

A New Wishard Is On the Way

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On the morning of November 4, 2009, the *Indianapolis Star* blazoned the headline, “A New Wishard Is On the Way.” The previous evening, as the *Star* reported, balloons and confetti had fallen as Indianapolis mayor Greg Ballard called the results of an election in which voters overwhelmingly approved the building of a new \$754 million modern complex to replace Wishard Memorial Hospital’s labyrinth of outdated and outmoded buildings just west of downtown. Matt Gutwein, president of the municipal public health corporation that operates the hospital, remarked that the voters’ decision reflected the city’s character: caring, compassionate, and decent.¹ Wishard’s 150-year history, however, reveals a far more complex relationship between the hospital, its medical practitioners, its patients, other hospitals in the city, and the community at large.

Since its founding as the Indianapolis City Hospital, Wishard has provided the majority of charity medical care in Indianapolis and Marion County, Indiana. Yet its identity as a hospital of last resort, and the attendant connotation of inferior quality, has long plagued its

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¹“A New Wishard Is On the Way,” *Indianapolis Star*, November 4, 2009, p. 1.

medical practitioners and frustrated its patients. Wishard and the Indianapolis taxpayers have had, at best, an uneasy relationship: the citizenry has agreed that a public charity hospital should exist but has been reluctant—and often unwilling—to pay for it. Doctors and business leaders who comprised the philanthropic community have instead ensured the hospital's existence through a public-private partnership unique among American hospitals. By funding significant hospital improvements over the last hundred years, private philanthropy has allowed Indianapolis's charity hospital to survive even as public hospitals' doors around the country slammed shut.²

Philanthropy occupies a distinctive place in the American landscape. A contrasting distrust of strong government and confidence in voluntary associations to address community needs originates in the colonial era. This strong reliance on the "voluntary sector" continues to shape today's three-sector society, in which government, business, and philanthropy compete, collaborate, and complement one another.³ No sector necessarily outranks the other, yet each sector's behavior depends on the performance of the others, and each steps in to serve unmet demands. The story of how Indianapolis residents have chosen to care for their sick poor exemplifies this continuous cycle of public provision, perceived shortfalls, and private response.

At the time of Wishard's founding as Indianapolis City Hospital, American philanthropy connoted not only the love of humanity but charity, benevolence, humanitarianism, and social reform, as well.⁴ Philanthropic studies scholars Robert Payton and Michael Moody, who

²Several sources on Indianapolis history contain brief descriptions of Wishard. The only full-length institutional history is an internally published book without citations or notes. Academic hospital histories do not encompass Indianapolis or Wishard; thus this study fills a gap in both Indiana historiography and hospital historiography. For recent trends in hospital historiography, see Lucinda McCray Beier, *Health Culture in the Heartland, 1880-1980: An Oral History* (Urbana, Ill., 2009), x-xi; J. T. H. Connor, "Hospital History in Canada and the United States," *Reviews in American History* 7 (1990), 93-104; Judith Walzer Leavitt, "Medicine in Context: A Review Essay of the History of Medicine," *American Historical Review* 95 (December 1990), 1471-84.

³The interchangeable terms "voluntary sector," "third sector," and "independent sector" were crystallized in the 1975 Filer Commission report by the pathbreaking national group instigated by John D. Rockefeller III to study the role of philanthropy and nonprofit organizations in American society. Commission on Private Philanthropy and Public Needs, *Giving in America: Toward a Stronger Voluntary Sector* (Indianapolis, Ind., 1975).

⁴Merle Curti, "American Philanthropy and the National Character," in *America's Voluntary Spirit: A Book of Readings*, ed. Brian O'Connell (New York, 1983), 161.

define philanthropy broadly as “voluntary action for the public good,” note that it encompasses donating, volunteering, voluntary association, and advocacy.⁵ The story of Wishard’s survival has witnessed philanthropy in all of these forms originating in a variety of sources, including private and corporate donors, women’s service groups, medical professional advocates, and citizens’ action committees. While philanthropy of all these sorts did not affect the early decades of the hospital’s existence, they evolved together over time into a significant force that maintained, stabilized, and expanded Indianapolis’s public hospital.

The initial vision for a city hospital in Indianapolis came to Dr. Livingston Dunlap in the 1830s, a time when the city had few residents and the state contained no hospitals. Dunlap was a professor at Indianapolis’s Central Medical College, the town’s only surgeon, and the first president of the Indiana State Medical Association. Like many others in the profession, he felt that growing cities should establish permanent homes for the sick—especially for victims of epidemics such as cholera and smallpox—but his concept of an acute-care hospital was ahead of its time.⁶ Larger eastern and midwestern cities had established almshouses to house the sick poor or pesthouses to confine the contagious, but most medical care took place in the home. Urban publics, meanwhile, generally viewed hospitals—many of which evolved out of the almshouse tradition—with suspicion and even disdain. Hospitals housed only the indigent; they were places of last resort and lacked a clear delineation between sickness and dependence.⁷ Many, believing in a syndrome known as hospitalism, which attributed contagions to the building itself and its foul atmosphere, felt that hospitals themselves caused diseases.

Dunlap’s vision incubated for several years until smallpox arrived in the city in 1847. The Indianapolis Common Council created a board of health to monitor infectious and contagious diseases and to develop vaccination or other suitable public health programs. By 1848, Dunlap

⁵Robert L. Payton and Michael L. Moody, *Understanding Philanthropy: Its Meaning and Mission* (Bloomington, Ind., 2008), 6.

⁶By the time of the 1840 census, the city’s population was only 2,692. Charles A. Bonsett, “Medical Museum Notes: Indianapolis City Hospital,” *Journal of the Indiana State Medical Association* 76, no. 10 (October 1983), 657.

⁷Charles E. Rosenberg, “And Heal the Sick: The Hospital and the Patient in 19th-Century America,” *Journal of Social History* 10 (Summer 1977), 430-32.

was a member of this new board of health and a commissioner of the newly built Indiana Hospital for the Insane. Despite Dunlap's prominence, his idea gained no momentum. The *Indianapolis Journal* called the public hospital idea "a monument of Democratic folly in the brain of Dr. Dunlap," and the hospital thereafter became popularly known as "Dunlap's Folly."⁸

In 1854, smallpox threatened the city once again. The Common Council, with Dr. Dunlap as a full member, now authorized construction of a hospital "to receive the stranger, the unfortunate, and the destitute" at the taxpayer's expense.⁹ Completed in 1859, the small frame building—located on a swampy site at the extreme northwest corner of Indianapolis—cost five times more than the council's initial authorization. In the meantime, the smallpox scare had dissipated, insects swarmed the area, farm animals trampled the fence gates, and the roof already leaked. Any popular support that had existed for the project rapidly evaporated as prostitutes and derelicts moved in. The council considered repurposing the building as a home for friendless women or an asylum for mentally disabled children, while the city tried unsuccessfully to donate it to the Sisters of Charity.¹⁰ Dunlap's Folly was now the council's folly—they could not give it away.

The 1861 outbreak of the Civil War gave the City Hospital a new lease on life. The city eagerly gave the building to the federal government, which put it into use as a military hospital and operated it for the duration of the war. Catholic sisters were the only trained nurses available in the U.S. at the time, and five Sisters of Providence from St. Mary-of-the-Woods, Indiana, agreed to staff the operation. Finding the "new hospital in a miserable state of filth and disorder, and the sick in a wretched condition," the sisters set to the task of bringing order to the chaos.¹¹ They scrubbed the facility, directed the kitchen staff, maintained vital records, arranged patients in wards according to diseases, and nursed sick and wounded soldiers. In 1864, the *Indianapolis Daily*

⁸Katherine Mandusic McDonnell, "The Indianapolis City Hospital, 1833-1866," *Indiana Medical History Quarterly* 9 (June 1983), 3-12.

⁹Hester Anne Hale, *Caring for the Community: The History of Wishard Hospital* (Indianapolis, Ind., 1999), 11.

¹⁰Thurman B. Rice, "History of the Medical Campus: Indianapolis, Indiana," *Indiana State Board of Health Monthly Bulletin* (April 1947), 92.

¹¹John F. McShane, *The Hand of Providence* (Indianapolis, Ind., 1949), 15.

Journal documented the transformation from Dunlap's Folly to a proper hospital "in fine condition."¹² Public opinion of City Hospital had shifted from disgust to support.¹³

Federal authorities returned the hospital to the city in 1865 and the Sisters of Providence went home. In 1866, the Common Council at last established City Hospital as a permanent acute-care hospital, to be operated at city expense and governed by the Board of Health and Charities, which in turn hired the medical staff. The hospital had a seventy-five-bed capacity and accepted both paying and charity patients. The board, hoping to increase the institution's stature in the community, appointed prominent local physician Greenly Woollen as the hospital's first superintendent.¹⁴ Unlike earlier institutions, with their admission requirements of poverty and dependence, postwar hospitals began using medical need as a criterion of admission.¹⁵ In its early years, City Hospital's patient census reflected this trend. Length of stay ranged from a few days to one month, and diagnoses included fractures, fevers, syphilis, dysentery, and cancer.¹⁶ The City Dispensary and Bobbs Dispensary provided free outpatient care to poor Indianapolis residents.

Following Woollen's four-year term (1866-1870), five different superintendents managed City Hospital over the next nine years. Although the council technically appointed superintendents, doctors informally decided among themselves who should manage the hospital and shoulder what they perceived as an onerous responsibility.¹⁷ From the beginning, the hospital always treated the indigent and spent more than it received in patient payments—a reality that plagues this institution and most other city general hospitals to this day.¹⁸ The city allocated

¹²Sister Mary Theodosia Mug, *Lest We Forget: The Sisters of Providence of St. Mary-of-the-Woods in Civil War Service* (St. Mary-of-the-Woods, Ind., 1931), 39-50.

¹³McDonnell, "The Indianapolis City Hospital," 14.

¹⁴Jacob Piatt Dunn, *Greater Indianapolis: The History, the Industries, the Institutions, and the People of a City of Homes*, vol. 2 (Chicago, 1910), 781-82; and McDonnell, "The Indianapolis City Hospital," 17.

