

Institutional Expansion, Community Relations, and the Hospital Next Door

by

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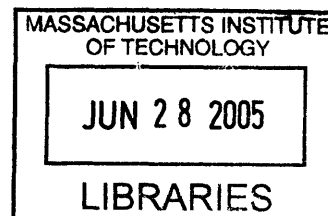
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ABSTRACT

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Hospitals play many roles in a city: alternately, they may be caretakers of the sick, economic engines, intellectual hubs, major employers, and neighbors. This last role has evolved greatly over the last 45 years. The relationship between hospitals and the communities in which they are located has been affected by constantly changing economic, political, and social factors. During the early days of urban renewal in the 1950s and early 1960s, large teaching hospitals in Boston experienced a surge of political and economic power that allowed them to expand with few constraints, often to the detriment of their residential neighbors. Today, the same hospitals must broker complex deals with their neighbors if they wish to expand, offering up a host of community benefits. The process by which the hospital-community power dynamic has evolved has been shaped by the mediating entity of the Boston Redevelopment Agency, which is in turn influenced by the Mayor's Office in Boston. Despite their many roles in the city, it is their sheer physical presence that drives hospitals' relationships with their neighbors. The health care and employment benefits they can provide are not major bargaining chips in disputes over expansion; the important considerations are the tangible elements of power – money and land. The primacy of physical presence as a relationship driver can be illustrated by the differences in the negotiation process that hospitals directly bordering residential communities and extending into them experience, as opposed to hospitals that are not directly on the residential fringe.

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introduction

Hospitals and health care centers represent an enormous and growing sector of the United States economy. In 2003, health care expenditures made up 15 percent of the United States GDP, and that number is expected to rise even further in coming years, reaching 16 percent in 2005. [1] Compared to other industries, health care weathers economic cycles well. During recessions and in depressed communities, the health care sector can become the primary local employer. Health care and hospitals are a crucial stabilizing force in the American economy. This economic strength is accompanied by significant political power at the local level. In many urban areas, teaching hospitals associated with prestigious universities are especially looked to as economic drivers. Many cities have pinned their hopes for the economic future to the field of biotechnology. Much potentially profitable biotechnology research by definition must be associated with clinical research facilities, usually a teaching hospital. It is these large urban research and teaching hospitals that I seek to explore in more detail.

Much like other institutions, hospitals impose certain negative externalities on surrounding residential neighborhoods. They can create traffic and parking congestion; create noise from ambulances and helicopters; manifest urban design that is out of scale with the neighborhood; create physical barriers for residents; and drive up rents in the vicinity as hospital employees pursue local housing. Moreover, research hospitals have a tendency to expand, and when they do, they may eliminate beloved neighborhood

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institutions or even their neighbors' homes. This last issue of institutional expansion on the part of research hospitals is the focus of my thesis.

Alongside these negative impacts, hospitals, unlike many other institutions, are uniquely poised to extend significant benefits to their communities. They often provide relatively well-paying jobs across a wide spectrum of educational levels. Their health care facilities may be the only ones to which the underinsured have access. Their facilities may become informal community centers in neighborhoods where public spaces are not readily available. Progressive hospitals that interpret their mandate to provide "health care" liberally implement a host of neighborhood services that directly or indirectly improve public health, from basic health education to charter schools or homeownership programs.

Among hospitals, teaching and research institutions often magnify both positive and negative effects. Some academic medical research centers are multi-building complexes spanning many city blocks and spreading deep into residential neighborhoods. They have access to public and private grants for biomedical research, and their budgets often reach hundreds of millions of dollars, which can support extensive community benefit programs. If the relationship between hospitals and the communities surrounding them is viewed as a tradeoff between negative and positive effects, this tradeoff is magnified in large research hospitals. It is also constantly in flux; because of their technical needs, they must undertake new construction and renovation projects from time to time, which change their physical footprint in the neighborhood. It logically follows that an increase in a hospital's negative impact on a neighborhood be accompanied by an increase in the benefits it offers. Indeed, an intricate and ritualized system of bargaining a hospital's right to expand against increased benefits to its neighbors has emerged. This bargaining, whether it happens directly, through conflict, or through a government agency, is an ongoing, evolving process.

Thus, given the dynamic relationship between teaching hospitals and their surrounding communities, these institutions provide an ideal vehicle for pursuing my research question:

How have the negotiations¹ between hospitals' physical expansion and their community benefits changed from the height of the urban renewal movement to the present day, in both process and content?

To answer this question, I explored the recent history of two hospital complexes in detail, both surrounded by residential neighborhoods in Boston, Massachusetts. These case studies were the Tufts-New England Medical Center, which is located in Boston's Chinatown, and the Longwood Medical Area, which is surrounded by the Fenway and Mission Hill neighborhoods. I found that their physical development since 1960 was, indeed, inextricably linked to their relationships with their surrounding communities.

To better understand *how* hospital-community relationships have changed over the years, I sought to understand *why*. Thus, I examined how the social and economic environments of different eras influenced the expansion-benefits negotiation, and I found that a third major player was involved: Boston's municipal government, in the form of the Mayor's Office and the Boston Redevelopment Agency (BRA). A new factor that the City must consider is that the overall mission of hospitals is perceived as one of greater good to

¹ Before delving further into their stories, I must explain the use of the word "negotiation" in this thesis. There are many ways that hospitals and communities have interacted so that a final plan for expansion and community benefits has resulted. Sometimes this is conflict; sometimes both parties expressing their desires to a governmental third party that mediates; and sometimes through actual conversations between hospital administrators and community representatives. Sometimes all parties are happy with the results, and sometimes they are not. I refer to all these interactions as "negotiations" in the broad sense of the word, even when the form they take is not as straightforward as two parties wrangling with each other at a business meeting.

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society. This “mission” card is one that many institutions can play, but few with hospitals’ compelling capacity to quite literally save lives. The city, the hospitals, and the neighborhoods were engaged in a complicated and shifting trilateral balance of power. In my investigations, I paid especially close attention to whether the unique benefits hospitals can offer their communities as health care centers influenced this process over the years. Did the health care and jobs offered by hospitals play a significant role in the expansion-benefits negotiations, or were hospitals’ relationships with their communities essentially the same as those of other institutions?

I was fortunate to find a large body of information about the dynamic relationship among hospitals, communities, and government regulators, and how it is negotiated in response to periodic expansions and other events. The histories of these case studies are rich and emblematic of the Boston zeitgeist at many points in recent history. Using my case studies, I will show that, because of changing economic and political environments, periods of expansion have indeed become concurrent with large increases in hospitals’ community benefits over the past 50 years.

Research Genesis and Methodology

My interest in this topic stemmed from the implications of the institutional sector, especially health care, as it becomes more and more prominent in American cities. Little has been written about it recently at the local level, and institution-neighborhood dynamics are not well understood. Because institutions can be such a powerful force to benefit or detract from neighborhoods, however, greater knowledge about the power dynamics of their external relationships is an important goal. To this end, my thesis will explore the histories of two case studies and their interactions with surrounding communities in detail, tracing the historical patterns of physical growth and community benefit programs and the negotiations between the two.

The first case study, Boston's Longwood Medical Area (LMA), is a 213-acre grouping of hospitals and educational institutions, including Harvard Medical School, the Harvard School of Public Health, and the Harvard School of Dental Medicine. The LMA abuts the dense residential neighborhood of Mission Hill, and it is separated from its other residential neighbors in the Fenway by the parkland of Boston's famous "Emerald Necklace". The boundaries between the LMA and surrounding communities are fairly sharply delineated, and its institutions have instituted major community benefits as well. These include a job-placement program and financing for affordable housing development through linkage funds extracted by the City.

My second case study is the Tufts-New England Medical Center (T-NEMC), a tightly packed 11-acre area interwoven with the dense surrounding Chinatown neighborhood, which has resulted in a close-knit relationship between the hospital and community. In response, T-NEMC has offered substantial community benefits, making the building of affordable housing feasible and financing a new YMCA.

In the course of my research, I interviewed hospital and university employees, community organization leaders, an employee of the multi-hospital consortium MASCO, and a representative of the Boston Redevelopment Agency. I also interviewed players in the past struggles between hospital and community to get an accurate historical picture. Finally, I gathered data through primary source research, finding newspaper and magazine articles and other archival materials like maps and plans.

Some disadvantages are associated with the method of using just two case studies. I do not have the breadth or sample size to make solid generalizations about hospitals in general and their relationships with surrounding communities, nor can I perform statistical analysis of the relationships. The depth of data I was able to collect by focusing exclusively on two cases, however, paints a nuanced picture that is invaluable for

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understanding the complexity of hospital-community relationships. These two case studies represent a solid beginning for understanding this topic.

On some level at least, the data I have collected speaks for itself; it tells a fascinating empirical story of how hospital-community relations have evolved over the years. The parallel evolution of both case studies demonstrates how the negotiating process has been influenced by similar dynamic external factors. To delve beneath their surface, however, I also analyzed the case studies through the lens of social conflict theory. I drew on the work of Richard Senett and Lewis Coser to discuss the ways in which conflicts are necessary to solidify and maintain social order. In the context of hospital-community relations, conflict has proven necessary to bring the power equilibrium among hospitals, communities, and the city into balance when external conditions change. Even today, I will argue, an unspoken contentious relationship lies beneath the cordial surface relations among the players and is necessary for maintaining what orderliness exists in the hospital expansion-community benefits negotiation.

Initial Research Findings

The story of the hospital-community relations and the hospital expansion-community benefits negotiation can best be told through the shifting relationships among the triad of entities mentioned above: hospitals, communities, and the city. The connections between these players waxed and waned, as did their power relative to one another. At the advent of urban renewal, the communities had very little power, and Boston's Mayor's Office and BRA had allied itself with the city's institutions and large redevelopment projects in general. Hospitals, then, could essentially do as they pleased. This period lasted from the mid-1950s to around 1965.

An era of conflict followed between 1965 and 1985, as community groups arose to fight bitterly against institutions that were expanding into their neighborhoods. Hospitals could no longer purchase land and develop it as they pleased with impunity. The BRA

gradually evolved into a mediator, and then as a strong advocate for the neighborhoods, a role it retains today. Finally, the relationship between hospitals and community groups evolved as well, becoming less contentious over the years and more businesslike.

Today the relationship between them appears quite cordial. If they are not directly adjacent to each other, hospitals and community groups tend to interact minimally with each other, and the formal negotiations over expansion happen between institutions and the BRA. If they do lie directly next to each other, hospitals and neighborhood groups interact more directly and substantially, but the discourse of confrontation has evolved into one of seeking mutually beneficial solutions to expansion-related disagreements. Conflict was not only the medium of negotiation for many years; it also shaped the power balance among the players. Specifically, when hospitals pushed too hard against the neighborhoods and the city, overreaching the bottom line of what they would accept in terms of hospital development, they were forced to retreat at great expense. The expense could be in terms of project delay or in enormous future concessions. Therefore, hospitals eventually learned not to push as hard for expansion. Hospital-community conflict shaped the discourse of the expansion-benefits negotiation, changing the parameters of what was acceptable on the part of hospitals and what was expected on the part of neighbors. Even today, it is the potential for such conflict that keeps hospital-community relations cordial and stable. Community organizations in Chinatown, Mission Hill, and the Fenway wield a great deal of political clout in Boston, and hospitals could find themselves in trouble if these groups decided to wield an all-holds-barred campaign against them. Thus, today, hospitals accept as a fact of their existence the necessity to bring any expansion plans before community groups for input and approval. A ritual of community collaboration has evolved from which hospitals dare not deviate.

Historical events and trends in Boston and the country at large led to these changes. The macroenvironment that fostered them included the general economy, the health care economy, social trends, federal legislation concerning urban renewal and health care

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funding, and local political events such as changes in mayoral administrations. An individual hospital's physical interface with the surrounding community also had a strong affect on the political relationship with it. Interestingly, the special health care-related community benefits of hospitals played less of a role than I had anticipated in land use negotiations. While they may help shape the overall perceptions of neighbors toward hospitals, they did not carry enough political weight to be leveraged as a negotiating tool. Instead, negotiations revolved around the tangible elements of power: money and land. These provided the leverage hospitals needed and organized the story.

Report Structure

Chapter Two of this thesis provides background for my research. It presents a brief account of urban renewal in Boston, as well as a history of American hospitals from 1900 to 1960, when the events detailed in my thesis begin. Chapter Two also contains a summary of Lewis Coser's and Richard Sennet's studies on conflict and its positive role in society. I will later use their work in explaining how hospital-community relations in my case studies evolved.

Chapters Three and Four present the bulk of my primary-source research, presenting two detailed case studies: the Longwood Medical Area and the Tufts-New England Medical Center.

Chapter Five contains a more thorough analysis of hospitals' community benefits throughout Massachusetts, in order to provide a context for the benefits programs of my case studies. In Chapter Five, I examine these hospitals' benefits both qualitatively and quantitatively and present several possible explanations for why these major teaching hospitals' benefits are different from Massachusetts' hospitals in general.

Finally, my findings are tied together in the conclusions of Chapter Six.

introduction

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background on hospital-community conflict

A Brief History of Urban Renewal

The history of urban renewal and health care in Boston has dramatically shaped the relationships between hospitals and communities today. The onset of Urban Renewal in Boston began in the mid-1950s. Urban Renewal as a phenomenon was driven by the drastic stagnation of Boston's economy midway through the 20th century. The 1930s had seen Boston's once-thriving shipping and trade industries on which the city depended dwindle dramatically. Meanwhile, traditional New England industries like leather, footwear, and textiles were also fleeing the region and continued to do so into the 1940s. The Boston area's nascent technology sector could have been reason for hope, but the majority of these young companies were located far from the city limits along Route 128. "With old businesses drying up, and with new businesses moving out into the suburbs, Bostonians became panicky as they anticipated a return to the disastrous conditions of the Depression era...." writes historian Thomas H. O'Connor. [1, p. 19] City officials and civic leaders were desperate to breathe new life into the city.

Much has been written about how this spirit of desperation led to the demolition of Boston's West End. The diverse, working-class neighborhood of 7000 residents was completely razed with almost no public input to make way for developer Jerome Rappaport's luxury Charles River Park apartment complex, which city officials hoped would bring more affluent people to live in Boston. The demolition left many of its

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residents rootless and heartbroken as they scattered from the tightly knit community they had come to rely on. [2]

Little, however, has been written about the relationship between the Massachusetts General Hospital (MGH), in whose shadow the West End lies, and the neighborhood itself. According to Herbert Gans's *The Urban Villagers*, during the period before the demolition, West Enders tended to feel somewhat distrustful and hostile toward MGH and to fear doctors and hospitals in general. Erich Lindemann, in "Moving As a Crisis," paints a more complex picture: that despite their distrust of and conflict with MGH, West End residents were closely attached to it, even "dependent" on it. He claims that the hospital was one of the few institutions with which they maintained personal relationships as their political power in the city waned. [3]

The MGH-West End relationship also cut two ways during the West End's demise. Although the literature about the period almost exclusively refers to the Charles River Park project as the demolition's beneficiary, it can be argued that MGH also benefited from the clearance, which freed up territory for it to expand and construct parking facilities. In fact, Gans even posits that many West Enders' suspicions that these benefits to MGH were a motivating force in their relocation are "essentially accurate". [2]

On the other hand, some MGH employees maintained a loyalty to the neighborhood as it was before demolition. A dedicated team of researchers led by MGH's Chief of Psychiatry Service, Erich Lindemann, was at the forefront of documenting the emotional and psychological fallout of the West End's clearance. Continuing the complex relationship between the hospital and its former neighbors, Lindemann received a five-year National Institute of Mental Health grant to establish a Center for Community Studies at the hospital and examine the mental health effects of forced relocation on the West Enders. Leveraging the general upheaval surrounding the redevelopment and the traditional relationship between West Enders and MGH, Lindemann and his associates,

including Marc Fried, were able to penetrate deeply into a community that had traditionally been closed to outsiders. [3]

The result of their work, described in Fried's *Grieving for a Lost Home*, was a disturbing indictment of the irreversible emotional devastation relocation had inflicted on the West End's former inhabitants. [4] In fact, Fried and Lindemann showed that the very aspect of the community that had made it expendable to Boston's leaders – its lower-income nature, manifested in deteriorating buildings – was tied to a deep dependence for emotional and material support on large, complex networks of “family and quasi-family groups” [4] that could not be translated out of the physical space of the West End. Thus, the destruction of the West End was far more devastating for its working-class inhabitants than it would have been had it been made up of small, autonomous middle-class households. Similar inward-looking neighborhoods bore the brunt of hospital expansion elsewhere in Boston, as described in the case studies of Chapters Three and Four.

As an aside, Lindemann was prescient enough to note that the traditional distrust of residents for institutions made the bitter and contentious public meetings that characterized the early days of public participation natural and to be expected. “Responsible participation cannot be demanded of people overnight,” he says, but “Meetings at which people shout and get angry with each other . . . may represent a salutary phase of communal growth, even though they alarm the public and put a severe strain on the political process.” [3, pp. 147-8] This too anticipated the rancorous conflict between hospitals' master planning efforts for expansion and the public of their neighborhoods.

Thus, the West End can be seen as a foreshadowing of the complex hospital-neighborhood relationships that would change so dramatically over the next half of the twentieth century. Meetings at which people shouted and got angry with each other,

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disturbing as they were, ultimately played an important role in the constant reshaping of the relationships between hospitals, communities, and the city.

After the West End debacle, two countervailing forces emerged to shape the dynamic between Boston's large academic research hospitals and the neighborhoods that surrounded them. The first was neighborhood resistance to urban renewal following the general horror at what happened in the West End. Many West Enders had never believed that their neighborhood would truly be demolished until it was too late to stop the bureaucratic machinery that led to its demise. It would never again be so easy to take residential land for urban renewal projects, with minimal organized neighborhood opposition during the planning process. At the same time, the trend toward including an active community voice in planning was growing nationally. In Boston, this trend was manifested through the election of Mayor John F. Collins, who ran on a platform opposing the West End-like excesses of Urban Renewal and served from 1960 to 1968. Collins appointed the well-known Edward Logue as his BRA director, in order to implement a more community-oriented version of urban renewal in Boston. [1]

The second emerging force was a dramatic shift of power toward institutions that accompanied urban renewal. A stagnant urban economy meant that few private developers were willing to invest in Boston. However, for well-endowed institutions that were already there, primarily universities and hospitals, investment in their immediate surroundings was a necessity. The hospital-community conflicts that ensued were a logical outcome of the rise in power held by these opposing forces.

Institutions were given large incentives by the federal government for major capital projects. The Hill-Burton Construction Act was passed in 1946, earmarking federal money specifically for hospital construction; in fact, the Boston Dispensary, the precursor to the Tufts-New England Medical Center, was the inspiration for the legislation. [5]

Background on hospital-community conflict

In 1949, Congress earmarked money for urban redevelopment via Title I of the National Housing Act. In the financial logic of urban renewal, if a city created a redevelopment plan, and the Department of Housing and Urban Development (HUD) approved it, the federal government would pay a generous 2/3 of land acquisition and clearance costs. The municipality paid just 1/3 of these costs. [1] Some institutions also qualified for this program as redeveloping entities. The institution would cover the city's 1/3, providing a financial windfall for the city. Hospitals as institutions did not qualify under the original version of the act, but in 1961, Congress amended it to include them. Moreover, hospitals and universities did not have to adhere to a rule that stipulated the redevelopment project must be predominantly residential – and they could even use the funds for land that was outside designated urban renewal areas within a certain radius. Using the City's power of eminent domain, institutions could by proxy force surrounding landowners to sell crucial parcels. [6]

Since 2/3 of Boston hospitals' expansion costs were being subsidized by the federal government by 1961, it was the interest of Boston officials to encourage hospitals to expand. The economic development and “renewal” accompanying them came free of charge to the city and heavily subsidized by the federal government at a time when it was sorely needed. Essentially, then, the combination of economic stagnation and urban renewal policies reshaped the political landscape between 1949 and 1961, giving institutions, including hospitals, a great deal more power than they had held previously.

