public money for emergency medical systems. In doing so, Los Angeles County officials simply applied a policy position to accommodate the health needs of the region's immigrant community by sustaining a policy the county had settled on in 1981 in regards to the health infrastructure of the county's poor black community. This policy *built up* emergency medical systems by *taking apart* preventative health infrastructure in the county's poor and immigrant neighborhoods. In short, amnesty and EMTALA encouraged County leaders to double-down their efforts to de-fund preventative health services by shifting funds to state-of-the-art emergency rooms attached to truncated county health services.

According to many public health experts, public investment in emergency medical systems appears irrational and unnecessarily costly in comparison with the sensible and more cost effective outlay of public resources in education programs, clinics, and hospital services.[430] Rather than refute these claims by public health experts, my reading looks elsewhere to account for the unprecedented concentration of public funds into emergency medical services by the early 1980s. Some elected officials stewarding public health funds actively ignored the claims of public health experts and community activists and instead capitalized on the social, political, and sexual panic around racialized violence, particularly the figure of the black and brown youth "gang member" to advertise and build up emergency medical services (EMS) as a new publicly-funded solution to egalitarian and democratic healthcare.

Although science and medical progress played a role in developing the modern emergency room (ER), this chapter focuses on how crime, violence, and citizen fear of being caught in the wrong place

[430] Of the many works by public health experts and scholars who hold this perspective see: Paul Farmer. *Pathologies of Power: Health, Human Rights, and the New War on the Poor*. (Berkeley: University of California Press, 2005); Jenna Loyd. *Health Rights are Civil Rights: Peace and Justice Activism in Los Angeles, 1963-1978* (Minneapolis: University of Minnesota Press, 2014); and Randall M. Packard. *The Making of a Tropical Disease: A Short History of Malaria.* (Baltimore: Johns Hopkins University Press, 2007)

fueled citizen desire for emergency rooms and trauma centers. Citizens defended public funding to these institutions not so much for their attachment to extensive public health infrastructures but for their primary role in holding up a new security archipelago of police, fire, 9-1-1 operators, ambulance services, prisons, and state hospitals that helped citizens maintain a sense of safety and security. Unlike hospital services and clinics with limited geographic reach to the neighborhoods sitting immediately around them, mostly white suburban and rural citizens in developing neighborhoods supported continued public funding to emergency rooms because they addressed a minimum level of care guaranteed to citizens through a new public-private partnership forged between ambulance companies, emergency rooms, and public officials.

The experience of living in far off "rural" and subrurban neighborhoods grew as residents moved into newly formed bedroom communities on the outskirts of the Los Angeles basin.[431] These movements left behind large swaths of neighborhoods now characterized by racialized working poverty and unemployment despite the fact that the city's high-paying financial and service sectors still sat in the city's interior. Longer commutes into the city made the question of publicly-funded emergency rooms politically unavoidable, since private hospitals in Los Angeles' interior found it difficult to sustain around-the-clock trauma services in such low-wage and under- and un-insured markets.[432] For commuters, it was seen as more necessary to maintain publicly-funded emergency rooms but less urgent to maintain other publicly offered health services attached to them.

To mostly white suburban commuters, publicly subsidized hospital and clinic services curiously gained greater association in their minds as "welfare" services for an increasingly violent and unworthy permanent underclass while reasonably-distanced emergency rooms from their homes and offices gained new importance for white collective safety and mobility. Being caught in the "wrong place" thus indexed

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[431] William Fulton argues that neighborhoods formerly considered "suburban" in the 1950s suddenly became a part of a larger network of "hub cities" in the 1970s and 1980s associated with the inner city. In turn, areas 45 minutes - 1 hour away from Los Angeles were now considered suburban. See: Introduction and his section titled "Power" in William B. Fulton. *The Reluctant Metropolis: The Politics of Urban Growth in Los Angeles*. (Baltimore, Johns Hopkins University Press, 2001) pages 1-98.

[432] See Fig. 1

a fear of finding oneself in the "ghetto" or finding oneself in a neighborhood where no ambulance or suitable trauma center was located nearby. In this regard, emergency rooms did not just appeal to white citizens but also black, brown, and Asian citizens fearful of being in the wrong place and wrong time in their *own* neighborhoods. Collectively, citizens supported emergency rooms as they did the building of prisons and police forces with their own tax money despite being considerably more reticent about funding welfare and preventative public health programs.

Emergency Rooms in an Era of Working Poverty and Surplus Labor

The shift from an emphasis on preventative healthcare to emergency medical care is usually read by scholars as a divestment from a welfare and civil rights-oriented state associated with the 1960s to a new "colorblind" and austere "neoliberal" state associated with the 1980s.[433] Recently, scholars of racial capitalism have read with and against the grain of this thinking to consider how the state's animated concentration of capital in certain state infrastructure represents the opposite.[434] As the issues presented before Supervisor Schabarum indicate, large metropolitan governments were dealing with the compounded crises of working poverty, chronic unemployment, and crime — issues symptomatic of larger global restructuring of capital in the 1970s and 1980s. Generally, these attributes are seen as proof of economic deterioration but the movement to concentrate public funding in certain state services over others indicates political willingness to prioritize certain functions of the welfare state over others.

[433] Within public health discourse, Dr. Paul Farmer's work juxtaposes a "human rights" approach to healthcare that is more rational and sensible to "neoliberalism." In contrast to a human rights approach centered on education, clinics, and greater access to acute care services, Farmer lambasts neoliberalism as an "ideology that advocates the dominance of a competition-driven market model [that views all individuals] as autonomous, rational producers and consumers whose decisions are motivated primarily by economic and material concerns." Farmer continues to say that this "ideology has little to say about the social and economic inequalities that distort real economies." (5) Paul Farmer. *Pathologies of Power: Health, Human Rights, and the New War on the Poor*. (Berkeley: University of California Press, 2005)

[434] Here I highlight the work of Ruth Wilson Gilmore, *Golden Gulag: Prisons, Surplus, Crisis, and Opposition in Globalizing California.* (Berkeley: University of California, 2007); and, Eyal Weizman. *Hollow Land: Israel's Architecture of Occupation* (New York: Verso, 2007); and their discursive connection to the work of Karl Polanyi. *The Great Transformation: The Political and Economic Origins of Our Time* (Boston: Massachusetts, 2001); and, Neil Smith. *Uneven Development: Nature, Capital, and the Production of Space* (Athens: University of Georgia, 1984).

In fact, social science scholars such as Ruth Wilson Gilmore argue that un- and under-employment rates can be read by some political actors as signs of economic health that produce new modes of social and economic productivity for a global economy. Social science scholars argue that the build up and concentration of state services related to prisons mirror a movement in the profound concentration of capital, talent, labor, technology, and infrastructure in "global cities," metropolitan centers that connect regional markets to international markets elsewhere.[435] In the United States, this incredible concentration of capital caused an unprecedented shift in the economy from a manufacturing base to a service-based economy focused on much smaller industries related to finance, real estate, and insurance. Competition for this smaller labor pool of global finance workers amongst U.S. Cities meant that politicians supported infrastructure and business practices that recruited and secured this select set of labor interests.

As other social science scholars point out, cities competed regionally with each other to make business appealing and cost effective for finance interests by supporting manpower and community development policies focused on producing middle-class service workers like doctors, lawyers, policemen, and artists; and, a larger supporting number of working class jobs like janitors, domestic, security, and restaurant workers.[436] Labor studies scholars argue that to secure a small community of financial interests, business and political leaders in cities including Los Angeles, New York, and Chicago took advantage of the growing undocumented, immigrant, and urban workforces by paying workers wages below the poverty line, without benefits, and without any employment protection to service the

[435] Saskia Sassen first popularized the term from research she performed throughout the 1980s. She names a conglomeration of labor interests she names as F-I-R-E, Financial, Insurance, and Real Estate workers as particularly important for global city status. Saskia Sassen. *The Global City: New York, London, Tokyo*. (Princeton: Princeton University Press, 1991)

[436] Sharon Zukin argues that cities began to invest in what she refers to as a "symbolic economy" based on tourism, media, and entertainment to appeal to financial, real estate, and insurance laborers. By looking to the restaurant workers and artistic and entertainment sector for evidence, she argues that the consumptive excess of shopping, arts entertainment, and fine dining for the rich anchors and supports the reproduction of consumption for workers down the wage scale. This argument is supported by Mike Davis' argument for the meaning of Los Angeles County's "Museum Archipelago" and the cultural laborers he names playfully as the Boosters, Debunkers, Noirs, Exiles, Sorcerers, Communards, and Mercenaries in his chapter, "Sunshine or Noir?" See: Sharon Zukin. *The Cultures of Cities* (New York: Wiley Press, 1997) and Mike Davis. City of Quartz: Excavating the Future in Los Angeles (New York: Verso, 1990) p. 15-98.

lifestyles of a temperamental financial class.[437] As this new global arrangement of capital continued to unfold throughout the 1970s and 1980s, the presence of working poverty was quietly seen by city leaders as proof of the city's economic survival and not its deterioration.

Instead of eradicating working poverty, Los Angeles politicians sustained its reproduction as a way to secure the economic health of the region. In exchange for the maximum continued labor participation of all sectors needed for a global economy, city and county leaders consciously absorbed health and welfare costs for the city's poorest as a strategy to encourage the working poor from moving to other competing labor markets. Starting in 1971, for instance, Los Angeles County bureaucrats continued to provide comprehensive health services to the city's working poor and undocumented citizens despite that the State of California had reformed its subsidized form of medicaid, MediCal, to conform to national caselaw that affirmed state rights to ban preventative health services for the undocumented.[438] By the mid-1980s, city officials also began assisting undocumented immigrants living in skid row with programs designed to aid with resettlement in areas outside of it.[439]

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[437] See: Ruth Milkman. *L.A. Story: Immigrant Workers and the Future of the U.S. Labor Movement*. (New York: Russell Sage Foundation, 2006); Ruth Milkman. *Organizing Immigrants: The Challenge for Unions in Contemporary California* (Ithaca: ILR Press, 2000); Pierrette Hondagneu-Sotelo. *Domestica: Immigrant Workers Cleaning and Caring in the Shadows of Affluence (*Berkeley: University of California Press, 2001); William B. Fulton. *The Reluctant Metropolis: The Politics of Urban Growth in Los Angeles*. (Baltimore, Johns Hopkins University Press, 2001)

[438] In 1971, hoping to secure federal support for "alien services" rendered by Los Angeles County, James M. Pollard, legislative consultant to the Los Angeles County Board of Supervisors, explained to John Veneman, Undersecretary of the DHEW, that the County was prepared to spend "$22.4 million dollars in the 1972-1973 fiscal year….drawn exclusively from County funds" for health services rendered to residents with "alien status." Pollard noted that the County was willing to dispense these funds even though the State legislature had reformed its subsidized Medicare program (MediCal) to retain coverage for single indigent adults but not those with alien status. He explained that the state's withdrawal of support meant that the County was prepared to sustain its services to undocumented immigrants through its own funds. It also intended to continue its historical use of "the question of residence or intended residence in the area" as the only "test" for those seeking care from the County even though the Supreme Court's ruling on *Graham vs. Richardson* was inconsistent with this practice. Letter from Joseph M. Pollard, Legislative Consultant to the Los Angeles County Board of Supervisors to John G. Veneman, Under Secretary of Department of Health, Education, and Welfare, June 13, 1972. RG 235 General Records of the Department of Health, Education, and Welfare, Box 405 Office of the Secretary, Secretary's Subject Correspondence *(*National Archives Record Administration, College Park, MD)

[439] Declaring that "Skid Row is no place for children," the City of Los Angeles implemented a new policy for skid row called the "containment and mitigation policy" to highlight the intended character of the neighborhood as a place for single unattached adults and not as a place for immigrant families. According to Cindy I-Fen Cheng, the City then authorized new funding initiatives to relocate undocumented immigrant families outside of the district into areas deemed more suitable for children. See: Bunker Hill Redevelopment Project Records, Collection no. 0226, Regional History Collection. Box 5, Folder 14, "Changing Face of Misery" (Special Collections, USC Libraries,

Gilmore argues that, in addition to working poverty, chronic under- and un-employment also was productive for global capitalism. She argues that an intrinsic value produced by capitalism called "surplus labor," or, a "standing army" of laborers who cannot be absorbed by the needs of a labor market, proved incredibly productive and profitable for a new prison economy that serviced capitalist and labor need in both rural and inner-city contexts.[440] She writes that rural real estate interests, wrecked by corporate agriculture, courted the development of prisons as new manpower and community development schemes that were dependent on enlarged policing regimes in urban cities. Languishing from the flight of heavy manufacturing elsewhere, this new rural-urban economy made chronic unemployment and crime productive for a new carceral economy of prisons.

