Medical Care Functions of the Detroit Health Department

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Something is to be gained from the lack of standardized administrative practice in the ways the public health is promoted and protected by the ruggedly individualistic communities of our land. Essentially it is true that no two places see alike their problems and the ways to their solution. This is the story of what one city has done, generation after generation to centralize, rather than departmentalize, its health and medical care services.

Although the earliest beginnings of public health in Detroit are difficult to ascertain, it is apparent that the primary concern of the city authorities was devoted to complaints of nuisances. As early as 1825 the Common Council appointed a committee to make an examination of nuisances and recommend action for their abatement. In 1827 a commission of three physicians was appointed to report to the Common Council, "such measures both general and particular embracing objects both of public and individual police as they may consider conducive to the health of the city." These are apparently the first recorded official actions taken by the city in developing an environmental health program. Gradually this program became more important and included the cleaning up of the Detroit and other rivers, the control and provision of public water supplies, and sewage disposal systems until now the environmental health program embraces every aspect, including pollen studies, noxious weed destruction, and air pollution studies.

On October 1, 1831, the Common Council added "one physician to the Board of Health" because "there is reason to apprehend the arrival at this port (Detroit) of a vessel or vessels on board of which there may be cases of smallpox." Two days later a report of the Board of Health recounted that they had visited "a black man—labouring under unequivocal confluent smallpox." As a result, Drs. R. S. Rice and J. L. Whiting (signers of the report) were "appointed health officers" whose duty it was to visit all vessels to examine all persons on board and clearing such persons for landing. Further, it was required that the health officers proceed from house to house throughout the city and vaccinate all persons who may not have been previously vaccinated or had smallpox. A committee of the Common Council was appointed to erect or procure a "pest house" for the reception of all such persons as are infected or who have been exposed. Thus, the earliest history of public health includes not only environmental sanitation, but communicable disease control, epidemiology, prevention through iso-

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lation of cases, quarantine of contacts and vaccination of susceptibles. To be sure, medical care was furnished only to those who were "infected" and placed in the "pest house," and to those who were paupers. The maintenance of the "poor, lame and sick—who are not able to maintain themselves was authorized by the Territorial Legislature in 1809." "Three discreet persons" were appointed by the judges of the district court and directed to "provide houses, nurses, physicians and surgeons, for such persons as they shall judge necessary."

Detroit's first public hospital was the rented "pest house" of 1831. In 1839 a cheap one-story shed was built for the care of the homeless and destitute patients. Other victims of the smallpox outbreak were cared for in private homes whose owners were paid for board and nursing. From 1848 to 1851 the city built a small hospital consisting of two log cabins where care was given to smallpox victims.

At first the destitute poor were cared for in a hospital built (1845) by the Sisters of St. Vincent de Paul under a contract made by the City Director of the Poor or by city physicians who were under him. In 1861 the Board of Health was empowered to "rent proper houses to be used for pest houses and hospitals." In the ensuing years the Board of Health was charged with having control of all city hospitals and to employ "such nurses, officers, agents, servants or assistance as may be deemed necessary." Other ordinances authorized the Board of Poor Commissioners to control and supervise not only the care of paupers who were a charge of the city and sick from infectious disease, but any pest house established for shelter of such cases. The commission was also authorized to contract with private hospitals for the care of the indigent sick.

In the interim between 1848 and 1948, there was a split in the operation of hospitals by the two departments of the city government. In 1881 the city government was reorganized. Dr. O.W. Wight became the first full-time health officer at a salary of $3,000. In 1883 the county purchased a site, part of the grounds of the present Herman Kiefer Hospital, and the city built a hospital to accommodate 50 patients. The Sisters of Charity operated the hospital for the care of patients ill with contagious disease and received $12 per week for each patient. These buildings