A Brief History of Hospitals in the Early Twentieth Century

To put hospitals as they existed in 1960 in perspective, it is instructive to recapitulate their evolution since the turn of the century. The early 1900s marked a dramatic shift in the principles behind hospitals in the United States. Until the turn of the century, they had been mainly charitable organizations focused on sheltering and comforting the ill. As new medical technologies like x-rays and clinical laboratories developed, they soon became institutions that considered themselves highly scientific and business-oriented.

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Curing their patients to full recovery became hospitals' goal, and they began to be financially supported by charging patients for care. Efficiency and privacy became paramount in the design of hospitals. They rose to a typical height of six or seven stories and provided single and double rooms for their clientele instead of wards and pavilions. By the 1920s, hospitals were competing with one another for patients. [7]

The idea that medical schools should be associated with hospitals where students could learn clinical skills was also new at the turn of the century, but it gained ground quickly. Hospitals benefited from being associated with prestigious medical schools and having students and professors as ancillary staff. They began to improve and expand their facilities to suit medical schools' needs. Guenter Risse calls hospitals of the 1920s "economic hybrids, proclaiming a charitable mission while operating like a business." Health became a commodity, and medicine became fully professionalized through modern technology and scholarship. [7]

Middle class Americans began to worry deeply about the rising costs of health care in the mid-1920s, brought about in part by the skyrocketing rate of traumatic automobile accidents. Economists suggested that the country had simply built too many hospitals during an era of great enthusiasm for modern health care. By the Great Depression, hospitals had already been suffering deeply financially. Some began to turn poor patients away without care. Fortunately, the concept of health insurance was developed in the early 1930s, and this new industry lifted hospitals from their economic morass. The advent of workmen's compensation and social security also provided financial relief to hospitals and ensured that they would be paid for the bulk of the care they provided. [7]

The post-World War II era's general economic boom was accompanied by another dramatic expansion for hospitals, as well as the professionalization of nurses. New technologies like EKGs continued to come online. As mentioned earlier, the 1949 Hill-Burton Act provided federal funds for hospital construction, and Medicare in the late

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1960s was another financial boon for hospitals. Finally, the National Institute of Health (NIH), which provided grants that could be used for hospital construction and renovation, grew precipitously. The NIH gave out 624 times as much funding in 1965 as it did in 1945. [7]

Biomedical research and treating patients with rare acute diseases replaced caring for patients in a local catchment area as the backbone of teaching hospitals. Risse writes, “Such concentration limited involvement with broader social and economic issues.” [7, p. 578] Hospitals also began to select their patients more carefully to align with professors’ teaching and research interests after World War II. Patients began to be used as experimental subjects. Thus, the movement away from community health care provision coincided with a period of expansionism for hospitals. The conflicts that resulted were not limited to Boston but occurred nationally as well. In the 1960s, writes Risse,

“Academic centers nationwide, many located in decaying urban neighborhoods, were increasingly condemned for employing deceptively expedient methods in procuring real estate to remodel and expand facilities without considering their impact on adjacent neighborhoods and infrastructure.” [7, p. 585]

This move toward specialized research and away from primary care for surrounding communities could not have been more poorly timed. Hospitals were flexing the new power urban renewal conferred on them as institutions and simultaneously ignoring their neighbors’ needs and health. It is difficult to imagine that this change of medical focus did not contribute to the growing resentment of hospitals in the 1960s. Yet the two phenomena could not have occurred separately. They both arose from the postwar spirit of faith in the scientific realm to solve all manner of human problems. Urban renewal was a way to scientifically reprogram a city to function better, and scientific biomedical research represented society’s great hope against disease. A third health care trend of the post-World War II period was the rise of patient autonomy, in contrast to the passivity earlier expected of them. For the first time, doctors’ absolute authority was being questioned – as well as the authority of the medical institutions that employed them.

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Many changes were taking place as 1960 approached. Urban renewal was still a powerful force in Boston, but the idea of widespread clearance had fallen out of favor. The health care sector of the economy was booming, and within it, major research and teaching hospitals were thriving. At the same time, grassroots political organizing was emerging as a tool for ordinary citizens to attain political power in the context of many different issues. The confluence of these forces led hospital-community relationships to take on new and evolving forms, as the following case studies will demonstrate.

Background on the Theory and Practice of Conflict

As a final piece of background material, I would like to write very briefly about the work of sociologist Lewis Coser, which is highly relevant to this study of hospital-community relations. Understanding these hospital-community-city interactions requires an understanding of conflict and its implications on an institutional level. In *The Functions of Social Conflict*, Coser makes several critical points. First, he writes that conflict is necessary for human relations and has many social functions. One of these functions is to bind groups together against a common enemy; conflict can unite groups or individuals allied together on one side of a conflict, bringing them closer to one another. [8]

Coser writes that another function of conflict is to establish decision-making processes and structures in communities. Although it may be a conflict that catalyzes the creation of these processes and structures, once they are created, they can continue to serve communities as ongoing institutions. Similarly, conflict can establish or alter a relationship between two groups by testing the relative strength of two parties. As we shall see in upcoming chapters, conflict as a generator of processes, structures, and relationships will be a common theme in the area of hospital-community relations.[8]

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chapter 3

the longwood medical area case study

The Longwood Medical Area (LMA) is an enormous complex of medical and educational institutions. Its 213 acres contain Boston's second largest employment cluster, with 37,000 workers. Its hospitals and medical centers include the world-renowned Brigham and Women's Hospital, Beth Israel-Deaconess Medical Center, Children's Hospital of Boston, the Dana-Farber Cancer Institute, and the Joslin Diabetes Center. All affiliated with Harvard Medical School, also located in the LMA, these institutions comprise a biomedical research powerhouse. Greater Boston receives more National Institute of Health (NIH) funding than any other metropolitan region in the United States. Over half of Boston's NIH grant money is funneled into the LMA. [1]

Unfortunately, the LMA occupies a somewhat awkward place in Boston's urban fabric. To travel from the Central Business District to the LMA, one must pass through many neighborhoods in between. For a major employment and educational hub in Boston, it is poorly served by transit. Its clearest boundary is the arterial Huntington Avenue, to the northwest of which lies the LMA, and to the southeast of which lies the tightly knit residential neighborhood of Mission Hill. The LMA's other boundaries are Francis Street to the southwest, over which it is gradually encroaching; and the parkland of Boston's "Emerald Necklace" on its other sides. Please see Figure 1 on page 31 for a map of the present-day Longwood Medical Area.

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Fifty-five years ago, in 1950, the area was a hodgepodge of schools, hospitals, clinics, and religious buildings. These institutions responded to the expansion-friendly social forces of urban renewal (see Chapter Two) enthusiastically, embarking on an aggressive land acquisition crusade in the 1950s and 1960s. Harvard made its first major move when it bought a 9-acre former quarry for its medical school. This piece of real estate, known as the “Ledge” parcel, would be a touchstone in hospital-community conflict for years to come. It is located across Huntington Avenue and Tremont Street from what was then the Peter Bent Brigham Hospital. [2] For this and other points of interest in the LMA case study, please see Figure 2 on page 33.

Until then, Huntington Avenue and Francis Street had been well-defined tacit boundaries of the LMA. On one side of these streets lay the working-class residential neighborhood of Mission Hill, and on the other side, the famous medical institutions. At the time, they included many precursors to today’s hospitals: the Peter Bent Brigham Hospital, Boston Lying-In Hospital, Beth Israel Hospital, New England Deaconess Hospital, the Channing Home Consumptive Hospital, the Baker Clinic, the Massachusetts Home for Aged Women, the Hospital of the House of the Good Samaritan, and the Angell Memorial Animal Hospital. Many of these were Harvard Medical School teaching institutions then as well as now. [3] Two hospitals were also located on top of Mission Hill, in the heart of the residential neighborhood: the Robert Breck Brigham Hospital and New England Baptist Hospital. The Massachusetts Mental Health Center (MMHC) was located two blocks south of Francis Street.

Figure 1: Land uses in the Longwood Medical Area vicinity

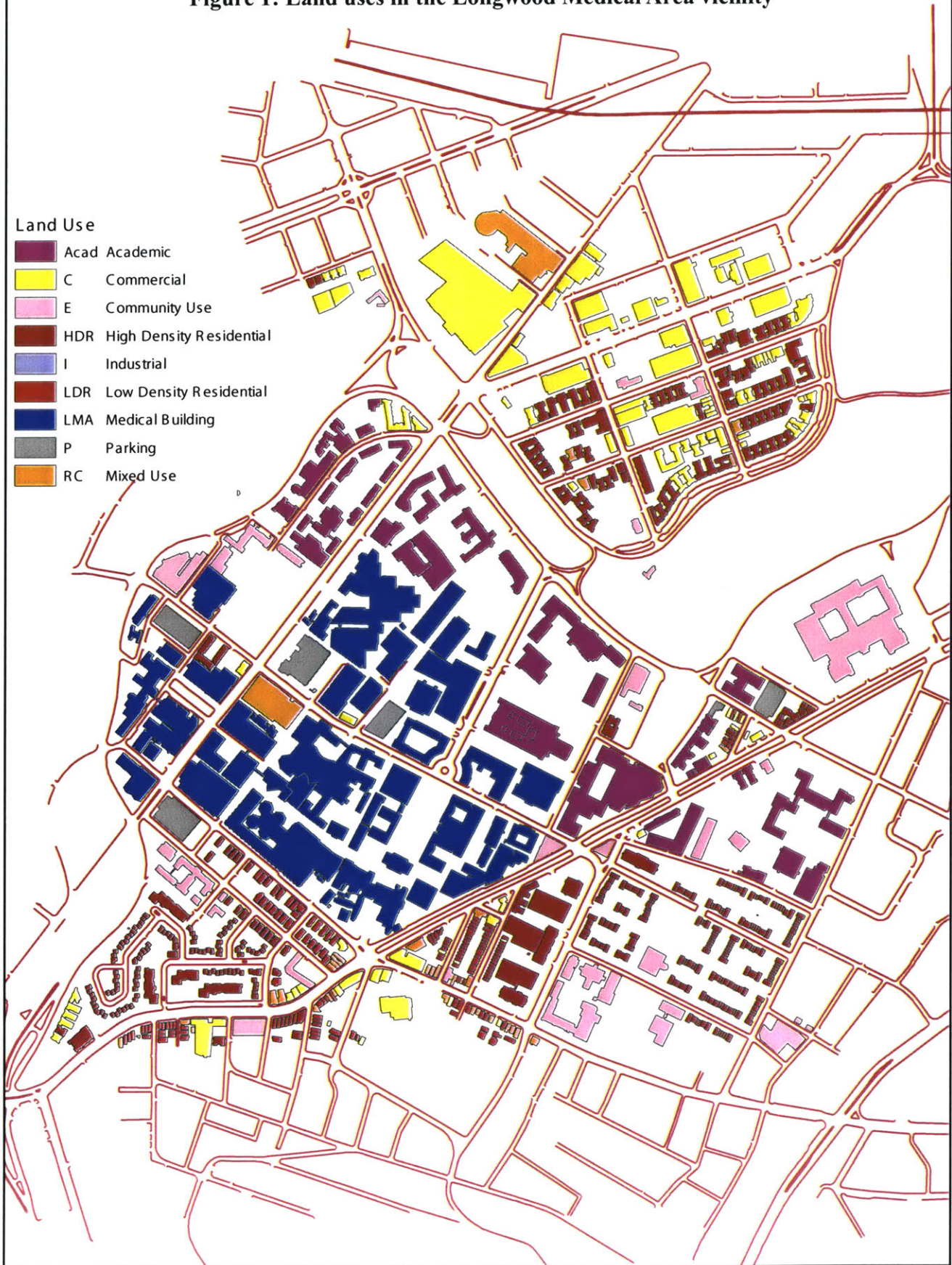
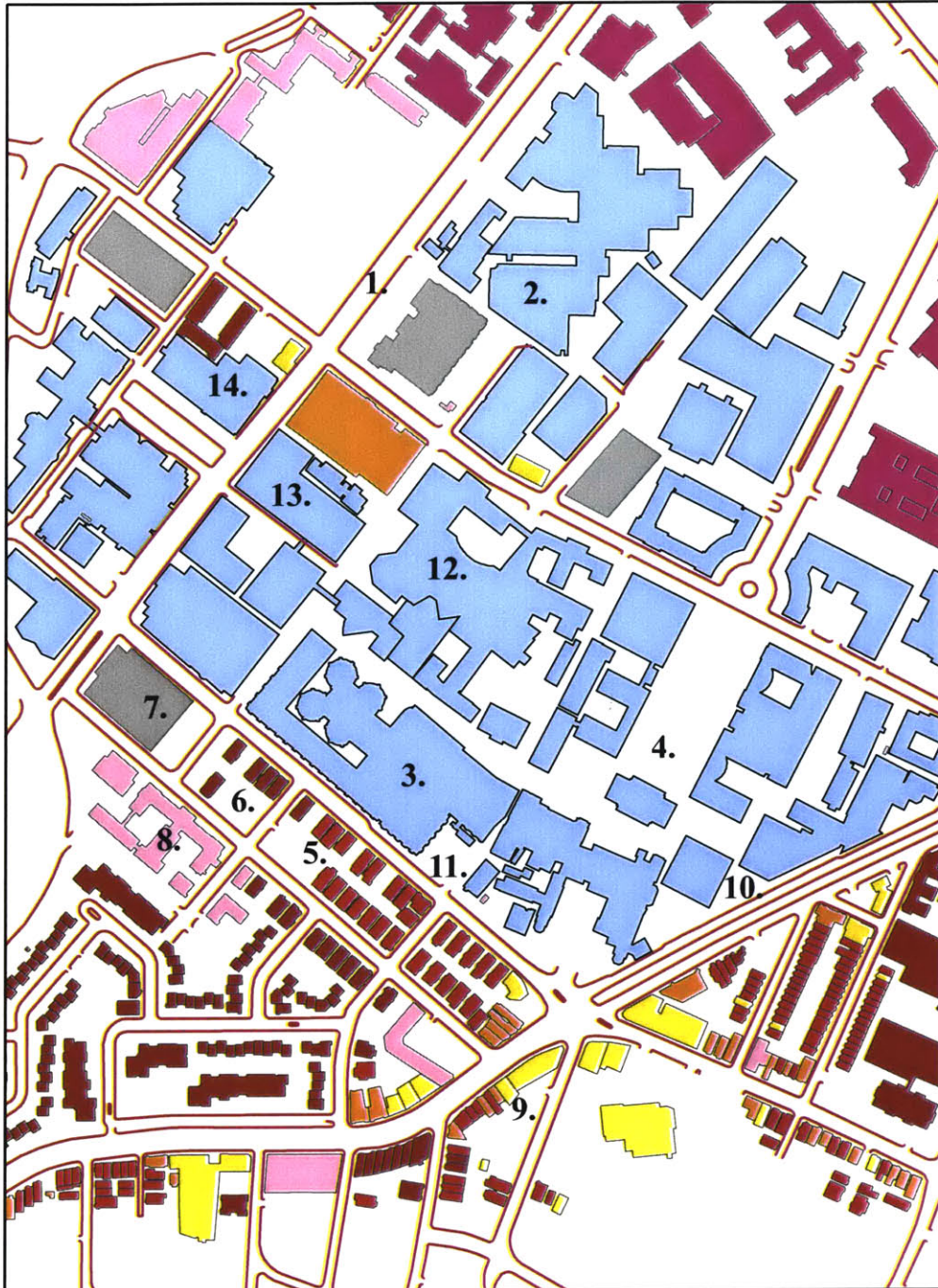


Figure 2: Points of interest in the Longwood Medical Area



- | | |
|---|---|
| <p>1. Brookline Avenue</p> <p>2. Beth Israel-Deaconess Medical Center</p> <p>3. Brigham and Women's Hospital</p> <p>4. Harvard Medical School</p> <p>5. Residential block originally slated to be cleared for Affiliated Hospital Complex</p> <p>6. Residential block cleared in recent BWH expansion</p> | <p>7. Residential block that was cleared in the 1970s to make a parking garage for the result of the AHC planning</p> <p>8. Massachusetts Mental Health Center</p> <p>9. The "Ledge" parcel</p> <p>10. Huntington Avenue</p> <p>11. Francis Street</p> <p>12. Children's Hospital of Boston</p> <p>13. Dana-Farber Cancer Institute</p> <p>14. Joslin Diabetes Center</p> |
|---|---|

Harvard Medical School (HMS) continued its land acquisition activities, attempting in 1960 to acquire the square block of houses between Francis Street and the aging MMHC via the Commonwealth of Massachusetts's power of eminent domain. HMS hoped to collaborate with the state to construct a new home for the hospital, thereby upgrading its teaching facilities. Now that Bostonians had witnessed the eradication of the West End and the very real threat that urban renewal posed to their neighborhoods, however, acts of eminent domain were received much less placidly than in the mid-1950s. The residents of Mission Hill had much in common with the people Gans describes in the *Urban Villagers*: they made up a tightly-knit working-class neighborhood and depended on their physical community. Mission Hill residents organized fiercely against Harvard's proposed taking, and a march of 3000 protesters on the Massachusetts State House in 1960 succeeded in convincing legislators to block the act of eminent domain. [2] Harvard Medical School was not stymied by the failure of its eminent domain action, however. Blessed with deep pockets, HMS turned to the private market to facilitate its expansion. The school began to buy individual properties in the same block it had unsuccessfully tried to take by eminent domain three years later, in 1963.

Meanwhile, six major Harvard teaching hospitals, including the Peter Bent Brigham Hospital (PBBH), Robert Breck Brigham, and Boston Lying-In Hospital, began discussions about merging into a single institution they then called the Affiliated Hospital Complex¹ (AHC). As noted in Chapter 2, by the beginning of the 1960s, a research boom had begun to dominate hospitals' work as they looked inward instead of to their communities for their mission. By combining their resources, these already prestigious hospitals would have an even greater competitive advantage. The hospitals would also be able to share services and save money through economies of scale. [2]

¹ This large consolidated hospital would eventually open as what is now Brigham and Women's Hospital in 1980.

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At this point, hospitals held most of the cards. If the relationship between hospital, city, and neighborhood could be summed up by a circle representing the relative power of the three entities, it would look like this:

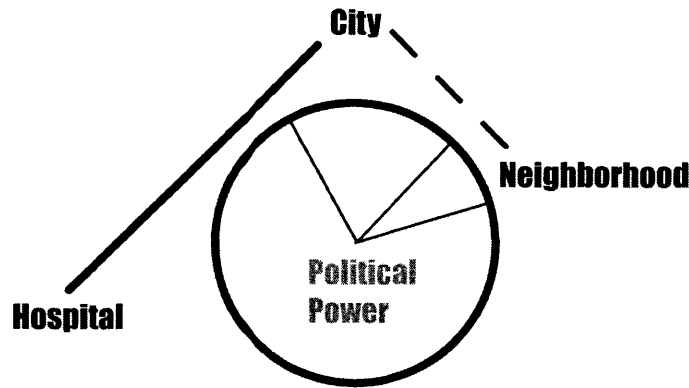


Figure 3: The hospital-neighborhood-city triad pre-1965

With their vast financial resources and little oversight, hospitals were essentially free to buy land around them on the private market to expand into as they wished. The hospitals had no relationship with community leaders to speak of, and the relationship between the BRA and the neighborhoods was just emerging. Meanwhile, hospitals had many cheerleaders at the municipal level that saw their expansion as an economic boon to the city, and those who did not had little precedent to stop it.

