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someday, the nation’s 200 HSAs remain an intriguing target for many local activists. And they have attracted the time and energy of some 30,000 “consumer” members nationwide, a feat unparalleled by any other political entity in the health system.

What is the ultimate potential of HSAs for progressive change in the U.S. health care system? Clearly no consensus has yet emerged on the question. Health/PAC has looked at HSAs in two previous articles without putting the matter to rest. The past five years have generated a wealth of experience in and around local HSAs, and the article in this issue concerning the collapse of the Los Angeles HSA suggests a need for such clear case studies to shed light on particular local experiences.

Pending a weighing of more evidence, however, some common observations based on the limited available experience are already emerging:

The Illusion of Power: Many activists seem to have been attracted because, limited as HSA authority is, it seems to offer a tiny corner on power in the health system. The tools of Certificate of Need (CON—the required review of new expenditures for plants or equipment) and review and approval of federal funds (PUFF), at first glance, seem to offer a real chance to democratize the dominance of large institutional and professional interests currently dominating health care delivery.

For veteran participants, however, the extremely trivial nature of such power in the hardball world of health politics has already become clear. The HSA’s regulatory clout, in fact, has more often than not been overridden by State or Federal bodies that can supercede it by law. The relative impotence of the HSA’s meager tools is made all-too-obvious when one realizes that billions of dollars for new plants and equipment have been vetoed by local HSAs throughout the country over the past five years without even slightly dampening the fires of health care cost inflation.

Further, the real outcomes of what little power the HSAs can concentrate may ultimately contribute more to the problem than the solution. This seems largely due to the ideological and political bias structured into HSAs from the beginning.

The Ideology of Regionalization: Perhaps the most dangerous aspect of HSAs is their inherent susceptibility to becoming the legitimizers of backroom deals between the wholesalers of medical care under the guise of “regionalization.” The concept of regionalization sounds like the sort of technically neutral, rational approach to planning that no sane person could oppose, with its visions of the efficient use of scarce resources and the checking of runaway expansion and duplication.

In operational form, however, attacking “waste” in the system begs the question of whose fat is to be trimmed. Many HSAs, despite technical majority control by consumers, have proven easy vehicles for manipulation by alliances of large tertiary hospitals and kindred providers. The result: smaller facilities are driven out of business on the basis of such unexamined half-truths as “supply generates demand” and “low volume equals low quality.” This “survival of the largest” strategy often overlooks the obscene high costs bred by the giant institutions or the appropriateness of the commodities they deliver to the health needs of the population as a whole.

Potential for Protest: If HSAs have proven normally weak and occasionally harmful, one might return to the question: What do they offer for health care activists?

Obviously, in the absence of a clearly articulated ideology to counter the regionalization/monopolization forces, and lacking the kind of local political base that can effectively take on the large providers, community activists will experience working through the local HSA as a sideshow at best, cooption at worst. Having mapped these dangers, however, the task is hardly complete.

In addition to the pitfalls and problems of any pluralistic structure in a society where some conflicts are permanent and the parties are of vastly unequal power, HSAs also offer a progressive potential. This potential arises more from current political necessity than legislative intent: HSAs of-

The ideology of acute-care, corporate medicine equates quality with Star Wars gadgetry and diverts public attention from preventive medicine to the tantalizing illusion of a ‘technological fix’

Continued on Page 14
**Vital Signs**

WHERE ARE THEY NOW?

During the calm on college campuses after the Vietnam era, the one issue which still generated enough outrage to precipitate demonstrations at docile Princeton, Yale and Staten Island Community College was the genetic I.Q. debate. In 1969, in the *Harvard Educational Review*, a then little-known academic from the University of California at Berkeley, Arthur Jensen, reported on studies which concluded that the differences between the I.Q. scores achieved by Blacks and Whites were due to genetic factors.

With Richard Herrnstein of Harvard and William Shockley, the Nobel laureate in physics from Stanford, Jensen popularized the "new eugenics" of racial genetic inferiority and superiority in the name of science and "objectivity." His article, published when the Nixon administration had just taken power and was looking for a rationale for dismantling Head Start, begins, "Compensatory education has been tried and apparently has failed." Shockley proposed sterilization bounties for Black welfare mothers to prevent "dysgenics" in his barn-storming tours of college campuses.

"Jensenism" rekindled old racist arguments which have gone under the name of science since 1869 when Francis Galton published *Hereditary Genius*, claiming that the British aristocracy had inherited its superior intelligence (let alone its property); several years later he developed a test to prove his claims! Much of the evidence for the "new eugenics" came from the work of Cyril Burt, the founder of educational psychology and the first psychologist to be knighted, whose work with twins separated at birth suggested a major influence of genetic endowment in intelligence scores. After several years' investigation into the actual data of the studies, the *Times Literary Supplement* in 1976 exposed Burt as a falsifier of data; not only had his original data disappeared (supposedly destroyed by his housekeeper shortly after his death in 1971) but so did the two collaborators in his later work! This did not change Jensen's views—he still believes in the primary "heritability of I.Q."

A year after Burt was discredited Arthur Jensen was elected a fellow of the American Association for the Advancement of Science, leading that normally quiet and contemplative group into bitter conflict. Margaret Mead called his work "unspeakable," while others called it an "endorsement of racism" and resigned from the A.A.A.S. So where should Arthur Jensen now appear but on the Editorial Board of the *Hispanic Journal of Behavioral Sciences*, the only publication of its kind in the United States. The journal, devoted to empirical and theoretical research on Hispanic populations, is published by the Spanish Speaking Mental Health Research Center at UCLA, sponsored by the National Institute of Mental Health and founded in 1971 by the Nixon Administration. Elsewhere in this issue, Bohique, a group of Puerto Ricans in mental health and the behavioral sciences describe their "Fifth Column" efforts to change this sad irony.


—Hal Strelnick
THE OPEC OF PILLS EYES SOME FUTURE PROFITS

Don’t believe all you hear about Valium, Librium, and supplemental vitamins not being good for you. At least if your name is Hoff­man-La Roche, these are all very good for you—and for your bottom line. For years, Valium and Librium kept this corporation’s income statement vigorous and vibrant at the same time they were making millions of mental patients lethargic and moribund. But even Valium and Librium—the pills that made this secretive Swiss giant rich—can not sustain Hoffman-La Roche’s profits and power as long as they can sustain passivity in patients. The pill patents are expiring, letting other companies in on the boondoggle. So H-LR needs a large dose of the vitamin business to stay healthy.

And a large dose they’ve got. Hoffman-La Roche dominates the world’s bulk vitamin production like Saudi Arabia dominates oil extraction. In a February 5 article, Forbes Magazine quotes estimates that Hoffman-La Roche “either makes or sells 60% to possibly 70% of the bulk vitamins in the U.S. and Free World.” They are involved with every major vitamin and have exclusive rights on some vitamins. A distant second in the multinational vitamin sweepstakes is Takeda Chemical Industries, Ltd. of Japan with $2 billion in annual sales compared to H-LR’s $3.3 billion. An even more distant third is West Germany’s E. Merck & Co. (no relation to the U.S.’s Merck & Co.). And the rest of the capitalist world’s 30 bulk producers of the ten or so major substances in the vitamin trade pale by comparison.

With this dominance—rare even by the standards of monopoly capitalism—it is no wonder that Hoffman-La Roche likes to avoid the public eye. So it hides behind the 500 or so formulators and distributors which punch out and package the pills under a multitude of different labels. Hoffman-La Roche likes this camouflage so much that it provides consultant services to new entrants. Another layer of cover is provided by the tens of thousands of foreign employees the corporation employs worldwide.
of retail outlets—the drugstores, supermarkets, and healthfood stores which are glad to help shield H-LR in exchange for their markups of upwards of 36%.

Behind these smokescreens of small industrial and commercial capitalists the quiet giant resides in picturesque, clean-aired Switzerland, protected from the piercing glare of victims or trustbusters who wonder whether washing down Valium or Librium with bulk vitamins makes shy transnational corporations healthy or obscenely obese.

—George Lowrey

**MASSACHUSETTS RE-REGULATES ITS NURSES**

During the first half of the 1970s, nurse practitioners (NPs) came to play an increasingly important role in the American health care system. As their numbers and importance have grown, so too has the pressure to develop clear and accepted occupational definitions by which this new group of providers could be neatly spliced into the existing health care hierarchy. Such pressure has historically stemmed from the desire of each successive new occupation to achieve legitimacy by carving out a piece of the turf and from the concurrent desire of the established occupations - notably medicine - to bring the new occupations into the hierarchy where they could be controlled.

In the case of the similar and equally new occupation of physician assistant (PA), the process of integration into the hierarchy has been simplified by the PAs' relatively small numbers and clearly expressed identification with the traditional goals and objectives of medicine. Thus, it has been a relatively simple matter to regulate physician assistants through the mechanisms and according to the priorities which serve for the medical profession itself.

With nurse practitioners, the situation is complicated by the fact that NPs equally clearly do not directly identify with the traditional goals and objectives of medicine, at least in their rhetoric (although the realities of NP practice are not in fact radically different from PAs). Nurse practitioners have argued that their work is within the scope of nursing practice and should therefore appropriately be regulated by the mechanisms already in existence to regulate nursing. On the other hand, many aspects of NP practice do include functions which were traditionally performed by physicians and are even reserved to the medical profession through medical practice acts. As a result, the medical profession has generally felt that it should be involved in regulating NPs just as it is with PAs.

Within nursing itself, unanimity has been difficult to come by. While there are those in the profession who regard the nurse practitioner and other expanded role nurses as a new breed entirely, there are also those who feel that all nurses are practitioners and see the NP label as an artificial distinction serving essentially status purposes. Probably the largest faction tries to grasp at both straws at once, viewing the nurse practitioner role as either a glorious new development or an integral part of every nurse's practice, depending largely upon which argument best meets the needs of a given situation.

Nationally, the response to the nurse practitioner has varied widely from state to state. Over half the states have modified either their existing nurse practice or medical practice acts to eliminate what amounted to virtual prohibitions on some NP functions, most notably diagnosis. Others have achieved similar effects through "delegatory amendments" to their medical practice acts, and still others have redefined "the practice of professional nursing" to include some or all functions performed by NPs. Fourteen states have made no changes in their legislation affecting NP practice at all.

The regulatory agent also varies. In two states the state medical board administers NP regulations exclusively, while eleven states invest the state nursing board with that exclusive right. Other states intertwine the regulatory authority of the two boards to one degree or another. The most widely used mechanism for regulating nurse practitioners of all types is certification, with the individual's original license as a Registered Nurse serving as the primary qualifier. In a few cases a new and distinct license is 5
required. In most cases the criteria for approving NPs are the standards of professional organizations such as the American College of Nurse Midwives.

In Massachusetts, the process of developing regulatory mechanisms for both nurse practitioners and physician assistants has been complicated by the reluctance of a very conservative state medical society to come to grips with the issues at all. Massachusetts has one of the highest ratios of physicians to population in the nation. This factor combines with the state’s relatively small geographic area to create an impression that the population should have little or no problems in obtaining medical care. Thus, physicians in Massachusetts have seen little need for either NPs or PAs to practice in the state and have actually seen them as competition. However, the maldistribution of physicians in the state is so severe that a number of areas, both rural and urban, including the city of Boston, have been designated as Health Manpower Shortage Areas by HEW.

Given this environment of apparent surpluses and real shortages, the medical profession and its regulatory agency, the Massachusetts Board of Registration and Discipline in Medicine, has been slow to become a party to regulation of either nurse practitioners or physician assistants. The PAs pressed for regulation in the early seventies through the one program which trains most PAs practicing in the state, and the state legislature passed a bill establishing a Board of Approval for Physician Assistants in 1973. The Board certifies but does not license PAs, and is a totally separate entity from the medical board which, at the time, did not wish to be involved in the process of regulating PAs. With time, the medical board adopted regulations dealing with physicians collaborating with physician assistants.

Those regulations carefully define the relationship between physician and PA, including specification of a large number of functions which can be delegated to a PA by the supervising physician. The regulations also limit the number of PAs whom a physician
may supervise to two, and those two must be registered by name and approved by the medical board.

The first step in development of regulations for nurse practitioners came in 1975, when the legislature amended the State's Nurse Practice Act and defined professional nursing in such a way as to permit nurses to practice in the "expanded role." The expanded role was to be defined in regulations which would be adopted by the Board of Registration in Nursing with the approval of the Board of Registration and Discipline in Medicine. After a year and a half of work on its own, the nursing board presented a set of proposed regulations to the medical board for its approval only to have them rejected as being so vague as not to be regulations at all. Thereupon, a joint project was established, with representation from both the nursing and medical professions, to develop a set of regulations which both boards could accept. The results of these efforts were finally published in the fall of 1978. They proved largely unacceptable to all involved, albeit for widely divergent reasons.

The proposed "Regulations Governing the Practice of Nursing in the Expanded Role" specify four distinct types of expanded role nurse – nurse-midwife, nurse anesthetist, nurse practitioner, and psychiatric nurse/mental health clinician. Interestingly, these four specialties are dealt with in virtually identical fashion, although the first two have long histories and well established roles while the latter two are still essentially in the early stages of development. In fact, nurse-midwifery and nurse anesthesia are narrowly specialized occupations which have little similarity to the general practice of nursing, while nurse practitioners and psychiatric nurse clinicians are basically expanding on the traditional broad nursing role. The two types of specialty are sufficiently different and require sufficiently different regulatory approaches that it is difficult to explain their marriage here other than as an attempt to lend to the two new specialties some of the hard won legitimacy and acceptance of the old.