Gilmore's framework to viewing economic crisis and deterioration as moments for new opportunities for global and racial capitalism to function is useful for thinking through the rise of emergency medical services. Her analysis names incarceration as a process of racial capitalism that does not seek to draw labor directly from one class of people (the incarcerated) but draws labor and profit from those who collude to directly prevent them from labor participation (such as prison guards and police) and the legion of citizens who profit, knowingly and unknowingly, from this carceral economy (such as the middle class and the working poor). Here, emergency rooms are flexible instruments that meet the needs of the state to provide *some* care to valorized populations that include some segments of the working poor while making life saving, capital-intensive, and costly emergency room services profitable amongst middle class consumers through the demonstration of its usefulness on the lives of black and brown youth labeled as "gang members."

Street and drug violence thus did not just culturally underwrite the rise of prisons but also the rise of emergency rooms. Until the 1970s, emergency rooms were not associated with modernity, desirable

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University of Southern California) p. 54; and, Cindy I-Fen Cheng. Paper Presentation. "From Sanctuary to Skid Row: Governmentally and the Resettlement of Central Americans in Los Angeles" University of Southern California Center for Transpacific Studies Lecture. November 18, 2014, Los Angeles, California.

[440] Ruth Wilson Gilmore. *Golden Gulag: Prisons, Surplus, Crisis, and Opposition in Globalizing California.* (Berkeley: University of California, 2007) p. 70-78.

services, and high costs but with poverty, poor care, and charity.[441] Before the 1970s, citizens in Los Angeles associated emergency rooms with overcrowded public hospital waiting rooms filled with immigrants and people of color too poor to have a regular physician or too busy to have regularized care. Mainstream physicians and consumers alike generally viewed emergency rooms with disdain, characterizing care within them as non-specialized, poor in quality, and unpleasant. Hospitals responded accordingly, hiring foreign-trained and "moonlighter" physicians and dedicating the least amount of resources as possible to ER service.

Fortunes changed locally for the reputation of emergency rooms in Los Angeles in 1965. In August, the Watts riots drew attention to poverty and the lack of healthcare access of black residents in Los Angeles through the figure of the black youth "rioter." This figure captured the racial and sexual anxiety of culture of poverty theory. It proved incredibly productive in mobilizing momentum around new Medicare, Medicaid, and War on Poverty funds to build new health infrastructure in the neighborhood. Led by County Supervisor Kenneth Hahn and members of the all-black Drew Medical Society, the Los Angeles Board of Supervisors placed forward a ballot referendum, Proposition A, in Spring of 1966 to raise hospital funds through a new county tax to build a new "modern" public health system as an official riot and poverty remediation plan.[442] Hahn campaigned on the premise that this new system would rid the association of poor care with emergency rooms and charity care by replacing it with a suite of comprehensive health clinics that would control access to new acute care hospital services.

For Hahn and other liberal progressives, the referendum results marked the limits of welfare state expansion and racial liberalism in California in the late 1960s. Although roughly 62 percent of County

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[441] According to Brian Zink, MD, many pioneers of emergency medicine received their first experience in the ER as "largely unqualified physician provider[s]." As he explains, "a common method of ER staffing… was to have a nurse assigned to the ER who would assess patients, make triage decisions, and then call an appropriate physician to deliver care. Physicians were not obligated to provide this care," and "by 1960, most larger hospitals began to staff their ERs with physicians, residents, or medical students." "Since emergency practice was not considered a real occupation for a physician, only those without a regular job were available to be hired." Brian Zink, MD. *Anyone, Anything, Anytime: A History of Emergency Medicine*. (Maryland Heights: Mosby-Elsevier, 2006) p. 13-14

[442] In Press Releases sent and used widely by Los Angeles newspapers, Hahn emphasized that "by building a quality hospital, jobs will be created, services will be rendered, lives will be saved, and the health of the community will be improved." Proposition A Fact Sheet - South Los Angeles County Hospital. Kenneth Hahn Collection, Box 200, Folder 3. (Huntington Library, San Marino, CA)

residents voted in favor of the measure, it did not pass the legal threshold of 66 percent to pass as a tax referendum. In spite of the electoral loss, the County Board of Supervisors voted unanimously to fund the hospital from the County's general fund.[443] The Board of Supervisors cited that its executive decision to use general funds without strict voter consent was consistent with a past practice of building infrastructure needed for public safety (county jails, juvenile halls, and courthouses) that also failed to pass as public tax referendums.[444]

More importantly, the loss framed future expectations over hospital construction in the county. Proposition A's failure marked the first time in a century that Los Angeles County citizens had failed to build a public hospital for a growing section of the region. From 1858 to 1960, County voters had consistently voted for the construction and expansion of the County's hospital branches in the region's growing migrant communities in East Los Angeles (County General Hospital), the San Fernando Valley (Olive View General Hospital), and Torrance (Harbor General Hospital).[445] Instead of giving citizens and politicians a mechanism to build a hospital in communities too poor to build a hospital on their own, 1966's Proposition A ensured that any new hospital construction in the County would be determined by free market forces rather than on need. In short, the ballot offered a sobering future where any growth of public health services would have to operate within the 1965 context of infrastructure.

Extending the Power of the Public through the Private Sphere

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[443] Despite failing to reach the necessary two-thirds majority, Hahn interpreted the sixty-two percent garnered by the measure as a public mandate. "We're going to build it," Supervisors Kenneth Hahn asserted in the *Los Angeles Times*, "We'll find a way." *The Los Angeles Times*, March 11, 1966 Kenneth Hahn Collection, Box 215, Folder 34 (Huntington Library, San Marino, CA)

[444] A Report titled "Projects included in failing bond proposals which were subsequently constructed by other means" enumerated five different capital construction projects built by the county from 1947 to 1965 that included a Civic Center Superior Court, Downtown Juvenile Hall Center, County Courthouses, Men's Jail, and the San Fernando Valley Juvenile Hall. June 3, 1966 Use of Public Authority and Non-Profit Corporation for Financing County Construction Kenneth Hahn Collection, Box 203, Folder 33 (Huntington Library, San Marino, CA)

[445] In fact, some newspapers, like the *Monterey Park Californian* used the historical precedent to urge voters to the polls. They reminded voters that, "in previous elections [county voters] have approved health facilities in the central area, San Fernando Valley and the Harbor area," and that "now is the time" to support Watts as the next area to receive support. *Monterey Park Californian* May 26, 1966. Kenneth Hahn Collection Box 201, Folder 4 (Huntington Library, San Marino, CA)

Proposition A set the County on two experimental pathways to extend the health needs of county residents. King-Drew's new health system would model for the county new public efforts that rooted public healthcare around preventative and primary care. Based on designs drafted for King-Drew Medical Center, the County Supervisors voted to "regionalize" the county's public hospital system in 1973 by building out a suite of comprehensive health clinics situated in medically underserved areas of the city. Each clinic would, in turn, be attached to a district led by one of the four acute care public hospitals (County General, Olive View, Harbor, and King-Drew). This new network provided a local place for primary and preventative care while providing a reasonably close public option for acute care services. The coverage of this infrastructure, however, could only reach so far.

Initially working independently from the Board of Supervisors, Hahn felt inspired after the referendum loss to develop an alternative mechanism for public health coverage for regions well outside the reasonable reach of county clinics and hospitals. Hahn anticipated the growth of Los Angeles to continue and wanted to create a serviced citizen desire for health provisions that did not end in new public hospital construction. Hahn approached County Forester and Fire Department Warden Chief K.E. Klinger with a proposal to connect rural and poor regions to hospitals through a new "paramedic program."[446] Stating that "the saving of life and the preservation of health is a primary function of government," Hahn attempted to convince Klinger to enrich the county's rescue units to provide a new service for "areas which are remote or where [private] ambulance service is not satisfactory for the public." Klinger, however, was hesitant to divide the department's strained budget for new services outside of the traditional realm of firefighting.

The concept sat dormant until 1969 when Hahn and a handful of willing firefighters like James O. Page, a former fire chief who served as one of the first demonstration grant paramedics, successfully launched a county-supervised paramedic program funded by a demonstration grant from the Department of Health, Education, and Welfare. The program initially ran out of the County's second largest public

[446] "Memo to Chief K.E. Klinger, Forester and Fire Warden from Kenneth Hahn September 22, 1966" Kenneth Hahn Collection Box 949, Folder 1 Paramedic Program, 1966-1969 (Huntington Library, San Marino, CA)

hospital, Harbor-UCLA, also located in Hahn's district. The grant did more than enrich rescue unit services, it provided a physical venue to reconstitute technology and systems developed elsewhere and for other purposes into one coherent new purpose: the emergency medical system.[447] The effect redefined an entire industry of ambulance services. Ambulances were mostly seen as cumbersome privately-owned medical transport services. Staff were paid to be drivers, had little more than first aid kits on board their vehicles, and were not expected to have any specialized medical knowledge.

By 1972, television viewers across the nation were captivated by the new concept of ambulance services provided by Los Angeles County's Fire Department. Under the consultation of James O. Page, the NBC television show, *Emergency!* (1972-1978), profiled paramedic firefighters of a fictional unit called Squad 51. The pilot featured characters based on Hahn and Page and narrated a plot line focused on Hahn's difficult but eventual victory in winning one of the first paramedic laws in California, the Wedworth-Townsend Act (Ca. SB 772, 1970).[448] More importantly, viewers were exposed through Squad 51's simulated rescues to a very sophisticated integrated system of county services that included a paramedic base station, a two-way communication system, a dedicated physician and nurse staff for receiving transported patients, and a paramedic team empowered with enough medical knowledge and technology on board their ambulance units to stabilize patients from trauma scene to emergency room.

The overnight demand for similar emergency medical services across the nation created a new dilemma for Hahn in the wake of the popularity of the television series. Hahn had envisioned emergency medical services as, more or less, a community action program housed under cash-strapped local governments. As a public utility, county-run ambulance services raised new revenue in times where anti-tax revolts by citizens were depleting public coffers. Paramedic units also required a bevy of ancillary laborers that included mechanics, repair technicians, and 9-1-1 operators that constituted good paying

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[447] For a better accounting of how disparate technologies were "sifted, evaluated, and transformed" to create a unified emergency medical system through federal grants and evaluations, see Andrew T. Simpson. "Transporting Lazarus: Physicians, the State, and the Creation of the Modern Paramedic and Ambulance, 1955-1973" in *Journal of History of Medicine* Vol. 68, April 2013 p. 163-197

[448] *Emergency!* Episode 1, Season 1, "The Wedsworth—Townsend Act" first aired January 15, 1972 NBC (Directed by Jack Webb and Written by Harold Bloom and Robert Cinader) Supposedly the character Randolph Mantooth and Assemblyman Michael Wolski were fictional representations of James O. Page and Kenneth Hahn respectively.

government jobs for locally recruited residents. King-Drew leaders, for example, attempted to develop EMS projects with Model Cities Funding and, with Hahn, also tried to locate a paramedic training base at Drew Medical School.[449] One successfully funded federal program called MEDEX re-trained Vietnam War military corpsman from both black and Latino communities as Physician Assistants assigned to emergency rooms.[450] Other localities also attempted to use veterans of color for their paramedic units.[451]

Government-funded EMS projects, however, were quickly being outpaced by a new entrepreneurial set of private EMS contractors eager to cash in the new demand for ambulance services. The popularity of *Emergency!* eventually turned Page into a private consultant for local municipalities seeking to establish their own EMS systems. In the process of consulting for local municipalities, Page eventually became one of the strongest proponents of privately-owned ambulance firms. Page quickly saw that private ambulance companies could raise capital and absorb risk much quicker than the rural municipalities that had contracted him to develop sophisticated EMS systems. Page began advising municipalities on which services could be developed in-house and which services could be contracted out to private companies.

