Changing Composition of Voluntary Hospital Boards—

An Inevitable Prospect for the 1970's

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In bygone days, to question a person's credentials for membership on the board of a nonprofit, voluntary hospital would have been deemed presumptuous. The conventional qualifications for a seat on almost any hospital board were (*a*) the generosity of one's periodic donations to the institution, (*b*) the notability of one's social rank, and (*c*) sometimes both. Generosity and rank had a reciprocity of cause and effect. In a mobile society lacking aristocratic lineage, contributions to charities were obligatory to achieve and maintain rank —and the size and frequency of one's donations were expected to be in keeping with one's alleged financial worth.

Hospital boards comprised the rich and the generous, if not precisely the well born. The confluence of such qualities generally connoted skill in amassing and retaining money. In practice, then, ability was a qualification for membership. Rich men who were willing to serve on hospital boards were rarely talentless fops, dependent exclusively on the interest payments from patrimonies for their economic survival and aggrandizement. They brought to every hospital board meeting the equivalent of thousands of dollars worth of gratis consultations in business, law, investment, and government, and the voluntary hospitals prospered.

In the community's pecking order of private eleemosynary agencies, the local hospital board occupied the pinnacle. Membership remained economically patrician and almost exclusively white Anglo-Saxon Protestant, except for an occasional house Catholic or Jew. The atmosphere was clubby. Black membership was unknown. The board was self-perpetuating. New recruits joined only after undergoing discreet screening and clearance by the veteran members for suitability and potential usefulness. The talents and connections requisite to deliberate hospital policy were believed to reside preferentially in successful bankers, attorneys, accountants, stockbrokers, and

businessmen. And the composition of the board reflected this notion.

A seat on the hospital board conferred prestige, but just as often it confirmed and symbolized a distinction the member already possessed. With absolute sincerity, most members viewed their board work as playing out their self-perceived service roles for the community, and especially for the less fortunate. Moreover, some philanthropists among the members made the board virtually their entire vocation, to the neglect of their private affairs. At the end of the fiscal year, the hospital administrator would politely call the institution's deficit to the attention of the board, and with some good-natured groaning the wealthier board members would write checks to liquidate it.

Decline of Philanthropic Percentage

The halcyon days are over! Economic and social changes are intruding in this somewhat idealized picture of the hospital board. The percentage of the operating hospital budget that is supported by private philanthropy has atrophied until it is about 2 to 4 percent in many of the nation's formally voluntary institutions. In New York City the tax-supported Medicaid program accounts for roughly 25 percent of inpatient days at voluntary hospitals and 50 percent of outpatient department visits. Medicare funds represent another 30 percent of inpatient days. Most of the remaining hospitalized patients finance their care through Blue Cross-Blue Shield, the Health Insurance Plan, or commercial insurance. What this means is that 40 to 60 percent of today's operating budget of the voluntary hospital is derived from governmental funding, and most of the rest comes from third-party payment. Philanthropy is a relatively minor source of financing in the operating expenses of today's voluntary hospital.

To a significant extent, capital construction or the expansion of physical facilities of voluntary hospitals continues to depend on private contributions. A decline of philanthropic funding could spell disaster in the construction of facilities; but here, too, the funds to build additional wings, laboratories, and equipment increasingly originate in governmental agencies.

This is not startling news to hospital administrators and informed hospital board members, but the average layman is innocent. He continues to believe that the much-publicized annual hospital fund drive actually supports a substantial portion of the hospital's operating budget. In fact, the fund provides only a fraction of 1 percent of the hospital's operating budget—whatever its usefulness may be in fostering public interest in intramural health care services.

In short, the extraordinary shifts in sources of hospital funding, particularly for the operating budget of the institution, have rendered private philanthropy less plausible as a major criterion for board membership. Prevalent attitudes also are inhospitable to the notion that social status, in the traditional sense, is relevant to the question of qualifications for board membership. Noblesse oblige as an operative premise provokes annoyance if not outright anger. The middle and lower socioeconomic classes are similarly impatient with any hint of condescension or aristocratic trusteeship. Clearly, the assumptions about board membership deserve reappraisal by thoughtful observers of the hospital system.