¹⁵Charles E. Rosenberg, "Community and Communities," in *The American General Hospital: Communities and Social Contexts*, eds. Diana Elizabeth Long and Janet Golden (Ithaca, N.Y., 1989), 8.

¹⁶McDonnell, "The Indianapolis City Hospital," 18.

¹⁷Rice, "History of the Medical Campus," (April 1947), 94.

¹⁸Harry R. Dowling, *City Hospitals: The Undercare of the Underprivileged* (Cambridge, Mass., 1982), 38.

funds to operate but not maintain the facility, much less improve it, and public enthusiasm waned. This situation would change in 1879, when William Niles Wishard ushered in an eight-year era that would come to define the hospital far into the future.

Wishard, who hailed from a well-known medical family, was only twenty-seven years old, with just three years' medical practice experience, when he took over as superintendent of City Hospital.¹⁹ Yet the anecdotes that survive of his time there suggest the stature he has obtained in hospital memory. The fledgling superintendent lived in the hospital, which was in deplorable condition. During his first night, a coal-oil lamp exploded in the hall next to his bedroom and nearly set the building on fire. The ventilation was poor, the floors warped, and snow blew in and settled on patients' beds. The roof leaked so badly that the cook allegedly prepared meals with one hand while holding an umbrella with the other.²⁰

It was Wishard's embrace of change that led the institution to become a more respectable, modern general hospital. His term coincided with the beginning of the scientific medical revolution and thus marked the start of a pivotal period in City Hospital's history. The banner of science brought hospital expansion, the rise of surgery as a viable treatment, and medical professionalization throughout the country. Wishard's tenure reflected all three of these broad national movements.

His first order of business was improvement of the physical plant. The City Council initially brushed off Wishard's request for capital improvements; some council members even felt the hospital "had better be abandoned."²¹ Undeterred, the new superintendent lobbied for several years, enlisted the advocacy of influential doctors, and finally obtained the council's financial support. He secured funding for a complex of three new buildings that opened between 1883 and 1885 and increased capacity to 150 beds. Function superseded comfort as a prior-

¹⁹Dr. William Niles Wishard's father, Dr. William Henry Wishard, co-founded the Indiana State Medical Society along with Dunlap, volunteered as a civilian doctor during the Civil War, and served as Marion County coroner. Rodney A. Mannion, "William Henry Wishard (1816-1913): The Urologist's Father or a Physician of the Old School," *Journal of the Indiana State Medical Association* 70, no. 4 (April 1977), 186; and Elizabeth Moreland Wishard, *William Henry Wishard: A Doctor of the Old School* (Indianapolis, Ind., 1920), 247.

²⁰William Niles Wishard, "Address to Graduating Class of the Indianapolis City Hospital Training School for Nurses," *Journal of the Indiana State Medical Association* 4, no. 1 (January 1911), 303-304.

²¹Wishard, "Address to Graduating Class," 304.

ity in patient wards. Although clean, wards were dark, lit by gas rather than natural light, with bare floors and walls and with beds placed only a foot or two apart.

As Wishard began his term, hospitals were still in the process of consistently adopting surgical antisepsis procedures. Joseph Lister's ideas were still relatively new, and many doctors patently disregarded Ignaz Semmelweis's pleas for hand washing. Surgeries had just begun at City Hospital—an institution whose antisepsis practices Wishard described as only “imperfectly” applied. “Pus,” he recalled, “was the order of the day.”²² Wishard acquired carbolic gauze, protective silks, and carbolic steam spray apparatus and instituted their regular use. He also required doctors to wash their hands and dress obstetrical patients in clothing treated with carbolic acid solution to reduce the high incidence of puerperal fever.²³ His willingness to adopt these new antisepsis procedures reflected Wishard's knowledge, open-mindedness, and devotion to patient care. His efforts were clearly effective. By 1887, Wishard's last year at the helm, the hospital reported that the mortality rate in its obstetrical ward, with close to one hundred births annually, had dropped from 5 percent to zero.²⁴

The late nineteenth-century scientific revolution brought the concepts of localized diagnosis, germ theory, antisepsis, and anesthetic to professional medicine. Taken together, these factors contributed to surgery's evolution into a premier treatment of disease. Surgery and hospitals became inextricably linked, as Indianapolis doctor Frank Wynn noted in 1900: “Surgeons and physicians have found the best possible ends in treatment are secured in a hospital.”²⁵ At City Hospital, most antisepsis procedures and anesthetics became standard. In operating rooms, tile, metal, and glass replaced wood as the material of choice for floors, beds, tables, and instrument racks. The majority of surgical patients received ether, chloroform, or cocaine as anesthetics. By 1900, surgeons performed approximately 375 operations annually with one in

²²Ibid., 306.

²³William Niles Wishard, Jr., “The Genesis of Marion County General Hospital and its Training School for Nurses,” *Journal of the Indiana State Medical Association* 59, no. 3 (March 1966), 268-70.

²⁴Hale, *Caring for the Community*, 34.

²⁵Edward A. Leary and Kenneth E. Reed, *The History of Methodist Hospital of Indiana Inc.: A Mission of Compassionate Health Care* (Indianapolis, Ind., 1984), 8.



First City Hospital operating room, 1887. Surgeons, from left to right, are Dr. Churchill, Dr. Moffett, and Dr. Jobs.

Courtesy, Indiana Historical Society, M0430



Children's Ward, 1887. William Niles Wishard, who served as superintendent of City Hospital from 1879 to 1887, oversaw the expansion of the facility as it increased to 150-bed capacity by 1885.

Courtesy, Indiana Historical Society, M0430

five admissions being for surgery. Surgeons operated in a new suite fitted with an amphitheater in which up to two hundred medical students could gather for an intimate view of procedures illuminated by bright gas and electric lighting.²⁶ Teams of attending doctors and nurses, both male and female, assisted the surgeons and managed the medical instruments and anesthesia.

City Hospital employed only two nurses when Wishard arrived in 1879, one male (a former patient), in charge of all male wards, and one female, in charge of the medical and obstetrical female patients. As a result, patients often had to fend for themselves. Bedside tables accordingly sported thermometers, medicine glasses, watches to time dosages, and bells to summon assistance. Nurses cleaned the wards, bathed patients, administered medicine to patients unable to take drugs themselves, and changed dressings. While many citizens, in Indianapolis and elsewhere, felt upstanding women should avoid hospital work, nursing evolved in subsequent decades, from the domain of Dickens's stereotypical Sairey Gamp into a legitimate profession, and a legitimate profession for women to pursue. American hospital-based nurse training programs skyrocketed from fifteen in 1880 to seventeen hundred in 1920.²⁷

City Hospital established its nursing school relatively early, in 1883, under the joint leadership of Wishard, the Indianapolis Charity Organization Society's Reverend Oscar McCulloch, and the Flower Mission of Indianapolis, a society of women who carried flowers to the sick poor. Wishard patterned the hospital's school after Chicago's Illinois Training School for Nurses; he later recalled proudly that Indianapolis was only the second midwestern city to institute formal nurse training. Nursing students lived in the hospital and created their own professional registry, housed at McCulloch's Plymouth Church.²⁸ The Flower Mission Training School for Nurses brought respectability and more trained nurses to City Hospital. Fifty graduated from the two-year program within its first ten years, becoming qualified to take on duties well

²⁶Hale, *Caring for the Community*, 42; and Rice, "History of the Medical Campus," (August 1948), 185.

²⁷Richard Harrison Shryock, "Nursing Emerges as a Profession: The American Experience," *Clio Medica* 3 (1968), 133.

²⁸*Indianapolis Journal*, February 2, 1885, as quoted in Rice, "History of the Medical Campus" (July 1948), 164. The Indiana State Board of Registration and Examination for Nurses assumed all nursing school registries in 1905. Wishard, "Address to Graduating Class," 309.

beyond the scope of Wishard's first two nurses. When the bank holding the school's deposits failed in the wake of the Panic of 1893, the program was fully subsumed as a department of City Hospital in 1897.²⁹

As his second term drew to a close, Wishard weighed his options. He had developed his expertise in genitourinary surgery while at the hospital and longed "to go out into practice" in this emerging field. When one of Wishard's colleagues asked him if he felt ready to leave City Hospital, he reportedly replied, "Yes, I think I had better. I don't want to have hospitalitis."³⁰ In 1887, Indianapolis medical and civic leaders honored the outgoing Wishard with a testimonial evening. The opening toasts noted the transformation from "The Old City Hospital, 'Dunlap's Folly'" to "The New City Hospital, 'Wishard's Wisdom.'"³¹ Wishard's area of specialty was an audacious choice for the times. While friends warned him that he would be "classified with quacks," he went on to lead his field with distinction, maintaining his status as a celebrated physician for generations to come.³²

City Hospital's perpetual financial straits, party politics, and the complexity of liaising between city government and medical staff all contributed to the continuous turnover that followed Wishard's departure in 1887. A series of nineteen superintendents served for an average of two years each over the next four decades, their situation typical of municipal hospital leaders caught between the Scylla and Charybdis of politics and medical administration.³³ Men held the superintendent positions at City Hospital, and women directed the nursing school; this gendered division of leadership prevailed until the nursing school closed in 1980. During the late nineteenth and early twentieth centuries, women held superintendent positions at many private, often denominational,

²⁹Hale, *Caring for the Community*, 29-32; Rice, "History of the Medical Campus" (July 1948), 157-66; Wishard, "Address to Graduating Class," 306; and Wishard, Jr., "The Genesis of Marion County General Hospital," 272.

³⁰William Niles Wishard, Jr., "Wm. Niles Wishard, Sr.: Urologist, Educator, Administrator, Medical Statesman, Church and Family Man," *Urological Survey* 19, no. 3 (June 1969), 115.

³¹Program Card, "The William Niles Wishard Testimonial 1879 to 1887," Visual Collection Box 9, Marion County General Hospital Collection, 1861-1979, collection #M0430, Indiana Historical Society, Indianapolis, Indiana (hereafter Marion County General Hospital Collection).

³²Thurman B. Rice, "The Hoosier Health Officer," *Indiana State Board of Health Monthly Bulletin* (December 1943), 282.

