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Peer Review

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Human Experimentation

Medical research inevitably involves human experimentation in order to extend the boundaries of scientific knowledge. Horror stories about the effects of such experimentation abound: retarded children at NY's Willowbrook State Mental Hospital intentionally given hepatitis, Chicano women in Texas put on placebo birth control pills, Black men in Tuskegee, Alabama not given penicillin to treat their syphilis.

Yet there has been very little systematic investigation of the risks of biomedical research to the health of experimental subjects. While racism, sexism, and class discrimination tend to characterize many of the widely publicized abuses, the research reported below indicates that the prevalence of abuse may, in fact, stem from the nature of "acceptable" research methodology. Scientific practices themselves might lead to the likely abuse of human subjects.

A new type of intrauterine device (IUD)—a Stainless Steel Spring (SSS)—was tested on 123 Bellevue Hospital patients in the Family Planning clinic under a grant-in-aid from the Population Council of Rockefeller University. The physician investigators reported, in 1972 in the New York State Journal of Medicine (1), that they stopped inserting the IUDs into new experimental subjects at the end of the second year of the three year study "because of the number of complications experienced with this device." They did not, however, remove the IUDs from women who did not develop observable symptoms despite the problems which led to aborting the study and the noted presence of asymptomatic perforations. The final tally of damage to patients involved in the study included 37 IUD removals because of complications; 26 because of vaginal bleeding, and 6 because of severe vaginal discharge.

The women who participated in the Bellevue experiment were undoubtedly recruited from those who went to the clinic seeking birth control assistance. Presumably, all were deemed healthy prior to the insertion of the SSS-IUDs. Within two years 37 had been made sick by the experiment, and three had unwanted pregnancies.

Making a healthy person sick, or a sick person sicker, seems to be the antithesis of medicine. Yet both are frequently the consequences of human experimentation.

In order to know how a drug, device, or procedure affects human beings, it is always necessary to test it on people. Despite all previous laboratory and/or animal studies, there is always a risk implicit in trying something unproven or untested with human subjects. The only certainty in experimentation is that the results are unknown. Otherwise, why experiment?

Yet there should be some standards that minimize the abuse inherent in the experimental process. At a bare minimum, no experiment should be designed to do deliberate harm to a patient. No experiment involving human beings should be initiated until after appropriate animal experiments have been completed. And, if there are sickening consequences, the patient should be informed and given a chance to discontinue his/her participation. Most importantly, no one should ever be used as a research subject without having given intelligent and knowing consent.

A study of all articles published over a three-year period (1973-1975) by Obstetrics and Gynecology faculty members of four New York City medical schools (Columbia University College of Physicians and Surgeons, the State University of NY at Downstate Medical Center, Mount Sinai School of Medicine, and NY Medical College) shows frequent violations of these standards. All 74 of the faculty members' articles that used human subjects were analyzed for evidence of abuse. The results were stunning. One out of eight published papers revealed serious ethical problems involving the exposure of human subjects to unnecessary harm.

Continued on Page 43
Vital Signs

DRUG COMPANIES HAVE A LOT OF CASH

Corporations in the drug and medical supplies industries are sitting on a large pile of cash. According to Business Week's September 18th Corporate Cash Scoreboard, the nation's largest corporations tend to be cash rich right now, cautiously awaiting new developments in the economy before committing themselves to more investments. The drug and medical supply industry—defined broadly to include ethical, proprietary, medical and hospital supplies—is among the heaviest cash-laden industries, with nearly one of every four dollars in current assets being held in the form of cash, bank deposits or short-term notes.

...which they use to buy other companies...

While there may be some uncertainty as to best use of their cash, don't think for a minute that these corporations are about to open up a suggestion box for ideas. After all, people might suggest lowering prices, starting drug education programs or other no-growth strategies. According to the rules of the capitalism game, corporations cannot simply be content to do a good job. They must grow in order to survive in the face of competition and takeover threats. Stagnation is death.

Growth can come from selling more of your products or inventing new products. But if your products have lost their pizzazz, the best way to grow may be to buy smaller companies—like big fish eating little fish.

Most corporations in the medical industry have been doing just that.

Recently, reports Business Week in the same September 18th issue, Bristol-Myers bought Unitex, a dental supplies company; Johnson and Johnson acquired kidney dialysis maker Extracorporeal Medical Specialties; and Eli Lilly purchased Ivac, a producer of monitoring devices for intravenous drugs. And, just in case anyone needs a reminder that capitalist behavior knows no national boundaries, it notes that foreign companies have been doing the same thing. Bayer recently bought Miles Laboratories; Ciba-Geigy Ltd. bought Alza; and Nestle purchased Alcon Laboratories. Several other deals have been announced but not yet consummated.

While little fish may not like being eaten by anyone, these deals do have advantages for all. Large companies gain technology and rapid growth. Small companies gain the financial strength and ready made marketing infrastructures of the biggies.

...and to pay their exec hefty salaries...

Meanwhile, back at the top of the corporation, chief executive officers of pharmaceutical corporations have done their personal bit to absorb some of that cash. A recent Arthur Young & Co. study shows that executives in this industry received the average $392,000 in total compensation (salary and fringes) in 1977. This earned them a cool second place among the 14 manufacturing industries studied. First place ($448,500) went to another drug...
industry, but one large enough
to have its own separate cat-

egory—the tobacco industry.

A LEAK IN THE I.V. MARKET

There’s trouble in the intra­
venous solution market. Compe­
tition is intense and profit margins
may drop—stock prices are al­
ready down. Executives and in­
vestors are worried. Why? Lower
prices. Some hospitals have re­
cieved discounts as large as 77%
of the cost of I.V. products, due
to what the September 21st Wall
Street Journal called “a full­
fledged price war” between the
three largest producers of I.V.
products, Baxter Travenol Labo­
ratories, Abbott Laboratories, and
American Hospital Supply.

Expanded manufacturing ca­
pacity explains part of the in­
creased competition. But smaller
and more cost-conscious hospitals
are helping their own cause. Ac­
cording to Oppenheimer & Co.
Vice President Jules L. Marx (no,
we didn’t make that up), hospital
purchasing agents are sharing
more information on product
prices and driving harder bargains
in efforts to keep costs down.

But Wall Street worries are not
overly concerned. Many larger
I.V. accounts have been un­
touched by the discount prices.
David Talbot of Drexel Burnham
Lambert, Inc. optimistically pre­
dicts that new products will save
the day. “There are five or six
categories of new products...that
command substantial (price) pre­
miums. These products are selling
4 at a rapid rate.”

FRICITION AMONG THE
FRACTIONATORS

Times are rough in the blood
market. First, the U.S. lost the
source of 10% of its plasma when
a 150-bed collection center in Ni­
caragua burned down in political
riots early this year. (Was Samoza
about to start a cartel to control
Third World blood exports called
the Organization of Blood Export­
ing Countries—OBEC?—the Tran­
sylvanian solution to balance of
payments deficits.) Then, foreign
countries with more money than
blood started buying U.S. blood
processing centers. After all, the
U.S. is the major exporter of
plasma fractions (components).

According to the September 11th
issue of Business Week, French
and German companies bought
U.S. plasma producers in 1975
and Green Cross Corp. of Japan
bought one this year.

But commercial processors are
most upset by a recent into blood
processing by the American Na­
tional Red Cross. By far the larg­
est collector and distributor of
blood in the U.S., the Red Cross
recently announced plans to build
a plant in a $40 to $50 million
joint venture with Baxter Trave­
not Laboratories, Inc., one of the
largest commercial processors.
Competitors complain that the
deal will give Baxter an unfair ac­
tess to supply and the Red Cross
an advantage over commercial fractionators. The Red Cross counters that the move was required because of the poor service it received from commercial fractionators and, according to Red Cross Chairman Frank Stanton in a letter appearing in the October 2nd Business Week, "to allow them to develop techniques for the production of needed new and rare blood derivatives that hold no interest for commercial fractionators."

LAB KICKBACKS CONTINUE

Twenty Detroit area residents, including five physicians and two alleged organized crime figures, have been charged in eight indictments with a scheme to defraud the Medicare and Medicaid Programs. The alleged scheme involved setting up a dummy corporation to funnel kickbacks to physicians in exchange for sending their Medicaid-Medicare Laboratory testing to a local lab.

According to the Detroit Free Press, "The indictment charges the defendants with using false invoices, false sales commissions, false consulting agreements and other phony methods to cover up more than $200,000 in alleged kickbacks and extortion payments during a three-year period."

This is one of the latest in the continuing scandals around laboratory kickbacks. A Wall Street Journal article reported that "payoffs remain both widespread and difficult to prove in court." Physicians often regard kickbacks from laboratories as legitimate compensation; critics charge that the kickbacks are incentives to win business from physicians and are often associated with excessive lab charges. Federal laws governing Medicaid and Medicare prohibit such kickbacks.

The problem appears massive. According to the Journal, "With lab charges running at more than $11 billion a year— including $3.5 billion by the 7,000 or so independent labs that are considered mainly responsible for payoff—$1 billion of the total figure reflects kickbacks and other lab abuses, congressional witnesses have estimated." An Illinois investigator maintains that "As a rule, doctors want a 40% return on their testing business."

Although the practice remains widespread, and recurring scandals and investigations keep it in the public eye, little is being done to get at the root of the problem. Unless the overwhelming incentive for money making can be removed, the big ripoffs will continue.


A HOUSE DIVIDED CANNOT STAND: A CASE OF INTERNAL INSURRECTION IN THE HOUSE OF MEDICINE

After the AMA settled an antitrust lawsuit filed against them last year by a group of Pennsylvania chiropractors, three members of the AMA's own House of Delegates and four major specialty groups asked the U.S. District Court in Philadelphia to block the settlement. They claim the AMA cannot settle with outside parties before gaining their own House's approval.

Charging restraint of trade, the Pennsylvania chiropractors originally sued the AMA, Pennsylvania radiologists, pathologists, and hospitals for refusing to provide x-ray and laboratory services to their patients. The objectors claimed they were protected by the AMA code of ethics which "forbids physicians to associate professionally with practitioners of 'unscientific medicine'."

Actually in dispute is a revision of the AMA code of ethics. The Judicial Council is in the process of revising it. In 1976 the AMA's position was that a physician could "choose to accept or decline patients sent to him by licensed limited practitioners (dentists, Podiatrists, chiropractors, psychologists) or by laymen." However, this is only part of a broader change now being studied by an ad-hoc panel whose report is due in December.

The petitioners (the American College of Physicians, the American Academy of Orthopaedic Surgeons, the American College of Surgeons, the American College of Radiology, and three members of the AMA including the delegate from the American Association of Neurological Surgeons, the delegate from the American Roentgen Ray Society and an alternate representing the American College of Physicians) are asking the court for a delay so the House can vote on the ad hoc panel's recommendations. Buying time?

The rebellion is spreading. Similar anti-trust suits have been filed in New Jersey and Chicago.


EPA ISSUES LEAD STANDARD

On September 29, 1978 the Environmental Protection Agency
announced a health standard for lead in the air. The new standard will require lead concentrations to be no more than 1.5 micrograms per cubic meter of air. In some areas such as Los Angeles and Dallas concentrations of six micrograms are common. The lead standard is a first step toward needed air pollution standards to control toxic substances in the air.

EPA acted reluctantly. They finally responded to a court order brought about by a lawsuit filed by the Natural Resources Defense Council. Although the court order for EPA to act first came in 1974, only after numerous appeals was the EPA found in violation of the Clean Air Act and ordered to issue a standard by September 30. Meanwhile, research had been accumulating on the harmful effects of low-level concentrations of lead in the air on the neuropsychological functioning of children.

The smelting industry is most immediately affected: EPA estimates the standard may cost smelters $530 million by 1982. EPA Administrator Douglas Costle said, "We don't believe that a major disruption of this industry is an acceptable consequence." A study is now underway on the costs and benefits of the new standard. Costle claims that if this study shows "economic effects unwarranted by the health protection involved" the EPA may try so far as to ask Congress to amend the Clean Air Act.


RESTRICTIONS SLATED ON FOREIGN NURSES

The first phase in restricting the immigration of foreign nursing graduates (numbering 42,000 between 1972 and 1976) is scheduled to commence in October. The Commission on Graduates of Foreign Nursing Schools (GFNS), an independent, non-profit group, was recently organized to administer tests to nurses in their home countries. The Commission was established at the suggestion of DHEW, and under the sponsorship of the American Nurses Association and the National League for Nursing.

Tests will be given in English and will include sections on the five major areas of nursing covered by state boards, plus an English-language competency test. Applicants must have graduated from a secondary school, a government-approved nursing school, and have passed the licensing exam required by their home country. The tests will be given in 32 cities around the world, seven in East Asia, seven in Latin America and the Caribbean, two in Africa, four in the Middle East, and twelve in Europe.

CGFNS pronouncements gush with sisterly concern for foreign nurses: "When foreign nurses who fail the state nursing examinations have had to leave this country, they have felt discriminated against and disenchanted with the United States. . . . Or, others have remained in this country and have been hired as nurses' aides and then pushed into taking regis-

. . . but what of the people who need health care workers who speak their language?

The effect of the exams will be to make fluency in English a prerequisite to working in this country . . .

Nurses Association and the National League for Nursing.

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... but what of the people who need health care workers who speak their language?

The exams are not mandatory, but this is probably a temporary situation. The U.S. Immigration and Naturalization Service has said it "would be prepared" to require successful completion of the exams as a condition for immigration. Successful completion may also be made a prerequisite for taking state boards, and "be helpful in obtaining a work permit" from the Labor Department.

Significantly, nurses who have passed the Canadian licensing examination are to be exempt from these requirements. The CGFNS suggests that foreign nurses might want to immigrate to Canada, pass that country's licensing exam, then come to the United States without special restrictions. This is the height of cynicism, how-
ever, given Canada's increasingly strict immigration policies regarding workers from the Third World.

No doubt taking moral inspiration from President Carter, the CGFNS executive director has declared: "Our Commission supports the U.N. Declaration of Human Rights, which affirms the freedom of the individual to migrate."

As justification for the exams, the CGFNS cites the statistic that 84 percent of the foreign nurses taking state boards in 1976 failed. Admitting that language problems are a significant barrier to foreign nurses (or Puerto Rican and Chicano nurses from this country), incremental progress has been made in eliminating cultural bias from tests. But in this context, the CGFNS exams are clearly a step backward. If testing of nursing knowledge were primary and English secondary, then the nursing component would be given in the nurse's native tongue.

The effect of the CGFNS exams will be to make fluency in English a prerequisite to working as a nurse in this country.

It is well known that blacks have higher rates of hypertension than whites in the U.S. This racial difference is related to differences in the social conditions of blacks and whites.

National surveys have established that in the U.S. lower socioeconomic status is associated with higher blood pressures and a greater prevalence of hypertension (1). As can be seen from the Figure, the differences in blood pressure associated with differences in educational level are much larger than the differences in blood pressure associated with race per se.

A study in North Carolina has shown that hypertension-related death rates are high in counties with low socioeconomic status (particularly for whites) and also in counties with high social instability, as indicated by high rates of crime and divorce (2). In Detroit, comparisons have been made between black and white high and low stress areas (3). High stress areas were defined as those with low levels of income and education and high rates of crime and marital instability. Blood pressures were consistently higher in the high stress areas. Black men who lived in a low stress area had blood pressures as low as white men who lived in a low stress area.

These findings indicate that in the U.S., those who suffer the social disadvantages associated with low education and income or residence in neighborhoods with high crime and divorce rates also suffer higher rates of hypertension. These observations lead us to the conclusion that racial differences in blood pressure are due in large part to the social conditions resulting from racial discrimination.

References
At first blush this may seem reasonable, but the question of language raises larger issues for the health care system as a whole. Should state boards be given, or certain facilities in urban areas be run, exclusively in English? While a working knowledge of English is certainly necessary to negotiate the broader health care system, there are community facilities a majority of whose patients speak anything from Spanish to Chinese. These people need health care workers who speak their language to give them safe, comprehensive care. America is unilingual in law, not in fact.

Stripped of its pretentions, the work of the Commission on Graduates of Foreign Nursing Schools comes dangerously close to good old-fashioned American xenophobia.

—Glenn Jenkins


**OSHA BENZENE STANDARD BLOCKED**

In a decision with far-reaching implications, the U.S. appeals court in New Orleans struck down the new OSHA benzene standard because the need for the regulation was not demonstrated through cost-benefit analysis. The decision was a major victory for the American Petroleum Institute and for 'business in general. The strategy of tying up standards in the courts by demanding cost-benefit criteria proved successful. According to OSHA head Eula Bingham, "the action of the court will leave thousands of workers at an increased risk of leukemia."

Previously OSHA had only taken into account whether compliance with a proposed standard was economically feasible for industry. As an OSHA spokesman put it, "We haven't been held to any kind of cost-benefit analysis in previous decisions. We didn't engage in that kind of analysis (in the benzene rules). We can't and we shouldn't."

The court, however, held that the estimated $500 million cost to reduce benzene exposure to one part per million was not justified on the basis of the scientific data presented. OSHA had not, the court ruled, shown a "reasonable relationship" between measurable benefits and costs.

OSHA finds the decision "disturbing" and is considering an appeal. The proposed 1 ppm standard had been issued as an emergency temporary standard in May, 1977, after new studies confirmed that benzene caused leukemia, although OSHA actually held the view that benzene caused leukemia, although OSHA actually held the view that there is no safe exposure level for any carcinogen. The proposed standard was immediately blocked in court and has never gone into effect. If the cost-benefit test is upheld, it could complicate the standard-setting process and weaken the standards themselves. OSHA would then have to put a "value on workers' lives" rather than regulate carcinogens at the lowest feasible level of exposure.


**DRUGS**

The New York State Department of Audit and Control recently released a report on three state mental hospitals selected randomly for study. Widespread medication abuses, including indiscriminate polypharmacy (multiple drug treatment) and excessive dosages, were found in the three facilities (Rockland, Creedmore, and Utica-Marcy). The Rockland County Medical Examiner further charged that the heavy use of tranquilizers at Rockland Psychiatric Center and nearby Letchworth Village Developmental Center caused an unusual number of patients to choke to death. In responding to a subpoena by the state supreme court, he said his records showed a "glaringly ostensible association between psychiatric drugs and deaths due to aspiration of food and vomitous materials." 30% of autopsied patients showed this as the cause of death (the national average being 1.7%).

Near the center of the controversy is Dr. Nathan A. Kline, director of the Rockland Research Institute and tireless proponent of the wonders of psychopharmacology. Because of Kline's world-wide reputation (he is rumored to get $500 a shot for private consultations) he was paraded out at a recent press conference to refute the allegations of drug abuse and reassure the public of the safety of tranquilizers and sedatives. Kline and his associates have virtual experimental carte
blanche in the state hospital system of New York. While investigations are held into the Rockland deaths, they continue their "high dosage" experiments on patients in various locations.

