Hospitals and health facilities, and the planning that leads to their establishment, always seemed to bear a close relationship to man's need for the general well-being of himself and his family.

*Edwin A. Salmon*

In the decade after World War II, hospitals began programs of physical expansion that contributed to New York's redevelopment and redefined the place of medical care in the city. The La Guardia era's ideals of community medicine drove the process, but city provision of subsidized real estate made it possible. With a variety of municipal aids, hospitals refurbished obsolete plants, filled vacant space, and began fund-raising campaigns that would turn them into medical centers. Although their expansion sacrificed only a fraction of the city's housing stock, several hospitals stamped portions of Manhattan as preserves for advanced research, along with the redeveloped housing they considered necessary for their clinical and laboratory workers. Urban experts heralded this the inevitable triumph of the postindustrial economy, but behind the inevitable lay medicine's version of the Moses machine.¹

Hospital administrators made demands on the city in the name of rational needs that seemed to be nonpartisan and beyond debate. For a generation, they had basked in the public's admiration of heroic, scientific healing, while a host of medical-education task forces emphasized the interrelationships of hospital, medical school,
and laboratory. This social message pleased Mayor La Guardia, who believed that modern healing went hand in hand with civic reform. Advised by staunch advocates of medical centers, notably hospital commissioners Sigismund S. Goldwater and Edward M. Bernecker, the mayor found money to build a pattern of dispensaries for neighborhood care and centralized complexes to advance the frontiers of science. They were guided by the Hospital Council of Greater New York, a lobby of voluntary hospitals and medical insurance plans, who devised the modern, self-contained hospital complex. Their combined endeavors helped create a planning domain that was within the city but never part of it.2

Hospitals added facilities in response to the Hospital Council’s master plans, which were contrived to meet fund-raising deadlines and booster ambitions. Estimates of demand for medical care had scant validity when hospital administrators believed that the redeveloped city would generate new clients—and that hospital complexes would generate redevelopment. Behind their appraisals lay visions of metropolitan opportunity and, thanks to modern aviation, even dreams of a global role for ambitious medical centers. Normal constraints on the nonprofit sector were dismissed by hospital administrators, who believed that hospitals followed a higher ordination. When hospitals abrogated the rules that disciplined central-city institutions, the implications for urban land-use policy were incalculable.

The hospital sector’s penchant for planning without constraint was reflected in the multiple roles assumed by architect Edwin A. Salmon. The son of a distinguished psychiatrist and public health administrator, Salmon had helped design the city’s system of district health centers after Mayor La Guardia appointed him to the City Planning Commission in 1938. Salmon was a consultant to Memorial Hospital for the Treatment of Cancer and Allied Diseases while serving on the commission, and he personally handled Memorial’s negotiations with the city to limit the scale of a proposed municipal cancer hospital. When Rexford Tugwell resigned from the commission in 1941, Salmon succeeded him as chairman, and he also became chairman ex officio of the Hospital Council’s master plan committee, which coordinated the voluntary hospitals’ requests for public funds for postwar expansion. As City Planning Commission chairman, Salmon called on the voluntary to contribute to the modernization of civic life and to postwar full employment. And as a member of numerous hospital boards, he was in a position to implement that contribution. When Salmon wrote “we at Memorial” on City Plan-
ning Commission stationery, his blurred sense of responsibility was understandable and widely shared. He embodied the conviction that modern medicine had a special place in La Guardia’s New York.³

Reversing Limits

The hospital sector came out of the 1930s with no mission to change the city, much less the world. Mayor La Guardia’s public works binge had left municipal hospitals overbuilt. In 1935, the Mayor’s Committee on City Planning estimated that with 36,540 general-care beds soon to be available in the city’s municipal and voluntary wards, only 2,230 more (the equivalent of one large municipal center) would be needed over the next decade. Underutilization of the voluntaries, where ward occupancy remained at about 80 percent, was more pervasive. In 1940, Memorial Hospital counted sixty empty beds and operated an outpatient facility at half capacity. Trying to deter plans for a city cancer center, Memorial’s director argued that his hospital saw “no constant demand which the existing beds cannot supply.” Any increase in cases related to an aging population, he added, would be canceled out by the decline in Manhattan’s population. Lenox Hill Hospital also had lowered its horizons. “Naturally we want to complete our block,” its superintendent wrote Edwin Salmon, but he had no plans for the foreseeable future. “All of us know that the upper east side of New York, excluding the Harlem district, is perhaps over-hospitalized.” As late as 1945, the 366-bed Brooklyn Hospital, located between downtown and the congested Navy Yard, contemplated no enlargements and budgeted improvements worth only $50,000.⁴

The turnaround came during the height of the war, when hospital leaders realized that the La Guardia administration would commit vast sums to rebuild the city, a realization that City Planning Commissioner Salmon helped shape. Trying to convince Salmon to go beyond his ex officio role and actually direct the Hospital Council’s planning committee, council member Arthur Ballantine observed that Salmon “has the modern concept . . . of looking ahead to what the growth of the City and the various communities within the City will be.” Salmon hesitated about whether he could spare time from the City Planning Commission. But Ballantine persisted, reminding his fellow council members that Salmon, who enjoyed the mayor’s support, could give “invaluable direction” to the work. Elected by
acclamation in October 1944, Salmon directed the council’s planning committee toward a master plan for hospitals within “the entire realm of community development, such as population distribution, property use, arterial highways, and neighborhood developments.” Although Salmon denied that he was overemphasizing central hospitals at the expense of local clinics, his priority remained the creation of medical centers.5

Postwar trends made that an inescapable obligation. Hospital boards throughout the city, Salmon remarked, were impatient for the council to endorse their construction plans so that they could get started on fund-raising. His colleagues did not know whether to applaud or condemn the enthusiasm. Arthur Ballantine knew half a dozen boards of trustees that were anxious to begin campaigns for capital improvements. He asked whether the council should urge a “combined drive” rather than endorse the individual scurrying for funds. But ferment among the voluntaries made talk of restraint pointless.6

One of the most successful drives began in 1944, when Mount Sinai Hospital on the Upper East Side adopted a campaign for a “Greater Mount Sinai.” Trustees agreed that the hospital could become a full-fledged medical center if it reorganized attending physicians as full-time residents, doubled the number of interns, and created a pediatrics section and an institute for mental illness. The real driving force, however, was the expected growth of Manhattan’s middle class. Staff physicians predicted increased demand for medical care from people enrolled in prepaid hospital insurance. Those who once accepted the wards, a staff report observed, “now look to the Hospital for semi-private care in reward for their thrift.” Social change required new buildings arranged on a generous scale.7

