1 Health Care by the Ton:
CRISIS IN THE MINE WORKERS' HEALTH AND WELFARE PROGRAMS. Tying benefits to production and financial mismanagement have combined to threaten the future of the Mine Workers' health and pension programs.

9 Scandal at Gauley Bridge:
LOOKING BACK AT THE NATION'S WORST OCCUPATIONAL TRAGEDY. Never in American history have race, class and occupational hazards conspired to kill so many so quickly.

17 Columns:
WASHINGTON: Cost Control
WOMEN: Lay Midwifery
NEW YORK: Body Snatchers
WORK/ENVIRON: OSHA Cancer Policy

34 Vital Signs

37 Cumulative Index

Health Care by the Ton
The United Mine Workers' Welfare and Retirement Funds have pioneered a comprehensive health care delivery system in the US coal fields for over a quarter of a century. A model for health-care reformers—and anathema to "free-enterprise" medical practitioners—it was once the largest prepaid medical group proc-
The following article by Curtis Seltzer traces the history of the Funds, recounts their important accomplishments and seeks to identify the underlying causes of the present crisis. The roots of the crisis in the Funds, the author suggests, lie both in the financial manipulations of Fund monies by UMWA presidents Lewis and Boyle and in the unusual financing mechanism by which Fund income—and miner benefits—are linked directly to the tonnage of coal mined.

When miners first struck over health care cutbacks last summer, Max Fine, Director of the labor-backed Committee for National Health Insurance, stressed that this is not the problem of a single union. Indeed, Fine noted, the crisis in the Funds touches major and precedent-setting national health issues: universal coverage, the regressiveness of copayment and coinsurance, and the content of progressively-organized community-based health services, among others.

We trust miners and their families whose health benefits, jobs and incomes are currently on the line will find this history useful in their long struggle. Its lessons are many and important for all who seek a health system comprehensive in scope, preventive in orientation, free at the point of delivery and controlled by those who use it and work in it.

In the lobby of the United Mine Workers' headquarters in Washington, DC, an outsized bust of John L. Lewis watches the tumbings of his successors. Not only does Lewis watch, he judges. His is a constant, scowling glare, fashioned deliberately to inspire fear and awe. Lewis' shadow darkens the union of coal miners in life and death.

Like a polygon, Lewis had many sides. It follows that the institutions he shaped to express his view of the world would be as complicated. So it is with the United Mine Workers of America (UMWA)—a coal miners' union—and its Welfare and Retirement Funds.* The fund, designed in 1946 to provide health care and pensions to coal miners and their families, has been and is today a source both of comfort and anguish to its beneficiaries.

After four years of erratic beginnings the Fund was reconstituted in 1950 at a time when the coal industry was losing its two biggest markets: railroads and commercial heating. John L. Lewis, longtime president of the UMWA, saw the industry collapsing and—to save it—switched from fiery opposition to the big coal operators to a strategy of helping them cut labor costs through encouraging labor-saving mechanization. In return, Lewis persuaded the industry to finance a self-contained, UMWA-controlled health and retirement plan, and thus the UMWA Welfare and Retirement Fund was born.

In the decade that followed the Fund built and sponsored a unique health system, one of the most progressive in the nation—a network of hospitals

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* Until the 1974 contract, the UMWA health and pension plans were known as the Welfare and Retirement Fund. The 1974 contract divided the plan into four parts, collectively called The Funds in this article. When used in the singular, Fund refers to the pre-1974 plan.
and community clinics that offered prepaid, nearly comprehensive health care in the coalfields. "The broadest medical care plan undertaken for a nationwide industrial grouping up to that time in the United States, extending services to almost two million people," one commentator described it.¹

Yet the Fund has been from its inception beset with contradictions. It has been marked by a peculiar sweet-and-sour flavor explained in part by the collection of cooks that have seasoned it over the years. The Fund has always been a creature of collective bargaining between the union and the coal operators. By informal agreement UMWA presidents have always controlled its assets and set basic institutional directions until 1973. Meanwhile the Fund's medical program was conceived and implemented by some of America's most radical medical people.

The resulting oil-and-water mixture of progressive medical personnel and conservative—and often corrupt—UMWA presidents has fermented in the Fund for some 25 years. While the service-oriented left-wingers strove to build a model health-care system, UMWA presidents Lewis and Boyle turned the Fund into a carnival of financial jugglers, pickpockets and sideshow sharpies.

### Table 1

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<th>Years</th>
<th>Fatalities</th>
<th>Disabling Injuries</th>
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<tr>
<td>1906-1910</td>
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<tr>
<td>1911-1915</td>
<td>12,583</td>
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<td>1916-1920</td>
<td>12,097</td>
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<td>1921-1925</td>
<td>11,077</td>
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<td>1926-1930</td>
<td>11,175</td>
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<td>1931-1935</td>
<td>6,202</td>
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<td>1941-1945</td>
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<td>1946-1950</td>
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<td>1966-1970</td>
<td>1,229</td>
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<td>757</td>
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<td>1976</td>
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<tr>
<td>1906-1976</td>
<td>91,662</td>
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SOURCE: Reference 25.

* Data for 1930 only.

While the service-oriented left-wingers strove to build a model health-care system, UMWA presidents Lewis and Boyle turned the Fund into a carnival of financial jugglers, pickpockets and sideshow sharpies. To production and productivity, the Fund tied itself closely to the fortunes of the industry. The plan was barely in place when in the early 1960s it began a series of contractions which have reduced it from a vision of a comprehensive health system to little more than a health insurance scheme. The hospitals have been sold, prepayment axed, clinic support cut, eligibility and benefit levels dramatically reduced. Last June these cutbacks precipitated a summer-long wildcat strike of 80,000 miners and are now a major issue in the nationwide UMWA strike.

Today the Fund stands at the crossroads of historical changes both in the industry and in the union. The UMWA-big coal operator alliance that structured the political economy of the industry since 1950 has collapsed. The traditional Eastern leadership of the industry by Consolidation Coal and US Steel is now challenged by big non-unionized, strip mines in the West, led by Amax. And...
the UMWA is fragmented. Like a directionless meteor, it has broken from its rank-and-file orbit and disintegrates in space. The future of coalfield health care and pensions is directly tied to the strength of the UMWA in collective bargaining—a strength which is being severely tested now.

Origins

Prior to 1945 occupational safety and health, not to mention health care benefits, took a back seat to what John L. Lewis considered more urgent demands: union recognition, the union shop, the eight-hour day and higher wages. Yet between 1920 and 1950, an average of over 1,000 miners died on the job each year and another 50,000 were injured. Of the 41,677 miners retiring between 1948 and 1951, 47 percent did so because they were disabled, reported the UMWA Welfare and Retirement Fund. (See Table 1.)

The only health care available usually was provided by a company-hired doctor who was supported by a compulsory—and later, voluntary—wage deduction called "the check-off." By the mid-1940s, 70 percent of coal miners had a company doctor-prepayment plan, but dissatisfaction with the quality of care was widespread and justified. Occupational death, disability and disease coupled with a staggeringly deficient community health care system in the coalfields was an open sore.

World War II imposed a wage-freeze on American workers. Health care benefits were wedged into collective bargaining, however, when the National Labor Board ruled that a sickness benefit program not exceeding five percent of payroll costs was acceptably non-inflationary. Companies faced with excess profits could deduct the costs of health benefits as business expenses with "... little actual expense, since they would have had in any case to have paid much of it out in taxes." The Department of Labor estimated about 600,000 US workers "were covered by health benefit plans established through collective bargaining" by 1945.

In the spring of 1945 Lewis demanded an industrial health plan from the operators. (Pensions were not part of the original proposal.) The plan would be financed by a 10 cent-per-ton royalty on UMWA-mined coal. The operators refused. Labor Secretary Frances Perkins, in unsuccessful mediation attempts, rejected the health plan demand. Miners walked out when their contract expired in 1945. President Truman subsequently seized the mines and the miners returned to work under a conditional contract with the US government soon after.

Lewis renewed the demand for health benefits and linked it with a pension plan in his 1946 negotiations with Secretary of the Interior Julius Krug, manager of the now-federalized coal industry. Lewis argued for compensation, not prevention. "Social insurance and pensions should be considered as part of normal business costs to take care of temporary and permanent depreciation in the human 'machine' in much the same way as provision is made for depreciation and insurance of plant and machinery. This obligation should be among the first charges in revenue." "... the men who own the coal mines in this country, and use up the manpower of our industry... should bear that... cost of production."

Linking Health Benefits to Production

Lewis first asked that the health and welfare fund be financed by a seven percent payroll tax on operators, but soon shifted back to a tonnage royalty for reasons shrouded in historical mists. Eventually, Lewis persuaded Krug to go along with a five cent royalty (five cents to the Fund for every ton of coal mined), and the Fund was born in 1946.

Financing the Fund on the basis of output vested the UMWA with an interest in higher production and productivity, but not necessarily in a large number of working miners.
financed by employer and/or employee contributions per worker, thus linking the size of the benefit fund to the size of the labor force.

It also soon became apparent that when health and safety concerns in the workplace rubbed against productivity goals, production won. In an ironic way, then, the Fund "won" as the rank-and-file was losing. But what Lewis conceded in occupational health and safety, he hoped to make good through quality health care provided by the Fund.

**No Fund, No Coal**

Between 1946 and 1950 Lewis' Welfare and Retirement Fund was repeatedly sabotaged by federal administrators and industry opponents.11
Krug refused to activate the Fund by refusing to name the third (neutral) trustee. "No Fund, no coal," threatened Lewis in the fall of 1946, only to be hit with a temporary restraining order. Miners nevertheless struck and Lewis and the UMWA were slugged with big contempt penalties. Only after a federal study—the Boone Report—documented the disgraceful level of coalfield health care and the Centralia (Illinois) mining disaster claimed 111 victims did Krug activate the Fund.

The 1947 contract included a ten-cent royalty for the Fund. But the Fund was thwarted again when the operators deadlocked with Lewis over a $1,200 annual pension. The operators' trustee filed four suits to stop the Fund's operation. Strikes and Taft-Hartley injunctions followed one another like rungs on a ladder.

Finally, in 1948, the operators activated both the health care and pension provisions. The demand for coal, however, dropped like a lead sinker that year and another round of strikes, injunctions and impasse commenced. The Fund had made a beginning by 1950, but by then the dynamics of collective bargaining and coal's loss of the railroad and home-heating markets kept its books balanced on the edge of bankruptcy.

Labor of Love

The 1950 contract negotiated between Lewis and George Love of Consolidation Coal (Consol) is a benchmark in coal history. Cheap oil was driving dirty coal from its traditional markets. Thousands of miners were out of work. Hundreds of thousands were working short weeks. The big coal operators wrote this prescription for themselves: 1) concentrate production in a handful of dominant companies; 2) anoint a "Czar"—Consol's Love—to end intra-industry chaos; 3) mechanize production to reduce labor costs and to increase profitability; 4) accommodate Lewis in order to guarantee a stable work force; 5) delete the clause from the contract which had given the UMWA and its locals the legal right to strike since 1947; and 6) forestall additional federal intervention in coal affairs. Put simply, Love reoriented the big operators from trying to break the UMWA to using it.

"The policy of the UMWA will inevitably bring about the utmost employment of machinery of which coal mining is physically capable."
—John L. Lewis (1925)

Coincidentally, Lewis had wanted to ally with coal oligarchs for years, but they had never given him the chance. His own prescription for the industry, set out first in his book, The Miners' Fight for American Standards, which appeared in 1925, called for concentrated production units, mechanization and free enterprise coordinated through an industry-union alliance. In his own words:

"The policy of the United Mine Workers of America at this time [1925] is neither new nor revolutionary. It does not command the admiration of visionaries and Utopians. It ought to have the support of every thinking business man in the United States because it proposes to allow natural laws free play in the production and distribution of coal." (p. 15)

"The policy of the United Mine Workers of America will inevitably bring about the utmost employment of machinery of which coal mining is physically capable... Fair wages and American standards of living are inextricably bound up with the progressive substitutions of mechanical for human power." (pp. 108-109)

"...the development of low cost operations [mechanized] will automatically eliminate the un-economic mine... and anything which retards the development of low cost operations and forces them to divide the market with less well equipped mines will inevitably delay the mechanization of the industry.” (p. 113)

Mechanization, he believed, would make the coal industry competitive with oil and gas and bring high wages and benefits to those miners who continued to work. That was the catch: mechanization meant most miners—three out of four—would no longer be miners. (Between 1950 and 1969 the workforce fell from 415,000 to 124,000.) Many argue that Lewis had little choice with regard to mechanization. But it is one thing to phase in machines while seeking as many protections for the workforce as can be negotiated. It is quite another to simply write off thousands of loyal union members as industrial surplus.
Financing Mechanization

So Lewis and Love made their deal. They agreed to stabilize labor relations. The right to strike was axed and the UMWA did not authorize a contract strike for the next 20 years. Lewis had demanded publicly in 1950 a guaranteed annual wage of 200 work days, a big wage increase and a 20 cent boost in the Fund royalty. He settled for much less. Lewis agreed to help Love and the companies finance mechanization and drive the small operators out of business. Lewis loaned millions of UMWA dollars to the big companies to finance their mechanization plans in the 1950s.