Sources: New York Daily News; Village Voice; City News.

Q. WHEN IS A DOCTOR NOT A DOCTOR?
A. WHEN SHE'S A DOCTOR OF NURSING.

In a move to upgrade nurses' education, a new degree—Doctor of Nursing (N.D.)—will be offered beginning in September by Case Western Reserve University's Frances Payne Bolton School of Nursing. The three year curriculum open to students who have a bachelor's degree and basic science backgrounds will emphasize clinical practice. RNs interested in teaching can go on and earn a Ph.D. in nursing.

The American Nurses' Association's Commission on Nursing Education endorses this plan and sees this training as a way to extend health care beyond the hospital. The Association of American Medical Colleges is in favor of the new "professional nurse" as a way to fill the general care void created by medical specialization. One family physician from California criticized medical schools for not producing enough "people doctors" and sees the nurse as a natural to fill this gap.

Will the real doctor please stand up?


FEAR OF LITHIUM DANGER

Lithium, "wunderkind" of Psychoactive medications has as its major drawback the fact that the line between a "therapeutic" and toxic careful monitoring of blood levels make the danger negligible; however, a recent study supported by Roerig Pharmaceuticals, Rowell Labs (both manufacturers of Lithium carbonate), NIH, and the VA suggests otherwise.

The researchers reported numerous cases of toxic manifestation occurring when serum lithium levels were normal. Lithium poisoning carries the potential for irreversible tissue damage and death. Researchers also found that even at therapeutic levels, lithium may cause chronic renal structural damage. They could observe no constellation of symptoms that could be considered characteristic of lithium intoxification and noted one suicide where coma did not occur until three days after ingestion.

The researchers expressed a hope that red blood cell count might turn out to be an indicator of toxicity, but found that, presently, no reliable measure of lithium poisoning exists.

Source: Psychiatric Annals: September, 1978

COPS IN THE EMERGENCY ROOM; NURSES IN JAIL

"Nurses in this city have expressed shock and concern over the case of an emergency room nurse who, after attempting to provide care to an 18-year-old patient who allegedly had been beaten by two police officers who brought him to the hospital, was arrested, handcuffed, and removed to a police station where she was issued a summons for harassment of the two officers." (AJN May, 1978, p. 765)

The incident occurred at North Central Bronx Hospital, on February 25, 1978 at approximately 1 A.M. The two officers brought in a patient who was suffering from an overdose of drugs. The patient was not under arrest. After informing the nurses on duty that the patient was a "psych," the officers took him to a quiet room reserved for psychotics. The ER nurse in charge said she went to the room when she heard the patient "screaming for help." Despite objections from the officer, the nurse stayed with the patient who was bleeding profusely from the nose and mouth. The patient asked her not to leave him, reporting that the officers had kicked him. The nurse left them momentarily to obtain supplies for a bandage, and upon returning, was placed under arrest for "obstructing justice."

The incident described above is important to nurses and other hospital workers for several reasons. First, it represents an assault on nurses in the exercise of the most basic of nursing functions, patient advocacy. And second, it is important in light of the compromise made by the hospital management as a solution to the problem.

The emergency room, with its dual function of serving as the hospital's face to the community, and providing resources for emergency/crisis situations in the community, assembles potentially opposite interests within its walls.
The AJN article describes a conflict between the interests of law enforcement and the provision of health care to the population. (That these interests should become mutually exclusive in any situation poses some important philosophical/practical questions beyond the scope of this article.)

For nurses, the emergency room is a place of work. Certain conditions that are true for other hospital workers are sometimes acute in the emergency room. Overcrowding, high utilization rates and staffing shortages reflect emerging policy decisions to cut the health care budget. Practically, the emergency room is forced to assume the responsibility of providing otherwise non-existent outpatient services. Nurses, as officers of health, are obligated to “protect the rights and welfare of patients” entrusted to them.

Officers of the law have jurisdiction over prisoners. Their authority is limited by the patient’s right to medical care. Nurses and police officers are forced to maintain a symbiotic relationship. The realities of personnel shortages require that nurses often rely on officers to assist with “combative” or “violent” patients. On the other hand, police officers are in an extraneous environment and need to establish rapport with nurses. Often, this association is colored by the traditional sex roles which have characterized the sexual politics of nursing and women’s subordination to male authority.

Hospital management responded to the incident with a compromise. They agreed that an officer cannot arrest any hospital employee during the employee’s tour of duty, but they failed to take an unequivocal stand in support of the nurses’ role as patient advocate. This incident focuses attention on the need for clarification of the rights of patients to protection and the rights of nurses in the exercise of their work.

HEALTH PLANNERS NETWORK

Health Planners Network (HPN) is being convened at Health/PAC in New York for mutual support and reporting among critical, activist and community-oriented planning practitioners, teachers and analysts. We are now holding monthly Health Planning Roundtables at Health/PAC to discuss issues, case studies and teaching approaches. Case study reports and policy briefs on health planning are being solicited for future Health/PAC BULLETINS.

Close communication is being sought with health and social planning-interested people across the country in the Planners Network (360 Elizabeth Street, San Francisco, CA 94114) and in local Planners Network meetings such as the New York City PN/American Institute of Architects Forum. We also hope to be in close personal contact with health planning-interested participants at upcoming national meetings such as Health Service Action/Committee for National Health Service in Pittsburgh, January 26-28; Planning Praxis Conference in Ithaca, April 26-28; American Planning Association in Baltimore, October 15-18; and the American Public Health Association in New York, November 4-8. We seek to be active and practical allies as planners through cooperation with the national Consumer Coalition for Health (Suite 220, 1511 K Street NW, Washington, DC 20005).

If a critical mass of materials and notes are generated that go beyond the Health/PAC BULLETIN and Planners Network formats, we are considering developing a special newsletter.
Blood:

The posters in the hospital corridor tear at the heart—"Blood is life, pass it on" or "Your blood was free, please share it freely."

It's hard to pass by too many times without realizing that only healthy people can help patients who need transfusions. It takes just a few minutes to lie on the couch, needle dangling from an elbow vein, then to sip juice and munch cookies, not a penny richer but feeling good all over.

Would it make any difference to know that a blood bank or hospital administrator may be smiling too, for a reason that is less than humanitarian? They may call themselves "non-profit," but contrary to popular belief a pint of blood can be worth money—a lot of it—to them.

The person who receives a transfusion will be told the blood is "free" but he or she will be charged from $20 to $60 for each unit in processing charges just the same. For a good sized, well-run blood bank, only $30 or so is legitimate.

What's more, there may also be a "non-replacement" or "penalty" fee of from $20 to $50 a unit—not covered by insurance—that a patient will have to ante up if no blood has been "pre-deposited" or if a friend or relative can't be found to donate. A third of the nation's blood is transfused with this stipulation.

To top it all off, giving as part of a "coverage" or blood "assurance" plan doesn't make an iota of difference when someone gets sick, except perhaps to avoid those penalty charges. At best, a "coverage" plan is a sham. At worst, it's a fraudulent way for blood banks to make money.

Hospitals give blood to patients in order of medical need, not in order of coverage. When there's a blood shortage around Labor Day weekend or over the Christmas Holidays, both patients who are "covered" and patients who are not are hurt equally. An honest recruiter, says Russell Merritt, executive director of the Chicago Regional Blood Program, knows coverage is a "fiction" and promising it is just a trick of the trade.

The Blood Collection System

To understand blood banking is to know something about blood itself and something about how the United States has evolved a huge blood
collection system backed by volunteer donors. We have come to regard the life-saving gift of blood as special and personal, immune from the traditional laws of the marketplace. Blood “is a bond that links all men and women in the world so closely and intimately that every difference of colour, religious belief and cultural heritage is insignificant beside it,” the British social scientist Richard M. Titmuss wrote in The Gift Relationship, his pathmark book extolling the virtues of an all volunteer blood system. It’s something to be proud of that 93 per cent of the more than 10 million units of whole blood collected each year in the United States are donated by volunteers.

“Why should somebody (the elderly or the young) who cannot replace blood have to pay at least twice what anyone else would have to pay?”
—Dr. Carroll Spurling

Blood, once sucked from the sick with leeches to drive out “evil spirits” (George Washington died this way) now flows from the veins of healthy people into sterile plastic bags. Its major components are (1) packed red cells, the oxygen-carrying hemoglobin material; (2) plasma, the straw-colored protein solution, and (3) platelets, important for blood clotting.

The method for donating blood—tourniquet, needle, rubber doughnut squeezed slowly to help the blood flow, and pressure bandage that seals the wound—has changed little since 1937, when Chicago’s Cook County Hospital became the first to store donated blood in the refrigerator. The three major components can be separated in less than an hour with a refrigerator, a centrifuge, an anticoagulant solution and sterile lab technique. The red blood cells can be stored for 21 days in a refrigerator or frozen for years. The platelets are good for three days and the plasma can be frozen indefinitely. The red cells can go to a patient with anemia, the plasma to a burn victim in shock and the platelets to a leukemia patient who is hemorrhaging.

Until the early 1970’s, much of the blood in certain areas of the country was provided by paid donors. A disturbing number were hepatitis-ridden skid row derelicts who hocked their blood for cash. A patient played Russian roulette when he received a transfusion of commercial blood. Spurred on by a Chicago Tribune expose, Illinois adopted the nation’s first blood labeling act in 1972 and volunteer blood is now the law in most states. Donors understand blood to be a special gift, not a market commodity.

Almost all of the nation’s blood is collected by centers affiliated with one of three national groups, The American Association of Blood Banks (AABB), the American National Red Cross, headquartered in Washington, D.C., and the Council of Community Blood Centers (CCBC), run from Scottsdale, Arizona. Each is an umbrella group, coordinating the operations of blood suppliers for regions, cities, parts of cities, or just one hospital. The individual supplier sets the processing fee charges, and penalty charges, if any. There is no special government regulation.

From a technical standpoint, there is no difference in the purity or safety of the product produced by any of these groups. But their blood-collection ideologies and policies are at loggerheads.

The Red Cross and the Council of Community Blood Centers endorse a philosophy of “community responsibility.” That means blood is collected for use as the common property of everyone in a particular geographic region. Donors should receive no special considerations at all compared to non-donors. Red Cross and CCBC centers are largely independent of hospitals, acting as a supplier just like a drug company.

The AABB, which represents most of the nation’s hospitals and clinical pathologists as well as free-standing blood banks, endorses a philosophy of “individual responsibility.” That means that it is the responsibility of patients and their families to provide for their potential or actual blood needs. The AABB feels donors need this monetary incentive to make the system work. Many of its member groups thus assess penalty charges—“nonreplacement fees”—for those who do not pay back in kind for the blood they use. The AABB has a knack for quaint conservative pronouncements to justify its philosophy. In one trade journal interview, AABB president Dr. Richard Walker called community responsibility
“blood socialism” and then explained, “There is no relationship between income and blood volume. A poor person with very little income has the same blood volume as a millionaire. Some patients on welfare don’t want to donate blood or pay bills—it’s their choice.”

Recruitment: The Miseducation of Donors

Aside from penalty fees, the AABB, the Red Cross, and the CCBC employ similar techniques when it comes to recruiting donors. They stress the general need for blood and tell where it can be given. But they also “sell” coverage or blood assurance plans—essentially the same thing. The idea of a coverage plan is that it guarantees the availability of blood and provides an exemption from penalty fees. A typical individual coverage plan guarantees blood for all members of a family for a year if one member gives blood once a year. A typical community or industry plan guarantees blood for all group members if 20 per cent—or some other number—donate annually. Whether a patient is covered or not, he or she is still liable for all processing charges. Processing charges may, in turn, be picked up by insurance companies.

A coverage plan is a fraud because of the simple fact that patients who require transfusions receive them with equal priority whether they are covered or not. The concept simply contributes to the chronic miseducation of donors. “Coverage is a recruiting tool,” says Chicago’s Merritt. “It lets somebody promise they can do something for you. But it hurts those who need blood, because it only encourages a minimum donation... Recruiters in (the Chicago) area have done an excellent job convincing people that only one member of a family need give once a year, when the real need is for all healthy members of a family to give regularly.”

Penalty Fees: Blood for Profit

With this background, it is possible to understand how some hospitals and blood banks can turn a profit from the collection of blood. Take Los Angeles, for example. On July 1, 1977, transfusing blood from paid donors became illegal in California. The Red Cross, which supplies blood as cheaply as anyone, began shipping it to the Los Angeles area from across the nation. It met 95 per cent of the total need. It did not require hospitals to collect penalty fees. But 78 of the 125 hospitals which received all their blood from the Red Cross continued to charge penalty fees of from $20 to $58 a unit.

“If I told you what I really think you couldn’t print it,” said Dr. Carroll Spurling, director of the Los Angeles-Orange County Red Cross Blood Program. “Here is somebody drawing blood with no strings attached and they put a fee on it. Why should somebody (the elderly or the young) who cannot replace blood have to pay at least twice what anyone else would have to pay?” A conservative guess is that 125 hospitals stood to make over a million dollars a year. But with

Some recruiters will go to their graves convinced they need to fake a crisis every two months to keep the blood flowing

strong pressure—largely from the Red Cross—all but a handful have dropped the fee.

The examples go on and on. The Central Texas Red Cross Blood Center received a request in March, 1976, to replace more than 60 units of blood for a patient from Bedias, Texas who needed only 21. The hospital in Bedias had set a three-for-one blood replacement policy. Indeed, the AABB found that 37 per cent of some 345 blood banks it surveyed in 1976 had policies based on more than one-to-one replacement.

Two Indianapolis, Indiana leukemia patients were hit with $8,000 penalty fee bills after treatment at a medical center in the midwest. John Keilholz of the Central Indiana Regional Blood Center called it “daylight robbery” and was able to cut the charges in half through negotiation. In Cincinnati, the Paul I. Hoxworth Blood Center had a two-for-one replacement requirement on the first unit of blood (or $60) until two years ago, when local “pressure” forced it to start a one-for-one program.

The University of Pennsylvania Hospital in Philadelphia uses both Red Cross blood and material from its own blood bank. Patients are charged $21 a unit for Red Cross blood. For
the hospital's own blood, the fee is $37.50 a unit, plus a $45 replacement fee.

Finally, in New York, the state consumer protection board is pressing for the elimination of the fees. A survey of 14 New York City hospitals it released in June showed non-replacement fees as high as $83 at some institutions and for a first unit of blood varying from $59 to $149. By comparison, the Greater New York Blood Program will supply a hospital with a unit of whole blood for $34.50. (Some of the hospitals named, such as Doctors' Hospital, have subsequently eliminated the fee and raised other charges.)

To somebody who needs at most a pint or two of blood, the fees at issue may seem trivial compared to the cost of even a day's hospitalization. For the poor, the elderly, and those with serious blood diseases requiring hundreds of units, penalty fees can be substantial burdens.

"The non-replacement fee generates more money than blood," says Dr. Dennis Donohue, director of the Puget Sound Blood Center in Seattle, where the fee was dropped in 1971. "During the period it was in effect here, our assets increased to a level of about $3 million, of which several hundred thousand was in cash," he told Mai Schechter, who publishes a blood banking newsletter from Washington, D.C.

"As an hypothetical example, if the Puget Sound Blood Center was to re-institute a replacement guarantee fee today, our revenue might increase by an amount close to $1 million a year. . . . We would have to spend that money in higher salaries, fringe benefits and plush offices, hardly in keeping with the intent of a non-profit organization."

The San Francisco Suit

Charging of replacement fees is being most squarely contested in San Francisco, where the state sued the Irwin Memorial Blood Bank on June 1, 1977, charging that imposition of a $30 penalty fee for blood on top of a $20 processing fee was "lucrative" and a "depressing abuse of the community's trust." Richard B. Spohn, director of the California Department of Consumer Affairs, charged Irwin with amassing $2 million in bank accounts, about twice what it needed. The litany of charges included price-fixing, false and deceptive advertising, and unfair business practices.

In a field where most people think that a controversial subject is, for example, deciding what brand of cookies to serve donors, the questions generated by this attack have been profound, at times reaching heights that might follow a papal edict sanctioning abortion.

On the surface, Irwin's response stressed the threat to the blood supply at 52 hospitals in the eight-county San Francisco area if the penalty fee was precipitously junked. (There are 98 blood donations per 1,000 people in the area each year, twice the national average). Executive di-

It is disheartening that the ethical standards of all the blood banks don't equal those of most donors

rector Mrs. Bernice Hemphill said 98 per cent of the donors give blood to establish credit or replace blood and many might be lost forever if these options were removed. Eliminate penalty fees, Hemphill and others argue, and processing fees would just increase enough to make up for the lost revenue, because a blood bank's total expenses would not change.

Irwin soon revved up the printing presses in its public relations department and the publicity releases began to flow, accusing the Department of Consumer Affairs of "singling out" Irwin Memorial as the "mothership" to sink before all of California blood banks were "bullied" into doing things its way. "There's no reason all blood banks must recruit donors just one way," Hemphill said. She feels the pre-deposit system gives a justified break to those who give--after all, you can't transfuse non-replacement fees. It also puts more of a financial burden on those who don't give.

"That's totally phoney," responds Donald Avoy, director of the Central California Regional Blood Bank in nearby San Jose. He has been constantly feuding with Hemphill over just these questions. About 35 per cent of the blood collected by Irwin was actually replaced in 1977; the rest of the fees were pocketed. "The more they fail to get donors, the more money they get," Avoy explained. "It is a very financially successful failure." Steven Fleisher, lawyer for the Depart-
ment of Consumer Affairs, says that of 113,000 credits created by Irwin during 1976, only 52,000 were used and 61,000 expired. "It is a colossally complicated system" he said. "We have spent over a year just getting to understand it." One finding was that Irwin had no cost-accounting to speak of until after the suit was filed and "didn't know what it cost to make a unit of blood."

The suit itself continues with no trial date in sight. Irwin unsuccessfully tried to get it thrown out of court last year. The depositions and interrogatories pile up. Irwin says adverse publicity has led to hostility among donors. Fleisher predicts the "end of the non-replacement fee" as one of the suit's main consequences. "It is not a necessary incentive, it contributes to the high cost of blood and it gives rise to opportunities for fraud and deception," he said.

"The pre-deposit system is a very financially successful failure"

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National Blood Policy

On a national level, the disputes in San Francisco, New York and other places mark only the latest in a series of skirmishes between the big three of the blood banking industry, the AABB, the CCBC and the Red Cross. The three are federated in the American Blood Commission. This is an industry group established in the Spring of 1975 to formulate a national blood policy. More pragmatically, it is designed to head off more governmental control of the industry. The types of programs it works on are regionalization of the blood supply, general education programs for donors and improvements in the technical competence of its member groups. The Department of Health, Education and Welfare is keeping an eye on the American Blood Commission and is expected to report on its effectiveness in 1979.