³³Roster of superintendents in Hale, *Caring for the Community*, 182. He went on to lead Central State Hospital until his death in 1923.

hospitals in the U.S., but this phenomenon did not necessarily extend to municipal hospitals.³⁴

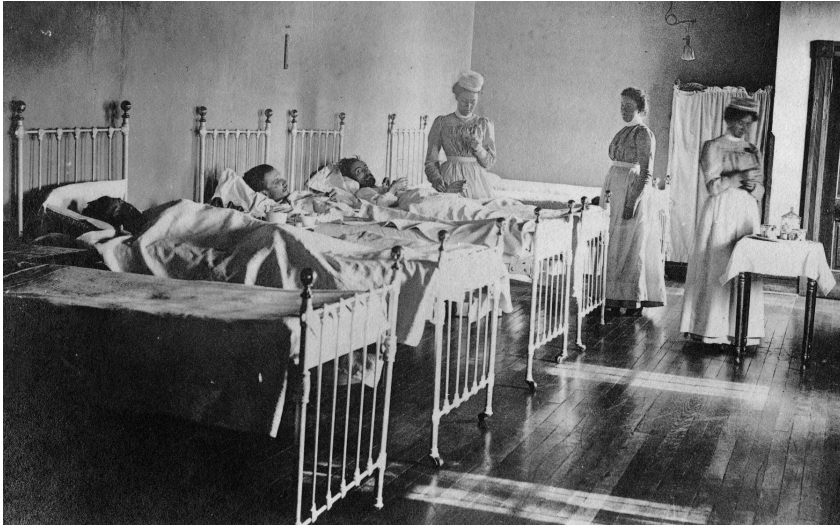
By the turn of the twentieth century, hospitals had emerged from their roots among asylums and poorhouses as distinct, legitimate institutions in which people of all classes sought medical treatment. Nationally, the number of hospital buildings expanded dramatically from 173 in 1873 to 4,359 in 1909. Hospital ownership generally fell into four categories: government, proprietary, private charitable, and religious. Charitable and religious institutions accounted for the lion's share of this growth; despite the building boom, only seventy-eight public general hospitals existed in the U.S. by 1910.³⁵

Several hospitals began operations in Indianapolis during this period. While taxes continued to fund City Hospital, philanthropy helped to establish an array of private institutions that competed with it and that segregated their patients along religious and class lines. Religious organizations opened institutions primarily to serve their denominations: St. Vincent Hospital (1889), Methodist Hospital of Indiana (1899), Protestant Deaconess Hospital (1899-1935), and St. Francis Hospital (1914). Colonel and Mrs. Eli Lilly underwrote a short-lived children's hospital, Eleanor Hospital, from 1895 to 1909. Once the Indiana University School of Medicine (IUSM) was established in 1907, philanthropists provided capital for new facilities, and the Indianapolis campus rapidly expanded: Long Hospital to serve the rural poor (1914), James Whitcomb Riley Memorial Hospital for Children (1924), and Coleman Hospital for Women (1927). IUSM's presence ended City Hospital's isolation in the blocks west of downtown. No longer the sole occupant of a swampy site in the corner of the city, it now operated as an integral member of a larger medical community at the core of Indianapolis.

With people of all classes seeking hospital treatment, the plethora of competing hospitals resoundingly and permanently forged City Hospital's identity as a charity institution for the poor. Contemporary

³⁴David Rosner, "Doing Well or Doing Good: The Ambivalent Focus of Hospital Administration," in *The American General Hospital*, Long and Golden, 159-62. Wishard's nursing school operated the longest of Indianapolis's major hospital-based nursing schools, St. Vincent Hospital (1896-1970) and Methodist Hospital (1908-1968).

³⁵Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century* (New York, 1989), 20-28.



Patient Ward, 1899. Although clean, early patient wards were sparse with beds placed only a foot or two apart.

Courtesy, Indiana Historical Society, M0430

accounts such as Hyman's *Handbook of Indianapolis* (1909), which characterized City Hospital's "beneficiaries [as] the sick poor," reflected this identity.³⁶ The Indiana University academic catalogue described the facility as "the largest charity institution in the State."³⁷ Although the hospital accepted paying patients, they were clearly the exception. In 1917, for example, city appropriations of \$173,125 for charity care dwarfed patient fees of just \$5,660.³⁸

Other area hospitals accepted charity patients, but indigent care did not form their core mission, and most patients paid for services.³⁹ The "worthy-unworthy poor" construct persisted during this period and affected hospital admission guidelines. Hospitals exhibited more

³⁶Max R. Hyman, *Hyman's Handbook of Indianapolis: An Outline History* (Indianapolis, Ind., 1909), 90.

³⁷Indiana University, "Catalogue Indiana University," *Indiana University Bulletin* 15, no. 10 (August 1917), 190.

³⁸Bureau of Municipal Research, *Report on a Survey of the City Government of Indianapolis, Indiana* (Indianapolis, Ind., 1917), 367, 387.

³⁹Dowling, *City Hospitals*, 27; and Stevens, *In Sickness and in Wealth*, 28, 42.

tolerance for those they deemed worthy: respectable people of character who suffered from illness, injury, or bad luck. The unworthy putatively suffered from character flaws such as ignorance, shiftlessness, intemperance, or gambling. Methodist Hospital, for example, attempted to draw this fine line in its policy of accepting the sick poor if “recommended by pastors under proper rules and regulations, not as charity patients, but as guests of the Church.”⁴⁰ St. Vincent and St. Francis hospitals both served poor patients, but expected the indigent to remain a minority of their patient populations, and devoted themselves to serving the city’s Catholic community more generally.⁴¹ Public hospitals, however, did not enjoy the luxury of screening patients along social, religious, or class-based criteria.⁴² Around the country, municipal and county hospitals, including City Hospital, served all types of poor patients, who were often immigrant or African American.

The frenzy of local hospital building reflected the convergence of several simultaneous forces: the national hospital movement, Indianapolis’s rapid population growth, wealth accumulation in particular communities, philanthropic support for hospital development, an unprecedented demand from paying clients for inpatient services, and the willingness of the sick to travel for medical treatment.⁴³ Hospital construction could not keep up with demand. In 1901, Methodist Hospital officials reported that up to 75 percent of the city’s patients desiring hospital treatment came from outside the city limits, and that aggregate hospital capacity could accommodate only half of those who sought care.⁴⁴ City Hospital remained constantly crowded despite its

⁴⁰Leary and Reed, *The History of Methodist Hospital of Indiana*, 33; William H. Walsh, *The Hospitals of Indianapolis: A Survey Conducted under the Auspices of the Indianapolis Foundation* (Indianapolis, Ind., 1930), 15

⁴¹St. Vincent and St. Francis Catholic hospitals did not refuse poor or African American patients, yet those populations did not comprise the majority of their patients. St. Vincent includes service to the poor in their core mission, although both Catholic systems expect the majority of patients to pay for care and have generally been profitable. Bill Beck, *St. Vincent: The Spirit of Caring, 1881-2006 Celebrating 125 Years* (Indianapolis, Ind., 2006), 49, 57, 68; Katherine Mandusic McDonnell, “Hospitals,” in *The Encyclopedia of Indianapolis*, eds. David J. Bodenhamer and Robert G. Barrows (Bloomington, Ind., 1994), 712.

⁴²Morris J. Vogel, *The Invention of the Modern Hospital: Boston, 1879-1930* (Chicago, 1980), 32-35.

⁴³By 1900, the city’s population was over 169,000; by 1910, Indianapolis claimed more than 233,000 residents. See the U.S. Census figures online at <http://www.census.gov>.

⁴⁴Leary and Reed, *The History of Methodist Hospital of Indiana*, 14.

1880s expansion, a problem endemic to municipal hospitals.⁴⁵ Scientific and technical advances such as x-ray diagnostic equipment meant higher costs for any hospital that wished to keep pace with rising medical standards. Yet public hospitals were unable to maintain existing facilities, much less to acquire new technology, at their traditional levels of funding.⁴⁶

In 1908, City Hospital administrators petitioned the City Council for a capital appropriation for a program of construction and expansion. With isolation long the prevailing method to control the spread of typhoid and smallpox epidemics, the hospital had maintained only outside pavilions for the contagious. In the dingy pesthouse, patients lived crammed together on flimsy cots, in a manner reminiscent of the tenement dwellers photographed by Jacob Riis in his *How the Other Half Lives*.⁴⁷ At the time of the hospital's request for funds, the pesthouse measured just thirty by forty feet and housed up to twenty patients. The city refused to appropriate the additional funds.

The challenge of filling the gap between tax appropriations and necessary funding would eventually require the cooperation not just of city and hospital, but of local philanthropists as well. This new form of partnership began with a 1913 bequest from Alfred Burdsal, of the A. Burdsal Paint Company, who left the bulk of his \$700,000 estate to the city for expansion of the hospital and development of a nearby parkway. Burdsal specifically designated his gift for the construction of "modern" wards, intended for those patients unable to pay for their care.⁴⁸ The Burdsal B and C adult and pediatric wards opened in 1914 and displayed a marked improvement over the old facilities. The new men's and women's wards gleamed with natural light that illuminated windows, tile floors, white walls, and iron beds. Even the pediatric wards were bright, with white iron cribs nestled in clusters. Design was still based on function over patients' privacy or comfort, with wide open corridors flanked by rows of beds. The stark atmosphere inspired St. Margaret's Guild, the hospital ladies auxiliary, to decorate the new wards. The

⁴⁵Dowling, *City Hospitals*, 78, 93.

⁴⁶Vogel, *The Invention of the Modern Hospital*, 66-67.

⁴⁷Jacob Riis, *How the Other Half Lives: Studies Among the Tenements of New York* (New York, 1890).

⁴⁸Cinnamon Catlin-Leguto, *The Art of Healing: The Wishard Art Collection* (Indianapolis, Ind., 2004), 2.



Men's Ward with murals, 1910s. A 1913 bequest from Alfred Burdsal allowed the hospital to open two new wards in 1914. With the aid of contributions by St. Margaret's Guild, the Board of Health, and other private donors, the hospital commissioned thirty-three murals and paintings from sixteen Indiana artists to enliven the new wards.