Through the mid-1960s, while hospital administrators struggled to agree on a merger and physical expansion plan, Harvard Medical School nevertheless laid the physical groundwork for the potential AHC. It continued to gradually buy residential properties surrounding the medical area, in order to sell them in the future to its teaching hospitals. When a family vacated a unit, Harvard's real estate agent would often replace its tenants by renting to a member of the more transient populations of students, young hospital professionals, and "hippies". Neighborhood and expansion advocates alike also alleged that Harvard kept its residential property in grave disrepair, anticipating the block's impending demise. [2] [4]

The board of the Affiliated Hospital Complex considered four possible sites for the new hospital: The “Ledge” parcel mentioned earlier, kitty-corner to PBBH; a parking lot two blocks away from HMS that the medical school had bought from the Archdiocese of Boston; the PBBH parking lot; and the Francis Street residential block, encompassing the dwellings of 182 families, which Harvard had gradually bought. [2]

Ultimately, in 1968, three of the original six hospitals² that had considered the AHC deal (Peter Bent Brigham, Robert Breck Brigham, and the Boston Hospital for Women) announced that together they would build a new hospital complex on the most heavily populated potential site, the residential block, because of its sizeable area and proximity to the Medical School and Children’s Hospital. [2] Harvard notified the 182 families living there that they would have to vacate by 1971. The similarities between this scenario and that of the West End are striking, even ten years later, with one significant difference: Harvard was forced to buy the land on the private market before evicting the residents.

The First Hospital-Neighborhood Clash: 1969

Once again, because times had changed since the West End, Harvard’s announcement set off a firestorm of conflict between the medical school and its neighbors. It marked the beginning of an extremely contentious period. Some Harvard medical students protested the actions of their own school, most notably at an April 1969 “student strike” at which students “occupied” University Hall in Cambridge, and they encouraged Harvard’s tenants to organize and resist the University. [2] Not all students and faculty agreed with the protesters. The preeminent Harvard surgeon and professor Dr. Francis D. Moore wrote,

² Note that the Boston Lying-In Hospital and the Free Hospital for Women merged to become Boston Hospital for Women in 1966.

“All too often protest... seeks to *denigrate, rough-up or destroy institutions* or people rather than to accomplish any worthwhile mission with relation to those people or those institutions. Many had hoped that medical students, somewhat older, somewhat more dedicated to a mission for the sick, would be more helpful.... Some of the more concerned medical students have held a steady eye toward the medical mission itself, undistracted by the clamor of their more vocal fellows, and in so doing they have restored the faith of the older generation in the motivation and goodwill of the young.” [4, p. 1008, emphasis added].

Nevertheless, the student protesters had a marked effect on the Harvard administration, and they also made a conscientious effort to reach out to the residential population of Mission Hill. Neighborhood residents, particularly those who lived in the threatened block, simultaneously began to organize themselves. The community had been divided along the lines of race and class, as new groups had begun to move into what had traditionally been a working-class Irish enclave. The threat to their homes spurred organizers to work toward bridging these divisions. [2] With a common threat in Harvard Medical School, residents of Mission Hill proved to be a manifestation of Coser’s theory (see Chapter Two) that conflict with an outside enemy can bring groups closer together. [5] To give a sense of the strength of the conflict, and how long its memory has persisted, a 1996 *Boston Globe* article reminded its readers, “The Mission Hill neighborhood was crushed in the 1960s and 1970s by suburban flight and the expansion of medical and educational institutions.” [6] While the neighborhood may not have been crushed – indeed, it was able to make a strong fight against the encroaching institution – in the popular imagination, the battle between hospital and neighborhood was bitter, and certainly cause for resentment on the part of Mission Hill.

The First Neighborhood Victory

What Harvard wished to take away from this primitive version of “negotiation” with the community was clear. Its teaching hospitals hoped to expand, displacing 182 households, and some say they planned to build a facility without the outpatient care facilities that would serve neighborhood residents. “Tenants found that many of their neighbors shared

the feeling that the hospital would not serve the community....,” Waitzkin writes.³ [2, p. 1004] [4] To offset the negative effects of its expansion project, Harvard’s public plans for the AHC included relocation assistance to displaced households from the very beginning, and in May 1969, after the student protest, Harvard upped the ante, offering to build affordable housing itself. At one point, Harvard announced it would build 1100 new housing units in the area, 30 percent of them affordable to low-income families. The university even promised not to engage in hospital construction until the units were completed. [2] Harvard offered all this even while internal expansion advocates like Dr. Moore argued that the complexities of acting as a housing provider would distract the hospitals from their medical missions and ultimately be a disservice to the field of health care. [4]

Despite Harvard’s offer to build 1100 units of affordable housing, which some critics deemed infeasible, community and student opposition to the originally designated AHC site did not wane. Projecting costly delays, the AHC board quickly reconsidered its planned location. When a delegation of neighborhood residents presented a petition signed by 175 residents who wished to remain in their homes to the Dean of the Medical School, Robert Ebert, he told them that the AHC’s planned site had changed, sparing their homes from demolition. Finally, in August 1969, the AHC board announced that the new consolidated hospital would be built on the PBBH parking lot and half of a residential block, demolishing just one third the number of the homes that would be destroyed by the original plan. [2] This site had the disadvantage of its small size, poor fit with the local traffic pattern, and relative distance from Harvard Medical School. Moreover, Harvard would assist as many families as possible with moving into another home in Mission Hill by paying for their moving expenses. [4] Harvard also promised to build replacement housing for displaced tenants on a nearby 10-acre site it owned, which

³ Moore contradicts this assertion, arguing that from the beginning, the hospitals dreamed of establishing a community-care center.

later became the Riverway at Mission Park mixed-income housing development. [7] Thirty years later, William Franklin, a charter member of Roxbury Tenants of Harvard, told the Boston Globe, “We hadn’t any sort of idea we could do it, but we fought Harvard, and luckily, we won out.” [8]

The balance of power had shifted after this tumultuous period. The new political triangle looked more like this:

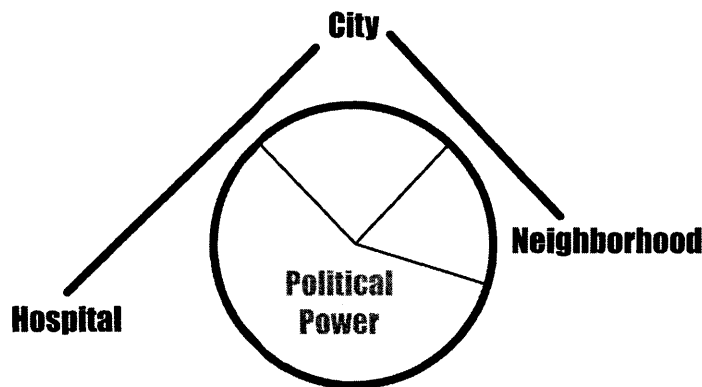


Figure 4: The hospital-neighborhood-city triad 1965 - 1970

Following the election of John Collins as mayor, The BRA moved away from monolithic support for institutions under the direction of Collins’s appointee Ed Logue. Many planners at the BRA in the 1960s were idealists who rejected the more brutal elements of urban renewal. Instead of legal power, the Mission Hill community fought the hospitals with sound and fury, using public opinion and capitalizing on the fact that many individuals within Harvard, especially medical students, disagreed with the institution’s actions. Internal dissent on the part of Harvard weakened it relative to the Mission Hill community. The hospitals were still wealthy and powerful, but the neighborhood had shown that it could make enough trouble for the hospitals that the institutions would not always get their way.

A Shift in Power Away from Hospitals in the 1970s

The economic dominance of research hospitals in the 1960s also began to wane in the 1970s. Although the NIH continued to give out substantial amounts of research money, its value was diminished by inflation. At the same time, government reimbursements for Medicare and Medicaid increased, making patient care more lucrative relative to research. [9]

This shift in power away from research hospitals was accompanied by a shift of power toward community groups. Mayor Kevin White, who took office in 1968, was a populist in the style of Mayor Collins and continued to favor individual neighborhood interests. Equally important was the growing trend of grassroots political organizing. As noted earlier, in 1969, when Mission Hill residents who lived in the block slated for demolition were beginning to organize against the AHC, they formed the organization Roxbury Tenants of Harvard. The group originally formed solely to prevent Harvard-owned homes from destruction and to obtain better maintenance and service from their institutional landlord, but it quickly grew in power and still exists today as a landlord itself.

Many nearby community development corporations (CDCs) followed in its wake. In 1973, a group of Fenway residents formed the Fenway Community Development Corporation (Fenway CDC). The impetus for the group's creation was the Fenway Urban Renewal Plan, approved in 1967, which included a sizeable amount of clearance in the neighborhood, as well as the potential for private demolition of housing. Over time, the mission of the Fenway CDC evolved to include affordable housing development and advancing its own physical plans for the Fenway. [10]

Mission Hill followed suit in 1975, when neighborhood activists formed Mission Hill Neighborhood Housing Services to fight institutional expansion and the inevitable

redlining of their homes that accompanied it. Like the Fenway CDC, it has also evolved to encompass a variety of programs to help people obtain and keep housing.

The fact that these new organizations helped to even out the balance of power between hospitals and their neighbors did not decrease the animosity between the two groups. Indeed, it emboldened community members to fight against their powerful institutional neighbors. “Tension between ... Harvard Medical School and community groups dates back to the 1970s, when institutional incursion across Huntington Avenue meant war with the neighborhood,” a Boston Globe editorial proclaimed in 1996. [11] Another Globe article recalled Harvard Medical School as a “neighborhood nemesis” in that era. [12]

The new reality that hospitals could not act autonomously when making land use decisions deeply affected their planning ambitions. The federal regulatory landscape was changing as well, rolling back the powers granted large institutions during the era of Urban Renewal. Significantly, federal funding for urban renewal projects began to dwindle in the late 1960s under the Nixon administration. [13] In 1974, the Senate passed a bill ending Hill-Burton funding for hospital construction and expanding localities’ powers to disallow hospital construction or expansion when a need for additional hospital beds cannot be demonstrated. [14] The new community organizations, with their political clout, were helping to turn political will against institutional expansion at the municipal level. Negotiation with communities, whether directly or through the BRA, had become a necessity for hospitals wishing to expand. Once again, the power balance among hospitals, the city, and neighborhoods had shifted:

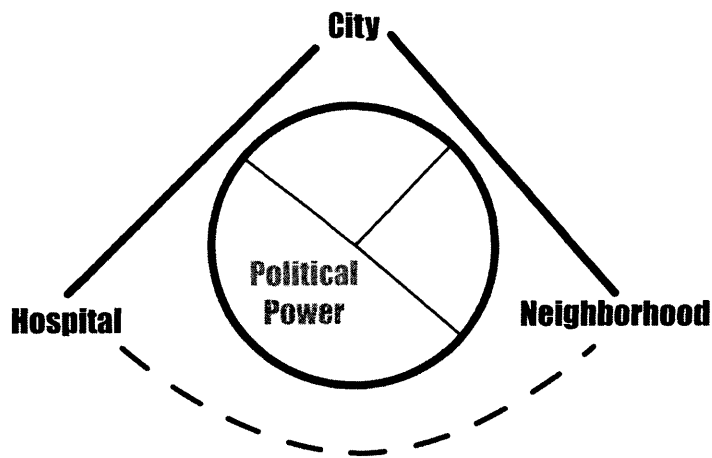


Figure 5: The hospital-city-neighborhood triad 1970-1985

It is therefore not surprising that in 1977, the LMA institutions and representatives of Mission Hill signed an agreement that stipulated any institutional development on the southeast side of Huntington Avenue would require community consent to move forward, formalizing the de facto situation that had existed for years. [15]

The previous year, in 1976, Harvard Medical School broke ground on two complementary projects: a controversial diesel power plant that would serve the needs of many hospitals, located on the corner of Brookline Avenue and Francis Street; and a building containing 775 low-income apartments.

The housing project, dubbed the Riverway at Mission Park, was far more successful. Harvard had owned the former House of the Good Shepherd convent site since the late 1960s, originally planning to use it for expansion purposes. Members of Roxbury Tenants of Harvard (RTH) and Students for a Democratic Society campaigned to make sure that Harvard would keep its promise from the 1970 AHC deal and develop it for affordable housing. After three years of negotiations, Harvard gave the land to RTH and put up seed money to develop the affordable housing project as planned by the non-profit. [8] By

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agreeing to develop the parcel residentially, Harvard tacitly acknowledged that it was retreating from its expansionist plans of earlier decades; the parcel would never be used for medical purposes, and the LMA would simply not extend as deeply into Mission Hill as its institutions once imagined it would.

The diesel-powered Medical Area Total Energy Plant (MATEP), in contrast, was furiously opposed by neighborhood residents. During the 10-year struggle around it, the power plant replaced residential displacement as the touchstone of disagreement between the Harvard-affiliated hospitals and their neighbors. Community groups won a 1978 injunction against the plant's assembly, arguing that the plant's nitrogen dioxide emissions would be a public health hazard. [16] After the injunction was overturned and the plant completed in 1980, it was again prevented from coming online when the Massachusetts Supreme Judicial Court ordered the Massachusetts Department of Environmental Quality Engineering to consider the effects of particulate matter in evaluating its overall effect on public health. At that time, diesel technology was becoming outdated, and energy plants in urban areas had turned to cleaner fuels like natural gas. [17] By the time the plant opened in 1986, the effect of the long delay raised the project's total cost from a projected \$50 million to an eventual \$336 million. Although the facility today generates a healthy operating surplus, it is not enough to pay down the heavy debt service burden on the project. [18] In the final analysis, then, MATEP as a project was a net loss for Harvard because of community resistance to it. It served to teach Harvard, through conflict with its surrounding communities, that the power balance between the two players had changed.

In following with Coser's model of the social functions of conflict, the tumult of the 1970s was the result of the changing power balance among hospitals, communities, and local government during that time. The "rules" of the land use game were rapidly changing. Through systemic changes and their own organizing, community groups had

unprecedented power with respect to hospitals. Yet exactly how much was unclear. Harvard Medical School caved on its former convent parcel, building affordable housing there as the community wished; but at the same time, through years of bitter struggle, it pushed its power plant through to completion over the constant and vocal opposition from its neighbors. The failure of MATEP beautifully illustrates Coser's thoughts about one of the functions conflict serves: recalibrating the relationship between two parties by demonstrating changes in their relative power. MATEP modified the norms of the political process to reach a new power equilibrium. [5]

By 1980, it was clear that the balance of power had tipped further toward the community over the preceding decade. Instead of simply cutting back the amount of land it would take and clear for institutional expansion, Harvard had thrown up its hands and simply followed through with its agreement to build affordable housing. Community power was the new paradigm in planning. In addition, as we shall see, hospitals were struggling economically themselves, making costly fights like the one over MATEP even more unwelcome.

Tough Times for Hospitals in the 1980s

Across the United States in the early 1980s, Reagan-era cuts to Medicare reimbursements forced teaching hospitals to pay more attention to their patient care activities to stay solvent. Many turned to competing for highly expensive procedures like organ transplantation. The advent of managed care in the 1980s, whereby insurance companies dictated to hospitals what they would pay for procedures, forced many to close or merge in the mid-1980s. As hospitals became more focused on high technology, primary care moved to outpatient clinic locations far from hospitals. [9]

Hospitals continued to suffer into the late 1980s. Between 1984 and 1993, 949 hospitals shut their doors in the United States. Indeed, the ongoing trend over at least the past two

decades has been net hospital closures, brought about by declining occupancy and revenue alongside rising costs. In the year 2000, over 5000 hospitals existed in the United States, and an average of about 40 hospitals had closed each year for the past decade, most of them in urban areas. [19]

**The Era of Reconciliation:
New Partnerships Between Hospital and Community, 1985 – Present**

The 1980s saw a gradual easing of tensions between communities and hospitals. Hospitals perhaps were humbled by their economic troubles and weary of constant fighting with their neighbors. The community empowerment paradigm gradually shifted away from that of protesting against the system as perpetual outsiders. Instead, community activists began to become insiders, making deals with other insiders. Recall that Harvard professor and expansion advocate F. D. Moore wrote disparagingly in 1970 that activists' method of choice was "roughing up institutions." [4] Moore's "roughing up" was no longer necessary. Community organizations had earned their place at the bargaining table. The memories of the "roughing up" of which they were still capable, however, did not fade. The ongoing potential for "roughing up" the institutions of the LMA was one factor that contributed to the community groups' new power.

The 1990s were a decade of unprecedented cooperation between hospitals and universities. In 1992, Children's Hospital of Boston and the Fenway CDC made a groundbreaking agreement of their own, circumventing the BRA. The Fenway had never experienced the same level of intense conflict with the Longwood medical institutions that Mission Hill had, for a variety of reasons. It was buffered from the area by parkland; the population of the Fenway was more affluent and thus more enfranchised; and the Fenway had other institutional neighbors that were greater sources of conflict over the decades, including Northeastern University and the Boston Red Sox. [20] [21]

The forces that brought Children's Hospital and the Fenway CDC together were serendipitous. The CDC had assumed the role of affordable housing developer since 1980, and its leaders were intrigued by the possibility of partnering with a nearby institution to defray upfront costs. Partnering with a medical institution would cause less of a political credibility problem for the CDC than partnering with a university like Northeastern that was strongly disliked by Fenway residents. [21] Children's was the first of several institutions of the Longwood Medical Area to develop their first initiatives in conjunction with the Fenway and Mission Hill. Another impetus for changes in hospital-community relations was the arrival of a new vice president of operations at the LMA's Medical Academic and Scientific Community Organization (MASCO), according to Carl Koechlin. [10]

MASCO dates from 1972, when it was formed as the Shared Services Corporation to coordinate operations and planning among its member institutions to reduce costs. A secondary goal of the Corporation was to improve the relationship between the institutions as a whole and their neighbors in the Fenway and Mission Hill. The organization continues to operate as the Medical Academic and Scientific Community Organization, Inc. (MASCO). In FY 2003, MASCO received over \$24 million in revenues from its member institutions and other sources. Much of its operations budget goes toward providing a complex private transit network that carries students and employees back and forth from Harvard, MIT, satellite parking lots, and several MBTA transit nodes.

David Eppstein, the second person to hold MASCO's Director of Community Affairs position, had come from a community organizing background. He made a point of making contact with local non-profits, so former Fenway CDC staffer Bob van Meter and David Eppstein had formed the beginnings of a professional relationship. Meanwhile, Children's Hospital was planning a major expansion and had linkage obligations to the

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city. It was the shortage of local housing for hospital staff that originally drew planners at Children's to the idea of earmarking their linkage money for a local housing project.