Declining Generosity

"People don't give the way they used to." The absolute figures may belie this, but today's degree of personal sacrifice in making contributions is not as it once was in an idealized past with its religious ethic, its greater propensity for tithing, and its dependence on personal rather than governmental benevolence.

In health services some of this decline may be due to the wholehearted adoption of the principle that basic social services should cease to depend on the inconstancies of altruism. If health care is no longer a "privilege" but rather a "right," or less emotively a "social utility," then Government as guardian of both the rights and utilities of its citizens is obliged to see to it that the status of a person's private finances does not block his access to this social utility. The rationale for tax support of health care becomes irrefutable once the initial premise is granted.

In a world where the relatively affluent citizen characterizes the current level of taxation for subsidization of social services as just short of confiscatory, to constrain one's generosity to private hospitals is a logical response. The conscience is clear. Hospitals have evolved as a responsibility of society and society's taxation rather than of private philanthropy.

Decline of Religio-Ethnic Hospitals

Implicit in the Judeo-Christian ethic has been the religious imperative to serve the community. Service includes the provision of health care. In-

deed, in the Western World many of the most distinguished hospitals were developed under the auspices of the church. But the historical raison d'etre of religio-ethnic hospitals has derived from other considerations as well.

The religio-ethnic hospitals ministered predominantly to the physical and emotional needs of patients within a culturally compatible milieu. The intragroup rapport between the patient and the professional staff, because of their common Weltanschauung, was expected to promote better care. The Italian, French, Swedish, or Jewish patient presumably felt more comfortable with health care workers who conversed in his own idiom. The Catholic, Protestant, or Jewish patient was not subjected to the disturbing symbols of an alien creed. Patients had convenient access to their own clergy and chapels of their own faith. The patient was at cultural ease. This consideration seemed particularly salient for immigrant groups, who considered their stay at the hospital to be more than an encounter with impersonal cosmopolitan science.

For professionals, there were personal considerations as well. Religo-ethnic hospitals provided indispensable internship and residency training as well as staff appointments, opportunities, and jobs for physicians who were routinely rejected elsewhere because of restrictive or exclusive religious and ethnic quotas. In the memory of most New York City physicians certain hospitals, as a matter of policy, excluded Catholic and Jewish physicians. Black interns or residents were as rare as Tibetans in the wards of New York City voluntary hospitals. In some hospitals a bizarre mosaic of acceptance and rejection prevailed. These hospitals customarily accepted a limited number from "undesirable" ethnic groups for specific residencies like internal medicine or pediatrics, but rigidly excluded the same physicians from surgery or radiology. Nor have such policies completely vanished in some New York City hospitals. Predictably, the reasons mentioned for establishing and maintaining religio-ethnic hospitals have become less and less important as patients have become acculturated and hospital employment policies have been liberalized.

Cultural Assimilation and Assertiveness

A confluence of social, cultural, and economic changes within religio-ethnic groups is increasingly having its fiscal impact on voluntary hospitals. There are symptoms that today's priorities in allocating funds of the organized religious charities may shift to educational agencies at the expense of hospitals, social services, and recreation.

A few generations ago immigrants and their children were consumed with an obsession to Americanize themselves; that is, to assimilate maximally to the "numerically dominant and allegedly superior culture." This meant jettisoning the languages and customs of the old country. Sometimes it meant religious apostasy, and almost always it meant some protestantization of religious form.

In this generation the refining process continues, but active cultural self-immolation has been supplanted by ethnic and religious self-awareness. Black nationalism is the most recently publicized manifestation of the phenomenon. Attempts by activists to identify with the cultural values of their grandparents and great-grandparents are characteristic of many ethnic groups today. A recent augury is the sit-in at the Federation of Jewish Philanthropies by Jewish college students, who demanded that Jewish philanthropic funds be used predominantly for salaries of teachers and operating expenses of schools rather than for hospitals and recreational activities. A few generations ago a demonstration from such a secularistically inclined youth would have been inconceivable. The Black-studies phenomenon of ethnic particularism has its growing counterpart elsewhere.