Table 1—Herman Kiefer Hospital

1953	Admissions
Tuberculosis Unit	1,390
Contagious "	1,491
Maternity "	4,923 (deliveries)
Antepartum and Postpartum	14,516 (visits)
Well Child Clinic	2,306 (visits)
Premature Clinic (Started 1954)	
Tuberculosis Outpatient	83,853 (visits)
Public Health and Hospital Laboratory	1,067,364 (examinations)
Houses Division of Maternal and Child Health	
" " " Industrial Hygiene	
" Nutrition Section	
" District Headquarters	
" Rehabilitation Institute	
Research	
Teaching Wayne University Medical School	

were destroyed by fire in 1892 and the Board of Health leased for two years the steamer, the "Milton D. Ward," to care for the expected victims of a cholera outbreak which did not materialize. In 1894 a temporary hospital of canvas tents was leveled in a storm overnight and several smallpox patients died of exposure. Within a month a small frame building was erected to handle the epidemic. Other contagious diseases were cared for in private hospitals. It was not until 1911, however, that the present Herman Kiefer Hospital (see Table 1) was formally opened to handle all types of contagious disease, as well as smallpox and tuberculosis whose victims were overcrowding the "pest house" built in 1894 for the care of smallpox patients.

Over a period of years units have been added and old buildings replaced. In 1915 a tuberculosis unit was built. In 1919 a maternity unit was opened. In 1920 a new institution, the Maybury Sanatorium, located outside the city limits was opened for tuberculosis by the Detroit Health Department and in 1954 a new 250-bed unit for tuberculosis was opened at the Herman Kiefer Hospital.

In 1913 the city determined it would furnish more hospital space for its sick poor and under the Board of Poor Commissioners constructed the first unit of the Detroit Receiving Hospital. The City Physician's Office became attached to the Receiving Hospital.

In 1948 the Welfare Department, which operated the Receiving Hospital, was severely criticized and as a result of the vote of the citizens the 538-bed Receiving Hospital, its branch, the Redford Receiving Hospital, containing a 48-bed emergency unit, and the City Physician's Office were transferred to the Health Department. Since 1949, therefore, all city operated medical hospital facilities in Detroit have been administered by the Health Department.

Medical Care Activities

At the present time, in addition to operating the classical preventive program of public health, the Detroit Health Department is engaged in operating extensive medical care programs. These include:

Table 2—Facilities Operated by Detroit Health Department

1953	No. of Admissions
Central Office X-Ray Clinic	27,989
5 District Health Centers Well-Child Conferences	11,115
Herman Kiefer Hospital	7,989
Maybury Sanatorium	821
Receiving Hospital	19,487
Redford Emergency Branch	14,473
City Physician's Service	36,007 (visits)
2 Mobile X-Ray Units	56,410
School Dental Program (including Receiving Hospital Clinic)	71,154 (visits)

The transfer of the Receiving Hospital was motivated by a City Efficiency Committee appointed by the Mayor to study and recommend means whereby the services at the Receiving Hospital could be made more effective. It was the opinion of the committee that the hospitals of the city should be operated by a single department and that the Welfare Department should concern itself with the administration of relief and not operate a hospital facility. It made these alternative suggestions: (1) the creation of a Department of Hospitals by transferring to it the hospitals from the Welfare and Health Department; or (2) the transfer of the Receiving Hospital to the Health Department.

After testimony by the Health Commissioner, the final decision was reached to transfer these services to the Health Department and the City Charter was amended to this effect in 1949.

Table 3—Receiving Hospital

1953	Admissions
General Hospital	13,134
Psychiatric Unit	6,353
Emergency	121,462
Outpatient Clinic	126,540 (visits)
Dental Clinic	80,272 (")
Drug Addiction Clinic	111 (cases)
Venereal Disease Clinic	45,203
Prenatal Clinic (Started 1954)	
Redford Emergency Branch	14,473
City Physicians' Office	36,007 (visits)
Home Delivery Service	274 (deliveries)
Ambulance Service	23,566 (runs)
Research	
Teaching Wayne University Medical School	