His consultation strategy helped develop the EMS industry's profile as a unique blend of public-private partnerships that are, still to this day, extremely uneven and particular to their local conditions.[452] By 1975, however, the competition generated between publicly-funded ambulance units and privately-owned ambulance firms became an ethical issue facing the Los Angeles County Economy and Efficiency Commission, an oversight committee created by the County of Los Angeles to monitor internal

[449] The Master Plan detailed a proposal for continued Model Cities Funded Physician Assistant Program that placed students in shorted staffed areas like Emergency and Psychiatry. The School also applied for EMS Development funds from the Regional Medical Program. The Master Plan Study, Summary Report, Section 2 of the Master Plan Vol. I. (The Study Plan) Commonwealth Fund Series 18: Grants, Box 981, Folder 891. (Special Collections, Rockefeller Archives)
[450] "MEDEX Broshure for King-Drew Health Service Area" Commonwealth Fund Series 18: Grants, Box 981, Folder 891. (Special Collections, Rockefeller Archives)
[451] The State of North Carolina hired James Page to consult on its hiring practices of recruiting former military medics."Dynamic State EMS System, Warren and Page Conference Paper" Collection 461 James O Page Collection Box 1, Folder 1 (Special Collections at the UCLA Darling Biomedical Library, Los Angeles, CA)
[452] This claim is made by Manish Shah. "The Formation of Emergency Medical Services System" in the *American Journal of Public Health*. March 2006. Vol. 96. No. 3

government funding.[453] Influenced by private ambulance firms, the Commission argued that Hahn had created a "conflict of interest" in formulating EMS services by making it a requirement that ambulance companies obtain permission with cities first before receiving operating certificates.[454] The effect made doing business in Los Angeles uninviting and risky for private firms who had to compete with the County's monopoly on ambulance services.

Page argued to local city officials in Los Angeles and elsewhere that the objectives of social justice and economic equity that framed the goals of Hahn's EMS system actually hurt the quality of product provided to consumers. He was particularly antagonistic to affirmative action policies to locally recruit paramedics from the communities they served. For instance, Page argued to his municipal clients in North Carolina, that their stated desire for "equity and equality in hiring" ultimately did "not provide for consideration of such factors as motivation, enthusiasm, [and] depth of commitment," needed in selecting the best candidates.[455] He also found that "former military medics" often lacked the skills to think and act independently. His consultations encouraged municipal leaders to see contracts held with private firms as capable of delivering a product equal to or better than that of any services located in-house or supervised by a public agency could.

In the end, Page's lobbying on behalf of private ambulance firms locally and around the nation appeared successful. In 1975, the Los Angeles County Economy and Efficiency Commission noted that

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[453] According to the report, The overall effect clearly favored municipally-run ambulances, producing 26 cities with fire department paramedics and only 4 cities with private ambulance companies. "Report on the Paramedic Committee by the Task Force on Commissions and Committees. Los Angeles Economy and Efficiency Commission. August 1975." Kenneth Hahn Collection Box 950, Folder 5 Paramedic Program, 1975 (Special Collections, Huntington Library)

[454] In 1975, the Los Angeles Economy and Efficiency Commission issued an independent task force report on EMS services stating that the County's paramedic training and certification process had a "preferential effect, if not intent" to favor county- and city-run ambulances over privately owned companies. They cited that as the official body that trains, certifies, and provides EMS services the County had created a "conflict of interest," particularly through the requirement that ambulance companies obtain permission and contract with cities first before receiving certification to operate. "To meet such standards," a private company seeking to operate in Los Angeles had to "forego any consideration of achieving economies of scale because of the limitation of geographic boundaries." "Report on the Paramedic Committee by the Task Force on Commissions and Committees. Los Angeles Economy and Efficiency Commission. August 1975." Kenneth Hahn Collection Box 950, Folder 5 Paramedic Program, 1975 (Special Collections, Huntington Library)

[455] "Dynamic State EMS System, Warren and Page Conference Paper" Collection 461 James O Page Collection Box 1, Folder 1 (Special Collections, UCLA Darling Biomedical Library)

"a number of local jurisdictions have recently begun to compare the costs of public and private services for similar levels of quality. Some are finding that the use of private providers may have a cost advantage."[456] As this statement suggests, the lobbying efforts of private firms to win contracts only goaded Hahn and public ambulance services into deeper market competition with them. While this competitive atmosphere drove both public and private ambulance units to invest in better technology, training, and forms of labor organization to raise standards of care, the entire effect also made EMS services more expensive.

The tremendous concentration of technology, expertise, and resources into county-funded ambulance services was only outmatched by the simultaneous concentration of capital into emergency rooms. In 1971, Los Angeles County General Hospital with its affiliated medical school, the University of Southern California, became the first Emergency Medicine department in the nation. Under the direction of an Obstetrics and Gynecology specialist, Dr. Gail V. Anderson, the program produced some of the first physicians ever trained specifically as emergency medicine doctors. The program's biggest innovation, however, was the assignment of a full complement of around-the-clock specialists (such as anesthesiologists, surgeons, surgical pediatricians, and orthopedic surgeons) who staffed the emergency room alongside emergency medicine doctors.

This organization of specialized labor took advantage of two things. First, emergency medicine departments maximized the reflexive recall of specialist knowledge in time sensitive complex medical cases to treat trauma victims immediately. Secondly and relatedly, emergency rooms in academic medical centers took advantage of the flexible labor of resident physicians, who are paid at lower rates as physicians-in-training then their fully trained and free laboring counterparts. Fully accredited emergency medicine departments are so costly and capital-intensive that many academic medical centers and private

[456] "Report on the Paramedic Committee by the Task Force on Commissions and Committees. Los Angeles Economy and Efficiency Commission. August 1975." Kenneth Hahn Collection Box 950, Folder 5 Paramedic Program, 1975 (Special Collections, Huntington Library)

hospitals are either unable to sustain them or make profit from them.[457] Thus, despite being able to save lives, as Dr. Brian Zink argues, for people anyone, anytime, and anyplace, the labor and operating costs for these services are extremely sensitive to market conditions.

Developing King-Drew's Public Health Clinics and Emergency Room

Hahn's efforts in the wake of the 1965 Watts Riots constituted the county's health policy up until the early 1980s which built out services mostly concentrated in acute care hospitals to a full complement of preventative and emergency room services dispersed throughout the county. As the county's newest public hospital and the only one built entirely from the ground up to the specifications of new federal, state, and local policy, King-Drew's CHCs and emergency room acquainted the larger citizen public with the usefulness and functionality of each of these new health services through the race and sexuality of its mostly black and brown patient base. Ultimately, this process of racialization and sexualization produced two effects. First, it created a framework for citizens to evaluate the meaning and value of new health services based on race and sexuality, and, it created a new context for profitability for private healthcare corporations who benefitted from the tax-supported expenditure of these services.

The first prong of investment mirrored President Nixon's and corporate medicine's movement towards health maintenance organizations (HMOs) amongst privately insured consumers.[458] One of the biggest and most nationally recognized of these was Kaiser Permanente, a privately-owned healthcare corporation who built regionally situated acute care hospitals linked to medical office buildings populated with clinics in surrounding neighborhoods. These efforts were duplicated in the public health sphere. In 1976, the Los Angeles County Department of Health opened the Hubert Humphrey CHC (initially named the Southeast Los Angeles CHC), a two-story $7.2 million clinic located in a neighborhood with four

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[457] In 1975, only 18 such emergency medicine programs existed nation-wide and only 43 had been accredited by 1980. As Brian Zink indicates, 5 programs opened and closed between 1970 and 1978, suggesting that such cost intensive staffing and equipment needs made such programs volatile. Brian Zink, MD. *Anyone, Anything, Anytime: A History of Emergency Medicine*. (Maryland Heights: Mosby-Elsevier, 2006) p. 189-192

[458] Bradford H. Gray. "The Rise and Decline of the HMO: A Chapter in U.S. Health-Policy History" in *History and Health Policy in the United States: Putting the Past Back In.* Rosemary Stevens, Charles Rosenberg, Lawton Burns (eds.) (New Brunswick: Rutgers, 2006), pp. 309-339

different public housing units as a satellite clinic for King-Drew Medical Center. Humphrey was completely new but the County also used the managed care movement as an opportunity to renovate old deteriorating county infrastructure. For example, C. Claude Hudson CHC, formerly an old county hospital (John Wesley Hospital), and the Florence-Firestone CHC, a former multipurpose neighborhood center, were both deteriorating city and county infrastructure before being repurposed.

The managed care movement emphasized primary and preventative care services offered through clinics to prevent costly services and treatments in acute care hospital settings. Instead of emphasizing curative treatments, managed care advocates like King-Drew's Director of Community Medicine, Dr. M. Alfred Haynes, used the clinic to cultivate a desiring subject of health, who was proactive, vigilant, and responsible enough to avoid hospitalization. To bolster the chances of producing this "healthy" subject, the health services at Humphrey CHC were accompanied by social workers who assisted patients in coordinating welfare programs. According to the *Los Angeles Times*, Humphrey stood as the "first multiple health service complex in Los Angeles County to combine outpatient mental care and welfare services under one roof."[459] As Lister Witherhill, Los Angeles County's Director of Health Services explained,"the [County's] unification program will enable us to use our tax dollars more effectively by ending duplicated and fragmented services and decreasing costly hospitalizations."[460]

Emergency rooms, however, added a new unanticipated service point to the comprehensive health service spectrum by creating a place of care for unpredictable medical emergencies. The racialized depictions of gang and drug violence of the King-Drew health service area accentuated this realm of unpredictable "accidents" better than any popular television program did. Emergency rooms conflated crime, violence, and drug use with irresponsible racialized manhood for the broader public by extending an underlying public critique of the presumed domestic space of black and brown youth. Their wayward activities conjured the ills of welfare dependency and racial and sexual lifestyles that countered normative expectations. Together, the street violence of urban neighborhoods racialized and sexualized the

[459] "Health Facility Due" July 13, 1975. *Los Angeles Times* p. G14
[460] "Program Stresses County Health Care" March 6, 1975. *The Los Angeles Sentinel*. p. A3

emergency room with black and brown children while associating their domestic arrangements with public health programs found within CHCs. These processes created a framework of meaning and value for preventative and emergency health services to a broader consumer public that split support for their funding as tax-supported programs.

Whereas emergency rooms offered a valued concrete health outcome (life or death), citizens began to understand the value of managed care programs as a version of medical self-help. Managed care clinics offered consumers education that patients could use at their own discretion to self-fashion a healthy lifestyle as they pleased but emergency rooms promised the alluring resuscitation of bringing one back from the brink of life or death that was not possible without expert help. These distinctions drew a divide between the low-cost payments associated with primary care and the high costs of emergency room treatments. Despite managed care's promises to lower health insurance costs for consumers, rising health insurance rates began to associate the education programs of primary care programs as a luxury rather than a life-and-death necessity. As I will show, taxpayers turned to their own health insurance rates by conflating CHC services with welfare abuse while valorizing emergency services as fundamental to modern living.

Ironically, King-Drew's close association with emergency medical services was not inevitable. Originally, the leaders of King-Drew, Drs. Mitchell Spellman and M. Alfred Haynes designed the medical center without an emergency room in order to shed the stigma of charity once associated with it and public hospitals. When the medical center opened in 1972, however, Spellman and Haynes reluctantly opened one along with an outpatient clinic with services available on the weekends and at night. Federal consultants hired to evaluate the newly opened hospital found this shocking given that homicides and accidents accounted for the fourth and fifth leading causes of death in the neighborhood after cancer, heart disease, and stroke.[461] Further studies conducted by King-Drew's Medical Director Dr. Philip M.