Courtesy, Indiana Historical Society, M0430



Surgery, 1920s. The late nineteenth-century scientific revolution brought the concepts of localized diagnosis, germ theory, antisepsis, and anesthetic to professional medicine. Taken together, these factors contributed to surgery's evolution into a premier treatment of disease with surgery and hospitals eventually becoming inextricably linked.

Courtesy, Indiana Historical Society, M0430

guild, the Board of Health, and other private donors together funded public art in patient wards and dayrooms. With the aid of their contributions, the hospital commissioned thirty-three murals and paintings from sixteen Indiana artists, including the well-known T.C. Steele—a remarkable quarter-mile of artwork in all.⁴⁹ The Burdsal bequest significantly altered City Hospital: capacity more than doubled to 350 beds, dedicated children's wards opened, and the tradition of therapeutic art was launched.⁵⁰

Education of doctors in the U.S. profoundly changed alongside hospital modernization and growth. Medical instruction migrated gradually away from individual practitioners toward full-time academics and teaching hospitals with colleges assuming the full burden of physicians' training by around 1900.⁵¹ Abraham Flexner's *Medical Education in the United States and Canada* (1910) further accelerated the nationwide shift from commercial, sectarian schools toward research-based university programs. Based on the model established at Johns Hopkins University, such reforms firmly located medical student training programs in hospitals.⁵² Clinical facilities that provided students access to a wide variety of patients became crucial, and large city hospitals attracted medical schools like magnets.⁵³ City Hospital's intern program had begun in the late nineteenth century with two of IUSM's predecessor schools, the Medical College of Indiana and the College of Physicians and Surgeons; its residency program commenced in the early 1920s. From the time that IUSM began instruction in Indianapolis in 1906, as many as one-third of its students have rotated through City Hospital for clinical experience annually. City Hospital and IUSM also entered into a

⁴⁹Ibid., 4-7.

⁵⁰The Sunnyside Sanitarium and Flower Mission pavilion on hospital grounds provided another two hundred beds for tuberculosis patients. Bureau of Municipal Research, *Report on a Survey of the City Government of Indianapolis*, 359, 369; Hale, *Caring for the Community*, 53-56; and Rice, "History of the Medical Campus" (October 1948), 235-39.

⁵¹Abraham Flexner, *Medical Education in the United States and Canada* (New York, 1910), 20; and Kenneth Ludmerer, *Learning to Heal: The Development of American Medical Education* (New York, 1985), 6.

⁵²A. McGehee Harvey, et al., "A Model of Its Kind: A Century of Medicine at Johns Hopkins," *Journal of the American Medical Association* 261, no. 21 (June 1989), 3136-42; and Ludmerer, *Learning to Heal*, 7.

⁵³Dowling, *City Hospitals*, 62.

teaching affiliation agreement authorizing school faculty to serve as hospital staff physicians.⁵⁴

City Hospital's teaching role gave it a national profile during World War I, when staff participated in a national consortium of eighteen medical schools and forty-two teaching hospitals that established fifty mobile base hospitals in France and Great Britain to specialize in wartime surgery.⁵⁵ City Hospital organized Base Hospital No. 32 in Contrexéville, France, staffed by 150 Indianapolis personnel and funded in part by a gift from Eli Lilly and Company. The prestige and visibility of the base hospital belied the chaos back home, where wartime staffing shortages and inflated operating costs threatened the hospital's ability to continue its mission. The chronic lack of maintenance funds caused marked deterioration throughout the facility, even in the new Burdsal wards. Hospital leadership was in turmoil, prompting the resignations of the superintendent and entire Board of Health (the hospital's governing body) in 1918.⁵⁶

The leadership crisis and economic conditions stabilized after the war. Charles W. Myers became superintendent in 1931 and remained in the position until 1952, the longest-serving superintendent in the hospital's history. In 1927, the City Council at last appropriated funds for remodeling the contagion ward and adding an administration building and a dormitory for student nurses. A new building with surgical suites and patient wards replaced the 1895 structure, a testimony to surgery's permanent role in the treatment of disease.

In 1927, the relatively new Indianapolis Foundation commissioned a comprehensive study of Indianapolis hospitals' services, capacity, and governance. The report underscored that City Hospital was "undoubtedly intended" as the city's provider of charity care and heightened citizens' awareness of the need for philanthropy to complement public funding.⁵⁷ City Hospital's 541 beds made it the city's largest provider; other area hospitals combined accounted for another 1,300 beds. City Hospital provided health care at by far the lowest cost of

⁵⁴Hale, *Caring for the Community*, 52, 100; Indiana University, "Catalogue Indiana University," 190.

⁵⁵Stevens, *In Sickness and in Wealth*, 90-93.

⁵⁶Hale, *Caring for the Community*, 56-59.

⁵⁷Walsh, *The Hospitals of Indianapolis*, 28.

\$3.22 per patient per day, compared to an average of \$4.90. Patients hospitalized at City stayed in open wards; all the charitable and religious hospitals offered either single or double rooms. Charity care and no-frills open wards were one and the same: City Hospital's patient census was 84 percent free, 15 percent partially paid, and only 1 percent paid. Religious hospitals, in contrast, reported up to 10 percent of their census as free care.⁵⁸

Patient fees, philanthropy, and the denominations themselves assured the viability and growth of the city's religious hospitals.⁵⁹ At the same time, philanthropic residents recognized the need to augment City Hospital's public funding, and in 1929 the Board of Health's president noted that "more and more the citizens are becoming conscious of the work of ... the hospital."⁶⁰ Gifts from several sources followed in the 1920s and 1930s. The Indianapolis Foundation and St. Margaret's Guild built the therapy ward together; Eli Lilly donated funds for the city's first iron lung; and significant bequests from the prominent Butler family provided medical supplies for the children's ward.⁶¹ A gift from Mr. and Mrs. Edwin Patrick, of the C.B. Cones Manufacturing Co., allowed the consolidation and expansion of free outpatient services for the poor. The Patricks designated City Hospital, they explained, because "there was no way in which so many people could be reached so effectively."⁶²

For decades, outpatient care had served as an important counterpart to inpatient treatment for the indigent or destitute. Outpatient clinics, known as dispensaries, served large numbers of ambulatory but poor patients who did not require hospitalization and provided follow-up care once patients had left the hospital.⁶³ The City Dispensary and Bobbs

⁵⁸Other data compiled for St. Vincent, Methodist, Christian nonprofit hospitals and, at Indiana University, Coleman, Long, and Riley hospitals. Riley did not charge fees for children's care at the time; Long Hospital for the rural poor reported 72 percent free care. Walsh, *The Hospitals of Indianapolis*, 19, 21, 119.

⁵⁹Walsh, *The Hospitals of Indianapolis*, 118.

⁶⁰"Two Gifts Made to City Hospital," *Indianapolis Times*, March 27, 1929, folder 11, box 1, Marion County General Hospital Collection.

⁶¹"City Hospital to Get Large Contributions," *Indianapolis Times*, March 27, 1929, folder 11, box 1, Marion County General Hospital Collection.

⁶²"Hospital Annex to be Dedicated," *Indianapolis Star*, February 11, 1927, folder 11, box 1, Marion County General Hospital Collection.

⁶³"City Hospital Among Foremost of Nation," *Indianapolis News*, November 25, 1925, folder 11, box 1, Marion County General Hospital Collection.

Dispensary, both established downtown in the 1870s, provided free care in addition to City Hospital's own outpatient services. The two dispensaries merged into the City Dispensary in 1909, and IUSM took over its operations. Outpatient departments were fixtures of medical schools, and many independent dispensaries folded into university programs so that students could observe a high volume and wide variety of cases. Dispensaries accordingly contributed to the development of specialization and served as natural conduits to inpatient units.⁶⁴

The city and IUSM underwrote the City Dispensary's operating expenses but did not upgrade its physical facility. The building was old and dilapidated; nearby street noises were so loud that they interfered with diagnosis.⁶⁵ The dispensary was supposed to serve those who could not afford any other form of care, but patients of some means still sought free care.⁶⁶ In 1915, the City Dispensary instituted a contentious ten-cent charge for such patients, although it promised the community that "no worthy person was turned away for failure to pay the fee."⁶⁷ Demand continued to exceed capacity, as no other area hospital besides City either provided, or contemplated providing, dispensary services.⁶⁸ Finally, recognizing their common missions, the hospital's and City Dispensary's outpatient services, and their accompanying social service departments, merged into City Hospital's new A wing in 1929.

In its first year of operation, the newly combined facility recorded more than 67,000 visits—an average of more than two hundred patients every day. Daily outpatient visits outnumbered inpatient admissions eight to one. Over the following four years, while the number of hospitalized patients grew gradually at a few percentage points annually, the number of outpatients nearly doubled. Through the 1930s, the hospital continued to treat between four hundred and five hundred outpatients

⁶⁴Stevens, *In Sickness and in Wealth*, 48-49; and Vogel, *The Invention of the Modern Hospital*, 88-89.

⁶⁵Bureau of Municipal Research, *Report on a Survey of the City Government of Indianapolis*, 331, 371.

⁶⁶"Report of the C.O.S.," untitled newspaper, November 6, 1902, Bound Volume 1170, Family Service Association of Indianapolis Records, 1879-1971, collection #M0102, Indiana Historical Society, Indianapolis, Indiana.

⁶⁷October 15, 1915, untitled newspaper clipping, folder 11, box 1, Marion County General Hospital Collection.