Located between Fifth Avenue and Madison Avenue, Mount Sinai, with city help, made the most of a potential superblock. After “prolonged negotiations,” as hospital trustee Alfred Rheinstein reported, the city ceded 99th Street for a token $1,000 in 1945. With that, Rheinstein’s building committee embarked on $13 million in construction to knit old and new facilities into a “well integrated whole.” Rheinstein’s campaign ally was James Felt, real estate advisor and Mount Sinai trustee. Favoring preemptive purchase, Felt guided property acquisition along Madison Avenue, East 98th Street, and East 100th Street, which made Mount Sinai a landlord of low-income tenants and thus a relocator. The trustees expected Felt’s committee to “acquire apartments for the Hospital’s use as they
become vacant” while sheltering tenants evicted for hospital construction. Like the greater city, the hospital had become a manager of relocation housing.8

Mount Sinai pursued several expedients to obtain low-cost staff housing. In 1945, the trustees asked Rheinstein to investigate public subsidies for hospital expansion, including the Lanham Act, the federal program for war housing. Their search took them to the tenements across Madison Avenue that were occupied by blacks, which meant bridging the racial chasm when the hospital, like all the voluntaries, practiced Jim Crow. The Housing Authority had already designated the other side of Madison Avenue, from 102nd to 106th streets, as the site for the George Washington Carver Houses, a low-income project to shelter 1,500 families in twelve-story buildings. The high-rises’ potential to alienate tenants worried reformers, who stressed the importance of compensating community facilities. In September of 1946, the Mount Sinai trustees asked Rheinstein to request that housing officials extend Carver south to 101st Street to provide city-built housing for hospital staff. For a time, hospital administrators kept their options open on the east side of Madison Avenue, then retreated, except to claim the corner of 101st Street for staff parking. Hoping for municipal condemnation to provide the lot, the hospital administration was reported “in favor of the [Carver] project right across the street . . . as a benefit to the hospital.”9

The Carver Houses also offered opportunities in patient care that were crucial to the Greater Mount Sinai campaign. Although hospital trustees failed to convince the Federation of Jewish Philanthropies to support a $4 million psychiatric institute, the idea became the basis for a “community medical program” at Carver in 1950. The Housing Authority announced the prototype, a Mount Sinai “family doctor” for Carver tenants, which it hoped to extend to other projects. The hospital planned treatment rooms and doctors’ offices in Carver, but the real emphasis was on “preventive psychiatry.” As Mount Sinai’s historian explained, “the Hospital intends to try to raise the cultural and social level of its neighbors, as well as to take care of their physical health.” Although the medical staff deemed the project “valuable” to the hospital and community, it was never carried out with enthusiasm. With Mount Sinai support pegged to outside funding, the hospital’s contribution came to a few thousand dollars.10

Nevertheless, the involvement in community medicine paid off in 1948, when the Hospital Council designated Mount Sinai a “central” hospital, the first among the voluntaries to achieve this highest
status. New construction, along with planned additions in maternity and gynecological services, influenced the decision. "In the interest of the community," a council member explained, "the Master Plan Committee can make exceptions where a hospital is so far ahead as to training, capacity, etc., even though all definite specifications are not present." The council could have debated further, but a favorable vote, members acknowledged, was "the sales material of the Council." In the fund-raising environment, Mount Sinai and the Hospital Council would expand together.\(^1\)

Postwar euphoria brought the expansion of Memorial Hospital as headquarters for a veritable Manhattan Project to "conquer cancer." "Our experience in both medical and industrial science, in fact our experience during the war," observed Memorial trustee Lewis Douglas in July of 1945, "has been that carefully planned and coordinated research backed by adequate support and carried on by competent scientists working together has produced startling results." Douglas argued that enlarged and centralized laboratories would attract the research specialists who would pursue the industrial approach to a breakthrough. Their presence, in turn, would draw patients in unprecedented numbers. Worries of empty wards soon changed to fears that unless Memorial's facilities reached institutional size, they would never meet "the demands being made on them . . . as a complete cancer center."\(^2\)

Steps toward that institutional mass were reached before V-J Day. During the summer of 1945, Memorial began construction under city contract of the 300-bed Ewing Hospital. In August came the announcement that the Alfred P. Sloan Foundation would grant $2 million to build the Sloan-Kettering Institute on adjacent property. The gift energized the hospital's trustees to reach donors across the country, based on their belief that "if Memorial is to be a World Cancer Center it is most necessary that the people realize that fact." Memorial's campaign for national recognition was climaxed by a fund-raising dinner broadcast on network radio. But local significance was even more important, starting with Memorial's place on the Hospital Council's master plan. City Planning Commissioner Salmon took care of the arrangement, which called for "one cancer center defined almost identically with Memorial." As a Hospital Council member added to Memorial's director, "presumably this was the work of Ted Salmon who sat on your Board."\(^3\)

Memorial's role as a center for medical research shaped neighborhood planning initiatives over the next ten years. Writing for "we at Memorial" in 1945, City Planning Commission chairman Salmon
alerted Robert Moses that the hospital was eager to start slum clearance as a consortium effort with nearby New York Hospital–Cornell Medical Center and the Rockefeller Institute. Administrators had in mind a broad campaign, explained Salmon, “to provide medium-priced housing for the great number of relatively low-paid technicians, post-graduate students, instructors, and other professional personnel employed in the three institutions.” At the time, Moses failed to see the East Side as the place to engage the fiduciaries under the Redevelopment Companies Law. Salmon could proclaim all he wanted, but he would have to proceed with private money. A bequest to Memorial by John D. Rockefeller, Jr., of the block bounded by 68th and 69th streets and Second and Third avenues provided the first site. General Otto Nelson, New York Life Insurance vice-president, was attracted to redevelopment promoted by hospital improvements, and he looked to middle-income apartment construction south of 64th Street between Second and Third avenues. The hospitals ranged along York Avenue had just begun to stake their claims on the city’s redevelopment machinery.14