Each category of expanded role nurse will be licensed individually and distinct from the license as a registered nurse, which is, however, one of the requirements for licensure in the expanded role. The only other requirements are completion of a training program approved by either the American Nurses Association or the National League for Nursing and certification by whichever, professional association or specialty board claims authority at the present time.

During a full day of testimony at public hearings on the proposed regulations, representatives of the nursing profession objected strenuously to the requirement for second licensure for expanded role nurses and to the overly restrictive scope of practice definitions. It was clear that the nurses saw the separation of expanded role practice from nursing in general as a distinct threat to the autonomy which they seek in defining the future development of nursing. On the other hand, physicians testifying at the hearings objected to the regulations as insufficiently protecting the public against nurses doing things for which no one save a physician could possibly be qualified. In fact, the regulations as written provide little guidance at all in clarifying the roles particularly of nurse practitioners and psychiatric nurses. The open-ended "additional acts" clauses are vulnerable to abuse by either nurse or physician, depending upon the situation.

Still more controversial were the proposed amendments to the Medical Practice Act governing "Physician Collaboration with a Nurse Practicing in the Expanded Role." These were developed by the medical board without consultation with nursing representatives and were modeled after the board's earlier regulations on collaboration with physician assistants. As such they showed no understanding of the differences between PAs and NPs or of the realities of current practice by expanded role nurses in the state. The result could most accurately be interpreted as obstructive, no less so for the fact that its source was apparent ignorance.

Under the medical board's proposed amendments, a physician wishing to collaborate with an expanded role nurse would be required to go through a process amounting virtually to second licensure. The physician would also have to submit to the board the names and qualifications of the nurse or nurses with whom s/he wished to collaborate with specification of the duties of each individual nurse. The entire process would have to be repeated every two years in order to renew the board's approval. Any change in the status of any of the parties involved or in the nature of the practice would also require repetition of the approval process. An individual physician would be restricted to collaboration with no more than two expanded role nurses.

Physicians testifying at the hearings objected on the grounds that the license to practice medicine should be comprehensive enough to cover any collaboration with (or, as they repeatedly referred to it, supervision of) lesser health professions. They were, however, quite supportive of the second licensure requirement for the nurses. The nurses objected to the requirement for individual approval by the medi-
Is There a Doctor in the Shop?

With the growing interest in occupational health and safety during the last decade has come renewed interest in the role of the company doctor. Because of their strategic location, these doctors could make an important contribution to preventive health care by seeking out and locating the causes within the plant of the diseases and injuries they treat. Yet they are deeply distrusted by workers and their practice is held in low repute by many in the medical system.

At the heart of the conflict between their promise and perceptions of their practice is a conflict of interest between allegiance to the industries which employ them and to the workers who are their patients.

Health/PAC is presently engaged in a study of the role of company physicians and the impact of this conflict of interest on their practice. This study has limited itself to company doctors since this is the primary mode by which companies address the problems of occupational injury and disease. It is clearly not the only, or necessarily the best alternative in many situations, but exploration of the potential roles of other medical personnel is beyond the scope of this article.

In order to study the role of company doctors, it is first necessary to know who they are. Or, more to the point, one must ask who businesses and industries select to be their company physicians. How does their average age and, more important, type of medical practice compare with those of other doctors in their localities? Among the specialists employed, what aspects of occupational problems are they particularly trained to address—injuries and/or illnesses; detection, treatment and/or prevention?

The answers to these are not known in general. Recent studies of occupational physicians have been restricted either to those doctors who are members of professional societies for occupational medicine (1) or to those who practice in very large industries (2). These categories include only
a fraction of the doctors who routinely treat worker injuries and illness, however, and probably reflect the better trained group of doctors, at that.

Health/PAC was interested in the nature of the typical company physician. Thus it surveyed all factories in one local area—Hudson County, N.J.—to find the doctors associated with each, either on a full-time, part-time, or on-call basis. The following article is a report of that survey, carried out by Health/PAC with assistance from a then-student intern (GJ) from the Department of Metropolitan Studies at New York University. As far as we know, this is the first study of its kind in recent years.

One subway stop from the cosmopolitan World Trade Center in New York City's Wall Street area is the entrance to "Cancer Alley," a belt of industrial counties running from northeast to west central New Jersey, where some of the highest cancer death rates in the U.S. occur. Among them, a dubious first place is held by Hudson County. A large, old, slowly deteriorating industrial area with over half-a-million residents, Hudson County is located on the west bank of the Hudson River, across from New York City. Thirteen hundred of its residents died of cancer in 1974, according to the New Jersey State Department of Health (3).

The World Health Organization, in its now-famous report on the causes of cancer, suggests that the vast majority of cancers are broadly environmental in origin; industrial cancer among workers contributes significantly to this. Thus occupational health problems are suspect a priori as a cause of Hudson County's high cancer toll.

Eighty-five thousand workers in 1,728 manufacturing plants in Hudson County make up a hefty ten percent of New Jersey's industrial workforce. The County's industries range from the refineries of Bayonne, to the sprawling electronics plants of Kearny, to the garment sweatshops of Hoboken and West New York.

Typically, most of the workforce is concentrated in a relatively few large industries. Of the 1,728 manufacturing plants in the County, only 176 employ more than 100 workers each; this totals almost 65,000 people, over 75 percent of the County's industrial workforce. Among these 176, ten firms employ more than 1,000 workers each. The largest plant in the county, by far, is the Western Electric plant in Kearny, one of the manufacturing arms of ITT's Bell Telephone system, which employs 14,000 people (4).

**Questionnaire**

Health/PAC mailed questionnaires to all the 176 manufacturing plants in Hudson County with 100 or more workers and to about half (207) of the 396 plants with 26-99 workers, for a total of 383 inquiries.

The questionnaire asked for the names and addresses of physicians to whom the company regularly referred employees with on-the-job medical problems.

It also asked about medical personnel and facilities available within the plant. Because doctors outside the plant are generally less acquainted with the production process than in-plant personnel, they are less likely to notice patterns of injury from a particular worksite or early signs of toxic exposure. Thus availability of medical personnel within the plant provides at least a potential for early detection and prevention of occupational hazards.

The questionnaire was mailed to the personnel director of each plant at the address listed in the industry directory of the U.S. Commerce Department's publication on County Business Patterns (4). In many cases the name of the personnel director was known from the New Jersey Industrial Directory (5). (The letter was mailed directly to the medical director if such a person was listed in the Directory.) In some instances, if no response was received within ten days, the surveyor called and administered the questionnaire by phone.

Forty-five of the 383 plants queried (12 percent) had closed down or moved since the 1974 industrial directory had been compiled—a disturbing commentary in its own right. Of the remaining 338 plants, 137 responded, yielding an overall response rate of 41 percent; this is considered quite good for a mail questionnaire. This high rate was probably due in part to the great public concern—and many legislative investigations—then current on the state's high cancer rate and its relationship to industrial exposures. The response rate was best for large companies and poorest for small ones.

A breakdown of the response by company size is given in Table 1. All ten manufacturing plants with a thousand or more employees responded. Only seven firms, most of them small, refused outright to cooperate. One of them, White Chemical in
Table 1

Response to Questionnaire by Plant Size

<table>
<thead>
<tr>
<th>Number of Employees in Plant</th>
<th>Number of Plants Listed</th>
<th>Number of Questionnaires Sent</th>
<th>Number of Plants Closed</th>
<th>Refused to Cooperate</th>
<th>Number of Responses</th>
<th>% Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over 1000</td>
<td>11</td>
<td>11</td>
<td>1</td>
<td>0</td>
<td>10</td>
<td>100%</td>
</tr>
<tr>
<td>100-1000</td>
<td>165</td>
<td>165</td>
<td>22</td>
<td>2</td>
<td>79</td>
<td>55%</td>
</tr>
<tr>
<td>25-99</td>
<td>396</td>
<td>207</td>
<td>22</td>
<td>5</td>
<td>48</td>
<td>26%</td>
</tr>
<tr>
<td>Total</td>
<td>572</td>
<td>383</td>
<td>45</td>
<td>7</td>
<td>137</td>
<td>40.5%</td>
</tr>
</tbody>
</table>

Bayonne, was involved at the time in litigation over a welding accident in which an employee was killed.

In-Plant Medical Personnel by Plant Size

The distribution of medical personnel by plant size is given in Table 2.

Large plants (more than 1,000 workers): A total of 15 doctors were employed on a full- or part-time basis by the ten plants employing more than 1,000 workers each. Eight of these doctors worked at the large Western Electric plant in Kearny. Two of the ten plants employed full-time, in-plant doctors and nurses; six used part-time, in-plant doctors and full-time nurses. Two plants, with 1,800 and 1,015 workers each, used only part-time medical personnel.

Intermediate plants (100-1,000 workers): Fifty-one of 79 responding plants in this category (65 percent) employed neither full- nor part-time medical personnel of any kind. Two had full-time doctors (one of these was a drug manufacturing plant with 160 workers) and three had part-time doctors. Thus of 79 plants, only five (six percent) had in-plant physicians, full- or part-time. Ten (13 percent) had a full-time nurse; nine (11 percent) listed first-aid trained workers as their in-plant resource. Thirty-two plants cited one physician to whom they made outside referrals; 15 cited more than one.

Small plants (25-99 workers): None of the 48 firms responding in this category had any in-plant medical personnel, either full- or part-time. Eleven companies referred their workers to a particular doctor outside, and three listed more than one.

Seventy-eight percent of the combined total of small and intermediate sized plants (99 of the 127) had no in-plant medical personnel—either doctors, nurses or others, full- or part-time. It seems reasonable to assume, further, that the firms which did not respond to our questionnaire had similar, if not poorer, medical programs than those which did. Thus the absence of in-plant medical personnel is widespread in Hudson County. Factories of small and intermediate size have virtually no potential for the early detection and prevention of occupational hazards, except for the most obvious problems.

OSHA findings show a particularly high injury and illness rate among intermediate size firms, a fact which appears to indicate a particular need for in-plant medical services. Injury and illness rates among intermediate size private sector firms run 50 to 100 percent higher than those for very small firms (less than 20 workers) (6). About 25 percent of all intermediate size private sector firms (100-1,000 employees) reported rates of 10-19.9 injuries and illnesses per 100 workers in 1975; about 15 percent reported 20-49.9; and about 1.5 percent reported 50 or more (7). Thus a factory of 500 workers reporting a rate of 35 injuries or illnesses per 100 workers will have 175 incidents of illness or injury a year requiring more than first aid treatment, or three to four incidents a week. (Undoubtedly the rate for Hudson County

Table 2

In-Plant Medical Personnel by Company Size *

<table>
<thead>
<tr>
<th>Size</th>
<th>Number of Plants Responding</th>
<th>Number of Full-time MDs</th>
<th>Number of Part-time MDs</th>
<th>Number of Full-time RNs</th>
<th>Number of Part-time RNs</th>
<th>Number of Plants stating &quot;First Aid&quot; Personnel</th>
</tr>
</thead>
<tbody>
<tr>
<td>More than 1000</td>
<td>10</td>
<td>4</td>
<td>11</td>
<td>10</td>
<td>25</td>
<td>2</td>
</tr>
<tr>
<td>100-1000 workers</td>
<td>79</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>14</td>
<td>9</td>
</tr>
<tr>
<td>25-99 workers</td>
<td>48</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

*Some plants have medical personnel in two or more categories
is much higher since these figures pertain to all private sector firms; manufacturing firms are only a small fraction of these and traditionally have a much higher injury and illness rate (8).

**Workers Compensation Clinics**

Clinics and group practices are nothing new to occupational medicine. They frequently serve small companies which cannot afford their own facilities and play an especially important role in the determination of workers' compensation cases. Thus 35 (28 percent) of the responding small or intermediate size plants listed clinics as their medical resource.

Surprisingly, however, the majority of these plants used the two northern New Jersey clinics of their insurance carrier, the New Jersey Manufacturers Insurance Company! Since the clinics are run by the insurance companies that may later contest workers' claims, it is fair to wonder what kind of care they render and what kind of trust they engender among their worker-patients. A worker sent to such a clinic can only have an adversary relationship with the doctor.

**Profile of the Doctors**

The names of 88 doctors were obtained from the questionnaires. This is less than the total number of responses (137) because some respondents did not give the doctors' names, but listed instead the extent of their utilization and their specialties.

Each doctor's age, specialty board certification, if any, and stated medical specialties were obtained from standard directories (9). Stated specialties are areas of practice in which doctors have declared their interest, as reported in the American Medical Directory. Doctors need not be board certified—that is, have passed a professional examination—to practice in their stated specialty. (The categories of specialty board certification and stated medical specialties were of particular interest because they give evidence of two important qualifications for doctors who treat workers for job-related medical problems: medical training and interest in the field of occupational safety and health.)

Nineteen of the 88 doctors (22 percent) were not listed in any directory, presumably because they had moved or retired. The listed doctors as a group tend to be rather old, although they are slightly younger than the median for all physicians listed by the Hudson County Medical Society (59.3 years compared to 60.4). This pattern of older doctors typifies older, urban areas.