Paradoxically, the antithetical tendencies of cultural assimilation and cultural assertiveness are simultaneously allied to diminish religio-ethnic financial support of religio-ethnic hospitals. Why? Hospitals have always been the socially acceptable recipients of contributions by the culturally assimilated philanthropist who is hypersensitive to potential accusations of his dual cultural loyalties. Such a person unhesitatingly gives thousands of dollars to the hospital but shudders at the thought of contributing more than token sums to the cultural, educational, or proselytizing activities of his religio-ethnic group. As a philanthropy, the hospital is sanitarily nonsectarian and remains nonsuspect in the ethos of the American melting pot.

Indeed, the questions may properly be posed: What makes today's Catholic hospital Catholic? or today's Protestant hospital Protestant? or today's Jewish hospital Jewish? For spiritual succor, one can call upon the religious ministries of any of these faiths at any hospital. Often the hospital administrators do not belong to the sponsoring faith of their own institution—a sign less of ecu-

menicism than of secularization and indifferentism. The Protestant hospital generally shows no outward sign of religious sponsorship. In Catholic hospitals the nursing orders of nuns are gradually being replaced by lay nurses. At Jewish hospitals kosher food may not ordinarily be served unless specifically requested by patients, just as at any other hospital, and a Christmas tree may be on the hospital grounds at Christmas, symbolizing the demise of Jewishly particularistic features. What we view today is the consequence of at least three decades of desectarianization of the voluntary hospitals.

Today's wholly assimilated philanthropist feels less and less compulsion to defer to the ancestral memories of his partially assimilated father, so he contributes less money to the hospitals founded or supported by his immigrant and ethnically proud grandfather. For the cultural activist, on the other hand, the hospital is a trivial institutional mechanism to animate the religio-ethnic renaissance of his group. Precisely because the hospital is operationally so nonsectarian, it can count on diminishing funds for sectarian purposes. The studiously "neutral" religio-ethnic image of the voluntary hospital, in fact, fails to please either group. For the assimilationist, it is too culturally activist. For the activist, it is too culturally tepid.

Disenchantment alone is not responsible for the drop in charitable contributions. Competition has come from other attractive causes as well. Religious education, for instance, is becoming a major competitor.

The increasing laicization of the staffs of Catholic parochial schools has caused operational expenses to soar. The Catholic community faces a dilemma. Should its schools be closed, except those that can be supported by private tuition? Should the elementary parochial schools alone be closed, leaving intensive religious education to the secondary schools? In the opinion of the Church, not less but more intensive religious education is needed. Obviously, money is needed.

Nor is the educational fiscal crisis limited to the Catholic community. Since World War II, the number of Jewish elementary and high schools has veritably exploded. The number of parochial schools of Protestant denominations has likewise burgeoned, even of those sects not hitherto reputed for their support of church-sponsored religious and secular education. Costs of buildings and faculty salaries are enormous. Government may find a constitutional way to subsidize the worst financial disabilities of these schools rather than have them collapse and transfer their enormous student bodies to a faltering public school system.

It is doubtful, though, whether Government will ever assume a sufficient budgetary burden to supplant the religio-ethnic funds that are being increasingly siphoned off to education. To what extent can we attribute the growing popularity of parochial schools to the alleged decline in the quality of public education? Certainly, private nonparochial schools are growing rapidly as well. Probably several motives incite parents to transfer their children from the local public school with its publicized deficiencies to a school requiring tuition. From the hospitals' viewpoint it matters little whether the parental motivation is religious, educational, or both. The result is the same. The competition is overwhelming. Less money becomes available from hitherto reliable religious auspices.Parents seldom constitute a major source of contributions, but the schools they support become competing institutions to deflect philanthropic funds that otherwise might go to hospitals.

