Phil Brickner, M.D.
SVCMC / Community Medicine

I am the last of 3 generations of physicians in my family. My grandfather and both my parents were physicians. I went to Columbia medical school. The only time when I was not living in NY was when I was in university (Swarthmore, Pennsylvania) and when I served in the military (in Western Nebraska) for 2 years, from 1955 to 1956. There was no active internship because, frankly, I needed the income. My residency salary was not enough to support my wife and first child.

My work with "homeless" dates back to 1969. I was in the (Saint Vincent's) hospital's emergency room and ran into an intern, Arthur Kaufman. He said, "what is going on; all these 'derelicts' are coming into our emergency room DOA".

Arthur ended up in Albuquerque, a professor of Community Medicine at the University of New Mexico's School of Medicine. I said "Arthur, why don't we find out where these people are coming from"

These men – they were all men – were living at a Single Room Occupancy hotel (SRO) at 160 Bleecker Street, in Greenwich Village. The hotel was built in 1898, one of the 'Mill's hotels', inexpensive hotels built to house your working men, the working poor. Early photographs show a group of vigorous young working men in the lobby, all nicely dressed, wearing straw hats. A later picture at the same location shows older men looking sad, depleted, poorly dressed. Some were aggressively begging; they were considered a "plague" to the neighborhood.

In 1969 the building sheltered 1200 men. About 200 were elderly men on small pensions or social security income, who had lived there for decades. About 400 men were deteriorated alcoholics of middle age and about 600 men were, drug addicts, younger men, placed there by New York City following their discharge from Riker's Island jail, where many had been incarcerated for drug related crimes.

Arthurs and I went to this building and met the stereotypically venal hotel proprietor who was ripping off the system. He gave us 3 rooms to use as a clinic. The interior of the building had 8 floors divided into cubicles, each 6x8 feet. The walls of these cubicles were cinderblock, 6 feet in height; the next 2 feet were chicken wire. The entire floor was 1 big space. Each cubicle contained a tiny cot and foot locker. There was an area of group bathrooms on each floor. It was a chaotic setting. The younger, more aggressive men preyed on the sodden alcoholics and frail elderly for their few assets.

We established a free clinic (a term from the 1960's), staffed 3 days a week by physicians from St. Vincent's. We saw any man who wanted health care. The most common cause for seeing us was trauma inflicted by other person in the hotel. 18 Months after we started the clinic we found 2 buses outside the building labeled 'New York City Department of Housing and Urban Relocation'. The place was emptied out because of community opposition to the presence of these men in the Greenwich Village neighborhood. People saw the m en as "pathogens", a source of petty crime and assault in the streets and in Washington Square Park. Someone threw a table off the hotel roof and killed a pedestrian.

When the building at 160 Bleecker Street closed as an SRO hotel, it was taken over by a realtor who turned it into expensive condominiums. Despite these "improvements" there is still visible, over the pediment, chiseled in stone, the words "Mill's hotel number 1"

That's how we began. We learned fast. There were people in other settings, drop-in centers, shelters and SRO hotels, who needed help. 35 Years later our staff works in some 34 such places. This is more than a generation of work. The language used to describe the homeless has changed. In 1969 these people were considered "derelicts, a word that connotes people who are themselves at fault; they are derelict in their self-duty. The world "homeless" came later, a word that is itself suspect. In those days we did not see homeless women, children, and entire families fit into that expanding concept.

How did our homeless healthcare program evolve? How did we give comprehensive care to men and women throughout New York City? How did we sustain comprehensive care from the moment we first met these folks, or those who are willing to participate in their own healthcare, through hospitalization and post hospital care? This has not been easy. The mission of the hospital, founded by the Sisters of Charity in 1840, had as its stated purpose the care of the sick poor. The Department of Community Medicine greeted our homeless men and women with open arms.