[461] A study team hired by the Department of Health, Education, and Welfare and the Commonwealth studied the newly opened King-Drew Center for a year and a half. Their findings associated "the high incidence of accidents and homicides" - the fourth and fifth leading causes of death in the community after cancer, heart disease, and stroke - with the high rate of "drug traffic that exists on the streets…housing projects and… schools." The Master Plan

Smith revealed that, in actuality, "trauma and homicide result in more person years lost in the King Hospital Service Area than heart disease, cancer, and infant mortality combined."[462] Statements like these bolstered the investment of more resources into building a fully staffed emergency room at King-Drew.

That investment would turn out to make King-Drew a leading center for emergency medicine training and education. Over the next six years, the County's efforts to build a paramedic base station, a separate trauma care area, and enlarged patient waiting room at King-Drew culminated in the opening of an emergency medicine residency program in 1978.[463] By 1981 and 1982, over half the caseload of trauma patients were victims of street violence. Of 508 trauma procedures in 1981 and 478 trauma procedures in 1982, the emergency medicine program at King-Drew had boasted an impressive 97.6% and 97.9% survival rate.[464] Reporting on the progress of the program to Hahn, Acting Director Dr. Subramium Balusubramium observed that emergency medicine programs in the region and across the nation had begun to "view [King-Drew] as the leader in the field."[465] By 1989, the program had become so astute at treating gunshot victims that the U.S. Army instituted a program to train their surgeons in its trauma center before sending them to war theaters abroad.[466]

Balasubramium's comments illuminate how King-Drew's emergency services, along with the emergency rooms at Harbor-UCLA and County General-USC, were celebrated as leading institutions in a new medical frontier centered on emergency medicine. His comments also allude to the boon to private healthcare corporations who scrambled to construct and open emergency rooms to turn profits from increased citizen demand by privately insured patients. As Beatrix Hoffman argues, news reports worked with hospital advertisements and televisions shows to represent ERs "as a 'welcoming beacon' and an

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Study, Master Plan Report, Section I of the Master Plan Vol. II. (Historical Context) Commonwealth Fund Series 18: Grants, Box 981, Folder 891. (Special Collections, Rockefeller Archives), p. I-6

462 "Nov. 29, 1973 Letter to Hahn from Medical Director Philip M. Smith." Kenneth Hahn Collection Box 206, Folder 1.24.2.6.5.75 (Special Collections, Huntington Library)

463 The Medical Center made the physical expansion of the ER and Trauma Center in 1976. It would take two years before authenticating the residency program. "June 30, 1974 Memo from Melvin Fleming to John O'Connor Subject: Paramedic Base Station King Hospital" and "December 22, 1975 Memo From Dan Grindell to William Delgardo" Kenneth Hahn Collection. Box 206, Folder 1.24.2.6.5.80 (Special Collections, Huntington Library)

464 "Martin Luther King Hospital Has Top Trauma Team" July 7, 1983 *The Los Angeles Times*. p. A2

465 "December 17, 1984 Letter from S. Balasubramium, Acting Chief of Emergency Medicine to Kenneth Hahn" Kenneth Hahn Collection. Box 209, Folder 1.24.2.6.5.103 (Special Collections, Huntington Library)

466 "King-Drew to Train Military Surgeons" Nov. 16, 1989. *Los Angeles Sentinel*. p. A1

‘open door’ offering immediate, convenient access to the most highly trained doctors and most advanced medical technologies.”[467] By 1982, this enticement to new profits rapidly increased the number of emergency rooms in Los Angeles to an astounding 97 locations in Los Angeles County.

Hoffman argues that publicly-offered emergency services were important to this boon but it was critical that private hospitals with their own emergency not outcompete or eliminate them. She argues that private hospitals skimmed the market of the most profitable patients seeking emergency room service (those with health insurance) while “dumped” indigent patients admitted into their care after they had been stabilized into public hospital systems.[468] Here, private hospitals used California’s state subsidized form of medicaid, MediCal, as a form of corporate welfare that absorbed costs for indigent care in emergency rooms while insulated the private market from loss. Publicly-offered emergency care, however, also set emergency care standards that made such services desirable and profitable for others but did not lawfully mandate that private emergency rooms follow them.

In other words, despite that 97 emergency rooms existed in Los Angeles in 1982, only 13 of them had proper staffing arrangements to treat trauma cases. (See Figure 8.1) Additionally, more than half of these were located in resource rich private hospitals in far off affluent neighborhoods. Without any regulatory agency determining who and what constituted a proper emergency room, private hospital owners staffed their emergency rooms with specialists based on costs, profit, and convenience rather than on public safety to keep profits flowing.[469] The unevenness of emergency room staffing levels caused a scandal whose flames were stoked by a special series published in the *Los Angeles Times*. Readers in

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[467] Beatrix Hoffman. “Emergency Rooms: The Reluctant Safety Net” in *History and Health Policy in the United States: Putting the Past Back In.* Rosemary Stevens, Charles Rosenberg, Lawton Burns (eds.) (New Brunswick: Rutgers, 2006), p. 266

[468] Beatrix Hoffman. “Emergency Rooms: The Reluctant Safety Net” in *History and Health Policy in the United States: Putting the Past Back In.* Rosemary Stevens, Charles Rosenberg, Lawton Burns (eds.) (New Brunswick: Rutgers, 2006), p. 250-272.

[469] Hospital owners, fearful of losing to competing hospitals, were incredibly resistant to closing their emergency rooms and to agreeing to emergency room standards. Their intransigence caused EMS proponents like Page, Dr. Anderson, and Hahn to join a campaign to institute a new voluntary system devised by Dr. Richard Trumkey for Los Angeles that was not instituted until 1984. The Trumkey plan awarded the designation of a “trauma center” to hospitals willing to agree to a minimum full complement of hospital emergency room staff. The plan created a tier system that delivered the most complex patient cases to trauma centers like those at King-Drew while permitting less severe cases to go to any hospital with a basic emergency room.

1981 were guided through the unpredictability of private hospital emergency room staffing and the amount of death and unnecessary treatment and delay resulting from them. As Andrea Bourquin, RN, of Los Angeles County General Hospital commented to the *Los Angeles Times*, "I have watched patients die because they were taken to the nearest hospital with a 24-hour emergency room rather than the hospital best equipped to care for them."[470]

Emergency Medical Services as Symbol of Responsible Citizenship

Bourquin's comments highlight the growing importance of and critical support for publicly-funded emergency rooms by citizens throughout the County of Los Angeles at the exact moment in which local and state governments were experiencing their greatest budget challenge since the Great Depression. In early 1981, President Reagan announced that he would reverse national trends in supporting federal health and human service programs by cutting them by $1 billion while increasing federal military spending by $14.5 billion. The federal retreat triggered a battle between the California State legislature and County governments in how to divide new responsibilities for health and human service program funding from 1981 to 1983. This fiscal crisis was also exacerbated by the depletion of a $6 billion surplus leftover from 1978 that had been used since the passage of the anti-tax initiative Proposition 13 to fund state and county health programs.

For emergency medical service proponents, the new financial landscape caused anxiety that diminishing allocations for publicly funded emergency rooms would implode the entire EMS system. As the lynchpin to connecting the services of publicly-held fire, police, and 9-1-1 resources, and privately-run ambulance and hospital services, publicly-funded emergency rooms were vital to an entire network of financial interests not directly connected to healthcare. As a survival strategy, EMS proponents including James O. Page took advantage of racial and sexual anxieties around crime and welfare abuse surrounding CHC programs to free up money for EMS. The racialization and sexualization of public healthcare thus did not only benefit individuals like Page but also liberal and conservative lawmakers who used

[470] "Trauma Care in Los Angeles." Jul 16, 1982, *Los Angeles Times,* D6.

discussions about race and sexuality to forward their own political agendas. On one hand, liberal progressives rhetorically defended public health provisions for racial households as necessary in producing Los Angeles as a global city and for rearing future productive citizens while conservatives focused on youth gang and drug violence to end public expenditure to undocumented households and homes on welfare.

This attention discursively produced a shared, albeit contested, ideal of multicultural citizenship based on moral and financial responsibility that actually accounted for the collective prioritization of emergency medicine funding by the mid-1980s. The public focus on saving primary and preventative health care thus actually obscured how liberal progressive responses to the county budget crises of 1981 and 1982 actually fortified conservative claims to expand free market healthcare by repositioning publicly-funded emergency rooms to lubricate an expanded emergency medicine industry and security archipelago. In the minds of many, however, the credit for de-funding public health programs in Los Angeles County did go to the conservative majority of the County Board of Supervisors led by Supervisor Peter Schabarum. Together with Deane Dana and Michael Antonovich, they wielded a 3 vote majority over liberal Supervisors Kenneth Hahn and Ed Edelman.

Schabarum's leadership over the 1981 and 1982 County budgets mirrored President Reagan's actions by cutting $75 million in 1981 and proposing $100 million in cuts in 1982 from the county's health budgets while leaving law enforcement and county fire department money associated with emergency medical services untouched.[471] The cuts immediately cut funding across the board for programs by 10-16%, a 75% reduction in King-Drew's Family Medicine program, and the closure of 8 CHC clinics in the county's system.[472] The County also jettisoned preventative care programs for medically indigent single adults and undocumented citizens through a new billing policy (DHS Policy

[471] According to *New York Times* reporter Robert Lindsay, the crisis was the "most dire fiscal crisis since the Depression." His article reported on how County Supervisors "have begun ordering substantial cuts in the amount of medical and health services provided by the county and are reducing by 10 to 16 percent the scope of virtually every other service it provides except police and fire protection." Robert Lindsey. "Tax Limit in California Threatening to Cut Los Angeles County Services" Juluy 2, 1981. *New York Times.* p. A14

[472] Bill Boyarski. "New LA County Budget Cuts Proposed: More Hospital, Neighborhood Health Center Reductions Included" April 27, 1982. *The Los Angeles Times* (Orange County Edition) p. A5

No. 516) in April 1981 that required citizens seeking county care to reveal either their eligibility for Medicaid/Medicare or their ability to pay for services rendered through a lien or wage garnishment.[473] The cuts drastically isolated the patient profile of CHCs to women on welfare while shifting the entry of care for a majority of the medically indigent and undocumented to the emergency room.

