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Losing Patience
"What did he know? And when did he know it?" These terse questions by Senator Howard Baker cut straight to the heart of President Nixon's culpability in the Watergate scandal. They are no less apt in establishing the culpability of the asbestos industry in the scandal of epidemic deaths among asbestos workers. What did the corporate management of the asbestos industry know about the certain deadliness of asbestos exposure to its workers, and when did they
Medical studies for over half a century have singled out asbestos as a major occupational killer. (See Health/PAC BULLETIN, No. 61, Nov.-Dec., 1974.) Yet for years Johns-Manville, giant of the US asbestos industry, with over $1 billion in sales annually and 21 plants across the US, publicly denied or minimized its lethal role. Retrospective examination reveals overwhelming circumstantial evidence that for decades Johns-Manville has acted with the full knowledge of damaging medical consequences to its workers. Yet like Watergate, circumstantial evidence, no matter how overwhelming, is insufficient to finally establish culpability, either among large segments of public opinion or in many courts. Whether the epidemic of asbestos deaths was the unfortunate, but unforeseen consequence of ignorant, well-meaning corporate decision-makers or the necessary human cost of a carefully calculated corporate decision, rests upon finding the "smoking gun"—irrefutable, self-incriminating evidence that those in question acted in full knowledge of the consequences of their actions.

For President Nixon, the smoking gun was discovery of the Watergate tapes. For the Johns-Manville company, the smoking guns are just coming to light as the result of legal requests in literally thousands of lawsuits being waged against the asbestos industry by workers, consumers and their families.

The following series of medical conferences on workers' health were conducted by Johns-Manville corporate medical staff during the period 1957-58, long after asbestos was recognized by industry to be an occupational health hazard, but still several years before it was brought to public and broader medical attention as a serious health hazard.

These reports were introduced into the public record and verified as authentic by Johns-Manville company officials during the now-famous case of Vela vs. Wise, in which a worker received $365,000 in a successful suit against a corporate physician for not informing him of his asbestos-related illness. The records were obtained from the company by Paul Gillenwater, a Knoxville attorney representing asbestos workers and users in a number of recent suits, who has made them available to Health/PAC.

The reports are especially illuminating of the multiple roles played by Johns-Manville (J-M) corporate physicians — roles as doctors, lawyers and managerial officials. They show in case after case delays and failures to inform their worker/patients of known or suspected medical conditions and attempts to disguise or gloss over the seriousness of their signs and symptoms. These reports highlight the critical conflict of interest which company physicians face — are they primarily legal advisors to and protectors of their corporate employers, or are they primarily medical advisors to their worker/patients? Or can they be both simultaneously without compromising one interest or the other?

What They Don't Know Won't Hurt Us

In some cases physicians simply decided not to tell workers of known or suspected medical conditions. For example, in the following two cases doctors observed possible lung tumors in the X-rays and yet decided explicitly not to tell the affected workers. In the first case, this is indicated on the record by the notation "No H.C." or No Health Counselling. (All emphases and insertions in this and following quotes are the author's.) The first case occurred during the medical conference of July 10, 1957:


X-ray: Equivocal area of increased density right apex...

Diagnosis: Might be infection or tumor. No occupational disease or TB. X-ray changes of unknown origin.

Dr. Z: 1. No tab
  2. No AHS (Air Hygiene Survey)
  3. Do not notify plant manager

In another case, at the conference of April 9, 1958:

Patient B: Male, no age given.

Nurse W: On 3/26/58 — [Dr. A, a physician affiliated with the Somerset County, NJ Tuberculosis Association] reported — Presence of a solitary lesion at the right 5th anterior rib and interspace, is confirmed. I am unable to identify it in earlier films, although it is suggested a year ago by a much smaller slight density. A question is raised as to whether a similar density lies peripherally to it. I would advise this lesion being evaluated. Solitary nodules raise a question of neoplasm as well as TB which should not be ignored.

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GOING OVER LIKE A LEAD BALLOON

Lead poisoning, like drug abuse, is moving out of the ghetto and into the suburbs. Recent surveys in Baltimore and Philadelphia have found half of the reported cases of childhood lead poisoning outside the so-called "lead belt" or "inner city." Children from middle and upper middle class homes in rural Dutchess County, New York, and Litchfield County, Connecticut, were found with excessive lead levels. More than 40 percent of children tested in Charleston, North Carolina, had excessive blood lead levels. Even ten years ago ingestion of lead paint, the classical source of lead poisoning in children, could account for only three of four cases. Now, old cracking and chipped paint accounts for about half of the detected cases, while the epidemic grows. Between 1973 and 1978, 163,000 children were found with undue lead absorption, 21,000 requiring intensive treatment.