⁶⁸Walsh, *The Hospitals of Indianapolis*, 123.

daily.⁶⁹ But a new facility unfortunately did not mean streamlined service. The hospital's Social Service Department reported in 1935 that "patients new and old are so easily confused and lost" in rules, regulations, confusion, and congestion.⁷⁰ The lobby was usually packed. Lines of people waiting to register stretched down long, narrow hallways. Such conditions characterized many city hospitals, in which patients stood interminably for hours in barnlike waiting rooms.⁷¹

The outpatient A wing housed admitting wards, the emergency ward, and an expanded Lilly Research Clinic. The hospital and Eli Lilly and Company had opened the Lilly Clinic in 1921, making it the second hospital-corporate joint venture research laboratory in the country. Lilly underwrote the clinic staff's salaries and donated the equipment. The hospital's patients provided plentiful and varied subject matter for the clinic's research. The hospital directors considered the clinic's educational advantages "incalculable," and interns from all over the world applied to work there.⁷² The research department produced scores of publications and developed antidotes—later adopted by other emergency departments—for strychnine, cyanide, and bichloride poisonings.⁷³

The link between laboratories and city hospitals was crucial, as many city hospitals served as proving grounds for the testing of new antibiotics in the 1930s and 1940s. The development of pathology paralleled the growth of laboratory research, especially in city hospitals, where so many patients suffered from unusual or advanced illnesses less often seen in nonprofit hospitals.⁷⁴ Indeed, City Hospital's pathology department reported bustling levels of activity, including four hundred to five hundred autopsies annually.

Large-scale public health initiatives together with advances in scientific medicine led to the early twentieth-century epidemiological

⁶⁹Annual Report of the City Hospital Indianapolis 1929 to 1939, folder 19, box 1, Marion County General Hospital Collection.

⁷⁰Annual Report of the City Hospital Indianapolis 1935, folder 19, box 1, Marion County General Hospital Collection.

⁷¹Dowling, *City Hospitals*, 138.

⁷²Minutes of City Hospital board meeting November 17, 1944, folder 17, box 1, Marion County General Hospital Collection.

⁷³"New Antidote Developed at City Hospital," *Indianapolis Times*, May 26, 1935, folder 11, box 1, Marion County General Hospital Collection; and Annual Report of the City Hospital Indianapolis 1934, folder 19, box 1, Marion County General Hospital Collection.

⁷⁴Dowling, *City Hospitals*, 59, 128-32.

transition from infectious to degenerative diseases as leading causes of death. Tuberculosis, however, remained a leading cause of death until scientists perfected antibiotic treatment in the 1940s. The Board of Health's Division of Contagious Disease and the City Hospital shared responsibility for tuberculosis treatment—usually confinement in sanatoria. Although contagious disease had spawned the city's original interest in founding City Hospital, the facility maintained only a small ramshackle annex to isolate its contagious patients. From 1903 to 1937, the private Flower Mission operated a separate, twenty-five-bed hospital for incurable tubercular patients on City Hospital grounds, while the two-hundred-bed Sunnyside Sanitarium (1917-1967), an extension of the hospital's pulmonary department, operated as the county's tuberculosis clinic for incipient cases on the far-east side of the city.⁷⁵

It bears noting that these other facilities primarily served white patients. Through the 1940s, City Hospital was the only viable hospital in the city that accepted black patients. African Americans had established their own hospitals as early as 1909, but none survived.⁷⁶ Flanner House settlement operated a free tuberculosis clinic for black citizens but lacked inpatient facilities. Black patients suffering from tuberculosis were doubly stricken, as the Indianapolis Charity Organization Society had reported in 1918:

The care of dependent colored tubercular patients is a most perplexing one . . . cases too far advanced for Sunnyside—City Hospital does not take tubercular patients, and Flower Mission Hospital does not take colored patients—and the County Farm does not take cases of Chronic Sickness. Could there be a more complete shut-out?⁷⁷

⁷⁵St. Vincent's, Methodist, Riley, Long, and St. Francis hospitals specified tuberculosis or contagious patients as "inadmissible." Walsh, *The Hospitals of Indianapolis*, 15; Bureau of Municipal Research, *Report on a Survey of the City Government of Indianapolis*, 329-35, 369. Sunnyside was fully subsumed into General Hospital in 1961. "General, Sunnyside are Merged," *Indianapolis Times*, December 31, 1961, folder 11, box 1, Marion County General Hospital Collection.

⁷⁶Hale, *Caring for the Community*, 76-77; McDonnell, "Hospitals," 712; St. Vincent's admissions policy did not specify African American cases as "inadmissible," but white patients objected so vehemently to black patients that the hospital did not admit them. Walsh, *The Hospitals of Indianapolis*, 15, 92.

⁷⁷Report of General Secretary, February 26, 1918, Bound Volume 1171, The Family Service Association of Indianapolis Records, 1879-1971, collection #M0102, Indiana Historical Society, Indianapolis, Indiana.

An \$86,000 Public Works Administration (PWA) grant and a \$71,000 Works Progress Administration (WPA) grant, matched by city appropriations, brought the remedy in 1937.⁷⁸ PWA and WPA Depression-era federal programs targeted government hospital deficiencies and tuberculosis institutions in particular.⁷⁹ City Hospital used the funds to construct a dedicated ninety-six-bed tuberculosis facility and fully assume the Flower Mission hospital. It also built the F wing to replace the 1880s buildings and increased its number of licensed beds to 726, the capacity at which the hospital would operate for the next fifty years. The F wing, opened in 1939, provided segregated wards for African American patients and housing for African American interns and nursing students. Well into the 1940s, the country's expectation of segregation created difficulties for the hospital. Crowded conditions at times necessitated the comingling of white and black patients, as well as of paying patients with charity patients on open wards, situations that Myers acknowledged as problematic.⁸⁰

Scientists' increasing success in combating tuberculosis and other infectious diseases left cancer as a leading cause of death in the U.S., second only to heart disease. In 1937, Edwin Patrick, who had funded the outpatient clinic, left a large bequest to City Hospital for a free cancer clinic for the poor. While 210 cancer clinics operated in the U.S. for patients who could afford to pay for treatment at the time, Patrick noted his dismay of the lack of a single free municipal cancer clinic:

As you know there is no place for a poor person to go and receive treatment for cancer. Of course, the rich are able to receive the best treatment available, and it seemed to me that the poor should have a place to go when in need.⁸¹

⁷⁸"Work on New Hospital Unit to Begin Soon," *Indianapolis Star*, February 2, 1937, folder 11, box 1, Marion County General Hospital Collection.

⁷⁹Stevens, *In Sickness and in Wealth*, 168-69.

⁸⁰Annual Report of the City Hospital Indianapolis 1944 to 1948, folders 20-22, boxes 1 and 2, Marion County General Hospital Collection.

⁸¹"Dedicate Patrick Cancer Clinic," *Indianapolis Star*, August 19, 1938, folder 11, box 1, Marion County General Hospital Collection; "E.L. Patrick Gives \$100,000 for First Municipal Cancer Treatment Clinic in Nation," *Indianapolis News*, August 2, 1937, folder 11, box 1, Marion County General Hospital Collection.

Patrick's designation of City Hospital as his beneficiary reflected a growing perception of the need for philanthropy to supplement city appropriations and assure medical care for all citizens.

All types of admissions and services at City Hospital rose steadily through the 1930s, even as other hospitals' beds lay empty. The Depression exacerbated its normally crowded conditions as patients who could previously afford hospital fees gravitated to the public hospital for free services. This phenomenon, in turn, eroded private non-profit hospitals' paying bases. Public hospitals throughout the U.S. stayed full, at over 90 percent occupancy through the decade, while only about half of private hospitals' capacity remained in use. Responding to the crisis, private California hospitals in 1934 formed a lobbying association and brought a successful suit that required the state's county hospitals to treat only indigent patients.⁸²

Indianapolis saw similar conflicts. In the early 1930s, City Hospital proposed a \$500,000 bond issue to relieve overcrowding in its wards. Competing hospitals rose up in arms and sought to reclaim the paying patients they felt were rightfully theirs. Methodist Hospital's superintendent led the charge, which he summarized in an open letter to the mayor:

The City Hospital . . . was built to take care of indigent cases only and to be supported by taxes from the city. This is not the prevailing policy. We witness the strange spectacle of the City Hospital entering into competition with private supported hospitals . . . this is manifestly unfair.⁸³

Board of Health president Dr. Charles Myers appealed to "every citizen of Indianapolis who is interested in the welfare and progress of his city, or . . . the unfortunate indigent sick, whom 'we have always with us,'" stating that the "absolute lack of funds" made expansion

⁸² The California Supreme Court decision was upheld until Medicaid was enacted in the 1960s. Stevens, *In Sickness and in Wealth*, 149-54.

⁸³ Leary and Reed, *The History of Methodist Hospital of Indiana*, 70.

impossible even when it was desperately needed.⁸⁴ Myers took to the radio to remind Indianapolis citizens that City Hospital was not exclusively for indigents, and that paying patients also utilized its services. He further emphasized the hospital's emergency and trauma capabilities, which were coming to differentiate service in Indianapolis and in city hospitals around the country. "I don't want to be morbid," Myers told the public, "but it is a fact that you may sooner or later become one of our patients . . . if you are involved in an automobile accident and knocked unconscious."⁸⁵ Despite its defenders' pleas, the bond issue failed to pass, and Mayor Reginald H. Sullivan attempted to dissuade City Hospital from treating paying patients who could be transferred to nonprofit hospitals, further circumscribing City Hospital's role as the destination for the sick poor.

The outbreak of World War II brought renewed pressure on the already strapped hospital. As it had in World War I the hospital lost key staff to the war effort—half of its physicians and one-third of its interns. The local Red Cross, challenging Indianapolis to enlist five hundred student reserve nurses in one ninety-day period in 1943, expected City Hospital's nursing school to facilitate recruitment.⁸⁶ In a signal of the seriousness of the loss, new federal subsidies underwrote the hospital's nursing school expenses in order to attract prospective students to the nursing profession. The *Indianapolis Star* highlighted the local "nurse shortage" with a photograph of a men's ward housing forty patients, "some of them seriously ill," and only one nurse.⁸⁷

The federal aid given to City Hospital's nursing program presaged the increased governmental involvement in healthcare—as in so many other social programs—in the wake of the Depression and the Second

⁸⁴Annual Report of the City Hospital Indianapolis 1934, folder 19, box 1, Marion County General Hospital Collection.

⁸⁵Dr. Charles Myers Radio Address, September 27, 1936, folder 5, box 1, Marion County General Hospital Collection.