Advantages of Combination

Numerous advantages have accrued to the citizens as a result of this gradual consolidation. Illustrative of these benefits, which must be apparent to all, is the tuberculosis control program. Since the Tuberculosis Coordinator of the Health Department is concerned with the entire program, including case finding, health education, sanatorium admission care and discharge, as well as follow-up of the patient after discharge, there is possible a continuity of the program. There is no interruption of the schedule due to the red tape involved in a multiplicity of jurisdictions as is commonly observed where there is divided authority. As a result prompt hospitalization is available to the newly discovered case; contacts are rapidly examined in the hospital clinics; surgical procedures are centralized at the Herman Kiefer Hospital; and transfers from the Maybury Sanatorium to Herman Kiefer and back, in accordance with the patients' needs, are made without delay. Moreover, it is possible to utilize better the facilities of both institutions because of this ease of transfer of patients. With the advent of the antimicrobials and the development of more extensive home care treatment following the initial sanatorium treatment, Detroit tuberculosis patients are able to return to their homes earlier, since the same agency that controls the sanatorium has already determined the suitability of the home for continued antimicrobial treatment. Because the patient follow-up workers are employed by the same agency, there is rapid referral of cases and records are available without duplication. Since the outpatient services to which the home care patient returns for periodic re-evaluation are operated by the same agency, this continuity of uninterrupted care is assured the tubercular patient. The Health Department is in a better position to adapt care to the individual patient's need. As a matter of fact, only one additional facet is needed to make this program perfect—as dropping mortality and shortened sanatorium stays are indicating—and that is the prevention of the disease itself. This, too, has in part been initiated. Secondary prevention through early detection is a routine part of the program. Health education as in other departments plays an important role, but primary prevention through BCG vaccination is carried out on newborn infants who arrive at the Maternity Unit and are followed up in the Well Child Conference and vaccinated against tuberculosis in the Tuberculosis Outpatient Clinic. Since most of these are from the Negro population and are medically indigent, this is an example of primary prevention in a population group where tuberculosis is more prevalent than elsewhere in the city.

Another example of benefits that accrue to the family by this coordination of services is the development of the Maternity Unit at the Herman Kiefer Hospital. Prenatal clinics are housed at the Herman Kiefer Hospital and the

Receiving Hospital. Obstetrical services are available at the Herman Kiefer Hospital and a home delivery service is administered from the Receiving Hospital. Follow-up visits of the mother at these institutions and of the newborn infant are available at the department's Well Child Conferences. Thus, again, a continuity of care, without interruption, and with the avoidance of expensive duplication is available to the family. In turn, the staff is able to evaluate deviations from normal health, treatment, and follow-up. Clinical research requiring long observation is made possible; mother and infant can be studied as a unit. The effect of treatment can be evaluated from the point of view of the child, from the fetus through birth, infancy, and early childhood; and simultaneously it can be evaluated as it affects the mother. This is an excellent example of the way health supervision and medical care can be integrated by the Health Department. In addition, the department has recently undertaken a series of studies on premature infants which could not be made unless the families were available for observation for a period of years.

Many more examples could be cited of the advantages to the patient of the integration of public health and hospital administration within the same department. Police ambulances bring emergencies to the Receiving Hospital. Here every admission—emergency, inpatient, or outpatient is scheduled for a chest x-ray. All suspect tuberculosis cases are immediately followed up and if a positive diagnosis is established, the family contacts are investigated. If a patient is found to be an alcoholic and is judged rehabilitable, steps are taken to cure his condition. Similarly, drug addicts or persons with venereal infections are referred without delay for proper treatment and follow-up of contacts by persons who are skilled in these tasks.

Administrative Advantages and Problems

Since the department administers three hospitals (all the public hospitals of the City of Detroit) many administrative devices to bring about increased efficiency or effectiveness are made possible. The Board of Health acts in the capacity of "trustees" for all institutions. Personnel policies are uniform and there is no competition between public hospitals and other departments for health personnel. Purchases for all three are grouped and made on a basis of specifications and bids—thereby reducing red tape whenever possible and obtaining quantity discounts for larger orders. The development of a central storage facility would bring about further economies and recommendations for its establishment have already been made. Certain other devices have been centralized, such as ambulance services, the development of a uniform menu, and the development of uniform administrative and clinical records.

Preparation of budgets, the keeping of hospital accounts, and other fiscal control procedures are gradually being standardized. Perfection of these administrative procedures takes time and changes sometimes must await suitable opportunities for their initiation. As in all large departments involving several institutions, changes are costly and the alteration of established routines must first be tested in pilot studies. Thus, after careful evaluation of new procedures, those found to increase efficiency or economy can be instituted at an opportune time. This may have to await the utilization of existing printed forms, the beginning of a new fiscal year, or the retirement or other replacement of key personnel who may, for one reason or another, resist a change from the old routine.