Medical Capital of the World

Wartime decisions also catalyzed the relationship between New York University and Bellevue Hospital that created the medical center that overlooks the East River at Turtle Bay. At the start of the war, the NYU College of Medicine had a major, though not exclusive, affiliation with city-owned Bellevue Hospital. When approached by the Bellevue Nursing School to share expansion costs at the hospital (in exchange for affiliation with NYU’s Washington Square College), university administrators reacted against the nursing school’s scant endowment and obsolete facilities. Their wariness ended when they learned of the La Guardia administration’s plans for postwar spending. Hospital alterations and a new facility for the nursing school would require condemnation of the NYU College of Medicine’s Loomis Laboratory. The college dean, Dr. Currier McEwen, sensed that relocation of the lab for “modern clinical research” might give NYU an exclusive relationship with Bellevue. Dismissing his colleagues’ doubts about whether a public hospital could make rearrangements for a “private corporation,” McEwen said “the time is past when a great hospital can fulfill its function by merely providing beds. New laboratories will result in increased service to the patient
and in increased prestige to the hospital.” McEwen hoped that the university would make Loomis a gift to the city.\textsuperscript{15}

Dean McEwen’s ambitions for the Bellevue relationship grew stronger when Mayor La Guardia approved an array of new facilities at the hospital. La Guardia had been convinced by Hospital Commissioner Dr. Edward M. Bernecker to make Bellevue the location of an institute of forensic science, which would give the city medical examiner “something no other city in this country has.” Bernecker added that allowing the NYU College of Medicine to run the institute would insulate the medical examiner from “political interference.” La Guardia and federal officials had also agreed on a venereal disease center at Bellevue, and Bernecker’s department contemplated facilities for tropical medicine, which Dean McEwen reported “of current interest . . . as a result of the war.” Ceding the Loomis property, McEwen argued, “would make an important difference in ensuring us right and privilege in the [Forensic] Institute in later years.” But the university comptroller figured that Loomis was a $400,000 gift that NYU could not afford.\textsuperscript{16}

Within a few months, McEwen’s successor as college dean, Dr. Donal Sheehan, called on NYU to spend far more. With the right kind of campaign, he believed the NYU clinic at Bellevue could become “a complete medical service with standards second to none in the country.” “It will require,” Sheehan explained in early 1944, “the building of a modern Hospital and an adjacent Institute of Medical Sciences to house the laboratories of physiology, medicine, bacteriology, pharmacology, experimental therapeutics, and of those new fields demanding immediate attention in the future, namely, industrial medicine, social medicine, tropical diseases, aviation medicine, legal medicine, physical therapy, and geriatrics.” The creative interaction would draw specialists, whose practices, together with the medical college, would support a 500-bed hospital “to serve the downtown district of New York City in the future.” According to Sheehan, the plan would get strong support from the City Planning Commission, which had approved Stuyvesant Town and was “concerned with the future building developments in lower Manhattan.” In April of 1944 he reported that city hospital authorities were “enthusiastic” about his proposal. City Planning Commissioner Salmon, the dean added, urged him to rush details to the Hospital Council and the CPC.\textsuperscript{17}

The New York University Council’s (board of trustees) planning committee was eager to move forward, but NYU chancellor
Harry W. Chase wanted promises from Commissioner Salmon that
the university would get more from Bellevue than “some labora-
tory space of a specialized character.” Chase expected a guarantee of
NYU’s primacy in the complex. Salmon agreed to this and more.
Chase later recalled, “We found that Commissioner Salmon might
be induced to undertake this preliminary planning analysis himself,
as his contract with the City, like that of some of the other Com-
missioners, is such that he can, from time to time, with the Mayor’s
permission, undertake private work.” Salmon proposed a consul-
tancy that included an exhaustive study of property near Bellevue.
His preliminary estimates anticipated a $6.5 million campus for clin-
ics, labs, and classrooms, a 250-student residence hall, and a 300-bed
“university hospital,” plus a $1 million NYU dental center. Although
Chancellor Chase acknowledged that the $7.5 million might be
“worked toward perhaps over a whole generation,” he told the NYU
Council, “if we don’t begin our planning now in connection with
all the planning the city is doing in the area, we lose what perhaps
is the greatest chance to develop a medical-dental center that will
ever come our way.” After meeting with Salmon on July 18, 1944,
the NYU Council’s subcommittee retained him for the “functional
planning we need at the moment.” Tapping emergency funds, they
offered Salmon the standard architect’s fee, $37,500, which Chase
promised his colleagues was “in no way a commitment to enter a
drive to raise funds.”

As the chancellor soon argued, the university could not allow
the opportunity to slip away. In October of 1944, an NYU College
of Medicine committee reviewed Salmon’s preliminary plans and re-
jected a side-street location in favor of “the vast superiority of land
on the East River Drive.” The college’s “dignity” not only required
the riverfront, but acquiring the property “would prove a powerful
incentive to donors for the endowment and building program.” The
following month, the NYU Council reviewed Salmon’s alternatives
and decided on three blocks located north of Bellevue and facing the
Drive. The council members agreed, moreover, that “options could
be secured without very much actual expenditure if we went about
it the right way.”

As chief expeditor and go-between, Commissioner Salmon knew
how to proceed. Plans to integrate the NYU complex with Bellevue,
he advised Hospital Commissioner Bernecker, required closing off
side streets between East 30th and East 32nd streets, which, in turn,
affected city plans to keep truck access to the waterfront. The city
would have to decide whether it wanted trucks near a medical super-
block, and Salmon wanted Bernecker’s support on plans to restrict commercial traffic. Another decision involved shifting the institute of forensic medicine to the east side of First Avenue within the NYU-Bellevue complex. Salmon proposed consolidating NYU’s scattered parcels along First Avenue to make a site on the west side “for large-scale housing projects” financed by banks and insurance companies. Salmon believed the housing would make NYU synonymous “with this entire section of Manhattan.”

City Planning Commissioner Salmon could also manage the embarrassing negotiations for Hospital Council endorsement, which began when council secretary Frances K. Thomas clarified that Salmon “was sitting in on the session representing N.Y.U. and not the Council.” Thomas was sympathetic to the need for a university hospital for the private patients of the medical school faculty, but she warned that Salmon would have trouble convincing the Hospital Council that the new facility “was essential for the community welfare.” She added, “I told [NYU medical dean] Dr. Sheehan that on the face of it, it seemed unreasonable to have another hospital on the East Side unless one or more of the existing institutions are going to disappear.” She also doubted whether the NYU faculty had enough patients to fill a hospital of that size. When Sheehan replied that NYU planned only a minimum of general-care beds for research needs, Thomas commented that the council would have to convince the city that a new voluntary was needed on the East Side.