⁸⁶Undated letter by W. I. Longworth, chairman Indianapolis Red Cross, folder 15, box 1, Marion County General Hospital Collection.

⁸⁷"Nurse Shortage Perils Care of City Hospital Patients," *Indianapolis Star*, September 6, 1946, Bound Volume 2124, Marion County General Hospital Collection. The nursing school had graduated 1,125 nurses since 1885, but class sizes dwindled after 1947 and many nurses did not go to work for City Hospital. The shortage persisted into the 1950s, when the hospital launched an intensive campaign to engage civic groups to sponsor nursing students. "City Hospital will Recruit More Nurses," *Indianapolis Times*, September 13, 1954, folder 19, box 1, Marion County General Hospital Collection.

World War. The Hospital Survey and Construction Act of 1946, popularly known as the Hill-Burton Act, provided federal funding to survey and upgrade nonprofit and public hospitals. The act required, among other conditions, that hospitals accepting Hill-Burton funding provide a “reasonable volume” of charity care. Hill-Burton was landmark legislation and its impact especially profound in constructing hospitals in communities of under 10,000 in population.⁸⁸ The act contributed to a second wave of hospital construction and expansion across the country during the 1950s and 1960s.

The local Hill-Burton report recommended an additional 1,300 beds for Indianapolis to be considered adequate in terms of licensed beds per capita. Indiana’s hospital and civic leaders, however, were reticent to accept federal funding and what they perceived as attendant government control. The city instead formed the Indianapolis Hospital Development Association (IHDA) and ran a successful \$12 million capital campaign, which equated to about 700 additional beds to be shared among the private hospitals.⁸⁹ Institutions had to agree to accept African Americans in order to secure IHDA funds, so all area hospitals, no longer just City Hospital, began to admit black patients in the 1950s.⁹⁰ Private hospitals throughout the city expanded during the 1950s and 1960s as a result of the capital campaign, and the new physician-owned Winona Memorial Hospital (1956-2004) and Community Hospital (1956) also began operations. As other hospitals expanded, City Hospital’s name changed to Indianapolis General Hospital in 1947, then to Marion County General Hospital in 1951, as its service territory extended to the entire county. General Hospital thus took on additional communities unable to pay for care without concurrently increasing its capacity.⁹¹

⁸⁸Beatrix Hoffman, “Emergency Rooms: The Reluctant Safety Net,” in *History & Health Policy in the United States*, Rosemary Stevens, Charles E. Rosenberg, and Lawton R. Burns, eds. (New Brunswick, N.J., 2006), 263; and Stevens, *In Sickness and in Wealth*, 216-18.

⁸⁹Jack Killen, “Five Indianapolis Hospitals Succeed in \$12,000,000 Development Campaign,” *The American City* 69 (March 1954), 125-27; Leary and Reed, *The History of Methodist Hospital of Indiana*, 103-104; and David M. Leonard, “The History of Indiana Hospital Capital Financing,” in Indiana Hospital Association, *Hoosier Hospital Economics and Public Policy: A Collection of Historical Essays* (Indianapolis, Ind., 1995), 4-6.

⁹⁰General Hospital estimated the city’s African American population at 75,000 out of 427,000 in 1950. Annual Report of Indianapolis General Hospital 1950, folder 1, box 2, Marion County General Hospital Collection.

⁹¹General Hospital planned a one-hundred-bed psychiatric unit, but the Indiana State Supreme Court ruled against the bond issue that would have funded the expansion. “General Hospital

During his term, Myers made accreditation a priority. By 1947, the hospital had received accreditation from the American College of Surgeons, the American Hospital Association, the State Board of Health, the State Board of Nursing Association, and various specialty boards. The hospital struggled to handle the double-edged sword that such recognition presented. Certifications presumably enhanced the hospital's image and credibility, but could mean crushing amounts of bureaucratic red tape. Myers bemoaned that the hospital's operation had become "extremely difficult and involved" in the wake of so many compliance initiatives.⁹² At roughly the same time, a report issued by a consortium of public and private health agencies found, similarly to the local Hill-Burton report, that the city suffered from unmet healthcare needs; the committee recommended consolidated oversight of both the Indianapolis and Marion County health departments as well as of the city's poorhouse. In response, a new special-purpose municipal corporation, Health and Hospital Corporation of Marion County (H&H), assumed governance of the hospital in 1951. Myers, who became chairman of H&H on his retirement as hospital superintendent in 1952, soon clashed over several issues with his successor Dr. Robert Lowe, who was appointed in 1955. The conflict culminated in H&H firing Lowe in 1956.⁹³

The combination of Lowe's termination, the hospital's recently increased patient load, and years of chronic inadequate funding and staffing brought General Hospital to the brink of disaster. Local newspapers, long critical of patient care at General Hospital, had a field day; the *Indianapolis Times* alone ran a fourteen-part exposé on the, at times, inadequate patient care at the hospital.⁹⁴

outgrowth of 'Dunlap's Folly,'" *Indianapolis News*, September 26, 1949, folder 11, box 1, Marion County General Hospital Collection.

⁹²Annual Report of the City Hospital Indianapolis 1947, folder 1, box 2, Marion County General Hospital Collection. The American College of Surgeons inspected hospitals from 1918 to 1952, when the Joint Commission on Accreditation of Health Care Organizations assumed accreditation. City Hospital became ACS accredited in the 1920s and improved its rating from "C" to "A+" between 1922 and 1925. "City Hospital Among Foremost of Nation," *Indianapolis News*, November 25, 1925, folder 11, box 1, Marion County General Hospital Collection; and Stevens, *In Sickness and in Wealth*, 114-16.

⁹³Hale, *Caring for the Community*, 93.

⁹⁴Annual Report of the City Hospital Indianapolis 1953, folder 5, box 2, Marion County General Hospital Collection; "City Hospital will Recruit More Nurses," folder 19, box 1, Marion County General Hospital Collection.

The Indianapolis medical community flew into a rage. Seeking to understand the problem from the physician's point of view, the Indianapolis Medical Society created a fifteen-member citizens committee to investigate not only Lowe's firing but "the entire physical-medical-business setup" of the hospital.⁹⁵ The committee's eleven-page report, released in May 1957, found, according to the *Times*, that the H&H board had "shirked its duty to the taxpayers and the patients and staff."⁹⁶ The *News* noted the committee's call for a "realistic budget" as the most important step in correcting "numerous and serious deficiencies."⁹⁷ The report probably surprised no one familiar with the hospital's operations, mission, and history. Its most positive finding was that physician care of patients was good. Insufficient operating funds over the years had, however, created deficiencies in virtually every other area: nursing staff, housekeeping staff, inpatient ward and outpatient clinic space, facilities, diagnostic and treatment equipment, and supplies. The committee benchmarked General Hospital's operating costs against thirteen others (which remained unnamed) and concluded that its budget was insufficient (see Table 1). The committee made eleven recommendations to the hospital and H&H, ranging from the damning "follow JCAH standards" to "establish a realistic operating budget."⁹⁸

Dr. Arvine Popplewell left his position at Sunnyside Sanatorium to become General Hospital's medical director in 1956.⁹⁹ Popplewell garnered more balanced press coverage under the banner of the "new look" and new administration that he brought to his post. Patient testimonials, reported in local newspaper accounts, reinforced the sound medical care they received despite unattractive surroundings. A *Times* reporter spoke to one elderly man "in a crowded open ward" who "pointed to walls where paint was chipped and cracked and to the uncurtained windows."

⁹⁵"General Hospital to be Probed by New Citizens Committee," *Indianapolis Times*, October 15, 1956, folder 11, box 1, Marion County General Hospital Collection.

⁹⁶"Report Criticizes Old Hospital Board," *Indianapolis Times*, May 8, 1957, folder 11, box 1, Marion County General Hospital Collection.

⁹⁷"Citizens Group Says Remedy in Budget," *Indianapolis Star*, May 8, 1957.

⁹⁸Report on the Indianapolis General Hospital May 6, 1957, Citizens Committee Appointed by the Indianapolis Medical Society, folder 10, box 1, Marion County General Hospital Collection.

⁹⁹Myers and the H&H board presumably handpicked Popplewell to be superintendent; Popplewell served as medical director until 1975. "Sunnyside Chief to Head City Hospital," *Indianapolis Star*, August 28, 1956, Bound Volume 2125, Marion County General Hospital Collection.

Table 1
Cost Per Patient Per Day Comparison, Selected Years

Year	Hospital(s)	Cost Per Patient Per Day
1945	Indianapolis City Hospital ¹	\$5.36
1950	Indianapolis City Hospital	8.85
1955	Indianapolis City Hospital	13.43
1960	Indianapolis City Hospital ²	25.85
1955	Average, all U.S. state and local government hospitals ³	\$20.62
1950	Average, all U.S. acute-care hospitals ⁴	\$15.62
1960	Average, all U.S. acute-care hospitals	32.23
1960	Average, seven Indianapolis hospitals ²	34.11
Sources: ¹ Annual Report of the City Hospital Indianapolis 1945, 1950, 1955, folder 19, box 1, and folders 3 and 5, box 2, Marion County General Hospital Collection; ² "Record High Hospital Costs," <i>Indianapolis Times</i> August 5, 1962, Bound Volume 2590, Marion County General Hospital Collection; ³ Dowling, <i>City Hospitals</i> , 150; ⁴ Stevens, <i>In Sickness and in Wealth</i> , 263.		

The patient commented: "It isn't pretty to look at but I'm getting well, and that's what matters."¹⁰⁰

Other features emphasized the evolving role of the emergency department and ambulance services, distinguishing services of City Hospital that could benefit rich and poor alike.

Building on the citizen committee's recommendations, Popplewell undertook a protracted drive to secure funding to improve and expand the hospital. Myers had proposed a \$16 million building program in 1944; the project had remained on the drawing board ever since. Eli Lilly and Company announced a \$4 million lead gift, but taxpayers' groups repeatedly blocked bond issues that would have enabled the project to move forward. Members of the citizens committee engaged the media to drum up public interest, suggesting that other area hospitals relied on General Hospital to serve the indigent. "Marion County General *must* either expand or modernize or face loss of its accreditation," warned an op-ed in the *Indianapolis Star*, "because of crowded, outmoded and inadequate facilities." The worst case, abandonment of

¹⁰⁰Jeane Jones Jell, "A City Within a City," *Indianapolis Times*, April 23, 1957, Bound Volume 2126, Marion County General Hospital Collection.