One of the major battles within the American Blood Commission occurred in the Fall of 1976, when the Red Cross pulled out of its Clearinghouse agreement with the AABB. This is an elaborate nationwide system under which paper "credits" are recorded and traded for blood shipped nationwide. Red Cross Administrator Norman R. Kean found it an incredibly wasteful process with "a tremendous flow of verbiage and paper." In an internal memo, the Red Cross said the accord "worked primarily to serve nonreplacement fee and supplemental inventory assignments, not the blood needs of patients."

Donors are caught in the cross fire of this industry dispute. Take the case of Paul Bowersox of Lewisburg, Pa., as publicized by the Philadelphia Bulletin in March. Over many years, he had donated more than five gallons of his blood to the Red Cross. He then underwent open heart surgery at the Hershey Medical Center, during which time he received 16 units of blood. Because the Red Cross had pulled out of the Clearinghouse, Hershey, which belonged to the AABB, refused to honor his Red Cross donations. The bill was $480. "Paul had made it his business to give blood and he felt that if he ever needed it, it would be there for him," his wife said. "It's hard to accept when you find out you don't have it."

When a task force of the American Blood Commission surprisingly faced the issue head on and recommended over the summer the abolition of penalty fees nationwide, some AABB members viewed it as an open call for secession. That resolution, approved by the commission's board in December, put a thumbs down on all "coercive" appeals for donors, like coverage and blood assurance plans. The impact of the recommendation is unclear, for it was immediately shunted to another committee for an "impact" study. But such prestigious blood banks as the John Elliott Foundation in Miami and the Massachusetts General Hospital have dropped the fee this year.

The task force's message is that in a country where about 10 per cent of the eligible donors can-and do-supply everybody's blood needs, the only honest appeal is based on the theme of community responsibility and the only honest charge is the cost of doing business.

Implicit in the task force's recommendations are two conclusions: (1) Most of the nation's blood supply is adequate in both quality and quantity and critical shortages are infrequent exceptions rather than the rule and (2) Most blood shortages develop not from too few willing donors but rather from inefficiency and poor planning on the
Two Indianapolis, Indiana leukemia patients were hit with $8,000 penalty fee bills after treatment at a medical center in the midwest. Through negotiation, the charges were cut in half.

Drake calculated that a region needs about one unit of whole blood for every 20 people each year. Every eligible donor would have to give once every seven years to meet that need. He found that most nondonors had “never been pressed very hard” primarily because there hadn’t been a need. “If we had a 20 per cent increase in the number of donors (in 1976) . . . all parties concerned would have been embarrassed by the resulting outdating figures,” he wrote last year. (Refrigerated blood has a 21 day shelf life).

Our willingness to donate is illustrated by the invariably overwhelming response to emergency television and radio blood appeals. When it gets down to providing a rare blood type for 3 a.m. emergency surgery, a blood bank’s collection philosophy matters less than the quality of its administration. Some recruiters will go to their graves convinced they need to fake a crisis every two months to keep the blood flowing, while others just quietly get word out where the mobile drawing stations will be and make sure they show up on time. The fact of the matter, according to Drake, is that we as donors are an incredibly malleable lot, ready to parrot whatever reasons the local blood bank gives us for rolling up our sleeves. The only significant difference he has found between former and frequent participants is their awareness of an on-going solicitation and a reasonably convenient place to give. Thus, San Francisco has a stable, self-sufficient blood supply with a replacement fee; Milwaukee, Rochester, N.Y. and Indianapolis do just fine without it.

Chicago: A House Divided

Chicago is one of the best examples of a large city where needless fragmentation of and competition between blood banks jeopardizes the community blood supply. Total yearly collections are about 10 per cent short, with 30,000 units of the precious red liquid being imported from places like Springfield, Peoria and New York City. (The situation was much worse five years ago). The cost of blood ranges from $27.50 a unit from the Red Cross, to $46 a unit at the large Rush-Presbyterian-St. Luke’s Medical Center, plus a $15 non-replacement fee. Donations are 34 per 1,000 people, compared to the national average of 47 per 1000.

Chicago’s blood banks have been known to war with each other for donor groups and after years of debate are unable to agree upon unified collection and information sharing procedures, such as coordinated emergency appeals or a central listing of blood inventories. Nobody has any idea how much wasteful outdating of blood this causes. A key problem is that many large industries, including Illinois Bell, (the area’s largest employer with 30,000 workers), Commonwealth Edison, Nabisco, Johnson & Johnson, and Campbell Soup, don’t sponsor blood drives. By comparison in nearby Milwaukee, all blood comes from one center at $29 a unit and nearly all large firms, including the telephone and electric companies, have drives with average participations of between 15 and 20 per cent. “These are the national
problems in microcosm,” says Russell Merritt, the new director of the Chicago Regional Blood Program, who pins blame squarely on the blood banks themselves. “There is absolutely no reason Chicago or any other city can’t be self-sufficient for blood.”

One thing that no one is critiquing is the technical proficiency of most of the nation’s blood banks and the purity of their product. The modern blood collection center is chock full of centrifuges and Rube Goldberg-type machines for typing blood, checking for hepatitis and syphilis and separating whole blood into components. Unfortunately, some forms of hepatitis remain undetectable in advance but the basic problem remains getting enough blood to the processing centers so skilled technicians need not have time hanging heavy on their hands.

Yet to be addressed is the continuing commercial traffic in blood proteins, which represent the equivalent of millions of units of whole blood donations each year. Paid donors can receive $45 to $60 each month to have these proteins selectively “pheresed” or removed from their systems while the rest of their blood is then transfused back in. Pharmaceutical companies can turn the straw colored liquid into such diverse products as anti-hemophilia factor and serum for laboratory tests. Even out-dated plasma, once thrown away, can command $22 a liter. Indeed, two Red Cross employees in Philadelphia were arrested in December, charged with stealing 564 liters of plasma and trying to sell it for $18,000 to the local office of the Interstate Blood Bank, Inc., a commercial plasma processor and collector based in Memphis. The traffic in blood proteins is the dark underside of America’s volunteer blood donation system.

When the Public Finds Out

Somewhere into this morass of penalty fees, worthless coverage plans and inefficient collection plaguing an otherwise laudatory system, fit the voluntary donors who are in the unique position of providing a product in individual one-pint contributions that has no substitute. “I don’t think the public understands any of this,” says Merritt, formerly director of a model Red Cross program in Rochester, N.Y. “My fear is what is going to happen when they find out they’ve been lied to, or told what somebody believes is the truth.” “The premises of blood collection can be marginal, and possibly false . . . perhaps in the name of a ‘greater good,'” agrees Drake, who also fears a “crisis in public confidence.”

It shouldn’t be terribly difficult for blood bankers to change their advertising slogans and promises and legitimize all their charges, but don’t expect it to happen spontaneously. The immediate test is whether it takes the American Blood Commission several years or several decades to eliminate penalty fees. Moreover, the organization itself must withstand the internal bickering which will surely continue. It is disheartening that the ethical standards of all the blood banks don’t equal those of most donors. Until they do, the unfettered altruism of volunteers will continue to be compromised and tainted before their gifts ever reach the patients upstairs.

Robert Steinbrook, a student at the University of Pennsylvania Medical School, has worked for the Chicago Tribune and other newspapers.

Wechsler, Henry, Ph.D. and Anne K. Kibrick, R.N., Ed.D.
EXPLORATIONS IN NURSING RESEARCH
Nursing research has recently been gaining wide recognition for improving the quality of nursing care and in promoting and maintaining both physical and mental health. Studies have focused on such vital issues as health maintenance, disease prevention, modalities of treatment and care, promotion of recovery and coordination of health care services. This major work is the first to provide both nurses and nursing students with the essential skills for understanding the research process and for critically evaluating relevant studies. A broad range of current research is presented clearly illustrating each of the fundamental steps in the research process.

Because of the high cost of health care, as well as the involvement of

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Nursing’s Quest for Identity:

In 1974, the New York State Nurses Association (NYSNA) proposed that NY State’s nursing act be amended to limit the equivalent of Registered Nurse (RN) licensure to graduates of baccalaureate nursing programs. Graduates of associate degree (two-year) programs would qualify for the equivalent of Licensed Practical Nurse (LPN) licensure. Graduates of hospital-based diploma programs would be downgraded to traditional LPN licensures and traditional LPN programs would no longer qualify for any nursing license, although graduates could presumably work as nurses’ aides. Because the amendment would take effect in 1985, it has become known as the 1985 Proposal. (See also Health/PAC BULLETIN, September/October 1977, and January/February 1978).

In spite of the fact that the NY State legislature has shown little sympathy towards their proposal—apparently preferring new paraprofessions to new roles for nurses—and despite the fact that other public bodies and even significant sectors of their own membership have rejected this strategy for nearly fifty years, the NYSNA continues to persevere. Recent efforts to cosmetically change the face of the proposal have been for nought and the amendment now seems virtually dead.

But nursing leaders refuse to accept defeat, refuse to reconsider their strategy and, in fact, the NYSNA board reaffirmed as late as 1977 that: “The board believes that the major impediment to recognition of nursing as a profession, acceptance of nurses as professional practitioners, and support for nursing care services is the failure, to date, to establish an appropriate standard for entry into nursing. We must clarify: ‘who is the nurse? And who are the others?’” (Emphasis in the original)

Nursing’s leaders have pursued professional status and baccalaureate education as a condition for entry for 50 years. On first glance, this appears an eminently reasonable request. Surely, the BSN as a minimum level of preparation is not too much for nursing to ask. But the idea has remained elusive. Rank-and-file nurses have repeatedly resisted a proposal that is, after all, premised on their own
incompetence. Elite nurses, meanwhile, have never been able to agree on a sensible way of ensuring their elite status, particularly with physicians’ assistants moving into their turf. And state legislatures, faced with these and other conflicts, have been content to continue denying nurses control over access to their own profession.

The pursuit of professional status has consumed the time of many occupations. Although invariably couched in terms of insulating the public from incompetent or unscrupulous practitioners, most observers see economic self-improvement as the major motivating force behind such efforts. (It is noteworthy that no professional law for nurses has ever been sought by the public.)

The economic benefits of licensure (the legal stamp of professional status) inhere in two phenomena: 1) Access to the profession and the right to practice the trade is restricted and invariably made more difficult and expensive. This depresses supply. 2) The professional status implies to the public a consistently high level of quality and more than likely stimulates their desire for services. This increases demand. Lowered supply and increased demand translates into higher prices.

Substantial battles have been fought about whether particular groups are professions. Nursing has been no exception. Eli Ginzberg, the economist who chaired one of the many nursing study committees, offered the observation that nursing was not a profession and would not be until it put “all of [its] nursing programs under the direction of colleges and universities,” thereby creating a small number (about 70,000) of elite nurses with professional status. Ginzberg candidly concedes that the real issue is income: professional pay depends on professional status and professional status depends on better exclusionary mechanisms.

Nurses’ leaders are plainly ambivalent about such utterances. On the one hand, they want to motivate their members to push for baccalaureate training in order to achieve professional status. Some observers of the nursing scene tend to confirm that the 1985 Proposal, or something like it, is a precondition for professional status. On the other hand, many espouse the belief that nurses are already professionals.

Opponents of the trend are characterized by many nursing leaders as philistines seeking to protect the inferior programs they represent, or “practicing nurses with less adequate preparation to cope with present-day demands on the profession.” (1) The tendency of nursing leaders to slander the bottom 80 percent of the profession in order to push the 1985 Proposal and its predeces-

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**Controlling entry into the profession has been a major part of nursing leaders’ strategy to gain status and power**

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sors is alarmingly commonplace and perhaps, in part, accounts for rank-and-file hostility to nursing leadership’s efforts.

Putting aside questions of professional stature, lawyers define the two components of professional status as follows: 1) Is there an identifiable scope of practice which all non-licensed personnel can be excluded from performing for money? 2) Is the control over access to licensure held by those in the profession?

Nursing leaders have identified their goal in terms of the second component. They feel that their inability to restrict the number of people eligible to take the licensing exam has led to a glut on the market. Of course, phrasing the issues in those terms would be inelegant, and they have used as a proxy the question of which class of schools to accept graduates from. The hypocrisy of this theme is easily demonstrated by the fact that they do not urge stiffening accreditation or passing grades on licensure exams (never mind post-licensure scrutiny) because neither of these gambits can be guaranteed to work solely to the benefit of baccalaureate graduates.

The other component—identifiable scope of practice—is also a problem, although most seem to have only dimly perceived it. Most nursing scope-of-practice sections define nursing in terms of general mechanisms equally applicable to medicine (i.e. diagnosis, treatment, etc.) In fact, there is not a single “nursing” procedure that cannot legally be performed by physicians. The recent advent of physicians’ assistants adds another group which can lay claim to a variety of “nursing” acts.
There appears to be no way out of this fix for nurses. Unlike dentists and podiatrists, they have no area of the body to call their own. Even if they did, they would be more like podiatrists, who "share" it with other physicians, than dentists. Nor are they like chiropractors and therapists who have identifiable functions which they share with physicians (at the latter's option). At least these groups have been able to exclude all nonphysicians from that therapeutic turf.

The only turf nurses can claim, however, is in terms of institutional hierarchy, not any kind of functional differentiation. Nurses are the traditional generalists providing care within hospitals, public health agencies, nursing homes, schools, etc. (Even in those areas, there are historic and recent conflicts with LPNs and nurses' aides). Recognizing this, the 1985 Proposal distinguishes between professional and non-professional nurses not on the basis of function (which would probably be impossible) but on institutional roles: non-professional nurses will take orders from professional ones. Similarly, conflicts with physicians will be resolved administratively, not legally under unauthorized practice suits.

Nurses have, in effect, a closed-shop arrangement and not a profession. To put the matter another way, their monopoly is enforced institutionally, not legally. While it is true that freestanding nurse practitioners could not be characterized this way, they do, on the other hand, share functions with physicians and physicians' assistants (and perhaps others).

Expanding nursing's scope of practice to include psychological, educational, or social work tasks as is the current vogue would not help matters. Rather it would further dilute the "exclusiveness" of nursing's scope of practice, as workers in those fields will then be performing "nursing functions."

One possible approach might be to list all functions a nurse could perform, and list everyone else who could also perform them. This would make nursing functions more exclusive but hardly totally so. For example, it is unlikely that any legislature would prohibit all others from doing catherizations, blood pressures and the like. More to the point, such deliberate delineation may literally be impossible, although it is being attempted in part by defining lawful activities of nurse practitioners.

The fact is inescapable: nursing is medicine. As such, it is hard-pressed to define an exclusive scope of practice and seems unlikely to be able to achieve such a goal in the future.

One author noted that the education and training of nurses and physicians was about the same at the turn of the century. However, there was, and still is, a difference in the relative power of the two groups and it is this fact which created the dilemma for nurses: "... they were not their [physicians'] equals in the political and economic spheres of human activity, or in influence on the public, and it was this lack of equality that would shape their development far more than their professional ideals." (2)

The Professional Leaders

It is important to recognize that professions are not unified wholes. Like other American institutions, they are organized in a hierarchical fashion with elites and non-elites. Further, the benefits of professional status are not distributed evenly among the layers of practitioners nor exclusively with the profession. Therefore, the quest for professional status by the leaders of a vocation must also be seen as a quest for status and power over the vocation's members: "... this policy has been attractive to leaders of nursing associations, teachers in nursing schools, some nursing officials in government, and others whose responsibilities, prestige, and other satisfactions, would be magnified by an increase in the collective status of nursing." (3)

Controlling entry into the profession has been a major part of nursing leaders' strategy to gain status and power. One approach has been to try to gain control over licensing boards. This has proved, until now, to be a losing battle.

A second, equally valid approach is to attempt to gain hegemony over nursing schools. If all schools are controlled by one class of nurses, these 21
Nursing leadership's pursuit of professional status is a pursuit of power for themselves. Nursing leaders have pursued their own self-interest with a singlemindedness that would bring a blush to even the AMA's collective cheek.

is characteristic of their virtual inability to speak plainly. Read between the lines of the following excerpt, which attempts to put the proposed nature of the BSN-AD relationship as nicely as possible: "The AD graduate uses basic nursing knowledge... in planning and giving direct nursing care in supervised settings... The BS graduate, on the other hand, provides leadership in the delivery of direct and indirect nursing care. By indirect nursing care, we mean that the nurse works with and through other people in order to achieve nursing goals and monitors nursing activities of others. We define leadership as influencing the actions of others." (5) This article continues disingenuously to note that such leadership is to be based on "nursing knowledge," neglecting to note that its real basis is institutional hierarchy. Similarly the 1985 Proposal will command all institutions to put BSN nurses in charge of AD nurses.

One could go on about the snobbery and pomposity of nursing's "leaders." But the non-nursing reader is instead referred to their own writings, which testify more eloquently than any analysis to the tenor of this "leadership," should any legislature be foolish enough to compel it by legislation.

While there are many reasons for nurses to fear legalization of the current nursing leadership's authority, the public should also be ap-

The only turf nurses can claim is in terms of institutional hierarchy, not any kind of functional differentiation.

Continued on Page 39
DEATH AGAINST TAXES

"After January 20, I intend to provide the aggressive leadership that is needed to give our people a nationwide, comprehensive, effective health program, and you can depend on that."


"I don't think we should condition the guarantee to the American people of health care as a right on the state of the economy. That is a fundamental difference which can't be papered over...I could not in good conscience continue to support the approach that has been spelled out by the administration."

—Senator Edward Kennedy
August, 1978

"There are many people in this country for whom small changes and broad changes in coverage would make an enormous difference in their lives...there's no doubt that our ability as an Administration to enact any kind of legislation will depend on the efforts of groups such as yours to expand the range of dialogue. I totally applaud efforts to go beyond NHI to talk about a national health service."

—Joseph Onek
White House Assistant for Health to American Public Health Association, Los Angeles, California, October 17, 1978

From watching the spring presidential rite of whistling Dixie (see last BULLETIN), we have recently been noting the congressional Irish jig in a rightward dance of death against taxes.

In early summer the stalwart forces for national health insurance of big business, labor, and government appeared finally to be falling into place around the Carter Administration. Things were looking up. There was a growing acknowledgement—even among medical provider forces—that total health care costs and their gross product share in the U.S. are too high, that some intensive and defensive high technology medical procedures and devices are questionable, and that some facilities are over built.

Then, along came the full-fledged, Right-business-led War on Government and Taxes in the name of anti-inflation. The 95th Congress adjourned with no hospital cost-containment and cuts in basic Federal health programs. The haunting question has arisen: will there be a national government left to carry out national health financing reform?

The new political graffiti was on the wall a few weeks after the victory of anti-property-tax Proposition 13 in California. On July 29, President Carter issued his long-awaited "Ten Commandments" on national health insurance: "Thou shalt include the private insurance companies;" "Thou shalt require co-payments from users," etc. Senator Kennedy and AFL-CIO President Meany blasted these the day before.