In short, hospitals will never again be supported substantially by private or religious charities. For better or for worse, they are now dependent on public taxation and private payments through insurance mechanisms. Under the circumstances, it is not surprising that the traditional composition of voluntary hospital boards faces a challenge. Agitation for opening up voluntary hospital board membership to the consumer is spreading rapidly in New York City and elsewhere.

Community or Consumer?

Community participation or community control? The question recurs with predictable regularity. "From now on we'll act as decision makers—and not as supplicants who offer advice that you don't have to accept. We're no longer interested in serving on advisory boards. We'll serve on policy making boards." This was the gauntlet hurled down in education. It was only a matter of time before it would be hurled down in health as well.

Whatever polemic usefulness the term "community" possesses, it is imprecise. Every person belongs to many communities at the same time, each with its own specific demands. A community is a collection of people, sorted out by geography, age, ethnicity, religion, race, sex, marital status, physiological status, occupation, economic class,

social class, education, history, ownership of a specific type of health insurance coverage, and so on. Each is a bona fide community.

The issue most salient to a person will determine what "community" he recognizes as his own at any given moment. His ethnicity directs him to pursue the strategy of one community. His bourgeois identity persuades him to follow another. His ownership of a specific type of health insurance diverts him toward a third. Somehow he must reconcile the inherent contradictions among these several communities and find "the" community, which is always hard to find. It is far easier to identify the consumer of services of a particular hospital.

This is the age of consumer interest. With respect to board membership the term "community control" is connotatively misleading; the preferable term is "consumer control." Consumerism has burgeoned among the purchasers of hard goods; the movement has attracted the fancy of purchasers of social services as well. As time goes on, it becomes impossible to deny the logic of having representatives of the actual consumers of health care services help set policy on the quality, scope, and distribution of these services. And this principle need not be based on any concept of abstract social justice. It comes from Wall Street, where the owner of 51 percent of a corporation's stock can claim and receive 51 percent of the vote at the stockholders' meeting and have 100 percent of the seats on the board. Assuming this is reasonable, then, if 2 percent of a hospital's operating budget is derived from the philanthropic class, how can one justify 75 percent representation on the board by this same philanthropic class? To classify a nonprofit voluntary hospital as private when the major portion of its operating expenses derives from public funds is poor semantics and worse taxonomy.

In the real world, it is impossible politics. Realpolitik will compel Government to nudge the private voluntary hospitals into translating the new fiscal realities into modifying the composition of their boards.

Actual consumer representation on hospital boards can persuade the people that their institution has the potential of becoming more responsive to the wishes of the people who use the services. To some extent the consumer will be right. The conscientious board of trustees may set forth policies that are unquestionably important. Nevertheless, on a day-to-day basis, the will of the managerial class within the hospitals must prevail lest administrative anarchy result. Accordingly, some disillusionment is inevitable as nonplused consumers on the boards begin to ascertain the practical limitations of their powers. Consumers on the boards will find that their attempts to introduce higher standards of quality and a greater scope of services are ultimately baffled less by managerial incompetence or malevolence than by fiscal and manpower constraints—constraints that are outside the purview or influence of the most enthusiastic boards of trustees.

Locus of Hostility

Where is the potential opposition to opening voluntary hospital board membership to consumers? Predictions are perilous, but the experience of the New York City Department of Health in implementing the Ghetto Medicine Program has already identified the most likely loci of resistance. Under New York State aid to local health departments, funds of the State and City Ghetto Medicine Program are to be allocated to ambulatory services of voluntary hospitals to cover their annual deficit. And under the Ghetto Medicine Program, the New York City Department of Health is assigned the duty of overseeing standards of quality for ambulatory services of participating voluntary hospitals. The official guidelines call for community participants serving on advisory committees on ambulatory care to work with these hospitals. The New York City Department of Health is responsible for seeing that these guidelines are obeyed. If they are violated, the department has the authority to withhold Ghetto Medicine Program moneys. Clearly, the department has persuasive fiscal leverage.