Children's Ward Christmas, 1950s. The 1913 Burdsal bequest gave City Hospital the resources to open dedicated children's wards, by then commonplace among modern hospitals.

Courtesy, Indiana Historical Society, M0430

the hospital altogether, "would throw an insurmountable burden on the city's private hospitals that might well result in medical chaos for Marion County."¹⁰¹

The citizens committee published its own pamphlet, "Your Conscience Must Help Decide: The Crisis Facing Marion County General Hospital," to make the case for public support for the building program. The pamphlet brandished photographs of antiquated equipment, unsafe high-traffic areas, and the tragic conditions of psychiatric patients in rooms that resembled prison cells. "For conscientious

¹⁰¹"Keep the Heart Beating," *Indianapolis Star*, January 13, 1964, folder 13, box 1, Marion County General Hospital Collection.

citizens,” it admonished, “the course is clear.”¹⁰² The *Indianapolis News* reinforced the guilty-conscience theme. It reminded citizens that only 15 percent of General’s patients could afford to pay for care and chastised those in the city who objected to the bond issue: “General Hospital . . . is a reflection of the conscience of the community. And, like other consciences, it can be troublesome.”¹⁰³ An *Indianapolis Star Magazine* feature captured perfectly the dual core values in philanthropy’s history—compassion for fellow humans and duty to community—and appealed to residents’ self-interest:

Even if you never set foot in Marion County General Hospital’s vast outpatient department, it’s still an important service to you. It helps keep a lot of your fellow citizens healthy, it helps keep them able to work, to attend schools, to care for their families. So, aside from a purely humanitarian aspect, the service means dollars and cents in wages, taxes, a more healthy, prosperous community.¹⁰⁴

As the deluge of public relations continued, the project finally proceeded in 1966 after \$3 million of Hill-Burton funding tipped the scales. Nationally, philanthropy provided the major source of funds for non-profit hospitals while municipal bond issues underwrote the lion’s share of public construction projects. Locally, philanthropy accounted for a remarkable 25 percent of Marion County General Hospital’s 1960s construction costs, compared to a national average of less than 1 percent (see Table 2).¹⁰⁵ The new 538-bed, seven-story Myers Wing incorporated all the Sunnyside Sanitarium beds and replaced open patient wards.¹⁰⁶ Along with the Midtown Community Mental Health Center and an F wing

¹⁰²The Citizens Committee for Marion County General Hospital, “Your Conscience Must Help Decide: The Crisis Facing Marion County General Hospital,” Bound Volume 2134, Marion County General Hospital Collection.

¹⁰³“Your General Hospital,” *Indianapolis News*, January 1, 1963, Bound Volume 2128, Marion County General Hospital Collection.

¹⁰⁴“A Broader Program to Serve More People,” *Indianapolis Star Magazine*, March 25, 1962, Bound Volume 2590, Marion County General Hospital Collection.

¹⁰⁵Stevens, *In Sickness and in Wealth*, 295.

¹⁰⁶Sunnyside Sanatarium closed in 1969 and was razed in 1977. Hale, *Caring for the Community*, 107-12.

Table 2
Funding Sources for Hospital Construction, 1960s

Source	Percentage of Funds		
	Voluntary Nonprofit ¹	State and Local Government ¹	Marion County General Hospital ²
Hill-Burton	19.2%	23.4%	18.8%
Bond Indebtedness	3.2%	56.9%	56.2%
Long-term Borrowing	21.0%	8.1%	-
Private Philanthropy	40.7%	0.9%	25.0%
Hospital Reserves	11.1%	6.8%	-
Other	4.8%	3.9%	-
Total	100.0%	100.0%	100.0%
Sources: ¹ Stevens, <i>In Sickness and in Wealth</i> , 295; ² MCGH figures are for Myers Building construction (\$16mm). A mix of Hill-Burton, bond indebtedness, and philanthropy financed Midtown Mental Health Center and Regenstrief Health Center. Hale, <i>Caring for the Community</i> , 107-119.			

emergency room complex, the new structure opened in stages between 1968 and 1969. The project had taken twenty-five years to build.

General Hospital's newest phase of construction updated facilities but did not increase capacity, which had remained at 726 beds since 1939. During this time, local religious and private nonprofit hospitals undertook their own construction projects, eclipsing the public hospital in size. Methodist, St. Vincent's, St. Francis, Community, and the Indiana University Medical Center, with nearly five thousand beds in the aggregate, together dwarfed Marion County General Hospital and gave paying patients a myriad of hospitals from which to choose.

Medicare and Medicaid, designed to cover health care costs for the elderly and the indigent respectively, began in 1965. These federal programs filled gaps in health insurance coverage that neither Blue Cross Blue Shield associations nor employer-based commercial plans addressed. All the payors—Medicare, Medicaid, Blue Cross, and commercial insurance—became cost-reimbursement systems. Philanthropy, debt, and Hill-Burton drove hospital expansion, and federal programs now created a new pipeline of guaranteed payment for services rendered. Hospital spending increased dramatically, and medical costs skyrocketed. But Medicare benefited private hospitals more quickly and materially than Medicaid-funded public hospitals. The gaps between public and private institutions—in terms of their reputation, clientele, facilities, and funding—grew into chasms, as a 1973 national hospital conference noted:

The poor who get care do not like the public hospitals . . . city councils who have to raise taxes to support them do not like them; the people in general do not like them because they are stigmatized as providers of second class medicine; taxpayers resent their taxes going into facilities for the poor; and health planners want them to go away.¹⁰⁷

Popplewell hoped Medicare would allow General Hospital to draw more non-indigent patients, but it remained a predominantly charity institution, with only a modest base of paying or insured patients. Tax appropriations remained its largest continuous source of funds; municipal bonds, when authorized and issued, paid for capital improvements. In 1975, H&H reported the hospital's patient mix as 57.6 percent indigent, 19.4 percent Medicaid, 13.9 percent Medicare, and 9.1 percent Blue Cross.¹⁰⁸

General Hospital undertook several initiatives to combat its negative charity-hospital image. St. Margaret's Guild retained artists to transform the children's ward, as it had done in the Burdsal wards years ago. The pediatrics director described the metamorphosis from an old open ward, "so terrible nobody wanted to leave children here," to bright and cheerful semi-private rooms decorated with colorful murals of rainbows, suns, and stars.¹⁰⁹ General also stepped up its volunteer recognition program. In another public relations move, the hospital in 1975 took on a new name, Wishard Memorial Hospital, in honor of its pioneering superintendent William Niles Wishard.¹¹⁰ The hospital hoped to capital-

¹⁰⁷1972 Conference sponsored by the Council of Urban Health Providers and the Health Services and Mental Health Administration, as quoted in Dowling, *City Hospitals*, 173-74.

¹⁰⁸In 1966 General Hospital qualified to treat Medicare patients. Federal and state governments shared Medicaid reimbursement, so cost-sharing schemes had to be designed; Indiana's Medicaid program began in 1969. Annual Report of Health and Hospital Corporation 1976, folder 6, box 2, Marion County General Hospital Collection. The Indianapolis-Marion County governmental reorganization, known as Unigov, effective January 1, 1970, was virtually a non-event for H&H. H&H was subsumed under the Indiana Department of Public Health but has retained considerable independence. Neither Wishard's service territory nor tax base changed significantly. Bodenhamer and Barrows, eds., *The Encyclopedia of Indianapolis*, 666, 1359-61.

¹⁰⁹"Murals to Highlight New Décor: Guild's Donation Renovates Children's Ward," *Indianapolis Star*, January 1, 1976, folder 13, box 1, Marion County General Hospital Collection.

¹¹⁰Dr. William Niles Wishard had gone on to practice genito-urological surgery, teach medicine at Indiana University, serve on the State Board of Health, author the legislation that created the State Board of Medical Registration and Examination, and serve as Marion County's deputy

ize on this halo effect around its historic leader and, as the *Indianapolis Star* phrased it, to negate its “last resort” image.¹¹¹ H&H’s annual reports shifted in tone toward salesmanship, almost pleading with donors to remember that “Wishard is striving to overcome the *perception* and *attitude* that, as a public hospital, its purpose is to serve solely the indigent and that it is a health facility of last resort. These views are inaccurate and inappropriate.”¹¹² H&H stressed Wishard’s role as a provider of all forms of medical treatment, a community resource, and a collaborative partner with other hospitals in the city.

The hospital’s name change coincided with another initiative, as well: a revised IUSM contract in which the school assumed management of Wishard’s patient care, teaching, and research. IUSM took on this enhanced capacity when beds lay empty, several units of the hospital had to be closed, staff was inadequate, accreditation was at risk, and revenues were, as always, inadequate. The medical students benefited from the full range of patients, and the school improved operations and accreditation, generating increased revenue through patient referrals.¹¹³

In 1975, too, Wishard opened the Regenstrief Health Center, underwritten in part by a lead gift from the Regenstrief Foundation, to replace the hospital’s 1929 outpatient A wing. The A wing, built when outpatients had numbered almost five hundred a day, could scarcely accommodate patient demand when it was new. By the 1970s, outpatient visits ran close to seven hundred people daily. Patients crowded into long, unadorned hallways lined with wooden benches and waited for hours for appointments, confirming the classic dismal picture of the public hospital.¹¹⁴ In 1978, the emergency department moved into the new Dunlap Building, which connected Regenstrief with the Myers Building, literally bridging the outpatient and inpatient facilities.

coroner. He received numerous awards and honorary degrees for his contributions to the medical community. William Niles Wishard, Jr., “Biography: Dr. William Niles Wishard, Sr.,” *Urological Survey* 12, no. 3 (June 1962), 79-83.

¹¹¹“Wishard Hoping to Overcome ‘Last Resort’ Image in 2 Years,” *Indianapolis Star*, October 24, 1976, folder 13, box 1, Marion County General Hospital Collection.