The Carter Commandments

President Carter's "Ten Principles," released in a solemn press conference by HEW Sec-
retary Joseph Califano, contained the following provisions:

- **Multi-staging, 1984 to 2001?** —no additional federal spending until fiscal year 1983 and then "phased in gradually;"

- "Triggered" by Health of the Economy —implementation is to depend on health industry inflation being contained (even without comprehensive financing and structural reform) and general inflation and unemployment being lowered by '83: "Before I submit legislation, I want to be certain that the plan is consistent with our efforts to control inflation in the health care sector and the general economy.

- Victim-charging —co-payments and co-insurance for users as alleged disincentives to over-utilization, even though it has been consistently demonstrated that it is the medical providers and institutions who are the prescribers, referral agents, and organizers, while sick people have little or no control over their episodes of illness;

- **Private Insurance Industry** 'a significant role for the . . .;''

- **Off Federal Budget** —administrative entities would be funded separately from regular U.S. government appropriations after 1983, thus providing no public accountability or congressional budget control;

- **Covering of the "Uncovered" only** —Emphasis would be on insurance for the uninsured, not on guaranteeing the appropriate coverage or organization of care for everyone;

- Unrealistic "Cost Containment" Projections —the approximately $40 billion in additional federal funds which would eventually be required, are to come primarily from savings generated by the Administration’s proposed Hospital Cost-Containment Act, which provides for a national percentage "cap" on expenses. (This Bill has already been gutted by private hospital interests, but even if passed would have questionable efficacy under the existing system short of providing a mechanism for drastic cuts in needed services.)

Both the American Medical Association and the American Hospital Association found elements in the Administration statement that parallel their own proposals, such as phasing in the program and participation of the private insurance industry. The president of Blue Cross praised it as "sensible." White House Press Secretary Jody Powell, commenting on the opposition from Senator Kennedy, said, "This is no longer the New Deal . . . there is no constituency for undisciplined spending."

"This is no longer the New Deal . . . There is no constituency for undisciplined spending"
— Jody Powell
White House Press Secretary

But Kennedy and his forces disagreed. Claimed Kennedy, as he and the labor-backed Committee for National Health Insurance began promoting their own "Private Guaranteed Bill." "There is a growing grass-roots constituency," according to the senator. He enumerates: "the senior citizens, church groups and working men and women of this country are ready to move. Their ranks will be swelled, I believe, by the middle class which will see its premiums rising, its benefits falling because of inflation.

The new Kennedy "Private Guaranteed" Bill is described as non-inflationary, cost-containing, multi-staged, contributory and committed to comprehensiveness within 24 months—although some benefits will be phased in later. Unlike the Administration’s proposal, it is neither general economy-hedged, nor triggered, nor does it contain direct co-payments for the neediest users.

Much of the actual legislative language, e.g. regarding exact financing mechanisms, prospective budgeting process, and coverage regulations, won’t be unveiled until at least December. However some of the different principles are already being spelled out. Coverage will be multi-staged but eventually comprehensive benefits will be available for all, including home care and preventive services. Questions still hang heavily about full mental health and dental health coverage and about full chronic and elderly nursing coverages. Also unresolved are questions about which professions will be reimbursed, especially for prevention, health education and outreach services. Prescription drugs for the nonelderly are to be phased in later. Most notably absent is any mention of abortion coverage.

The Kennedy Bill creates three different national "competing consortia" for private benefits. Each will be subject to elaborate federal coverage criteria for inclusion. There is to be one for commercial insurance companies, one for Blue Cross-Blue
Shield, and one for health maintenance organizations (HMO's). There is no direct provision for community-based health centers, except under an HMO market qualification. It provides no separate public, government-owned hospital or health financing channel. This could mean the end of public hospitals, except as the worst imitators of private, fee-chasing, bed-filling, and high technology hospitals, although where else will those ultimately uncovered or dumped then go?

Although there are resource development funds under the Bill for currently underserved areas, none of these private consortia from which individuals ostensibly are to choose refer to communities where people live. It is hauntingly unclear how the federal government can force (much less interest) the insurance industry to join this plan when it already has access to the better middle class and employee markets. Private insurers and providers might have this approach tied up in litigation for years before it could begin to be implemented.

A Federal Public Authority, regulating mostly non-Congressionally appropriated funds and therefore "off federal budget," would emphasize prospective budgeting (advance/negotiated and planned payment amounts) for institutions and professional providers and would operate through 51 State Health Authorities (SHA's). Most of these SHA's would probably be based in current state health departments but under "strict federal guidelines."

Federally regulated financing calls for earnings-based employer premium payments plus employee contributions to cover up to one-fourth of costs. An estimated $21.7 billion of new "on budget" impact in federal expenditures is projected by 1983, primarily to cover the unemployed and the poorly paid.

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**It could mean the end of public hospitals, except as the worst imitators of private fee-chasing, bed-filling, and high technology hospitals. But where else will the uncovered or dumped then go?**

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**From Public to Private**

This new Kennedy Bill, based entirely as it is on "guaranteed" private insurance for all, moves completely away from the public principles of the old Kennedy-Corman Health Security Act of years past. Previous co-sponsor Rep. James Corman (D-CA) has criticized the total private insurance approach and lack of at least parallel support for public health and hospitals programs. The 51 newly created SHA's overlaying three private national consortia would vastly increase the number of places where community-oriented consumer and health worker forces will have to fight for basic coverage guarantees. The SHA's also lack any real community-level decentralization for program development accountability. Since states have generally been subject to the most focused special interest domination and unrepresentativeness, it is quite unclear how strong federal standards of meaningful 51% consumer control can be forced on the states or how agency designation could be effectively controlled.

Principles of broad and equitable coverage are articulated in the Bill. But a framework dependent on private insurers and providers, even with strong federal guidelines and incentives, cannot significantly affect the location, organization, or development of medical care resources towards our desperately underserved rural and inner city areas. The Bill's emphasis on cost-containment could likely lead, given these limits, to the dumping of those most vulnerable, "loss leader" services, those socially cost-effective and needed preventive and primary services, and the dropping of such controversial provisions as home birthing and abortion.

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**The Lesser of Two Losers**

Thus, before our eyes, the NHI controversy has been reduced to a battle between the President's "you'll be healthy if the economy's healthy" in his 1983 supplementary coverage proposal vs. Senator Kennedy's universal, but only loosely comprehensive regulation of private coverage to begin within two years.

Harsh questions confront these new rightward tinkerings and compromises in the fading name of NHI. Is the red, white, and especially blue tape of weak, multi-layered government regulation of a privately owned, nearly $200 billion medical industry possible except as a more costly nightmare akin to the subsidized energy monopoly? Is meaningful compromise in advance of legislation possible with private medical providers and in-
surers, whose business depends totally on the outcome? Although the new Kennedy Bill has approaches distressingly similar to the old American Medical Association-backed Medicredit (with more comprehensive government regulation and coverage requirements), it's already getting total AMA opposition. Tough negotiation by government, within the framework of a real, total national health financing system, yes; but legislative compromise in advance?

**The removal of comprehensive, public, national health financing from the political arena—for years assumed to be just around the corner linchpin of US health care system development—leaves people even more than ever with no national health policy**

It is becoming increasingly clear that the real issues are how to control costs, who pays and who's to blame for illness. Should there be comprehensive government intervention for financing and planning care, with guaranteed services for all? Or only minimally regulated government subsidy for so-called market alternatives, especially corporation-dominated HMO's? Should the systemic environment/occupational/agribusiness/social causes of illness be challenged? Or will major emphasis be on personal lifestyles, required care-disincentive co-payments, and other forms of individual victim-blaming?

A newly defined health coalition, more broadly labor and community-based than the current consumer coalition, may be necessary across the country, in order to develop satisfactory answers to these questions. In addition to immediate lobbying with expectations for national health financing reform, such a movement could be one which challenges the corporate environmental/occupational illness causation with community-based, advocacy health services, and one that builds on living local alternatives of publicly accountable health budgeting, planning, and organizational efforts.

The removal of comprehensive, public, national health financing from the political arena—for years assumed to be the just-around-the-corner linchpin of U.S. health care system development—leaves people perhaps ever more than ever with no national health policy.

Are we tragically caught for now in a classically false national policy choice of death against taxes?

—Robb Burlage

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**JOURNAL OF COMMUNITY HEALTH**

The Official Journal of the Association of Teachers of Preventive Medicine

Editor: Robert Kane, M.D.

The Rand Corporation

The *Journal* devotes itself to original articles on the practice, teaching, and research of community health and encompasses the areas of preventive medicine, new forms of health manpower, analysis of environmental factors, delivery of health care services, and the study of health maintenance and health insurance programs. Serving as a forum for the exchange of ideas and clarification, the *Journal* features articles on those projects which are making a significant impact on the education of health personnel.

Other noteworthy features of the *Journal* include a concise abstract which precedes each article, the bibliography of references with which each article is concluded, the list of new books in the field, and a particularly significant letter to the editor.

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A VICTORY FOR THE RIGHT

The political record of the last year has not been a heartening one. To some, it has become positively alarming. The record bears a closer look.

The Hyde Amendment, passed in November, 1977, halted abortion funding for poor women but allowed states to take over the cost. Of the 15 states which have exercised this option, four have since withdrawn funds because of the pressure of systematic Right-to-Life campaigns waged in state and local legislatures. More are likely to follow.

Eight abortion and women’s clinics have been firebombed since February 1977, blinding one woman and nearly trapping another on an operating table, in a mounting campaign of picketing, sit-ins, harassment, and terror directed at abortion clinics and the women who use them.

A campaign for a Constitutional Convention to draw up a Constitutional Amendment banning abortion has progressed swiftly, netting eleven of the necessary 34 states in less than a year; similar resolutions have passed one house of the state legislature in five other states and have been introduced in 12 others. Since no rules exist to govern such a convention, many fear the Constitution and Bill of Rights themselves might be subject to revision.

Overwhelming ballot box defeats of gay rights ordinances, first in Dade County, Florida and most recently in St. Paul, Minnesota, have fueled anti-gay sentiment around the country. Repeal of rights for gays is now on the ballot in Wichita, Kansas and Eugene, Oregon, and efforts are afoot to hold referendums in Seattle, Washington and in the State of California as well.

Abortion, the ERA, and gay rights are only the most volatile examples of the hostile winds blowing from the right. Also up for grabs in many areas of the country are school busing, affirmative action, sex education and liberal textbooks, daycare, welfare and other public services, the death penalty, right-to-work, environment, nuclear energy, OSHA and EPA, consumer protection, gun control and the Panama Canal Treaty, to name a few.

There is little disagreement that the political pendulum is swinging to the right. How serious that swing is, what it represents and what response it warrants from progressive forces, however, are subjects of growing debate.

The "Far Right" has been a perennial feature of the American political landscape, traditionally represented by such groups as the American Conservative Union, the Right to Work Committee, the John Birch Society and Young Americans for Freedom, as well as the Ku Klux Klan and the American Nazi Party at its extremist fringes. What is new and therefore threatening about the "New Right" of the 1970's is at least threefold:

A genuine social movement is taking place on the right, characterized by the activism of increasing numbers of ordinary individuals willing to contribute money, make phone calls, write
letters, ring doorbells, picket, sit-in or whatever.

Unlike the ideological and hidebound older formations of the right, the present, yet nascent movement is a pragmatic, issue-oriented, grassroots one that is propelling a large cross-section of female Americans into action.

An organizational and technical leadership is emerging with the potential to weave these diverse but related issues into a single integrated political fabric. Illustrative of this sophistication is the operation of Richard Viguerie, sometimes called the "Godfather" of the resurgent right wing. Viguerie has used the computerized culling of vast

From a campaign war chest of a mere $300,000 in 1972, the New Right will enter the 1978 elections with some $20 million, thanks largely to the Viguerie operation, estimates the ADA. With the recent election to national office of such far right-wingers as Orrin Hatch of Utah, Arban Strangeland of Minnesota, Robert Livingston of Louisiana and John Cunningham of Washington almost solely to his credit, Viguerie is moving from simple fundraising to building a political machine that will be able to offer campaign back-up and expertise to some 1,000 local and state national candidates this year.

Grassroots Political Activism

Progressive forces, alarmed by the growth of the New Right, have reacted primarily to the latter aspect—the growing organizational and technical sophistication of the Right. Yet to react simply to the Richard Vigueries is to risk ignoring the substance of the fear and discontent which feeds grassroots political activism on the right today. "We organize discontent, just as all successful movements do," says Howard Phillips, former Nixon aide famed for dismantling the Office of Economic Opportunity and presently the national director of the Conservative Caucus.

In many respects the expressed discontents mirror issues raised by the movement of the left that prevailed in the 1960s and early 1970s: anti-imperialism, minority, women's and gay rights, environment, occupational health, consumerism and the counterculture. The most potent and explosive of these is the reaction to the women's and gay movements.

One common thread that runs through many of these issues is the role and destiny of the nuclear family. At issue, thanks to these movements, are some of the most fundamental of social and personal issues: the viability and desirability of the nuclear family, the social, economic and sexual roles to be played by men and women, whether and under what circumstances to have children, and the nature of sexual identity, to name a few.

The very emotionality of the anti-ERA, abortion and gay rights movements suggests that these issues strike close to home, threatening critical stresses and barely-repressed needs among their members. At the deepest social and personal levels, the same needs may be fueling the growth of both the right and the left. This proposition is not only a plausible one; it is a hopeful one as well, and one therefore worthy of serious consideration.

To address this possibility, however, will require a new maturity of movements on the left—movements hitherto largely preoccupied with damning the nuclear family and its failures and declaring their own liberation from oppressive social conventions. Required will be a dialectical appreciation that, oppressive, eroding institution that it is, the family still offers to many the only source of security, identity, intimacy and meaning available in an otherwise alien and exploitative world. Required will also be an articulation that the left does not represent a threat to the fulfillment of these needs, but the opposite: their
fulfillment in an alternative and more viable context.
-Ronda Kotelchuck

NJ ABORTION GUIDELINES

New Jersey has joined the ranks of states, cities, and counties faced with Right-to-Life legislation. Identical bills have been introduced into the Senate and the Assembly which, if enacted into law, would serve to make abortions less accessible, more costly, and more emotionally draining. Some of the bills’ provisions include:

- the definition of life as beginning from the moment of conception;
- the requirement of parental notification for never married women under the age of 18;
- outlawing of saline amniocentesis procedures unless certified in writing to be medically indicated;
- the requirement that second trimester abortions be performed in a hospital equipped with life saving measures in case the fetus is viable, by two doctors, one of whom is for the potentially viable fetus;
- an exaggerated and biased informed consent procedure, which requires that the woman be told of the “possibility of immediate and long term physical dangers of abortion psychological trauma, sterility, increases in the incidence of premature births, tubal pregnancies and still births in subsequent pregnancies.” She must also be told “the probable physical competency and probable anatomical and physiological characteristics of the unborn child at the time the abortion is to be performed.”
- a 48 hour waiting period between consent and performance of abortion;
- the statement that “a woman should be encouraged to carry her child to term.”

On August 17, 1978, the New Jersey Senate held its first public hearings on S.1110, the proposed bill to regulate abortions.

Out of the seventeen people who presented testimony that day, six were in favor of the bill. But these six speakers monopolized that day’s hearings. Among the bill’s proponents were the Lutheran Church Missouri Synod, the N.J. Right to Life Committee, Americans United for Life Legal Defense Fund (Chicago), National Association of Obstetricians-Gynecologists (Chicago), and the Committee of Doctors and Nurses versus Abortions (New York).

The anti-abortion groups’ arguments went well beyond the traditional religious arguments with which they have been identified in the past. Only the representative of the Lutheran Church Missouri Synod approached the subject from that perspective. Professor John Gorby, representing the Americans United for Life Legal Defense Fund, submitted testimony to the committee which was about five inches thick. The testimony included rewrites of parts of the bill which he claimed would insure that it would hold up against the test of the Supreme Court. His oral testimony, which lasted an hour, described the legal maneuverings and issues involved. Testimony was supposed to be limited to five minutes.

Dr. Jasper Williams of the National Association of Obstetricians-Gynecologists in Chicago, took pains to establish his liberal credentials (member of the AME Church, against the culture of poverty theory, member of black caucuses in professional associations, etc.) before he proceeded to argue somewhat incoherently against liberalization of abortion regulations.

Asked by one of the Senators, “How did you hear about these hearings,” Dr. Williams responded by saying that someone from NJ (he wasn’t sure of the organization’s name) had contacted him to speak. Although there was no follow-up comment or question, the powerful centralization of the right’s intelligence gathering and deployment of forces was made very clear.

To complement the testimony of Dr. Ada Ryan, representing the Committee of Doctors and Nurses versus Abortions, was a very large drawing of a nine month fetus. Her presentation began with a medical explanation of pregnancy and the abortion procedures. After one unsuccessful attempt, she was finally asked to remove her picture, since it was misleading to the discussion at hand (first trimester abortions). In her testimony she denounced the Supreme Court decision which forbid any regulations of the abortion procedure. “As it stands right now,” she said, “I could perform an abortion in
the lobby of this building. A psychiatrist or a dermatologist could perform abortions." Although she was challenged by some of the Senators on this point she held her ground firmly. She spoke of numerous instances of medical incompetence, including botched abortions (very graphic descriptions of improperly performed vacuum aspiration procedures, etc.) and the lack of follow-up care from abortion clinics. Numbers of teens die each year, she said, from improperly performed legal abortions. Yet almost nowhere did she present statistical data to support her assertions.

Anti-abortion speakers repeatedly claimed that the black market adoption business is being fed by abortionists who urge their clients to carry to term their unwanted pregnancies. Counselors at referral agencies, these speakers charged, receive financial kickbacks from abortionists, and doctors who perform abortions do so out of their own purely economic interests. Although outnumbered by those arguing against the bill and in favor of the right to abortion, the Right to Lifers are far better financed and organized. Flying three people from Chicago to New Jersey requires both an economic solvency and a central coordinating effort.

Even more important to realize is that their arguments are not always so simple or obviously reactionary. They are increasingly co-opting the rhetoric, arguments, and tactics of the civil rights movements of the 60s and other liberal causes. Many of their arguments are the very same ones used to fight for the legalization of abortion (women are dying from improperly performed procedures, etc.).

The second and last day of Senate hearings was October 26, 1978. The Assembly held its hearings on one day in October. Both days of proceedings differed little from that described above. There was less technical, professional testimony, as testimony at these two came mainly from individuals, grass roots groups, and women's groups. Both sides were equally represented.

Unless joint hearings are held, which is unlikely, no further dates for hearings are set. It's all in the legislators' hands now, and quite frankly the picture is bleak.