**Specialty Board Certification**

The medical profession has a long-standing method of certifying expertise. Experts in the various fields sit on committees whose function is to determine minimum special education and training requirements for certification in particular medical specialties. Doctors who meet these special requirements and pass an examination are certified by their peers as qualified specialists ("board certified") in the field. Medical specialties are subdivided by the American Board of Medical

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**Hudson County is Not Alone**

In view of the striking lack of in-plant medical personnel and the limited training of industry doctors in occupational diseases in Hudson County, we sought to check these results, roughly, in two other counties near New York City: Nassau and Westchester Counties. Daniel Goldstein and Stuart Kurz of the Division of Urban Planning at Columbia University conducted these studies.

Nassau County, east of New York on Long Island, is both an industrial area and a bedroom county for New York City. With a total population of 1.5 million people, the county has 232 factories of 100 or more employees, with 102,000 employees working in them. In a small scale study with a mailed questionnaire, a small plant (100-1,000 employees) response rate of 17 percent and a large plant (over 1,000 employees) response rate of 50 percent, no plant with less than 500 workers reported any in-plant medical personnel or any medical facilities other than a first-aid kit. Larger plants reported in-plant nurses and/or doctors. Of 4,000 doctors in Nassau County, only one was board certified in occupational medicine, and only 29 stated occupational medicine as a specialty, according to the appropriate medical directories (9). The average age of these doctors was 68 years, and only 10 of them were still active in practice at last report.

Westchester County, north of New York City, is both a bedroom county for the city as well as a newly industrialized area of light industries based on specialized technology. Its trends were similar to those of Nassau (and Hudson) Counties with plants of less than 500 employees having no or few in-plant medical personnel, and the larger ones with nurses and/or doctors.
Specialties into Surgical Specialties (such as General Surgery, Neurosurgery, Obstetrics and Gynecology), Medical Specialties (such as Dermatology, Internal Medicine, Pediatrics) and Other Specialties (such as Radiology, Occupational Medicine, Public Health.)

Board certification is not required in order to practice in most specialties. Board certification signifies both advanced training in a field and a degree of interest in it. It does not, however, guarantee a broad view of medicine or treatment of the patient as a whole; indeed, many specialists tend to give narrow, fragmented care.

To become board certified in occupational medicine, a physician, after medical school, must complete at least one year of academic study in preventive or occupational medicine, at least one year of residency in occupational medicine, and at least one year of experience in the field (10). The academic year in almost every program emphasizes training in epidemiology, the study of the occurrence and determinants of disease in humans, as well as learning the symptoms and treatment of occupational illness and injury. These skills are paramount in the early detection of hazards and discovery of their relation to the workplace, from which preventive programs can be developed.

The most striking observation about the 88 doctors identified in the survey is that only two are board certified in occupational medicine. Both of them work at the 14,000 person Western Electric plant in Kearny. Employers of the remaining 65,000 manufacturing workers in Hudson County covered by this survey did not provide access, either on an in-plant or referral basis, to a board certified occupational medicine specialist. (Responding firms which did not name their doctor gave no indication that their in-plant or referral doctors were specialists in occupational medicine.)

Another 26 of the 88 doctors are board certified in other specialties. Thus specialists comprise 32 percent of all company doctors, comparable to the 30 percent figure for all members of the Hudson County Medical Society (11). Of these 26, 17 (65 percent) are certified in the surgical specialties, equipping them to treat the many traumatic injuries of the workplace.

Only five doctors, however—the two certified in occupational medicine and the three in internal medicine—are specially-trained to treat the cancers of internal organs, the lung diseases and the other occupational diseases of mounting public concern today. Three of these five are employed in the Western Electric plant. The two dermatologists also attend to a specialized, but important class of occupational diseases. In short, only a small minority of the minority of company doctors who are board certified in Hudson County are specialized in the critical areas of occupational disease.

These small numbers by no means reflect a
in the critical areas of occupational disease.

These small numbers by no means reflect a shortage of specialists in areas related to occupational disease in Hudson County, however. On the contrary, there are 25 board certified internal medicine specialists in Hudson County, only three of whom were utilized by the companies in the survey (see Table 3). By comparison, companies utilize five out of seven orthopedists and six out of nine eye doctors.

The nature of the medical personnel they select indicates that companies have given priority to the treatment of traumatic injuries, rather than to occupational diseases. While the traumatic nature of injuries demands medical personnel who can respond promptly, this is no justification for indifference to slower-acting occupational disease. A minimal commitment to this area suggests the need for occupational physicians and/or disease specialists, at least on a referral basis.

**Stated Medical Specialties**

The picture with respect to stated medical specialties is not reassuring either. These listings in the American Medical Directory indicate a doctor's specialty, irrespective of specialty board certification. This provides a picture of how non-board certified doctors view themselves and their practice.

Doctors are allowed to list a primary and secondary stated specialty. Forty-one of the nonboard certified Hudson County doctors, declaring a total of 56 specialties, were listed in the American Medical Directory (see Table 4). All 41 practice occupational medicine, according to company reports, yet only seven listed occupational medicine as a primary or secondary specialty. This is hardly an indication of keen interest in occupational medicine. As with board certification, many more doctors state surgical than medical specialties.

**Professional Society Membership**

Professional membership of the company physician provides further evidence of a lack of interest in this field. The American Occupational Medical Association (AOMA—formerly the Industrial Medical Association) is the foremost professional society in this field. It is the only association expressly for industrial physicians and it publishes the Journal of Occupational Medicine, the most widely-read journal in this field. Of the 88 company doctors named, only seven belonged to the AOMA, three of these from the Western Electric plant in Kearny.

**Will the Real Company Doctor Please Stand Up?**

Three salient features emerge from the Hudson County study:

- In-plant medical services for most Hudson County manufacturing workers are severely limited. The ten largest companies, employing about one-third of the County's manufacturing workforce, all have in-plant personnel on a full- or part-time basis. The remaining small and intermediate size firms, however, have little or no in-plant personnel, full- or part-time.
- The wide use of insurance company controlled clinics is a surprisingly frank expression of the politics of occupational health.
- The board certified specialists in the company doctor population are mostly injury-oriented, surgical specialists. Few are board certified in occupational medicine or in disease-related specialties.
- These practicing company physicians also evince little interest as a group in the field of occupational health and safety, as evidenced by their lack of formal training in the field, their lack of stated specialty interest in the field, and their lack of involvement in the professional society of the field.

Thus the study shows that physicians practicing occupational medicine lack training, not to mention apparent interest in the field. This finding is as much a reflection of company commitment, interest and priorities in addressing problems of occupational health as it is those of the individual physicians. In either case, the consequence for the workers is the same.

(The next step in this study is to examine the actual practice of company physicians and how they manage the tension involved in trying to serve their company and their worker-patients. This will be the subject of subsequent reports.)

—Glenn Jenkins and David Kotelchuck

**References**

7. Ibid., p. 3.
8. Ibid., p. 2.
fer, excellent forums for exposing and protesting the current balance of priorities and power in the health system.

If health activists approach HSAs neither as sources of power nor as bastions of an apolitically conceived progress through "planning", but as rare public rituals for the exposure of health care business as usual, they may find they are on to something.

Success in using HSAs, rather than being used by them, requires a strategy broader than the HSA itself. It requires articulating a vision of humane health services that can counter the ideology of regional monopoly. It requires the hard task of building dozens of local political bases broad enough to take on vested interests that currently dominate so much of the nation's health care regions.

Within such an agenda, HSAs can become vehicles for attacking the ideological and political hegemony of acute-care, high-technology, corporate medicine. This ideology equates quality with Star Wars gadgetry and diverts public hope and attention from the difficult task of prevention, with its many ramifications for social and political change, to the tantalizing illusion of a "technological fix." Such a progressive agenda is only likely to arise in the context of a public health approach that begins with public need, including needs for accountability and control, rather than beginning with providers' products and working backwards.

Finally, to seize this potential ultimately points to a real and deliberate break with an ideology that mirrors that of the providers—the ideology of consumerism. Besides falsely pitting the majority of users against the majority of health workers, consumerism inhibits the development of a truly public health agenda. The latter views health not as a commodity to be consumed by essentially passive consumers but as the outcome of creative activity. Caring for the sick is seen not as peripheral to production but as central to humane social organization. And health resources are treated not as scarce forms of private property but as public treasures.

It is perhaps on this ideological front, and towards this task of breaking the hegemony of the prevailing system, that efforts expended on local HSAs represent the most worthwhile objects of health activism.

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

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LA/HSA: Operation Successful, Patient Dies

The following article highlights the events surrounding the rise and fall of the Health Systems Agency of Los Angeles County, beginning in 1976 and ending with the agency's decertification in 1978. It is a story of three years of political intrigue, and of abortive attempts to reform an agency characterized by incompetence, patronage, racism and corruption. The author, Mark Kleiman, was employed as a Senior Planner by the HSA/LA and played a key role in the struggle surrounding its ultimate demise.

Los Angeles County defies description—at least in polite company. Its 7.1 million residents make it more populous than 42 states. Its residents are governed by a powerful five-member Board of Supervisors, each representing districts of between 1.2 and 1.7 million people. A highly mobile area in which more than half the county residents are renters, it has a strong third world flavor: 19 percent of its residents are Chicano, nearly 15 percent Black and the Asian population is rapidly growing.

The haphazard development of the region is mirrored in its health care sector, which features slightly over 200 general acute care hospitals sharing 30,000 beds. A substantial number of hospitals in the county are small, proprietary facilities, many of which are owned by chains such as American Medical International and National Medical Enterprises. The division between voluntary and proprietary has created two separate provider alliances: the Hospital Council of Southern California, representing voluntary institutions, and the United Hospital Association, representing the proprietaries. The Kaiser-Permanente empire, with over four million members throughout southern California, represents another strong force in the area. Blue Cross plays a relatively minor role, controlling less than 18 percent of California's insurance market. The presence of over 300 health insurers throughout California compounds this pluralistic network of health care providers and purchasers.

The wreck of the HSA/LA was a likely outcome given the course earlier charted for health planning in Los Angeles. Its predecessor, the Comprehensive Health Planning Council (COMP-LA), had followed the model of industry-dominated health planning efforts around the nation, conducting earnest studies of marginal topics while ignoring LA's spectacular overbedding problem and leaving untouched the major univer-

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sity medical empires of the region.

Yet COMP-LA exemplified industry domination with a "human face." Los Angeles' politics had been profoundly shaken by Black and Chicano rebellions in 1965 and 1970, leading to the construction of a large county hospital in the ghetto and the absorption of many minority activists into county government and regional planning bodies such as COMP-LA. COMP-LA was only one of a series of public agencies, however, which ostensible community leaders sought to use for personal gain. Substantial patronage opportunities were exchanged for political quiescence.

This historic compromise was well symbolized by one such community leader, Caffie Greene. A protege of the powerful LA County Supervisor Kenneth Hahn, Greene traded on her image as a Black community leader to attack other activists and used her political connections to build a patronage machine in south LA. Thus she bitterly opposed a 1973 strike by the Interns and Residents Association over patient care issues at the new Martin Luther King Hospital. Although the doctors refused a pay increase in favor of creating a patient care fund, she accused them of seeking to line their own pockets. The charge appears more true of Ms. Greene, however, who in 1968 was convicted of two counts of felony forgery for cashing the payroll checks of the teenage employees at the federally-funded Teen Post she directed.

Greene's work for Los Angeles County Supervisor Kenneth Hahn earned her an appointment to the COMP-LA board, whose Personnel Committee she chaired. In a pattern that was to become all too familiar, personnel decisions were made on patronage grounds. Her hand-picked Executive Director was ultimately convicted of embezzling $17,000 of COMP-LA funds.

Health planning in Los Angeles has been so ambiguous that it became a political Rorschach test in which each different interest group perceived a means of advancing or protecting its own interests.

The Comprehensive Health Planning Council was only one of a series of public agencies which ostensible community leaders sought to use for personal gain. Substantial patronage opportunities were exchanged for political quiescence.

Genesis

With the passage of PL 93-641, COMP-LA slipped quietly out of existence. Three contending forces applied to become the new Health Systems Agency: the forces behind the old COMP-LA, the LA County government, and a private coalition called simply the "Steering Committee." Few took the COMP-LA application seriously. Its administrative scandals and planning failures were highlighted by its inability to intervene in the construction of a new 1,100 bed hospital in Beverly Hills despite the more than 10,000 excess beds which already existed in the County.

LA County sought to run the HSA directly as a branch of county government. Some liberal activist observers favored this arrangement, believing that county government could at least be held accountable. This, they argued, represented a substantial improvement over COMP-LA. Others were suspicious of the county's plans to slash the budgets of its own public health and hospital services and hoped an independent HSA could be used as a forum to oppose such cutbacks.

Center stage was held by the Steering Committee, a peculiar hybrid of consumer and provider groups whose only common denominator was a distrust of county government. The Committee was dominated by the Hospital Council and the LA County Medical Association. Provider associations, fearing they would be unable to adequately control a county-run agency, bankrolled the Steering Committee. The Hospital Council also provided generous amounts of "technical assistance," going so far as having its director draft the by-laws for the proposed HSA, and its attorney codify them.