Hospital Boards

What attitudes have been discerned as the creation of consumer advisory committees has been encouraged?

Many members of voluntary hospital boards have privately acknowledged that a fundamental change of board membership is inevitable. Not all those making this admission consider the change desirable. How many do is speculative. Probably there are a few. Some board members oppose any change in membership. They threaten to resign first and withdraw financial support rather than serve on the same board with the "undesirable" consumers that they have read so much about recently. They fear for the future of the voluntary

hospital system and predict its demise if consumers participate in any large numbers on the boards. It is undeniable, they insist, that the track record of the voluntary hospitals, with all their defects, continues to surpass that of the public hospitals. Do we have the temerity, they ask, to jeopardize a system that has worked relatively well over the years? Is it worth dooming a system for the sake of democratizing hospital boards?

If elitist control is the price of excellence, they say, then so be it. The hospitals are dealing with lives and cannot afford the luxury of social experimentation to mollify leftist ideologues, whose follies in public education are there for all to see. So goes the rhetoric. Some board members are more sanguine and probably would not actively oppose consumer membership. Few, however, are enthusiastic about the anticipated development.

The most sophisticated proponents of the traditional board representation acknowledge the defects of voluntary hospitals. But, they emphasize, no board of zealots can counteract the fundamental deficiencies. Rising hospital costs are consequential to rising labor costs and inexorable inflationary pressures. The sellers' market of physicians and nurses, plus the maldistribution of health professionals, hobbles the most benign hospital administrator. Hospitals continue to depend on governmental funding to expand services, including the comprehensive, family-based, ambulatory care services that are so highly publicized, currently so fashionable, and, incidentally, so expensive. Should hospital boards become excessively politicized, these sophisticated traditionalists fear the voluntary hospitals will become extinct. The entire hospital system will become homogenized and leveled to the standards of mediocrity prevailing in the public hospitals.

The following comments of a talented hospital administrator are representative of the reservations of sophisticated opponents of consumer membership:

> There seems to be an assumption that consumer involvement in policy making decisions is going to improve the delivery of service in a voluntary hospital. I don't believe there is any basis for this presumption except for some magical notion on the part of many people in the public sector that this is desirable, good, the direction to go, etc. You well know that the responsibilities of sitting on a Board of Directors of anything presumes some degree of sophistication and knowledge, even if it is to allow the executives to "run the show." It seems to me that public pressure can be brought on an institution in a much more constructive fashion than having individuals sit on a Board of Directors where they may very well be confused and confounded by the whole process.
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> People who are on boards of hospitals are generally attuned to the complexities of operating businesses, industries, etc., and are not overwhelmed by the intricacies of the decision making process. In some cases, even the most sophisticated knowledgeable board members cannot comprehend what goes on, particularly when dealing with the financing of health care and all the forces that come to bear on this process.

A nationally known hospital administrator, regarded as a liberal by his colleagues, has commented:

> You point to the membership of hospital boards and emphasize the social and financial requirements for membership. What you leave out are the technical skills they bring with them which cannot be purchased in the market. I would not know where to get the sort of architectural supervision of our architects by Mr. X, the supervision of our general contractors by Mr. Y, the review of our house counsel's activities by the firm of Mr. Z, the supervision of our investment program by an investment committee consisting of six of the top stockbrokers in New York. I do not know what skills the middle class, the lower middle class or the lower class consumer can bring to help in the successful carrying out of the mission of the hospital which would in any way be equivalent to that which trustees, such as ours, provide. It is not just a matter of saying that clerks should smile; I want that too. I do not need consumer groups telling me that it is desirable. I need people who are skilled in the management of service industries to make suggestions regarding how such desirable ends could be obtained.