Lewis loaned millions of UMWA dollars to the big companies to finance their mechanization plans in the 1950s while he masterminded an “organizing” campaign against the small independents characterized by terror and dynamite.

while he masterminded an “organizing” campaign against the small independents characterized by terror and dynamite. His goal was extermination, not organization. 16

When the big operators later met secretly to engineer a series of mergers among themselves, Lewis praised their effort. 17 Lewis had encouraged Love’s initiatives for industrial oligarchy in 1950 in return for which Love gave Lewis absolute control of the Fund and a 30 cent-per-ton royalty, enough to change appreciably the quality of health care for working miners throughout the coalfields. (The royalty was increased to 40 cents per ton in 1952, where it remained for the next 20 years.)

Because Lewis had destroyed most elements of rank-and-file control—things like contract ratification, local self-rule, and rank-and-file participation in collective bargaining—in the 1920s, there was neither check nor balance on the Love-Lewis pact or its 20-year reign.

A Health System Blossoms

From the Fund’s point of view, the 1950 contract appeared to solve its financial worries. A higher royalty and stable output meant the Fund could begin to plan an alternative system of health care for miners—a UMWA-owned, prepaid health care system in the coalfields. For those who qualified, health care was prepaid, and nearly comprehensive.

By 1956 the Fund had completed a chain of 10 coalfield hospitals and helped to organize several dozen clinics that employed doctors—both general practitioners and specialists—in group practices. Services included inpatient and outpatient hospital care, in-hospital physicians’ care, rehabilitation, nursing home services, pharmaceuticals, short-term therapy in "good prognosis" mental cases and major appliances. Eyeglasses and dental care were not included.

The clinics provided comprehensive primary health care to their participants on a prepaid basis. They stressed continuous health supervision, health maintenance, disease prevention, early detection, outpatient specialist consultation, family-centered rehabilitation and social services. In some cases the clinics were organized and built by the UMWA; in others, locally-organized group practices were financed by the UMWA. Where neither arrangement could be made, flat-rate retainers were worked out with the most competent local providers to treat miners and their families. In addition, thousands of widows received modest death and maintenance benefits; modest pensions were distributed to eligible retirees.

Challenge to American Medicine

In the late 1940s the Fund hired politically active medical administrators and doctors for key

The Body Count

Coal mining has never been a safe occupation, nor is it safe today, although great improvements have been made since 1970.

Between 1906 and 1976, government agencies report that 91,662 coal miners were killed. (See Table 1.) If coal mining were an American war, it would rank third in number of deaths behind World War II (407,316 dead) and World War I (116,708 dead). 26

Between 1930 and 1976, coal miners sustained more nonfatal disabling injuries than have all of America’s soldiers in all of America’s principal wars between the Revolution and Viet Nam. Coal mine injuries in the 1930-1976 period numbered 1,647,994. Nonfatal wounds in American wars are estimated to total 1,580,000, according to the National Safety Council. 26
jobs. Many came to the Fund as refugees from Truman's red-hunting in the Public Health Service and later from McCarthy's binge. Lewis was willing to hire medical radicals in the teeth of McCarthyism because of their professional ability and willingness to work for a militant labor union. They in turn got jobs and a chance to do good work; he got a good health care system for his dwindling membership. Each side made its peace with the other. The radicals didn't challenge Lewis' alliance with the big companies, the fixed tonnage royalty or the eligibility cutbacks. In fact, advocacy of better health care led the Fund's idealists to welcome the cold cash Lewis coaxed from coal operators. Lewis in turn backed up the radicals when they were attacked by the AMA for practicing "socialized" medicine.

And attacked they were. The Fund's challenge to traditional fee-for-service care and its advocacy of group practice with consumer control enraged state and national medical societies who sabotaged and red-baited the Fund throughout the 1950s. Medical societies in Pennsylvania, Illinois, West Virginia and Colorado tried to break the Fund's quality-of-care rules and retainer arrangements.

In Pennsylvania, the president of the Allegheny County Medical Society charged the Fund was "compromising the free practice of medicine," and two hospitals refused to grant privileges to clinic practitioners. Hospitals in East Kentucky and Ohio used the same tactic. When the Fund decided in April, 1955 that beneficiaries must have preadmission consultations with an appropriate specialist to determine the necessity of hospitalization, county medical societies and the AMA condemned the Fund for discriminating against general practitioners. The day after the AMA passed a resolution to this effect, the Fund's medical administrator retreated, withdrawing the directive. When a local hospital in Russellton, Pennsylvania denied privileges to clinic physicians in 1956, however, the Fund boycotted it.

The Fund tried to stick to its principles while avoiding a totally adversary relationship with organized medicine. The AMA in 1957 adopted guidelines—and even tried to get Fund agreement—affirming the rightness of fee-for-service payments and asserting the principle that "the medical profession does not concede to a third party such as . . . the Fund . . . the prerogative of passing judgment on the treatment rendered by physicians, including the necessity of hospitalizations, length of stay, and the like." The Fund retaliated by dropping about 29 percent of the physicians on its approved lists. Although state and national medical societies called upon their members to boycott the Fund, local coalfield doctors worked out truces with the Fund because so much of their income came from treating coal miners.

Short of national health insurance (which labor had pressed on Congress since the 1940s), the Fund's health care system was as good as there was in the United States in the 1950s.

**Limitations of the Fund**

Yet, as good as the Fund was, it had its limits. The 1950 contract reconstituted the Fund under the absolute control of three appointed trustees:

The radicals didn't challenge Lewis' alliance with the big companies, the fixed tonnage royalty or the eligibility cutbacks. Lewis in turn backed them up when they were attacked by the AMA for practicing "socialized medicine."

Although Lewis retired as UMWA president in 1960, he served as the union's Fund trustee until 1969—and ran the show. His choice for the neutral trustee was Josephine Roche, a confidant, who served until the early 1970s. She was never known to vote against Lewis.

Rank-and-file or beneficiary participation in top-level Fund decision-making was totally absent. Neither miners nor beneficiaries were ever asked to advise the trustees or Fund administrators. While policy was made by professionals within the framework established by Lewis, Fund doctors and medical administrators at lower levels tried to devise ways of making medical programs accountable to miners and consumers; many of the clinics were consumer-controlled. At the level of health services, it was the Fund's principle and practice to make coal miners and their families the central constituency of the system rather than health providers—a radical notion both then and now.

Most of the notoriety the Fund suffered from its "bag-man" role in Lewis' financial manipulations derived from the terms of the corrupting alliance the UMWA had contrived with the major companies. When good medical principles conflicted with the requirements of industrial stability and
Scandal at Gauley Bridge

The nation's worst occupational tragedy.

It has been called miners' asthma, potters' rot, grinders' consumption, sewer disease, rock tuberculosis, ganisters' disease, stonewinders' phthisis and tunnelitis. Today we know it as silicosis—an occupational disease threatening the lives of over one million workers, according to Labor Department estimates. The most prevalent of dust diseases, silicosis threatens foundry workers, sandblasters, tunnel workers, coal and metal miners, and those engaged in the manufacture of abrasive soaps, rubber or stone products, concrete, pottery, brick, glass, machinery, insulation and paint.

Silicosis is caused by the inhalation of microscopic particles of silica dust. Once inhaled, these tiny particles pass unimpeded through the body's respiratory defenses and find their way into the air sacs of the lungs. The lung tissue reacts to their presence by forming scar tissue which, being hard and inelastic, cannot exchange oxygen and carbon dioxide between the blood and the lungs. The result is a wracking cough, chest pains, shortness of breath and an increased susceptibility to tuberculosis, pneumonia and other lung infections. At first victims experience shortness of breath only during physical exertion; eventually the individual reaches a point at which any movement is exhausting.

Silicosis may take one of two forms. In acute or rapidly developing silicosis, symptoms appear eight to ten months after first exposure and death may follow within a year. The course of chronic silicosis is similar though less rapid; symptoms may not appear for many years after exposure.

Silicosis is probably the oldest occupational disease—it has been known for centuries. The symptoms were first noted by Hippocrates in the Fourth Century B.C. References abound up through the Twentieth Century, both with regard to its cause and to methods of prevention. Wet drilling as a means of prevention was patented in Britain as early as 1713.

As mechanization introduced electric drills and air hammers, the amount of dust in the air increased and silicosis increased as well. By 1914, studies revealed that silicosis rates were running as high as 80 percent among miners, and silica was labelled "the most harmful industrial dust." At about the same time, the US Bureau of Mines began a 20-year campaign advising industries of the dangers of silicosis and informing them of the means of prevention: "Wet drilling, adequate and
proper ventilation and circulation of air, the use of respirators by workmen and drills equipped with a suction or vacuum cup mechanism, were the principal methods recommended. Thus, in 1927, when the New Kanawha Power Company filed a declaration of intent to build a water tunnel in the southern part of West Virginia, silicosis was a well-recognized, preventable occupational disease.

Silicosis is probably the oldest occupational disease—the first symptoms were noted by Hippocrates in the Fourth Century B.C.

The tunnel was begun in 1930 and completed in 1932 through the efforts of nearly 5,000 workers—mostly black, mostly unskilled and entirely non-unionized. By 1936, less than four years later, 500 of these men were known dead from silicosis; 1,500 more were known to have been disabled by the disease, and countless others were undoubtedly affected. An investigation into this tragedy by a House subcommittee subsequently found "irrefutable proof that the disaster at Gauley Bridge need not have happened."

How it happened, why it happened, and the results of its happening, bear further examination.

**The Tragedy at Gauley Bridge**

In May, 1927, the New Kanawha Power Company filed a declaration of intent to construct a hydroelectric power station on the New and Kanawha Rivers in southern West Virginia. A subsidiary of Union Carbide and Carbon Company, NKP was licensed by the West Virginia Power Commission in the following year. The stated purpose of the project was to supply much-needed power, through public sale, to the neighboring communities. In reality, the project was planned to supply power to another Union Carbide subsidiary, the Electro-Metallurgical Company of Alloy, West Virginia. (This latter objective was formalized in 1933 when Electro-Metallurgical bought out New Kanawha Power and assumed control of the project.)

Of the 35 contractors bidding on the construction contract, NKP selected the Rinehart and Dennis Company of Charlottesville, Virginia—a traveling contracting firm with thirty years experience in the field. The contract called for the construction of a power station to include a 3.75 mile tunnel to divert water from New River, through the Hawks' Nest Mountain, to a hydroelectric plant at Gauley Bridge. This 30,000 horsepower project was to include a diversion dam, power house, surge chamber, excavation and other minor features.

The original plan called for a tunnel 32 feet wide, but when initial test bores by Rinehart and Dennis geologists revealed that the rock through which they would be drilling was from 97-99% pure silica, the plan was changed. Rinehart and Dennis was instructed to increase the tunnel size to 46 feet and the extremely valuable silica rock was loaded onto railroad cars at the tunnel mouth, and shipped directly to Electro-Metallurgical where it was to be used—without refining—in their manufacturing plant.

With full knowledge that they would be tunneling through pure silica, Rinehart and Dennis set out to recruit a work force. In early 1930, with unemployment estimated to be 15 million nationally, they had no trouble finding what Time Magazine later called "cheap, transient labor, colored and white." Primarily unskilled, non-union, black workers, from as far away as Pennsylvania, Georgia, North and South Carolina, Florida, Kentucky, Alabama and Ohio signed up, as did hundreds of workers from neighboring towns who thought that the Gauley project would provide steady work at good wages. Some were unemployed miners, familiar with conditions underground; many others were farm workers from the south with no experience with mining or its dangers. None were informed of the hazardous nature of the work they were about to undertake—Rinehart and Dennis did not post notices of the danger. The men had not voluntarily assumed the risk they were about to undertake.

Rinehart and Dennis later stated that a total of 4,948 workers were employed during the two years of construction; 3,280 were black. The maximum number of workers employed at any
one time was 1,250, of whom 850 were black.\footnote{12} This represents a turnover rate of over 300%. An estimated 2,000 black and 500 white men worked underground at one time or another, constructing what was later to be tragically called the "Tunnel of Death."

**Working Conditions**

Excavation began in June, 1930 and "from that point on the venality of the contractors was almost beyond conception. Disregarding even the most elementary health and safety precautions or the warnings of the West Virginia Bureau of Mines...they pushed the job through with presumably but one thought in mind—that speed means money," according to US Rep. Vito Marcantonio who spearheaded a special subcommittee of the House which investigated the incident.\footnote{13} The conditions under which the work was conducted can only be described as horrendous. Neither ignorance nor inexperience could explain away the callous disregard of human life: the dangers of silica dust were commonly known; the methods of prevention readily available.

Testimony abounds as to the levels of dust in the tunnel: "the dust was so thick in the tunnel that the atmosphere resembled a patch of dense fog," said one worker.\footnote{14} "You couldn't see ten feet ahead of you, even with the headlight of the donkey engine." "You couldn't tell a white man from a colored man, fifteen feet away." "Silica dust covered us from head to feet, got in our hair, our eyes, our throats, befouled our drinking water." "Strong husky men gasped, choked and collapsed on the ground and were carried outside to revive."\footnote{15} "There was so much dust," testified one driller, "that the trees nearby the camps looked like 'somebody had sprinkled flour all around.'"