Consumer members of the Steering Committee represented a variety of interests. Health planning in LA was so ambiguous that it became a political Rorschach test in which each different interest
NOT WAITING FOR GODOT

Summer 1979. This round of National Health Insurance proposals, Kennedy vs. Carter vs. Long, may do its part to unmake or remake a President in 1980. Yet any NHI, even if passed by then, is unlikely to help anyone before years into what might come to be called the “We Decade” of the ’80s. Who can continue to afford pure “Me”-ism?!

Contrary to the plethora of general Washington reporting on health policy, actors and forces have not been lined up all these years simply stancing and waiting for the Godot of NHI. Now graying-at-the-temples, a boyish Senator Edward Kennedy introduced his first NHI bill in the mid-60s for total federal coverage. It has been a long time and, into the 70s, mostly downhill since. (See, e.g., “Washington: Death Against Taxes,” Health-PAC Bulletin, No. 81/82, Spring 1979.)

Leading NHI contenders—Carter and Long’s “catastrophic”-plus and Kennedy’s “private-guaranteed” proposals—have staging or delay mechanisms that make them pretty much 1984 Plans at best. The country seems stuck in an era of nervous political rumbles more to the Right than to the Left and featuring an evasively new personality-pondering definition of the Democratic Center. Which man would you most trust to trim your standard of living: Jimmy, Teddy, or Jerry?

Across the Capitol landscape, hundreds of coalitions, campaigns, committees, and caucuses generate a paper mountain of staff testimonies and press releases regarding, among other things, people’s health concerns. Meanwhile, the “Grand Coalition”—Labor, Civil Rights, and Liberals, focused on the Departments of Labor and HEW’s committees and processes—is under frontal attack from the Right, along with its agenda of social expenditures for health and federal regulation for health protection.

The reality is that labor, minorities’ social expenditures, women’s rights, and environmental-occupational protection advocates have been thrown on separate, specialized defenses which threaten the kind of day-to-day spirit, not to mention occasional positive social outcomes, associated with broad and deeply-rooted coalitions.

Out of this gloomy landscape, can we at least distinguish “peoples’ segments” of the “Health Lobbies” in Washington today?

The newer progressive entries affecting health politics in this tangled political setting include:

(1) **Realignment meta-coalitions**, notably the United Auto Workers-convened Progressive Alliance, the Machinists Union-initiated Citizen-Labor Energy Coalition (CLEC) and Consumers Opposed to Inflation in the Necessities (COIN);

(2) **Health-issue coalitions**, such as Consumer Coalition for Health, Urban Environment Conference and Coalition for a National Health Service, and activist linkage projects such as Public Citizen Health Research Group, National Health Project (NHELP), the National Rural Center, Rural America, Environmentalists for Full Employment, Women for Environmental Health, Feminist Anti-Nuclear Task Force, and the Public Resource Center; and,

(3) **Interest caucuses and networks**, such as the Black Congressional Caucus, with its “Health Brain Trust,” and the Na-
tional Women’s Health Network.

The Consumer Coalition for Health is a growing, AFL-CIO-endorsed, subsistence-funded, activist organization and network with strong principles about “system-blaming” and not victim-blaming regarding causes of illness. It concentrates on consumer, disadvantaged, and civil rights issues in current health planning (HSAs), including this year’s renewal legislation and amendments battles. “We’re not really equipped and funded to be lobbyists as such and can only concentrate on one emergency issue affecting our most essential purposes,” says Executive Director Mark Kleiman.

There are striking limits to the more established public health expenditure-oriented organizations whose full-time purposes revolve around public representation. For example, the American Health Planning Association (AHPA), trade association of many of the health planning agencies, including HSAs, across the country, has come under recent criticism for its narrow lobbying stance, and a new Progressive Caucus has formed among consumer-oriented planners within it.

The Urban Environment Conference seeks to bring together environmental, labor, civil rights and social justice organizations around unifying issues, notably occupational and inner city health environments. Its Director, George Coling, is a promoter of uniting health care and broadly preventive environmental concerns. Yet he sees traditional organizational barriers to broadly convergent efforts reflected in Congressional subcommittees and fragmented federal agencies themselves.

Except on a strained “inter-staff communications level” in Washington, one sees little of such outreach even among Labor-backed national health insurance or categorical health funding advocates.

The newly-organized Consumers Opposed to Inflation in the Necessities (COIN) side-stepped advice to emphasize the social and human costs of industrial pollution, and stresses instead a rather traditional emphasis on medical care insurance and regulation, only mentioning “preventive care” in passing. The potential for a broader preventive and environmental health coalition has moved very slowly around established health and environmental organizations.

Omnipresent, however, are the independent, pro-consumer, anti-corporate, and increasingly “alternate-economy” Nader-sponsored networks of public interest organizations, based in local and state Public Interest Research Groups (PIRGs). At the national level, the Public Citizens Health Research Group has pushed occupational-environmental, drug industry regulation and health planning activities. Congress-watch and Critical Mass (the latter a national anti-nuclear group leader that sparked the post-Three-Mile-Island, May 6, “No Nukes” mobilization of 125,000-plus to the Capitol steps) are other Nader offspring. Practical, issue-substantive, increasingly independent of Administration and Democratic Party political framework, and more recently committed to transforming the corporate-economy, this public interest legion has, nevertheless, found no unifying health services and environmental health line.

Meanwhile, of course, federal expenditures for preventive and primary health services are scrutinized and cut and $10s of billions in federal subsidies are being poured into the creation of illness. The latter includes a number of the measures aimed at “Energy Independence,” including synthetic gas development, as well as already committed nuclear power and fossil-fuels-as-usual—all of which can be projected to generate thousands of future cancer deaths resulting from production alone.

The convergence of health and survival issues, broadly speaking, may yet spawn a leftish third party for the 80 Presidential chase. A Citizens Party is currently forming with national health service advocate Ronald Dellums and antinuclear champions Barry Commoner and Ralph Nader as possible front-runners. But progressive policy outcomes cannot be expected anytime soon.

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The convergence of health and survival issues may spawn a leftish third party for the 1980 Presidential race. Barry Commoner and Ralph Nader would be front-runners

Where does this leave the "people's health lobby"? Paradoxically, it is yet thwarted by symptomatically reactive politics, smoke-screened by a Recession/Stagflation economic environment. It’s hard to organize while you’re busy ‘Queing in the Pollution.’

The contradictions of oil prices, nuclear power and petro-chemical industry dangers may yet serve to make energy and environmental policy the subject of effective frontal attack from a range of public interest consumer and environmental groups, already dramatically punctuated by militant anti-nuclear action. If only these hopeful signs of protest weren't matched by deeply troublesome backsliding about equalitative and qualitative issues on a national policy level; if only populists local organizing weren't connecting nationally only sporadically through individual advocates . . .

—Robb Burlage
HHC KILLS ITS OWN

The Koch administration's Plan for Improving the Effectiveness of Hospital Services in New York City, released by the Mayor's Health Policy Task Force on June 20, 1979, has served to mobilize and unite a wide array of community, labor, religious and professional groups in New York City. The Task Force Report represents the culmination of the Mayor's eight-month effort to cut back public hospital spending (See Health/PAC Bulletin, Triple Issue). The thrust of the report is clearly aimed at the Health and Hospitals Corporation (HHC), closing nine percent of municipal hospital beds. The Plan's basic recommendations would result in estimated savings in the municipal hospital budget of $30.5 million in 1981 and $47.8 million in 1983. The Task Force recommendations include:

- Close Metropolitan Hospital in East Harlem and Sydenham Hospital in West Harlem, while maintaining the psychiatric facility at Metropolitan.
- Establish an outpatient facility at the Metropolitan site operated by the Department of Health.
- Either merge or negotiate a management contract for North Central Bronx Hospital with Montefiore and for Queens Hospital with Long Island Jewish Hospital and eliminate 140 beds from Queens Hospital.
- Open Woodhull Hospital in July, 1981, simultaneously close Cumberland and Greenpoint Hospitals in Brooklyn and shrink Kings County Hospital by 297 beds.
- Reorganize the outpatient facility at Gouverneur Hospital in Lower Manhattan by turning it over to the Department of Health.
- Close eight voluntary and two proprietary hospitals, and reduce three others in size. (This requires the Governor's approval.)

The HHC Board of Directors' decision to rubber stamp the Task Force Report only one week after its release was not surprising. Several ex officio members of the HHC Board were also members of the Task Force, and much of the staff work on the report was provided by HHC's own Office of Planning. Approval was voted by the Board despite calls for a postponement until the Report could be reviewed and its recommendations debated.

The Task Force ignored the planning process required by the HHC Incorporation Act. The Act requires both public hearings and consultations with the HHC Council of Community Boards before such plans can be implemented. Even Victor Gotbaum, Executive Director of DC 37 and normally considered a part of the City's political elite, was outraged by the Task Force's sleight of hand: "The unions were not consulted," he said, "the State and the community groups were shut out, and at first not even the Health and Hospitals Corporation Board was consulted."

Meanwhile, the Mayor's so-called "rational plan" has been assailed by community and labor groups, and political critics of all persuasions. According to the recently formed Coalition for a Rational Health Policy for New York City, "The report fails to demonstrate that the plan will achieve its goals of improving the efficiency and quality of the municipal hospital system, of maintaining access to needed services or of yielding significant budgetary savings to the City."

A preliminary analysis of the Report completed by the Coalition found that the Report failed to identify the health needs of communities affected by its recommendations. The Coalition determined that the methodology used by the Task Force was biased against municipal and voluntary hospitals that serve
large numbers of Medicaid and self-pay (non-insured) patients. These hospitals carry substantial operating deficits as a result of low Medicaid reimbursement.

The Coalition also found that the Report failed to show to what extent the monies gained from closing hospitals and eliminating beds would be offset by increased city expenditures for the care of the medically indigent in other facilities. The Report assumes a willingness and capacity on the part of other municipal and voluntary hospitals to absorb and accept Medicaid and self-pay patients. However, some voluntary hospitals teeter on the brink of bankruptcy because they serve a high percentage of these patients. Moreover, all HHC facilities have been hit with budget cuts of up to 10 percent which will significantly hinder their capacity to accept an increased workload.

The Report's own calculations project a net loss of over 400,000 ambulatory care visits in the municipal hospital system and a loss of more than 98,000 visits in the voluntary sector as a result of proposed bed reductions and closures. These reductions are proposed despite the recent substantial cut backs in DOH services and despite the fact that 2.3 million New Yorkers live in areas designated as lacking adequate ambulatory care.

Whatever time, resources and expertise were spent in developing the Mayor's Report were basically used to justify two major policy recommendations. The first major recommendation is the long-standing attempt to "voluntarize" the municipal hospital system. Voluntarization is accomplished in two ways: first, by moving toward direct management contracts or outright merger with voluntary institutions; and second, by emphasizing tertiary level inpatient services in the remaining public hospitals and consolidating these services into larger institutions. The increased emphasis on high technology, high cost care will have little value for the majority of patients who need and seek out primary health care.

The second major policy direction is the transfer of operating responsibility for provision of ambulatory care to the New York City Health Department. Based on the experiences of other cities such as Newark, Denver and Detroit, this transfer has much to recommend it (See Health/PAC Bulletin, January/February 1978). However, in the context of the Task Force Report, this proposed move could be hazardous to the health of New Yorkers. The projected size and funding for the two proposed ambulatory care facilities (at Metropolitan and Gouverneur) underestimates expenses and overstates potential revenues. Some observers fear that the limited funding which would be provided to the already beleaguered Health Department for this expanded service responsibility makes this direction untenable.

If they are implemented, the Task Force's recommendations will result in an effective dispersal of responsibility for the delivery of health services in New York. The Report's twofold movement toward voluntarization and the Health Department takeover of ambulatory care reflects Koch's prevailing ideology that the city has only a limited capacity for serving its citizens. As a New York radio station recently editorialized, "From the day he took office, Mayor Koch has made it very clear...that as far as he is concerned the minorities and poor of New York do not rank very high on his list of priorities. New York's century-long tradition of offering social services to the poor is about to suffer an abrupt jolt if the Mayor's plan becomes a reality."

The fundamental assumption of the Koch administration plan is that the poor and minorities most affected by the proposed cuts in hospital services and the workers who provide these services cannot muster the political clout to mount an effective resistance. In the aftermath of the HHC Board vote, however, implementation of the plan is being contested.

Community and union activists have established a steering committee to coordinate demonstrations in each of the affected communities. The Coalition for a Rational Health Policy has managed to bring together a broad spectrum of groups and has appealed to people not traditionally devoted to the cause of public health services. It has proposed a moratorium on closings in the public and the private sector until a rational plan is developed. The Religious Committee on the New York City Health Crisis has also urged that there be a moratorium on closings of hospitals or cutbacks in health services until a plan is developed in an open and democratic manner. Community Action for Legal Services, Inc. has instituted a number of law suits in behalf of the HHC and action by NAACP Metropolitan Council of Branches has resulted in an investigation by HEW's Office of Civil Rights (OCR) of possible discriminatory implications of the cutbacks under Title VI of the Civil Rights Act of 1964. OCR's preliminary report confirmed that the information collected thus far "indicates that minorities will be adversely affected by the closures in such a manner as to constitute a violation of Title VI."

All of these actions are currently geared toward organizing a political constituency for health in the city. A real issue in the next few months will be how well these groups can reach, educate and activate a much broader constituency. What remains to be seen is whether this level of energy and organization can be sustained over time. Winning depends on it.