—Marilynn Norinsky

MILLIONS FOR OFFENSE, TWO CENTS FOR DEFENSE

Health insurance companies rarely cover contraceptive services, only partially cover abortion and maternity services, but virtually always pay in full for sterilization, according to a new survey of insurance coverage done by Charlotte Muller, associate director, Center for Social Research of the City University of New York.

Among 37 commercial health carriers surveyed, contraception coverage was "almost non-existent," 29 covered abortion services (mainly in a hospital setting) and 34 covered sterilization. These findings are in keeping with the illness-orientation of the medical system and its insurers and with prevailing patterns of discrimination encountered by women.

BIRTH OF A MOVEMENT?

The week of September 10-16 moved the issue of occupational safety and health to a place of new importance in the political life of the country and everyday public consciousness. For the first time, occupational safety and health began to look like a social movement with real political potential.

On September 11-13 the AFL-CIO held its first National Conference on Occupational Safety and Health in Washington D.C. Of the 1,000 people in attendance, most were rank-and-file workers or occupational safety and health staff from unions, including unions not in the AFL-CIO. Representatives from some of the 15 community-based Committee on Safety and Health (COSH) groups also attended. The conference coincided with the creation of the AFL-CIO's Department of Occupational Safety and Health, headed by George Taylor, with a budget of $400,000. Prominent speakers such as Walter Mondale, cabinet members, Congressmen, agency heads, and union officials were paraded in front of the convention. Yet the discussion extended beyond official presentations. The delegates in the workshops were largely organizers and people from local struggles who came together to be part of a political movement. This gathering marked a new stage in organized labor's concern with occupational safety and health and a chance for local people to get a sense of the activity of other unions and groups.

The conference took place in an atmosphere of major labor legislative defeats and declining membership. Hanging in the balance that week was the Bartlett Amendment, which would have severely restricted OSHA's ability to inspect workplaces with under 10 workers. The amendment was later killed in a conference committee.

Occupational safety and health is one of the few areas labor could point to for real victories. The current OSHA administration was loudly applauded as being strongly in labor's interest. The appointment of Dr. Anthony Robbins as the new Director of NIOSH, announced at the conference, was another labor victory.

The AFL-CIO has been the major force in the creation and defense of OSHA. As George Meany said in his speech: "OSHA is our law." A strong law and the means to make it work is a clear benefit organized labor can offer to unorganized members. Occupational safety and health must be in the forefront of labor's attempt to grow organizationally, strengthen itself politically, and improve the lives of workers. The safety and health movement promises to help revitalize organized labor itself.

HEW Secretary Joseph Califano turned the convention into a front page media event. His speech cited new National Cancer Institute and National Institute of Environmental Health Sciences estimates that "at least 20 percent of all cancer in the United States—and perhaps more—may be work related." Previous estimates had been as low as 1 to 5%, a figure commonly cited by industry spokesmen. The new study...
projects future occupational related cancers by estimating the increased cancer risk of known carcinogens and the number of people exposed. It excludes many known carcinogens for which there is inadequate human data to estimate risk; radiation is also excluded, so the projections may in fact be on the low side. The study estimates from 21 to 38% of cancers in future years may be occupationally related, with asbestos alone contributing to 13-18% of total cancer deaths.

Califano’s announcement projected a far larger estimate of the occupational cancer problem than had previously been expressed by government agencies. While all such estimates are crude, Califano gave credence to the opinion of many researchers and organizers that we can expect a massive epidemic of occupational cancers. The conference projected a mass movement to push for action to prevent such a tragedy from affecting millions of workers.

The NCI study estimates from 21 to 38% of cancers in future years may be occupationally related

Mayer had complained about chest pains from breathing fumes. First he brought a respirator to work; later, against his foreman’s wishes, he opened the door at work to let in fresh air. After staying out of work some days for medical reasons, he was fired, because, according to later court testimony, “he could not be depended upon for production.” Mayer filed an OSHA complaint charging he was fired for exercising his rights under the law. He requested an OSHA inspection, but no citations were issued. Last June a U.S. District Court judge decided the case in favor of the company.

Outmaneuvered by the company and bewildered by the law, workers are left with despair or anger

Fueling the movement is the growing awareness that workplace tragedies are all too often caused by the vast gulf in power between workers and management in determining how work and production are organized. As an experienced union health professional remarked at the AFL-CIO conference while listening to Labor Secretary Marshall extoll the virtues of labor-management cooperation, “occupational health is the clearest expression of class struggle.”

—Tony Bale
OCCUPATIONAL INJURIES AND ILLNESS AMONG BLACK WORKERS

High unemployment among Blacks is a major national problem. But the patterns of racism extend beyond the factory gate or the office door.

Black workers have a one-third greater chance than white workers of suffering an occupational injury or illness resulting in lost workdays, according to a recently completed Health/PAC study. The black worker also faces a roughly 20 percent greater chance of dying from job-related injuries or health problems.

A history of job discrimination has left Blacks now employed at relatively high rates in the more dangerous factory and blue collar jobs and at very low rates in white collar jobs in virtually every major sector of US industry. While Blacks made up 10.91 percent of the private sector workforce in 1975, they were employed in white collar jobs at rates much lower than 10.91 percent in every major industry category, and at rates higher than 10.91 percent for blue collar jobs in every industry except mining. (Table 1)

Since occupational injury, illness and death rates are greater for blue collar than white collar jobs, heavier employment of Blacks in blue collar jobs means a greater burden of risk for them. The numbers and overall rates of occupational injury, illness and death for Black workers were calculated from the EEOC employment figures and the corresponding 1975 OSHA death and injury data for each industry. These figures were then compared to those that would have been found if Blacks were employed without discrimination, that is, if they were employed at the same rate in each industrial job category as in the entire workforce, 10.91 percent.

The OSHA occupational data presented in Table 2 applies to all workers in a particular industry regardless of distinctions among types of jobs. As seen in Table 1, this data was further broken down into blue collar and white collar components because the essential job discrimination pattern for Blacks is between these two groups in every industry but mining.

The white collar injury and ill-

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### TABLE 1 Black Employment

<table>
<thead>
<tr>
<th>Industry</th>
<th>Total Employment in Thousands</th>
<th>Percent Black Workers</th>
<th>Percent Black Workers in Low Risk Jobs*</th>
<th>Percent Black Workers in High Risk Jobs*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agriculture</td>
<td>1,568.0</td>
<td>12.88%</td>
<td>2.03%</td>
<td>15.83%</td>
</tr>
<tr>
<td>Mining</td>
<td>744.7</td>
<td>4.99%</td>
<td>2.72%</td>
<td>6.16%</td>
</tr>
<tr>
<td>Construction</td>
<td>3,457.0</td>
<td>10.94%</td>
<td>2.56%</td>
<td>14.39%</td>
</tr>
<tr>
<td>Manufacturing</td>
<td>18,175.9</td>
<td>10.71%</td>
<td>3.68%</td>
<td>14.10%</td>
</tr>
<tr>
<td>Transportation</td>
<td>4,498.0</td>
<td>10.31%</td>
<td>8.02%</td>
<td>12.24%</td>
</tr>
<tr>
<td>Trade</td>
<td>16,947.8</td>
<td>8.94%</td>
<td>5.66%</td>
<td>14.24%</td>
</tr>
<tr>
<td>Finance</td>
<td>3,778.3</td>
<td>9.40%</td>
<td>7.72%</td>
<td>20.20%</td>
</tr>
<tr>
<td>Services</td>
<td>10,298.9</td>
<td>15.46%</td>
<td>7.99%</td>
<td>26.21%</td>
</tr>
<tr>
<td><strong>Private Sector Totals</strong></td>
<td><strong>59,468.9</strong></td>
<td><strong>10.91%</strong></td>
<td><strong>5.97%</strong></td>
<td><strong>15.75%</strong></td>
</tr>
</tbody>
</table>

SOURCE: Total employment figures are from the U.S. Department of Labor, Ref. 1. Percentages are from the EEOC Ref. 2 (EEOC total employment figures are less than those from the Labor Department because only employers with 100 or more workers are required to file EEOC reports and of these many don’t file.)

*Low Risk Jobs are jobs classified in the standard Department of Labor occupational categories: Officials and Managers, Professionals, Technicians, Sales Workers, and Office and Clerical Workers.

High Risk Jobs are jobs classified in the categories: Craft Workers, Operatives, Laborers, and Service Workers.
ness rate was estimated from the overall OSHA rate for the finance industry: banks, credit agencies, security brokers, insurance companies and real estate firms. The first four of these each employ 95 percent or more white collar workers, and their average incidence rate is 0.55 injuries and illnesses involving lost workdays per 100 workers. Assuming the 0.55 rate to be the same for low risk workers in every industry, we could calculate what the high risk rate must have been to give OSHA's overall rate for each industry.

Using these risk rates and the EEOC employment figures, we found that Blacks have an incidence rate for occupational injuries and illnesses of 4.33 per hundred Black workers. This is about 37 percent greater than the rate of 3.17 for White workers.

The results were basically the same when the white and blue collar rates varied within reasonable limits, so the results are not critically dependent on our choice of rates. For example, when we chose a white collar rate equal to the overall rate for the finance industry (0.8), as if injuries in the finance industry happened at the same rate to white and blue collar workers, the Black rate was found to be 32 percent greater than the White rate, only slightly less than the above result. Even when we chose the white collar rate to be a constant rate for each industry, so that white collar workers in more dangerous industries like mining and manufacturing are assumed to be at greater risk than white collar workers in the finance industry, the Black injury and illness rate was still found to be 37 percent greater than the White rate.

Based on a 37 percent greater rate, Blacks experienced 75,000 more reported injuries and illnesses in 1975 than the roughly 200,000 they would have experienced had their rate been the same as the White rate. Of these 75,000, about one-third occurred in the manufacturing industries and one-fifth in the service industries.

Although OSHA does not give occupational fatality data broken down in detail by industry, we made a similar calculation for the increased death rate of Blacks on the job compared to the White rate. Assuming a constant rate. Assuming a constant rate of white collar occupational death rate of 0.018 per thousand workers, just slightly less than the overall death rate for the finance industry (see Table 2), we found a 24 percent increase in the Black death rate on the job compared to that expected if they experienced the White death rate.

No matter how you slice it, this is a grim story. It can be changed, but only if this country begins to worry more about the discrimination that continues to prevail against Blacks and other minorities than "reverse discrimination" against the relatively small number of Whites who are adversely affected by needed change.

At the same time, those committed to the struggle against racism in the US must be sure that a major thrust of their efforts also be the elimination of occupational hazards for all workers, in so far as possible. An integrated workforce in which blue collar workers, Black and White, continue to be struck down on the job with great but equal severity is not an acceptable solution to the problems of Black and White workers.

—David Kotelchuck

(with assistance from Robert Forer, Joan Drake and Jacqueline Pope, student interns from Antioch College, University of North Carolina School of Public Health, and Columbia University Division of Urban Planning, respectively.)

<table>
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KOCH: HOW NOT TO SUCCEED WHILE REALLY TRYING

Most recent NYC mayoral administrations have had a stormy first year getting to know the labyrinth of programs and agencies that make up the City's government. And, as noted in these pages many times, few have ever gotten a real handle on health care policy—among the more Byzantine of arts in any case.

But never have we had a beginning like that of Edward "How'm I doing" Koch. In its first year in office, the Koch administration has left behind such a pile of scrapped health policy initiatives and discarded health care officials that one is reminded of former Comptroller Harrison Goldin's late lament, "Incompetence! Incompetence! Incompetence! Incompetence!" (quoted by Brian Ketchum and Stan Pinkwas in the Village Voice, Sept. 18, 1978).

The Koch record is not totally one of ineptness, however. Some perceive a pattern of "malign neglect" from the former Congressman who has long held and admitted a distaste for the City's municipal hospital system. Certainly, if the constant chaos in City health policy accomplished anything, it has been to strengthen the hand of those calling for the destruction of the 17 municipal hospitals. Sadly, the notion that the municipal institutions are the source of the City's soaring health care bill has come to be considered gospel—verified by an endorsement in early December by The New York Times. Calling the Health and Hospitals Corporation (HHC—the quasi-public agency which administers the municipal hospitals) the "most obvious target" for reducing municipal spending, the Times called for reducing current expenditures by half in the coming year.

The events of the past year were incredible. Taken together, they represent the worst omens yet for the public hospital system.

H. Alex Schupf, Mayor Koch's Special Assistant for Health and (thereby) Health Services Administrator and Chairman of the Board of the HHC quit in frustration in early September. The official explanation was "policy differences." But the key issue was: should the City continue to operate any municipal hospitals. In his brief tenure, Schupf had come to feel strongly that the City must maintain at least some of them, and also that there was a need to strengthen the public service orientation that has historically been their raison d'etre.

Public service, however, seems low on the Koch list of health service priorities. For that matter, it doesn't appear to be the key motivation for current HHC management, either. The HHC administration has thrown itself into a strategy that seems better calculated to abolish the municipal hospitals rather than save them. Schupf was beginning to recognize this strategy for the blind alley it is. In an interview with the Village Voice (Sept. 18, 1978), Schupf stated: "I fear that under the pressure of fiscal burdens and wooed by the siren song of simple managerial solutions, an attempt will be made to disembody this corporation. That must not and should not happen. In fact, it makes little financial sense because those of us..."
who have studied the issue carefully know that City expenses will increase—not decrease—without the municipal hospitals. The only way that proposition will not be true is if many fewer people are treated, if those at the margin whom we serve become the dispossessed..." Shupf was indeed onto something.

In July, Koch appointed Dr. Martin Cherkasky, president of Montefiore Hospital in the Bronx, to head a special panel to oversee planning for HHC's newest and most controversial hospital, Woodhull in North Brooklyn. Already under attack from within and without HHC, the Woodhull situation may symbolize the dead end that HHC's management strategy represents for municipal hospitals better than any partisan of public services could hope to accomplish with words alone (see below).

Cherkasky's appointment was cited by Schupf as the final straw. It also set the stage for Cherkasky's Task Force, reporting to Koch in late September, called for the creation of a public-private "consortium" of five Brooklyn hospitals to run Woodhull when, as the panel recommends, the institution opens in 1980 (a delay in the original HHC estimates of January and then June, 1979).

Hard on the heels of the Cherkasky report, Koch named Cherkasky to replace Shupf in an unusual half-time appointment as Special Assistant for Health, leaving Cherkasky's other two-and-a-half days a week presumably occupied with running Montefiore. Koch announced that Cherkasky will head a special Mayor's Policy Advisory Committee (Koch's Health/PAC?), a position he later seemed to back away from.

Suspecting a decision by Koch to move the City out of the hospital business altogether, many observers saw the move as putting the proverbial fox in charge of the chicken coop. Cherkasky is a long-time advocate of amalgamating the public and private hospital system; operationally, he has tended to translate this goal into mechanisms for subsidizing the private sector at public expense.

In late November, Koch demanded the resignation of Joseph T. Lynaugh from the $65,000 HHC presidency. Lynaugh reportedly drew Koch's wrath when he botched HHC's relationship with Misericordia Hospital Medical Center in the Bronx—and presumably with the politically powerful Archdiocese of NY, given the tension created by Lynaugh's bungling of the Lincoln affiliation transfer. He turned to Cherkasky who recommended a Ford Foundation executive, Eamon Kelly, whose last stint in government was as consultant to US Secretary of Labor, Ray Marshall. But, alas, the Koch luck struck again.

Less than a week after nominating Kelly, Koch learned that Kelly had been accused of "poor judgement" soon after leaving the job with the Labor Department. The "poor judgement" in question had to do with suggesting a lawyer for a major labor leader—Joseph Tonelli, president of the United Paperworkers International Union—who was being investigated for embezzlement. Kelly denied any impropriety, but withdrew his name from nomination, citing "the complexities and difficulties of the job."

Finally Koch named Joseph C. Hoffman as President of the HHC. Hoffman, formerly the City's deputy chief of police has no experience in the health system, except for a brief stint as head of

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The revenues from Medicaid and Medicare, it was proposed, would play the same function for the municipals that private insurance reimbursements had long played for voluntary hospitals: guaranteed annual income.

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While the continuing saga of who shall head (be-head?) the HHC draws the most headlines, it is the activity around the Woodhull situation that offers the clearest insight into the shape the City's health system seems destined to take under Koch.

Woodhull in North Brooklyn was to be the brightest and best municipal hospital in the City. Originally, it was to be a replacement for an antiquated municipal hospital. But as the fiscal crisis gathered steam in 1975, Woodhull was designated as the replacement for two existing municipal hospitals-Cumberland and Greenpoint. It was supposed to incorporate all the most modern innovations in hospital design including single occupant rooms, separate staff and public corridors and automated record keeping.

Woodhull has been standing, unopened for more than a year. It couldn't open because no one could figure out how to cover its projected cost of operation. The Cherkasky panel probably sidestepped the issue by suggesting that the hospital be run as part of a consortium of private and public hospitals in Brooklyn. To cover the deficit, they planned to close hospital beds throughout the borough and thus fill up the hospital with patients squeezed out elsewhere.

But the problem of Woodhull is not its potentially empty beds. Rather, it is its inappropriateness as a health institution for the population it will proffer to serve. The Cherkasky panel may have come up with a solution for the hospital crisis in Brooklyn, but not for the health crisis.

Conditions such as high infant mortality, chronic malnutrition, epidemic-level Vd, cirrhosis and drug-related diseases and deaths are indicative of a health crisis. Of course, low-income populations like that of North Brooklyn need hospital beds. But unfortunately, the Cherkasky group took only the most primitive look at how many and what kind of beds would serve North Brooklyn's people. Rather than assess needs for prevention, for primary care or for hospital beds, they framed the policy questions around how best to develop correct institutional investments and interests.

At the heart of the public stance of the Koch administration is a strategy of trying to make the municipal hospitals look and function like voluntary hospitals. The keystone of this strategy has become the replacement of older, smaller municipal hospitals by larger, more modern facilities. Such hospitals are projected as the case of an "upgraded," "First class," public system. Combined with the active pursuit of private patients, aggressive billing and collections policies, and conversion of outpatient services to a "group practice" model, this strategy, the argument goes, will reproduce the "success" displayed by the larger voluntaries.

The basic assumption inherent in this process—at least when done intentionally—is the American creed, "the private sector does it better." We will return to this question later.

The process whereby voluntarization is accomplished may vary from service to service. In the case of the NYC Municipal Hospital system, it is a process whose roots trace to the early 1960s and has progressed through three distinct stages.

The first stage was the NYC municipal hospitals affiliation plan, initiated in 1961 by then Commissioner of Hospitals, Dr. Ray Trussel. Trussel, noting recent findings of low quality care in the public hospitals and serious difficulties attracting medical staff, proposed that the city contract with several of the major medical schools in New York to provide physician staffing in the municipals in exchange for annual payments. These medical schools were already affiliated with a number of the city's major voluntary hospitals.