Man after man testified to this condition and many more testified that it was due, in the main, to the use of dry drills. The initial contract called for wet drilling—drilling run with a stream of water spraying over the points to catch the dust and prevent it from flying into the air—yet this was not done. Even though wet drilling was known to be far safer than dry drilling, it was also slower and as a result, more expensive. Thus while all 16 drills used on the project were equipped with water heads, they were generally—but not always—run dry.

As several workers later testified, foremen assigned men to act as "lookouts" to warn them of the arrival of state inspectors so that dry drilling could be stopped. As a result, several inspectors were able to testify that when they visited the site, the tunnel was practically dust free. This conscious decision to place profit over human rights was probably a key cause of the deaths and disease this project generated.

Although West Virginia mining law requires a thirty minute wait before re-entering a tunnel after blasting,\footnote{17} a host of men testified that they were driven back in immediately after the blasts. "If you wanted to keep your job," declared Deacon Jones, a local worker and lay preacher, "you had to go back right away." Black workers were sent in before whites. "Foremen used pick handles and drilling steel to knock the Negroses on the head if they refused to enter immediately," declared an engineer on the project. "The men were handled worse than I have ever seen before."\footnote{18}

The locomotive cars which carried the rock out of the headings were powered by gas motors, in spite of the repeated admonishments by inspectors of the Bureau of Mines to use battery powered cars. The gas fumes from the cars made the workers drowsy, and at times poisoned them. One night twenty-eight men were reportedly carried out of the tunnel because of carbon monoxide fumes from these gasoline motors.\footnote{19}

The ventilation in the Hawks Nest Tunnel was declared wholly inadequate by workers, doctors, engineers and other experts. A 24 inch ventilation duct and an 18 inch fan were used to provide fresh air to the men. (One contractor, testifying in court for Rinehart and Dennis, told of working in a tunnel half the size of Gauley Bridge, and using a 24 inch duct and 24 inch fan.)\footnote{20}

No personal protection was provided by Rinehart and Dennis for its employees. This in spite of the high dust levels and in spite of Bureau of Mine warnings to contractors as far back as 1914 that adequate ventilation and respirators should be provided and in spite of the fact that New Kanawha Power provided its own engineers with
masks for use whenever they went underground. Masks cost approximately $2.50 in 1930 and, as the purchasing agent for Rinehart and Dennis succinctly stated, as reported by the US House Subcommittee, "I wouldn't give $2.50 for all the niggers on the job."21

Twenty hours a day, six days a week, the tunnel excavation continued. Two shifts of workers were each paid for 10 hours of duty, although they often worked up to 12 hours a day.

“There was so much dust that the trees nearby the camps looked like somebody had sprinkled flour all around.’”

—Testimony of a Driller

In 1930, when excavation began, workers were paid 50 cents an hour for their labor. As the depression wore on, wages were cut back to 40 cents, then 30 cents and finally to 25 cents an hour.

Weekly pay checks could only be cashed at the company commissary—at a charge of 10 percent per week. The only way to avoid the 10 percent surcharge was to hold the check for a week—but no credit was given for purchases, so few could avail themselves of this privilege.

Rinehart and Dennis charged 50 to 75 cents a week for the shacks it provided in the camps. Twenty-five to thirty blacks (workers and, in some cases, their families) lived in these shacks which were approximately 10 to 12 feet wide, with only two to three bunks provided in each. The rent did not include linens, coal, electricity or a stove which workers and their families had to purchase themselves. Coal cost 25 to 50 cents per week and was taken out of the pay checks regardless of whether or not it was used.

Mandatory “health insurance”—doctor and hospital fees—was also extracted from the weekly check. Black workers paid 75 cents a week for the doctor; white workers, 50 cents. For his fee a worker could expect the following: “black pills” for everything from a wracking cough to a broken leg; and a diagnosis of “tunnelitis” or perhaps pneumonia as silicosis began to strike in epidemic proportions.

Sick workers were not, however, to be excused from their day’s labor. Several reported that they were forced to hide out from the shack “rouster” if they were too ill to work. The shack “rouster” was a licensed deputy sheriff, appointed after a recommendation by Rinehart and Dennis, who made daily shack rounds for the company to insure that all who were scheduled to work did so.22

The Impact

Soon illness began to spread among workers on the project. After as little as six weeks’ exposure to the highly-concentrated silica dust, men became ill. Wracking coughs and shortness of breath were commonplace within nine months after the project began. By 1931, “men were dying like flies.”23 “The ambulance clanged day and night to the Coal Valley Hospital.” “The turnover in negro workers was tremendous.”24

In spite of Rinehart and Dennis’ later denials—denials of unsafe conditions, denial of any deaths from silicosis—it is apparent that the illnesses and deaths which resulted were not only known to them, but expected by them. For as the purchasing agent for the contractor candidly stated, “I knew we was going to kill these niggers, but I didn’t know it was going to be this soon.”25 Sen. Holt of West Virginia reported that the company further stated openly that “if we kill off those, there were plenty of other men to be had.”26

More important than these off-the-cuff remarks, however, was the fact that early in the project Rinehart and Dennis contracted with a nearby undertaker to bury the dead at $55 apiece. Asked why he had accepted the job at a price so low that the local Gauley Bridge undertaker had evidently refused, H.C. White declared that the “company had assured him there would be a large number of deaths.”27

“I wouldn’t give $2.50 for all the niggers on the job.”

—Testimony of Purchasing Agent, Rinehart and Dennis, commenting on $2.50 cost of a face mask.

Mr. White performed his tasks with great efficiency—the standard time between death and burial was three hours. In this manner the company was able to avoid both the filing of a death certificate and the performance of a possibly incriminating autopsy.28

The actual number of workers buried in these mass, unmarked graves was unknown to Mr. White, as he claimed in court that his records had
been lost. Subsequent investigation revealed that 169 men are buried in this field in Summerville “with cornstalks as their only gravestones and with no other means of identification.”

The actual number of workers who were eventually affected has been hotly contested. Not only were records “lost” but diagnoses of pneumonia, tuberculosis or tunnelitis added to the confusion. Death certificates, when filed, rarely mentioned the fact that the deceased had worked on the project. Many men had left the area before the situation was made public; many others fled in panic when the dangers were finally revealed. It has been generally concluded after considerable investigation, however, that few of the 2,500 men who worked underground escaped the deadly effects of silica dust.

**The Reaction**

The magnitude of the tragedy was not widely understood until the spring of 1933 when the first of many lawsuits against Rinehart and Dennis was filed. Over the next several years, hundreds of workers or their survivors were to bring suit against the company. Settlements, for those lucky enough to receive anything, ranged from $80-$250 for blacks and from $350-$1,000 for whites.

The trials themselves were described as a “macabre burlesque” and were characterized by jury tampering, threats and intimidation. The company denied that conditions were in any way unsafe or unhealthy, or that anyone had died of silicosis as a result of their employment on the project. They even went so far as to claim that they had never heard of the disease.

While hardly satisfactory for the defendants, the lawsuits did serve to bring the situation into the public eye. Much of the eventual stir, however, focused on the impact of the lawsuit “racket” on industry instead of the needless tragedy that maimed and killed hundreds of workers.

As Selleck reports of this period in his official history of the Industrial Medical Association written in 1962, silicosis suits were widely considered to be an organized racket, a fraud. Industry was portrayed as the true victim of enterprising lawyers and workers out to make a quick buck.

As more and more workers across the country took to the courts seeking damages for death or disability from conditions of employment, industry turned to the state legislatures in an effort to protect themselves from what could have become a very costly situation both politically and economically.

**Workmen’s Compensation**

Decades before this tragic incident, industry had realized that Workmen’s Compensation for industrial accidents made good business sense. (See Health/PAC BULLETIN, July-August 1976.) Not only did it place clear limits on employer liability, but it did so under the auspices of state legislatures which were known for their responsiveness to local interests.

In 1934 none of the state programs compensated specifically for silicosis, but a flurry of legislation during the following years resulted in 16 states developing programs that compensated for occupational diseases in general. An examination of these laws quickly reveals that they were, indeed, set up primarily to protect the companies—not the employees.

All too typical was the West Virginia Workmen’s Compensation legislation which was designed specifically to exclude Gauley Bridge victims from coverage and which gave little...
protection to potential victims of similar disasters. The West Virginia law, for example, allowed compensation for silicosis only under the following conditions:

- A worker must have been employed for two years at the same job.
- He must have filed his claim within one year after leaving the job and,

**Early in the project Rinehart and Dennis contracted with a nearby undertaker to bury the dead at $55 apiece. "The company assured him that there would be a large number of deaths."**

—Testimony, Congressional Hearings

- He must have given a complete life history to his employer at the start of employment and,
- He must never have broken any safety rules.

**Congressional Investigation**

The scandal of the Gauley Bridge was not exposed to the public until several months after the passage of the West Virginia legislation, nearly four years after the tunneling was complete. *Time* magazine credited this exposure to the radical press which "dug up the skeleton of Gauley Bridge and rattled its bones." These "rattlings" were heard by Representative Vito Marcantonio of Harlem, who introduced the legislation which led to the House Labor subcommittee investigation of this incident.

These hearings exposed the magnitude of the tragedy to full public view. After hearing testimony of doctors, lawyers, social workers, engineers, workers and their families, the committee charged the company with negligence. "That such negligence was either willful or the result of inexcusable and indefensible ignorance there can be no doubt on the face of the evidence presented to the committee," declared the report of the full House committee.

Representatives of the companies involved again denied all the charges lodged against them and again declared themselves to be the true victims of this disaster. Although they declined to testify before the committee, they made their position known through the pages of the *Engineering News-Record* and the *New York Times*. An editorial in the *Engineering News-Record* labelled the committee’s charges "the most unwarranted and vicious that have ever been hurled against a reputable contractor anywhere."

A Union Carbide spokesman declared that the company was "very proud of its safety record everywhere" and denied that there had been a single death attributable to silicosis. P.H. Faulconer, president of Rinehart and Dennis, labelled the charges misrepresentations and falsehoods. In his official response to the committee’s charges he stated that:

"The methods used in this construction were the standard or better, than have been used not only by us but by other tunnel builders, both on private and in government projects. We used every safeguard of life and health that was known to us or other contractors in similar work. Wet drilling was insisted on at all times . . . Conditions were better in this tunnel, and were so considered by many visiting engineers and contractors, than in any other tunnel we had ever seen. We did not furnish nor use dust masks or respirators because no need for them was apparent. The disease silicosis was not known to us, nor to other contractors of our acquaintance, before we were surprised by the bringing of damage suits . . . We know of no case of silicosis contracted on this job." (Emphasis added.)

Yet, in spite of all their denials, the facts remain: hundreds, perhaps thousands of workers needlessly died of silicosis contracted while constructing the Gauley Bridge tunnel. In their drive for profits, the company completely disregarded the health, safety or future of these men and their families.

**Contributory Factors**

But the drive for profits motivates all industrial activity—in fact all economic activity—in this country and, in and of itself, can not explain how
and why this tragedy was allowed to occur. Several other factors appear to have been contributory.

First, the massive unemployment generated by the Depression allowed employers to force workers into accepting progressively deteriorating conditions. One either accepted a job on the employer's terms, or did not work.

Second, the drive to industrial unionism had not yet reached most workers, especially the black and poor laborers in the South. Thus, workers had no real weapon available to them to use in seeking decent, safe working conditions from the company. In fact, what little advance recorded in occupational health prior to the depression came to a grinding halt by the 1930s.

Third, discrimination by the employers against black (and other minority) workers clearly exacerbated the situation. Not only did they suffer from the general negligence of the company, but they were made to endure conditions and treatment "worse than if they was mules." Because there were black workers on the job the company tolerated far worse conditions than they would have if the work force had been all white.

Compounding these conditions—perhaps because of these conditions—no adequate legislation existed to protect employees against employer negligence or to adequately compensate victims.

Thus, the drive for profits, which motivated these companies, was able to move ahead virtually unlettered by any countervailing force.

Gauley Bridge has become a symbol of industrial disaster. It has, in fact, been described as the most horrible industrial disaster in history.

To avert such disasters, the federal Occupational Safety and Health Act (OSHA) was

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established in 1970. While it has identified many life-threatening substances, few have been fully studied; fewer still have had standards set for their control. Today, silica dust remains one of the five worst hazards facing American workers—with well over one million workers daily exposed to its dangers, according to the federal OSHA agency.  