—Rick Supin and Doug Dorman
The twin shocks of the Three Mile Island accident and gasoline shortage have driven the energy issue home in personal terms. The nuclear dream of “electricity too cheap to meter” has turned into a nightmare of high costs and higher risks. Can gas line sitters, in their despair, be persuaded to give nuclear power another try for a promise of greater availability of oil? Not unless they can forget the unsettling image of Pennsylvanians being forced to flee their homes that might have become uninhabited ghost houses for generations. The horrors of the nuclear path are now burned deep into our national political consciousness and personal fears.

Moreover, evidence continues to emerge which points up the connection between social relationships and political decisions and individual health problems. Soldiers exposed to nuclear bomb tests have made the connection between their cancers and their experiences as military guinea pigs. Similarly, communities in the path of the fallout now find themselves confronted with research offering evidence of elevated cancer rates. All are calling for compensation; their lives having been devastated not by a faceless germ but by a hazard aimed at them by their government—which was then covered up.

Due perhaps to radiation’s invisibility or its link to cancer, many, including those familiar with the scientific debate, find terms such as “threshold” or “safe level” dubious. Some respond to its horrors with fatalism; others, in growing numbers, express the desire to remove the threat altogether. For this latter group, attempts to deal with the threat bring them directly to the door of the corporations and the government. For unlike the threat from rootless germs, these diseases have an address at the corporate headquarters and government agencies of the land.
Nuclear Arrogance

Corporate and governmental spokesmen have made an overwhelming contribution to the anti-nuclear movement with their colossal arrogance and deceit. Increasingly this arrogance undermines any residual confidence that the threat might be contained by existing structures. The "nuclear priesthood" has begun to resemble a crew of mad scientists, reorganizing society along authoritarian lines, as they try to plug up new leaks in the nuclear dike.

There has been an unbroken line of deception from President Eisenhower's 1953 statement about how to handle the public's doubts about A-bomb testing, "Keep them confused," to the Nuclear Regulatory Commission's attempt to confuse the public about the seriousness of the Three Mile Island accident.

Rather than order an evacuation after Three Mile Island, officials tried to minimize the public impact in the hope that the problem would go away. A mass evacuation might well have meant the end of the nuclear program as it would have driven home the full measure of the threat from nuclear power. Thus the authorities chose to preserve what shreds of credibility they still had for the industry at the cost of playing fast and loose with people's lives. "Which amendment is it that guarantees freedom of the press?" Nuclear Regulatory Chairman Hendrie asked at Harrisburg. "Well, I am against it."

It has become increasingly clear that a beginning stage light water reactor technology, developed in the mid-1950s, was sold to the public as a finished product. In their arrogance, the nuclear industry and the government used the successful experience of a few, small-scale prototype reactors as the justification for the large scale introduction of this technology. Only later have they, and we, learned that the costs and design flaws of running these large light water reactors were way beyond their earlier projections.

Today, the high degree of credibility which had allowed for the premature proliferation of nuclear power plants has all but vanished. A New York Times/CBS News poll taken on April 10, 1979, showed widespread distrust of the government's statements on the Three Mile Island accident, and of the industry as a whole. Only 39 percent of those polled would approve of the construction of a nuclear power plant in their community, while half felt that accidents such as Three Mile Island were likely to occur again.

Yet neither public opinion nor the near meltdown itself has sensitized the industry to the nation's fears. Metropolitan Edison cut the salaries of pregnant secretaries who refused to return to work after the Three Mile Island accident. Who could trust an industry that produces tons of deadly waste without having a secure place to put it?

Political Possibilities

As accidents that "couldn't happen" occur and the cover-ups unravel, the ideological stranglehold of nuclear "theology" becomes severely eroded: growing numbers of people no longer feel safe from the invisible, yet omnipresent radiation threat. Americans are waking up to find their lives and homes threatened by a governmental and corporate enemy; their fears and anger fueled by the growing realization that they have been the victims of a long and cruel deception.

More and more people are beginning to see through the cruelty of a social system that seems to place little value on their lives. Arrogance, deceit, and a rush to reward a nuclear authoritarian order have opened up the public consciousness to visions of a new society which places life and democratic values over profit and fear.

The anti-nuclear movement is beginning to give such visions concrete forms: the struggle to protect one's life and health is becoming a struggle for control over corporations and the government.

Moreover, evidence continues to emerge which points up the connection between social relationships and political decisions and individual health problems.

With the nuclear industry's legitimacy in shambles, and corporate and government credibility reeling, the door is now wide open for such a people's movement to move rapidly forward towards fulfilling its vision of a truly healthy, democratic society.

—Tony Bale
In early March, just as our column on electronic fetal monitoring was going to press, the National Institute of Child Health and Human Development held a Consensus Development Conference on Antenatal Diagnosis. Draft reports and recommendations of three task forces were circulated for comment, and a final report prepared. The task force on predictors of fetal distress focused its attention primarily on EFM.

The final report of the Task Force on Predictors of Fetal Distress will be published shortly. A NICHD summary reported that the task force urged consideration of the use of electronic fetal monitoring for high risk birthing women, including situations where an abnormal fetal heart rate is detected through human monitoring (auscultation). For women of low risk status there is no evidence that EFM reduces mortality or morbidity. The Task Force therefore found human monitoring (every 15 minutes during the first stage of labor, every 5 minutes during the second stage of labor, 30 seconds immediately following a contraction for both stages) to be medically acceptable for these low risk women.

Further recommendations of the Task Force included the use of fetal scalp blood pH determination as an adjunct to electronic fetal heart monitoring on the basis that scalp blood testing may provide additional information that could reduce monitoring-associated cesarean rates; the need for staff awareness of the hazards of EFM; importance of careful placement of fetal scalp electrode and intrauterine pressure catheter to avoid risk of infection; the avoidance of prolonged supine (lying down flat) position of the mother and "unnecessary" limitation of her mobility; the avoidance of routine rupture of the amniotic sac solely for the purpose of inserting an internal monitor.

Although the final recommendations of the Task Force are encouraging, they appear to be somewhat modified from the draft recommendations which were more skeptical of the benefits of EFM for high risk birthing women, took a stronger stand against routine monitoring of low risk women, were more concerned about the effects of intrusive technology on the birth situation as a whole, and did not suggest that all birthing facilities should have EFM available.

The modification of the Task Force recommendations after "public" discussion draws attention once again to the gap between medical practice and medical research, particularly as related to new technologies. As Banta and Thacker point out in their recently published full report on EFM (April 1979), there is a "widely held belief in medicine that more information will lead to a better outcome." The fact that the most scientific studies of EFM have not indicated that the information produced leads to a better outcome—for high or low risk women—has not yet appeared to make a dent in obstetrical practice. If practitioners make medical care decisions based on beliefs rather than scientific expertise, consumers should understand that they stand as equals in this decision-making process.

—Marsha Hurst and Pamela Summey
Bohique is a young and small organization constituted to advance the social condition of Puerto Ricans—on the mainland and the Island—through the means and mechanisms available on the behavioral sciences. We take our name, Bohique, from the Indian who treated behavioral disorders in the Taino culture. We do this in order to stress our commitment to national Puerto Rican values.

Bohique has elaborated the following general objectives to guide our functioning:

a. To include and encourage discussion of social issues in the Puerto Rican behavioral sciences.

b. To group Puerto Ricans in the behavioral sciences with a progressive point of view in order to compliment our knowledge and resources.

c. To critically evaluate significant developments in the Puerto Rican behavioral sciences.

d. To produce original works that will open new theoretical, clinical, or research pathways.

e. To exchange information and coordinate work (including clinical services) with other persons, groups, organizations or institutions wherever it may be judged politically or professionally advisable.

At this point in our short history, we believe it necessary to begin a process of communication and liaison with others who share our concerns. We propose to do this mainly through the Bohique Newsletter to be published three times a year. We encourage readers to submit short original articles, reactions to Bohique articles, book reviews, letters, and opinions for publication in the Newsletter or for our review and study.

We are working toward becoming a center of discussion and ferment for Puerto Ricans in the behavioral sciences. We need the input of all those who share our concerns—we need suggestions, ideas, contributions, reading material, etc. If you have written an article or have read one that for some reason you feel we should be aware of, please write or inform us. We will be glad to correspond and provide our point of view. We wish to serve through Bohique Newsletter as a pulse of interests.

Presently, we are developing a campaign to inform and protest the inclusion of Dr. Arthur Jensen in the editorial board of the Hispanic Journal of the Behavioral Sciences (see related story in this issue's Vital Signs). We believe that the publication of the first Hispanic Journal dealing with the behavioral sciences is a significant and important event and one which we support. Yet, the inclusion of Dr. Jensen cannot be overlooked for his identification with intellectual racism. We urge all progressive individuals and organizations to write and protest the inclusion of Dr. Jensen in the Hispanic Journal.

At this point, we want to let our organization and newsletter be known. We depend on all those who share our interests and concerns. Subscriptions to the Newsletter cost $2 a year.

For further information about Bohique please write to us:

BOHIQUE INC.
P.O. BOX 93
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BRONX, N.Y. 10452

—Jorge Colberg
Jaime Inclan
LA/HSA: Operation Successful, Patient Dies

Greene and Campbell completely undermined the agency’s staff through patronage appointments and left it utterly incapable of discharging basic responsibilities. Finally, they delivered HSA’s governing body into the hands of the medical industry.

Continued from Page 16

...in exchange, the medical industry’s representatives supported most of the patronage decisions, supported HSA give-aways and turned the other cheek in the face of obvious abuses
When the General Accounting Office, the Los Angeles County Grand Jury, the District Attorney and HEW began investigating irregularities, the agency responded in Nixonian fashion by ‘stonewalling’ projects. In turn Campbell and Greene worked hard to deliver the HSA’s governing body into the hands of the medical industry. Of 101 consumers and providers elected to SACs in June 1977, 78 had been endorsed by the industry.

The industry’s key objective was to paralyze the regulatory function of the HSA. Despite repeated requests from the state and a direct order from HEW, Campbell stubbornly refused to conduct Certificate of Need (CON) reviews. He even ordered his Director of Plan Implementation not to train the staff to conduct review activities. With the HSA responsible for more than a third of the state’s medical resources refusing to participate in the program, the already beleaguered state agency staff were spread impossibly thin in an attempt to pick up HSA/LA’s fumbled balls.

Campbell also suppressed staff initiatives. Two senior staffers led an audit of the state agency’s mishandling of hospital applications to be exempted from the review process. Their findings documented how nearly all of the $3.5 billion in exempted projects failed to meet the state’s own criteria—yet were approved anyway. Although Campbell had supported the study, he swiftly ordered the findings suppressed as “too controversial.”

In exchange for sabotage of the agency’s regulatory functions, industry representatives supported most of the patronage decisions. Industry leaders who made vitriolic attacks on the HSA in the midst of other providers were quick to defend HSA giveaways that were criticized at board meetings. Thus while hospital representatives questioned legitimate HSA expenses they rejected an inquiry into the possible savings achieved by hiring a staff attorney—even though the HSA incurred $82,000 in legal fees in its first seven months of operation. They also fell strangely silent when the agency spent $11,000 on a lavish two-day retreat for the staff and outgoing board members.

Other pieces of the patronage pie included an arrangement with attorney Andy Camacho who ran up nearly $200,000 in legal bills in eighteen months while conducting only one major lawsuit to account for his time. Camacho had previously worked for the law firm of a former state assemblyman who was subsequently investigated by the U.S. Senate for using political influence to protect corrupt prepaid health plans which were ultimately shut down after the scandal reached national proportions.

The industry’s disinterest in patronage issues was reciprocated by the Greene machine’s disinterest in planning. Ms. Greene was, however, definitely interested in grants review. Fully designated HSAs are to have review and approval authority over a wide range of federal grants in the health and mental health fields. Although these grants were of little concern to the private sector, they represented a major source of capital in communities like south Los Angeles. Ms. Greene’s friends were on the Grants Review committee and she handpicked the key staff for that part of the program.

The Turning Point

The election of the HSA SubArea Councils proved to be the turning point for the LA/HSA. The Board poured its energy into diverting and destroying what was designed to be a model of representative democracy.

Foreseeing controversy, one key staff member suggested that the entire election be handled by an outside accounting firm with experience conducting similar elections for the County Bar Association. Campbell rejected the advice, bluntly stating, “No, then I couldn’t control it.” And control it he did.

HSA by-laws allowed registration (for HSA membership and thus for voting in the election) by mail and the use of volunteer registrars who might register persons at their homes, community centers or workplaces. The Board countermanded this, requiring instead that those wishing to register come in person to the HSA office—an unreasonable hardship, particularly for the elderly and disabled, in a county as big and devoid of public transit as Los Angeles. Alternatively, those wishing to register could do so at a series of community participation meetings. Thus registering for the HSA election became more difficult than registering for general elections in Los Angeles.

“Community participation” meetings were frequently located near clusters of hospitals which
HSA officials damaged their own cause with overt racism. Their attorney said that 'the Jews and the unions were out to get us' and Greene said she didn’t like most white folks conveniently gave their staff release time to register. Providers outnumbered consumers more than four to one at some of these meetings. Those few consumers who did attend were bored by a droning and highly bureaucratic rendition of the HSA’s responsibilities replete with a slide show featuring slides of typed, single-spaced sheets of paper. In spite of the obstacles, an amazing number of people, nearly 24,000, managed to become registered to vote in the election. Few were surprised when the close of registration revealed that 61 percent of HSA’s members were providers.