To a chronically underfinanced public hospitals system, this "solution" added a new set of problems. Medical school priorities began to pervade the wards of municipal hospitals. The annual affiliations payments to the medical schools took a rapidly increasing bite out of the Department of Hospitals' budget. And payments for affiliations—parts of which were later found to have been mis-sent by the schools—added to the financial woes faced by the munipals.

To this situation was added, in
The revenues from Medicare/ Medicaid, it was proposed, would play the same function for the municipals that private insurance reimbursements had long played for voluntary hospitals: guaranteed annual income.

With the dawn of HHC, the goal of "imitate the voluntaries" led to a considerable shift in priorities at the managerial level in the public system. "Revenue enhancement," "more aggressive collections," "stricter billing," and cost savings by reducing "non-allowable" costs (those not reimbursable) became the new watchwords and guidelines to policy.

**The Koch record is not totally one of ineptness. Some perceive a pattern of "malign neglect"**

Much of this was stimulated at the beginning by widespread beliefs that Medicaid benefits would gradually be widened to include a greater and greater proportion of the poor (beyond the original ceilings on eligibility) and that, in a matter of years, universal National Health Insurance would be a reality.

The reality, of course, has been quite different: Medicaid eligibility and reimbursements have been steadily reduced and restricted during the 1970s. The result is that today, in NYC, there is an enormous population of persons with real medical needs who are ineligible for Medicaid, Medicare, or any other form of coverage.

This population includes the "working poor" (those above the current Medicaid cut-off but uncovered by private health insurance), many Medicaid eligibles who remain unenrolled, many documented persons afraid to enroll in Medicaid, and some whose medical problems are not covered under Medicaid (e.g., mental patients and the chronically ill).

This population continues to have virtually no alternative but the municipal system. Voluntary hospitals, by controlling the mix of cases and availability of services by "dumping" to municipal institutions and by outright discrimination in admissions and marketing policies, have effectively rid themselves of nonreimbursed patients.

It is in this context that it seems to some observers that the municipals are being pressured as well as encouraged to enter the third—and final—stage of voluntarization. In this stage, the municipals would bring their fiscal management into harmony with the voluntaries by excluding nonpaying patients (not necessarily directly or system-wide at the beginning). Individual municipal hospitals—especially those with the more modern physical plants and equipment—would then be "spun off" into the private sector, i.e., would transfer management to decentralized, nongovernmental local boards (whether the latter be a "subsidiary corporation" of a "consortium" or "private management firm" or an existing voluntary hospital is relatively inconsequential).

In short, "successful" municipal hospitals would become—first in fact, later in legal and fiscal reality—voluntary hospitals.
Continued from Page 22

not for regulating nursing education, for auton­
omy but not for accountability in delivering
nursing care, and for more, not less barriers
to entry into nursing. The record of nursing
leaders in dealing with misconduct and incom­
petence in nursing is as lacklustre as those of
other professions. They have generally ab­
dicated any leadership role in debates over health
insurance or national health service, cost con­
tainment, or the efficacy of medical technology.
Their response to any innovation is steadfastly
one of analyzing all issues in terms of their own
role and authority. To borrow from the
1960s, nursing leaders present an “echo,” not
a “choice” on the health care scene.

In short, nursing leadership’s “reforms” pro­
mise the vast majority of nurses an authori­
tarian, rigidly stratified, status-seeking vocational
environment, while offering the public no relief
whatever from the worst features of the American
medical system.

While the elite is out campaigning on its own
behalf, the gap between leadership and rank-and-
file widens. As far back as 1970, when the Ameri­
can Journal of Nursing completed a survey of its
readers, a remarkable gap in attitude and politics
between nursing’s leaders and the rank-and-file was
revealed. In the main, graduates of associate and
diploma programs felt neglected and looked
down upon by nursing’s leaders and their bacca­
laureate-trained supporters.

An editorial in the Journal the next month
commented upon the findings, pointing out that
the perception of “lower echelon nurses” that
they were underrepresented in national nursing or­
ganizations is probably true. While the editorial
did not in any way back off from the substantive
positions the national nursing organizations have
taken with reference to lower echelon members,
it did confess that the positions have been carried
out with abysmal insensitivity to others. It sug­
gested as a partial solution that it might be more
honest to restrict ANA membership to graduates
with baccalaureate degrees because they were
the only people being represented in the organiza­
tion. Noting the competitive threat that trade

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**Nursing leaders have generally abdicated any leadership role in debates over health insurance, cost containment or the efficacy of medical technology. Their response to any innovation is steadfastly one of analyzing all issues in terms of their own role and authority.**

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**Rank-and-file nurses have begun to improve their lot through militant trade unionism, avoiding the “professional” route so vociferously advocated by their leaders**

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**The Trade Union Alternative**

Growing numbers of these “inappropriately educated” rank-and-file nurses have come to recognize the true nature of their leadership’s strategy. As a result, some have begun to improve their lot through militant trade unionism, avoiding the “professional” route so vociferously ad­
vocated by their leaders.

There are several advantages to this strategy. First, and foremost, trade unionism speaks to the needs of the vast majority of working nurses. Professional status, were it achievable, would only
serve a small minority of the 700,000 working nurses. As Ginzberg pointed out, the realities
are such that “professional” wages could only
be achieved by a small number (he suggested
70,000) and this means that a rigid hier­
archy would be necessary with large numbers

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of nurses being thrown overboard. Such pursuit puts all nurses in a position of scrambling to be included in the handful destined for elite treatment.

Furthermore, trade unionism has resulted in substantive gains for many groups of workers. For nurses, it is a realistic means to material improvements in wages, working conditions and job satisfaction. The trade union device enables nurses seeking these objectives to raise issues more directly and have them debated on their merits. It offers potential wage scales in line with workers of similar skill and responsibility and, given a strong grievance process, some amelioration of the relations between nurses and their nurse-physician bosses. Some public benefit, in the form of improved nursing care, could be expected if this were to make rank-and-file nursing a more satisfying job.

Nursing leaders have yet to demonstrate that the 1985 Proposal would actually improve patient care—although that is ostensibly its main purpose. They have not shown that BSN nurses would provide superior care or that “1985” would not impact negatively on the supply or cost of care. They have not adequately answered the charge that it would impact disproportionately on those of minority or working class origin. And, because the real goals of the 1985 Proposal are unmentionable, the NYSNA continues to dissemble or evade all of these issues.

It is interesting to note that while much of the attention has focused on “1985,” nursing associations seem to have been of two minds about union activity. On the one hand, they share with union activists the recognition that the current job situation for nurses is poor and should be improved; on the other hand, they feel it is professionalization—a la Ginzberg, not unionism, that will translate into improvements. However, the developments of recent years have shown that rank-and-file nursing organizations do not share this ambivalence and many have become involved in job actions with or without nursing association approval and usually without its active backing.

In 1946 the American Nurses Association initiated an Economic Security Program designed to enable state and local nurses’ associations to bargain for their members. Since that time, these associations have seemed to spearhead the unionization movement. However, upon closer analysis, their effect seems to have largely restrained the trade union movement, heading off militant job actions and selling themselves to management as the ones who can keep the lid on things. Specific accounts of nursing struggles confirm this impression.

An account of the Bay Area Strike of 1974 documents the tendency of nursing associations to restrain leaders of job actions. Similarly, a fascinating account of four job disputes as told by their participants in Nursing 77 reveals association fears of rank-and-file movements. One account tells how nursing supervisors decided to take charge lest the rank-and-file seize control.

Association interest and supervisor participation are greatest when the struggle involves control of nursing (their control of nursing) rather than simple job conditions and wages. Association leadership and supervisors frequently have a different agenda than rank and file nurses: their own status and power, issues hardly central to the everyday condition on the floors. The AJN survey mentioned earlier supports the observation that nurses are beginning to recognize the differential in goals among various nursing sectors. At the same time, nurses need to recognize that a commonality of goals does exist with many of their fellow hospital workers. Thus while breaking with one ally, nurses adopting a trade union approach pick up a more reliable, more viable and more powerful ally—one whose goals more closely parallel those of rank-and-file nurses.

**Divide and Conquer**

Hospitals are complicated places. Management can survive best if groups “go out” one by one, because of the fungibility of their workers' skills. Unfortunately, nurses have historically acquiesced to this divide-and-conquer tactic. What forces an issue in a strike situation, however, is the ability of groups to go out at one time to shut the institution down, necessitating the transfer of patients to other institutions. A unionized group would be prudent to agree to help in the transfer process, but ordinarily not in maintaining
patients in "struck" institutions. This will require difficult decisions and must be confronted on an institution-by-institution basis to avoid loss of life and undue hardship by patients. But it is necessary in order to deprive the institution of revenue in the form of patient days and fees. That is, historically, the point of all strikes.

The new federal law authorizing unionization in health facilities plays upon this historic separation among health care workers by specifically providing for professionals to opt out of bargaining units. Given a history of such spurious appeals to their professional and special status, it remains to be seen whether nurses can learn to unite with the spectrum of health workers who have already chosen union status. Although this spectrum runs from aides to social workers, nurses may yet experience a strong urge to "go it alone." Such separation, on balance, would seem to be a strategic mistake.

However, the separation of rank-and-file nurses from supervisors is crucial. A nursing supervisor is a supervisor first and a nurse second.

**Nursing Self Interest**

One consistent theme in nursing's efforts to improve working conditions has been to couch those efforts in terms of improving nursing care. Virtually every strike described in the literature has joined professional or patient care issues with strike demands. In the case of professional issues this unfortunately often involves rank-and-file fighting for the power prerogatives of their supervisors. In the case of patient care, it involves nurses presuming to act for others without being asked to do so.

In part, this undoubtedly stems from women's reluctance to assert their rights, except as incidental to someone else's welfare. Compounding the difficulty, all professionals, having wed their entire lives to the myth of selfless public service, tend to contort all their rationale for action into some mode of selflessness. Although unfortunate, this tendency is understandable in light of the stigma of avarice and greed that has come to be identified with doctors. It is fair to say that the AMA has given self-interest a bad name. But what nurses have to realize is that they have little to fear in demanding decent wages, a benign work environment and satisfying work. In fact, there is likely to be much gained in doing so honestly, rather than hiding behind the guise of helping the patient or the public.

Let me be clear. A situation that results in understaffing is oppressive to nursing workers there. It should be redressed in those terms. Poor wages result in poor care, but also result in poor life for the workers. The latter is reason enough to strike.

On the other hand, nurses would do well to combine with the consumer and other groups to affect changes in hospitals and throughout the health system. Such actions are appropriate but do go beyond trade union issues, often involving the collective self-interest of women and all working people in the society. It should not be naively assumed that the interests of nurses as a stratum will always coincide with broader progressive goals.

**Conclusion**

Trade unionism, while offering a real alternative to the 1985 strategy, is not a panacea. Discussions with and written accounts by nurses engaged in such activities reveal that these efforts carry with them real risks. Nurses may not always be welcomed by other health workers in the trade unions, given the uneasy relations of the past. Further, some would dissuade nurses from this route because of the pitfalls of union organizing in other industries and the potential for abuse inherent in any self-seeking group activities.

Against this set of problems, however, must be balanced the many real gains and, for that matter, frequent heroism to be found in the history of trade unionism. More importantly, nurses now have an opportunity to join with other workers and consumers to improve their own lot honestly through a strategy with demonstrable advantages and a good track record.

In doing so, the growing number of nurses who are choosing trade union membership will not resolve every frustration and form of alienation that feeds their currently growing militance. Much of that frustration and alienation arises from the racist, sexist, and class-divided social relations in the larger society. Overcoming these, of course, suggests a broader political and social movement than can be produced by any one stratum of workers. The struggle to do so is also likely to take longer and...
involve a good deal more upheaval than any union election.

In the meanwhile, though, rank-and-file nurses do seem to have taken up the NYSNA challenge to answer the question, "Who are the nurses? Who are the others?" For a growing number, nursing workers are "the nurses" and nursing leaders are the "others."

—Andy Dolan

(Andy Dolan teaches law at the University of Washington)

References


Human Experimentation
Continued from Page 2

At the inception of an experiment the researcher can often predict some of the outcomes. Experimental designs should be developed in such a way as to minimize risks to potential subjects—especially where the experimenter expects that the customary treatment would have been safer, more convenient and less painful. The following four studies involve inconvenience for the patients and anticipate outcomes which are countertherapeutic.

In order to test the truth of the commonly accepted obstetrical wisdom that hyperventilation (deep breathing) can harm the fetus by creating alkalosis in its blood, twenty women in uncomplicated labor were instructed to hyperventilate. The investigators, reporting their results in the American Journal of Obstetrics and Gynecology (2), mentioned no possible benefit for the mothers or fetuses in the study. To implement this ill-conceived experiment the investigators subjected their patients to additional risks by taking five samples of fetal scalp blood during each delivery. This procedure involved risk of fetal scalp abcesses and scalp hemorrhages to the babies and infection in the mothers.

Another experiment that anticipated (and found) counter-therapeutic results was conducted by three experimenters at Brooklyn-Cumberland Medical Center. They devised a study which they expected would increase the complications of abortion. 116 women receiving second trimester abortions were given either routine hypertonic saline (50 women) or hypertonic saline with one of two anti-inflammatory drugs added (66 women). The study was designed to test the hypothesis—already supposed in previous studies—that anti-inflammatory drugs would increase the
time between the saline injection and expulsion of the fetus (called I/AT: Installation/Abortion Time). This in spite of the fact that earlier work had established the value of decreasing I/AT, decreasing the duration of labor and thus decreasing the complications of abortions. (3)

Two years later the same three experimenters reported in the same journal the same results of a similar study. This time they subjected 108 women to three different analgesics: sodium salicylate (an analog of aspirin, but more toxic), propoxyphene hydrochloride (Darvon) or acetaminophen (Tylenol). Since they were essentially repeating an earlier experiment, the investigators were again able to correctly predict the results: the drugs caused an increase in the time between injection and completion of the abortion. (4)

The most disturbing example of deliberate harm was found in a study of fourteen women who sought abortions at Downstate Medical Center. The experimenters gave these women, all in their first seven weeks of pregnancy, prostaglandin-in-saline abortions, rather than other "more standard methods of abortion." A previous study of first trimester prostaglandin abortions had found that "35% . . . had experienced severe adverse reactions and the overall abortion rate was only 65%." The Downstate investigators were evidently not satisfied with these published results and repeated the experiment.

Their results confirmed the earlier findings. Pelvic infections developed in 12 of the 14 women; six women required dilation and curettage (D & C) to treat persistent bleeding. Half of the women experienced increased blood pressures of 20 mg Hg or more. Other side effects cited in the article included "strong uterine cramps," nausea, vomiting and restlessness or uneasiness. The authors grudgingly conceded that "the efficiency rate of this technique is below conventional methods." (5)

Incomplete Animal Studies

Over the past few decades there has been general acceptance of the importance of animal trials in order to minimize the risks to human subjects. Researchers have become quite ingenious in developing methods and finding species in which to test new procedures. It is, of course, essential that the animal studies be fully analyzed before human experimentation begins—if the humans are to be protected from dangers for which the animals are being screened.

A Downstate Medical Center professor, interested in testing a new instrument, reported in the American Journal of Obstetrics and Gynecology that he had performed hysterotomies on eleven women who had sought second trimester abortions. Hysterotomy is the name given to a Cesarean Section when it is being performed for an abortion. The instrument, an endoamniroscope, was used to take blood and skin samples from the fetus. Hysterotomy is more dangerous than saline abortion, which was already in routine use. Hysterotomy requires general anesthesia and involves an increased risk of infection, embolism, shock, and hemorrhage. The investigator wrote in his report: "The safety of endoamniroscopy and fetal biopsy is being evaluated in pregnant monkeys." (6)

The same professor later reported, in Obstetrics and Gynecology, that he had continued his study, and had performed fifteen hysterotomies in testing the endoamniroscope. Again, he wrote: "the safety of endoamniroscopy is being evaluated in pregnant Rhesus monkeys and in hysterotomy patients." He was obviously so eager to try out the instrument that he was unwilling to await the results of animal studies before subjecting women to unnecessary surgery. (7)
No animal studies were done before 17 women seeking sterilization at Bronx Lebanon Hospital were subjected to electrocautery of the fallopian tubes. This experimental sterilization procedure was substituted for more conventional tubal ligations. The procedure was sufficiently uncertain for the researchers to recommend that the women use other methods of contraception until follow-up tests determined if in fact they had been sterilized.

To determine the effectiveness of the sterilization the researchers put the women through hysterosalpingograms. This unpleasant and occasionally risky test (in which a dye is introduced into the uterus and fallopian tubes and then x-rayed) is done to see if the tubes are completely closed off. One woman refused to have the x-ray. Of the remaining 16, one had both tubes still open and three others had one tube un­closed—a whopping 25% failure rate. If these four women still wanted to go through with a sterilization, they had to subject themselves to a second operation. In their eagerness to test their sterilization technique, the experimenters even included two asthmatic patients in the study group, both of whom required longer hospital stays. (8)

The same group of doctors who conducted the Bronx-Lebannon research reported on the use of electrocautery with and without a second un­tested sterilization method—insertion of a mesh plug into the fallopian tubes—on 47 women who came to a Bangkok, Thailand clinic. Well aware of the unreliability of their procedure, the experimenters gave each woman an injection of Depo-Provera, a long-acting contraceptive with serious side effects (see below). Follow up hysterosalpingograms showed that 16% of the women had not been successfully sterilized. Side effects of the procedure on the Thai women were scantily noted. However, the investigators did list one perforated uterus, one hysterectomy seven days after their procedure (reason not given) and some patients (number not noted) with vaginal bleeding. An interesting insight into the potential usefulness of the procedure, despite its relatively low success rate, was provided by the experimenters in their article in the American Journal of Obstetrics and Gynecology: “Among the striking features of this study were the speed and ease with which forty-six women could undergo a sterilization procedure. . . . It is also impor­tant that the period of essential contact with professional personnel was short, usually less than 15 minutes.” (9)

“Informed Consent”

Authors of research studies rarely include accounts of how patient consent was elicited. Thus the adequacy of the information upon which the patient’s consent is based can usually only be inferred. Even if the doctor does provide information to the patient, it is often difficult for the patient to interpret, and even more difficult to refuse consent.

In 1975, four researchers wrote in Obstetrics and Gynecology about their experiment with 100 consecutive women undergoing Cesarean Section at Metropolitan Hospital. Half were given powerful antibiotics before, during, and after their surgery; the other half received no antibiotics. The experimenters wanted to study the prophylactic effect of the drugs.

Multiple studies have documented the risks of developing antibiotic-resistant bacteria on wards where prophylactic antibiotics are used. Additionally, one of the drugs tested in this case (Kanamycin) is known to cause severe or total hearing loss, even with short courses and in low doses. Is it possible that informed of the risks, one hundred consecutive women would consent to being subjects? (10)

A 1974 article by three doctors from Downstate Medical Center describes a study of the effect of a long-acting injection of medroxyprogesterone acetate (Depo-Provera) on the adrenal glands of ten normal women who sought birth control. The women received an injection of Depo-Provera every 90 days for one year and were given intensive metabolic testing in the hospital three times during the year.