The city also had second thoughts about Salmon’s enthusiasms. Mayor La Guardia, although supportive of NYU’s plans, refused to say whether the city would aid with property condemnations. After all the fuss about Stuyvesant Town, La Guardia hesitated to turn land over to quasi-public institutions that paid no property taxes. He wanted guarantees, reported Chancellor Chase, “that if we moved to the new site we would dispose of our present holdings to private corporations so that they would not also be tax-free.” But within days, after NYU officials pledged no duplication of Bellevue’s facilities, La Guardia accepted the idea of an NYU hospital of 450 beds next to a Bellevue complex of 3,200 beds. The mayor boasted over WNYC radio that the city would get “one of the greatest hospital centers in the world.”

The Hospital Council endorsed the deal after tortuous reasoning of its own. The major hurdle remained duplication of Bellevue, although the master plan committee set this aside, citing needs for “a general hospital associated with a medical school to provide service for all economic levels of the population.” The rationale was
the medical version of Moses’s talk about mixed housing. Nevertheless, committee chairman Dr. J. J. Golub could not ignore the fact that putting more beds on the East Side clashed with the Hospital Council’s master plan. Golub advised the council to “separate the program of New York University from that to be carried out for the community as a whole.” Golub promised “a frank statement of how the committee reached decisions on points which it would ordinarily argue against.” But Salmon reminded the council that NYU needed a prompt endorsement so it could move ahead with fund-raising. What clinched the issue was NYU’s contribution to the redeveloped city. When Golub pointed out that new housing projects, Stuyvesant Town and Peter Cooper Village, would increase the local population by 30,000, Hospital Council secretary Thomas added that the middle income “character of the group would change from those requiring care in a place like Bellevue to those who could afford private and semi-private care.”

Hospital Council chairman Salmon notified NYU that the council had endorsed the 470-bed university hospital. Salmon explained that the council expected the complex to assume a mixed character, with NYU providing the private and semiprivate care that Bellevue, because of its commitment toward the city’s poor, could not. The NYU College of Medicine needed the diversity of “patients of all economic levels coming from any locality, . . . to draw and retain physicians of eminence on its faculty.” Excess bed capacity would diminish, Salmon predicted, when other voluntries merged with NYU. He soon passed word to Dean Sheehan that NYU had to act quickly. He was worried that NYU’s plans and publicity would get lost among pending announcements for Columbia Presbyterian, Cornell Medical College, Long Island College of Medicine, and Memorial. “Mr. Salmon feels very strong that we would lose our position in the ‘race’ if we waited much longer,” reported Sheehan. The bemused academician added that Salmon had urged the medical college to “invite some of the leading figures in journalism—Mrs. Ogden Reed [sic], Roy Larsen, etc., and inform them personally of the project. Following this, a large press conference with representatives of all newspapers should be held and that highballs served at such a meeting would greatly facilitate it! (This is apparently the technique of Bob Moses!)”

Acting on Salmon’s urgency, the university assembled the machinery to realize the “NYU-Bellevue Medical Center.” Chancellor Chase contracted the fund-raising to professionals, who outlined a $20 million drive, and the search was begun for a campaign head
with contacts in finance and industry. One enthusiastic supporter, businessman Robert W. Johnson of Johnson & Johnson, proposed to solicit contributions from companies with prepaid medical plans “so that the whole metropolitan business life could come in on a quota basis.” Johnson added that money would flow from “small industry and insurance, where we can make an arrangement for some sort of health care of the employees of those firms.” He said his “good friend,” Metropolitan Life chief Frederick Ecker, had “similar ideas.”

During spring of 1946, the NYU Council, advised by Metropolitan Life vice-president James L. Madden, concluded that the time was ripe to option property on the East River Drive and to solicit philanthropic donors. Approaching the George F. Baker Charity Trust, Chancellor Chase delivered a spirited pitch for the medical complex in the modern metropolis. NYU planned an institution that would lead the city’s movement in community health, fulfill the College of Medicine’s promise as educator of immigrants, and create the kind of community “we said we would build for our people once the war was over.” The city needed a medical facility that could draw in one place private and semiprivate patients previously scattered across the city. But the project hinged, Chase emphasized, on timely acquisition of land, which had progressed as far as possible as a quasi-public operation in which NYU negotiators asked owners not to sell to speculators. The whole project turned on a philanthropic bequest.

While NYU waited for the Baker Trust’s informal “yes,” the university campaign shifted into high gear. On June 19, 1946, the NYU Council Committee on Medicine and Dentistry voted to establish an NYU-Bellevue Medical Center. Chancellor Chase named James Madden to the NYU Council, where one colleague welcomed him as “new blood” and another rued the need to “snuggle up very closely to life insurance interests.” Throughout the summer, the NYU finance office optioned property, and was nearly finished by October. It overcame one last obstacle, difficult negotiations for the block between 33rd and 34th streets, thanks to property data supplied by Commissioner Salmon. At the end, NYU provost LeRoy E. Kimball reported that his agents had purchased the land plus “an additional amount of space which we would like to have as a safety measure.” In the meantime, architects from Skidmore, Owings & Merrill met with Salmon and a council committee to work on the blueprints.

Difficulties with the city were not overcome until fall 1946 with the decisive involvement of Mayor William O’Dwyer, who relied on advice from commissioners Salmon and Bernecker. Having taken
options on more than half the site, Chancellor Chase wanted the city to follow through with street closings to create the superblock and signal holdouts to accept a fair price. Chase particularly wanted prompt closing of 30th Street to permit landscaping “for the proper outlook of both Bellevue and University Hospital.” Final decisions also hinged on the elevated portion of the East River Drive and removal of the Sanitation Department’s facilities at 32nd Street. In return, Chase repeated the university’s offer of space for the institute of forensic medicine. To round out the promise of a “world center of medicine,” the university also extended a welcome to the Veterans Administration, which was examining a hospital site south of 25th Street. Currier McEwen forwarded NYU’s property surveys, along with Commissioner Salmon’s own data. McEwen conveyed to VA officials the magnitude of the complex that was taking shape, the “protected” nature of the Metropolitan Life redevelopments to the south, and Salmon’s visions for middle-income projects along First Avenue.²⁸