Before the election was over, many staff members had become campaign workers for various candidates. Four members of Campbell’s personal staff had locked themselves in a room to put out a mailing for one of the candidates. HSA attorney Camacho had obtained a bulk mailing permit for another, and a temporary employee had been hired to “collect” over 400 “absentee ballots” from voters at their homes.

The election procedure itself featured 1,439 candidates in all, nearly 300 candidates on each SAC ballot—all out of alphabetical order. Curiously enough, the names of candidates on key provider slates were at or very near the top of the list for many individual seats. Since the names of candidates were not alphabetized, and there was only one voting machine in each of the 25 polling places, HSA members had to wait between one and three hours to cast their ballots—a distinct advantage for hospital employees who had been handed employer endorsed slates.

The election results yielded few surprises. Candidates endorsed by professional medical and hospital groups won overwhelmingly against independents for both provider and consumer seats. Commenting on the election, Campbell cryptically noted that “The County Medical Assn. and the Hospital Council evidently got their act together.” By the time the smoke had cleared there were outraged howls from consumers—and lawsuits by the cities of Los Angeles, Torrance and Pasadena seeking to void the election. In the wake of the election, many people were forced to conclude that the agency’s apparent “mistakes” were, in fact, deliberate policy decisions made by Campbell and his supporters. Staff response to this perception took different forms. Some people began to push harder for agency reform; others gave up hope that reform was possible. Two staff members—the author and Richard Walden—occupying key positions within the HSA/LA, drew a more extreme conclusion from the events surrounding the election. Believing reform to be an unrealistic if not impossible alternative, we decided the only hope for change lay in destroying the agency and rebuilding a new one in its place.

As staff members in the agency, Walden and I were in an anomalous position. Prior to joining the HSA/LA we had both been appointed by Governor Brown to several state health bodies and thus were part-time state officials. Originally hired by Campbell to function as a bridge to the left-liberal community, we had been given a free hand to joust with the state over planning and regulatory strategy.

In our attempt to stop the course that HSA/LA had chartered for itself, we decided to capitalize on our freedom within the agency and on our political contacts at the state level. Soon after the election, we were sent to the HEW regional office to transmit to HEW—some budget modification requests we knew to contain false information. Along with the written materials, we also gave the project officer a summary of agency wrongdoing, including election fraud and patronage hiring practices. Within three days, the project officer fully disclosed our confidences to Campbell and Greene.

We also took our case to HSA President Fred Wasserman, director of a small HMO, and perceived to be a neutral figure in these matters. With some coaching, Wasserman began his own investigation, collecting taped and sworn statements from various HSA staff willing to disclose their knowledge of events. Wasserman attempted to convene a board meeting in executive session in order to discuss his findings. Camacho ruled the meeting illegal, however, by deliberately misreading the requirement for open meetings. At this point, Wasserman panicked and turned his materials over to Campbell and Camacho, claiming it his duty to look out for “the corporate interests of the agency.” Unable to make further headway inside the
In response to Campbell's threats, several employees provided the GAO with sworn statements describing his remarks, and pointing out that Campbell was seeking to obstruct a federal investigation. The most damaging information of all, however, was not the corruption and threats but the agency's obvious inability to do health planning—something no amount of coaching could successfully conceal. Indeed, the combined state/federal site visit concluded in November, 1977, that the HSA/LA was not prepared to write a plan or to conduct certificate of need reviews.

**If At First You Don't Succeed**

The next critical hurdle for the LA/HSA was recognition by the State Advisory Health Council (AHC) as the official planning body for Los Angeles County. Between November 1977 and March 1978, the agency applied twice and had been rejected, pending the outcome of investigations of the agency. As HSA/LA began lobbying for approval of its third application early in 1978, community pressure began to build.

As the March 1978 meeting of the AHC approached, letters critical of the agency began pouring in. Directors of other California HSAs, concerned that LA's "pirate ship" image would endanger the credibility of the entire health planning effort, raised the problem at the state and federal levels. As the showdown neared, Walden and I redoubled our lobbying efforts. We worked closely with a small group of city officials, community clinic leaders and Chicano organizers to keep up the pressure. Our efforts met with particular success when the East Los Angeles Community Union, a powerful and well regarded community organization, publicly withdrew its support of the HSA/LA.

To the growing chorus of community protests was added a new voice. The just-completed GAO report was released by Congressman Waxman just two days before the Advisory Health Council met. The report confirmed many of the charges which had been leveled against the agency. Moreover, the GAO, whose mandate does not include criminal investigations, stated that some of the issues raised during their investigation were beyond their purview. The House Subcommittee on Oversight and Investigations announced plans for its own inquiry and requested the GAO to turn its evidence over to the U.S. Department of Justice. Justice announced that FBI would look into the matter.

HSA/LA's lobbying effort was buried by an avalanche of adverse publicity. In March of 1978, to no one's surprise, a committee of the Advisory Health Council voted ten to three to reject the
Meanwhile, HSA/LA board members, sensing that their status as "civic leaders" might be tarnished by the highly visible, conflict-ridden agency, began to form a reform caucus. The caucus crystallized around a conservative insurance executive, Tom Allen, who had developed a reputation for fairness and had cultivated an image of distaste for incompetence. Posing little threat to the medical industry but professing a desire to "clean up the mess," Allen quickly garnered a broad base of support. In an election of Board officers, the "reform" candidates—Allen and Robert Tranquada, associate dean of UCLA Medical School—handily won offices as Vice-President and Treasurer. The handpicked candidate of Greene and Campbell, Phil Wax, was elected President by a single vote. Phil Wax had never been involved in health planning, but had a long relationship with a key HSA political operative and obligingly stacked HSA/LA committees on behalf of the old Hospital Council/Greene machine alliance. Shortly after his election, Wax suffered a heart attack and was temporarily replaced by the reform Vice-President, Tom Allen.

Despite genuine concern over the agency's credibility, the reformers' political naiveté made them no match for the veteran politicos determined to preserve business as usual. The reform caucus let itself be sidetracked by the urging of Campbell to form a blue-ribbon committee to "investigate the GAO report." The reformers took the bait and a five-member committee was appointed. Although the "reformist" Tom Allen chaired the committee, and was backed up by his ally, Robert Tranquada, they were outnumbered and hopelessly outgunned by Caffie Greene and two of her staunchest political allies.

Meanwhile a new HEW project officer, Al Lauderbaugh, had been appointed. He had his own agenda for the blue ribbon committee. In his view, Allen and Tranquada represented the potential for a new board leadership which could effect needed internal reforms of the agency. Consequently Lauderbaugh convinced Allen and Tranquada to stake their reputations on the HSA's ability to reform itself.

Accepting this task, Allen and Tranquada presided over a whitewash of the GAO report. Under their direction, the committee heard an uncontested series of management denials of the GAO findings. The whitewash was approved by the board, and Allen and Tranquada, under Lauderbaugh's tutelage, began to carefully maneuver the agency out of the pit it had dug for itself.

In June 1978, Campbell marshalled old allies in his fourth and final attempt to win official recognition from the state Advisory Health Council. In return for its support, Campbell offered a "re-examination" of CON review criteria to the Hospital Council. The Hospital Council subsequently appeared before the AHC, vigorously supporting the HSA/LA. Simultaneously, LA/HSA's political operatives were busily calling in support from state legislators who owed Greene and Supervisor Hahn favors. Having whitewashed the GAO report, Lauderbaugh, Allen and Tranquada now testified that the agency had been cleaned up. Apparently the Advisory Health Council was convinced. Soon thereafter, it designated HSA/LA as the official planning body for Los Angeles County.

By this time, activists were genuinely demoralized. Few doubted Lauderbaugh's good intentions. Yet it was clear that the HSA responded only to the most extreme pressure and now official state designation had removed that pressure. Some gave up, while others like Walden and myself waited for the right opportunity to expose the agency's leadership.

The Return of the Repressed

With state designation under his belt and Board President Wax recovered, Campbell went headlong for the final victory: full HEW designation for the HSA/LA. With full designation, the HSA would be nearly invulnerable—and would wield authority over tens of millions in federal grants in the county. In direct defiance of orders from Lauderbaugh, Campbell sent two staff members to Washington D.C. to rally congressional support for full designation of the agency by HEW.

Predictably, the two HSA/LA emissaries to Washington grossly misrepresented the HSA's history and status. They lied to Congressman Barry Goldwater Jr., assuring him that nothing was amiss with the agency. They falsely asserted to other congressmen that the GAO had not really found any wrongdoing. Ultimately, these actions boomeranged when angry Congressmen...
besieged HEW and the LA press with charges they had been conned.

Back at home HSA officials damaged their own cause with overt racism. At a farewell party for the HSA Associate Director, Caffie Greene, who had been strangely silent for some months, was unleashed. In her benediction, she allowed that while she didn't like most white folks, in fact she didn't like them at all, the outgoing manager had been good and loyal. For many disgruntled staff-
ers, it was simply too much. With little urging they complained to the project officer, Lauderbaugh. When Lauderbaugh arrived in Los Angeles to inquire into the matter, Campbell offered only a sullen "No comment." President Wax refused Lauderbaugh's request that Ms. Greene be temporarily suspended as chair of the Personnel Committee. It became painfully clear to Lauderbaugh that he had overestimated his ability to control the agency. With this conclusion, he grimly set about documenting HSA/LA's numerous deficiencies, picking up where the community activists had left off months before.

Lauderbaugh's increasingly tough position, however, was concealed from HEW officials. His boss, HEW Regional Planning Chief, Margaret Smith, appeared to be giving only "blue sky" reports on LA/HSA's progress to Health Resources Administration Chief Henry Foley, who had final responsibility for the health planning program. An articulate and dedicated black woman, Smith had been viciously attacked by Caffie Greene for her leadership in the critical state/federal site visit of November 1977. Yet oddly, she reluctantly supported the agency and kept Lauderbaugh's increasingly ominous reports from reaching Washington. Smith's boss, Regional Health Administrator Sheridan Weinstein, maintained a strange silence as well. The motives of these various HEW bureaucrats were not clear. What was obvious, however, was that Foley knew little about the lobbying fiasco or the scandals until informed by angered California congressmen.

Several California congressmen, very disturbed by the agency's clumsy lobbying attempts, requested a meeting with Foley. Congressman Waxman was particularly angered when he received from Walden a damning package of Lauderbaugh's increasingly firm letters to the HSA. Alarmed by the discrepancy between Lauderbaugh's reports and Foley's earlier assurances, Waxman went into the meeting knowing more about HSA/LA's operation than did Foley himself. At the meeting a consensus was quickly reached that HSA/LA would not be given full designation, but another conditional designation. Lauderbaugh was given the authority to bring the pirate ship to helm.

Foley flew to California and personally announced the imposition of a thirty-day conditional designation, effective August 12, 1978. Lauderbaugh imposed a series of conditions on the HSA/LA for prompt reform of the agency board and executive staff. In a letter to President Wax dated July 27, 1978, Lauderbaugh commented that "The world has little mourned nor long remembered the previous health planning agencies in Los Angeles. HSA/LA is at considerable risk of becoming a new artifact in a Federal records center. A lot depends on the actions you and the Governing Body take before August 12, 1978."

At the same time, the FBI had begun the investigation requested by the Moss Subcommittee nearly five months before. Joining the FBI were investigators from HEW's Office of the Inspector General (IG) which had previously exhibited a sustained lack of interest in the case. Their orientation toward Medicaid fraud and more openly criminal activities led them to feel that examining fraudulent and abusive management practices in a federally funded agency was scutwork, a position fortunately reversed by the intense congressional interest.

The HSA/LA Board increasingly began to pour its energy into diverting and destroying what was designed to be a model of representative democracy

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The Party's Over

Incredibly, despite the mountain of evidence to the contrary, HEW officials still hoped the HSA/LA could be saved. Many HSAs had drawn fire from local politicians, and HEW was committed to defending its program. The steadily mounting congressional pressure took an ominous turn, however, when right-wing Congressman Barry Goldwater Jr., sensing a chance to attack the whole health planning program, announced he would hold his own hearings on HSA/LA. Alarmed, HEW officials realized that their failure to control the HSA was threatening the entire health planning program at a time when Congress was reviewing P L 93-641.
With all the holds rapidly filling with water, HSA/LA's board finally prepared to act. Under Lauderbaugh's coaching, twenty of the thirty board members signed petitions for a special meeting to discuss the impeachment of President Wax. The agency's now-beleaguered allies quickly mobilized for the fight. As several of Campbell's staff began drafting Wax's speech, others marshalled their dwindling forces in the community to turn out for the meeting. As a final touch, Camacho engineered a "stylistic" change in the official public notice for the meeting. The original call for a meeting to discuss Wax's removal was magically transformed into "a discussion of HSA/LA governing body composition."

As the tense meeting began, hundreds of people crowded into the auditorium. Wax began the meeting by announcing he would read a statement clarifying his position and would accept comments from other board members only after he was done. He then stumbled through a statement which took a full forty minutes.