This study illustrates violation of two different standards: harm by design and lack of informed consent. The authors cite animal studies published in 1961, 1964, and 1969 that show MPA to be “a potent suppressor of adrenal function” which, “when administered for a two-week period, results in adrenal atrophy.” In normal practice, physicians go to great lengths to avoid suppression of the adrenal glands because of their physiological importance. The investigators involved with this study reported that they found adrenal
suppression among the subjects during the experiment.

The investigators exposed the ten women to significant risk by administering Depo-Provera. Although the drug is an effective contraceptive, there is an “increased evidence of spotting, staining, bleeding and amenorrhea.” More importantly, Depo-Provera was known (before this experiment was initiated) to cause an increased risk of cervical cancer (in humans) and breast cancer (in dogs), as well as an increase in the rate of birth defects in fetuses conceived before administration of Depo-Provera, and a very high rate of long-standing sterility after discontinuation of the drug. It is extremely difficult to imagine that the investigators provided the subjects with enough information to make an informed decision about participating in this experiment. (11)

**Doing Harm by Design**

Abuse of human subjects is not an exception, but more often than not, it is the rule. The eleven studies described above were designed and implemented on patients in New York City during the last decade: not in a prison, a mental hospital or in Tuskegee, Alabama 40 years ago. Presumably consent was solicited from each of the patients involved, the studies were reviewed by medical school departments and research councils, and finally each article was reviewed by the editorial boards of the prestigious medical journals which published them—boards whose standing policies prohibit publication of ethically questionable articles. Yet each of these built-in safeguards failed to protect the patients.

Informed consent is the legally mandated process by which the patient is provided complete information about the risks and benefits of participating in an experiment and agrees voluntarily to participate. Theoretically, informed consent should stop most abuses, since no sane patient would agree to place him or herself in jeopardy. Unfortunately, in reality, this is not how it works.

There is a massive asymmetry of power between the doctor and patient. The doctor alone knows what drugs will be administered, what risks will be incurred and what procedures undertaken in any experiment. Moreover, the physician is not a neutral disinterested party in presenting this information to the patient. He (or she) is a partisan, enthusiastic about the research, whose goal is to recruit subjects. Doctors tend to understate possible side effects and complications. Patients put into this situation often fear that their refusal to participate will risk the displeasure of the doctor, if not outright alienation from him or her. Thus informed consent, by its very nature, often functions as a single-edged sword hanging directly over the neck of a prospective subject.

Peer review is cited as another key safeguard against experimental abuse. Most members of the medical profession maintain that only physicians are qualified to judge each other’s work. Abuses, they claim, have occurred because of the inadequacy of peer review. Yet physicians have never been especially forthcoming in pointing a finger at other physicians lest the favor be returned—or worse. Like other tightly knit professions, the medical fraternity protects doctors much better than it does patients.

Ethical review by publishers is perhaps the most dubious safeguard of all. The need to publish results, some argue, makes researchers self-conscious during the data-gathering phase of an experiment. Most journals do have a policy of publishing only those articles deemed ethical by their editorial boards. The fact that serious ethical problems were found in the experiments cited above, all published in legitimate journals, belies the efficacy of review by prospective publishers. At best, ethical review by such boards comes after the fact of abuse and cannot, therefore, remedy those abuses and risks which have already been inflicted on subjects of rejected researchers.

Revelations of outrageous experimentation abuses disclosed in the early 1970’s led to the creation of Institutional Review Boards (IRBs) to certify the safety of all federally funded medical research. Despite the requirement of non-physician representation on these boards, however, the majority of IRB members are physician-re-
researchers whose bias is toward the interests of research and researchers rather than the interests of patients. IRBs are thus subject to the same flaw as peer review—the reluctance of peers to interfere with each other’s work.

A 1975 study of IRBs by Bradford Gray (13) suggests that the presence of IRBs may, in fact, be worse than if no IRBs existed at all. Researchers need only seek the blessings of the IRB, and once these are received, no longer need worry about risks to their subjects. Gray found most committees either very permissive or virtually inactive. Even in the best of circumstances, according to Gray, where researchers had conscientiously attempted to inform their subjects, nearly 40 percent of the patients were still unaware that they were participating in experiments.

Lastly, patient advocates have been created at many hospitals in an attempt to equalize the disparity of power between doctors and patients. Acting as ombudsman, the patient advocate might be the perfect intermediary to present prospective research subjects with information about risks and benefits. Unfortunately, patient advocates suffer many of the problems plaguing IRBs—they are part of the institutional structure and can be expected to function as such in the face of any conflict of interest. Most often, patient advocates are attached to a hospital’s public relations department, serving to pacify patients, not to aid them.

Thus, in their present form, both IRBs and patient advocates as ethical guarantees are seriously flawed. They both offer the potential, however, of being effective tools for combating research abuse. But neither will work unless they can counteract some of the forces which create and foster abuse; peer pressure, asymmetry of power and depersonalization are critical among the culprits. Until IRBs and patient advocates are independent of both professional and institutional interests, one can expect that abuses of the type documented above will continue to characterize human experimentation.

Hopefully, the methodology employed in this article will help community and patient groups to periodically check the goings-on of the clinical research establishment. No special access to the inner sanctum of the hospital or laboratory is needed. The names of members of a medical school’s faculty or a hospital’s staff are easily obtained. By reviewing their published works, one can get a reasonable reading on the violence done to the old Hippocratic dictum: “Above all else, do no harm.”

—Ken Rosenberg

with the assistance of Willa Wing and Jon Lukomnik.

References

Shortly after the birth of my third child (fourth counting a stepchild) I decided to have a vasectomy through the Planned Parenthood clinic. My trepidations concerning submission to any medical procedure, large though they were, soon vanished in the face of a wholly unexpected assault on my privacy and dignity. After objecting to dozens of questions, including such irrelevant medical history as whether I was frequently depressed or how often I had sex with my wife, and watching the intake worker code the answers on a key punch form for a computerized records system, I was told that I was not “a fit candidate” for the clinic’s services. My rejection was rescinded only on the condition that I submit to the required invasion of privacy. After this beginning, the medical procedure was uneventful.

Such assaults on privacy and dignity are commonplace in the experience with medical care, as they are with all institutions in our society. Frequently, the consequences are much more serious for an individual’s health, employment, education, dignity or even freedom than the minor incident I experienced.

Much of this assault on privacy is associated with the spread of computerized records systems. In the last five years, there has been growing awareness and controversy over the development of mass computerized information systems and its significance for citizens’ rights to privacy. In 1973, the Department of Health, Education and Welfare released a report entitled Records, Computers and the Rights of Citizens (MIT Press) which expressed alarm at the extent of invasion of privacy and recommended extensive legislation to protect privacy. In 1974, President Ford called privacy “the most basic of all rights,” and Congress passed the first bill dealing directly with regulation of governmental information systems—the Privacy Act of 1974. Nine states have subsequently extended these legislative provisions to state agencies in Fair Information Practices Acts. The Federal Privacy Protection Study Commission issued a report on Personal Privacy in an Information Society (Washington, D.C. 1977).

This growing concern about privacy is particularly important to the health industry because of the rapid growth in computerization of medical records. Recently, Professor Alan Westin, one of the country’s leading civil libertarians and an early critic of computerized information systems, carried out a comprehensive review of the computerization of medical records. In the resulting report, Computers, Health Records and Citizen Rights, Westin and his associates, Michael Baker and George Annas, find few flagrant cases of privacy violations in computer systems today, but they warn that serious invasions of privacy are made possible in computerized systems:

“What we conclude is that the main problem today in computerized health data systems is potential harm. As we will see, what makes such potential harm parti-
cularly serious for civil liberties is the fact that these possibilities of misuse have not been taken into account and dealt with effectively by the managers of such computerized systems." (p. 218)

**Computers and Health Records**

While one can cite a variety of dramatic instances in which computers in the health care system are being used to improve delivery of care--such as for diagnostic and life support systems or for clinical research. The vast majority of computer systems--80%--are being used for purely administrative purposes such as billing inventories or personnel.

As computerized systems have replaced manual systems, the ability of an institution to maintain larger and more complex files has been increased. Taking advantage of this capability, the types and amounts of data being collected and stored by these institutions are growing rapidly.

Perhaps even more significant than the computers' ability to store large data files is their ability to associate files from a wide variety of sources.

It was always possible to compile a police or intelligence dossier on an individual if the agency were willing to spend enough time and money to do so. The cost of this effort, however, required that the practice be limited and the same limitation has applied to medical life histories. Employers and insurance companies generally settle for far less than a complete record. Because of the mobile nature of our society, and the local maintenance of medical records in manual files, even doctors rarely have access to complete medical histories. It is, in fact, nearly impossible to have medical records transferred from one doctor to another, often to the frustration and disadvantage of patients.

Computerization of medical records, even within the framework of the existing predominantly private health system--to say nothing about the impact of a potential national health system--creates the possibility of reversing this fragmented recordkeeping practice. There are no technical obstacles today to the creation of complete medical records systems on a cradle-to-grave basis, with the consolidation of data from a variety of points of contact. Major steps in this direction are already occurring in conjunction with expanded research, environmental and occupational health studies, the centralization of payments records system (both public and private), and in private agencies like the Medical Information Bureau.

The primary issue in the computerization of medical records is how their capabilities will be used. More complete and more accurate medical history data could lead to vastly improved health care, particularly to improvements in diagnostic and preventative care. However, more accurate, more complete files may be used to serve other objectives of the institutions which maintain them--or which have access to them. Information previously subject to the doctor/patient tradition of confidentiality, previously stored in the doctor's head or office is now practically public domain and thus potentially available for the social, political and economic ends of the institutions controlling them.

The role of computers in this issue must be understood clearly. Computers are tools, very sophisticated and very expensive, but tools nonetheless. It is people who use the tools; people who input data on machines, who prepare the instruction [programs] which direct the functioning of the machines and people who operate them. It is the institutions in our society, however, which define the roles of these people and which determine the uses to which computers will be put. It is the values and objectives of these institutions, therefore, which must be analyzed to understand the impact of computers on our society.

One of the strengths of Westin's report is his emphasis on the institutional determination of health record-keeping practices. In essence he argues that the numerous privacy problems in medical records systems are the result of traditional institutional values and practices. He feels that the expanded use of computer systems has created the potential for even greater problems, but he argues that computerization has not changed the basic problems, but he argues that computerization has not changed the basic issues, which he views through the civil liberties perspective.

"The basic concern of health care professionals, civil liberties observers, and computer experts is this: given the more detailed, more centralized, more permanent, more easily-transmissible quality of computerized medical records, the flawed procedures and policies currently employed with respect to manual records threaten to be seriously inadequate to the computer era." (pp. 117-118)

**The Institutional Setting of Health Records Systems**

Westin defines three major institutional settings in which medical records systems raise privacy concerns: doctors' offices and hospitals; service payers (insurance
companies, Medicare and Medicaid) and health care review agencies (PSRO's), and secondary private and social users of health data (employers, law enforcement and credit, and social control agencies).

In each institutional setting, Westin defines record-keeping practices and privacy issues both more pronounced. There were, in 1975, over 11,000 people employed as medical records administrators. Centralization of medical records in these institutions has also created privacy problems. Westin writes,

"In many hospitals in the pre-computer era, record-keeping was hit-or-miss, and though lots of paper accumulated in the record, these documents were often in disarray, without any indexing or current summary. Now... the automated personal data are being more systematically collected, more fully recorded and more centralized in permanent files. Patients are systematically asked to disclose the full range of physical, social, family, emotional and other personal data, and the resulting detailed patient profiles become a regular feature of the file, updated steadily as the patient remains with that health care provider." (p. 99)

Westin found that few hospitals have gone very far in developing comprehensive health information systems. In those that have, however—and the number is increasing rapidly—these trends are even

Information previously subject to the doctor-patient tradition of confidentiality is now practically public domain and thus potentially available for the social, political and economic ends of the institutions controlling them

The medical data collected from the patients will become more extensive, its disclosure more mandatory, under the new computerized systems

before & after the introduction of computerized systems.

It is in doctors' offices and hospitals that most health data is collected. It is commonly understood that patients must make full disclosure of their medical history in order for the medical workers to deliver good health care. In turn, doctors are bound by well-established principles of confidentiality. Westin observes, however, that as more private practitioners begin to use computer systems for record-keeping, several changes occur. First, the medical data collected from the patients tends to become more extensive, its disclosure more often mandatory than voluntary; more standardized and more abbreviated—often with misleading reasons. Secondly, as record-keeping becomes more centralized, more people become involved with that data and have access to it—medical workers who are not clearly subject to the confidentiality tradition.

Westin found that few hospitals have gone very far in developing comprehensive health information systems. In those that have, however—and the number is increasing rapidly—these trends are even

records are full, up-to-date, easily understood and are linked together from various departments and previous episodes. From a civil liberties standpoint, however, this trend means that all the medical and paramedical personnel in a facility who have access to the computerized files now have more detailed personal data and more comprehensive social histories than in the typical manual system, except for psychiatric facilities.” (p 100)

Mental health records present particularly sensitive privacy problems. While finding that these records are generally treated with greater concern over access, confidentiality and dissemination, Westin is not satisfied with the adequacy of existing protections in light of computerization:

"...the very existence of easily retrieved, identified records on people whose problems include drug abuse, alcoholism, sexual deviations and violent episodes is a tremendous temptation to local..." (p. 199)

Although most health data are collected in doctors' offices and hospitals, “law and public norms require considerable disclosure of what is collected (there), the recording of personal data in primary care can no longer be analyzed in isolation...” (p. 39)

Noting this, Westin turns his attention to the second institu-
tional setting of medical records systems — payment institutions, including insurance companies and Medicare/Medicaid agencies, and the health care review agencies that have grown up in conjunction with the expansion of public financing and malpractice controversies.

In these settings, Westin finds the issues to be quite different: data collection, storage and dissemination of medical records. In fact, the demands of these institutions for data are often resisted by medical workers because of the burdens put on them to supply the data. Clearly, the confidential doctor-patient relationship does not apply at all in these institutions, but is sacrificed to business and public interest claims. Furthermore, the decisions made about individuals in these agencies do not bear directly on improved health care at all.

Westin's primary focus here is on the tradition of "implied consent" as a violation of privacy rights under the civil liberties principle of restricting access to records to the agency which collected them, and to the purposes for which they were collected. "As a practical matter, general consent forms and the legal doctrine of implied consent result in the patient unknowingly surrendering control over what is furnished to Zone II organizations and how it is used." (p. 56)

Secondary Users of Medical Records

It is the third setting, the private and social users of medical data, that disturbs Westin most deeply, and correctly so. It is in employment decisions, licensing decisions, judicial and law enforcement decisions, and social welfare benefit decisions in social control decisions that medical information is used in ways least related to the original purpose of its collection, and in which the information is least subject to the medical tradition of confidentiality. Yet, these decision-making agencies increasingly utilize the expanded medical records systems in their procedures through a variety of informal and legislated practices in which confidentiality is sacrificed to public and business interests.

Westin places the discussion of these social uses of medical records in the perspective of controversy and concern over the decision-making functions in our society, not in terms of the medical context of the records. Noting that much of the protest over the uses of this data relate to decisions which discriminate against individuals and groups, he concludes: "The debates such critics initiate over 'privacy' are often really challenges to the way that 51
conventional society confers its rewards and favors among the population.” (p. 85) Westin adds that growing public distrust of official decision-making agencies gives rise to concerns even when the intent of the use of medical records is well-founded.

It is predominantly in the secondary use of medical records that horror stories are most common, and Westin provides a number of these. But horror stories may be misleading because they tend to involve dramatic exceptions to standard record-keeping practices. What is lost in this kind of analysis is the more common and more insidious form which occur far more often but, in fact, attract little notice. It is these common situations to which attention should be directed in order to change standard practice. Exceptional cases will exist in any system: the point is to control for the routine cases.

Civil Liberties and Health Records

In the end, Westin’s analysis places most of the blame for privacy violations concerning medical records on existing medical and legal tradition and institutional practices. It voices concern that computerization will make these problems worse.

He concludes his study with a section devoted to recommendations on how to strengthen the privacy of medical records. He proposes, for example, that institutions have a legal and moral responsibility for the protection of individual privacy; that “reasonable care” must be exercised to guarantee that information stored and disseminated is up-to-date and correct, and be held confidential except for its stated purposes; that public notice be required of the existence and uses of records systems; that independent review agencies protect individual rights against abuses.

To support these principles, Westin argues that legislation must be sought which removes the medical records exemption to the Fair Credit Reporting Act, thereby widening the application of due process to health records. He proposes that medical research files be protected under privileged information statutes. Provisions related to medical records should be incorporated into state “fair information practices” laws. Finally, Westin argues that strong privacy protections must be written into any national health insurance acts, particularly guarantees of privileged status of the records systems and the prohibition against storing records identifiable with common codes.

Within Westin’s civil liberties perspective, these are sound recommendations. They are, however, subject to the problems of definition and implementation that privacy regulations have faced in other other settings. The essential privacy argument is that people have a basic right to maintain some substantial degree of control over the ways in which information about them is used by others.

Central to all discussions of privacy, however, is the recognition that there are contradictions between the rights of individuals and the needs of the state (i.e., public interest) and private institutions (i.e., business interests). These contradictions limit the individual’s control of personal information, and compromises must be reached between the two interests. The substance of the privacy issue has been where to draw this compromise in a variety of situations.

Conflicts concerning privacy of medical records, or arrest or financial records, therefore, are unlikely to be resolved simply by legislating principles concerning, for example, limiting access to medical records to “legitimate” uses outside the collecting agency. Legislation is implemented through regulations and enforcement by agencies within which “patient” (i.e., public) interest is often poorly represented. What, for example, should constitute a “legitimate” use of medical records outside the primary care setting? The use of medical records in employment, credentials, insurance and credit decisions is legitimate from the perspective of the institutions using them, but these uses are often challenged by the subjects of these decisions. In other words, regulations do not resolve conflicts between individual rights and institutional needs; they only channel these conflicts within confines established by the prevailing balance of power. At the present, the balance of power is heavily weighted in favor of institutional needs.

Westin attempts to redefine the issue by the principle that infor-
information privacy be considered a property right. This “contract” theory, however, provides little protection in other record-keeping situations involving private sector institutions. If individuals do not like the terms of the “contract” offered, they are free only to go without bank accounts, insurance policies, jobs or medical treatment. To make this right effective would require enforceable legislation guaranteeing individuals the right to receive service from institutions whether they agree to provide requested information or not, a demand which is impossible to even raise within our society because of its contradiction with “free enterprise.”