An Employee Award Fund, adminis-

tered by the City Controller, offers cash awards to employees who make suggestions for the improvement of services of the city government. An unusually high percentage of these awards have been won by Health Department personnel, particularly in the Receiving Hospital. This suggests a high morale of the department's employees, especially in the hospital which has most recently come within the department's jurisdiction.

Professional Relations

Another intangible but realistic advantage to the department is the friendly and intimate relations which have been established between the various professional organizations and the department. Contacts between department employees and private practitioners are much more numerous. Thus, because of these contacts, the private practitioner has a better opportunity to understand the objectives of public health and, on the other hand, the department staff is more aware of problems of the family doctor. The combination of these aspects of health gives the personnel a more rounded outlook and an appreciation of more of the facets of any program than if the department were responsible for preventive services alone.

Since the staff of the Department of Preventive Medicine of Wayne University Medical School is made up entirely from the staff of the Health Department, there is a close relationship between these two departments. The Receiving Hospital and the Herman Kiefer Hospital are the primary clinical teaching facilities of the medical school. The hospital staffs serve in professorial and instructor positions in the medical school. So, from the very beginning of his medical career, the Wayne medical student is imbued with the concept of prevention in the practice of medicine. This association is mutually advantageous, the medical school as well as the department can obtain better staffs, and the exchange of professional relations is immeasurably increased. The medical student profits the most since he learns of the compatibility of preventive and curative medicine—to him they are one without artificial schism.

Symbiosis Not Dilution

It is true that the board, the Commissioner, and his immediate assistants must divide their time between institutional management and public health services, but the board meets weekly and the department has additional specialists who handle over-all administrative policies and procedures for the department as a whole. In the final analysis, while it is true that a health officer must divide his time between hospital administration and public health practice, this need not be a disadvantage as some public health administrators contend. In a properly integrated health department, adequately staffed with competent specialists, the integration within it of all major health activities, including hospital administration, not only makes these services more efficient and economical, but also offers an additional challenge and opportunity to the personnel to do a better job. Moreover, personnel in such a department are better qualified to do both jobs—public health practice as well as hospital administration. Private practitioners, as well as the public, seem to prefer to go to a single place to settle all health problems concerning the city government.

Conclusion

In Detroit, contrary to the recently prevailing trend, there has been a centralization of municipal health activities

within the Health Department. Through this integration of medical home care of the indigent, hospitalization of the indigent and emergency cases, hospitalization of indigent maternity cases, communicable disease cases, and tuberculosis, together with the usual public health activities, the public has been able to buy better health; the doctor knows where to take his problem; and the Health Department personnel can give maximum service at the least inconvenience to those served. The people, the city officials, the vendors of service (practitioners) as well as the Health Department staff like the integration and profit by it.

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Newburgh's 10 Year Fluoridation

The Newburgh-Kingston Fluoridation Study in New York celebrated its 10th anniversary on April 21 in ceremonies in which it was reported that "reports confirm earlier findings that water fluoridation has no demonstrable systemic or developmental effect on children except for the known dental benefits of reduction in tooth decay." Addresses were made by three staff members of the New York State Department of Health, including the director of Bureau of Dental Health, David B. Ast, D.D.S., and by Samuel Z. Levine, M.D., pediatrician-in-chief, New York Hospital, and a member of the State Health Department's Technical Advisory Committee on Fluoridation of Water Supplies.

As a part of the study, the city authorities of Newburgh approved the fluoridation of the city water supply while those of Kingston with a fluoride-deficient water supply agreed to participate as a control area. For the six- and seven-year-old Newburgh children, who had consumed fluoridated water all their lives, the decayed, missing, and filled rate for permanent teeth was 75 per cent and 68 per cent lower than for those for comparable Kingston children.

The total cost of the study including the cost of fluoridating Newburgh's water supply has been about $300,000 or about $30,000 annually. Said Morton Levin, M.D., making one of the day's speeches, "A reduction in dental caries of approximately two-thirds among children and the adults of the future makes the cost of this study and the costs of fluoridating water supplies a truly economical practice."