Eppstein brought leaders of the Fenway CDC and Children's together (he refers to himself as Longwood's "yenta") to formulate a plan to jointly develop affordable housing in the Fenway, using Children's linkage obligations as a funding source. According to van Meter, the BRA was not initially receptive to the plan, because it counted on linkage money from such expansions for its "slush fund" to support high-priority projects throughout the city. Ultimately, however, the BRA agreed to the deal, and the housing project was completed. The rules have since been tightened. [21] According to Jane Matlaw at Beth Israel-Deaconess Medical Center, although hospitals would like to earmark linkage funds to individual nonprofits, it is no longer possible today; CDCs must write grants themselves to access linkage funds. [22]

The Fenway CDC continued its productive relationship with MASCO. In 1991-1992, MASCO built a parking garage and daycare center on a large parcel it had bought from Temple Israel. MASCO committed 25% of the garage's city-mandated payment-in-lieu-of-taxes (PILOT) obligations, or approximately \$18,000 yearly, to support the work of the Fenway CDC. This continues to be a funding source for the nonprofit. [21]

In 1994, the Fenway CDC and MASCO collaborated on a new program to place low-income Fenway residents into LMA jobs, which they named the "Walk-to-Work" initiative. Walk-to-Work was funded by linkage money from LMA institutions. By working with human resource managers at hospitals, Barbara Burnham at the Fenway CDC was able to identify "points of access" for neighborhood residents into the relatively high-paying and stable health-care employment sector. [21] Another important employment program was "Bridges to the Future," which targeted low-wage "incumbent" health care workers from the neighborhoods surrounding the LMA.

“Bridges to the Future” helped them to move up the health care career ladder and ultimately secure a job paying a living wage. [23]

Outreach efforts were not just targeted to hospitals’ residential neighbors. In 1994, as part of the “Walk-to-Work” program, MASCO published a business directory of locally available services for distribution to its member institutions. According to David Eppstein, “It’s the little steps that help people realize that the institutions don’t have to turn their backs on the neighborhood.” [20] In 1996, the Mission Hill Board of Trade followed suit as it published coupon books for Mission Hill businesses and distributed them in Longwood medical institutions. The books are associated with the remarkably named “Hands Across Huntington Avenue” campaign, and institutional administrators eagerly responded to this show of goodwill. [6] Although this campaign targeted the local business community instead of the residential community, Eppstein feels that it was a milestone in hospital-community relationships, demonstrating to local businesses that the LMA was making an effort to treat them respectfully and take them seriously as potential partners. The power balance between hospitals and communities had evened out.

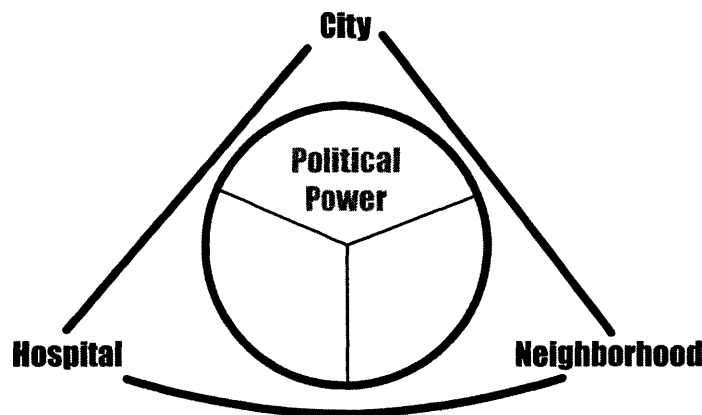


Figure 6: The hospital-city-neighborhood triad 1985 - 2005

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Giving Control to the Community in the 1990s

Just before the Children's-Fenway deal, in 1989, Harvard put an end to the most contentious era of hospital-community relations by offering its "Ledge" parcel for sale. This parcel had been a bone of contention every since its purchase by Harvard in 1958, as a symbol of the institution's impending expansion across Huntington Avenue and into the residential heart of Mission Hill. The rise of neighborhood power in the 1970s had ensured that the Longwood Medical Area never crossed Huntington Avenue, but actually giving the parcel up was an acknowledgment of defeat by Harvard. As through the Riverway at Mission Park development, Harvard retreated from its expansion plans and ensured that it would stay within the confines of Huntington Avenue.

Harvard approached Mission Hill Neighborhood Housing Services (MHNHS), its former political foe, for help in finding a buyer that would develop the parcel according to the neighborhood's wishes. [24] While Harvard originally gave MHNHS just two years to find a buyer, after a community planning process that resulted in a scheme for retail, office, and open space, the organization finally issued an request for proposals (RFP) to developers in 1995. It chose a developer in 1996 [11], and the development was completed in May 2003. The finished project contained profitable office space, neighborhood-serving retail, and open space. The development represented another opportunity for reconciliation between the hospitals and Mission Hill, as the office space MHNHS leased at market rates to medical tenants offset the financial losses generated by the other uses desired by the community. [7]

Harvard continued its gradual withdrawal from residential neighborhoods as it made plans to sell its Riverway at Mission Park affordable housing development to Roxbury Tenants of Harvard in the late 1990s. [8] Ownership was finally transferred to RTH in 2001. [25]

By the end of the 20th century, the new paradigm of negotiation had calmed the tensions between the hospitals and neighborhoods. When Harvard decided to sell Mission Park, Robert Parks, director of RTH, told the Boston Globe, “Harvard did the right thing and kept to every commitment.” [26] This observation would have been astonishing 30 years earlier, when Parks, about to be evicted by Harvard from his Mission Hill apartment, was a leader in the anti-expansion struggles. [8]

A brief example that demonstrates the new relationship between community, hospital, and the BRA is the disposition of the former Massachusetts College of Art building when MassArt moved to its current location on the Avenue of the Arts in the mid-1990s. Beth Israel purchased the building from the Massachusetts Department of Capital Assets for new clinical facilities. The Fenway CDC’s Bob van Meter does not recall anger from the Fenway at Beth Israel’s expansion, nor a great discussion of alternative uses for the building. Instead, he said, the Fenway’s focus was on the benefits to the neighborhood that could be derived from the expansion. That Beth Israel’s expansion would happen and that the BRA would require it to make concessions to the community in return was simply a given at that point. [21]

Hospital-Community Relations Today

The LMA has not seen the end of institutional expansion, but strict and clearly defined rules have guided new development since 2001. A controversial project proposed by the Joslin Diabetes Center that included a 300’ tower sparked so much neighborhood criticism that the BRA began a process of creating interim planning guidelines as a preamble to rezoning the LMA. [27]

By the end of 2001, Boston’s overall economy had crashed, and institutions in the city saw an opportunity to expand. It wasn’t just the Joslin Center that had extensive plans. Hundreds of thousands of square feet of new construction were being proposed. Elected

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officials, planners at the BRA, and community groups all became concerned about the potential for an out-of-control LMA growth spurt. A movement arose to create a new plan for the LMA, which had not been rezoned since the 1950s. In February 2003, the BRA adopted a set of interim guidelines for the area, with the goal of completing a permanent plan within 18 months. Representatives of MASCO worked with the BRA on the guidelines, and several public meetings were held during the development process. According to BRA planner Keith Craig, while he would have liked more public involvement in the form of working groups and charrettes, the process needed to move too quickly for such workshops to be feasible. The guidelines set an absolute height limit of 205' for the area and gave developers density bonuses for specific public benefits like providing housing, extraordinary urban design, and even workforce development. As of May 2005, the BRA has not yet completed the permanent new plan for the area. Craig imagines that it will reflect the interim guidelines. [28] [27]

Ironically, the Joslin Center's political lightning rod of a tower was not even the institution's idea. When it purchased a parcel abutting the clinic on the corner of Brookline and Longwood Avenues, which contained an 84-unit apartment building, its goal was simply to build space to conduct diabetes research. According to former Joslin Center attorney Carl Finn, when the institution approached the mayor's office, Mayor Menino was very supportive of both the economic growth and medical mission of the project; however, his deep concern with housing availability in Boston led him to insist that the Joslin Center replace every apartment it tore down with two new ones. [29]

The Joslin Center had no choice but to cooperate. Representatives attended a series of community meetings to hear community reactions to an iteration of design proposals. Although there was no formal negotiation with community groups, both parties knew that the BRA would not approve a plan that was completely unpalatable to the community. Finn calls this "indirect negotiation." Ultimately, the Joslin Center was permitted to build

500,000 square feet of clinical, research, and housing space. The Center agreed to position the tower to minimize the impact of its shadow; to make 10 percent of its apartments affordable and supply an equal number of affordable apartments offsite; to grant tenants who had lived in the building for at least five years the right to one of the new apartments and pay for their housing and moving costs during construction; to locate its loading dock underground; and fund a job development program in partnership with the Fenway CDC. While Finn recognizes the importance of community concerns, he stresses the importance of the mission the Center is undertaking with its new research building: “[the new building] is important and necessary for diabetes research, so that we can cure this insidious disease.” [29]

Also in 2001, Brigham and Women’s Hospital (BWH, the infamous Affiliated Hospital Complex of the 1970 Harvard-Mission Hill showdown) went through a process similar to the Joslin Center’s. The hospital required a new building to house its proposed Center for Advanced Medicine. The small block across Francis Street from BWH, containing vacant lots and a few houses, was the hospital’s ideal location. Not only did neighborhood groups now have a great deal of influence with the BRA, but Roxbury Tenants of Harvard actually held an interest in the block as real estate managers. Harvard, acting on behalf of BWH, was forced to negotiate with the community directly and indirectly. It held monthly meetings and some focus groups to keep the community updated on its latest architectural plans.

The two parties made a deal with very favorable terms for the non-profit. [7] Through a three-way land transaction involving Harvard, BWH, and RTH, RTH granted permission for six buildings on the lot in question to be physically moved to a new location one block away. Harvard sold 31 houses to RTH at favorable prices, and BWH transferred 7 buildings, lots, and mixed-use properties to the non-profit. The Brigham also began working with the tenants group to extend the services it provided the neighborhood,

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including job training and adult education classes in computing skills, ESL, and GED preparation. [30] In return, the neighborhood groups made it known to the BRA that they supported Harvard in developing its 10 story, \$150 million research center. The BRA approved the development. [27]

Both these deals are good examples of the new paradigm for institutional expansion in Boston. Hospitals must keep communities informed of their plans and take their concerns and reactions seriously if they hope to win approval for their projects. They can also expect to make substantial concessions to the community. It is not just the BRA that wields power over institutions, forcing them to do the right thing. The tumultuous 1960s and 1970s are not forgotten in the Fenway and Mission Hill. At public meetings for projects like the Joslin Center, a small but vocal group angry residents can be counted on to denounce the hospitals in no uncertain terms. [27] What if hospitals decided once again to expand across Huntington Avenue perhaps, buying up land and ignoring their neighbors? Organizations like Roxbury Tenants of Harvard and the Community Housing Corporation of Mission Hill have only become stronger over time. If a hospital crossed the line, these groups could mobilize their members, politicians, and even students. Thus, the peace between hospital and neighborhood is somewhat fragile, with an undercurrent of tension. While Keith Craig of the BRA calls the process “unpredictable,” it has its own logic and rhythm. The players know what to expect from each other, and they know the routine they must take part in.

Hospital-community negotiations in this model are ongoing. The Dana-Farber Cancer Institute (DFCI) plans to build a clinical and research building where a parking lot and two low buildings currently reside. Anne Levine, the DFCI’s Vice-President of External Affairs, plans to bring preliminary designs before the LMA Forum (a regularly held public meeting that MASCO facilitates) in May or June of 2005 and is foreseeing an iterative negotiating process both at the Forum and with the BRA. “We know we’ll have

to provide housing and job training linkage in compliance with city's formula," she says, also anticipating that the agency will ask DFCI to make improvements to the nearby streetscape, sidewalks, and lighting. [31]

Likewise, Brigham and Women's Hospital is planning to collaborate with Roxbury Tenants of Harvard in developing the former Massachusetts Mental Hospital site in Mission Hill, creating housing, research space, and a parking garage. John McGonagle of BWH acknowledges that the hospital works much more closely with community groups in its physical planning than do other institutions of the LMA, actively consulting and partnering with them instead of presenting plans and hearing feedback at a public meeting. "We're the only institution in the LMA that abuts a neighborhood," he explains, an example of how a hospital's place in the urban fabric affects its relationship with its neighbors. [7]

The Effect of Ongoing Community Benefits Programs on Hospital-Community Relations

Even at the height of hospital-community conflict, the hospitals of the Longwood Medical Area provided important services to local residents. Moore stated that 30 percent of surgeries at Peter Bent Brigham were emergency, unscheduled procedures. "We have many patients of ghetto background or foreign extraction, many who are black, brown, or yellow..." he notes, adding, "There are clinics for family planning, alcoholism, venereal disease; there are evening clinics and a home-care service." [4, p. 1010]

Today, according to David Eppstein at MASCO, the "hard" benefits like land or cash offered communities by their hospital neighbors tend to get the most publicity. The benefits to the neighborhoods of ongoing "soft" programs like free or reduced-cost health care, however, are at least as great. Eppstein cites both "hard" and "soft" benefits as crucial to maintaining positive hospital-community relations. [20] Anne Levine at Dana-Farber agrees, saying, "We have partnered with city on a number of cancer outreach

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efforts, and that has given us a good foundation,” when negotiating with government officials. “It’s in our interest to do good work in the community,” John McGonagle agrees.

All the hospitals in the LMA maintain substantial community benefits programs, spending a relatively high percentage of their budgets on community programs. (See Chapter 5 for more details.) As a representative example, Beth Israel-Deaconess Medical Center (BIDMC) spends \$27 million out of a \$533 million budget annually on community benefits.

Yet, as Eppstein pointed out, it is difficult to quantify the effect these ongoing benefits have on hospital-community relations. While they may improve people’s lives, programs are not necessarily well known in the community. For example, the “Walk to Work” employment program described above was cited by many of my interviewees as an excellent example of hospital-community cooperation. Yet the program’s instigator, Sarah Griffen, is reluctant to claim that it has had a dramatic effect on people’s opinions of the LMA, especially in its initial incarnation as a “career ladder” program for people already employed by the hospitals. When the program began working with hospitals to hire new workers, it gained greater recognition in the surrounding neighborhoods. According to Griffen, although the pre-employment program is more visible, ultimately, an \$8 - \$10 per hour job is not enough for a local employee; thus, the incumbency program is critical in helping people to advance until they earn a living wage. [23]

Finally, Jane Matlaw at BIDMC says that the community benefits provided by the hospital undoubtedly contribute to an improved relationship with the community, but that relationships with community groups often start when a group is in a financial crisis and looks to Beth Israel for financial help. For Matlaw, this can be a way to get the group involved in Beth Israel’s ongoing community health work. [22] Many community

benefits programs are not terribly visible in the community, even those that have a strong positive impact on people's lives. Also, many people perceive providing community health care as simply a hospital's job, not something that will win it additional favor from the community.

Unresolved Issues and Tensions in the Neighborhood

The relationship between the hospitals of the LMA and their surrounding neighborhoods has steadily improved since Harvard's 1958 land grab. No matter how cordial the parties are with each other today, though, and no matter how many joint projects they undertake, the area can never be free of underlying hospital-community tensions. Some severe negative hospital impacts can never be eliminated, no matter how good a neighbor the hospitals become.

Perceptions of safety in the neighborhood have played a role in magnifying hospital-community conflict. In the 1970s and 1980s, Longwood institutions viewed the Fenway and Mission Hill as "bad neighborhoods," from which their employees had to be protected. Much of the street crime in the vicinity was attributed to the nearby Mission Hill housing project. Naturally, this made their neighbors feel that they were viewed as criminals and did little to improve community relations. Miriam Garmaise reports that tensions were high, and communication lacking in the early 1980s. [15]

Improving hospital-community relations began to ease the suspicions on both sides. The original Harvard School of Public Health (HSPH) had its back – a sheer blank wall – facing Huntington Avenue, sending a distinct unwelcoming message to Mission Hill. When HSPH built its new building in the early 1990s, it opened onto Huntington Avenue. Eventually, perceptions of safety changed in the LMA. MASCO soon discontinued an expensive private police patrol it had run every night from 4 pm to 8 am when the demand for it ceased. [20]

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Traffic congestion generated by the LMA rivals institutional expansion as a point of contention with the neighborhoods. The two primary arteries through the LMA, Brookline Street and Huntington Avenue, are also main streets for the Fenway and Mission Hill, respectively. Not only do these streets bring 37,000 workers and 10,000 patients into the LMA daily, but they also funnel traffic from outer neighborhoods and suburbs into Downtown Boston. Meanwhile, both neighborhoods have visions for their main streets that include creating a more pedestrian-friendly atmosphere, widening sidewalks, and narrowing the streets themselves. These visions are incompatible with current and projected traffic volumes through the LMA. MASCO's solution has been to lobby heavily for improved public transit access to the area and to run its own extensive private shuttle service to and from transit stations and offsite parking lots. While MASCO's alternative transportation programs have been successful in raising the LMA's share of all commuting modes other than single-passenger auto to the highest level in Boston, the mode share of alternative transportation is still just 37 percent. MASCO is planning to expand its offsite parking program for employees and to pilot a program that will allow neighborhood residents to ride free on certain shuttles. [20]

I originally postulated that hospital-related gentrification would be a bone of contention. According to Bob van Meter, though, while gentrification has been an ongoing issue in the Fenway for decades, there has not been a great deal of discussion about the medical area as a primary driver. He suspects that most doctors living in the vicinity of the LMA reside in Brookline rather than the Fenway and cites speculative condo conversion as a greater force behind gentrification. Nevertheless, the heavy jobs/housing imbalance in LMA and the transportation problems it causes are quite clear. While some institutions considered building housing specifically for their workforces in the Fenway during the 1990s, in order to mitigate the externalities of the LMA's many inbound commuters, it soon became clear that the hospitals' building enough housing in the vicinity to make any

perceivable difference in commuter congestion was a pipe dream; the commuting population was simply too large. [20]

Keith Craig agrees that the LMA is an anomaly, easier to work with than other hospitals and universities because it is a “huge machine,” with little “tight residential fabric” around it. Even some of Boston’s community-serving hospitals, such as Caritas St. Elizabeth’s Medical Center in Brighton and New England Baptist Hospital in Mission Hill, have had bitter conflicts with their residential neighbors in the last decade. They, like the LMA hospitals, wished to expand; however, they were physically enmeshed in their neighborhoods. Although many planners in his office have tried to do a master land use plan for the area, he argues that no Boston politician truly wants to restrict how the LMA can grow as an economic generator for Boston. The BRA must perform a difficult balancing act, allowing them to grow economically while protecting their neighbors. [27]

A final and intractable issue in the relationship between hospitals and communities is the medical mission of the hospitals. While medical institutions can have negative effects on their neighbors, the BRA acknowledges that many of the Longwood institutions are advancing medical science and saving many lives, as well as contributing the Boston’s economic and employment base. It is certainly not in the interest of the BRA to rein in the hospitals so much that they cannot fulfill their medical mission. As elsewhere in the real estate industry, in negotiations with the BRA, the hospitals make clear their bottom line, that is, what they need to be approved for the project to be feasible. Because of the specialized nature of the medical field, BRA staff members tend to be unfamiliar with industry standards, and it can be difficult to ascertain what concessions it is reasonable to ask of hospitals. As an example, Keith Craig cites the insistence of some hospitals that their research labs be in the same building as their clinical facilities instead of offsite, and it is difficult for the BRA to determine whether this proximity is truly a need of the research facilities or simply a strong desire. [27]

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Thus, ongoing tension underlies the balanced relationship between hospitals and communities today. Given that these issues can never quite be resolved, the potential for a no-holds-barred, furious protest against the hospitals still exists, were they to cross the line and truly act with disrespect for the neighborhoods. Alongside the hospitals' desires to do the right thing; alongside the BRA's general desire to advocate for communities in the regulatory process; this potential for serious conflict is a strong force for holding the hospitals of the LMA in check.