Our care is given directly at homeless shelters, drop-in-centers and SRO's. We take healthcare to where people are located. For most sub-specialty services, for example ophthalmology or cardiology, people come to the O'Toole building at St. Vincent's (where most out-patient the clinics are situated). We also conduct, at the O'Toole building, our own (Department of Community Medicine) clinic, staffed by the same workers who see these men and women at various sites. A pervading theme in working with these people is their sense of insecurity about institutions. They fear they will be mistreated or ignored. Over 35 years the relationship between our staff and the people seeking our help has generally been cordial.

St. Vincent's has always been a poor institution. How does the institution deal with economic aspects of having so many poor patients? When hospitalized all of our patients are provided with hospital Medicaid, which covers the cost of their care. For clinic visits, the situation is different. For the past 8 years the NY State Department of Health has allowed us to bill Medicaid under a regulation entitled 'Part time clinic', at some of our on-site clinics. This applies only to those covered by Medicaid. Many people don't have Medicaid. They are far under the system's radar. Many are illegal immigrants. We do not question their status in providing everyone with the same care.

We have over 100 employees in the department, health care workers (including nurses, physicians, social workers, nurse practitioners, substance abuse counselors, psychiatrists and medical assistants) and other staff, including clerical workers. Financial support has to come from somewhere. The money has come from the federal government, through the United States Public health Service, New York state grants and, very importantly, from private philanthropy. Other interesting work has evolved, such as our work on tuberculosis, including a national project to study the efficacy and safety of using ultraviolet energy in homeless shelters to prevent the spread of TB.

Our work – and this has always been true in the department of community medicine – is carried out by collegial teams (a doctor, nurse and social worker), in which nurses are predominant figures. In all the years I was chairman (until 2002) I do not remember hearing a complaint regarding any member of the team acting like an autocrat. The team concept has worked well. The basis for that lies is in the very nature and character of the people who chose to work here. I am often asked "how do you find doctors who want to spend their life working with homeless people". Within that question might be a sarcastic, incredulous tone. We have plenty of physicians working with us, others who want to work here that we can't afford to fund. I attribute out good fortune in finding wonderful people, including nursed, social workers and others, to a bell shaped curve of random distribution of people. Using doctors as the example, we see at one extreme a bunch of rascals, working for personal gain, who couldn't care less about others. In the middle are a very large number of hard working men and woman who do their best for patients. At the other

extreme are a few physicians who simply have to do this work; it is in their nature. They can't do anything else. It has become known that this department is a place where people who want to work with the poor can do so. That latter sliver of the bell-shaped curve is sufficiently large to find people who want to work here. A number of these folk, and I include myself, have been here for a long time. We have physician colleagues who have been in this department since the very first day. Dr. Ed Cagan has worked here for 35 year. We have other physicians – John McAdam, Bill. Vicic, for example-who would not think of leaving. Underlying this is the sense of personal and professional fulfillment in this work.

The Department of Community Medicine, of which homeless healthcare is one component, evolved into a basic design. How were we so smart to create this design? We had no idea what was one step before us. We blundered ahead, trying to put together the best possible structure. There was no design. The question is 'how did it happen?'

I was either humble enough or smart enough, from the beginning, to realize – this was based on past experience as a physician and a medical student – that doctors really are less important in the structure of healthcare work than nurses are. I never made the stupid mistake of trying to prevail over a nurse. We had nurse colleagues from the start – and this holds true for our current nurses – who were the real heroes, who got their hands dirty and their feet wet. I do not denigrate physician work; I am a doctor. I always found myself trailing behind our nurses. We started off well by realizing that the team certainly was going to be a nurse and doctor. We saw the complexities of issues folks faced – the same issues that arise with other community medicine programs working with the poor and elderly. A case worker is essential to help people get connected. We never dealt with social workers who want only to do psychological counseling. Our social workers are case workers. They are with us in field, at the shelters; trying to figure out how to get people on Medicaid, to get them benefits; how to get them medications; how to get them into the hospital; how to get them placed upon discharge from the hospital.

One step at a time, through the fog is how we developed. This department isn't heaven. Everyone has their problems but we are not driven apart by issues. There is a guiding principle, based on a congruity of purpose and underlying character. We are all driven to work with the poor, to provide something that is lacking and necessary, and we enjoy doing it.