It might be argued, however, that the Gauley Bridge incident was unique, a freak accident, and thus its significance to us is open to question. However, while it may be true that a tragedy of this magnitude—with so many lives lost in so short a time—is not likely to occur today, it must be recognized that thousands still die from similar conditions. The deaths may be occurring slowly from chronic rather than acute silicosis, but the deaths are occurring. Between 1954 and 1963, 1,129 workers in New York State alone received workers compensation for occupational dust diseases, 95 percent of them for cases of silicosis. Of these 1,129 workers, 451 had died—nearly the same number known dead in the Gauley Bridge scandal—and 567 were permanently and totally disabled. In 1973 alone, again only in New York State, a total of 103 workers were compensated for silicosis and other dust diseases, of whom 51 died and 39 were permanently and totally disabled. These 51 deaths represented 80 percent of all occupational death cases compensated by New York State that year.  

Compounding the ineffectiveness of the government response is the unwillingness of the industrial medical profession to acknowledge the magnitude of occupational safety and health problems. This is evidenced in the Industrial Medical Association-sponsored account of this incident, published only 15 years ago, in which the Gauley Bridge tragedy was said to have occurred “like a bolt of lightning” and which saw the tragedy of the situation as the subsequent rash of lawsuits which they describe as representing a “fraud that was... practiced on an extensive scale.”

Thus while the Gauley Bridge incident is in some respects unique—as are all such incidents—the lesson it suggests has yet to be learned: that it is not lack of knowledge which perpetuates occupational problems but a lack of commitment to change on the part of those with the power to do so. The recent scandal of the pesticide DBCP and its sterilizing effects upon workers gives continuing evidence for this. Until workers’ lives are considered more valuable than employers’ profits, such tragic deaths will undoubtedly continue.

—Pat Forman

(Pat Forman is a graduate student at the Columbia University School of Public Health.)

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WASHINGTON

ADAM SMITH NOMINATED COST CONTROL DIRECTOR

One year later, in Carter’s Washington, health policy seems to be marching backward into time. Lofty plans for health system reorganization and national health insurance, due a year ago, have dwindled instead into promises that “principles” of a national health program will be “outlined” sometime in the next year.

Health, in Carter’s Washington, has become a dollar problem and cost containment the watchword. Now as clumsy bureaucratic measures falter on this front, the destiny of this backward slide may be clear. Carter is rediscovering the wonders of Adam Smith’s “free market”—wonders to be worked not upon the monopolies of the health system but—you guessed it—upon the already heavily-loaded backs of consumers.

Stumbles and Stalls

Cost containment remains an unsolved puzzle. Carter’s hospital cost control bill is stuck in Congress, having suffered such severe attacks from the medical industry, led by the American Hospital Association, that HEW Secretary Joseph Califano complained that he wished the AHA would devote as much energy to controlling waste in hospitals as it did in blocking his bill. Now Senator Richard Schweiker (R., Pa) has introduced AHA-backed legislation that would turn cost containment efforts over to the always more malleable states. And, at the urging of Representative Dan Rostenkowski (D., Ill.), whose House Committee is considering these bills, the AHA, the Federation of American Hospitals, and the AMA are rushing to put together a “voluntary” cost containment program that will rely on adverse publicity to pressure hospitals into cost reductions. The AHA, having already launched a nationwide ad campaign to counter its bad press, knows in advance what a soft touch that will be.

Health, in Carter’s Washington, has become a dollar problem and cost containment the watchword.

Meanwhile, HEW’s other cost control efforts stumble along. A recently-completed HEW Departmental evaluation of PSROs finds them to be ineffective at cutting costs. Its new HSA-based planning structure, too, is having trouble getting off the ground. Health planning guidelines proposed by HEW to limit the availability of hospital beds and services have come under sharp attack, with more than 12,000 mostly-critical comments received so far. The regs have been viewed uniformly as too restrictive, too much oriented toward cost control rather than health care enhancement, and too binding on HSAs.

And so the search for cost containment goes on, taking HEW Secretary Califano to such diverse zones as Wisconsin, Texas, California, Canada, England, and Germany in search of the Holy Mixed-Medical Economy, while back at home HEW is hiring dozens of economists to solve its health insurance and planning dilemmas.

The Light at the End of the Tunnel?

In the latest wrinkle, Califano has called in a former Pentagon Whiz Kid-turned-Stanford business professor, Alain Enthoven, to apply to social policy the same wisdom that was applied a decade ago to taming the arms race and pacifying Vietnam. Enthoven’s Plan, termed the Consumer Choice Health Plan, is being touted to the White House and the business community as a way to use the competitive market place to tame medical inflation and build a national health insurance program. HEW has conducted a two-day seminar for business and labor representatives on the Plan, at a plush setting on Virginia’s Skyline Drive, and Califano has presented the Plan at a White House meeting with Carter and other key advisors.

The search for cost containment goes on, taking HEW Secretary Califano to such diverse zones as Wisconsin, Texas, California, Canada, England and Germany in search of the Holy Mixed-Medical Economy.
industry, too, loves Enthoven; he keynoted recent conferences of the Washington Business Group on Health and the Group Health Association of America.

Having seen their earlier cost containment initiatives either be rejected or fail, Califano and his cohorts now want to turn cost control over to the victims of rising costs, the consumers. For the Enthoven Plan is not a health plan; it is a cost control plan. Its objective is to encourage consumers to spend less on health care—by eliminating the proportionate tax deduction on insurance premiums and out-of-pocket expenses, by making employer health benefit contributions taxable, and by encouraging the publication of pricing information that will lead the consumer to choose the lowest-cost health plan. To compensate for this loss of tax breaks, Enthoven would give a fixed tax credit to all households that join a qualified private insurance or prepaid health plan, and it would give an income-tested voucher for health plan costs to low-income households.

The Plan’s most direct antecedent is the AMA’s Medicredit Plan, which also would have provided a tax subsidy for private insurance premiums. What is new here is Enthoven’s attempt to use consumer pressure to contain costs and encourage “organized” health systems, i.e., HMOs, Individual Practice Associations, etc. (True to his free-market ideology, Enthoven does not include Community Health Centers among the organized health systems he wants to encourage.) However, no subsidy is provided in the Plan to encourage the creation of HMOs, beyond their supposed cost advantage to the consumer. Max Fine, director of organized labor’s consumer lobby, the Committee for National Health Insurance, has sharply attacked the Enthoven Plan, pointing out that “HMOs will not be started unless there are real incentives for providers to start them, for consumers to join them, and a sizable resource development fund to get them off the ground.”

The Plan would set up an elaborate process of federally-regulated consumer information and open-season enrollment intended to spur competition among alternative health plans—though it is silent on how it is going to create competition in the highly-monopolized medical care financing industry. Enthoven assumes that competing plans will somehow appear, and he then wants to “give consumers an incentive to seek out systems that provide care economically by letting them keep the savings.” He told the Washington BizGroup that the consumers should shop for the best health plan exactly as they would for a car—if the consumers choose to purchase a Chevy instead of a Cadillac, he told the representatives of Big Business, they can pocket the savings!

Enthoven’s Plan embodies the worst aspects of the Carter administration’s drive to return America’s economy to a fondly-remembered “free market.” It is right in line with the views of Carter’s chief economic advisor, Charles Schultze, who has written recently that “harnessing” material self-interest was “perhaps the most important social invention mankind has yet made.” Picking up on Carter’s by-now-notorious assertion that “life is unfair,” Enthoven puts down any attempt to compare his plan with “some hypothetical egalitarian ideal.”

In a time of multibillion-dollar insurance giants, metro-region-wide hospital empires, and powerful professional control groups, Enthoven would eliminate whatever slim bargaining power workers now have through their unions and insist that selection of a health plan be an individual matter of “consumer choice.”

In the face of such thinking, can things get any worse? Perhaps they can. Califano, recently

Califano has called in a former Pentagon Whiz Kid-turned-Stanford business professor, Alain Enthoven, to apply to social policy the same wisdom that was applied a decade ago to taming the arms race and pacifying Vietnam.
LAY MIDWIFERY: THE OLD BECOMES THE NEW?

The practice of lay midwifery—delivery of a child by anyone other than a licensed physician or nurse-midwife—is illegal in the United States today. A precedent-setting bill—supported amazingly enough by the Brown Administration—before the California State Legislature now proposes to change that.

There have always been midwives—special birth attendants have aided women in labor and delivery in every culture. While it is estimated that 80% of the births in the world are attended by midwives, the practice of midwifery has only recently reemerged as a legitimate occupation—and then only as nurse-midwifery—in the US.

The right of midwives to practice—i.e., assist in normal childbirth without the supervision of an attending physician—directly challenges the medical profession’s current monopoly over the definition and treatment of childbirth in this society. Challengers cite growing evidence indicating the dangers of hospital births and the success of home births as alternatives.

In California, the struggle over the legality of the practice of lay-midwifery has reached a decisive point. The conflict over the right of midwives to practice became a public issue in 1974 when several of the midwives associated with the Birth Center in Santa Cruz were arrested for practicing medicine without a license. A three-year court battle followed the arrests, which resulted in the decision that lay-midwifery cannot be practiced legally in California.

Those involved in the home-birth and midwifery movement have decided to go beyond the courts. Midwives continue to practice and have taken the issue to the state legislature. The Midwifery Practice Act of 1978—AB 1896—was introduced to the Subcommittee on Health Personnel on August 10, 1977, and is scheduled to go before the California Assembly in January, 1978. This bill is supported by midwives, advocates of homebirth, and, significantly, Governor Jerry Brown. Those opposing the bill include some obstetricians and some nurse-midwives (a profession made legal in California about two years ago).

The Midwifery Practice Act of 1978 would legalize lay-midwifery and give it autonomy from the medical profession and its interpretation of the condition and roles of the pregnant woman, her partner, relatives and friends, and the birth attendant. Some of the significant provisions of the bill include:

- Prospective midwives could choose between extensive apprenticeship or an educational program (to be established) for the training of midwives;

The average cost of hospital birth in California ranges from $1,000 to $1,500; estimates of the costs of midwives’ services as licensed under AB 1896 are from $250 to $400.

- Midwives would be licensed to practice independently, though in consultation with physicians, and they would be eligible for compensation under the Medical program (California’s Medi-Cal program);

- The licensing program would be regulated by a Midwifery Examining Committee appointed by the Governor and organized as an independent committee under the Board of Medical Quality Assurance;

- The cost of childbirth would be cut drastically; the average cost of hospital birth in California ranges from $1,000 to $1,500; estimates of costs of midwives’ services as licensed under AB 1896 are from $250 to $400.

An earlier attempt to revive lay-midwifery during the period from 1830 to 1870 parallels many of the present social and political circumstances. The Popular Health Movement chal-
lenged the monopolization of health care by the medical profession, the technological and supposedly scientific basis by which the licensed medical practitioners substantiated their control and what they felt to be the primary motive of their control—profits. Strong connections existed then as now between the Popular Health Movement and the newly-emerging Feminist Movement. They argued that the humanistic ideology presented by the medical profession was not what indeed was being practiced. In this climate of criticism and its concurrent search for alternatives gave birth to the revival of lay-midwifery. This movement was opposed by the existing medical establishment and was ultimately defeated.

The activities of this period are similar in several ways to the current struggles in this country around feminism and health care. As one writer has pointed out, "The social climate of the 1960s, increasing consumer dissatisfaction with the health care system and the feminist movement have contributed largely toward the renewed interest in and the increasingly favorable climate for the acceptance and utilization of midwives." 4

If the California bill passes and lay-midwives are licensed in that state, it will reflect a new understanding of pregnancy and childbirth as "well" and "normal" rather than the traditional view of them as "abnormal" and "dangerous" medical processes. And, perhaps more importantly, it will signify a change in the power of medicine to define and treat pregnancy and childbirth.

If the California bill passes and lay-midwives are licensed in that state, it will reflect a new understanding of pregnancy and childbirth as "well" and "normal" rather than the traditional view of them as "abnormal" and "dangerous" medical processes.

Whether or not the legislation passes, however, as one member of the Association for Childbirth at Home, International said, the need and demand for the home-birth alternative exists and will continue to be met. 5

—Catherine Ryan
Del Mar, California

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RETURN OF THE BODY SNATCHERS

The war for beds—or more correctly for bodies to fill them—has heated up in recent weeks among New York City's hospitals. One clear signal: early warning shots exchanged in late November between the private and public sector over control of the city's ambulance services.

The likelihood of a war has been brewing since at least last year when New York State Commissioner of Health, Dr. Robert P. Whalen, signalled the State's intent to close 13 New York City hospitals and the State Planning Commission thereafter obligingly announced its "discovery" of 5,000 excess beds in the city. (See "Politics Makes Strange Beds," July-August, 1977, BULLETIN.)

The rationales for cutting beds and closing institutions are complex, but two key arguments—that excess beds stimulate overutilization and thus inflate costs, and that institutions with low utilization rates provide inferior care—have been converted from partial truths to major ideological weapons employed by the city's giant medical centers to focus all closings on small private or municipal hospitals. This "cut anybody but us" stance by the major voluntary hospital-medical school complexes is rooted in the reality that both small private hospitals and municipal ones have experienced sagging inpatient utilization in recent years. Again, the factors underlying this decline are complex, but several critics have noted with alarm that one outcome of the strategy is likely to be further monopolization of services around the major institutions.

At least it is clear that the specter of closings has worsened the already-murderous competition for patients and the income they represent. And the forms this competition can take—with results that are often literally fatal—are strikingly foreshadowed in the ambulance skirmish and the issues it immediately raised.