By the spring of 1947, Commissioner Salmon had put the finishing touches on the Hospital Council’s master plan, which urged “the integration of medical care, research and teaching” in hospitals attached to university medical schools. Presented to Mayor O’Dwyer and given front-page coverage in the New York Times, the plan was the capstone of Salmon’s civic endeavor, and within a week he sent the mayor his resignation from the City Planning Commission. NYU took the master plan as a direct endorsement of its health-care proposals. In turn, Chancellor Chase took the message of the medical complex as metropolitan anchorage to the city’s financial establishment. The NYU-Bellevue partnership in industrial and social medicine would bolster the city’s economy, Chase said, and location near the United Nations would secure “New York’s pre-eminence as the medical capital of the world.” On April 28, 1947, Salmon was named director of the NYU project, with every hope that his talents, as the NYU Council claimed, “would be most effective in planning the new development.” Within several months that expectation was vindicated. On July 24, 1947, Chancellor Chase, Provost Kimball, and Salmon met with Mayor O’Dwyer, Robert Moses, and members of the Board of Estimate. They signed a memorandum of understanding that fixed the medical center in the city’s future. City officials pledged to cede streets on the Bellevue site and to expedite the legal consents through the municipal bureaucracy. NYU agreed to start construction of the medical college and hospital as rapidly as possible.²⁹
Medicine for the modern city, c. 1949. Looking south from 34th Street along the Franklin D. Roosevelt Drive, the Skidmore, Owings & Merrill model of the New York University–Bellevue Medical Center showed the promise of modern medical facilities near arterial highways. Proponents of postwar medical centers were convinced that they were building not only for the city’s existing population, but also for the upper-income residents that redevelopment and modern highways would bring to their doors. Courtesy of the La Guardia and Wagner Archives, La Guardia Community College, The City University of New York.

Because of delays in fund-raising and construction plans, NYU and Mayor O'Dwyer could not unveil the sleek Skidmore, Owings & Merrill designs until January of 1949. By then, cost estimates had doubled, but so had campaign revenues. The center’s “primary aim” had undergone a subtle shift from providing care for the city’s diverse population to providing “the finest medical care for persons most in need of that care—the middle income group.” The complex, combined with the adjoining VA hospital between 23rd and 25th streets, would change the economic nature of the East Side. It would wipe out warehouses, carpet and cleaning stores, a printing plant, a few shops, and about 1,400 jobs. It would also knock down thirty-nine tenements. Although the immediate impact was slight, the long-range implications were profound. With no exaggeration, Mayor O'Dwyer and Robert Moses proclaimed NYU-Bellevue as a step toward the redevelopment of the East Side. Moses could not help adding to reporters that “west of this area a great deal remains to be done.” 30
NYU-Bellevue soon overwhelmed the district’s medical capacity, but East Side redevelopment seemed to justify new priorities. Despite Mayor La Guardia’s apprehensions about duplicated facilities, plans for the (now) 600-bed NYU hospital forced shrinkage of Bellevue. By 1949, the municipal hospital’s bed capacity of nearly 3,000 was slashed by almost one-third, and the postwar vogue in construction of modern facilities convinced the Hospital Council in January 1952, to suggest a severe cut to 1,000 general-care beds. An added squeeze came from the nearby VA Hospital. By 1954, medical administrators agreed that the NYU complex was affecting hospital capacity throughout the East Side by drawing away patients and would soon force the closing of at least one municipal facility, Gouverneur Hospital. NYU’s long struggle to gain municipal purpose for its upper-middle-class facility now impinged upon city responsibility for medical care of the poor. Hospitals as engines of redevelopment also posed a threat to their homes.31

Public Purpose

By the early 1950s, many hospitals crossed a psychological threshold that transformed them from health-care facilities into modern complexes with social responsibilities to the greater city. Postwar forces, particularly prepaid insurance and federal subsidies for hospital construction under the Hill-Burton Act of 1946, underwrote this change of perspective. But the language of redevelopment was a potent additive. Medical centers would provide value-added care for the upper-middle-class residents gathered around them. They would become the focal points of communities filled with the professionals that cities needed to survive.

While this crucial role was proclaimed wherever hospital administrators thought their institutions were fundamental to the redeveloped city, the conviction was strongest among the institutions of the Upper East Side. In late 1951, Lenox Hill Hospital asked the Hospital Council’s advice concerning plans to replace its 77th Street building with a modern structure. The council approved as long as the change involved no increase in capacity in an area “over-supplied with general care beds.” Accepting the constraint, Lenox Hill proposed to slash ward space, but increase private and particularly semi-private facilities, which were badly strained. Appraising Lenox Hill’s general plans, the Hospital Council suggested expansion of units “for tuberculosis, psychiatry, acute communicable diseases, conva-
lescence and rehabilitation, and long-term illnesses, as recommended by the Master Plan."

Businessman William H. Zinsser, president of the Lenox Hill board of trustees, saw a particular opportunity in the health crisis among teenagers. "The founders of Lenox Hill Hospital must have sensed from the beginning that the future of America depended on its annual baby crop," he wrote. "Something must be done medically to prepare these future children . . . in a world already alarmed at unchecked juvenile delinquency, drug addiction and all-time high percentages of draft rejections." For some time, he added, the trustees had mulled over these considerations, "but only within the last year have courageously studied plans to knit together under one roof all these related problems of youth." Pointing out that integrated hospital facilities had led neighborhood renewal elsewhere in Manhattan, Zinsser added that adolescent clinics and psychiatric care were central to the struggle against youth crime. He was convinced that the hospital that perfected the "medical approach to juvenile delinquency," would set an example for the nation. "I do not have to tell you," Zinsser confided, "that the crowding of the colored and Puerto Rican element is going down Madison and Fifth avenues closer and closer to Lenox Hill."

In December of 1954, Lenox Hill trustees, led by Wall Street attorneys James H. Wickersham and John J. McCloy, unveiled a $10 million modernization that included a twelve-story wing and an adolescent clinic. Fund-raising would soon get under way for a large structure at Lexington Avenue and 77th Street to contain a diagnostic laboratory, a nurses' residence, and a student-activities center, and Wickersham talked confidently about a third unit for "middle income families being attracted to the Lenox Hill neighborhood by improvements now under way." Within a year, those plans were expanded again, as trustees raised their sights to an $11 million program, including a community clinic for young adults and a nurses' quarters. Lenox Hill was angling for federal construction subsidies, but the Hospital Council advised that with too many general-care beds in Manhattan, there was little prospect for Hill-Burton funds unless it introduced "some new service, such as psychiatric beds."