The next chapter will explore a parallel evolution of hospital expansion-community benefits negotiation in Boston's Chinatown. The similarities between these two case studies are striking. Chapter Six will synthesize the data presented in Chapters Three and Four to draw more general conclusions about hospital-community relations.

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chapter 4

the tufts-new england medical center case study

What is now Boston's Chinatown was first constructed as middle-class housing on tidal flats that had been filled in the early 1800s. Its original occupants moved out in the latter half of the 19th century, and the area became the first American home for many Irish, Jewish, Italian, and Syrian immigrants. [1] Around the turn of the 20th century, Chinese-Americans began to settle the area, and the Chinese population grew steadily thereafter. As more Chinese immigrants settled in the 87-acre area that had become the traditional jumping-off point for new ethnic groups, it became known as Boston's Chinatown, and while its physical area has dwindled, it remains largely an Asian immigrant enclave today. [2]

The area has also been home to medical institutions for many decades. The New England Medical Center (NEMC) as it existed in 1950 was the descendent of a venerable hospital known as the Boston Dispensary, founded in 1796. Boston's Floating Hospital for Children, a unique shipboard medical facility whose original mission had been to expose children to the healthy sea breezes, had built a landside facility adjacent to the Dispensary in 1931. In 1950, the Tufts School of Medicine moved from its former location adjacent to Boston Common to its current Harrison Street one to be closer to NEMC, its teaching hospital. The four medical institutions became concentrated in one small area. [3] Please see Figures 7 and 8 on pages 65 and 67 for a geographic representation of the area.

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The first few years of the 20th century foreshadowed the development pressure that would come to Chinatown many decades later. Commercial development in Boston's downtown burgeoned, putting pressure on the ethnic enclave to its south. However, by the century's midpoint, Boston as a whole was stagnating. City-dwellers were exiting in droves to the suburbs, leaving flagging urban neighborhoods behind them. Boston officials did not expect Chinatown to thrive any more than the rest of the city.

Boston's Chinatown, however, defied these predictions, largely because of the 1965 Immigration and Nationality Act, which removed restrictive quotas specifically targeted at Asian immigrants. Once these provisions were removed, and Asians were allowed to immigrate at the same rate as Europeans, the population of Chinatown grew faster instead of declining. [2] In fact, its population tripled between 1950 and 1987. [1]

While convenient for its residents, Chinatown's proximity to the central business district became problematic for the neighborhood during the era of Urban Renewal. Boston's downtown had suffered through the first half of the 20th century because no high-volume transportation link ran through it. Rail lines terminated at South Station, on the south edge of downtown, and at North Station on the north edge, but the rail lines leading north and south of the city did not (and still do not) connect with each other. Before the advent of highways, there was no remotely speedy way to travel through downtown Boston. With federal funding for highway construction widely available and automobiles newly dominating the world of transportation, Boston leaders were desperate to create an elevated freeway connecting its downtown to the North and South Shores outside the city. This project would come to be known as the Central Artery. The Central Artery required land to be built over, and it was not surprising that the eyes of Boston's leaders turned to a centrally located, low-income, non-white neighborhood for this purpose. [4]

Figure 7:
Land uses in the Tufts-New England Medical Center vicinity

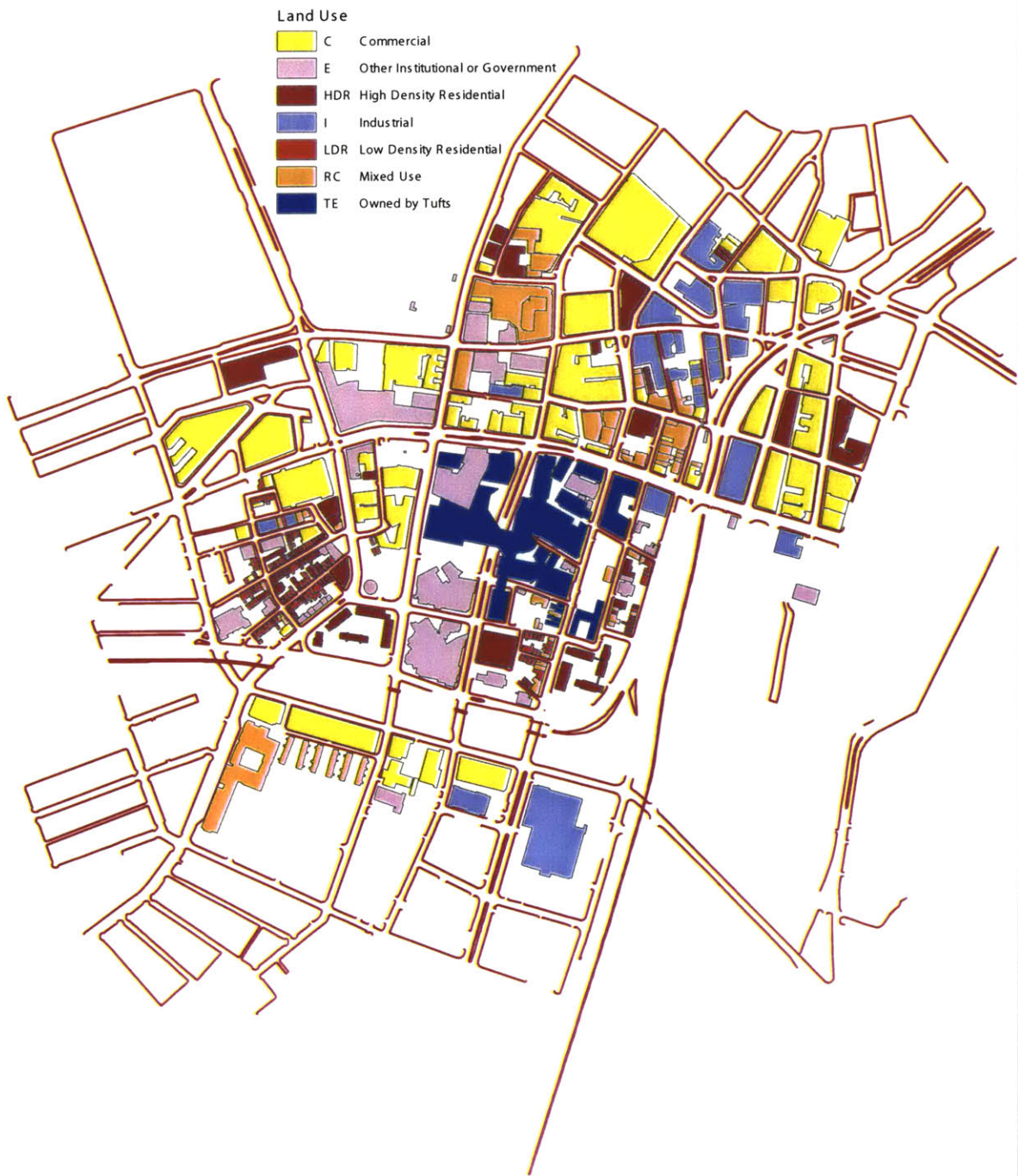
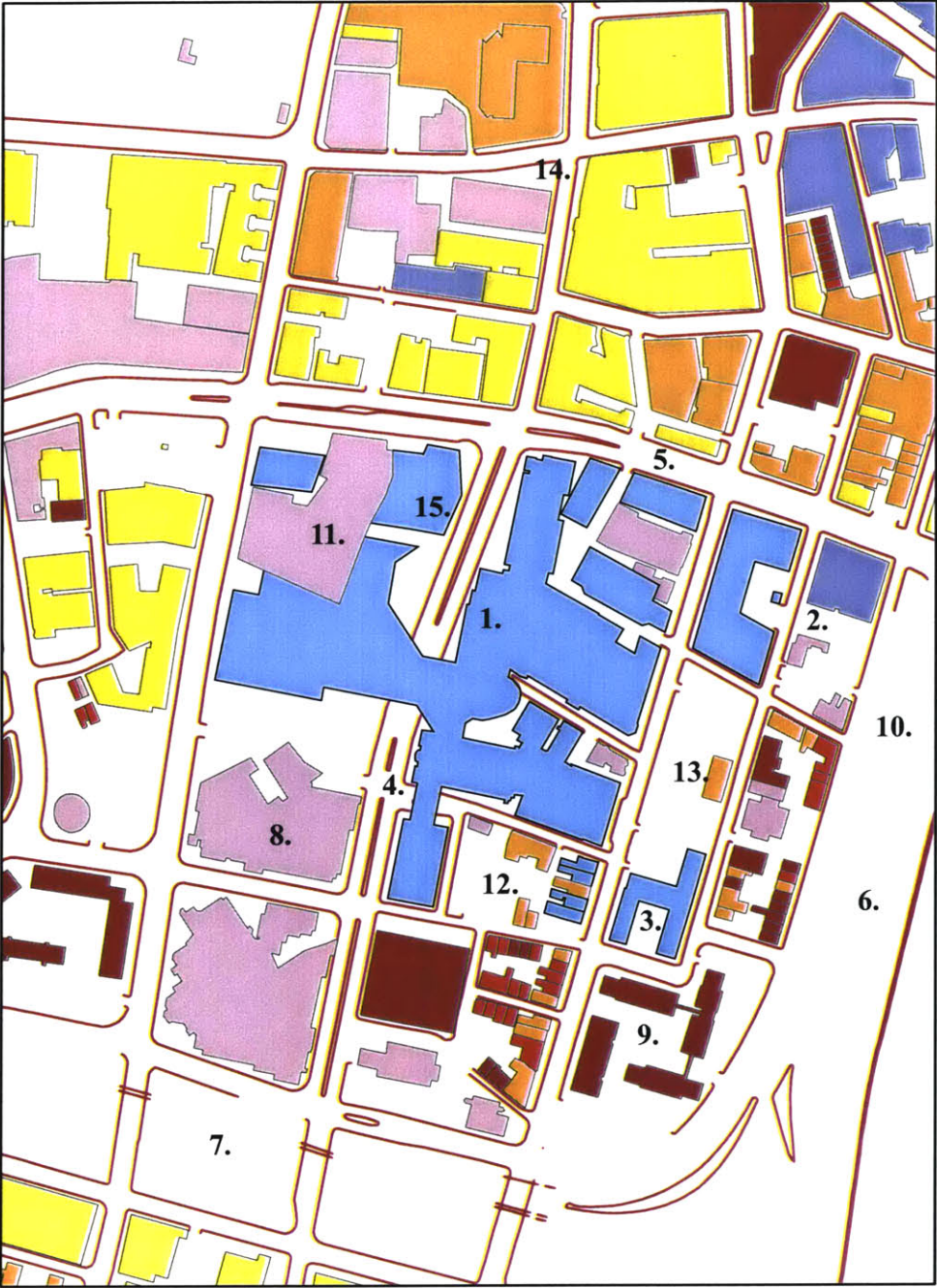


Figure 8: Points of interest around the Tufts-New England Medical Center



- | | |
|-------------------------------------|--|
| 1. Tufts-New England Medical Center | 9. Tai Tung Village affordable housing complex |
| 2. Location of old YMCA | 10. Parcel 24 |
| 3. Posner Hall | 11. Wang Center for the Performing Arts
(former Metropolitan Theater) |
| 4. Washington Street | 12. Parcel C |
| 5. Stuart and Kneeland Streets | 13. Tyler Street Parcel |
| 6. The Central Artery | 14. The Combat Zone |
| 7. The Turnpike Extension | 15. The Sackler Center |
| 8. Former Don Bosco High School | |

the tufts-new england medical center case study

The first proposed route for the Artery took it through Chinatown and the predominantly Italian North End, leading to vociferous protests from both neighborhoods. Ultimately, the path of the freeway was rerouted, sparing the North End and taking just one block of Chinatown. [4] Although it took less land than anticipated, the artery had a devastating effect on the neighborhood. It was built between 1953 and 1959 and cut Chinatown off from the transit hub of South Station, the employment center of the Leather District, and Boston Harbor, all to the east.

The Massachusetts Turnpike Extension was a similar highway project driven by the need for a high-volume transportation corridor from Downtown and the Artery to the area west of Boston. Begun in 1963, its construction cleared even more of Chinatown's land than the Artery did, destroying hundreds of residences. The Turnpike Extension also cut Chinatown off from the residential South End neighborhood to its west. Together, these highway projects covered half of Chinatown's former physical area. [5] Another blow to Chinatown was the zoning of several nearby blocks on Washington Street for adult entertainment, creating the notorious "Combat Zone," which became a red-light district and a magnet for crime after Copley Square, the former de facto adult district, was cleared. [2] Thus, the Combat Zone cut Chinatown off from the CBD as well. [1]

T-NEMC's Strategic Planning in Chinatown Pre-1965

The Tufts-New England Medical Center, now embedded in Chinatown, also had a profound effect on the neighborhood during the 1960s. The institutions of T-NEMC had begun buying nearby parcels of land on the open market in the early 1950s and continued through the 1960s, setting the stage for a dramatic physical expansion in the next two decades. In the early 1960s, T-NEMC bought two major parcels, the Metropolitan Theater (now the Wang Center) and the Wilbur Theater. [6]

By 1964, T-NEMC owned 11 acres in the area [5], and over the two decades from 1950 to 1970 increased its holdings by 8 acres. [2] Some parcels were of a fine-grained urban

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fabric, containing small, tightly knit commercial and multi-family residential buildings, like those east of Harrison Avenue and south of Nassau Street. A few were large, venerable theater parcels and parking lots across Washington Street from the existing medical center. T-NEMC was disinclined to be a landlord; when it acquired these buildings, it tended to demolish them when possible or leave them vacant. Before the master planning process of the 1960s, there was little to keep T-NEMC from buying the properties and tearing them down, whether the community opposed their actions or not; the institutions were essentially free to do as they liked with their newly acquired parcels. [6] In total, from 1940 to 1971, Tufts razed 167 housing units in the Chinatown/South Cove area. [2]

T-NEMC's first new construction of the urban renewal era, the Posner Hall dormitory for dental and medical students, was built in 1954. [7] Residential buildings inhabited by Chinese families were torn down to make way for it, which compromised the character of the entire block as a cohesive row of Chinese-owned houses. Their demolition foreshadowed the eventual demise of the entire block between Tyler and Hudson streets as a residential neighborhood. The fact that so many residences were torn down, either to make way for Posner or for general clearance, strained the relationship between T-NEMC and the community and caused others who lived nearby to fear also losing their housing to institutional expansion. [6]

Those who participated in the events have differing recollections of the relationship between hospital and community at the time. Elliot Rothman, a Boston architect who worked in the T-NEMC planning office from 1961 to 1964, recalls that the zeitgeist of urban renewal had a profound effect on Tufts officials. Rothman remembers a group of idealistic "visionaries" in the university's administration – Herman Field, Geneva Cass, and Dr. Lewis J. P. Colissi Jr. – who saw the movement as an exciting opportunity to make a bold plan for the medical institutions. This plan would improve the institution, the neighborhood, and the city itself. [6] Others remember T-NEMC as a hostile neighbor

preoccupied with its own expansion ambitions and a hospital that refused to provide health care for the neighborhood's uninsured. [2] [8]

What is certain is that T-NEMC, like the LMA, was free to do as it pleased in the 1950s, as is evidenced by its unimpeded construction of Posner Hall and the purchasing and clearance of a great deal of property around the institution. At this time, T-NEMC was a very powerful entity. The Chinese community had no power to speak of in the land use decision-making process, and the BRA was not involved. This power balance, weighted heavily toward the medical center, was to change over the next decades, just as did the power balance between the LMA and its surrounding neighborhoods. The same circle diagram from the last chapter is relevant to this case study, as well.

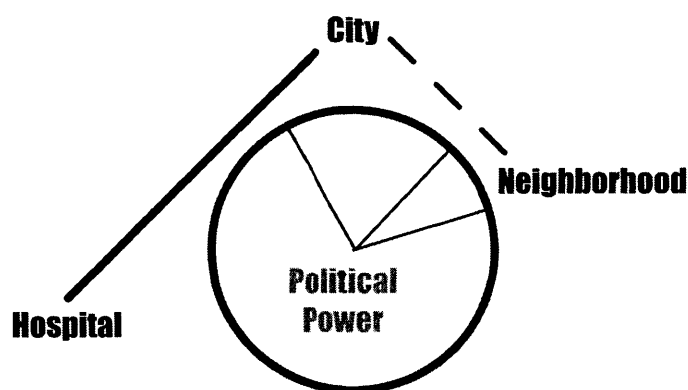


Figure 5: The pre-1965 power balance

The End of T-NEMC's Autonomy: 1965

NEMC embarked on a major comprehensive planning effort starting in 1961. As noted in the previous chapter, the Boston Redevelopment Agency, under development administrator Edward J. Logue, was on good terms with the city's large institutions at that time and eager to work together with them on urban renewal projects. In the era of institutional reorganization, the New England Medical Center and Tufts formed an alliance, becoming the Tufts-New England Medical Center (T-NEMC) in 1962 [2], and in 1965, T-NEMC merged with the Floating Hospital for Children. [9]

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T-NEMC's strategy was to wait until the BRA had completed its own urban renewal efforts in Chinatown to make any major moves. The institution provided some input into the plan and gave the BRA information about its own needs and desires. The BRA then successfully petitioned the Federal office of Housing and Urban Development (HUD) to designate Chinatown and nearby blocks as the South Cove Urban Renewal Zone. "[Ed] Logue and the city were good friends," Rothman recalls. The BRA and T-NEMC simultaneously worked on their plans for the area, negotiating the limits of T-NEMC's expansion. The BRA was in a tricky position, realizing both the great value of Chinatown to its residents and the city as a whole, as well as the economic potential of T-NEMC.

Eventually, the BRA and T-NEMC came to an agreement: the hospital would not expand south of Oak Street or east of Tyler Street; nor would it expand across Kneeland Street to the north. In return, the BRA agreed to support the construction of new institutional facilities, including some medical office uses in the Kneeland-Stuart Street area and a parking garage somewhere on the outskirts of the medical complex. Representatives of T-NEMC initially opposed the creation of any new housing in its vicinity, but agreed to the residential designation of the area that would become Tai Tung Village, an affordable housing development, in order to get the BRA's blessing for its own expansion plans. The BRA and the Chinatown community agreed on a vision for a school, housing, and parking on the site bounded by Washington Street, the Turnpike, and Shawmut Avenue, to the southwest of the medical center. [8]

During the early 1960s, then, the balance of power shifted in Chinatown. T-NEMC could no longer build freely on its own land. The BRA stepped into the hospital-neighborhood conflict and took the side of the neighborhood. Having a government agency as an advocate was new for Chinatown; the Commonwealth and Turnpike Authority had been responsible for the devastating clearance projects associated with the Central Artery and Turnpike Extension. This shift of power, whereby the BRA assisted the community,

happened earlier than it had in the LMA, perhaps because of the imminent threat of major clearance for institutional expansion. T-NEMC was busily working on a master plan that included wide-ranging clearance, and it hoped to implement its plan as soon as possible. Since T-NEMC owned so much land in its vicinity, creating an alternative for the neighborhood was critical.