The cuts did not just impact services that had been built since the mid-1960s but acute care services that had been traditionally offered by the County health system since its inception.[474] The prospect that public healthcare was moving towards simply being a system of emergency rooms attached to anemic acute care services alarmed State Legislator Art Torres who passed a bill strengthening the Bielensen Act, a state provision that requires counties contemplating health care reductions to hold public hearings and determine that the cuts will not affect certain categories of people. According to the Los Angeles Times, the bill prevented Los Angeles county "from implementing cuts until the state Department of Health Services conducted its own review and concurred that the reductions would not hurt the poor."[475] As Paul Press, Torres' legislative aide phrased it, liberal legislators were compelled to pass it because, "'the feeling was that the Los Angeles County board was no longer interested in being in the health service business."[476]

Over the course of the budget debates a multicultural coalition consisting of civil rights activists, labor unions, churches, and community based organizations protested weekly at Supervisor meetings and

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[473] The final policy language read as follows: "to be eligible to receive non-emergency medical services other than medical services to protect the health of the community (see Policy No. 521) a patient shall be required to provide financial data, execute financial arrangements and to establish program eligibility, where applicable, before non-emergent care is rendered. This process shall include the following minimum requirements: a) signed declaration of personal employment (or) prepaid health plan status; b) Provision of acceptable address verification, or a valid Medi-Cal or Medicare card in those cases were no self-pay liability is likely to result; c) assignment of all declared insurance benefits to the County; d) execution of property liens, where applicable; e) application for medical where potential eligibility is indicated. Where potential Medi-Cal is not indicated, a reimbursement agreement will be required. Such reimbursement agreement shall cover any amount remaining after all third-party benefits have been exhausted or the patient's liability under the County's Ability-to-Pay Plan ifs that is less. Advance patient payments may also be deducted." "Letter to Melvin J. Fleming, Deputy Director of Hospitals from William A. Delgardo, Administrator; Subject: Treatment Policy Revisions" Kenneth Hahn Collection. Box 208, Folder 1.24.2.6.5.90 1981 (Special Collections, Huntington Library)

[474] According to Jean Merl of the *Los Angeles Times*, the "Board of Supervisors will be asked today to add another $100 million in health services to a list of potential cuts already totaling more than $90 million. Both inpatient and outpatient services at all seven county hospitals may be affected, according to a board memo." Jean Merl. "More County Health-Care Cuts Studied" March 23, 1982. *Los Angeles Times*, p. C1

[475] Jean Merl."Panel Approves Bill to Limit Health Cuts" Aug. 20, 1981 *Los Angeles Times* p. C1

[476] "Public Health Hearing" April 1, 1982. *Los Angeles Sentinel*. p. A2

gathered at sites impacted by the cuts.[477] The rallies served as a platform to project an image of the community as full of hardworking, moral, and responsible citizens who stood against their racialization and sexualization as criminals, drug users, and morally irresponsible people. An exemplary event sponsored by the *Los Angeles Sentinel* and Councilman David Cunningham on July 19, 1981, was billed as a rally with three purposes. Held near "one of the 'hotspots' of illegal drug activity," on the corner of Victoria and Adams Boulevards, black and brown community activists came together in an assembly originally "slated as an anti-PCP rally" to "address the seriousness of the health department budget cuts" and "express extreme displeasure in which the *Los Angeles Times* treated the black community in a [recent] series of articles."[478]

The *Los Angeles Times* article served as the vehicle to bridge community discussion around the health cuts and neighborhood crime, suggesting that citizens believed that the health budget cuts were a part of retaliatory response to black and brown crime that others were calling a "white backlash." Rather than focus on the diversity of views held on crime, the article flattened black and brown life in the city by only focusing on the criminal activity of some residents. Published on July 12th, 1981, the *Los Angeles Times* circulated an investigative report titled, "Marauders from Inner City Prey on L.A.'s Suburbs."[479] The article, spread out over five newspaper pages, blended computerized statistics of black and brown crime, sophisticated mappings of supposed gang "raids", and stylized accounts of drug use, rape, and robbery, to "investigate an emerging phenomenon in America: the permanent underclass" in the city's black "ghettos" and brown "barrios."

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[477] These organizations included but were not limited to: the Coalition for Economic Survival, the County Health Alliance, the South Central Health Coalition, the Japanese Welfare Rights Organization, the Southern Christian Leadership Conference, the NAACP, the National Urban League, the Los Angeles County Federation of Labor, the Watts Health Foundation, Kwanza (a black activist group of women involved in theater arts). These organizations were also joined by the offices of Congressmen Dixon, Dymally, Hawkins, Assemblywoman Maxine Waters, Councilman David Dunningham, Supervisor Kenneth Hahn, and LAPD Deputy Chief Jesse Brewer. See: "Rev. Lawson Leads Angry Protests Over Health Cuts" July 30, 1981 *Los Angeles Sentine*l p. A1; "Supervisors Earmark $1 Million to Salve Cuts in Health Services" August 5, 1981 *Los Angeles Times* p. D1; "Some Leaders are Leading" August 6, 1981. *Los Angeles Sentinel* p. A6; and "Proposed Health Cuts Hit" October 8, 1981 *Los Angeles Sentinel*, p. A3.

[478] James H. Cleaver. "Massive Street Rally Slated Sunday at Victoria and Adams" July 16, 1981 *Los Angeles Sentinel*. p. A1

[479] Richard E. Meyer and Mike Goodman. "Marauders from Inner City Prey on L.A.'s Suburbs" July 12, 1981 *The Los Angeles Times* p. A1

Ultimately, activists attending the rally took issue with the article because it emphasized a common belief amongst community activists that public funding was contingent on the community fighting crime and racism. According to rally leader and *Sentinel* executive editor, Jim Cleaver, "We do not deny the validity of the article but it tells half the truth."[480] Subsequent speakers focused on activating citizens to grow the community as a neighborhood of respectable and responsible people. Mary Henry, executive director of the public health clinic called the Avalon Carver Center, for example, implored those in attendance to fight against crime and racism by boycotting businesses around the drug corner "until the drug traffic is eliminated" and the *Los Angeles Times* until it "cleans up it's act." She declared, "I'm going to be fighting what is wrong in this community as long as I live," and, " I can tell you as an old Christian lady that God is on our side."

For those living outside the neighborhood, however, the idea that public health clinics were funding crime and causing a budget crisis for tax payers was a real opinion. At a conference in Houston in 1981, James O. Page declared, "health education, especially preventative medicine" was "one of government's biggest failures."[481] Unable to "change life-styles, change personal habits, improve diet" and provide "quality health care for all citizens," Page argued that the government's scheme to produce healthy individuals over the 1960s and 1970s has resulted in "an economic imbalance that could easily break our nation." He explained that rather than helping the poor become healthier, the program has sunk precious tax dollars into those segments of society that "lack of individual motivation." In stating that "people [who] are not motivated to accept personal responsibility for their own health are not likely to learn how," Page offered an alternative opinion on the effect of preventative health programs. Instead of helping patients to become self-responsible individuals, he held the belief that such programs only further encouraged their dependence on state services.

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[480] James H. Cleaver. "Massive Street Rally Slated Sunday at Victoria and Adams" July 16, 1981 *Los Angeles Sentinel*. p. A1

[481] "Conference on Citizen CPR" James Page Collection 461 Box 1, Folder 4 (Special Collections, UCLA Darling Biomedical Library)

Page's comments disguise how he believed that financial interests of both public and private corporations vested in EMS services were in peril if significant public support for public health clinics were to continue at the expense of funding public emergency rooms. His targeting of public health clinics reveal an opinion that the government ought to continue funding emergency rooms as a matter of upholding services for otherwise responsible and productive citizens caught in unfortunate "accidents." In the context of a fiscal crisis where questions about program usefulness, immediate efficacy, and popularity were more pertinent to prioritizing health budgets, Page's comments appear to resonate in the County's budget prioritization in the early 1980s.

Conclusion

From the perspective of Jim O Page, the County's shifting priorities symbolized not a strict divestment from communities of color but rather a deliberate uneven distribution of resources that split society between a multicultural cosmopolitan class of respectable and self-responsible citizens and a multiracial permanent underclass consisting of the working poor, unemployed, and undocumented. Instead of eroding the welfare state completely, the County's 1981 and 1982 budgets pivoted the function of the welfare state on the emergency room by lowering the number of public health provisions to them and by strengthening their place within a security state. By anchoring the welfare state in the emergency room, the County essentially mandated that any citizen seeking care could minimally get it through the emergency room while any citizen seeking "comprehensive" healthcare had to get it by working, marrying, or being dependent on a financial actor who could pay for it in the free market.

These actions essentially produced emergency rooms as a new "right" while taking away rights to other services by the state's willingness to go into debt on behalf of an enlarged private healthcare and public prison economy. In other words, the county's budget by 1982 did not only produce a new policy position centered on emergency room healthcare but also adjusted to settle on the idea that the emergency room would replace the CHC in supporting working poverty. Although the County's new billing policy in 1981 requiring county patients to declare their citizenship status was meant to expunge undocumented

citizens from care completely, an injunction filed by immigrant and civil rights lawyers produced a new right. Lawyers won the right of undocumented immigrants to seek care in emergency rooms while losing their right to seek primary and preventative care services.[482] By 1982, the settlement established a policy for the County was willing to accept and a precedent that President Reagan would ratify later as a matter of national law in EMTALA in 1986. Nationally, the Act would be known, as former director of the federal centers for Medicare and Medicaid, Thomas Scully, phrased it, "a backdoor way to get people universal access to at least emergency room 'care'."[483]

From the viewpoint of private hospitals who had initiated the phenomenon of "patient dumping" on county hospitals, the Los Angeles County Supervisors under Peter Schabarum had surprisingly taken up the practice of "dumping" on themselves. By "dumping" a segment of the poor onto the emergency room, the County momentarily isolated the care of undocumented citizens, the medically indigent, and black and brown youth in emergency rooms while heightening the association of black mothers with CHCs until IRCA granted amnesty to immigrants who now had access to the number of public health clinics that had managed to survive the gambit of the early 1980s budget crisis. In that interim, it is no coincidence that President Reagan's vilification of the "welfare Queen" was so racialized and sexualized as a problem of black poverty and increasingly became associated with Latina immigration as the 1980s unfolded.

If emergency rooms are, as I am arguing, more fundamental to a security archipelago than they are to public health infrastructure, then the future expansion of access to healthcare options resides in the dismantling of the institutions that make up the carceral state. Here, there is an ethical crisis that splits public health strategies along the lines of where health should and ought to reside. Public health scholars such as Jena Loyd argue that a truly egalitarian and democratic approach to health policy must center itself on the dismantling of the military industrial complex that grew exponentially under President

[482] To Executive Committee from Robert White Subject: Treatment Policy April 1, 1981 Hahn 208 1.24.2.6.5.90 Kenneth Hahn Collection, mssHahn Collection, Huntington Library, San Marino, CA
[483] Thomas Scully. 2003 interview on "All Things Considered," National Public Radio, 3 September

Reagan's administration.[484] She argues that military and prison infrastructure built under his administration overwhelmingly abandoned the health rights as civil rights project instituted in the 1960s.

It also requires public health scholars to think critically about dismantling the prison industrial complex that does not reduce itself to or succumb to leaving those currently behind bars languishing in infrastructure with little to no health infrastructure. Prison healthcare is itself a growing element of the prison industrial complex that appears to support the strengthening of the carceral economy. In this regard, the process of racialization and sexualization of those a part suspected of being a part of the "permanent underclass" prompts consideration of a political coalition for better healthcare access that spans public health advocates, immigrant rights activists, welfare rights activists, the unemployed, prison abolitionists, and those incarcerated.

[484] Jenna Loyd. *Health Rights are Civil Rights: Peace and Justice Activism in Los Angeles, 1963-1978* (Minneapolis: University of Minnesota Press, 2014)

Figure 8.1 Trauma Centers in Los Angeles County 1986

Figure 8.1 Trauma Centers in 1986. By 1983, Los Angeles had instituted a voluntary Trauma Center designation that differentiated highly specialized emergency rooms from emergency rooms with intermittent staffing levels. Note the strategic location of publicly-funded trauma centers. Map made for author by Breanna Spears.

Conclusion
The Twilight of Multiculturalism?

My own personal experience working at King-Drew Medical Center began in the summer of 2005. As a labor organizer for a national healthcare union who represented the interns and residents at King-Drew, I was sent to record testimonials from union members for public health proceedings known in California as "Beilensen hearings" (California Health and Safety Code 1442.5), which require county officials to gather information on the impact of public health programs slated for closure.[485] My assigned task was to help record, dictate, and transcribe the testimonials of King-Drew's resident physicians on the impact of Los Angeles County's Department of Health planned closures of the medical center's mother and baby service programs, including the neonatal intensive care unit and the obstetrics and pediatrics units. The Los Angeles County Board of Supervisors, on advice of Navigant, a consultant company paid $15 million to make recommendations on improving the facility, defended the actions as necessary to focus attention on saving and fixing the hospital's remaining services.[486]

The mother and baby units, however, were not considered by physicians and community members as the biggest problem services at King-Drew. In fact, by the time I arrived, the Los Angeles County Board of Supervisors had already closed King-Drew's famed trauma center in December 2004. Despite being a top ranked academic medical program and the second busiest trauma center in Los Angeles, County Supervisors Gloria Molina, Zev Yaroslavsky, Don Knabe, and Michael Antonovich voted to shift provision of services to Harbor-UCLA and give an initial $2.9 Million contract to the for-profit California

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[485] From 2004 to 2006, I worked for the Committee of Interns and Residents (CIR), a national local affiliated with the Service Employees International Union (SEIU), the largest nationwide healthcare union in the nation. Beilensen hearings are named after Anthony Beilensen, a California Assemblyman, State Senator, and U.S. House Representative for Southern California.