The opening round was fired by the City's beleaguered Health and Hospitals Corporation (HHC—the quasi-public corporate parent of the 17 municipal hospitals). HHC notified Manhattan's Cabrini Health Care Center in November that it was withdrawing the $100,000 annual contract with Cabrini for ambulance services. Under the contract, one of several HHC has with voluntary institutions throughout the city, Cabrini is subsidized for operating HHC ambulances out of its own emergency room and staffed by its own personnel. When persons needing an ambulance call "911" in the city, they are connected with HHC's ambulance dispatch center located in Maspeth, Queens. Cabrini's contract "covers" one of the 22 ambulance districts in the city allocated to private institutions, out of a total of 36 districts. Under the subsidy arrangements, the private institutions get the emergency business generated within their territory in exchange for responding to all calls.

The importance of such contracts for the hospitals that receive them is suggested by Cabrini administrator John F. Reilly's estimate that 15 percent of its inpatient admissions are generated through the ambulance service. The figure nationally is estimated to be closer to 25 percent (see "Contracting for Emergencies," September/October, 1977, BULLETIN).

HHC's precipitous move to revoke Cabrini's contractor status seems tied up with HHC's long-range plan to regionalize all Emergency Medical Services (EMS) into a unified system under HHC control. The plan—developed with HEW funds and in collaboration with the NYC Health Systems Agency—would incorporate all existing ambulance services: proprietary, voluntary and municipal. The plan's implementation is still months away, however, so that the slap at Cabrini struck some observers as either a trial balloon or a case of jumping the gun by HHC administrators.
Cabrini patients for nearby Bellevue (whose general care beds occupancy rate is down to near 70 percent) and added that the move was the beginning of a campaign to "pick off the voluntaries one at a time." (New York Times, November 30, 1977) A later story in the Times quoted such luminaries as Dr. S.

If Lynaugh plans to convert the municipal system into a dead ringer for the private sector, is the Emergency Medical Services move the opening gambit in his game plan?

David Pomrinse, President of the Greater New York Hospital Association (trade association for the city’s voluntaries), Dr. Lowell E. Bellin, former City Health Commissioner; acting HHC President Joseph T. Lynaugh, and unnamed HHC officials, all of whom concurred about a "fight for bodies" (Pomrinse), a "battle to fill beds" (Bellin), and a problem of "patient rustling" (Lynaugh). So serious was the perception of the Cabrini incident that representatives from Greater New York Hospital Association and District 1199, the union representing voluntary hospital workers, demanded an immediate meeting with Lynaugh to warn HHC off. Lynaugh reportedly assured their spokespersons only that future attacks will be preceded by advance warnings.

Lurking in the shadows of this battle are the ghosts of a number of enormous unresolved public policy issues that continue to underly the beds war. Among these are:

- How does HHC’s EMS regionalization plan—or the Cabrini decision—relate to Lynaugh’s stated agenda for salvaging the troubled municipal system? Lynaugh’s strategy emphasizes a sort of "second string" set of affiliations between municipal hospitals and "better" Medicaid mills, prepaid group practice plans and various other proprietary interests. The latter would generate new patient business for the municipals as well as offering real competition to the voluntary affiliates which now provide the bulk of medical staffing for HHC facilities. The object: fill municipal beds. The danger: sacrifice of the health care purpose of the public institutions to the god of institutional solvency—in short, Lynaugh’s plan to further volunteerize and even privatize the municipal system may cost it its relevance to the health problems of the population it serves. If Lynaugh plans to convert the municipal system into a dead ringer for the private sector, is the EMS move the opening gambit in his game plan?

- The overall bed-closing strategy purports to offer both reduced costs and more effective delivery. Can it truly accomplish either? Critics note that the likeliest result is a consolidation of services around fewer but larger private institutions. It would beg incredulity to claim that such centralization will really lower costs in a service sector already marked by substantial regional monopoly. As for better delivery, sharp questions need to be raised about the glib assumptions that institutions with lower occupancy rates are medically ineffective in general. In fact, many services provided by both the smaller private hospitals and the municipals probably deteriorate when centralized into fewer, larger institutions. Examples are maternal and pediatric care, routine surgery and most forms of ambulatory care. (Opponents of a plan to close smaller, less-utilized obstetrical units on Long Island recently cited a study by State Deputy Health Commissioner Andrew Fleck that found no difference in infant mortality based on the unit’s size).

- Despite mounting evidence from throughout the country and, indeed, the world that community-based primary and preventive care is more cost-effective and medically sound than much of the available hospital care, why does all NYC and NYS health policy and politics seem to revolve around hospital-based services? Why does NYC lag behind many US cities—Newark, Baltimore, Detroit are examples—in moving toward integrated networks of primary/preventive care centers that are non-hospital based? While the bed war rages many NYC neighborhoods—and millions of New Yorkers—have little or no access to routine, primary care. For answers to these and other questions, please stay tuned.

—Michael E. Clark
OSHA CANCER POLICY:  
A BREATH OF FRESH AIR

On October 4, 1977 Dr. Eula Bingham, Assistant Secretary of Labor for Occupational Safety and Health, published in the Federal Register—in 80 pages of fine print—a proposal to regulate suspected cancer-causing agents (carcinogens) in the workplace.

The cancer policy proposal is sensible in its staged approach to regulating literally thousands of cancer suspect agents in the workplace, conservative of human life in the best traditions of public health policy (in a field where action customarily follows rather than precedes a body count) and notable as an act of political leadership by OSHA.

Consequently, far out in the bureaucratic sea of paper which daily emanates from Washington, a storm of major proportions is developing. One of the surest storm signals is that, for the first time during Dr. Bingham’s tenure, rumors are circulating that she may resign. The rumors have no apparent basis in developments internal to the OSHA agency, and Dr. Bingham has specifically denied them. One strongly suspects that the rumors are in fact a trial balloon by some industries (which seem to be the source of the rumors) to force her resignation or dismissal. In the Washington tradition of leaks and media manipulation, the way to launch such an idea is to first give it public reality, hoping that it will go on to become the proverbial self-fulfilling prophecy.

Certainly industry is quite unhappy about the OSHA proposal and can be expected to strongly attack it when hearings begin next April in Washington.

Toxic Substance Categories

Basically the OSHA document proposes to classify all workplace chemicals which cause cancer in humans or animals into one of four toxic-substance categories, based on the strength of scientific evidence against the chemical, and to reduce human exposure correspondingly. Specifically,

• A Category I Toxic Substance is defined as a substance which is known to cause cancer in humans, which has been shown in two separate studies to cause cancer in mammalian animals of the same or different species, or which has been shown in one mammalian study to cause cancer and in one bacterial study to cause genetic mutations.

Within six months, according to the proposal, workplace exposure to this substance must be reduced to the “lowest feasible level” based solely on engineering and work-practice controls—not on use of personal protective devices. (During the six-month period following initial classification, personal protective devices such as face masks are allowed to reduce worker exposure.)

• A Category II Toxic Substance is one shown only in one animal study to cause cancer. Also if one or both of the two animal studies needed for a Category I classification are judged incomplete or inadequate, the material is classified in Category II. Because high exposure to suspected carcinogens often produces other maladies as well, the proposed standard would limit exposure to Category II substances, within six months, to a level free of these other adverse health effects. Thus, in this case, where there is some, but insufficient evidence that a substance causes cancer, the proposal would at least place some limit on worker exposure until further studies can be carried out.

• A Category III Toxic Substance is one for which evidence of carcinogenicity (i.e., ability to cause cancer) is admittedly meager. Here no new exposure standard is set. OSHA is required, however, to publish the evidence leading to this categorization, thus encouraging further studies and publicly warning workers and others of the potential cancer danger.

• Category IV is also one which involves publication of evidence, in this case for substances which are suspect carcinogens but not now known to be used in workplaces in this country.
In short, action against a substance is staged depending on the strength of evidence against it. Where animal tests, for example, indicate potential cancer danger, exposure must be limited to the lowest extent feasible. Where these tests are inadequate or only one animal test has been made, some limitation of exposure must be made within six months. If evidence of danger is only suggestive, based, for example, on a bacterial test such as the Ames test, exposure is not regulated, but the experimental evidence is publicly released.

The Critical Decisions

At the heart of this proposal are two fundamental policy decisions based on the weight of available scientific evidence: animal studies are treated as predictive of human cancer, and no safe level of exposure to a carcinogen is considered to exist.
profits, the former suffered. To keep the big companies competitive with oil and gas in the electric utility market, Lewis and his successors chose not to seek an increase in the 40 cent royalty through collective bargaining for 20 years. Consequently the Fund had to cut off unemployed miners from health care. In the early 1960s the static royalty forced the Fund to sell its hospitals at a financial and spiritual loss. Without the hospitals, the Fund, like any prepaid health system, no longer had a yardstick with which to measure the quality of other coalfield health services.

The Fund’s medical staff had to fudge their commitment to preventive medicine when it involved occupational injury and disease. To do otherwise would necessarily challenge Lewis’ alliance with Love. Anything that impinged on the profitability—like dust and methane control systems or better roof-control practices—could not be pushed hard by the medical people or demanded by Lewis in collective bargaining. Britain had recognized black lung as an occupational disease of coal miners in 1942, yet the Fund did little to pin the growing incidence of the disease on the new machines that were the core of the post-1950 mechanization. The Fund supported the occupational health work of Dr. Lorin Kerr, but little was done to follow it up.

Neither the UMWA nor the Fund pushed for black lung disability compensation until the late 1960s, and no thought at all was given to industry-financed compensation. It took the rank-and-file black lung revolt in West Virginia in 1969 to flush out the UMWA on black lung compensation and even then the union’s role was tainted by its Johnny-come-lately character. Though Lewis had boasted the Fund in 1946 as a device to make the industry bear the “human costs of production,” at no time were there any significant efforts to prevent occupational disease and injury. Consequently, the Fund’s practice of preventive medicine was limited to communities and did not include the workplace.

Beyond its health and pension programs, what strikes the observer is how little the Fund actually did for the “welfare” of coal miners. If the money had been there, the Fund could have provided disability benefits and unemployment insurance to soften the impact of the depression that enveloped coal miners in the 1950s and 1960s. Moreover, the Fund could have begun programs in housing, education, job training, and recreation for its beneficiaries. But the money wasn’t there because Lewis judged the industry could not afford to put it there. (This point is disputed. The 1950s saw the demise of many small operators but, some argue, brought relative prosperity to the large ones.)

Inflation and mismanagement cut into the Fund’s resources in the 1960s, resulting in the erosion of the Fund’s health and pension benefits. Eligibility for health benefits became increasingly restrictive. Thousands of miners and widows had their health cards cancelled while the Fund’s assets were loaned interest-free to coal operators and its cash reserves were used to purchase coal company and utility stocks.

Pensions were also denied disabled miners and some widows for “economy” reasons. For those who did receive them, pensions never moved much beyond $100 a month until Tony Boyle, Lewis’ eventual successor, maneuvered them up to $150 in order to capture the pensioner vote in his 1969 election battle with reformer Jock Yablonski. Meanwhile the Fund’s medical staff did little to protest the financial and administrative practices of Lewis and Boyle.

**Rank-and-File Revolt**

By the late 1960s, conditions in the workplace and in the union had produced a rank-and-file revolt. Disabled miners and widows shut down the West Virginia coalfields in 1968 in a dispute over Fund eligibility. The West Virginia Black Lung movement succeeded in winning a state compensation law through a month-long wildcat strike in 1969. The methane explosion at Consol’s Farmington, West Virginia mine in November, 1968 shamed Congress into debating mine safety. The union reform drive led by Jock Yablonski focused rank-and-file attention on Boyle’s corruption in the UMWA and the Fund. Yablonski’s subsequent
murder in December, 1969 spotlighted Boyle's reign in the coalfields.

(Unfortunately, Yablonski never pinned the tail on the patriarchal donkey—Lewis. Yablonski always tried to portray himself as Lewis' descendant instead of tracing the excesses of Boyle's regime back to the structure Lewis had built in

Thousands of miners and widows had their health cards cancelled while the Fund's assets were loaned interest-free to coal operators and its cash reserves were used to purchase coal company and utility stocks.

1950. Even today, Lewis' mantle gets draped around aspiring union politicians, even those who know better. Boyle was Lewis' dark side without the benefit of his grays and whites.)

Numerous lawsuits successfully challenged Boyle's management of the UMWA and the Fund. One of these, Blankenship v. Boyle, was brought on behalf of 17,000 miners and widows by an earnest lawyer, Harry Huge of Arnold and Porter, a well-connected Washington firm. The US District Court in Washington said Lewis, Roche and the National Bank of Washington conspired in holding the Fund's assets in non-interest-bearing accounts. Judge Gerhard Gesell concluded that Lewis and Roche had advanced "the interests of the union and the bank in disregard of the paramount interest of the beneficiaries." He also found violations by the trustees in the "withholding of health cards from members when their employers became delinquent in royalty payments" among other irregularities. Boyle and Roche were removed from the Fund.