What rejoinder can there possibly be to this eloquent challenge with respect to the desirable skills of potential trustees? Simply this! The consumer of services has his unique technical expertise to contribute—the poignant insights of the consumer. No inventory of the functions of the trustees could be deemed complete today without including the use of the hospital services that provide such insight, including both use of the outpatient clinic and the luxury private room.

The Community

Here again is a spectrum of opinion. The most militant in the community demand nothing less than absolute takeover by the consumers (the poor). Their rhetoric calls for an ultimate restructuring of society, symbolized in the health services by immediate community control of the policies, programs, hiring, and purchasing practices of the hospitals.

Militants rarely use the local hospital services. They can afford to insist on their definition of

ideological purity and consistent strategy. They are frequently young, unencumbered, unmarried, and mobile. They have few loved ones who are held hostage to the system. They are indisposed to compromise their nonnegotiable demands. It is not to their interest to see a partial resolution of the problem. In their view, the more abrasive the confrontation, the more likely the radicalization of potential allies. Partial representation on the board they would characterize scornfully as "token" and a cunning means on the part of a malicious establishment to co-opt the people.

The most relevant community member is a relatively high user of ambulatory and emergency hospital services. Such a person is likely to be more responsible because his family's health depends on the availability and quality of services. Here, puristic ideology crumbles before reality.

But even moderates in the community want at least some consumer representation as a first step. Neither the militants nor the moderates are satisfied with representation on advisory committees, although some moderates are prepared to accept this step as a temporary measure to educate consumers in the intricacies of board membership.

Consumers trying to penetrate the boards do not concede that the boards are impotent. If board members derive limited gratification, consumers wonder, why do they hang on so tenaciously to membership? To the extent that boards can maneuver and accomplish anything positive, the recipients of these services want to participate in the maneuvers and in the accomplishments. Consumers suggest that the only way to impose the type of political pressure that the veterans organizations have found so effective vis-a-vis the Veterans Administration hospitals, for example, is to throw open the elitist voluntary hospital boards to widespread community representation. The diffusion of knowledge about hospital problems among a newly sensitized population of voters will compel increasing governmental support of the hospitals because it will become politically expeditious to render such support. Presumably, governmental responsiveness in health affairs will increase inversely as the naivete of the citizen diminishes.

Actually, among community activists of whatever intensity, there is no longer any serious question as to whether consumers will join hospital boards. The only questions are (*a*) how many? and (*b*) how soon? The advent can be retarded, but not permanently stopped, by an objective alliance among the most radical fringes of the communities, the most recalcitrant hospital administrators, and the most stand-pat board members.

The ensuing polemics and Byzantine maneuvering could sufficiently frighten the moderates on the boards, the hospital administrators, and the communities, causing them to conclude that a substantial change in hospital board structure is likely to attenuate the scope or quality of services to which they have become accustomed. Under such circumstances, moderates might cast their lot with those who hold that the traditional governance of the voluntary hospitals by the socioeconomic elite remains better than any alternative likely to emerge.

In the interest of democratization of the boards, a sophisticated New York City population would hardly countenance the transmutation of a Columbia Presbyterian Hospital, a St. Vincent's Hospital, or a Mt. Sinai Hospital into a Bellevue or a Kings County Hospital. If moderates should conclude that the alternatives are either (*a*) high-quality health services or (*b*) consumer control, they are likely to opt for quality. Proponents of consumer representation are obliged to convince moderates that *a* and *b* are not mutually exclusive, and moreover that *a* will result from *b*. "Localism" as a political principle has been most recently trumpeted by the Left. Historically, localism, rather than centralization, has been among the prominent traditional sancta of political conservatives. Now disenchantment with bureaucracy has transferred localism to the ideological armamentarium of liberals and ultraliberals as well. Here is a principle on which the political right and left unite.

With the authority to pay or withhold payment, the city health department has the ability to prod hospital boards and administrators. The New York City Department of Health has already shown that it has the will to use such authority. In implementing its Ghetto Medicine Program, the health department has used the power of the purse to persuade voluntary hospitals to work with community advisory committees on ambulatory care services. In contradistinction, the city has comparatively limited influence upon elements that may escalate demands and invective in an attempt to provoke confrontation. The community can "blow" it. Only the community has the means to contain its irresponsible fringe, which, perhaps

more than hospital boards and hospital administrators, can perversely retard organizational evolution toward board representation.