[486] Mitchell Landsberg and Jack Leonard. "King-Drew's Trauma Unit Ordered Shut." November 24, 2004. *The Los Angeles Times*. Supervisor Michael Antonovich stated, "these actions truly are the first step in a long road to restore medical standards and excellence to the hospital. Right now, anyone being treated there is being treated at a danger to their health and their life." "[Zev] Yaroslavsky, who voted to close the [trauma] unit along with Antonovich and Supervisors Don Knabe and Gloria Molina, added that the board's objective now was "to restore this hospital to a level of service, a quality of service, that is not just standard — I hope better than standard."

Hospital Medical Center to operate a trauma center.[487] Far from being problematic, the trauma center and mother and baby services at King-Drew were exemplary care units that brought significant medical prestige and, more importantly, crucial federal training and education funds to Drew Medical School.[488]

Describing the County's actions as "the cure that cripples," Dr. Felix Aguilar of the California Latino Medical Association and Dr. Robert Tranquada and USC Schools of Medicine and Public Policy explained to *Los Angeles Times* readers that closing both the medical center's trauma center and mother and baby programs, would "leave King-Drew generally unequipped to serve acute-care needs of the community (which has a markedly higher-than-average proportion of young people."[489] Aguilar and Tranquada suggested that the displacement of Drew's key and lucrative services into the hands of other providers exposed the County's deeper desire to rid itself of its relationship with Drew Medical School. As they phrased it, "losing its obstetrics, pediatrics and neonatal capabilities would demolish its most important teaching programs, threatening the Charles Drew University Medical School's very existence."[490]

As detailed by Darnell Hunt and Ana-Cristina Ramon, the County Board of Supervisors actions appeared to be fueled by the relentless reporting of the *Los Angeles Times,* who would go on to win a 2005 Pulitzer for "Public Service" for its 2004 coverage of King-Drew.[491] The *Los Angeles Times* reported on a list of horrors recounted to it by current and former staff, patients, and community members of King-Drew that included: allegations of chronically absent, late, or missing medical staff; lack of supervision of medical trainees and of critically ill patients; and, a slew of medical errors and mistakes

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[487] The only member to not vote for the measure was Yvonne Braithwaite-Burke, who represents the district that King-Drew sits in. She abstained.

[488] The Emergency Medicine program became well known for its treatment of gunshot and stabbing victims and the Neonatal Intensive Care Unit became renowned for its care of newborns afflicted with substance addiction (pejoratively known as "crack babies"). These programs provided Drew Medical School with considerable national prestige and federal money for their training programs.

[489] Felix Aguilar and Robert Tranquada. "The Cure that Cripples" October 6, 2005. *The Los Angeles Times*. Accessed online: http://www.latimes.com/ March 20, 2017

[490] Felix Aguilar and Robert Tranquada. "The Cure that Cripples" October 6, 2005. *The Los Angeles Times*. Accessed online: http://www.latimes.com/ March 20, 2017

[491] Darnell Hunt and Ana-Cristina Ramon. "Killing 'Killer King': The *Los Angeles Times* and a 'Troubled' Hospital in the 'Hood," in *Black Los Angeles: American Dreams and Racial Realities* (New York: New York University Press, 2010)

ending in preventable morbidity. Rather than account for the generally poorer and sicker population of Watts, King-Drew's lackluster performance and costly operating costs were compared with Harbor-UCLA, another county facility with higher performance rates and lower operating costs.[492] The *Times* reported that the County Board of Supervisors knew of all these problems for years but failed to act in fear of being called "racists."[493] "Given the choice," Mitchell Landsberg of the *Los Angeles Times* asserted, "the distress of racial politics on the one side, the likelihood of more needless deaths on the other — the board chose to risk the latter."[494]

Although the *Los Angeles Times* lambasted the Supervisors as part of the problem, its reporting was productive for the Supervisors in helping to re-frame the school's leadership as failing to manage the health of the city's poorest citizens. The public now stood behind the Supervisors to act, ironically, in the name of deaths at King-Drew it had failed to intervene on previously. With greater public support, the Supervisors severed its relationship with the Drew School. Under the direction of a new County Health Director, Dr. Bruce Chernof, the County redesigned King-Drew's health services under the leadership from authorities at Harbor-UCLA.[495] However, when the hospital failed to pass a "make-or-break" Medicare and Medicaid re-certification in 2006, the County Board of Supervisors downgraded the facility in 2007 from a hospital to a County-run comprehensive healthcare center with no acute care services.[496]

After eight years without acute care services, Watts residents celebrated the return of an acute care hospital with the opening of Martin Luther King, Jr. Community Hospital, a for-profit hospital, on the

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[492] According to the Times, King-Drew spent $492 more per patient daily than Olive View-UCLA, $685 more than County-USC and $815 more than Harbor-UCLA in 2002-2003. They reported that "the hospital with the most comparable budget is Harbor-UCLA, a much bigger facility 10 miles away. Last year, Harbor-UCLA had nearly $372 million to work with, not much more than King-Drew's $342 million. Harbor-UCLA, however, did far more with its money. It treated 61% more people in its emergency room and admitted 91% more patients." Charles Ornstein, Tracy Weber, and Steve Hymon. "Underfunding is a Myth, but the Squandering is Real." December 6, 2004. The Los Angeles Times. Accessed online: http://www.latimes.com/ March 20, 2017

[493] Mitchell Landsberg. "Why Supervisors Let Deadly Problems Slide" December 9, 2004. *The Los Angeles Times*, p. A1.

[494] Mitchell Landsberg. "Why Supervisors Let Deadly Problems Slide" December 9, 2004. *The Los Angeles Times*, p. A1.

[495] See: Alison Hewitt. "King-Drew to be Run by Harbor?" September 27, 2006 *The Torrance Daily Breeze*. p. A1 and Susannah Rosenblatt, and; Steve Hymon. "Supervisors OK King-Drew Plan" October 18, 2006. *The Los Angeles Times*. p. B1

[496] Jack Leonard. "King-Harbor Inspection Report Released" August 14, 2007. *Los Angeles Times*. Accessed online: http://www.latimes.com/ March 20, 2017

same campus that King-Drew Medical Center sat. The area's healthcare renaissance was made possible by new federal legislation, the Affordable Care Act, also known as Obamacare, passed in 2010 by President Obama that infused new federal healthcare dollars into the area. As I will explain, the hospital revives the same public-private relationship between the county and a new private agency, the MLK, Jr. Los Angeles Healthcare Corporation, to service the area's now surrounding majority Latino/a neighborhood. Unlike its predecessor, the hospital is not attached to a medical school but is a venture led entirely by an independent board of directors. At the time of writing this dissertation, however, the future of King Community Hospital is uncertain. President Obama's landmark healthcare law is targeted for repeal and replacement with President Trump's American Health Care Act, known variously by political pundits as Trumpcare and Ryancare (after the President and current Speaker of the House).

In this Conclusion, I argue that the *Los Angeles Times'* re-hashing of culture of poverty theory in 2007 permitted the County Board of Supervisors to retreat from its responsibility over a permanent underclass by playing up a belief that the Drew Medical School had become arbiters of slumlord care. I situate my analysis of Obamacare and Trump/Ryancare as two federal responses that continue to address inequitable distribution of healthcare through the functions of racial capitalism that promise to exacerbate the problem rather than abate them. By bringing the lens of racial capitalism to bear on the limits and possibilities of both healthcare legislations, I offer opinions on the need for new social movement voices that can imagine a world that do not reify or replace multiculturalism with more damaging paradigms of race and class.

The Voices of King-Drew's Resident Physicians

The actions of the Board of Supervisors to close the trauma center and the mother and baby services at King-Drew placed the resident physicians in Drew's medical training programs in a difficult position because it implicated the care provided by them as compromised. Despite the leadership of the County and the National Medical Association to address the effect of stigma of race and class on medical professionals in the 1970s, *The Los Angeles Times* framing of King-Drew's physicians posited that this

strategy had failed. The effect of the news coverage drew attention to the work ethic, standards of responsibility, and commitment to self- and community improvement of King-Drew's medical professionals as no better than those accused of being a part of the "permanent underclass."

The *Los Angeles Times* reporters Charles Ornstein and Tracy Weber, for instance, argued that "mistakes and lax supervision at times have debilitated King-Drew's pharmacy and doctor-training programs, which affect nearly every patient."[497] Recounting detailed cases of questionable medical decisions performed by resident physicians to "highlight [the] dangerous lapses in the supervision of King-Drew's doctor-training programs," the authors found a residency training program curiously out of sync with Drew's founding mission to "turn out talented physicians to serve the nation's impoverished minority communities."[498] They highlighted cases of "absenteeism, profiteering, [and] even the commission of felonies in off hours" by resident physicians in its orthopedic surgery program and deeply explored the patterns of malpractice litigation against of one resident in its obstetrics and gynecology department.[499] While Ornstein and Weber collaborated with the voices of experts to assert that medical residents, "are expected to make mistakes," they argued that, "experienced physicians overseeing them are expected to catch the errors."[500]

Times reporters Ornstein, Weber, and Steve Hymon followed these stories with detailed accounts of those in charge of the Medical School. *The Times* singled out Dr. George Locke, the Chief of Neurosurgery and Neuroscience, who they introduced to readers as "a member of King-Drew's ruling class."[501] Earning a combined salary from the hospital and medical school of more than $1 million over the course of two years, *The Times* argued that his pay rate did not match his productivity. County documents revealed that Locke only took part in 15 out of 501 surgeries performed by his department

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[497] Charles Ornstein and Tracy Weber. "The Troubles at King-Drew; How whole departments fail a hospital's patients." December 4, 2004. *The Los Angeles Times*, A1.
[498] Charles Ornstein and Tracy Weber. "The Troubles at King-Drew; How whole departments fail a hospital's patients." December 4, 2004. *The Los Angeles Times*, A1.
[499] Charles Ornstein, Tracy Weber, and Steve Hymon. "Underfunding is a Myth, but the Squandering is Real." December 6, 2004. The Los Angeles Times. Accessed online: http://www.latimes.com/ March 20, 2017
[500] Charles Ornstein, Tracy Weber, and Steve Hymon. "Underfunding is a Myth, but the Squandering is Real." December 6, 2004. The Los Angeles Times. Accessed online: http://www.latimes.com/ March 20, 2017
[501] Charles Ornstein, Tracy Weber, and Steve Hymon. "Underfunding is a Myth, but the Squandering is Real." December 6, 2004. The Los Angeles Times. Accessed online: http://www.latimes.com/ March 20, 2017

over a period of four years. In interviewing Dr. Martin Holland, Chief of Neurosurgery at San Francisco General Hospital, to construct a comparison, *The Times* highlighted that Holland performed 100 surgeries in the previous year and earned half of what Locke earns. These points generally emphasized that poor medical care in the medical center was the direct result of the absent, money hungry, and careless approach to healthcare by the medical center's academic leadership.

The articles thus drew upon the racial scripts of culture of poverty theory to argue that the pathologies of the urban underclass could also be applied onto the medical professionals providing them care.[502] The behavior of King-Drew physicians, as described in the *Los Angeles Times,* countered the normative expectations of physicians and the medical world. Their actions were interpreted by readers as aspirations that reaped and abused the benefits and privilege of being medical professionals that were seen as self aggrandizing, opportunistic, and above all, dangerous to patient care. These values appeared out of place with the ideals of selfless service, compassion, and ethic of "do no harm" normally assigned to those in the profession. Rather than help readers imagine the medical center as a place of order and healing, the newspaper painted a picture where the chaos and disorder of the medical center was undifferentiated from the surrounding "ghetto."