Despite genuine concern over the agency's credibility, the reformers were no match for the veteran politicos determined to preserve business as usual

As Wax's intention to deny his opponents the floor became clear, the auditorium rang with loud choruses of objections and points of order. An HSA staff member attempted to control the situation by gleefully turning off the public address system whenever the opposition became too persistent. It took nearly a full hour to get a motion to impeach Wax on the floor. Incredibly, Wax continued to chair the meeting as his own impeachment was discussed. It took a consumer activist, whose enraged roar arose over the dead microphone, to invoke the HSA's by-laws and demand that the board vote on whether Wax had a conflict of interest in chairing the debate over his own impeachment. When Wax was temporarily removed as chair by a 20-6 vote, his supporters leapt to their feet, shouting angrily and preventing the meeting from continuing.

The Wax-Campbell-Greene loyalists made it clear they would not permit the meeting to continue without Wax as chair. A shoving match erupted over one of the floor mikes and ended with one near-hysterical staff member towering over and threatening the seated Lauderbaugh. Responding to the threatened civil disturbance, eight uniformed members of the Los Angeles Police Department adjourned the meeting.

The turn of events shocked even the most battle-hardened activists. In Washington, HEW officials shook their heads in amazement at stories of the evening's festivities. On his way out of the meeting, Lauderbaugh had responded to a reporter's query by announcing his decision to recommend termination of the agency. Thus Lauderbaugh went to work nailing shut the coffin with the same exacting determination he had applied to saving the agency just a few weeks before.

In San Francisco at the HEW regional office tensions were mounting. Lauderbaugh's boss, regional planning chief Smith, abruptly announced her resignation. In a final gesture she wrote Lauderbaugh a detailed memo commending him for his courage under fire. Sheridan Weinstein, the regional health administrator, stubbornly refused to close the HSA/LA, even as Lauderbaugh announced his intentions to do so. As Weinstein vainly sought some middle ground solution, political pressure on HEW mounted.

Other HSAs, openly panicked that HSA/LA's self-evisceration would hurt the entire planning program, added to the fire. At a meeting of the California Association of HSAs, several HSA directors timidly drafted a veiled statement pleading with HEW to please do something. HSA volunteers at the meeting were more direct. Concerned about the credibility of their own agencies and the ramifications for their own reputations, they had little interest in circumspection. A resolution was quickly drafted calling on Weinstein to take immediate action to either clean up HSA/LA or shut it down. It passed unanimously. Pressured from every side, Weinstein finally acceded to Foley and put the agency out of its misery.

On September 9, 1978, not quite one hundred days after HSA/LA was designated by the Advisory Health Council, HEW announced termination of the Los Angeles Health Systems Agency. HEW generously allowed the moribund agency over $750,000 in phase-out funds and allowed Campbell to continue drawing his $4,500-per-month salary for nearly six more months. But the party was over.

Aftermath

HEW has begun accepting applications for designation as the new HSA. It has strongly encouraged county government to apply despite the fact that the most destructive elements on the last board had been county appointees. Many observers charge that the difference between direct...
and indirect county control is the difference between slow cancer and a heart attack. Even those with more faith in the county worry that a county-run HSA might be less than objective in reviewing proposed cuts in county services.

A "Stop County" group with heavy provider participation is being chaired by Nixon's former HEW Secretary Robert Finch. Spearheaded by United Way, it includes many of the "reform caucus" members from the last HSA who seem anxious for another attempt. Also joining the ranks are some community groups such as the Council of Free Clinics and the East Los Angeles Community Union. Afraid of losing out altogether, they have thrown in with the hospitals in hopes of getting a piece of the action. Ms. Greene's absence has left the provider associations exposed and on center stage.

A consumer/community health coalition has turned in its own application. Calling itself the LA County Health Application Committee (LAC/HAC), this alliance brings together grass-roots community groups, civil rights organizations, senior citizens, mental health providers, veteran defenders of the county hospital system, and a few progressive elected officials. LAC/HAC's application has won high marks from planners close to HEW, and has even been praised by its County opponents for its focus on community mobilization to address health needs.

The extensive work required to organize LAC/HAC is a strong criticism of our tactics in LA. Try as we might, we never successfully linked the fight over the HSA with many important community health struggles. Although an honest planning agency is an absolute prerequisite for the kind of organizing we envisioned, most community health groups were reduced to passive observers as we fought through the bureaucratic intricacies to close the agency. Many of those who cheered us on had little direct investment in the fight—and their alienation from it has made LAC/HAC's job all the tougher.

On the national level it is clear that HEW will only hold HSAs accountable as local pressure forces them to. Comparable scandals exist in the New York City and Chicago HSAs, but local pressure has been insufficient to move HEW. HEW imposed forty-seven separate conditions on the New York City agency—and then ignored the HSA's defiance of them. The Chicago HSA, a zombie left-over from the Daley machine, continues to aid private sector attempts to dismantle the public hospital system. HEW has done nothing about Chicago HSA's refusal to even count Cook County Hospital as a health resource. It refuses to act because the HSA is a creature of the City of Chicago, and HEW, part of a Democratic administration, is unwilling to buck an important Democratic machine.

The California Connection

Why was California different? How did we manage to take the HSA down?

Blatant Corruption and Racism: HSA/LA made no attempt to conceal its activities or its attitudes. It refused to accept even the rules of good taste that require a more effective cover-up. The racism and anti-Semitism of the agency's leadership inflamed many. (Whether HEW is equally concerned about white racism remains to be seen. Both the New Orleans HSA and the Louisiana SHPDA have violated direct orders to prohibit the expansion of hospitals which discriminate against Blacks. Although HEW has threatened the SHPDA, they have done nothing to the HSA.)

National Visibility: The LA Follies received sustained national attention. The sheer size of the second largest HSA helped gain this attention. Many of us worked hard to attract and maintain media and congressional interest. Keeping the story in front of the public proved invaluable in forcing HEW's hand.

Reform or Resistance?: Activists must definitively answer this question before they can carve out a successful strategy. Chicago, New York, and Denver activists have never taken a strong stand on this issue. Without a clear goal, organizers waver, lack clear plans and sometimes appear confused. Ambiguity makes it harder to attract supporters for either reform or termination.

Pressure at the Top: Bad news rarely travels uphill. Staff in the Bureau of Health Planning's Central Office, and their bosses in the Health Resources Administration are often woefully ignorant of events in the "front lines" of the planning program. In fact, they seem to have an interest in maintaining their ignorance. A steady stream of information helped make them accountable. HEW could hardly deny knowledge of scandals we had taken such great pains to inform them of.

Prospects are bleak for the long-range effectiveness of the planning program. HEW's failure to make HSAs accountable invites industry capture. HSAs which respond to community pressure or make HSAs accountable invites industry capture. HEW's failure to move HEW. HEW imposed forty-seven separate conditions on the New York City agency—and then ignored the HSA's defiance of them. The Chicago HSA, a zombie left-over from the Daley machine, continues to aid private sector attempts to dismantle the public hospital system. HEW has done nothing about Chicago HSA's refusal to even count Cook County Hospital as a health resource. It refuses to act because the HSA is a creature of the City of Chicago, and HEW, part of a Democratic administration, is unwilling to buck an important Democratic machine.

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Reform or Resistance?: Activists must definitively answer this question before they can carve out a successful strategy. Chicago, New York, and Denver activists have never taken a strong stand on this issue. Without a clear goal, organizers waver, lack clear plans and sometimes appear confused. Ambiguity makes it harder to attract supporters for either reform or termination.

Pressure at the Top: Bad news rarely travels uphill. Staff in the Bureau of Health Planning's Central Office, and their bosses in the Health Resources Administration are often woefully ignorant of events in the "front lines" of the planning program. In fact, they seem to have an interest in maintaining their ignorance. A steady stream of information helped make them accountable. HEW could hardly deny knowledge of scandals we had taken such great pains to inform them of.

Prospects are bleak for the long-range effectiveness of the planning program. HEW's failure to make HSAs accountable invites industry capture. HSAs which respond to community pressure or stress local involvement will obviously incur industry wrath—but HEW is often wary of such innovations. Despite this, HSAs are fertile soil for organizing. We won't be able to harvest a new system, but perhaps we can certainly sow the seeds for it.

—Mark Kleiman
(Mark Kleiman is the Executive Director of the Consumer Coalition for Health in Washington, D.C.)
In 1971 the Nixon Administration and the Congress declared war on cancer. With an outlook befitting the peak of the age of science and a militarism consistent with contemporary foreign policy, the nation’s research and medical institutions were equipped with the dollars, resources and freedom from administrative oversight to wage an all out war on the scourge of modern man.

Battalions of unknown rats, squadrons of monkeys, divisions of mice, all made the ultimate sacrifice in skirmishes from Bethesda to Brookhaven and from LaJolla to Houston. Thousands of volunteers throughout the land supported the war effort and raised money through bake sales, charity balls, raffles, and the like, contributing their collections to the USO of this particular war, the American Cancer Society. Yet nine years later, after fleetingly few victories, the fighting is mired in the trenches, the enemy is intractable and the war drags on, seemingly unwinnable.

As the decade draws to a close, however, a new breed is rising in the ranks and a new philosophy and approach are slowly supplanting the tactics and beliefs of the last generation of scientists. Though represented only by an occasional colonel, a few captains, some lieutenants, and the foot soldiers of the public interest movement, the clarion calls of the new breed are “Prevention!” “Work Hazard!” and “Environment!”

Although it has been recognized since 1964 that 70 to 80 percent of cancers are environmental (not genetic) in origin, and theoretically preventable to an undetermined extent, the bulk of the medical and scientific work in cancer has been curative, not preventive. As with most fields of medicine, little attention and few resources have been devoted to understanding and controlling the causes of cancer while prodigious amounts have been dedicated to dealing with the active disease.

In the late 1960s and early 1970s, however, a new coalition of interests appeared on the scene. Environmental groups, many evolving from older conservation organizations, shifted their historically preservational, aesthetic and recreational perspective to cover human health concerns in their efforts to bring a halt to the use of a variety of carcinogenic pesticides. Labor groups, too, took increasing interest in health issues and began to more vigorously press for protection from occupational hazards, fighting management’s view that health is a negotiable item, not a fundamental human right. Joining these forces were assorted other interests, including public health advocates, social activists, public interest scientists, and, inevitably, lawyers.

The scientific, legislative and educational muscle of this coalition is beginning to win results. Though facing a scramble for resources and power in the cost conscious climate of the current day, research and regulatory perspectives have changed. The right to a healthy environment and safe workplace is becoming accepted as fundamental, not as a luxury for good times. And the right of industry to poison workers, pollute air, water and land, and market dangerous products is slowly being revoked. As the new conflict unfolds, the
As with most fields of medicine, little attention and few resources have been devoted to understanding and controlling the causes of cancer while prodigious amounts of money have been dedicated to dealing with the active disease.

struggle becomes, not man against disease, but people against people, people against economic interests and people against the modern age. In the months to come the new breed will be conducting some critical fights.

In the vanguard of the coalition which elevated environmental and occupational health into the public consciousness is Samuel S. Epstein, himself an amalgam of the major components of the public interest movement: physician, research scientist, environmentalist, labor consultant and activist. Epstein has given us, in The Politics of Cancer, a compendium of information relating to all facets of the struggle to prevent, on a population level, the development of cancer. Charged with energy, the book builds a solid, exhaustive case for the regulation of carcinogens as the only sensible, effective and moral method of cancer control.

Epstein hasn’t hesitated to take the opposition head on: industrial, academic, governmental and judicial venality is exposed, bias and distortion are uncovered, and the specious argumentation of the economically self-interested is vigorously impugned. Epstein knows the ropes.

The Politics of Cancer is designed to make activists of its readers. It is consistently hard-hitting and unyielding in the view that cancer is due primarily to exposure to carcinogens and that there is no safe level for exposure. Epstein attempts, successfully, to arm his readers with a breadth of information sufficient to permit them to lobby legislators, industry, the media, unions and private organizations to join ranks with the many groups he tediously lists in the text, to strengthen and broaden the environmental and occupational cancer coalition.

The book begins by laying a brief but adequate foundation of scientific precepts central to cancer research and epidemiology, then proceeds to discuss thirteen case studies of carcinogens, following the history of their use, recognition as health hazards and regulation. The chemicals that Epstein writes about are not exceptions or unusual in any way other than that there exist plenty of data on the hazard that they pose and the regulatory case against them is complete or well on the way to completion, with several exceptions.

The scenario on chemical after chemical would be monotonous were it not so appalling. The chemical is introduced; epidemiologists, physicians or others note excessive cancers in either the workers who produce it or those who are exposed to it in the environment, or both; industry denies any danger and hires a fleet of consultants to disprove, contradict and ridicule critics; government fails to act or responds with too little, too late; and so on. An important factor that Epstein raises is the use by industry of academic consultants with corporate interests, who fail to divulge their source of bias. This, of course, occurs in many branches of science, particularly with energy and environmental issues, and is a major ethical, political and scientific problem.

It is alarming to read of professional groups which disregard the supposed tenets of professional conduct and act against the interests of their ostensible beneficiaries. The American College of Obstetricians and Gynecologists, for example, filed suit with the Pharmaceutical Manufacturers Association assailing a Food and Drug Administration proposal requiring patient package inserts for oral contraceptives and estrogens, protesting that the provision of such information would "discourage patients from accepting estrogen therapy when prescribed by their doctor which will reduce the sale of the drug and others."