Instead, Lenox Hill settled on expansion built upon pediatrics and semiprivate accommodations linked to prepaid insurance. The trustees looked forward to the block-long complex on East 77th Street from Park Avenue to Lexington Avenue. The campaign, reported Zinsser, "envisages the final solution of Lenox Hill's 'housing problem.'" Nurses, interns, and maintenance personnel removed
to off-site quarters would free space for laboratories, classrooms, and support facilities. The investment capitalized on the growing numbers of white, middle-class families drawn to the redeveloped East Side.\textsuperscript{35}

The social roles assumed by hospitals justified a degree of municipal intervention that had been unthinkable before the war. In late 1954, Moses remarked that Mount Sinai’s growth had been facilitated by state cooperation despite the surrounding area’s “borderline” qualifications for slum clearance. The hospital needed room, and the trustees wanted to raze eighteen tenements on Madison Avenue between 101st and 102nd streets for staff apartments and garages to relieve what Moses called an “extraordinarily tight parking problem.” Moses arranged for the Housing Authority to acquire the parcel near the Carver Houses under the state housing law that allowed “clearance and rehabilitation of substandard areas adjacent to public housing.” “It will not only assist in preserving and protecting the Carver project against adverse influences,” the Housing Authority explained, “but will also aid in the orderly improvement of the surrounding neighborhood.”\textsuperscript{36}

Later in the decade, the city completed its aid package for Greater Mount Sinai. It turned over title to 100th Street, which allowed the hospital to occupy the entire superblock. The hospital knocked down tenements along 100th Street to build psychiatric facilities and a staff dormitory. By this time, as well, ambitions to create a medical school led to considerations for student housing. The administration noted that through bequests and judicious purchases the hospital had gained control over most of the north side of 101st Street and could obtain a “racially mixed” apartment house on 101st Street and Fifth Avenue. In addition, it eyed property along 98th Street and, with further state subsidies, began construction of a 100-unit nurses’ quarters.\textsuperscript{37}

Elsewhere on the Upper East Side, the massed institutions proclaimed their community obligation to redevelopment housing. Spurred by Edwin Salmon, Memorial Hospital had long considered building housing under the Redevelopment Companies Law. However, it was the Rockefeller Institute trustees, led by David Rockefeller, who cajoled Memorial, Sloan-Kettering Institute, and New York Hospital–Cornell Medical Center to form a corporation to acquire a half block on the west side of York Avenue, between 66th and 67th streets. They had no illusions about proceeding without public subsidy, and so Rockefeller attorneys approached State Housing Commissioner Stichman, Housing Authority chair-
man Philip Cruise, and, of course, Robert Moses. The officials endorsed the idea, despite uncertainties about city condemnation and tax relief. When David Rockefeller alerted his brother Laurence that the state was “anxious to proceed,” he set his legal advisor, Thomas Debevoise, to the task.38

The chief problem was choosing among redevelopment instruments that offered trade-offs and imponderables. Moses had already ruled out using Title I; the tract had too few slums for slum clearance. The sponsors looked at the condemnation and tax abatements of the Redevelopment Companies Law, but questioned whether the required rent limits (roughly $20 per room) were worth the city tax break, which was subject to the politics of the Board of Estimate. Debevoise met with Cruise and Stichman, who concluded that the Limited Dividends Companies Law made more sense because East 66th featured “substandard” tenements. One alternative was the law’s “Mount Sinai” variant, which allowed a state write-down of property and city tax abatements to the hospital to build housing that it rented to personnel. Debevoise doubted that the Rockefeller Institute wanted to get involved with staff housing, but neither could it build without the write-down or tax abatement. A glance at rents on York Avenue told Debevoise that the limited-dividends’ write-down was preferable because it meant “less entangling restrictions” on tenancy and rents. Stichman and Cruise agreed that the state could provide the write-down if sponsors provided adequate public-use language. They advised the consortium to request Board of Estimate condemnation, claiming that the property was substandard, that the consortium planned a community center, and that the hospitals’ middle-income housing would counteract what they called Yorkville’s “economic stratification.”39

Unexpected difficulties emerged as the planning moved forward. Realtor James Felt, who advised on relocation, counted 450 site families and estimated relocation costs at $500 per household. Debevoise’s experts figured that the city could, in theory, cover the cost of removing 60 percent of the families into public housing, but conceded that this pushed “far more on the City than they will take.” A grave obstacle loomed when Moses warned that the planned rent of $35 per room made tax abatement unlikely. He bluntly told Laurence Rockefeller that the project was “borderline,” ordinarily “quite impossible” for the city to support. Pointing out that he and other officials “exercised every legal ingenuity” to realize the redevelopment, Moses suggested how the Rockefellers might run the gauntlet of the Board of Estimate:
When the smoke clears, and after the initial writedown, the project must be full taxpaying. The rentals will be up to you . . . I renew my original suggestion that you and David personally talk to [Borough President] Hulan Jack and that you offer every aid in moving people not eligible for public housing or unwilling to go into public projects. If you will hire two or three reliable, small Yorkville firms—not the big fellows—I think they can dig you up twenty or more partly or wholly boarded up tenements in the area which you can buy, rehabilitate, use for the displaced people.

Moses would strong-arm the politicians, but the Rockefellers would have to supply the moral force. 40

David and Laurence Rockefeller prepared a memorandum loaded with the public-interest rhetoric that had served Mount Sinai for their meeting with Manhattan Borough President Hulan Jack. The next day, they met with Mayor Wagner, and then walked the site with the borough president. Both were reported to be “favorable.” Moses learned that the borough president “was generally satisfied with what David & Laurence R had told him . . . , but that his office was studying the relocation aspects.” A few days later, Moses heard that Jack expected to recommend the project but did not want to be pushed. Moses’s people backed off, but soon learned that the borough president was looking for an alternative block of tenements further south because “the area proposed is too good.” Moses asked Housing Authority chairman Philip Cruise whether he could think of any other locations. 41

The educators, however, were in no mood for substitutes. Rockefeller Institute president Detlev Bronk was committed to the 66th Street site. A research physiologist who had established Rockefeller as a world-renowned facility, Bronk was infuriated by the political diversions, particularly Mayor Wagner’s irresolution. Bronk had just read an interview with the mayor in U. S. News & World Report in which Wagner fended off questions about the city’s racial change, rising unemployment, and alleged “decline.” Bronk thought Wagner had given a lame response. Appalled by the mayor’s lack of vision, Bronk told David Rockefeller, “I want more than ever to throw myself into the undertaking to make New York the glowing pattern for the future of urban living.” 42

Borough President Jack suggested a compromise to David Rockefeller that the politician thought might win over the Board of Estimate. He urged the sponsors to employ a reliable realtor who would work with Jack’s office to survey site tenants’ needs and to plan relocation. The Rockefellers promptly acted on the suggestion.
But Moses also advised them to invite Jack to the institute “and pin him down on your nearby slum clearance project. I urge you to emphasize the tie up with the Institute and Memorial, and find a name like ‘Medical Research Annex,’ or ‘Research Residency.’” The Rockefellers had the borough president to a power lunch at the institute on June 30, 1955, but he still hedged. As a Rockefeller staffer surmised, Jack opposed any improvement that forced out too many tenants. He was “strictly a politician,” who “counts up the votes.”