Another weakness in Westin’s proposals, and one common to all proposed privacy regulations, derives from the need to make the regulations acceptable to the institutions to be regulated. Passage of the 1974 Privacy Act raised controversy primarily expressed in terms of the costs of administering the regulations, particularly those relating to public notice, consent and access. As a consequence of the cost issue, implementation of these principles has placed the burden of gaining these rights on individuals rather than on the institutions. The same argument has been the primary defense of the private sector institutions to extending privacy regulations into their records systems.

In order to meet these objections, Westin presents relatively weak, although definitely progressive, proposals on notice, disclosure and access. For individuals on whom records are collected and disseminated at every turn, usually without their conscious knowledge, really adequate protections would have to include provisions like mandatory annual notice of the existence and contents of a record concerning an individual, periodic reports of all routine disseminations of the records, explicit authorizations of each dissemination on an excep-

tation basis, annual renewals of authorization to maintain records and disseminate them. Under present circumstances, of course, institutions would never permit the enactment of such regulations.

A final problem with Westin’s civil liberties perspective, unique to the case of medical records, is the question of patient access to their own records. Following the due process tradition, Westin makes a strong case for completely open access by patients to their own records. However, this focus masks the real issue which is how to guarantee that health care and health records serve the interests of the patients. That is not a civil liberties problem. Thus while Weston recognizes that computers are not the problem per se, but how they are used by the institute controlling them—he fails to move to the logical conclusion of that argument. It is not a civil liberty issue we are facing—but an issue of power and social control. It is not the fact that information is being disseminated but who decides what is to be disseminated and how that disseminated information is used.

Dr. Alfred M. Freedman, chairman of the National Committee on Confidentiality of Health Records, has struck this defensive posture: “We all need to be constantly aware of the delicate, com-

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It is not a civil liberty issue we are facing—but an issue of power and social control. It is not the fact that information is being disseminated but who decides what is to be disseminated and that information is used

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This defensive posture grows out of the inadequacy of the civil liberties tradition to cope with sweeping computerization under the direction of the corporate state. On the one hand, Freedman offers sound advice given the current balance of power. On the other hand, we cannot tolerate an environment that makes such behavior necessary. An effective health system cannot
function under a cloak of secrecy. Indeed, extended to all other areas touched by computerized records, this posture would make freedom and communication impossible and would create a closed, stagnant society. We must instead find new principles for the organization of society which return control over their lives—and recorded information about them—to people themselves, for use in their own interests.

Beyond Civil Liberties
Professor Westin is, of course, right when he observes that the privacy of health records is primarily a problem of the use of the information by other institutions for purposes unrelated to health care. He also correctly analyzes the inadequacy of existing institutional practices to limit these invasions of privacy, particularly with the advent of computerized records systems. He presents a reasonably thorough set of proposals to strengthen institutional safeguards of record privacy. For these successes, his book is of major value to health workers concerned with information use and privacy. Yet, and particularly in the last effort, the result is unconvincing. We are dealing with wholesale use of personal information for social control to which Westin's civil liberties principles have no answers. In his emphasis on struggles in society which have generated concern for privacy, he is awfully close to recognizing the real depth of these struggles, but he does not quite break out of his liberal traditions.

Institutional Change and Social Struggle
In the health sector, computerized records systems are the products of the growth of corporate health power. The potential development of a national health system will focus privacy issues, and perhaps make it easier to establish controls. In the proposed national health bills, however, privacy rights have received little attention. Only the Dellums Bill (H.R. 6894, The Health Services Act) contains guarantees of confidentiality and patient access to records. We need, as Westin advises, to establish such controls as we can, but we must go beyond defensive postures to challenge the institutions which control and use computerized records. Until we face this challenge, we cannot move to construct institutions in which, for example, computerized health records systems should function only to improve the delivery of health care.

—Laird Cummings

PROGNOSIS NEGATIVE: CRISIS IN THE HEALTH CARE SYSTEM
edited by David Kotelchuck

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Safety has never been a bottom line for the American coal industry. Profits and production have. The 1978 contract, which 56 percent of the voting coal miners approved on March 24, after 109 days of defiance, puts this basic economic fact in bold face.

The operators did not give an inch on safety. They refused to accept any of the numerous health and safety improvements the United Mine Workers of America (UMWA) rank and file endorsed at their 1976 convention. This was done in the face of a deteriorating safety situation in the mines.

The rate of non-fatal, disabling injuries underground has increased steadily for the past three years. It's now about 50 injuries per million hours of work—no better than the rates recorded in the 1950s and 1960s! The underground fatality rate also may be increasing—it rose last year for the first time since 1970. In all, 141 miners died in 1977 and 15,000 were injured in accidents on-the-job, both above and underground.

Although the contract is now six months old, its implications are still unraveling. Wildcat strikes have not been as frequent as they were a year ago. Peace in the coalfields? Hardly. Miners can't strike when they don't work. As of late September, about one-third of West Virginia's coal workforce was idle. Demand for metallurgical coal (used in steel making) from Central Appalachia has been cut to the bone as domestic and foreign steel mills face shrinking markets. And for several months, rail clerks shut down lines carrying the coal that was mined.

Still, some trends are apparent; with the phasing out of the UMWA's medical plan, coalfield hospitals and clinics are cutting back. One hospital in southern West Virginia shut down entirely and 60 doctors at last count had quit their clinic jobs as a result of funding cutbacks initiated in June, 1977 and reaffirmed in the March contract. Gone entirely is the vision of a union-controlled medical system.

Although production is currently at a low point—coal markets tend to be unpredictable—the 1980s promise to be an unprecedented boom decade for coal if utility demand matches current forecasts. It appears that the operators are planning to take no chances: they know all too
Death

Last year's toll of 50 mine injuries per million hours of work may not sound large, but in fact it is an enormously large injury rate.

Consider this rate in the more graphic terms of injuries per person per year. A person employed 40 hours per week for 50 weeks works 2,000 weeks per year. Thus 50 injuries per million work hours is 50 x 2,000/1,000,000 = 0.1 injuries/person-year.

That is, accidents happened at such a rate that one fully employed miner in 10 would have suffered a disabling injury last year.

With the strike and layoffs, last year, of course, miners didn't work this many hours, so each person's chances of injury went down accordingly. Nevertheless, this was one of the highest injury rates in all of U.S. industry.

well that if fortune does smile, they must be able to guarantee delivery of their product. That guarantee is contingent on having a controlled, dependable work force.

Dependability of supply is what the 130-member Bituminous Coal Operator's Association (BCOA) demanded from the United Mine Workers of America (UMWA) this winter. Dependability requires "labor stability," which the companies sought to achieve by rigging together a gauntlet of threats, penalties and baited traps that would befall any miner "who so much as quacked when he should have clucked," as one union member put it.

A turbulent, three-year struggle over control of the workplace since the 1974 contract had resulted in record-breaking time lost due to wildcat strikes, absenteeism and slowdowns. (See BULLETIN, November-December 1977). Output and productivity of Appalachian-centered companies, particularly those with extensive underground operations, had been cut deeply. Strikes, in particular, defied coal operators, union officials and federal judges. Breaking the rank and file's ability to stop production was the BCOA's major bargaining goal, and the hard-line operators were willing to wait out a long strike to get it. What remains to be seen is just how successful their strategy was. An initial reading of the contract seems to indicate that the operators' stonewalling did, indeed, prove worthwhile.

The March 24 contract is only slightly less regressive than the two earlier contract offers which the miners rejected. Wages will increase 31% over the life of the contract, but once inflation, the new $200 medical deductible and higher taxes take their bite, real income will rise only 6% to 9%. Real pension income will not increase at all.

None of the BCOA's initial "labor stability" penalties was included in the contract, but there is a sleeper provision. Through a vaguely worded, back-of-the-contract memorandum of understanding, the UMWA and BCOA agreed to carry over all pre-settlement decisions of the arbitration review board for the life of the contract. In October, 1977, just six weeks before the end of the old contract, the board had ruled that operators had the right to discharge and discipline picketers, agitators and even advocates of a strike, subject only to review by the arbitration board. Miners, in voting for the contract, thought all the punitive labor stability provisions had been deleted.

Health "Benefits"

All 140,000 working miners, 6,000 recent retirees (retired since 1976–members of the so-called 1974 Benefits Trust)(1) and their families have been switched over to employer-managed health insurance plans for the life of the contract. The 82,000 miners who retired before 1976 (members of the 1950 Benefits Trust)(2) and their families will remain with the union-controlled Benefit Fund. Thus in one fell swoop the Fund is losing most of its health beneficiaries. And when the older retirees and their dependents have died off, the UMWA's role in health care will be no more.

The contract also provides for a system of deductibles, out-of-pocket costs paid by the miners themselves. Working miners will pay $7.50 per physician visit up to a maximum of $150 yearly per family, and $5 per prescription up to a maximum of $50 yearly per family—for a total cost of up to $200 yearly per family. Similarly, retirees will pay $5 per physician visit up to $100 yearly, and $5 per prescription up to $50 yearly—for a total of up to $150 yearly. Costs of surgery and other covered hospital benefits will be paid in full.
Thus hospital-based acute care will continue to get full coverage, while access to primary care is restricted (which of course limits preventive care and early detection of disease as well).

Benefits are now "guaranteed" and presumably not contingent, as before, on production levels. But uncertainty exists both as to how the operators interpret the scope of benefits they are guaranteeing and who will oversee the administration of their health insurance plans. Some doctors and hospitals have refused to accept the new company sponsored insurance cards and instead demand cash up front from the miner who then must haggle with the insurance company.

The UMWA helped set up about 50 clinics since 1950. Many were consumer-managed, miner-oriented facilities that paid physicians a salary and provided reasonably good health care in remote areas. The UMWA Fund paid each clinic a fixed retainer that facilitated program planning and underwrote a wide range of medical services for miners and others in their communities. The clinics were switched to a fee-for-service basis in June 1977, and as a result many have been forced to lay off personnel and reduce services.

Health and Safety in the Mines

During the strike, the White House and the BCOA harmonized on two refrains: (1) health and safety are inflationary; and (2) coal's productivity must be raised. Increased productivity (measured in tonnage per worker per shift) reduces an operator's cost and boosts his profits. The UMWA has

Dust

Respirable coal mine dust—smaller than a speck of dust—kills more coal miners than roof falls and explosions. About 4,000 disabled and retired miners die annually from coal workers' pneumoconiosis and black lung disease (which includes occupational bronchitis and emphysema). Preventing dust disease requires maintaining dust levels below the 2 mg./cm\(^3\) federal standard. Compliance is determined by sampling dusty jobs in each mine section a couple of times a year.

Health advocates and the UMWA charge that the current sampling program, which is managed by the individual mine operator, results in repeated falsifying of sample data, voiding of "bad" (non-compliance) samples and pressuring miners to take "good" samples to avoid job discrimination. After eight years of watching the operators turn the sampling program into a deadly charade, miners are fighting back.

In early September, the UMWA proposed that Labor's Mine Safety and Health Administration (MSHA) give miners control of dust monitoring. Dozens of rank-and-file miners testified at MSHA hearings this summer about the unreliability of the current program and the need for miner control. The original idea for a miner-elected dust person at each mine was developed by union miners at their 1976 convention. UMWA health professionals, staffers (who are miners) and others fleshed out the proposal late in the summer.

The UMWA proposed that Labor authorize a peer-elected miner to sample his/her mine for respirable dust more or less continuously. Personal samplers (those that miners carry individually) would generate dust-level data to determine compliance and affix civil penalties if warranted. Each dust person would also be equipped with an area sampler—a monitoring device that prints out dust levels on tape—to determine daily dust levels. After three consecutive days of non-compliance, the UMWA dust person would have the right to "danger-off" the dangerous section, a power that union miners have in relation to other hazards. The UMWA plan would give miners immediate unchallengeable knowledge of hazardous dust levels and enable them to force operators to come into compliance.

If the UMWA is successful, miners will have won a precedent-setting occupational health right.
traditionally opposed productivity-enhancing bonus schemes, fearing safety would suffer. (Indeed, had industrywide productivity in 1977—8½ tons per day—been that of 1969—a little more than 16 tons per day—the number of fatalities and injuries would likely have doubled).

The 1978 contract gives employers the right to institute incentive plans to increase productivity. The operators hope that by dangling cash bonuses in front of their employees, they will close their eyes to the risks of speed-up. Once a local votes for an incentive plan, it cannot rescind it. Only the company can. Older miners will put a lot of pressure on younger, less financially strapped workers to vote in a plan. Then there will be a lot of pressure in the workplace to meet the magic bonus targets. As a result, incentives will be built into the work process to cut corners, operate unsafe equipment, speed up the pace of work and not strike over job and safety rights.

Some of the new bonus plans are linked to fixed injury goals, that is, so many disabling injuries are allowed before the cash bonus is reduced. Many plans even create incentives for disabling injuries to be counted as non-disabling injuries by allowing an injured worker to accept a “benchwarming” non-job for as long as it’s necessary for him to recuperate.

Safety will suffer under the bonus plans, but the real loss will be to the miners’ health. No cash penalties are triggered if dust levels rise, and since health impacts are hard to measure on a day-to-day basis, they are not to be considered at all. To get the extra tonnage, miners will be encouraged—and will encourage each other—to mine without proper ventilation and water sprays. Twenty years from the day they pocket a couple of extra fifties, they’ll get their real bonus in the form of dust-caused lung diseases: pneumoconiosis, bronchitis and emphysema.

The operators’ plan to boost productivity comes when the UMWA’s safety program is in disarray and federal enforcement of the 1969 Coal Act and the 1977 Amendments is in doubt. The union’s safety division has been the victim of the factionalism that has divided union officials for four years. Safety personnel are appointed by UMWA president Arnold Miller, and his critics charge that political loyalty rather than competence were the grounds for selection in a number of cases.

Not a factor in Energy Policy, Federal mine safety and health enforcement was shifted from Interior to the Labor Department last spring. Despite President Carter’s solemn expressions of concern for the health and safety of coal miners (expressed when he invoked Taft-Hartley), nothing is being done to boost production without increasing death, injury and disease. If anything, things are moving backward:

Neither the White House nor the Department of Energy regularly factors occupational health and safety considerations into their coal policies;

A recent report to the White House from an HEW task force on the environmental and health problems of increasing coal utilization (directed by Dr. David P. Rall of the National Institute of Environmental Health Sciences) said the health and safety costs of meeting Carter’s coal goals were acceptable. The Rall commission did not, however, mention its own NIOSH-generated report that projects an almost three-fold increase in annual coal mining fatalities—to 374—and a doubling of disabling injuries—to 25,800 by the year 2000 at 1976 accident rates—if Carter’s goals are met.

President Carter nominated Governor John D. Rockefeller, IV (D.—W.Va.) to head a presidential commission on coal’s productivity and “labor stability” problems. Preliminary indications are that the Rockefeller commission will view health and safety as “constraints” on production and productivity rather than as “non-incurred costs,” let alone “benefits.” Meanwhile, the Energy Department has let several contracts recently on the problem of increasing productivity. Lost amid the shrill cries of the productivity barkers, are the simple facts that production and profits have risen steadily despite declining productivity. Even more deeply lost in the cacophany is the opinion of many observers that coal’s productivity will rise in the future as long as recent trends continue.

The 1978 UMWA contract with the BCOA will take its historical significance from the things it ended and from the things it began. It ended UMWA leverage on coalfield health care. It ended the vision of a union-controlled medical system. It began a new round of health-for-production trade-offs. It began dividing the union’s membership at the mine level by setting bonus-hungry workers against militants. It may have begun dicing the union into smaller, more digestible chunks for the operators to chew on. While coal’s future is bright for some, it is uncertain and ominous for others.

—Curtis Seltzer
Peer Review

Family Practice Revisited

Dear Health/PAC:

I am writing both to express approval of the inclusion in your January/February bulletin of a detailed statement on the evolutionary changes of general medical practice towards family practice and concern that the author found so little of value in this process that she concludes by postulating a subtle, professional conspiracy and proposing a dehumanized mass-production health care system.

In the first place, this paper presents the chronology of “first contact or primary” medical care during the twentieth century with emphasis in changes both in effectiveness and expectations that have developed. The fact that the medical profession has listened and responded to the public expression of the 1960’s is a basic and revolutionary change from the elite “ivory tower” attitude of the profession in previous centuries. The observation that medical students have a tendency to move from broad, humanitarian ideals to narrow personal goals is more a statement regarding our cultural values than a specific medical phenomena. The lack of a valid, innovative approach to health care in our urban areas is real but hardly reason to damn a process that is seemingly developing a more acceptable and available health system for our rural and suburban population.

What the author does not seem to acknowledge is the basic philosophical change that is essential to the “family medicine” concept. This is the emphasis on examining and treating the “whole” person (the patient interacting with significant others) and not just the patient as a disease entity. Furthermore, it is clear that such health care can only occur when the practitioner is able to relate to and thus become a part of the patient’s total experience. This is the new practice of medicine which is evolving, the experience of which will make significant changes in us, the practitioners.

After noting the definition of the family physician as developed by the Council on Medical Education of the AMA in 1964, the author, for reasons that are not clarified, found it necessary to attack the whole concept of “family” and proposed that health care should be given to communities rather than people involved in specific interpersonal relationships. I fear the logic of this proposal would lead to impersonal, bureaucratic, superficial and static health care rather than care in touch with the true dynamics of people’s lives.

A much better approach would be to develop physicians knowledgeable about the realities of urban life—social, environmental and personal—motivated to work with a multi-professional delivery system and yet committed to a personalized approach to each patient in each clinical situation. This simply means that we must take seriously the 1964 definition of family physician and seek ways to provide an opportunity for such physicians to practice in our urban as well as suburban and rural areas. To achieve this, a confrontation with specialty controlled hospitals, inappropriate hospital-oriented payment systems
and politically controlled centralized public health bureaucracy must be made, and soon.

Sincerely,

-W.P. Reagan, M.D.
Department of Family Medicine
State University of New York

New Periodical

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In Memoriam

SAMUEL RUBIN

The Health/PAC Editorial Board and Staff mourn the loss of Mr. Samuel Rubin, who died at the age of 76 on December 21, 1978. Mr. Rubin was a philanthropist and political activist who brought a deep personal commitment and abiding generosity and a keen sense of strategy to his concerns about the injustice and oppression he witnessed in this country and abroad.

Health/PAC was born largely out of Mr. Rubin’s generosity and out of his dismay at the dual system of health care he witnessed in New York City. His keen insight into the workings of that system helped guide Health/PAC to many of its landmark critiques and Mr. Rubin’s inspiration and support have been invaluable to Health/PAC throughout its history.

Mr. Rubin leaves a living legacy of organizations, projects, institutions and individuals who will continue striving long after his death to achieve his vision of a just society. Health/PAC is proud to be part of that legacy.