The County Department of Health leveraged the image of King-Drew physicians as "unfit" to provide care to argue that the acute care services in Watts were, in addition to being abnormally expensive, were actually redundant. Under the leadership of Health Department Director, Thomas Garthwaite, the Board of Supervisors argued that the acute care needs of Watts' citizens could be better served by the area's surrounding for-profit hospitals. He argued that "obstetric and pediatric services are widely available at other nearby hospitals and little used at King-Drew."[503] Since, "all children under 6

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[502] Here I use the term racial scripts as Natalia Molina does. She argues that racial scripts highlight the ways in which the lives of racialzied groups are linked across time and space and thereby affect one another, even when they do not directly cross paths. (6) Natalia Molina. *How Race is Made in America: Immigration, Citizenship, and the Historical Power of Racial Scripts*. (Berkeley: University of California Press, 2014)

[503] Alison Shackleford Hewitt. "Molina, Burke want Supervisors to Delay Vote on King-Drew Cuts" August 16, 2005 *The Torrance Daily Breeze*, A6.

and pregnant women can qualify for federal insurance programs," Garthwaite suggested that it was now "much easier for [poor expecting mothers] to get care at private hospitals."[504]

By making the role of acute care physicians appear as poor in quality and not popular, Garthwaite argued that the closure of King-Drew's expensive mother and baby programs would re-focus the energy of the county facility on services that he claimed were in higher demand. "Closing departments simplifies the mission, simplifies the number of procedures that have to be fixed," he argued, so that the hospital can be freed up to provide needed care around "diabetes care, cancer screening and treatment for high blood pressure."[505] Unlike the costly needs associated with surgical operating rooms, specialized staff, and technology of labor and delivery, nurseries, and post operative care, these programs effectively downgraded the hospital to a wellness clinic focused on patient education and lifestyle counseling.

Many of the resident physicians I interacted with used their Bielensen hearing testimony as an avenue to refute how the *Los Angeles Times* and the Board of Supervisors were framing the closure of acute care healthcare services. In addition to asserting that the care they provided was not substandard or carelessly administered, the physicians I spoke with believed it was dangerous to limit the types of public care options in low income neighborhoods because their absence often meant that local citizens would likely not receive any care at all. The absence of local acute care services would mean a return to pre-1965 care options - forcing residents to travel ten miles north to County-USC or ten miles south to Harbor-UCLA to receive services once reachable by foot or by quick bus ride. As Dr. Yusef Morantwade of the Obstetrics and Gynecology Department testified, "the difference between a paramedic driving ten minutes to King-Drew and thirty or sixty minutes to another County hospital can significantly alter the outcome of a situation, with tragic consequences."[506]

[504] Alison Shackleford Hewitt. "Molina, Burke want Supervisors to Delay Vote on King-Drew Cuts" August 16, 2005 *The Torrance Daily Breeze*, A6.
[505] Alison Shackleford Hewitt. "Molina, Burke want Supervisors to Delay Vote on King-Drew Cuts" August 16, 2005 *The Torrance Daily Breeze*, A6.
[506] Declaration of Yusef Morantwade, MD. Beilensen Hearing Testimony. September 29, 2005. Personal Archive of Author.

Contrary to the opinion of the Garthwaite and the Supervisors, the physicians were skeptical of the assertion that access to better services existed elsewhere in the community. They did not expect for profit hospitals to be welcoming or tolerant of no- or low- income patients. King-Drew resident physicians made careful descriptions of the patients they served, speaking about the poverty of the Spanish-speaking, African American, and to a lesser extent, Tagalog-speaking patients, under their care. As resident physician leader, Dr. Regina Edmond of the Obstetrics and Gynecology Department, phrased it, "our patients are unique to this community."[507] "They routinely have co-morbid conditions that are at their tertiary stage (medical terms that expressed advanced stages of disease that are deadly), and social issues that require experienced practitioners to delicately address their concerns and provide the extra treatment that is often required." Her statements were collaborated by another resident physician leader, Dr. Gina Jefferson, of the Otolaryngology/Head & Neck Surgery Department, who testified that there were two main reasons why patients tended to present with advanced stage diseases. She wrote that "our patients are either too busy working and trying to make ends meet" or "are [here] illegally in the US and [are] afraid they will be discovered and sent back to Mexico."[508]

As Pediatrics resident physician Dr. Alan Dakdak explained, these factors meant that no real alternative option for care existed outside of King-Drew. He wrote, "there is no purpose in going to a private facility that will not take care of them unless they have an emergency, especially if they do not have private insurance."[509] In his testimony, Dakdak recounted the story of a 9-year old Hispanic boy who presented to him after an injury two weeks prior caused pain in his left arm. The child's crying grandfather told Dakdak that, "he went everywhere and called every orthopedic surgeon he could find in the area and none of them would do it because he had MediCal and none of them will see a MediCal patient."

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[507] Declaration of Regina Edmond, MD. Beilensen Hearing Testimony. October 1, 2005. Personal Archive of Author.
[508] Declaration of Gina Jefferson, MD. Beilensen Hearing Testimony. September 30, 2005. Personal Archive of Author.
[509] Declaration of Alan Dakdak, MD. Beilensen Hearing Testimony. September 26, 2005. Personal Archive of Author.

While all of the physicians did not oppose investing in programs focused on diabetes, heart disease, and cancer screening, they saw the trade off in converting the hospital into a community health center as a deadly one. For many resident physicians in the obstetrics and gynecology department, closure meant sending the complicated cases they regularly receive to hospitals unaccustomed to seeing such complicated patient profiles. While Garthwaite and the Supervisors "say that our [patient consumer] numbers are low," Dr. Helena Mba of the Obstetrics and Gynecology Department stated, "each of our patients is high-risk, whether because of substance abuse, past C-sections, or other problems too numerous to mention."[510] Since they observed that many mothers in the neighborhood wait to see a doctor until they give birth, Dr. Guillermo Giron of the Obstetrics and Gynecology Department argued that "eight out of ten deliveries [at King-Drew] are high-risk and have complications."[511] For Giron, this meant that doctors at King-Drew "receive very good training and experience" in comparison to physicians who are accustomed to patients who receive prenatal care and do not present with the complications of substance abuse and poverty.

The testimonies provided by resident physicians reveal that the County's health services were critical in managing poverty in the area by keeping costly and complicated patient cases from entering the for profit market. Obstetric and Gynecology resident physician Dr. Ramy Eskander, for example, related that colleagues at nearby St. Francis Medical Center, "are not familiar nor are they excited, to put it nicely, about serving King-Drew patients who are either sick to being with, have multiple morbidities, are poly-substance abusers, or have very little prenatal care."[512] Since "most people do not want to take care of these King-Drew patients," Eskander testified, "the result will be that women, children, and newborns will either be left in the cold or will have to wait months to receive treatment."

The Containment of Poverty

[510] Declaration of Helen Mba, MD. Beilensen Hearing Testimony. September 29, 2005. Personal Archive of Author.
[511] Declaration of Guillermo Giron, MD. Beilensen Hearing Testimony. September 26, 2005. Personal Archive of Author.
[512] Declaration of Ramy Eskender, MD. Beilensen Hearing Testimony. September 26, 2005. Personal Archive of Author.

What is striking about the Beilensen hearing testimony of King-Drew's residents is how the physicians accepted the unique role that they played in the healthcare landscape of Los Angeles as physicians working in a "safety net" hospital. Their testimony underlined how their care was critical, life-saving, and needed because they cared for a population that no other voluntary hospital took responsibility for. They also understood clearly that their role in the healthcare landscape managed poverty and sickness more than alleviate it. Their testimony positioned this role as desirable to all parties involved, arguing that King-Drew's role in the community mitigated health crises of indigent and undocumented citizens who elected to seek care at the hospital, produced well-trained physicians able to manage high-risk cases successfully after they finished their residency programs, and kept surrounding for-profit hospitals profitable by keeping their waiting rooms free of complicated and financially burdensome medical cases.

The collapse of this system in 2007 suggests that a new crisis was emerging that required new responses to contain it. While the County did not totally abscond from the neighborhood, the conversion of the hospital into a community health center represented a retreat that invested only enough local resources to run programs primarily seeded from federal and state funding. While a citizen of Watts was still able to seek healthcare advice and be screened for health complications after 2007 in King's Multipurpose Ambulatory Care Center and/or for mental disorders at Augustus Hawkins Mental Health Center, they would no longer have the ability to receive immediate local treatment for life threatening conditions. For these, patients would have to be referred for treatment at County-USC and Harbor-UCLA. In short, the county's retreat signaled an unprecedented relinquishment of health responsibility to the sickest citizens of the city's poorest neighborhoods.

The resident physicians' testimony provided a large clue to as why the County desired to relinquish responsibility for the health of the residents in the area. Their testimony demonstrates that support for public health services to indigent and undocumented populations was contingent on the ability of the facility to train good quality physicians that could provide reasonable care to the city's working poor. Both products - competent physicians and able-bodied workers - were critical in sustaining the global

economy of Los Angeles. Since the medical center appeared to do neither successfully, the County retreated from its responsibilities knowing full well that the consequences would be deadly.

The testimony of the resident physicians also demonstrates that public care provisions continued to be costly because of social and political causes that prevented citizens from seeking care earlier. Physicians continually cited the effects of unemployment, under-employment, and undocumented immigration on shaping citizen's perceptions of access and safety in seeking care. The testimonies of resident physicians reveal that most citizens in the area could barely find time to seek care or felt that receiving care could end in deportation. These facts point to the presence of stigma, shame, and fear that continue to underpin the provision of healthcare services that exist because of the public's unwillingness to address these problems as meaningful obstacles to equitable healthcare distribution.

Moreover, as I have shown in this dissertation, theories about how best to transition the poor out of a culture of poverty engendered skepticism, doubt, and antagonism between and amongst community activists, local physicians, the County, and the physicians of Drew Medical School. If anything, the tensions over the best approach to get the poor to live healthy lifestyles likely made services at King-Drew useful but ultimately uninviting for many in the community, particularly health programming that measured citizens against normative middle class and heterosexual patriarchal paradigms. These factors account for why many citizens continued to stay way from its services until they could no longer avoid seeking care.

A New Day?

It is tempting to narrate the 2015 opening of a new hospital, the Martin Luther King, Jr. Community Hospital, on the grounds of the King-Drew Medical Center campus as a return to the pre-2004 healthcare service levels. The 131-bed hospital revives critically needed acute care emergency (not trauma) and obstetric and gynecology services with a full complement of other specialty programs. A closer look at the design of the hospital reveals that such services attempt to win back the Medicaid and Medicare eligible cases that the county had displaced onto other for-profit hospitals in 2005 while

limiting admission based on a patient's ability to pay. In short, the new hospital does not recuperate services to those individuals covered under the County's indigent provisions.

Instead, the hospital's existence and intended consumer targets can be interpreted by the role that Obamacare plays in shaping the mission of the new hospital. The ACA is a significant extension of President Johnson's Medicare and Medicaid legislations of 1965 that enlarges the pool of consumers and providers participating in underserved healthcare markets beyond Medicare and Medicaid by creating a new pool of consumers through a "health exchange." The objective of the exchange is to maximize participation of all possible consumers in the medical market who are not covered by their employer or by Medicare and Medicaid eligibility. It does this by making health plans affordable enough to draw consumers who shied away from purchasing plans because they considered themselves healthy or young enough to forego insurance. By bringing this key demographic into the health market, sicker and older consumers normally priced out of the market benefit from new lower cost premiums based on the participation of younger and healthier consumers.

The law also targets traditional providers of health insurance - employers and states - to expand coverage and options for their plan beneficiaries. It mandates that employers with more than 50 employees must purchase health plans for their workers and sets up incentive programs for states to share the costs with the federal government to expand their Medicaid plans to cover more of the poor. By 2017, 31 states and the District of Columbia expanded their Medicaid programs to cover low-income citizens without children.[513] Overall, the law draws private health insurance companies and providers to provide care for consumers and geographic markets considered risky by maximizing the participation of all insurance-eligible consumers.