Academic consultants have disputed the validity of data showing carcinogenic properties of asbestos, DDT, benzene, elements of tobacco smoke and any other suspected or confirmed carcinogen with the conviction and determination of the people who sell them. Perhaps worse than academic or professional consultants who use their reputation and stature to further industrial interests are the prestigious consulting firms which hire out a flock of PhDs to anyone willing to foot the bill and who reach conclusions surprisingly consistent with the views of the industry signing the paychecks. For example, Epstein tells us, when regulations reducing the levels of vinyl chloride to which workers may be exposed were first proposed, industry turned to the celebrated Arthur D. Little, Inc. firm, which
As the new conflict unfolds, the struggle becomes not man against disease, but people against people, people against economic interests and people against the modern age. It is alarming to read of professional groups which disregard the supposed tenets of professional conduct and act against the interests of their ostensible beneficiaries.

Issued a report predicting staggering economic losses and massive layoffs which would result from implementation of the new standards. In fact, the new standard, eventually adopted despite the cries of industry, caused little economic trauma and even led to considerable savings by eliminating previous production losses. Throughout this section of the book Epstein is lucid, enlightening and comprehensive, though plagued by minor stylistic and grammatical imperfections.

From here, however, the book moves on to discuss its main topic, as one gathers from the title, what Epstein calls the “politics of cancer,” but what is in fact only an annotated guidebook to the governmental regulatory and research structure and a directory to private interest group involvement in the federal process. The format that Epstein has chosen to employ greatly limits any possibilities of meaningful analysis of the workings of the political process which constitutes cancer research and carcinogen control. We are, in essence, given a report card, a grade list of the major (and many minor) actors in the production, commentary on how well each has done his or her job. Agency by agency Epstein gives a brief history and then assesses the past performance and future potential of the various people who, at the time of publication, held the key jobs.

By superficially focusing on personalities, Epstein leads the reader down the wrong path. Agency heads suffer from excessive mortality, and, while they certainly can make or break a program or policy, they themselves are but pieces of a machine; how and why the larger apparatus works is the issue to be addressed and here Epstein falls short. The problems of cancer prevention and carcinogen control transcend the ability of a single administrator to effectively and completely deal with them—they will be with us for a long time.

Funneling the energies of lobbyists onto individual bureaucrats is a short term strategy; long term change of the political structure in which medical science is concerned only with curing disease, patching up after the fact, and in which industry broadcasts the agents of disease, disability and death will not result from this sort of analysis.

Furthermore, Epstein is inconsistent in his grading of the government and clearly plays favorites. For instance, he opposes shifting the research function of an agency, the National Institute of Occupational Safety and Health, the director of which he approves, to other agencies, arguing that doing so would be putting “all one’s eggs in one basket.” Later he recommends removing responsibilities of another agency, the Department of Agriculture, of which he seems not to approve, arguing that there is a diffusion of authority and regulatory fragmentation. Different logic applies to friends and enemies.

In discussing nongovernmental policies and interest groups Epstein suffers from the same analytical anemia that afflicts his remarks on government. He begins by lamenting that industry has failed to understand the “magnitude of health and safety problems entailed in the manufacture and handling of hazardous, particularly toxic or carcinogenic, chemicals” and the costs which these problems inflict on society. He rails at management as unaware of its shortcomings in the health and safety field and for basing economic commitments on “short-term marketing considerations.” Yet management has had no need to be concerned with the external costs that production entails and, given the economic model in which industry operates, basing investment and production schedules on anything but profitability is untenable.

This, of course, is the real dilemma and its resolution requires, in addition to far more serious scholarship, political determination of the limits of the role of the state. It also requires satisfactory unraveling of the tangle of contradictions that leaves the bridling of enterprise and the exercise of marketplace conscience to an increasingly beleaguered regulatory structure that is the protectorate of the public interest.

Despite its lack of depth of poli-
tical analysis, Epstein has written an important and extremely useful book. He has consolidated the major pieces of his distinguished and dedicated career, to which the footnotes and references give ample testament, into a single, dynamic work which will find its way into the libraries of public interest groups, social activists, and concerned scientists, legislators and citizens. He has convincingly demonstrated the non-objectivity of science, opening the door to the recognition that solutions to what to some appear to be medical or scientific problems can, and should, only be political. Finally, he has dealt another major blow to the bunker mentality that led us naively down the path of using all out strategic warfare against an elusive enemy, which is in fact only symptomatic of the real foe.

—Richard E. Chaisson

(Richard E. Chaisson is currently on leave from the University of Massachusetts Medical School.)

What’s Happening in NEW YORK

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Dear Health/PAC:

I am no admirer of nursing leadership, or of the "1985 proposal." However, Andrew Dolan's article in the recent Health/PAC Bulletin "Nursing's Quest for Identity" distorts the nature of the proposal, and the issues it is intended to address almost beyond recognition.

Mr. Dolan's basic thesis is as follows: Nursing leadership, to advance its own narrow interests and for no other reason, is attempting to make a BSN degree the minimum standard for entry into professional nursing practice. As justification for this, nursing leadership uses nursing's claim (which Mr. Dolan rejects) to be considered a profession. In the process of pursuing their goal, nursing leadership is willfully trampling on the interests of the majority of RNs and the public.

As an alternative to these proposals, Mr. Dolan offers a pure and simple trade unionism, cleansed of concerns Mr. Dolan considers inappropriate.

Mr. Dolan's statement that nursing leadership's support of the "1985 Proposal" is "based on pursuit of power for themselves" is supported only by the statement that nursing leadership would benefit by the proposal's adoption. I do not, however, feel that this is the main point. The "1985 Proposal" is, at the base, an attempt to redress certain grievances that are common to all RNs. These grievances include:

- The exploitive nature of the traditional hospital (Diploma) schools of nursing, which is so well documented in Joann Ashley's *Hospitals, Paternalism, and the Role of the Nurse*.
- The subordination of nursing to medicine and hospital administration, which has always been justified by the latter two's greater formal education. The idea is that not only will greater formal education bring greater prestige in and of itself, but the more academic, more intellectual BSN nurses will be less intimidated by the academic credentials of medicine and administration.
- The sexual caste system, which in health care segregates men into high-paid mental work, and women into low-paid manual work. By redefining professional nursing as mental work (and therefore presumably high-paid), the caste system is breached if not broken.

The "1985 Proposal" is in my opinion a poor way to address these issues. Further, it ignores a number of equally important issues, most especially the racial caste system within health care. However, it is towards a solution of these problems that the "1985 Proposal" is aimed, and only a counter-proposal that deals realistically with these issues can effectively counter the "1985 Proposal."

Mr. Dolan spends much of his article combatting nursing's claim to be a profession. I feel that much of the discussion on this point is beside the point, since most RNs will continue to accept the professionalist ideology.

His one solid point—that the BSN minimum could contribute to the increased cost of health care is the same argument used by hospital administrators everywhere to keep the wages of hospital workers down—pay us a decent wage and hospital costs will go up. This is all the more puzzling in that Mr. Dolan later in his article endorses wage demands as legitimate collective...
bargaining demands for RNs.

Mr. Dolan’s other statements in support of his assertion include: “they [nursing leadership] have resolutely pursued their own self interest with a single-mindedness that would bring a blush to even the AMA’s collective cheek . . .”, and “the record of nursing leadership in dealing with malpractice and incompetence in nursing is as lackluster as those of other professions.” Even nursing leadership’s most self-serving proposals pale beside the limitation on the production of doctors imposed by the AMA, or the pathologists’ “commission” racket. While I would be the last to say that nursing is perfect in this respect, it cannot fairly be compared with medicine, law or education whose conspiracies of silence are notorious.

As an alternative to the policies of nursing leadership, Mr. Dolan proposes a sanitized trade unionism. Despite the gains that have been made by ANA bargaining units, the Association is dismissed as elitist, insufficiently militant, fearful of rank and file involvement, management dominated, and preoccupied with matters not its concern. The first charge is, in fact, correct. The NLRA as amended to cover voluntary health care institutions sets up separate RN bargaining units within those institutions regardless of who represents them, which reinforces RN’s unfortunate tendency towards elitism. This is a problem which, in my opinion, must be settled within nursing before any level of nursing will be able to fully benefit by collective bargaining. I do not see that choice of collective bargaining agent will have all that much effect on this problem.

While one particular union may be better than one particular state Association, it is unclear to me that there is any great overall advantage to unions over the Association in these terms. Mr. Dolan’s final accusation against ANA bargaining units is that they presume to bargain over issues outside their own self interest. He puts this alleged error down to “women’s reluctance to assert their rights except as incidental to someone else’s welfare.” Mr. Dolan further neglects to say how issues of patient care and of working conditions can be separated. In fact, such issues are inseparable—both in terms of practical solutions, and in terms of the subjective responses that lead to collective bargaining demands.

Another important matter is the nature of nursing leadership and its relationship with the nursing elite. Of the various strata of the nursing elite, nursing educators are dominant, being in effective control of nursing’s recognized voice, the ANA. Of the ANA’s 37 national officers, the President and 22 members of the board of directors and standing committees are nursing educators. Closely linked to nursing education for both ideological and practical reasons are the nursing practitioners. To nursing leadership, nursing practitioners serve ideologically as an example of an independent nursing profession. Practically, the practitioners are the main justification for the expansion of postgraduate nursing education. It is on the rational self-interests of these groups, rather than on a poorly defined “pursuit of power” that an analysis of nursing leadership’s self interests should be based.

Yours sincerely,
Richard Christopher NA, SN

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Look for Health/PAC
at the
American Public Health Association Annual Meeting
in New York City
November 3-8, 1979

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Is Informed Consent Possible?

Dear Health/PAC:

It feels good to be able to welcome the Health/PAC Bulletin back on the scene. To speak of its value as a conscience of the medical establishment almost seems too obvious. I missed it sorely and await each issue, once again, eagerly.

It was also nice to see Ken Rosenberg's piece "Human Experimentation" in the "first" issue. I had the privilege of consulting with the author on the subject during its preparation and was especially pleased that his excellent hypothesis and critique would now reach your readers. It's a subject that I am surprised the Bulletin did not cover before with what the problem being so rampant.

I am not sure, though, that it is a coincidence that the specialty of Obstetrics and Gynecology was the object of this article. Although I am convinced that Doctor Rosenberg could find many examples of male subjects (as opposed to calling them patients) I think it should be mentioned that a good part of the dynamics behind human medical exploitation is based on the ever present dominance over women. They became the victims because of the glory, the over professionalism, and the mystery of the medical community as well as the fact that male chauvinism has left them easier to victimize.

However, there is a second vital issue to make note of that for me is primary and was perhaps not stressed enough by this article. Doctor Rosenberg mentions four suggestions, none of which I object to, but which may miss the mark somewhat. He suggests we "... do no deliberate harm..."; that we do "... appropriate animal studies first..."; that the "... patient be able to discontinue... participation..."; and that "... most importantly... have (sic) knowing consent."

These are moot points. I expect that none of the experimenters set out to do "deliberate harm." It's much more subtle than that. Animal studies being done, no matter how complete, are in no way protection that certain humans will not be experimented with. Subjects caught in the web of the medical research community will not find it easy to extricate themselves from so overwhelming an authority. And lastly, is informed consent ever possible?

Why do I refute Ken Rosenberg's four suggestions? Because none are achievable as long as the basic failure of the American health care system exists. I refer to our two classes (three?) of medicine. There are no experiments, no studies, and no therapeutic or diagnostic tests done on "private" patients other than of the simplest and most benign nature. And then rarely. Human experimentation is simply and only a tool of the medical research community used on the underprivileged class or just simply whole Third World countries. In a word—the poor.

Their only protection would be to rearrange health delivery so as to equalize all patients. They would then be equally subjected to our exploitation and then may be Ken Rosenberg's four ideas might help. At least the equalizing itself would serve as its own control.

With best wishes and a long life to the Bulletin, I am

Sincerely yours,

Don Sloan, M.D.
Continued from Page 7

cal board (which might almost be regarded as third licensure) on the grounds that the medical board had neither jurisdiction nor competence in approving nurses. Both nurses and a number of employers of nurse practitioners objected to the limitation of collaboration to two specifically named nurses as crippling to the use of NPs in such settings as health centers and HMOs.

The requirement for medical board approval of collaborating nurses is completely duplicative of the nurses own regulations and expresses well the level of respect in which the medical board holds the nursing board. Limiting collaboration to two specifically named nurses might work quite well in private practice situations, but it would be a disaster in settings such as community health centers where many different physicians and nurses must work with each other at different times. If finally enacted, this provision would force most existing health centers (thirty-one in the city of Boston alone) to either violate the regulations or drastically curtail the utilization of existing personnel.

Both of the registration boards will now consider the testimony received concerning the proposed regulations and will in the near future publish final regulations with such changes as they deem appropriate. Once again, however, the medical board will be required to approve the nursing regulations. Indeed, one of the most surprising things to come out of the hearings was the generally passive acceptance by the nursing board of the medical board's proposals. (One member of the nursing board made a minority protest.)

It is difficult to be overly optimistic about the outcome of the entire process. Previous experience does nothing to make one expect that the medical board will be responsive to the needs and desires of anyone outside of the medical profession. And it is hard to imagine that any very positive result can come from the interaction of the medical and nursing boards on the nursing regulations. Both are, after all, working within the same basic framework—identification and institutionalization of an only slightly new order within an old hierarchy. Neither will have the slightest difficulty in identifying that framework and its own self-interest within it with the "public interest." Thus, it seems likely that consumers of health services will once again be ill served by the system in which those who provide and profit most from health care regulate themselves.

—David R. Denton, Ph.D.