Enter the Reformers

When the reformers, led by Arnold Miller and the Yablonski veterans, took over in December, 1972, both the UMWA and the Fund badly needed an overhaul. That work was begun, but it faced many problems and the odds against its success were surmountable, but barely. Huge was named the UMWA trustee and chairman of the Fund. Independence of the Fund from the UMWA was declared. (By law its policies and administration must be distinct from the union and the operators—a requirement openly disdained by Lewis and Boyle ever since the operators had conceded control of the Fund in the 1950 deal.)

Still, miners and other Fund beneficiaries had a right to expect that Huge would interpret the Fund's mandate in line with the reform sentiments of the miners who had recently elected Arnold Miller union president. They expected competence, compassion, honesty, openness and service.

Huge, a smart and ambitious man, was genuinely moved by the plight of the Fund's beneficiaries. He chose a legalistic and technical approach to solving Fund problems. He hired a veteran from the Law Enforcement Assistance Administration, Martin Danziger, to direct the Fund. Danziger had not one scintilla of knowledge about coal, coal miners, coal operators, the Fund, pensions or health care. His only qualification for the position was his "considerable administrative experience," as the Fund's Annual Report phrased it. Both Huge and Danziger now put their professional reputations on the line. They chose to equate the quality of care with efficiency of service. With that faulty equation, they concentrated on improving the Fund's administrative services.

The result was that their constituency became health providers, not health consumers.

Whereas the Fund of the 1950s was willing to fight medical society dogma when principles were at stake, the Funds under Huge and Danziger (there were four Funds after 1974—see below) have no bones to pick with state medical societies and the AMA. When the interests of health providers and health consumers parted ways, the Funds parted with their beneficiary constituency. Today the visibility and vocalness of established medical opinion serves as an omnipresent check on Huge and Danziger; in contrast beneficiary participation is still totally absent in Funds' policy making.

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Destroying the Fund to Save It

Huge and Danziger managed to ignore much of the good in the Fund's past. Efficiency to them meant scrapping existing administrative proce-
dures and denigrating existing personnel, many of whom had been with the Fund since the early 1950s and had demonstrated competence. The quality of care had not generally been an issue in the past, although access to that care and certain administrative practices had. Lacking the subtlety to leave the good and discard the bad, Huge and Danziger threw out both.

The new Funds also seemed to forget the activist principles of the early Fund. In the bright, encouraging days of 1973 and 1974, the Funds talked about "substantial changes in focus and attitude." The first open trustees' meeting in the Fund's history was held in Charleston, West Virginia. But as Huge's policies began to be implemented and criticized, the open meetings ended.

Dr. C. Arden Miller, president of the American Public Health Association, was commissioned to do an in-depth critique of the Funds' programs. Miller recommended the Funds "lean toward a health care policy that promotes prevention of disease." He urged a program of social advocacy, that the Funds "in the interest of the good health of [their] beneficiaries, should become active in the establishment of nutrition and school health programs... and advocate... social and governmental change." He felt "all types of Fund[s'] beneficiaries should be included on the governing bodies of all agencies which do business with the Fund[s]." (Quotes from the Funds' 1973-1974 Annual Report, pp. 18-19).

Miller's ambitious ideas and his notion of the Funds as a social-change advocate never got very far in Danziger's computers. The social advocacy rhetoric in the Funds' 1974 annual report was noticeably absent in the 1975 and 1976 editions. In another instance miners pleaded with Huge for one solid year to use the Funds' financial power on behalf of striking union hospital workers in Pikeville, Kentucky in 1973. Huge refused; the strike failed.

The final and most ironic twist is that Huge and Danziger have not even managed the Funds skillfully. Suzanne Jaworski Rhodenbaugh, a former health service specialist with the Johnston, Pennsylvania regional Funds' administrator, charged the recent cutbacks were due less to the effect of wildcats than to simple mismanagement:

"Technocrats... have made clear that neither people nor programs rank in importance to their introduction of a centralized, computerized method of paying medical bills and pension checks.

"Yet they have failed miserably at managing.
Many cost and quality controls in the health program have been lost. Medical bills are paid late (if not lost); duplicate claims are paid; pension checks to retired miners are delayed; eligibility controls are often out of control. Virtually all experienced top-level Funds staffers have been retired, fired, or have quit in disgust. In their place have come dozens of would-be technocrats who know nothing of labor, health, or pension programs, or management. These technocrats don’t stay long, however, and the incredible turnover fuels the problem.

“So much of the Funds’ program has been gutted while it was ‘modernized.’ And direct health expenditures and administrative costs have risen dramatically. Yet the self-serving press releases of the Funds—putting all the blame for the financial problems on the wildcats—have been blandly accepted.”

The Funds’ mismanagement has aggravated the money problem. The Funds no longer have any effective way of checking fees billed by the doctors. The result has been predictable: massive overcharging, which, if caught at all, comes after payment. In many regions the Funds have paid charges rather than haggle with local providers over cost-based arrangements—a reflection of the Funds’ bias toward their provider constituency.

Some hospital administrators acknowledge the Funds pay more for daily services than other plans, which amounts to a Funds’ subsidy for other coalfield health services.

The 1974 Contract

The UMWA reformers negotiated their first contract in late 1974. The operators, fattened off the 1973 oil embargo, knew the year-old Miller administration had to come up with a qualitatively different and quantitatively better contract. The companies tried to buy labor peace by giving Miller a big contract. They failed. The 1974 contract included better wages and benefits than its predecessors, but miners figured this was due them, given the bloated profits the companies had collected since 1971.

To ease the financial crisis of the old Fund, the UMWA and the operators agreed to split it into four separate Funds, each financed separately and each providing different benefits: the 1950 Pension Trust (with 82,000 pensioners), the 1950 Benefit Trust, the 1974 Pension Trust (with 6,000 pensioners) and the 1974 Benefit Trust. Both the 1950 Pension and the 1950 Benefit (health care) Funds continue to be financed by a tonnage royalty. The 1974 Pension and the 1974 Benefit Funds, however, are financed in whole or in part on an hours-worked basis.

In breaking up the Funds, the new contract established a two-tier pension system that discriminates against those miners who retired before 1976. Pre-contract pensioners are limited to $250 per month (a phased-in raise of $100 over their present pensions) while new retirees are allowed pensions of more than $350 a month on a sliding scale based on years worked and age at retirement. The artificial distinctions have embittered older pensioners and become a continuing source of division within the union.

Taken together the Funds are solvent, but separately the 1950 Pension and Benefit Trust are bankrupt. The industry, through negotiations or the Funds’ trustees, may try to dump the 1950 Pension Trust with its high obligations onto the federal government, but there are many uncertainties about this. If the federal Pension Benefits Guarantee Corporation did take over the liabilities of the 1950 Pension Trust, UMWA pensioners would be locked into a $210 a month benefit level, a $40 reduction from current standards.

UMWA strategists hoped that the 1974 Plans would draw in payments adequate to guarantee higher benefits. The 1950 pensioners were sacrificed for this goal; because pensioners do not vote in contract ratification, Miller could swap their...
interests for those of working miners. The industry now wants to drop the heavy obligations of the 1950 Pension Plan and the UMWA may go along, since its ability to organize non-UMWA miners is hindered by the heavy obligations of the 1950 Pension Plan.

**Bad Projections**

UMWA negotiators estimated the cash needs of the four trusts, projecting new Funds' beneficiaries, increased coal production, medical costs and inflation. Some of the projections were close; some were not. More beneficiaries were added than expected; less coal was mined and many fewer new mines were opened than the operators had promised; medical costs—for whatever reasons—went through the roof. The UMWA had assumed it could organize Western strip mines; it couldn’t. Bad winter weather in 1976 and 1977 cut into production.

Finally, no one could have predicted the wave after wave of wildcat strikes that have washed over the coalfields in the last three years. Since 1974 miners have quit work over a spectrum of workplace and non-workplace issues—gasoline rationing, the right to strike, offensive school textbooks, black lung legislation, seniority, safety, job rights, union politics and benefits cutbacks. Operators have encouraged some of these strikes when stockpiles were up or when spot-market prices were down. Because the other faulty projections left the Funds short of cash, wildcat strikes threatened to bankrupt the 1974 and 1950 Bene-

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**These days, coal operators can be heard lamenting the lack of a “strong coal union, a union led by someone like John L., who knew how to bargain with us,” as a former top Consol official put it recently.**

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Cutbacks

By last May, the Trustees decided that medical benefits would have to be cut. The Funds lacked the cash to continue providing “first-dollar coverage” (payment of all initial medical costs for covered services), so a cost-sharing scheme was promulgated that set up deductible and coinsurance payments with a $500 annual “cap” (maximum out-of-pocket payment) per eligible family.

The Trustees withheld the announcement, however, until June 20—six days after Arnold Miller
had squeaked through a rough reelection campaign. Huge was accused of delaying announcement of the cutbacks until after the election to avoid blowing Miller's chances. (He was also accused of conflict of interest in contributing some $1,000 to Miller forces in the campaign.) The cutback would certainly have done just that. As it

**Industry's strategy is to use the health care system to discipline rank-and-file miners for striking. It is a strategy designed to soften the on-the-job militancy of miners by attacking their off-the-job security.**

was, Miller lost the election among working miners, but won through the support of retirees.

The Funds also decided to cut back financial support for about two dozen coalfield clinics. These "miners" clinics are not formally affiliated with the UMWA or the Funds. Often set up through the combined efforts of the UMWA, local unions and the Funds, however, they have always enjoyed special retainer (prepayment) arrangements with the Funds. These retainers allowed the clinics to plan their programs and underwrite a wide range of medical services to miners and their communities not covered by specific fee-for-service payments. On July 1, 1977, without prior announcement, the Funds stopped the retainers; instead they instituted a fee-for-service formula where the Funds paid 60 percent of the bill and the patient 40 percent.

These cutbacks may be a lethal blow to one of the most innovative and, some would argue, successful elements of the Funds' health programs. The clinics not only provided competition to local providers, they embraced a different model of how health care should be provided. Many of the clinics were founded on—and retain—consumer-control mechanisms. Much of their programmatic thrust is toward prevention. A wide range of social services—including benefits counseling—is provided. The clinics claim they save the Funds millions of dollars by reducing hospitalizations and surgery although the claim is hard to prove. Each clinic has evolved differently over the years, and all have differences. Nevertheless, all have become medical outposts in the coalfields and important community institutions. Nothing will replace them if they fold.
To Huge and Danziger, with their implicit provider perspective, retrenchment of the clinics made sense when economies were demanded. A panel of coalfield beneficiaries would probably have acted differently had it been consulted. No panel existed, however; no consultations were made before the cuts. The clinics protested collectively to the Funds' trustees, without effect. Their fate now hangs precariously on the benefits-financing formula the UMWA and the operators agree to in the upcoming negotiations.

**His Head is Not the Point**

Had miners been involved, they would have known that the June cutbacks would precipitate a strike. The Funds' leadership, on the other hand, seemed surprised by the three-month wildcat that resulted. The strike finally wound down after a coalfield meeting between strikers and Arnold Miller; the UMWA president was given a 60-day reprieve to restore the cuts or call a nationwide strike. Miller has not asked Huge to resign, although the union's executive board requested his resignation. Coalfield petitions demanded Huge's head.

His head, however, is not the point; his perspective is. Huge and Danziger are neither evil nor crooked; rather their professed managerial "objectivity" translates into pro-provider policies. They now face a whirlpool of Watergate proportions that threatens to swamp their career boats and cause them to lose their captain's papers in the Washington fleet. That is their stake in the Funds now. (Huge was Miller's principal contract advisor even while he sat as a Fund trustee. When the operators threatened to sue over Huge's illegal dual roles, he resigned from the Fund and now directs UMWA negotiations. Huge, who is tightly knit with the Carter Administration, will undoubtedly receive the lion's share of the UMWA's lucrative legal business once the contract is ratified.)

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For instance the UMWA could seek a contractual guarantee from the Bituminous Coal Operators of America (BCOA) to pay all Funds expenses for contracted services whatever they may be. Winning this point in negotiations would free the miners' health care system from being hostage to inflation, production ups and downs and strikes, those initiated by miners and those precipitated by operators. This method could or could not continue the pay-as-you-go financing system, but it does remove the incentive for the Funds to cut back on services and benefits in emergencies.

Only the UMWA and the BCOA—the negotiating arm of the industry—can make such a change, and they are unlikely to do so. More likely is a switch to traditional Blue Cross/Blue Shield coverage, whereupon 25 years of coalfield health struggle goes down the drain.

The Funds, as always, will be the creature of collective bargaining. This year's negotiations promise to be the most important since the Lewis-

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**Breaking the Production Tie**

Throughout its history the UMWA pension and health-care plan has been tied into the level of production. This has been a singularly corrupting influence on UMWA leadership. It has, more importantly, also victimized coal miners in their workplace and communities. A necessary part of the solution to the impasse over coalfield medical care lies in negotiating a health and retirement plan that is not tied in to any particular index of operator prosperity, but finances benefits as they are needed.