Aware of the reality, the Rockefeller consortium submitted a formal request to the construction coordinator for city authority to clear a 300-foot section of East 67th Street. They claimed that fifteen New Law tenements, although less than fifty years old, were “obsolete . . . by today’s standards.” They cited their realtor’s finding that half the site families were eligible for public housing and concluded that relocation posed “no unusual difficulties.” With that, Moses’s office whipped together a favorable report from the City Planning Commission. As arranged, the Housing Authority’s recommendation to the Board of Estimate contained the tried-and-true language about obsolescent buildings and blight that threatened the district. The housing redevelopment, coupled with the phalanx of hospitals on York Avenue, would reverse the area’s “downward trend.” With this compelling social message, the Rockefellers had every reason to believe that the city would approve their contribution to the Upper East Side.

Noblesse Oblige

Edwin Salmon recalled that soon after passage of the Housing Act of 1949, he began examining the residential needs of medical institutions in the Bellevue area. Using Title I near Bellevue was an idea shared by Robert Moses, who, in early 1953, wrote to NYU-Bellevue trustee Winthrop Rockefeller about “rehabilitating the entire area surrounding the center.” Construction of the NYU facilities was only half complete when Salmon presented the trustees with the next step to reclaim the district. Salmon argued that not only the medical center, but also much of lower Manhattan suffered from “objectionable uses,” which deserved scientific excision. Salmon pinpointed the area between 23rd and 34th streets and west to Second Avenue, but he also was ready to propose “redevelopments on a broad neighborhood basis” from 14th to 42nd streets and west to Lexington Avenue.
Salmon said he was following sound planning principles, but he had stepped on dangerous ground. His inflated concept not only annoyed Moses, who favored redevelopment near the medical center, but also impinged on Moses’s plans for a 30th Street crosstown highway. While dining at architect Thomas Skidmore’s townhouse, Moses and NYU chancellor Henry T. Heald had already reached an understanding about a Bellevue Title I. Moses had offered to write down land to make possible $32-per-room rents that were within reach of the medical center’s personnel. Now he warned Heald that Salmon had created “misunderstandings as to the scope” of the slum clearance. He punctuated his anger by denying city funds for advanced Title I planning.46

Giving the go-ahead to the Bellevue Title I in May of 1953, the medical center trustees also endorsed Salmon’s broad agenda for area improvements. The advanced planning, paid with $25,000 from Winthrop Rockefeller, was contracted to the IBEC Housing Corporation, Winthrop and Nelson Rockefeller’s program of technical assistance in Latin America. IBEC had little experience in metropolitan affairs, but under Wallace Harrison’s direction it could perform the Bellevue work at cost. Salmon reworked the IBEC material into a memorandum that Winthrop Rockefeller addressed to the city and, seemingly, the North Atlantic community. Replanning the area was crucial, Rockefeller claimed, “as New York City becomes preeminent as an International Medical Center and through the United Nations Center—the Capital of the World.” The city should confer on NYU-Bellevue extraordinary redevelopment authority because it had withstood “waves of commercial pressure and of population shifts,” demonstrated what sophisticated planning could achieve, and already possessed a “quasi-public character.” Because East Side owners expected the medical center to spearhead community redevelopment, Rockefeller concluded, NYU-Bellevue had to act with “noblesse oblige.”47

Enraged by this flatulence, Moses called Chancellor Heald on the carpet. “Certainly the appearance in print at this time of any such report as Ted [Salmon] outlined would cause us much trouble and would be of little value to any one.” He went on, “If the result is to put ammunition into the hands of those who don’t like our slum clearance project and related public improvements . . ., I shall personally favor dropping the Title I project like a hot cake.” Heald agreed that Salmon had gone too far and promised that the IBEC-Salmon study would remain confidential. The medical center trustees buried Salmon’s report, and within a month he resigned as director.
to become its planning consultant. His successor, prominent accountant Samuel D. Leidesdorf, had his own redevelopment interests to take up with Moses and knew enough to leave large issues alone.48

Moses, in any case, kept medical center officials from further Title I planning. The CSC worked with the Industrial Engineering Company, which proposed to bid on $5-per-square-foot land and organize a redevelopment syndicate. During the summer of 1953, the Committee on Slum Clearance arranged the necessary brochures for City Planning Commission hearings on August 12, 1953. Salmon remained project spokesman, but Moses choreographed his appearance, along with appearances by Heald, Leidesdorf, and East Side commercial associations. Chancellor Heald reminded the City Planning Commission that NYU’s obligations to the area went back to before the war, whereas the city’s endorsement of NYU plans dated from the July 1947 memorandum of understanding. The combined medical institutions had already invested nearly $100 million between 23rd and 34th streets, Heald said, but decent housing for 10,000 employees lagged far behind.49

The City Planning Commission promptly approved the Bellevue Title I, but Moses anticipated opposition at the Board of Estimate. He postponed hearings on Bellevue and Washington Square Southeast until mid-November of 1953—after the city elections—and then until December in deference to Mayor-elect Robert F. Wagner, Jr. Warning NYU officials of real hurdles, Moses devised the division of labor to avoid overemphasis of the university’s role. Leidesdorf’s people would work on the Bellevue endorsement, while Heald’s staff would concentrate on Washington Square Southeast. Salmon urged the medical center’s friends, including Mrs. Nelson A. Rockefeller, head of the Bellevue School of Nursing board of managers, and Dr. Howard A. Rusk, pioneer in rehabilitative medicine, to emphasize NYU’s venerable association with the community and what Salmon called the “universal approval” given NYU’s plans. With East Side housing at a premium and waiting lists for Stuyvesant Town already filled with medical center personnel, the project was desperately needed.50