Unlike 1965, however, the law makes free market consumption a compulsory aspect of American citizenship by mandating that consumers outside the eligibility criteria of Medicare and Medicaid

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[513] According to the New York Times, "under the current health care law, 31 states and the District of Columbia expanded Medicaid to cover low-income Americans without children, a group that previously found it difficult to afford insurance." Haeyoun Park, K.K. Rebecca Lai, Jugal K. Patel, and Sarah Almukhtar. "C.B.O. Analysis: Republican Health Plan Will Save Money but Drive Up the Number of Uninsured." March 13, 2017. *The New York Times*. Accessed online: nytimes.com Accessed: March 20, 2017.

purchase healthcare or be penalized for it. If consumers fail to purchase healthcare, they risk being penalized on their individual tax returns. Initially, the law gained widespread support amongst the electorate because the law valorized the narratives of personal responsibility and productive consumer citizenship that were normalized and naturalized in 1965 healthcare law. It appealed to narratives of deservedness that reinforced that productive working members of society ought to be able to provide healthcare for themselves and their families.

While I show that working poverty had drawn large populations of black, Latino/a, and Asian American citizens into situations that made it difficult for working people of color to purchase healthcare insurance in the 1970s and 1980s, the arguments for Obamacare made by white, working-, and middle-class Americans from 2008 to 2010 show that the effects of racial capitalism had also come to draw them into similar financial situations in their geographic location in rural counties. Obamacare offered a multicultural corrective to this imbalance by providing a mechanism that controlled health insurance costs for all working people in both inner cities and rural counties. Since its implementation the law lowered the number of uninsured Americans in half, from 57 million before 2013 to 27 million people in 2017.[514] In Watts, Obamacare created an inviting space to re-assemble an old coalition of public and private actors to build a hospital on the same grounds as King-Drew.

With support of medical leaders from the University of California, Democrat County Supervisor Mark Ridley-Thomas, Republican Governor Arnold Schwarzenegger, and the Los Angeles County Department of Health, a new private entity was created — the Martin Luther King, Jr. Los Angeles Healthcare Corporation (MLK-LA).[515] This new private entity solely operates King Community Hospital, providing a private acute care facility for the community health clinics operated by the County of Los Angeles next to it to refer patients to. The joint facility guarantees that patients seeking primary care and health education services at the county's on-site community health clinics have the ability to be referred

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[514] Thomas Kaplan and Robert Pear. "Health Bill Would Add 24 Million Uninsured but Save $337 Billion, Report Says." March 13, 2017. *The New York Times*. Accessed online: nytimes.com March 20, 2917.
[515] All information relating to King Community Hospital is taken from their own website. http://www.mlkcommunityhospital.org/About-Us/Our-Story.aspx Accessed: March 20, 2017.

to acute care services at King Community Hospital if they have private insurance of their own, through their employer, on the insurance exchange through Obamacare, or have federal and state eligibility for Medicare and Medicaid. If the patient, however, cannot pay, the clinic refers patients to County-USC or Harbor-UCLA.

In short, the objective of this partnership is to support the growth of for profit medicine in the region through a Community Hospital that makes acute care consumption in far outlying county-run facilities undesirable and unpractical while making the self-realization of a full consumer profile attractive and logical. Essentially, the hospital serves no different of a function than the for-profit hospitals that surrounded Watts in 2004 because it does not and cannot account for the wide swath of indigent patients that fall outside of the eligibility of federal aid. Therefore, while Obamacare extends coverage to millions of Americans who were un-insured and under-insured, it also stigmatizes millions of citizens who continue to be unable to pay for health insurance because of their work status, their citizenship status, and their primary association with a permanent underclass. Here, the continued strain on taxpayer resources due to the use of emergency room services by indigent populations threatens to continue to vilify urban residents of color for their inability to access care through any other means.

The Twilight of Multiculturalism

The 2016 election of President Trump provides an opportunity to analyze how the production of a permanent underclass did not just effect people of color. Obamacare stretches the period of racial capitalism that I have covered in this dissertation from 1965 to 1986 to 2016 because the law leverages the government's power and position to lubricate free market healthcare and narratives of personal responsibility. In Chapter Seven of this dissertation, I demonstrated how skid row became a porous site of containment that included black, brown, undocumented, *and* poor white citizens impacted by the forces of global capitalism. In addition, Ruth Wilson Gilmore's arguments around the prison industrial complex also shows that poor, white and brown rural counties in California are not outside of these same economic

forces.[516] These points demonstrate that many more citizens had been drawn into unemployment and under-employment characteristic of global economies than just in cities.

The fact that many rural white voters who voted for Obama in 2012 and then voted for President Trump in 2016 demonstrates that the social and economic effects of global multiculturalism play out differently by geographic region. Obamacare was initially heralded by black, brown, and white voters across geographic and demographic boundaries precisely because it promised social and economic inclusion for citizens based on healthcare. Relative support for the law's individual mandate to purchase healthcare insurance suggests that the principles underlying the law affirmed national attitudes around personal responsibility and compulsory consumption in the free market that were popular and desirable.

After the mandate took effect, however, citizens began to turn against Obamacare because some saw their health insurance premium costs rise, failed to see lower cost options come to fruition, and/or faced tax penalties for leaving the market precisely because health insurance companies reacted to the law as hospitals and providers had done in the 1960s. Instead of rushing to compete for low-income consumers, health insurance companies cautiously and selectively entered markets for profits. The election of President Trump shows that many rural white voters attributed rising costs and the false promise of inclusion in the healthcare market as the direct result of social tolerance for social issues around undocumented immigration, women's rights, transgendered rights, and #blacklivesmatter. Instead of seeing their inability to purchase healthcare as the product of the same forces playing upon people of color in inner cities, rural white voters interpreted their position in the economy through the eyes of a growing "Alt-Right" movement that explicitly targeted people of color, immigrants, and LGBT citizens as the root of all social problems in the United States.

Rural white voters took to Trump's campaign message of "Make America Great Again" that promised to return manufacturing jobs that had absconded elsewhere, restore law and order in inner cities, deport undocumented immigrants, build a militarized border, ban muslim travel to the United States, and

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[516] Ruth Wilson Gilmore. *Golden Gulag: Prisons, Surplus, Crisis, and Opposition in Globalizing California.* (Berkeley: University of California, 2007)

peel back gains to women's and transgendered rights. One of the largest rallying cries, however, was the demand to repeal and replace Obamacare. Political pundits argued that President Trump's support for these policies signals a break with American policies that stretch back to President Johnson.

President Trump's election was not just criticized by liberals and Democrats but also many prominent leaders of conservative and Republican circles. During his time as the Republican party's candidate, Trump's brand of politics was derided by every past sitting President alive including Presidents George Bush Senior and George Bush Jr., Carter, Clinton, and Obama. Their criticism illuminates a dramatic turn away from the politics of multiculturalism that underpinned the United States' global role in the international community and its policy of racial and sexual tolerance at home. Within the first 100 days of inauguration, Trump instituted a series of policies that signaled his desire to close borders and institute trade tariffs that also increased surveillance and policing of immigrants, women, people of color, and trans people.

In March of 2017, President Trump and House Speaker Paul Ryan unveiled a bill that repeals and replaces Obamacare with the American Health Care Act (2017). Within days of its release, the Congressional Budget Office (CBO) released a report predicting its probable impact on the American economy and in resolving the nation's budget deficit.[517] According to Thomas Kaplan and Robert Pear of *The New York Times*, Trumpcare/Ryancare would save the government $337 Billion dollars by 2026 by making 24 million people uninsured.[518] Under the law, 14 million people would immediately lose health insurance coverage in the first year of implementation. Additionally, the law removes the individual mandate to purchase health insurance so that consumers crucial to bringing down health insurance premiums - healthy and younger Americans - would no longer be held to participate in the exchange.

According to the CBO report, the loss of 14 million consumers, particularly the loss of young, healthy consumers would start a domino effect that would disincentivized the participation of populations

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[517] Congressional Budget Office Cost Estimate - American Health Care Act. March 13, 2017.
[518] Thomas Kaplan and Robert Pear. "Health Bill Would Add 24 Million Uninsured but Save $337 Billion, Report Says." March 13, 2017. *The New York Times*. Accessed online: nytimes.com March 20, 2917.

that really need healthcare.[519] For instance, the absence of healthier consumers would raise costs for sick, older consumers who no longer would be able to afford health insurance despite a clear need for it. It would also make state participation in expanded Medicaid programs undesirable because higher health costs would not make it beneficial for states to provide more than what the federal government provides. According to the *New York Times*, "by 2026, the number of uninsured would be about double what it is [in 2017]." This means that, "in 10 years, the number of uninsured Americans would be closer to what it was before the Affordable Care Act."[520]

Trumpcare/Ryancare does not depart from Obamacare in one crucial aspect - it upholds compulsory consumption in the free market by incentivizing participation by age and by penalizing consumers who leave the healthcare insurance market. According to the *New York Times*, the Republican bill offers a "new tax credit based on age that would help people buy insurance on the individual market" and creates a new penalty that would levy a "a 30 percent surcharge in [consumer] premiums if [consumers] signed up for insurance after having gone without it for about two moths or more."[521] In short, the bill is designed to lock consumers into consumption of health insurance once they enter the market.

What is to be done?

The debate over Obamacare and Trumpcare/Ryancare demonstrates that both Democratic or Republican responses to the unequal distribution of health resources cannot imagine a solution that does not rely on capitalist principles. On one hand, Obamacare's limited reach has only heightened attention to the presence of a permanent underclass and the stigma associated with poverty and being uninsured amongst white rural Americans. On the other hand, Trumpcare/Ryancare threatens to flame discord

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[519] Congressional Budget Office Cost Estimate - American Health Care Act. March 13, 2017.
[520] Haeyoun Park, K.K. Rebecca Lai, Jugal K. Patel, and Sarah Almukhtar. "C.B.O. Analysis: Republican Health Plan Will Save Money but Drive Up the Number of Uninsured." March 13, 2017. *The New York Times*. Accessed online: nytimes.com Accessed: March 20, 2017.
[521] Thomas Kaplan and Robert Pear. "Health Bill Would Add 24 Million Uninsured but Save $337 Billion, Report Says." March 13, 2017. *The New York Times*. Accessed online: nytimes.com March 20, 2917.

between inner cities and rural Americans by obfuscating how racial capitalism has drawn economic and social asymmetries that actually bring these groups together.

My analysis of racial capitalism suggests that the queering effect that places people outside national belonging provides insight into how new social movements can shape health justice agendas in the future. I recognize that my dissertation has provided a critique of many beloved social justice movements - the gay, women's, welfare, disability, and civil rights movements amongst them - but I also do not want readers to read my critique as a complete damnation of them. The activists who banded together to create King-Drew made meaning and significance out of the materials available to them to respond to a crisis around race and poverty that was urgent and as real as activists today feel around the stakes of healthcare, prison abolition, undocumented immigration, and transgendered rights.

As Lefebvre would argue, King-Drew is the physical manifestation of a paradigmatic change in social ideology. In this dissertation, I have argued that King-Drew represents an ideology of "multiculturalism" that has persisted through its existence and rebirth as King Community Hospital. As this conclusion brings forward through the voices of resident physicians, King-Drew can be criticized for the contradictions it embodies of "multiculturalism" but it is undeniable that its care for indigent populations is a concrete product of social movement activism. Health continues to be an in issue that indexes many social problems and, as such, still serves as an important arena to contest and imagine different forms of kinship and belongings. This means that new ways of social organization and action can come from continued social justice activism around it.

Thus, my interest in producing this dissertation has been to map the limits and possibilities of the strategies that social movement actors took in the 1960s and measure their impact in the 1980s and to map new ways of thinking about the limits and possibilities of social movement actions today. I hope that this dissertation has shown how issues like healthcare, prison abolition, undocumented immigration, and transgendered rights are more deeply connected than they are often depicted in popular media. I also believe there is an urgency and opportunity to build coalitions and organizations that involve a deeper reflection of white poverty that does not reify the production of that social identity as separate from the

processes that have made the close association of the permanent underclass with racial poverty so conflated.

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