Fortunately for Chinatown, a new planning paradigm was emerging in which community groups had a voice in the decision-making process. The specter of the West End urban renewal disaster still hung over the Boston redevelopment world. BRA Director Ed Logue himself had suffered an embarrassing public relations defeat in Charlestown when the community protested furiously against his original urban renewal plans. Logue and then-mayor Collins were staunchly opposed to major West End-style clearance in the name of urban renewal. According to Elliot Rothman, Ed Logue made a point of consulting Chinatown community leaders during the planning process because urban renewal had become such a politically sensitive topic. The city pushed back against T-NEMC's expansion plans. Nevertheless, T-NEMC wielded a great deal of power via its own wealth and "112 credits" – the potential major Federal contributions to its land acquisition and clearance expenses, as noted in Chapter Two. Given the lack of precedent for intervening against institutional expansion, the agency's negotiations were not as hard-nosed as they might be today; indeed, the amount of new land devoted to institutional uses would be overwhelming by today's standards. In the final South Cove Urban Renewal Plan, many blocks were designated for T-NEMC's use, including the large theater parcels across Washington Street from the existing medical center. [8] "[The BRA] would never let an institution cross a major street again," Rothman opined wryly. [6] Still, the explicit goal for the South Cove Urban Renewal Plan was to avert another West End-style disaster and improve the neighborhood for its residents' sake. 1965 was a major shift in the T-NEMC-Chinatown-city power balance.

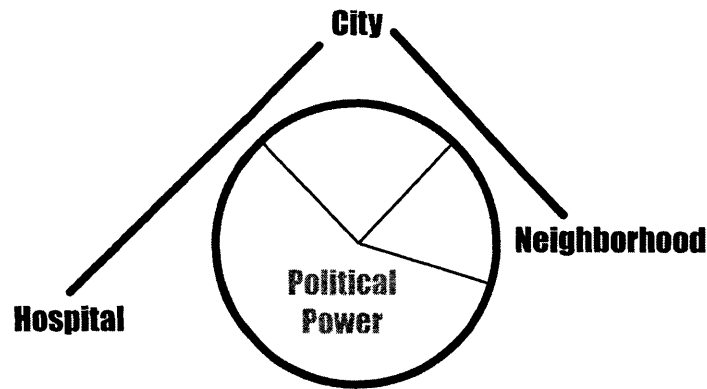


Figure 6: The 1965-1970 power balance

The 1965 T-NEMC Master Plan

T-NEMC published a draft version of its own master plan in 1964. [6] It represented the ideal outcome of BRA negotiations for the institution and advocated major expansion. This new growth would lie primarily to the west across Washington Street, using an NIH grant to build a new Boston Floating Hospital that would be connected to the current T-NEMC. Some new development would also occur to the east and south. Expansion to the north across Kneeland Street was deemed politically impossible even in the T-NEMC plan. [6] To accommodate additional future expansion, the plan also recommended buying as much land in the vicinity as possible.

According to this 1964 version of the 1965-1985 comprehensive plan, its goals were:

- “1) To break out of a land locked position which stood in the way of rational growth and long-range development of its facilities, and to acquire the property to achieve this where needed at a reasonable cost.
- 2) To arrest the progressing blight of the surrounding area, which has created an environment increasingly incompatible with the purposes of this Institution and detrimental to its proper functioning and growth.
- 3) To replace the present obsolete street and traffic pattern of the area with one that allows for full development of the Medical Center and other future functions of this part of downtown, and as part of this to meet the Medical Center’s future parking and transportation needs.

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- 4) To provide for a neighborhood housing supply of quantity and character to meet present and future Medical Center staff and student needs, and to provide a stabilizing and compatible land use in the Medical Center's vicinity.
- 5) To lay the basis for a stable viable downtown neighborhood, structured and planned for a permanent positive symbiosis of its institutional and other sectors.
- 6) To provide long-range land bank possibilities for later growth of the Medical Center beyond the foreseeable future." [5, pp. 1-2]

It seems that these goals implicitly assumed that what is good for T-NEMC would also be good for Chinatown as a whole, although it also acknowledged that Chinatown leaders had opposed T-NEMC's acquisition of additional land. [5] Elliot reports that the attitude of the medical center in that era was that it naturally "dominated" Chinatown, sharply contrasting with what he sees as the present acknowledgment that the center is a "guest" in the neighborhood.[6]

T-NEMC also proposed to materially assist the neighborhood of Bay Village lying several blocks to the west in improving its housing. Bay Village at the time was a predominantly white, emerging gay/bohemian residential area. To the east, two small blocks – a residential strip between Hudson and Tyler Streets and a block between Tyler Street and Harrison Avenue (lying immediately south of Posner Hall) – were to be maintained as housing for the "Chinese Community" [5], in agreement with the South Cove Urban Renewal Plan. T-NEMC also aimed to land bank the 8-10 acres NEMC and Don Bosco High School and the Turnpike Extension by developing 500 housing units and 700 parking spaces for its staff and students, which could be redeveloped someday for other institutional purposes. Finally, the entire area from Washington Street to Tyler Street and from Stuart Street to Oak Street would be devoted to T-NEMC's institutional uses, including a helipad and a skywalk over Washington Street.

Integral to the 1964 plan is the concept of "land banking," whereby T-NEMC would acquire land beyond that needed for its 20-year plan to facilitate unpredictable growth after 1985. Thus, T-NEMC wished to obtain additional land even outside these boundaries to account for future expansion needs. For example, the report suggests that

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T-NEMC acquire the four-block area northeast of Bay Village and develop it into high-rise apartments and parking as a land banking strategy. Likewise, the residential blocks east and south of T-NEMC were considered unlikely for immediate redevelopment but good land banking sites. The most feasible direction for major expansion for T-NEMC was westward, into a blighted area with relatively few residences. [5]

When the plan mentions community benefits, it cites mainly the additions T-NEMC could make to the field of medicine as a whole as a research institution and the high-quality services it could provide to individual patients. In terms of T-NEMC's benefits to the non-medical community, the plan cites its

“Specialized responsibilities of the Medical Center, in light of its crucial intown [sic] location in a changing city, to service nearby urban and suburban neighborhoods, rural areas of the New England region, particular sections of the nation, and selected foreign countries.” [5, p. 99]

The ambitious scope of this service mission strikes one as bewilderingly broad. Significantly, the plan does not single out its next-door neighbors in Chinatown any more than the rest of the world as candidates for its medical services. In fact, the plan states,

“An educational medical center must maintain a set of ‘gates’ that carefully monitor and control the numbers and kinds of patients that enter to be served. These ‘gates’ ... have more to do with planning decisions at the educational medical center than do community needs....” [5, p. 101]

On the other hand, the plan does make some references to community relations. It advocates an urban design appropriate to the neighborhood that would strengthen T-NEMC's relationship with the local community. The plan also recommends creating two open spaces accessible to the community, a park on the south side of Bennet Street and another small park north of Posner Hall.

Overall, the plan assumes a great deal of autonomy on the part of the medical center. While it includes some references to the community's wishes, its subtext is that T-NEMC grants master planning concessions to the community out of its own good will, not because of pressure from an authority or mandate.

Chinatown Community Organizing in the 1960s

During the first years of urban renewal, the Chinese Consolidated Benevolent Association (CCBA), a venerable umbrella organization, was seen as the voice of Chinatown. It represented some of the Chinese community's more influential members and served as the liaison from Chinatown to the BRA during the implementation of the South Cove Urban Renewal Plan. [2]

According to Elliot Rothman, the involvement of the Chinese community in T-NEMC's comprehensive planning process was "subtle" but existent. A social worker employed by the T-NEMC planning office would attend meetings at the Chinese Merchants Association to gain its members' feedback. Rothman reports that the attitude of T-NEMC planners toward the community was that the institutions dominated the power structure, but that they would be respectful of their neighbors. [6]

Rothman characterizes the Tufts-Chinatown relations at the time as "emergent" and says that the opinion of the Chinese community weighed heavily in his office's decisions, although the relationship had not yet been formalized by the BRA. For example, he recalls that Tufts, and especially his supervisor, Herman Field, supported the Chinese community's priority of locating a new public school in the area, which exists today as the Josiah Quincy Elementary School. [6] Thus, residents of Chinatown wielded some power, not just because the BRA was crafting the South Cove Urban Renewal Plan, but also because T-NEMC did not wish to completely alienate its neighbors.

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The aftermath of plan publication: 1965-1970

The federally approved South Cove Urban Renewal Plan, like similar plans in the Fenway and Mission Hill, was adopted in 1965. The plan was a far cry from demolition-heavy projects like the West End; its ultimate goal was to maintain the integrity of Chinatown as a neighborhood and increase the supply of housing in the area via dense residential developments like Tai Tung Village. [8] Nevertheless, the plan did posit that Chinatown had reached a state of “extreme blight,” noting that 70.5 percent of residential buildings had physical defects. The plan called for some “slum clearance” in Chinatown in order to build the Tai Tung Village affordable housing complex. Altogether, from the Central Artery to Tai Tung, 585 households in the neighborhood were displaced during the urban renewal years, approximately 57 percent of which were Chinese, for a total of at least 1000 Chinese residents. [2]

The next year, in 1966, two Memoranda of Understanding, one between the BRA and Chinatown and one between the BRA and T-NEMC, tentatively sorted out some of the thornier dilemmas in the neighborhood. One was land ownership: the area was a patchwork of public, private, and institutional land. The BRA facilitated a land swap whereby T-NEMC received additional land after giving up the rights to build on the aforementioned residential parcels, formalizing the Tyler Street/Oak Street line. These MOUs did not completely clarify ownership issues in the area, however, and their lack of clarity fostered land use disputes for decades to come, especially as the BRA’s attitude changed in the future, tipping the balance of power in the neighborhood further toward the community instead of T-NEMC. [10] The Memoranda of Understanding also solidified the Urban Renewal Plan’s promise of community-oriented uses, including housing and a school, which would be built in coming years.

The second half of the 1960s was a time of grassroots power building in Chinatown. New community organizations, such as the Chinese American Civic Association, began to spring up in the late 1960s. These newcomers did not necessarily agree with the business-

oriented CCBA's policies. They represented younger, less affluent, and more radical members of the community. [2] The community-oriented elements of the South Cove Urban Renewal Plan were essentially completed by the end of the 1970s. The Quincy school was built and included a "little city hall" and health center – neighborhood empowerment innovations developed by Mayor Kevin White. The nearby new MassPike and Castle Square affordable housing developments were able to absorb some of Chinatown's growth and loss of housing to T-NEMC. More significantly for hospital-community relations, the late-1960s construction of Tai Tung Village, a 240-unit affordable housing complex, filled a gap in Chinatown and blocked T-NEMC's expansion. According to Elliot Rothman, community fears that more housing would be destroyed were a key motivator in the development of Tai Tung Village. Without the urban renewal process to galvanize the community and provide for land acquisition and assembly via the BRA, he speculates, the development may never have happened. [6] As in the LMA case study, we can observe the manifestation of Coser's idea that an external threat can bring a community together, and conflict can put in place new organizational structures. [11] The era of community empowerment had caught up with T-NEMC.

Hospital Development and Community Organizing in the 1970s

The 1970s saw much of T-NEMC's master plan and the South Cove Urban Renewal Plan of the 1960s come to fruition. Tufts University's new Dental School at Kneeland and Washington Streets was constructed in 1971, followed by a brand new building for the Boston Floating Hospital (part of the Medical Center) in the mid-1970s. While federal funds for urban renewal dried up during this time, Federal funding for health care research and institutions provided hospitals like T-NEMC with continued support for expansion. In addition to the research and health care services they provided, the government saw supporting medical and dental schools as an investment in economic engines that could revitalize cities. To capitalize on this trend, T-NEMC established lobbyists at both the state and federal levels to guarantee its share of health care funding. [12]

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At the same time, new community institutions developed. The South Cove Community Health Center opened in 1972. The Chinese Progressive Association (CPA), another grassroots-oriented community organization, was founded in 1978. [2] While T-NEMC attempted to make some concessions to the community during this decade, tensions eased very little. Grassroots community organizing continued to gain ground, and community organizations became bolder and more powerful. At the beginning of the decade, a “Seven-Man Committee” made up of seven prominent Chinese citizens, was formed to represent the community in planning negotiations with T-NEMC. No public meetings were held, and this opaque negotiating style continued into the 1980s; however, by the end of the decade, younger activists like the CPA expanded the scope of who spoke for Chinatown and furthered a more populist agenda. [12]

Under Kevin White, Mayor of Boston from 1968 to 1984, the BRA became more influential in Chinatown and forced T-NEMC to negotiate seriously with the Chinese community and achieve some measure of approval in return for granting building permits. “Meetings could get boisterous, with people yelling back and forth, and then we’d have some dinner and yell some more,” Thomas Murnane recalls. [12] Lindemann’s predictions after observing the West End’s demise that “Meetings at which people shout and get angry with each other . . . may represent a salutary phase of communal growth, even though they alarm the public and put a severe strain on the political process,” had come true. [13] Just as the vocal protests against Harvard Medical School in the LMA led to an era of more harmonious relations, the yelling back and forth of the T-NEMC and Seven-Man Committee meetings would eventually subside into a relationship both could live with. Once both parties had taken a decade or so to feel out each other’s strength, the boisterous negotiations settled into a more predictable process. The hospital-community-city power balance settled at a new equilibrium.

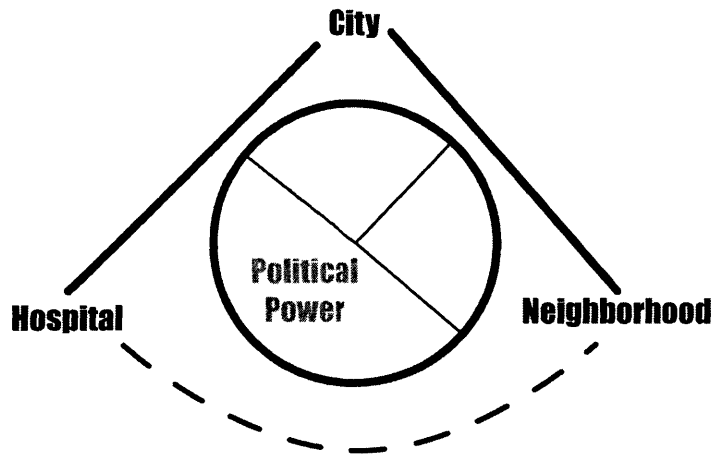


Figure 7: The 1970-1985 power balance

The data I gathered indicate that, for the T-NEMC/Chinatown case, the settling-down process would take a few years longer. Into the 1990s, when the institutions of the LMA were cutting all manner of deals with local CDCs, T-NEMC was still trying to go around the community to build a parking garage on Parcel C, as I will describe later. One reason for the longevity of hospital-community tensions could be the fine-grained urban boundary the two parties shared so intimately. Not only did T-NEMC immediately abut Chinatown, but a clear boundary had not always existed separated it from the community the way Huntington Avenue separated the LMA from Mission Hill. As T-NEMC had crept into residential Chinatown, its buildings had been at times chock-a-block to residents' homes, sharing the same narrow blocks. Another reason for continued hostility could have been the lack of an equivalent to the LMA's David Eppstein at MASCO, a trained community organizer. Although T-NEMC employed planners and community relations specialists, Eppstein's credibility as a former neighborhood advocate himself gave him credibility.

Thomas Murnane, a former Tufts senior vice president and dean of the dental school, recalls the 1970s as the beginning of a more cooperative era, albeit one in which cooperation was much less formal and transparent than it is today. The idea of

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community involvement was still in its formative years at T-NEMC. At the beginning of the 1970s, some Tufts administrators dreamed of opening a veterinary school at the Chinatown campus location but ultimately failed to convince the community of its value, so the veterinary school eventually opened in Grafton. [12] This was one of the first major development battles won by the residential community.

After the new Tufts Dental School and Floating Hospital opened successfully, Tufts Medical School decided to undergo a new round of enhancement in the mid-1970s, beginning to plan for its Sackler Center for Health Communications, which would open in 1983, and its Tupper research center, which would open in 1986.

The planning for the Sackler Center was something of a landmark for hospital-community relations, because it was the first time that the BRA insisted that T-NEMC negotiate significant community benefits for Chinatown in return for its permit approval, according to current Tufts University Director of Community Relations Barbara Rubel. [14] T-NEMC was forced to negotiate with St. James Church, from which it bought some of the property, as well as with the Chinese community. The Sackler Center's construction would mean the destruction of the Harrison Avenue raincoat factories that had become important employers, as well as a laundromat that was a popular gathering place. [12] In the process of obtaining a permit for the Sackler Center, which opened in 1983, Tufts agreed to build a rectory for St. James, give the Chinese Consolidated Benevolent Association \$100,000 to invest, and institute scholarships to Tufts to be administered by the CCBA. [14] Here were the very tangible "hard" community benefits of land and money being offered to community interests.

One unusual bone of contention between Tufts and the community in the 1970s was a service project Tufts instigated in Mound Bayou, Mississippi. The Medical Center had opened a community health center in the impoverished, all-African American town in 1967 to provide basic health care to the underserved, which it maintained through the

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1970s. While the program achieved great results in rural Mississippi, successfully fighting malnutrition and unemployment, Chinatown residents were somewhat outraged by it; after all, there were plenty of people underemployed and underserved by the health care system just blocks away from the Medical School. [8]

In the late 1970s, Tufts at one point considered expanding north into the “Combat Zone” around Washington Street. This provoked a violent response from the organized crime interests that oversaw some of the Combat Zone’s less savory activities; Murnane recalls receiving death threats, and saboteurs went so far as to set off explosives in his wife’s car in Marblehead during that period. The Tufts president carried his own gun. Ultimately, Tufts decided against expanding into the Combat Zone, [12] but in 1981, the institution bought garment factories 15-35 Kneeland Street, which, again, eliminated the jobs of 80 garment workers. [2]

Overall, Murnane describes the relationship between T-NEMC and the Chinese community thus: “We were both gracious and both determined.” While both parties had strong objectives, they stayed civil with each other. “I had a very good relationship with the Chinese community,” Murnane recalls. [12]

It is interesting to note the negotiating process in this era. While the BRA retained the power to approve or reject T-NEMC’s building permits, the institution engaged in negotiations of its own with the Seven-Man Committee. The BRA served as a legal arbiter, but it did not need to mediate between the two parties; they came together of their own accord. The 1970s were also a decade of beginning to understand the community’s needs. While conflict was intense, the Medical Center was beginning to involve community members in its planning process. The new political reality of citizen empowerment as a national movement, reinforced by President Carter nationally and Mayor Kevin White locally, contributed to this inclusion.

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The Beginning of a Dialogue in the 1980s

The era of reconciliation between the Chinatown community and T-NEMC did not begin until the mid-1980s. Tufts Director of Community Relations Barbara Rubel began working at Tufts in those years, and she recalls encountering a great deal of hostility between the institutions and community. She also found that the institution renegeing even on an earlier promise to allow the community use of its facilities for meeting spaces when she began her job, and she recalls that the community was very frustrated with the Medical Center's actions. [14]

Throughout the 1980s, under another populist mayor, Ray Flynn, and his BRA director, Stephen Coyle, the BRA continued as a strong ally of Chinatown. It prioritized curbing institutional expansion into the neighborhood's residential areas, from the Cultural District as well as from Tufts. The agency also worked with neighborhood organizations to facilitate the construction of new affordable housing. [15] Finally, the BRA rejected outright a 1988 T-NEMC proposal to build an 850-car garage on Parcel C, located south of the medical center. [2]

T-NEMC initially resisted some of the BRA's moves, such as resolving ownership patterns and development rights that had been disputed in the 1966 MOU in favor of the community. The institution went so far as to sue the BRA at one point. Ultimately, however, the BRA's actions helped to ease tensions between the neighborhood and institutions. [10]

By the end of the 1980s, Tufts administrators hoped to build a medical research center to capitalize on the economic potential the pharmaceutical industry represented at the time. By then, however, it had become truly infeasible for Tufts to build the large facility it envisioned in its Chinatown location. The institution won a BRA-sponsored competition to be the developer of the air rights over South Station by adding large office, hotel, and transportation components to its research project. The development agreement was aided

by Tufts' promises of \$ 8.1 million in housing linkage funds, \$ 1.6 million for jobs training, \$500,000 to a South Boston affordable housing program, \$50,000 to the Chinatown Neighborhood Center, technical help to community organizations planning for the use of a Kneeland Street parcel, and attempts to use more Chinatown vendors in its contracts. Tufts's credibility in the health care industry helped as well during the citywide economic downturn, for which the pharmaceutical industry was seen as a cure. [12] [16] These costly concessions represented new citywide rules for large commercial developments; developers were mandated to contribute a portion of their construction costs to housing and job trainings "linkage" funds.