Salmon applauded Moses’s “able presentation” at the Board of Estimate hearings, which finally took place in late January of 1954. But the opposition, he noted, “was fairly well organized and, except for 3 or 4 persons, consisted of tenants of the property involved, not owners, and representatives of civic groups and organizations who were arguing the entire problem of slum clearance.” Salmon was convinced, however, that the project would prevail because the
board had already approved Title I's for Washington Square Southeast and Pratt Institute that had similar relocation impact. He used this argument on Mayor Wagner, adding that relocations could be arranged to avoid "extreme hardship." Moses in the meantime contacted his old friend Bernard M. Baruch, believing that a letter from the Democratic sage and medical center benefactor would make all the difference. As Moses said, "Bernie knows how to do these things." Recalling his family's contributions to "public medicine" and his own interest in housing reform, Baruch lectured the city fathers on their "civic obligation." The Board of Estimate approved the Bellevue Title I several days later.\(^{51}\)

Ironically, the public-use rhetoric for NYU-Bellevue soon crimped Moses's further ambitions for the area. In February of 1955, Mayor Wagner alerted the medical center that Triborough Bridge and Tunnel Authority plans for a crosstown expressway on 30th Street would be carried on "an elevated structure" to the East River Drive. Salmon called the idea "detrimental" to the center, claiming that it violated understandings with the city that included promises from Moses himself. More serious was the Committee on Slum Clearance plan for public housing on First Avenue between 26th and 29th streets and for a medical-arts high school one block to the north. The plan varied from what Salmon heard Moses say, and he urged medical center director Samuel Leidesdorf to get things straight with the Wagner administration. "Astonished" by Salmon's claim of ignorance, Moses remarked that "he and all the others involved knew about the 30th Street Elevated Expressway." He accused the medical center of trying to "block" the expressway and threatened to walk away from any work connected with it. Salmon protested bitterly to Chancellor Heald that Moses's self-glorification obscured the fact that the medical center had moved ahead "with no help whatsoever from Commissioner Moses." He claimed "the University initiated the Title I project and took the leadership in meeting opposition." The city had always encouraged NYU-Bellevue, but never fulfilled its pledges.\(^{52}\)

Salmon attempted to run around Moses by approaching Borough President Hulan Jack on the expressway and the public housing issues. Moses, as usual, horned in on the discussions. Salmon and Leidesdorf could not kill the expressway, but they wrested an agreement that kept connections to the East River Drive at grade level and halted 30th Street improvements for the immediate future. The meeting ratified Housing Authority claims to the west side of First Avenue, but left the rent range wide enough to permit middle-
income tenants. By March of 1956, Salmon was relieved to learn that Moses had agreed that the blocks opposite Bellevue should be redeveloped by the Housing Authority with a middle-income project.\textsuperscript{53}

Salmon worked tirelessly to realize middle-class housing across from NYU-Bellevue. Conferring with Hulan Jack and other officials in May of 1956, Salmon tried his hand at a Moses-style assemblage, including middle-income housing between 23rd and 28th streets, facilities for the NYU School of Dentistry, a medical-arts high school, and headquarters for the New York Red Cross. By then, however, Salmon faced Moses’s coolness toward further write-downs near Bellevue. The Housing Authority soon withdrew because of the site costs and the Board of Education dropped the vocational high school. With little left, Salmon and the borough president still insisted on redevelopment across from the medical center “to prevent further deterioration, to protect and complement the institutional programs and to provide rehabilitation.” On this basis, Salmon made an offer to Paul and Norman Tishman, sponsors of Washington Square Southeast. With the Housing Authority out of the area, he hoped they might consider operating under Title I.\textsuperscript{54}

Moses had run out of patience with Salmon and NYU. The relationship ended when Moses read a letter, dated June 1, 1956, in the \textit{New York Times} by one of Chancellor Heald’s assistants that asserted that the university was “totally separate” from the Tishmans’ Washington Square redevelopment. Accusing the academics of running for cover while he took the heat, he reminded Heald that NYU was involved with the Bellevue Title I from the beginning. He reviewed all the negotiations to provide NYU with facilities for medical center employees. “Under these circumstances,” he added, “I cannot for the life of me understand why you are so eager to dissociate the University from the general neighborhood improvement.” Moses refrained from mentioning Salmon, but he recalled the advocacy of improvements “of such an extravagant, costly, and impractical nature that I had to request the Chancellor to bury the report for fear that it might kill off the realizable objectives.” Heald replied to Moses the only way he could, expressing his “admiration for you and what you mean to New York.”\textsuperscript{55}

But Salmon remained irrepressible. Two weeks later, he warned the Wagner administration that expansion of the NYU dental school depended on “land in connection with a redevelopment plan.” Salmon wanted the city to condemn 18 acres for an elementary school, a middle-income project, and Red Cross headquarters. Pressure
from Salmon and NYU-Bellevue finally worked. On July 26, 1956, the Board of Estimate approved a preliminary version of Salmon’s scheme, with the understanding that Moses would recommend Title I housing. But months later, Moses cited the “fund situation” to dump the project back on the mayor. In mid-1957, when Moses announced that adequate federal money would not be available for several years, the Title I sank into limbo.56

Salmon never gave up on broad endeavors with a social message. In 1960, he still talked about the needs of 10,000 NYU-Bellevue employees for $30-per-room rents. But he ignored the starkly different reality that he had been instrumental in bringing about. By then, Bellevue Title I had become an upper-middle-income project with little relevance to the medical center’s rank and file. Salmon said “long delays” had ballooned rent schedules. When the Title I, christened Kip’s Bay, was taken over by realtor William Zeckendorf, the average rent had climbed to $75 per room. Salmon remained the loyal booster, while conceding that this housing could help only a small number of institutional personnel.57

Edwin Salmon was forgotten by a historical perspective that emphasized Moses’s visible hand and what was called the inevitable character of the growth of research-based services in the postwar city. But his attitudes and professional demeanor were central to that postwar transformation. Salmon spearheaded the vast reconstruction of the medical sector because he skillfully grafted the promise of social medicine onto the physical renewal of La Guardia’s city. His approach to medical center planning was grandiose, if not bombastic. He saw these facilities not only as spearheads for a research-based industry, but also as the bedrock for upper-middle-income redevelopment to reclaim vast areas of the city. Much of the time, Moses had to limit Salmon’s fancies for more practical goals and remind the medical builders that Title I had some obligation toward middle-income rents.

By the time of Mayor La Guardia’s death in 1947, hospitals had become central to many of the city neighborhoods that they would soon consume. While integrating research laboratories and classrooms into new complexes and surrounding them with residential towers that put modern medicine’s signature on the skyline, few hospital administrators considered the possibility that their facilities might ravage the slums or threaten the livelihoods of slum dwellers. Such doubts were dismissed by the assumption that a city filled with creative middle-class people deserved value-added medicine.