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With the UMWA incapable of "organizing" its own membership, the big companies have given up trying to use the UMWA for their own ends. Now, it is likely they will try to break it clean and simple.
Love contract of 1950. The alliance between the UMWA and the big operators is broken. The UMWA is fragmenting. Consol's preeminence as the political and production leader has been successfully challenged by Western strip-mine companies. The industry may regionalize its contracts and set up individual benefits packages on a company-by-company or district-by-district basis. With the UMWA incapable of "organizing" its own membership, the big companies have given up trying to use the UMWA for their own ends. Now, it's likely they will try to break it, clean and simple.

Miners and mine-area health consumers are once again faced with the need to take control over their union and their health plan. They must do this both to get to the root of production-related illnesses, injuries and deaths in the mines and to establish once again an effective system of community-based health services in the coalfield regions.

Restorations of the cuts made by the trustees this summer is a necessary—but incomplete—demand. The real health cutbacks have been taking place since the 1960s and involve a sweeping programmatic retrenchment. Today, the Funds—even with the cuts restored—are simply an insurance scheme for miners and a pay-

Table 2

Summary of Equity Securities
UMWA Pension Trust
December 31, 1975

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<tr>
<th>Securities</th>
<th>Corporation</th>
<th>Cost</th>
<th>Market Value</th>
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<td>Potomac Electric Power $2.45 Cum Pld 58</td>
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<td>$725</td>
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<td>12,000</td>
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<td>Union Electric Company</td>
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$5,620,723               $4,527,500


What really needs restoring is the progressive vision of the early Fund, a vision of what a health care system should do. That vision is valid today. It sees a miner-controlled health service system where facilities are owned by miners and providers are employees of a workers' organization. It's that vision that should be restored.

—Curtis Seltzer with the assistance of Robb Burlage

(Curtis Seltzer was, for many years, a coalfield journalist. He founded the Appalachian News Service and now works in Washington.)
REFERENCES

8. The tonnage royalty was a financing mechanism that had been used in Britain since 1920 when a National Miners' Welfare Fund was established to improve the "social well-being, the recreation, and the living conditions of mine workers." It was financed by a one cent per ton royalty. See Ludwig Teleky, History of Factory and Mine Hygiene, New York, Columbia University Press, 1948, p. 227.
11. See the chronology of events for this period in UMWA Welfare and Retirement Fund, Four Year Summary, 1962.
12. The UMWA estimated in 1951 that more than 100,000 miners were out of work and that at least half of them were over 45 years old and would never find coal mine employment. See Michael Widmann, Assistant to the President and Director of Research and Marketing of the United Mine Workers of America, in a prepared statement before the United States Committee on Unemployment, October, 1951.

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TIME AND TERROR

Predicting that it will take "time and terror" (sic) for Mayor-elect Edward I. Koch to balance the NYC budget, the Wall Street Journal recently called on him to "make the mayor the ultimate authority" on municipal labor negotiations (November 10, 1977). Although it was unclear which drummer he was hearing, Koch's selection two weeks later of Basil A. Patterson as Deputy Mayor for Labor Relations seems to have tickled at least Victor Gotbaum. Gotbaum—head of the 100,000 member D.C. 37, the largest municipal union and the one that includes the city's 30,000 municipal hospital workers—called Patterson "somebody we trust." What this verbal stroking means for labor-management relations at the NYC Health and Hospitals Corporation—particularly whether it signals continued union tolerance of layoffs and attrition that cost 8,000 municipal hospitals workers jobs in the past four years—has so far not been reported in the local media.

YOUR JOB OR YOUR LIFE... AGAIN

In a decision that seriously undermines the right of workers to protect their own lives, a three-judge US Court of Appeals recently revoked a longstanding OSHA regulation protecting an employee's right to refuse work under unusually hazardous conditions.

The decision came in the case of Jimmy Simpson, a construction worker who helped connect steel beams high in the skeletons of tall buildings. One day as Simpson was working 150 feet above the ground, a strong wind developed which he believed threatened his life. He left the job and returned to the ground, for which he was fired.

Judges Clark and Roney argued as the majority that since Congress did not specifically include a provision in OSHA allowing workers to refuse work under hazardous conditions, the Secretary of Labor for OSHA could not issue an administrative regulation granting workers such a right. Thus they upheld Simpson's firing. They also expressed fear that workers, if granted it, might abuse this "privilege."

ROBBING THE HOSPITAL THAT FEEDS...

While D.C. 37 members continue to dwindle in the municipal hospitals due to attrition and reductions in the municipal system, the union announced in late November that it opposed Mayor-elect Koch's proposed requirement that all municipal employees be city residents, and, in a step filled with irony for many observers, announced that D.C. 37 members would henceforth be entitled to utilize the health benefits of a prepaid group practice plan in their area. The irony: although Manhattan members will have access to a plan at NYU-Bellevue, Brooklyn members will be offered a plan developed at Brooklyn's Brookdale Hospital—a private hospital. (Public Employee Press, November 25, 1977.) The imagery is terrible: municipal hospitals are evidently good enough for other people, but not those who work in them, etc., etc.
Judge Wisdom argued in dissent that "the importance of the majority’s holding extends far beyond this case." He concluded, "We are talking about whether Jimmy Simpson had to lose his job to avoid return to a dangerous workplace high on a wind-swept skeleton of steel. Congress felt that workers could live within the prescribed processes of this Act [OSHA]. I cannot believe that it required workers to die for them."

—Bureau of National Affairs, Occupational Safety and Health Reporter, December 6, 1977

99 BOTTLES OF TAB IN THE HALL

After many months of bitter controversy (see BULLETIN, May/June, 1977), the US Congress passed and President Carter signed a bill delaying by 18 months the proposed government ban on the use of saccharine as an artificial sweetener. The bill would also require cancer warnings on a variety of food products containing saccharine. For example, food products in interstate commerce must bear the warning:

"Use of this product may be hazardous to your health. This product contains saccharine which has been determined to cause cancer in laboratory animals."

One opponent of the delay, US Rep. Andrew Maguire (D-NJ), was so incensed by the congressional action that he proposed instead the following warning:

"Assurance—this product may not cause cancer in the opinion of your congressman although scientific evidence indicates that it does."


SUPPORT FOR CONSUMERS IN HEALTH PLANNING

A labor-backed Consumer Coalition for Health has been organized to promote stronger and more knowledgeable consumer participation in Health Systems Agencies under PL 93-641, the Health Planning and Resource Development Act of 1974 (see Health/PAC BULLETIN, May/June 1976). It is the first national advocacy and technical assistance network for consumer health planning. Its organizers—who include Herbert Semmel of the Center for Law and Social Policy and Ted Bogue of Ralph Nader’s Health Research Group—have been testifying and litigating for better HEW guidelines and for broader HSA board participation, especially including low-income communities. The Coalition is now distributing the Consumer Health Action Network (CHAN) in cooperation with the Health Research Group. The CCH address is 1511 K St. NW, Suite 220, Washington, DC 20005.

SMALL CHANGE(S)

While Washington wrestles with health economics, any concrete steps toward national health insurance will be put off again, at least until 1979. For this coming year Carter and Califano will, at most, be proposing only reorganizations and rearrangements: a consolidation of maternal and child health and family planning services (most optimistically seen as a mini-step toward "kiddie-care" health insurance); a modest reduction in Medicare copayments (which HEW is now convinced fail to reduce spending on unnecessary services); and an expansion of urban health programs.

Over this last year HEW staffs have been pushing an Integrated Urban Health Strategy, combining existing funds for Community Health Centers, the National Health Service Corps, and maternal and child health programs, toward improved preventive and primary care and reduced costs. They are now seeking an expansion of this program, to set up as many as 800 new Community Health Centers in the next four years as well as a new demonstration program to set up prepaid health plans for the poor in urban public hospitals, as a way to reduce Medicaid costs. In dollar-conscious Washington, even these modest programs may not make it past the Budget Gauntlet. (See Washington Column, this issue.)

A FALL OF MAJOR PROPORTIONS BEGINS WITH A SINGLE STEP

According to the US Consumer Product Safety Commission, stairs are the second most hazardous consumer product (after bicycles). Stairs are implicated in over two million accidents each year in the US. More than half a million Americans went to hospital emergency rooms last year for treatment of stair-related injuries; of these, four thousand died. No one knows how many of these occurred on the job.

Recently the Consumer Product Safety Commission sponsored a study on stairs and stair-related accidents by John Archea, an "architectural psychologist." In his final report, in an argument that parallels one in many other fields (occupational safety, for example), Archea argues that stair accidents cannot be attributed to human carelessness. People do have accidents because of carelessness. But in vir-
Eventually all cases, he insists, the reason they are careless—at least in part—is that they are distracted, deceived or otherwise confounded by the characteristics of the stair environment itself.

"Architecturally triggered human error causes most stair accidents," Archea argues. "You can say the person misread the situation. Yet the situation was designed to be misread."

The study is an interesting one; further information on it may be obtained from Peter Armstrong, Consumer Product Safety Commission, WTB-735, Washington, D.C. 20207.

—Job Safety and Health, US Dept. of Labor, September, 1977

LAETRILE: HEAVY POLITICS IN HARD SCIENCE

Memorial Sloan-Kettering Cancer Center, a major national cancer research and treatment center located in New York City, has backed off a widely publicized claim made in June that a particular set of Laetrile experiments performed there over the last five years had shown the controversial drug to fail where conventional cancer chemotherapy had succeeded, according to a statement recently released by the New York Academy of Sciences.

Contrary to the assertions made in the Sloan-Kettering article distributed to the press in June, "Laetrile was thus tested in a system in which it is difficult to demonstrate cures by any chemotherapy, and in which many clinically active drugs have never even been tested," Richard D. Smith asserts in a detailed article on the subject to be published in the January, 1978 issues of The Sciences, the magazine of the New York Academy of Sciences, of which he is associate editor.

According to Dr. C. Chester Stock, Sloan-Kettering Vice President for Academic Affairs and first author of the Sloan-Kettering article, the erroneous description in the article was based on information provided by the second author, Dr. Daniel Martin, which Stock told The Sciences reporter he had accepted at face value. Stock said the misleading statement has since been deleted from the article, which had already been accepted by the Journal of Surgical Oncology at the time of the June press conference.

Smith acknowledges in his Sciences article that these and other inconsistencies in the Sloan-Kettering article were brought to his attention by Dr. Ralph Moss, then Assistant Director for Public Affairs at Sloan-Kettering, who "was subsequently fired by Sloan-Kettering when he disclosed in November that he was a co-author of a separate report, released by a group called Second Opinion, that was a sweeping attack on the Sloan-Kettering Laetrile articles."

Another "inconsistency" that disturbed Smith was that previous work of the third author of the Sloan-Kettering article, veteran chemotherapy researcher Dr. Kanematsu Sugiuira, was described in June as "seriously challenged" by the study reported in the article. Yet at the press conference Dr. Sugiuira stuck to his interpretation of his previous work. Thus, Smith said, "He had put his name on the Sloan-Kettering article although he was not in full agreement with its main conclusion. If he did not believe that the other experiments reported in the paper of spontaneous tumors 'seriously challenged' his own conclusions, what were his reasons? He gave them neither in the article itself, nor at the press conference."

So many questions, so many answers.