A sudden economic downturn caused the complex South Station project to fizzle. Again, in 1998, Tufts seemed to have found a partner in developing a massive hotel, office, and research complex. [17] Although environmental difficulties slowed the project, as of September 2004, the MBTA, Tufts, and its private development partner still hoped they would see the project through. [18]

The Formalization of Expansion-Benefit Negotiation in the 1990s

In 1991, Rubel recalls, the BRA requested that Tufts create a new 20-year plan for the institution in accordance with a plan the BRA had created the previous year for Chinatown. She also asserts that it was the first time the BRA had asked an institution in the area for such a document, but that others would follow. This new mandate for institutions to create 20-year master plans for the BRA's approval was emblematic of the agency's taking an even more aggressive role in long range planning for the future of the neighborhood.

The BRA, then under the leadership of Stephen Coyle, made it clear that any future expansion on the part of T-NEMC should be confined to commercial areas, avoid residential areas, and provide significant community benefits. At the top of the BRA's

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agenda, as well as Chinatown's, was the creation of a new facility to replace the dilapidated, cramped South Cove YMCA between Tyler and Hudson streets. Tufts, in turn, wished to build a new research complex on its Posner parking lot, a large parcel located between Harrison Avenue and Tyler Street.

By this time, an elected neighborhood group, the Chinatown Neighborhood Council, was representing the Asian community in negotiations with Tufts. Other organizations like Chinatown YES, the Chinese Progressive Association, and the BCNC, also chimed in. The Chinese Consolidated Benevolent Association was no longer the primary voice of the community, but since the CCBA had some legal right to the R-1 parcel that housed the original YMCA, dating from the 1966 land use memoranda of understanding, it remained involved in negotiations. Negotiating the master plan, which was completed in 1993, took four years. Maintaining a relationship with the community was many times more difficult than in the days of the Seven-Man Committee; the number of community groups had multiplied, each with a different agenda. The "Chinese community" was finally recognized as not being a monolithic entity that a single voice could represent. [14]

It was clear to the Tufts planning office that, if they didn't make a deal the community approved, they receive no permit for their new research building. Hospital-community negotiations led to a complex land deal. Tufts quickly agreed to build the new YMCA. Originally, Tufts hoped to locate it within the research complex itself, but the CCBA insisted on an offsite facility. Tufts, however, wanted the old YMCA's lot for itself, so that its research locations would be contiguous. [14] In 1997, Tufts agreed to build a \$2 million, four-story YMCA shell on a parcel between Harrison and Tyler streets (the "Tyler" parcel), then serving as a parking lot. The university then swapped its Tyler Street parcel for the city-owned P-2 parcel, located, like the Posner parking lot, between Harrison Avenue and Tyler Street. In return, the BRA finally approved Tufts' 20-year master plan, which included zoning for an additional 700,000 square feet of research and

classroom space. [14, 19] This version of the Tufts master plan saw the institution scale back its dreams for expansion permanently. It finally sold the 193-5 and 203-5 Harrison Avenue parcel – the infamous “Parcel C” – to the city for a project that would benefit the Chinatown community: The Metropolitan, an affordable housing and nonprofit office space complex. [14]

Later that year, the Chinatown Neighborhood Council (CNC) voted to endorse Tufts’ plans for a 147,000 square foot nutrition research center on Harrison Avenue. The new YMCA had been a major bargaining chip, and the BRA had negotiated to keep the urban design of the nutrition center palatable to the community. Incredibly, council member Bill Moy is quoted as saying, “We feel like the university is being a good neighbor... this will bring jobs to the community and a new YMCA.” [20] The new Jaharis Family Center for Biomedical and Nutrition Sciences opened in 2002. [21]

Serendipitously, in the mid-1990s, the owners of the Don Bosco Catholic high school, located south of the old Metropolitan Theater parcel, decided to sell the building. Tufts and the CNC agreed that the school would be the perfect site for the new YMCA. This decision freed up the Tyler Street parcel for future building activity on T-NEMC’s part. [14]

The YMCA negotiations ended harmoniously. However, tensions had escalated earlier in the decade over the aforementioned Parcel C, a piece of land that emerged again and again as a point of contention since the 1960s. Bounded by Oak, Ash, Nassau, and Harrison streets, it had been cleared of housing during the urban renewal era, and Tufts had attempted to develop the parcel many times. Each time, community opposition had stopped it. While T-NEMC still envisioned an 8-story parking garage as late as 1994, the community was vociferously opposed to this project, despite T-NEMC’s offer to donate \$1.8 million for a community center if allowed to build it. Community leaders were concerned with both the environmental repercussions of a large parking garage and the

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lost opportunity to build a community-oriented project on the site. [22] The parking garage was never built, and Parcel C became The Metropolitan, a mixed-income housing and office space development. Despite their victory, some Chinatown activists came away from the battle with a lingering resentment of T-NEMC. According to community lawyers Zenobia Lai et al, the Medical Center had inflamed the conflict by attempting to build the garage after forging an agreement with the neighborhood not to. [2] The long struggle over Parcel C represented both the continuing tension between hospital and neighborhood, as well as the strength of the new reality that hospitals simply could no longer build without support from their communities.

Contemporary T-NEMC: a Truce Founded on Common Interests

T-NEMC's acquisition of land back in the 1950s and 1960s was an extremely shrewd maneuver. Even now, after it has returned some parcels to the community, it still has two empty sites and one that could be used more intensively. If not for this land banking with inherent development rights, it is questionable whether the Medical Center would ever be allowed to build again. For their part, Chinatown neighborhood organizations are continuing to function as developers. When the Turnpike Authority recently put out an RFP for the development of the sliver of land between Hudson Street and what was once the Central Artery ("Parcel 24"), ACDC responded. [14]

The hospital and neighborhood have found a venue in which they can work toward a common interest. Both T-NEMC and Chinatown residents have continued to be plagued by street crime and violence spilling over from the Combat Zone and Theater District area. T-NEMC increased the security of its buildings in response to both the 9/11 terrorist attacks and staff concerns about homeless people from several nearby shelters wandering into Tufts' buildings. Later, the institution's increased security became a point of tension with Chinatown. Members of the community could no longer enter the buildings at will, which made community functions in T-NEMC's facilities more cumbersome. Some residents also took offense at being restricted from the medical center's buildings, as if T-

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NEMC were suspicious of them. On the other hand, Tufts and Chinatown are working together to foster public safety in the neighborhood. Barbara Rubel herself has acted as secretary of the neighborhood Public Safety Committee for the last five years. Together, the institution and the neighborhood pressed the Boston Police Department to install security cameras on neighborhood streets. [14] Boston and MBTA police have undertaken a very recent crackdown on crime in the area, patrolling it heavily. [23] Here, Coser's theory of external conflict as a force of internal cohesion is manifested again; this time, though, the hospital and the community lie on the same side of the conflict. [11]

All in all, Rubel reports that the strong hostility of the mid-1980s and earlier no longer exists between T-NEMC and Chinatown. She says that the most negative attitude toward the institutions is that the community wishes they weren't there, so that more affordable housing could be built; after all, land is a painfully finite resource in Chinatown. [14] In a newspaper article, Chinatown Neighborhood Council member Bill Moy confirmed this view, stating that, while he would like to see all undeveloped parcels become affordable housing, with limited federal and state funding, the neighborhood would realistically have to consider other options that would bring community benefits with them. [20] Lydia Lowe, head of the Chinese Progressive Association, offered a similar opinion in a recent Boston Herald article: "I think the institutional needs of Tufts and the New England Medical Center run counter to the community needs, for parkland and for affordable housing." [24] As in the LMA, a fragile peace exists between the hospital and neighborhood.

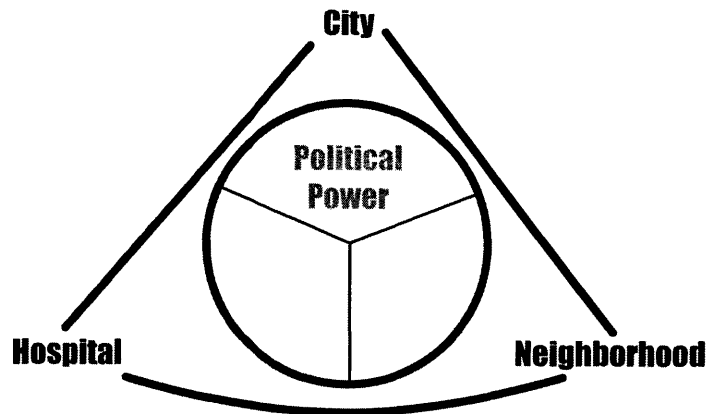


Figure 8: The 1985-2005 power balance

The Role of Ongoing Community Benefits Provided by T-NEMC

The role of T-NEMC as a health care provider has changed dramatically over the years. The magnitude of the discrepancy between the health care it provided the community in 1960 and the care it provides today is a subject of some dispute, however. When the South Cove Community Health Center was first formed a few blocks from T-NEMC, its doctors did not have admitting privileges to the Medical Center. Some even say that T-NEMC's failure to provide health care to the community was the reason for the Community Health Center's formation. [2] Some Chinatown advocates claim that even today most Chinatown residents do not receive health care at T-NEMC, and that many local residents had been turned away from the hospital in its early years. [2] Elliot Rothman, on the other hand, remembers that even in the early 1960s, T-NEMC had a Cantonese speaker on staff for emergency walk-ins. "There was never any dispute about anybody in the community being denied or not getting the care they needed, as far as I recall," Rothman says. [6] Despite conflicting memories of the era, it seems that T-NEMC's performance as a community-serving health care provider was lacking.

The grassroots-focused political climate of the 1970s gave rise to a host of new community benefit programs at T-NEMC. The dental school's Department of Social Dentistry was established, in order to perform outreach and provide free dental service in

underserved areas of the city. T-NEMC began to offer the use of its space to community groups for classes and services. [12] As we saw earlier, however, some community groups felt that Tufts was concentrating too much of its social service energy on far-flung communities and not enough on the health care needs of its own neighbors.

Today, Tufts provides much of its in-kind community service through its students. Many medical and dental students volunteer in a free clinic formerly housed in the Church of All Nations, which serves the homeless and is located just southwest of T-NEMC. The clinic has been forced to move, but it is still located on the MBTA's Orange Line in the hope that Chinatown residents will be able to take advantage of it. Tufts provides financial support for undergraduate who wish to undertake community service projects in the area, as well. T-NEMC continues to give financial support to a number of Chinatown initiatives like the "Healthy Chinatown" effort to bring organizations together to look at the community holistically, supporting it after federal funds dried up. [14] T-NEMC as a hospital, like many hospitals, provides extensive ongoing community benefits, which will be discussed more extensively in Chapter Five.

T-NEMC Case Summary: Trends that Parallel the LMA's

The changes in T-NEMC's relationship with its surrounding community over time essentially followed same pattern as the LMA's. At the end of the 1950s, the institutions were the players holding nearly all power in the hospital-community-city triangle. The BRA largely stayed out of T-NEMC's way when it wished to purchase land for development, and the residential community had no vehicle by which to prevent the hospital from doing what it wished with its own land. Beginning in the 1960s and continuing through the 1970s, however, the BRA backed the Chinatown community more and more in its struggles against T-NEMC. The BRA's reasons were a decline in the financial rewards from supporting hospitals with the end of federal urban renewal funding; a rise in the populist, grassroots neighborhood organizing movement that conferred power to local communities; and the change in mayoral administrations that

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ushered in populist mayors John Collins and Kevin White. More and more, the hospital was forced to consult the neighborhood when making planning and development decisions.

Heightened hostilities accompanied these changes in the balance of power in the 1970s; as the hospital came to accept the community's newfound strength, however, it began listening more to community concerns and making substantial concessions alongside its new development projects. In the 1980s, T-NEMC began to embrace the process of proactively fostering a positive relationship with the community. It was not always successful in pushing through its development plans, and when it was, it offered greater and greater community benefits. Finally, by the 1990s, hostilities between the two entities reached a low level. The hospital expansion-community benefits game had been played often enough that the negotiation pattern accompanying it had become familiar to all the players. T-NEMC and the community worked together on their common interest in public safety. Today, although its neighbors do not love the institution, they have accepted it as something they can live with and learned how to mitigate its effects.

It is interesting to note that the negotiation process between T-NEMC and its community resembles that of Brigham and Women's Hospital (BWH) and differs from that of the other Longwood institutions. Hospitals in the center of the LMA (e.g. Joslin Clinic and Dana-Farber) simply present iterations of their plans at public meetings, listened to community reactions, and incorporated comments into their design. In contrast, T-NEMC's planners, like BWH's, have involved the community actively in sincere dialogue about development decisions. One reason for this may be that T-NEMC and BWH are located similarly with respect to their residential neighbors, abutting their surrounding communities directly. The other Longwood hospitals do not. This physical intimacy between hospital and neighborhood mandates more community representation in decision making, because of the greater stake communities have in these hospitals.

~~the tufts-new england medical center case study~~

This greater interest in the actions of hospitals, of course, leads to the potential for more bitter and intense conflict, which hospitals naturally seek to avoid.

Also of note is that the urban fabrics of T-NEMC and Chinatown are even more interwoven than those of BWH and Mission Hill. A review of the two case studies demonstrates that the area of great hostility between T-NEMC and Chinatown ended later than it did for the Longwood Medical Area. As mentioned earlier, the manner in which both areas abut their neighbors differs. Instead of having a clean, neat boundary like Huntington Avenue between itself and residential areas, the medical center extends irregularly to the east and south and has had a similar pattern in the past. This difference in urban form could dictate the timing difference in hospital-community relations. With only two case studies, however, it is impossible to make a solid claim of this nature.

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hospital community service programs

The benefits that the renowned teaching hospitals of this study provide their communities are substantial – quantitatively, about 6 percent of their patient care expenditures. All hospitals in Massachusetts provide at least some community benefits, but at first glance, these academic research hospitals appear far more generous than most. I compared typical community benefits programs of both types of hospital, in both dollars spent and what they were spent on. I hoped that the comparison would lend me some insight into which, if any, parts of hospitals' community service programs served as tools to reduce community conflict and hostility.

Boston's Research Giants versus Massachusetts's Community Hospitals: A Community Benefits Comparison

I was not the first to study the role hospitals play in their surrounding communities. Hospital community benefit programs have come under particularly strict scrutiny in Massachusetts. In 1993, the fact that many of the state's hospitals were operating essentially as businesses came to the attention of state Attorney General Scott Harshbarger. He began scrutinizing hospitals' practices to determine whether they were serving their communities and carrying out a nonprofit mission worthy of their tax-free status. Ultimately, the Attorney General's office did not mandate that Massachusetts hospitals dedicate a specific percentage of the revenues for community benefits programs. Beginning in 1994, however, hospitals have been required to file detailed statements of their community service activities with the office to maintain their

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nonprofit status. The reports are updated every few years and contain data on expenditures for community benefits as well as each hospital's priorities, strategies, and successes. They are available on the Attorney General's Office website¹ and constitute a valuable record of how hospitals' service programs have changed over the years. [1]

Data is available for 47 non-profit hospitals and a single for-profit hospital in Massachusetts. Benefit programs ranged from \$370,270 (Nantucket Cottage Hospital) to \$78,000,000 (Massachusetts General Hospital) in FY 2003. Among the five hospitals listed that belong to my study areas (Beth Israel-Deaconess, Brigham and Women's, Children's, Dana-Farber, and Tufts-New England Medical Center²) the mean total annual spending on community benefits is \$26,079,790, and the median is \$26,437,952. Brigham and Women's had the highest expenditures of my group, at \$42,800,000, and Dana-Farber Cancer Institute had the lowest, at 11,416,412. This compares to a mean of \$9,078,969 and a median of \$3,741,839 for all hospitals in Massachusetts. Thus, the research and teaching hospitals in my study allocated far more dollars to community benefits programs than the typical Massachusetts hospital.

As a percentage of overall patient care costs, the hospitals in my study areas also outspent their counterparts in Massachusetts, although less dramatically. The average percent of patient care dollars spent on community benefits for the LMA and T-NEMC hospitals is 6.50 percent, and the median is 5.59 percent. Dana-Farber was the highest spender in the entire state percentage-wise, at 9.05 percent, and T-NEMC was the lowest, at 5.04 percent. This compares to a mean of 4.31 percent and a median of 3.93 percent among hospitals statewide. South Shore Hospital was the lowest spender in terms of percentages at 0.20 percent of patient care expenses. The less dramatic difference between the

¹ <http://www.ago.state.ma.us/sp.cfm?pageid=965>

² The Joslin Diabetes Center is not considered a hospital and was not required to submit a community benefits report to the Attorney General's Office.

teaching hospitals and Massachusetts hospitals in general in this category indicates that the teaching hospitals tend to have larger operations budgets.

The initial question appears intriguing: Why do major research and teaching hospitals spend more resources on community benefits than do smaller community hospitals, both in gross terms and as a percentage of patient care expenses? At first, this might seem counter-intuitive; after all, the very mission of community hospitals is to serve the health care needs of the populations that surround them. Health care delivery is just one part of the research and teaching hospital mission; these institutions add contributing to the medical world by conducting research, training physicians, and providing complex treatments to far-flung patients with unusual conditions to their missions. One could then argue that the large percentage of their budget research and teaching hospitals spend on community benefits programs is convincing evidence of the tradeoffs between the institutional expansion sought by these hospitals and community desires.

There may be many other reasons for greater community benefit levels among research institutions, however. The Dana-Farber Cancer Institute's Anne Levine gives two reasons that her employer leads the state in percentage of patient care expenses devoted to community benefits: first, that half of the institute's budget is devoted to research, "so that's taken out of the denominator"; and second, that millions of dollars of grants every year go to funding research on various community cancer-prevention initiatives, which are included in community benefit figures. It makes sense that, given the many different sources of funding received by research hospitals, it may be more financially feasible for them to take on large community benefits programs. Simply put, the discrepancy in community benefit levels could merely be an issue of accounting. [2]

Despite the ambitious and multi-faceted goals of research institutions, they can be deeply committed to their community programs. Beth Israel-Deaconess Medical Center (BIDMC) in the LMA provides an interesting counterpoint. The hospital faced a financial

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crisis at the beginning of this decade. According to Ediss Gandelman, director of community benefits for BIDMC, she and Paul Levy, the newly hired CEO, were determined to maintain the benefits they provided Boston communities even during a painful restructuring beginning in 2002. When a “slash-and-burn” consultant group recommended the hospital sever its ties to the seven Community Health Centers it supported, Gandelman reports that the hospital maintained its commitment to them, even while laying off over 600 employees. Gandelman reports that philanthropic donations unrelated to health care are more likely to be cut in tough economic times than health care provision itself. [3]

To determine whether economies of scale play a part in teaching hospitals’ relative generosity, I plotted total patient care spending versus the percentage going to community benefits for all hospitals in Massachusetts for which there is data. I found a correlation between total spending and percentage spent on benefits, but it is very weak, with an R^2 of just 0.15. Thus, the large size of T-NEMC and the hospitals of the LMA does little to explain the size of their benefits programs; their association with educational and research institutions could be more relevant. This institutional wealth gives hospitals the power to buy peace with their surrounding communities, as when Harvard showered Roxbury Tenants of Harvard with land in order to win the organization’s approval of the Brigham and Women’s expansion across Francis Street. Institutional deep pockets also give community groups power; knowing that the hospitals can access great financial resources gives the organizations a bargaining chip with which to ask for great benefits.