The New York City Department of Health is committed to preserving the voluntary hospital system. We are skeptical about the desirability of having a single auspice of hospital services. We support the coexistence of competing and complementary hospital systems. We acknowledge that the average private, voluntary, nonprofit hospital maintains higher standards of health care services than the average hospital supported primarily by taxation. All the ingredients that make this so cannot be identified. Although important, money is not the entire explanation. Under the circumstances, therefore, it would be folly to trade off any ingredient of the voluntary hospital system (for example, contributions, experience, talents, connections, and presence of the traditional philanthropic and socially elite membership of the boards) for the contributions, experience, talents, connections, and presence of the middle and lower class consumer. But no such trade-off is required or desirable. The voluntary hospital board needs all groups and can profitably encompass all groups. Sophisticated social policy will call for a comprehensive mixture of all socioeconomic classes of contributors and consumers as active participants in formulating hospital policy.

The Consumer as Monster

The term "consumer" has been defined as (*a*) one who or that which consumes and (*b*), in economics, as one who uses a commodity or service. "Consumer" is not a synonym for a poor person or a revolutionary. Most consumers of hospital services are unimpeachably bourgeois, with all the trappings, allegiances, values, and fundamental moderation typical of that class. It is the lower-middle or middle-middle class, no less than the medically indigent, that has been systematically and unwisely excluded from the decision-making activities of voluntary hospitals over the years.

A shrewd hospital leadership will no longer delay until overwhelming sociopolitical forces bludgeon it into modifying its traditional policies of board membership. To lead is to anticipate. A wise board will eschew any appearance of obstinacy or reaction and will take the initiative of inviting responsible consumers from all economic levels to serve. As a principle of the relationship between the governors and the governed in a democracy, there is nothing novel about representation. Without representation, according to the Revolutionary War slogan, taxation is tyranny. Without representation, social service has often deteriorated into complacency, inadequacy, and incompetency and, some would insist, into tyranny as well.

The hospitals had better move fast if they are to escape the trap of the radical fringe, which confidently counts on a combination of hospital stalling and inept strategy to madden the moderates and even the apathetic, who constitute the majority of the hospitals' patients, and to ultimately exasperate Government, which pays so large a percentage of the hospitals' bills. If the hospitals want vigorous, intelligent, and constructive consumers on their boards, they would be well advised to encourage recognized consumer groups to submit lists of candidates acceptable to the community. In this way both the communities and the hospital boards will participate in the selection process. The new members will learn from working with the veteran board members. Nor will the learning experience be unilateral. The veteran members will also benefit as they observe how their most morbid fears about the imminent dissolution of the voluntary hospital system are groundless as they work with actual consumers.

The doomsayers who are fearful of consumer participants might ponder this old tale:

Once a man was stumbling homeward from work through a dark forest a few moments before dawn. He looked up and immediately became sick with terror. Rapidly approaching him from the distance appeared to be the grotesque silhouette of an unearthly monster. The man was riveted to the spot, too frightened even to flee. When the ominous figure moved closer, the man discerned that the creature was of this natural world after all. It had the shape of a gigantic vicious ape. The man's superstitious terror abated somewhat, but he gave himself up for lost. As the beastly shape moved toward him, the man was slightly relieved to see that the distance and the shadows of the forest had originally distorted his vision. The creature was quite human—a man, a stranger, and probably a merciless brigand! Who else would be stealing through the forest at such an unusual hour? The man trembled and reached for his wallet, praying that the stranger would let him escape at least with his life. But when the threatening human figure emerged into the dawning light of the clearing close enough to touch, the man abruptly realized that the stranger was no brigand at all.

It was his brother whom he loved and who loved him—coming to search for him and bring him home.