¹¹²Emphasis in original. Annual Report of Health and Hospital Corporation 1976, folder 6, box 2, Marion County General Hospital Collection.

¹¹³In 1983, IUSM fully assumed the hospital’s business and medical management. Hale, *Caring for the Community*, 124-29.

¹¹⁴Hale, *Caring for the Community*, 116-17.

Consistent with national trends, Wishard's emergency department had risen in usage, receiving by the 1970s close to two hundred patients daily. Emergency and trauma expertise were the hospital's signature features; it was already a designated major trauma center for the state and would later become the first Level I Trauma Center in Indiana.¹¹⁵

Wishard, along with every hospital in the U.S., faced further financial distress in the 1980s. In an attempt to control soaring healthcare costs, Congress passed another landmark piece of healthcare legislation, the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). The act moved hospitals from retrospective to prospective cost reimbursement. Hospitals could no longer bill payers their actual expenditures for patient care, but had to seek reimbursement based on a fixed schedule of 467 disease categories known as diagnosis-related groups (DRGs). DRGs presumed that patients in each group could be treated in relatively homogeneous fashion with respect to hospital labor, medical technology, and length of stay.¹¹⁶ Suddenly hospitals were motivated to treat patients and release them quickly. After decades of striving to keep beds full, they now found financial success in empty beds. TEFRA, together with Medicare's Prospective Payment System, wreaked such havoc on hospitals' financial stability that many institutions had no choice but to close. After the expanded capacity created by the building boomlet of the 1960s, the drastic change in cost reimbursement methodology created a glut of licensed hospital beds virtually overnight. Almost five hundred U.S. hospitals closed between 1984 and 1997. More rural than urban hospitals closed, and more proprietary than nonprofit or public hospitals closed. Moreover, 190 mergers involving 450 hospitals occurred during this time period, and many more institutions reduced services such as emergency departments, staff, or both.¹¹⁷ Most hospitals,

¹¹⁵In the 1950s, emergency departments rose in usage due to the increase in auto accidents, prestige of emergency treatment, and patients' desire for immediate access to medical care even for non-emergent situations. A 1960 study of Methodist Hospital of Indiana revealed that only 15 percent of emergency department visits were truly urgent. Hoffman, "Emergency Rooms," 254-56; Margaret Duncan, "How to Evaluate Emergency Room Care," *Modern Hospital* 99, no. 5 (November 1962), 103-106.

¹¹⁶Indiana Medicaid converted to DRG reimbursement in 1994. William S. Hall, "Landmark Change: Rate Review to Managed Care," in Indiana Hospital Association, *Hoosier Hospital Economics and Public Policy*, 99; Stevens, *In Sickness and in Wealth*, 322-23.

¹¹⁷1500 emergency departments closed between 1988 and 1999. Lynne D. Richardson, Brent R. Asplin, and Robert A. Lowe, "Emergency Department Crowding as a Health Policy Issue: Past Development, Future Directions," *Annals of Emergency Medicine* 40, no. 4 (October 2002),

including Wishard, took licensed beds out of service and inpatient capacity shrank.

During the 1990s, charity hospitals became known as safety-net hospitals. Today approximately one hundred safety-net hospitals, seventy of which are public, devote the majority of their resources to indigent care and thus provide the majority of indigent care in their respective markets.¹¹⁸ About fifty of the five hundred total safety-net hospitals have been involved in mergers.¹¹⁹ Only three of the high-resource/high-market share safety-net hospitals have closed in the last twenty years, but they have not been unscathed. Almost half of safety-net hospitals are public. Many are financially vulnerable, and their uninsured patients have greater needs.¹²⁰ One-third of the nation's trauma centers—often a defining characteristic of safety-net hospitals—have closed in the past twenty years.¹²¹ When safety-net hospitals do close, the resulting domino effect can spell disaster. When Washington, D.C.'s General Hospital closed, other hospitals were so overrun with indigent patients that they closed as well. Wishard represents the quintessential safety-net, one of only one hundred U.S. hospitals characterized by both high resources and high market share. During the 1990s, for instance, between 40 and

389; Deborah Williams, Jack Hadley, and Julian Pettengill, "Profits, Community Role, and Hospital Closure: An Urban and Rural Analysis," *Medical Care* 30, no. 2 (February 1992), 174-87; Stephen Zuckerman, et al., "How Did Safety-Net Hospitals Cope in the 1990s?" *Health Affairs* 20, no. 4 (2001), 159.

¹¹⁸Researchers often use the Institute of Medicine's safety-net definition, which includes providers that deliver a significant level of health care to the uninsured, Medicaid, and vulnerable populations. Another four hundred hospitals are either high resource burden or high market share, but not both. Zuckerman, "How Did Safety-Net Hospitals Cope," 160.

¹¹⁹Gloria J. Bazzoli, et al., "An Update On Safety-Net Hospitals: Coping With the Late 1990s and Early 2000s," *Health Affairs* 24, no. 4 (July/August 2005), 1051; Zuckerman, "How Did Safety-Net Hospitals Cope," 162.

¹²⁰U.S. Department of Health & Human Services Agency for Health Care, "Serving the Uninsured: Safety-Net Hospitals, 2003," online at <http://archive.ahrq.gov/data/hcup/factbk8/fact bk8b.htm>.

¹²¹339 of 1,125 trauma centers closed between 1990 and 2005. Renee Yuen-Jan Hsia and Yu-Chu Shen, "Rising Closures of Hospital Trauma Centers Disproportionately Burden Vulnerable Populations," *Health Affairs* 30, no. 10 (2011), 1912. Trauma centers are more than emergency departments. Trauma systems require coordinated medical teams including trauma surgeons, burn care capability, communication, and transportation. As of 2005, 190 of approximately 700 trauma centers maintain the Level I designation. Howard R. Champion, Marcia S. Mabey, and J. Wayne Meredith, "The State of US Trauma Systems: Public Perceptions Versus Reality," *Journal of the American College of Surgeons* 203, no. 6 (December 2006), 953-59.

50 percent of Wishard's annual budget went to uncompensated care, compared to the national average of 4 to 7 percent of uncompensated care reported by nonprofit hospitals.¹²²

Wishard has survived. Today it is one of the five largest safety-net hospitals in the country, with one of only two adult Level I Trauma Centers in Indiana and state-of-the-art burn treatment expertise.¹²³ After enduring a 150-year identity crisis as Indianapolis's charity hospital, Wishard in 2009 conducted a masterful piece of public relations that led to voters' approval of a new hospital. The "New Wishard" campaign reprised, in many ways, the citizens' committee approach from fifty years ago. This time it brilliantly capitalized on the hospital's role as the city's safety net, champion, and advocate for the indigent and the underserved. It hit head-on the declining tax appropriations that had created the current abysmal conditions and high operating costs (see Figure 1), and it solemnly warned that if Wishard closed, thousands of indigent patients would engulf the other area hospitals.

As a result Indianapolis will for the first time in its history erect a new, modern, public hospital—not just an expansion or addition to the present decaying polyglot of buildings. The "New Wishard" campaign promises that public funds will finance only a small portion of the new construction, so philanthropy will necessarily play a key role. Sidney and Lois Eskenazi's lead gift of \$40 million represents the largest personal gift ever made to a public hospital in the U.S.¹²⁴ The "New Wishard" is currently projected to emerge as Eskenazi Health in 2014.

¹²²Comprehensive Annual Financial Report of Health and Hospital Corporation of Marion County 2004-2010, online at http://www.hhcorp.org/cafr_budgets.htm; and IRS survey of 487 nonprofit hospitals, Hospitals and Community Benefit - Interim Report, online at <http://www.irs.gov/charities/charitable/article/0,,id=172267,00.html>.

¹²³The Richard M. Fairbanks Foundation donated \$6 million to the burn center, Wishard's largest gift as of 2003. Wishard Health Services, "Our Next 150 Years: An Open Letter to the Community," July 17, 2009, 1, online at www.wishardfacts.org.

¹²⁴John Russell, "Initial Rejection Leads to \$40M Gift," *Indianapolis Star*, June 22, 2011. The author researched the foundation or endowment sizes of the ten largest public hospitals in the U.S. and all the public hospitals in the Midwest to verify this statement. Atlanta's public hospital, Grady Health System, transferred from governmental control to 501c3 status in 2008. Grady received a \$200 million grant from the Robert W. Woodruff Foundation as part of the privatization scheme. Woodruff's grant is obviously much larger than Wishard's Eskenazi gift but was made to a private, nonprofit hospital. None of the other ten largest public health systems appear to have ever received a gift or grant of the magnitude of the Eskenazi gift. 25 Largest Public Hospitals in America, www.beckershospitalreview.com; National Association of

Figure 1
Wishard Health Services, Tax Appropriation as Percentage of Operating Expenses



Source: <http://www.wishardfacts.org>

An interesting admixture of taxes, grants, bonds, fees, and philanthropic donations has funded Wishard Health Services, Indianapolis’s charity hospital, over its 150-year history. Even as federal funds flowed to Wishard in the forms of WPA, PWA, Hill-Burton, Medicare, and Medicaid, philanthropy has filled in the gaps, funding significant hospital improvements and culminating in the Eskenazi gift that will give the hospital its new name in 2014. Private philanthropy has funded many nonprofit and proprietary hospitals in the U.S., but the continued strong presence of philanthropy at a public charity hospital is unique. Philanthropy helped launch Indianapolis’s denominational, nonprofit, and university hospitals, but their strong payor bases have sustained and grown them since. Remarkably, philanthropy has helped keep a major city’s safety-net public hospital viable, allowing the “New Wishard” to

Public Hospitals and Health Systems, “America’s Public Hospital and Health Systems, 2003,” <http://www.naph.org/Main-Menu-Category/Publications/Safety-Net-Financing/survey2003.aspx?FT=.pdf>; Grady History, www.gradyhealth.org/history.html; and www.guidestar.org.

continue to provide the majority of Indianapolis's charity healthcare. Many stakeholders have benefited from the tradition of philanthropic giving at Wishard: the greater Indianapolis community, other area hospitals, medical staff and students, and, most of all, the patients who flock there each day in search of care.