In *The Uses of Disorder*, Richard Sennett musters the argument that affluence in general encourages inter-group conflict. In his view, societal affluence provides a “floor” to conflict; it serves as financial padding so that one party may lose a conflict without being decimated. In an affluent world, conflict is not a bitter, life-and-death struggle, so that groups may act on the tensions affecting them more freely. [4]

Hospitals may have their financial ups and downs, but a great deal of money flows through the health care system. With diverse funding sources to draw from in the 1960s, hospitals could easily be seen as affluent parties to their conflicts with neighbors. Sennet's point begs the following questions: Do research hospitals give away greater benefits because of the conflict with their communities? Or do communities incite conflict because hospitals have the affluence to afford greater benefits? Although this thesis assumes the former, the directionality of the conflict-benefit relationship is certainly a question worth thinking about.

The Role of “Soft” and “Hard” Benefits

The benefit programs in the reports filed with the Attorney General's Office go far beyond the fruits of the negotiations at the heart of this research. Likewise, some negotiated benefits are not included in the reports. For example, recall that Harvard's most recent deal with Roxbury Tenants of Harvard involved Harvard both turning over land deeds to the nonprofit as well as pledging financial support for its operations. While the financial support to a local organization would be included in the institution's community benefits report, the land swaps, although they were greatly to the community's benefit, would not be. These gaps would seem to indicate a lack of direct nexus between hospitals' direct community service programs and their expansion agendas.

The community benefit priority areas of each hospital, which must be reported to the Attorney General's Office alongside individual programs, represent a diverse collection of health care issues. Beth Israel's priorities are to improve access to health care in the community through its seven affiliated health centers; to improve access to health care in the hospital through respect and communication; and to reduce and eliminate racial and ethnic disparities in health care. [5] Brigham and Women's Hospital has focused on improving health-care access for low-income women and their families, particularly in the Mission Hill, Jamaica Plain, Roxbury, and Dorchester neighborhoods of Boston.

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Children's Hospital of Boston focuses on injury prevention, childhood asthma, and access to health care and mental health services for at-risk Boston children. The Dana-Farber Cancer Institute's community outreach mission is to prevent cancer and AIDS in at-risk and underserved populations in Massachusetts; serve as a consultant on cancer-related matters to Boston's community health providers; and raise the number of minorities participating in clinical trials. The Joslin Center for Diabetes has partnered with community health centers for diabetes outreach projects. Finally, Tufts-New England Medical Center works to improve access to healthcare and provide culturally and linguistically appropriate health outreach and education services to Boston's Asian community, especially its harder to reach segments. [6]

The role of soft benefits in hospital-community relations, and especially in negotiations between the two parties, is unclear. Typically, they appear in land use negotiations only as ongoing cash grants promised to neighborhood nonprofits. As David Eppstein and Sarah Griffen both pointed out, the ongoing benefits programs get very little press, since they are not news events in the same way that a new community center or a multi-million-dollar land swap are. Since they target specific and often small populations, community members' awareness of them varies. Hospital administrators tend to agree that their health care-related community work helps to build positive relationships with neighborhood groups, which can sometimes establish a more positive tone at community meetings. They tend to deny that ongoing "soft" benefits have a significant impact on hospital-community negotiations, however.

The explanation for the lesser significance of "soft" benefits in negotiating expansion need not be complex. I began this research with the perhaps naïve view that the special benefits hospitals as institutions could provide – health care services and stable employment – would play a significant role in hospital expansion/community benefit negotiations. I expected these special benefits to make hospitals' negotiations with their surrounding communities and the city unique among urban institutions. In retrospect,

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however, it makes perfect sense that these negotiations are essentially about land and money, both very tangible elements of power. Promises to enact health care or jobs programs can easily be broken or forgotten; checks cannot be unwritten, nor can deeds be un-transferred. It is also a reasonable expectation of communities that hospitals provide health care and jobs to their members simply in the day-to-day course of business. After all, that is what hospitals do. Therefore, the community benefits for extraordinary events like major expansions must likewise be extraordinary and outside of the realm of what hospitals typically provide. Finally, it is no surprise that community groups wish to control their own destiny. This may be the most compelling reason of all for the preeminence of land and cash over “soft” benefits, as impressive and far-reaching as they may be. Given the promise of community service programs, neighborhood groups only gain the power to wait and watch as the hospitals enact the programs. Given money or land, the same groups are vested with the power of leveraging their resources in whatever way they feel the community’s interest lies. Health care services provided by a hospital are a great benefit, but community empowerment lies in implementing benefits programs oneself.

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chapter 6

conclusion

Forty-Five Years of Changing Hospital-Community Relations

In both case studies examined in this report, hospital-community relations evolved greatly over the 45 years from the beginning of urban renewal to the present, and this evolution showed a strikingly similar pattern in both cases. Federal legislation; the macroeconomy; the health care economy; municipal administrations; and social trends all played a similar role in shaping hospital-community relations.

On the national level, urban renewal legislation gave hospitals, along with other institutions, great financial advantages for expansion projects. Urban renewal legislation enacted in 1949 to funnel money to blighted areas of cities was amended in 1961 to include hospitals as beneficiaries. [1] National Institute of Health funding for biomedical research had also grown immensely by the mid-1960s. [2] Urban renewal funding proceeded to trail off by the mid-1970s, and the power of research money was also diminished. The great Federal expenditures on the 1950s and 1960s on urban renewal have never been matched.

Meanwhile, the city's economy was very weak by the 1950s, leading to a municipal zest for urban renewal projects. Boston saw something of an economic recovery in the following decade, and the construction of the Prudential Center in 1965 set off a building boom in downtown office space. By 1970, Boston was flourishing relative to 20 years earlier. National recessions in the mid-1970s, early 1980s, early 1990s, and the turn of

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this century affected Boston negatively as well, but with its ever-present base of well-educated workers, Boston's economy is strong today. [3]

The health care economy followed a similar pattern of peaks and valleys but differed somewhat in its timing. While Boston's economy as a whole was gaining momentum into the 1970s, research hospitals were seeing their urban renewal and research funding diminish. On the other hand, they saw their fortunes grow during biotechnology booms at the end of the 1980s and 1990s (and continuing today). [2]

The election of Mayor John Collins in 1960 was the first in a streak of populist mayors that continued with Kevin White and Ray Flynn. In sync with national trends, through their BRA appointees, these mayors influenced planning in Boston such that neighborhood concerns played a large part in determining whether projects were approved. Mayor Tom Menino continues to place a priority on neighborhood issues like affordable housing and consistent urban design today.

Taken in sum, the result of these long-term shifts in hospitals' macroenvironments is a shift in hospitals' political power relative to communities and the city, as well as a shift in the various alliances among the three parties. These relationship shifts can be demonstrated via the series of circular diagrams we saw in earlier chapters.

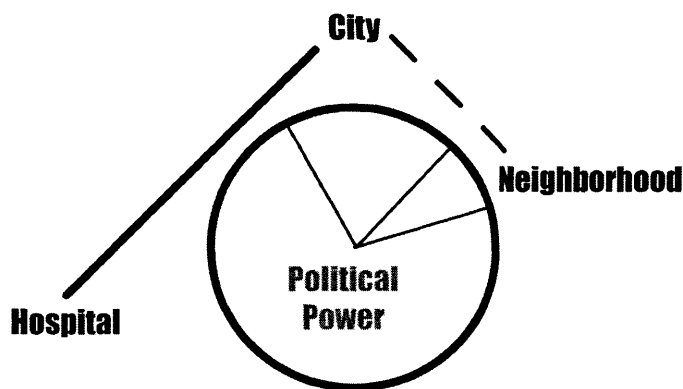


Figure 9: Before 1965, hospitals were primarily limited in their expansion only by the real estate market, and even that limitation was eased by generous urban renewal funding and hospitals' general postwar prosperity.

Figure 10: 1965 was a watershed year for planning in Boston. The South Cove Urban Renewal Plan was published, giving T-NEMC the first formal pushback against unbridled expansion. The social movements of the 1960s were

flourishing, and grassroots community groups began to form to advocate for their own interests. Between 1965 and 1970, the neighborhoods gained power and, with a friendly mayoral administration, forged closer ties with the BRA.

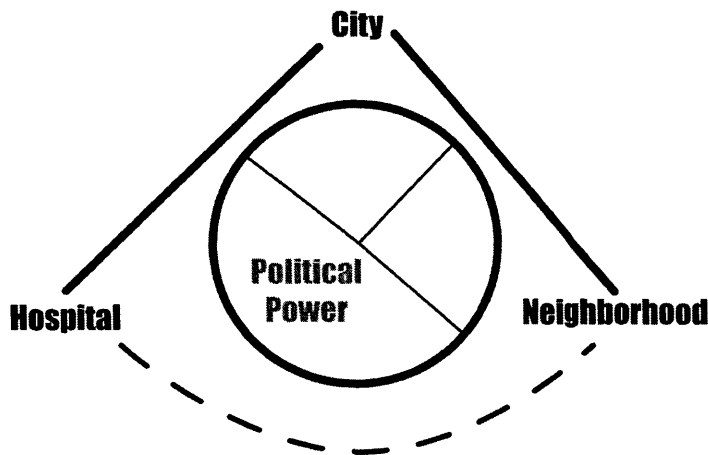
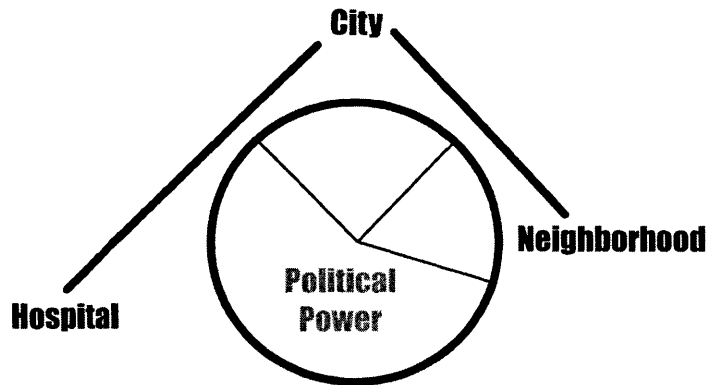
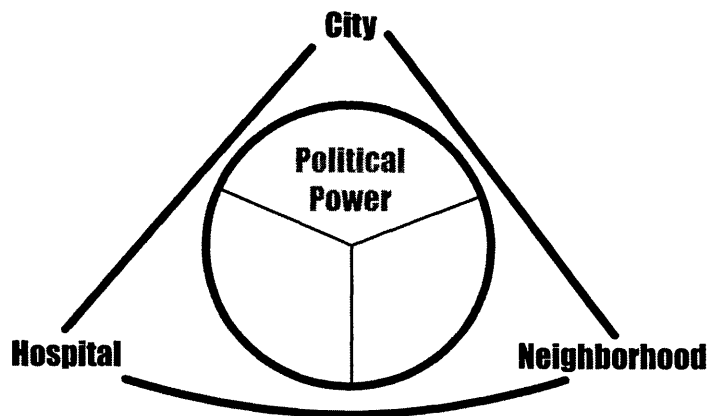


Figure 11: During the contentious struggles of the 1970s, the balance of power between the hospitals and neighborhood interests gradually evened out as both sides tested the other's strength in heady clashes. While hospitals and neighborhoods did make some effort to communicate, there was no terribly workable system in place to do so.

Figure 12: Around 1985, hospitals and communities began to take on shared projects in the self-interest of both parties and develop more effective communications. The BRA emerged as the major political power during this time, as it arbitrated between hospitals



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and neighborhoods and had the final word.

Forces that Drive Hospital-Community Negotiations

Health care missions. In contrast with the results I expected, the fact that these institutions are hospitals and provide health care in actuality has very little bearing on their negotiations over expansion. As shown in Chapter Five, as health care institutions, they have much to offer the communities that surround them; however, services like providing well-paying jobs and delivering health care were very seldom used as bargaining chips. Instead, negotiations around expansion almost exclusively focused on land and cash – the same bargaining tools any large institution would use. In Chapter Five, I hypothesized three reasons that these traditional manifestations of power – land and money – so overwhelmingly surpassed hospitals’ services in negotiations:

- 1) The transfer of land or funds is a more permanent transaction than the promise of service delivery and cannot be reneged as easily.
- 2) Health care and jobs are simply services expected from hospitals and not viewed as extraordinary benefits.
- 3) Finally, the transfer of land or money gives communities control over the programs and activities they think would best help their communities; they have autonomy over projects and are not limited to the services that hospitals can provide.

When the health care mission did play a role in negotiations, it did so because the BRA took into account hospitals’ service mission and importance to Boston’s economy to make sure that planning restrictions on them were not so strict as to severely stunt their functionality. The health care services provided by hospitals played a much more subtle role in hospital-community relations, maintaining an undercurrent of goodwill, such as it was, that had the potential to tone down hostilities at public and private meetings.

Urban form. The relationships and negotiations between the various hospitals in this study and their surrounding communities differ subtly from one another. A predictor of these differences is a hospital's physical form. T-NEMC, for example, is intimately woven into the fine-grained urban fabric of Chinatown, while the LMA stands as its own neighborhood, sharply bounded from residential neighborhoods by Huntington Avenue, Francis Street (currently, at least), the Fenway, and the Riverway. Alone in the LMA, Brigham and Women's Hospital (BWH) abuts its residential neighbors.

It is beyond the scope of this research to demonstrate a difference in the level of community benefits provided by different hospital locations with respect to the community. From examining the data, however, hospital location does seem to affect the way in which benefits are negotiated and community relationships themselves. Administrators from several of the interior Longwood institutions told me that they did not negotiate their development plans with community organizations per se; instead, they presented several iterations of expansion designs at community meetings organized by MASCO and the BRA, listened to community feedback, and incorporated it into their plans until the BRA was satisfied. [4] [5] In contrast, T-NEMC and BWH administrators have sat down at the table with community leaders and hammered out negotiations directly. [6] [7]

That communities would insist that their direct abutters negotiate more intimately with them is to be expected. The Fenway has a stake in what the Joslin Center does; increased shadow, congestion, environmental impacts, and parking pressure could all affect the neighborhood. However, if BWH built a residential tower directly across the street from Mission Hill, for example, the tower's proximity would magnify these effects. Even the interface between hospital and community may have an effect on their relationship. It is notable that T-NEMC employees are forced to be involved even in the day-to-day work of community organizers, as evidenced by Barbara Rubel's work on Chinatown's neighborhood safety committee. [7] Perhaps this is because of T-NEMC's blending

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physically with the neighborhood, while even the abutting BWH is separated by clean barriers from Mission Hill.

Ritual gleaned from conflict. It is striking how negotiations between hospitals and community groups have taken on a ritualistic form in recent decades. Both sides know the game of expansion negotiation very well; yet some degree of community outrage is necessary for the game to begin. It has morphed from an emotional David-and-Goliath showdown into a public deliberation between two more equal parties. Instead of fighting all institutional expansion tooth and nail, neighborhood groups have resigned themselves to the fact that some will happen no matter how strong their desires to maintain the status quo are. They have turned their attention to making sure that they get their allotted benefits out of any new construction. The case of Beth Israel-Deaconess's purchase of the MassArt building is an example of this. While the neighborhood raised some objections to the transaction, no serious consideration of other uses was made. The neighbors were primarily focused on the bottom line: what community benefits would come out of the deal? The transaction happened; Beth Israel-Deaconess expanded; and the community did indeed receive significant benefits.

Underlying this ritual is the potential for conflict if the hospitals were to cease playing by the rules that have been developed for expansion negotiation over the last 45 years. There are still plenty of residents who were active during the conflict-ridden 1960s and 1970s in the neighborhoods, and they remember the widespread resentment against the teaching hospitals. Suppose that an LMA hospital or T-NEMC began to once again purchase land across the agreed-upon boundary between hospital and neighborhood and go full-speed-ahead with expansion plans, bypassing the typical neighborhood consultation process. The result would be a public relations and regulatory disaster. The neighborhood could quickly start the machinery of an all-out protest and cause grave harm to the institution. While hospitals feel good about maintaining positive relations with the neighborhoods because it's the right thing to do, they also know that they have no other choice. A tacit

threat underlies the cordial relationship between hospitals and their neighbors, although the conflict has become domesticated. This disincentive on both sides to escalate conflict too much is an interurban, small-scale version of the political theory of mutually assured destruction.

Lessons for Practice

The primary lesson to glean from this research is how very critical it is to an institution's enlightened self-interest to establish a relationship with any nearby residential communities. If serious conflict does develop, institutions should be prepared to negotiate with more than in-kind benefits on the table. Ignoring a neighborhood's concerns or animosity and pretending they don't exist will yield poor results for a hospital. Trying to force expansion plans through via financial or political strength without a community's approval (or the closest possible version thereof) is often also ineffective.

It is difficult to predict what the future holds for hospital-community relations. One thing is certain: if the fluctuations of the past 45 years are any model, they will continue to evolve with changing times. Given the multitude of factors we have seen affect hospital-community-city negotiations – national policy, the general economy, trends in health care, and local politics – predicting future trends becomes a multi-faceted guessing game. Perhaps the most noticeable current trend in any of these areas is a rapid change in Boston's demographics. As real estate prices in Boston show no signs of ceasing to rise, formerly low-income or mixed-income neighborhoods have become desirable homes for affluent professionals. Although Chinatown and Mission Hill have not been overly gentrified yet, such a change is not outside the realm of possibility. A recent newspaper noted skyrocketing real estate values in Mission Hill, known for generations variably as either a solidly working-class or outright bad neighborhood. [8] If a new population of gentrifiers gains political power in a neighborhood like Chinatown or Mission Hill, they may have very different goals with respect to local hospitals. The construction and preservation of low-income housing (along with low-income health care) may be less of a

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pressing issue. For a more transient population, construction that is on a much larger scale than the rest of the neighborhood or changes its character may also cease to be cause for concern, since they view it as less of a permanent home. It is logical to assume that the power equilibrium between hospital and community reaches a new resting place when the residents on the border change. Paradoxically, while new, more affluent, and more enfranchised residents may wield more political power as a group, if they cease to fight for today's most cherished neighborhood causes, the balance of power may tip once again in favor of the hospitals.

Potential Directions for Future Research

The important component of race in hospital-community relations and institution-community relations in general was beyond the scope of this paper; yet it remains important to address. Both of the neighborhoods most negatively affected by hospital expansion, Chinatown and Mission Hill, are predominantly or significantly nonwhite. The population of Chinatown is mainly Asian-American, and a large proportion of Mission Hill residents are African-American, although at the time of urban renewal, its population was predominantly Irish-American.

This study has focused on the conflict of interest between community groups and hospitals, presenting the struggle between them in economic terms. I have not addressed at length additional issues that arise from the differences in culture between mainly white, professional hospital administrators and working-class communities of color, and how these cultural differences affect negotiations. It would be especially interesting to determine whether a parallel exists between the hospital-community and doctor-patient relationship, both of which have been criticized for inappropriate wielding of privilege on the part of the former parties.

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