THOSE EMERGENCY SORE THROATS

A survey by the Roper Organization for the American Hospital Association has found that two out of three Americans regard the emergency room as equivalent to the local physician's office for general and routine care. (Nursing Outlook, June, 1977) The study also found that about a third of the hospitals that participated in the survey did not offer initial treatment for non-urgent conditions. Perhaps most significantly, the study found the larger the hospital, the more likely that a patient seeking routine, non-emergency care would be referred to hospital-related primary centers or specialized clinics rather than an office-based physician. One AHA conclusion: increased utilization of the emergency room for such care has been the major factor in increased utilization of outpatient clinics as well. The results include a 103 percent increase in the last decade in outpatient utilization, versus a 25 percent rise in in-patient utilization.
### Cumulative Index
(December 31, 1977)

**A**

<table>
<thead>
<tr>
<th>Organization/Theme</th>
<th>Date(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abbott Laboratories</td>
<td>Sept.-Oct. ’76*</td>
</tr>
<tr>
<td>Achilles</td>
<td>June 68; Aug. 68; Nov.-Dec. ’68; Winter ’69; Apr. ’69; Jul.-Aug. ’69; Dec. ’71; Sept. ’73 (Montefiore-Prisons); Oct. ’73 (NYU-Bellevue); Jan.-Feb. ’74 (Montefiore-North Central Bronx)</td>
</tr>
<tr>
<td>Accreditation</td>
<td>Oct. ’70; Nov.-Dec. ’74</td>
</tr>
<tr>
<td>Alford</td>
<td>Robert R.—May-June ’76 (Review)</td>
</tr>
<tr>
<td>American Assn. for Labor Legislation</td>
<td>Jul.-Aug. ’76*</td>
</tr>
<tr>
<td>American Assn. of Foundations for Medical Care</td>
<td>Feb. ’73; Aug.-Aug. ’74</td>
</tr>
<tr>
<td>American Assn. of Inhalation Therapists</td>
<td>Nov.-July ’72</td>
</tr>
<tr>
<td>American College of Obstetricians and Gynecologists</td>
<td>Jan.-Feb. ’75; July-Aug. ’75</td>
</tr>
<tr>
<td>American Cont. of Gov’t. and Industrial Hygienists</td>
<td>Sept.-July ’72</td>
</tr>
<tr>
<td>American Medical Assn.</td>
<td>Nov.-July ’72; July-Aug. ’74; May-June ’75; May-June ’76; Jan.-Feb. ’77</td>
</tr>
<tr>
<td>American Medical Assn.</td>
<td>July-Aug. ’74; Jan.-Feb. ’75; May-June ’76; July-Aug. ’76; Jan.-Feb. ’76; May-June ’76; Mar.-April ’77</td>
</tr>
<tr>
<td>American Natl. Standards Institute</td>
<td>Sept.-July ’72</td>
</tr>
<tr>
<td>American Nurses Assn.</td>
<td>Nov.-July ’72; Sept.-Oct. ’75; Asm. for Retered Children</td>
</tr>
<tr>
<td>Asm. for Voluntary Sterilization</td>
<td>Jan.-Feb. ’75; July-Aug. ’75</td>
</tr>
<tr>
<td>Association of American Medical Colleges</td>
<td>July-Aug. ’69; Mar. ’70; Apr. ’74</td>
</tr>
<tr>
<td>Attica Prison</td>
<td>Nov. ’71; Sept.-July ’73 (Prison Health)</td>
</tr>
</tbody>
</table>

**B**

<table>
<thead>
<tr>
<th>Organization/Theme</th>
<th>Date(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bakke Case</td>
<td>May-June ’77</td>
</tr>
<tr>
<td>Beasley</td>
<td>Dr. Joseph—Sept.-Oct. ’75</td>
</tr>
<tr>
<td>Beryllium Poisoning</td>
<td>Sept.-July ’72</td>
</tr>
<tr>
<td>Beth Israel Hospital</td>
<td>July ’68; July-Aug. ’69; Sept. ’69; Apr. ’70; Oct. ’70; July-Aug. ’72</td>
</tr>
<tr>
<td>Beverly Enterprises</td>
<td>Apr. ’73</td>
</tr>
<tr>
<td>Birth Control</td>
<td>Apr. ’72; Jan.-Feb. ’75; July-Aug. ’75; Mar.-April ’77; May-June ’77; July-Aug. ’77; Sept.-Oct. ’77</td>
</tr>
<tr>
<td>Black Lung Disease</td>
<td>Sept.-July ’71</td>
</tr>
<tr>
<td>Boston City Hospital</td>
<td>July-Aug. ’70; Oct.-July ’73; Mar.-Apr. ’74 (letter); May-June ’74 (letter)</td>
</tr>
<tr>
<td>Boston Health Issues</td>
<td>Jul.-Aug. ’77 (Lahey Clinic)</td>
</tr>
<tr>
<td>Boston University Medical Center</td>
<td>Oct.-July ’73</td>
</tr>
<tr>
<td>Brian, Earl</td>
<td>Apr.-July ’73</td>
</tr>
<tr>
<td>Brindl, James</td>
<td>Oct.-July ’73</td>
</tr>
<tr>
<td>Brookdale Hospital</td>
<td>Sept.-Oct. ’77</td>
</tr>
<tr>
<td>Buffalo Medical School</td>
<td>Nov.-July ’71</td>
</tr>
<tr>
<td>Bureau of Occupational Safety and Health</td>
<td>Sept.-July ’72</td>
</tr>
<tr>
<td>Byarsica</td>
<td>Sept.-July ’72</td>
</tr>
</tbody>
</table>

**C**

<table>
<thead>
<tr>
<th>Organization/Theme</th>
<th>Date(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>California Public Hospitals</td>
<td>Apr.-July ’73; May-June ’74</td>
</tr>
<tr>
<td>California Nursing Assn.</td>
<td>Sept.-Oct. ’74</td>
</tr>
<tr>
<td>Cancer</td>
<td>Nov.-Dec. ’77 (OSHA)</td>
</tr>
<tr>
<td>Carnegie Foundation</td>
<td>Nov. ’71; May-June ’75</td>
</tr>
</tbody>
</table>

* Asterisks indicate short items—e.g., news briefs, announcements, etc. 

---

Carter, Jimmy (Pres.)—Sept.-Oct. ’76; Jan.-Feb. ’77 (NHI); Mar.-Apr. ’77 (cost control); May-June ’77; Jul.-Aug. ’77 (OSHA) |
Case Western Reserve Med. School—Jan.-July ’70; Sept.-July ’71 |
Center for the Prevention of Violence—Sept.-July ’73 |
Certified Hospital Admission Program—Feb. ’73 |
Charny Hospital (New Orleans) | Sept.-Oct. ’75 |
Cherkasky, Dr. Martin | Apr. ’69; Jan.-Feb. ’74 |
Chicago Health Movement | April ’71 |
Children’s Hospital, Boston—May-June ’72 |
Chinese Health System—Dec. ’72 |
Chlorinated Hydrocarbons | May-June ’76* |
Ciba-Geigy Pharmaceutical Co. | Nov.-Dec. ’75 |
Cincinnati People’s Health Movement | Sept.-July ’71 |
City University of NY Proposal (Med. School) | Oct.-July ’72 |
Citywide Save-Our-Homes Committee (NY) | May ’72 |
Cleveland | Sept.-July ’71 |
Colorado Hospital | Oct.-July ’69 |
Columbia Hospital | May-June ’71 |
Columbus Hospital (NY) | Nov.-July ’71; May-July ’72; Oct.-July ’72 |
Committee of Interns and Residents | Aug.-July ’68; Sept.-July ’69 |
Community Control | Oct.-July ’68; Nov.-Dec. ’69; Jan.-July ’72 |
Community Medical School Proposal (Lincoln) | Oct.-July ’72 |
Community Mental Health | Aug.-July ’68; Apr.-April ’69; May-June ’69 (Lincoln); Dec. ’69; May-July ’73; Jul.-Aug. ’75 |
Comprehensive Health Insurance Plan (CHIP) | Mar.-April ’74 |
Coney Island Hospital | May-June ’72 |
Cook County Hospital | Apr.-July ’73 |
Cornell/New York Hospital | Sept.-May-June ’77 |
Cost-Control | Mar.-April ’74; July-July ’77; July-Aug. ’77; Sept.-Oct. ’77 |

**D**

<table>
<thead>
<tr>
<th>Organization/Theme</th>
<th>Date(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Davis Medical School (Univ. of Calif.)</td>
<td>Apr.-July ’73; May-June ’75</td>
</tr>
<tr>
<td>Deinstitutionalization (Mental Health)</td>
<td>Jan.-July ’73; Jul.-Aug. ’75; Sept.-Oct. ’77 (review)</td>
</tr>
<tr>
<td>Delated Hospital</td>
<td>Nov.-Dec.-Aug. ’68; May-June ’72</td>
</tr>
<tr>
<td>Dellaun Proposal (NHI)</td>
<td>Jul.-Aug. ’77</td>
</tr>
<tr>
<td>Desflurane (ETCS)</td>
<td>May-June ’76*</td>
</tr>
<tr>
<td>Depression, The (Cost Control)</td>
<td>May-June ’76; Jan.-April ’77</td>
</tr>
<tr>
<td>Downstate Medical Center</td>
<td>Sept.-Oct. ’70; May-June ’77</td>
</tr>
<tr>
<td>Drug Companies</td>
<td>Sept.-Oct. ’76; May-June ’77</td>
</tr>
<tr>
<td>Dubois, Rene</td>
<td>Nov.-Dec. ’75</td>
</tr>
<tr>
<td>Duke Medical School</td>
<td>July-Aug. ’74</td>
</tr>
</tbody>
</table>

**E**

<table>
<thead>
<tr>
<th>Organization/Theme</th>
<th>Date(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Einstein-Montefiore</td>
<td>Apr. ’69; Sept.-July ’70; Oct.-July ’70; Jan.-July ’71; Nov.-July ’73 (Einstein); Sept.-July ’73 (Montefiore-Prisons); Jan.-Feb. ’74; May-June ’77</td>
</tr>
<tr>
<td>Eisenberg, Dr. Leon</td>
<td>Nov.-Dec. ’75</td>
</tr>
<tr>
<td>Ellwood, Dr. Paul</td>
<td>July-Aug. ’72</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>Apr. ’72; Mar.-April ’73; May-June ’73; July-Aug. ’73; Sept.-Oct. ’73</td>
</tr>
<tr>
<td>Environmental Health</td>
<td>May-June ’77</td>
</tr>
<tr>
<td>Exchange Visitor Program</td>
<td>Jan.-February ’76</td>
</tr>
</tbody>
</table>

**F**

<table>
<thead>
<tr>
<th>Organization/Theme</th>
<th>Date(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Health Foundation</td>
<td>Sept.-Oct. ’75</td>
</tr>
<tr>
<td>Federal Drug Administration</td>
<td>May-June ’77</td>
</tr>
<tr>
<td>Federal Health Policy</td>
<td>May-June ’77; Mar.-April ’77; Jul.-August ’77</td>
</tr>
<tr>
<td>Federation of Jewish Philanthropies</td>
<td>Apr.-July ’77</td>
</tr>
</tbody>
</table>

I


Industrial Medical Association—Sept. ’72.

Istant Formula—May-June ’76.

Institutional Liquor Ban—Nov. ’72.


I Wor Kuen—Oct. ’70.

J


Judson Mobile Unit—Nov. ’69.

K

Kaiser-Permanente—Nov. ’70; Nov. ’73; Mar.-Apr. ’74 (letter).

Key, Dr. Marcus—Sept. ’72.

King General Hospital—Apr. ’73.


L

Lahey Clinic (Boston)—Jul.-Aug. ’77.


Licensure—Nov. ’72.


Lincoln Community Mental Health Center—May ’69; Sept. ’69.


Louisiana State Univ. Medical Center—Sept.-Oct. ’75.


M

Madera County Hospital—Apr. ’73.

Maimonides Community Mental Health Center—May ’68.

Malpractice—May-June ’75; Jan.-Feb. ’76; May-June ’76; Nov.-Dec. ’76.

Martin Luther King Health Center—Oct. ’69.

Maryland—Jan.-Feb. ’76 (suburbs).

Maternal and Child Care—May ’73.


Medicaid Mills—Jul.-Aug. ’75; May-June ’76; July-Aug. ’77.

Medical Committee for Human Rights—Mar.-Apr. ’75.

Medical Education—Nov. ’71; Oct. ’72; May-June ’75; Mar.-Apr. ’76; Nov.-Dec. ’76; Mar.-Apr. ’77; May-June ’77.

Medical Efficacy—Mar.-Apr. ’77.


Medical Industrial Complex—Nov. ’69; Sept.-Oct. ’75; May-June ’76.

Medical Labs—Mar.-Apr. ’76.


Medical Technology—Mar.-Apr. ’77.


Mental Health—May-June ’69; May-June ’70; July-Aug. ’75; Nov.-Dec. ’75; Sept.-Oct. ’77.

Mental Retardation—Jan. ’73.

Meredith County Hospital—Apr. ’73.

Methodone—June ’70.

Methodist Hospital—Apr. ’72.

Metropolitan Hospital—Feb. ’70.


Military Medicine—Apr. ’70; June ’71.

Minority Enrollment (Medicaid School)—May-June ’77.

<table>
<thead>
<tr>
<th>Location</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valley Medical Center</td>
<td>Apr. '73</td>
</tr>
<tr>
<td>Vanderbilt Clinic</td>
<td>May '70</td>
</tr>
<tr>
<td>Veterans Administration Hospitals</td>
<td>Apr. '70; May '71</td>
</tr>
<tr>
<td>Virchow, Dr. Rudolph</td>
<td>Nov.-Dec. '75</td>
</tr>
<tr>
<td>Walsh-Healy Act</td>
<td>Sept. '72</td>
</tr>
<tr>
<td>Washington Business Group on Health</td>
<td>Sept.-Oct. '77</td>
</tr>
<tr>
<td>Washington Heights-Inwood Community Mental Health Center</td>
<td>Nov.-Dec. '68; Apr. '69; Dec. '69</td>
</tr>
<tr>
<td>Wesley Hospital (Chicago)</td>
<td>Jul.-Aug. '70</td>
</tr>
<tr>
<td>Willowbrook State School</td>
<td>Jan-'73</td>
</tr>
<tr>
<td>Women's Health</td>
<td>Mar. '70; Apr. '72; Dec. '72; Jan.-Feb. '75; Jul.-Aug. '75; May-June '77; Jul.-Aug. '77; Sept.-Oct. '77</td>
</tr>
<tr>
<td>Workers' Compensation</td>
<td>Jul.-Aug. '76</td>
</tr>
<tr>
<td>Yolo General Hospital</td>
<td>Apr. '73</td>
</tr>
<tr>
<td>Young Lords</td>
<td>Oct. '69; Feb. '70; Sept. '70; Oct. '70; Dec. '70; Jan. '72</td>
</tr>
</tbody>
</table>

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