On some fronts efforts to minimize lead exposure have been successful. In 1971 so-called "lead" pencils were found to have as much as 12.5 percent lead on their painted surfaces (and, of course, none in their graphite "leads"). The standards, self-imposed by the manufacturers themselves, limit this now to no more than one percent lead paint. (The old wives' warnings were prudent!) Under pressure from the FDA following surveys of evaporated milk showing potentially hazardous lead contents, the infant formula industry has presented evidence on the impact of lead soldering used to seal canned baby foods. The industry's representatives have presented studies showing little measurable increase in lead content during the canning process of their evaporated milk, canned infant formulas, canned fruit and vegetable juices, and glass-packed baby foods.

Children of lead workers and those living near lead smelters have been shown to be particularly vulnerable to lead poisoning. . . . Meanwhile, President Carter is relaxing restrictions on the use of leaded gasoline

Dr. Herbert Needleman, chairperson of the Center for Disease Control's advisory committee for the prevention of childhood lead poisoning, recently published a study of over 2,000 children from Chelsea and Somerville, Massachusetts, two working class suburbs of Boston. Playing the role of the Tooth Fairy, Needleman and his associates collected the deciduous teeth of first and second graders and examined them for their lead content. Controlling for their parents' education, socioeconomic status, and I.Q., the study demonstrated marked differences between high- and low-lead exposures in teachers' behavioral ratings and in a broad battery of intelligence and performance tests. This confirms other studies which have found higher incidence of gross and fine motor problems, irritability, impaired cognition, and hyperactivity among lead-exposed children which appear to become permanent at some point without treatment. All these problems, Needleman learned, were dose-related, undermining the long-standing belief that blood lead levels below a certain value were "safe." Few, if any, of these children had been exposed to lead paint.

Increasing evidence has shown that the major sources of lead today are airborne particles inhaled and fallout in street dust and soil. The lead content in one gram (roughly, ½ teaspoon) of New York City street sweepings or dirt from MacArthur Park in Los Angeles contains ten times the permissible daily intake for small children. Only small amounts of such dirt ingested regularly would provide potentially dangerous amounts of lead. And just this happens. A recent study of children in Rochester, New York, demonstrated how household dust concentrations of lead correlated with the children's blood levels and such common habits as dirt-eating, thumb-sucking, and mouthing objects.

The source of 98 percent of this airborne lead fallout is automobile exhaust. Much of this comes from the combustion of leaded gasolines, but with the energy crisis, increasing amounts are coming from diesel engines.
fuels with their heavy particulate emissions. The Environmental Protection Agency recognized this, and in 1978 directed states to develop monitoring programs for lead levels in the air and to begin control mechanisms where levels were above accepted standards. The EPA then proposed more stringent standards for air lead levels, originally scheduled to go into effect last year.

Since the latest energy crisis, however, the Department of Energy has advocated further relaxing the current restrictions on the use of leaded gas. President Carter, persisting with his "moral equivalent of war" until he actually has one, has ordered the EPA to delay implementing the lower standards for the legal amounts of lead permitted in gasoline. Knowledge about the some 20,000 particulate compounds emitted in diesel exhaust is in such a primitive state that standards remain years away.

The problem of lead pollution, however, remains ubiquitous with the intellectual development of countless children at stake. Children of lead workers and those living near lead smelters have already been shown to be particularly vulnerable. Recently, analysis of vegetables grown in urban "greening" gardens have shown unacceptably high lead contents. Researchers from Harvard and the California Institute of Technology had to go to the arid deserts of Peru to unearth 1,600 year old bodies to find human remains without significant amounts of lead. Their conclusion, summarized by Dr. Jonathan Ericson, is pertinent to the current public health controversy, "Based on what we already know about lead poisoning and its effect on neurological functions, it is extremely important for us to re-evaluate now the critical levels of lead permissible in our society." For the Department of Energy and President Carter, so far, this conclusion has gone over like a lead balloon. So, many states, though mandated by the EPA to develop standardized lead monitoring procedures, are still waiting to see which way the wind blows the lead balloon.

Sources:
Harris, Michael, "Getting the lead out: The energy crisis compounds a threat to public health," The Progressive 43: 27, October 1979.
Lin-Fu, Jane S., "Preventing..."


THAT AIN'T JUST CHICKEN FEED

For those who have believed that the major misuse of antibiotics came from profligate physicians prescribing inappropriately for the common cold and other viral infections, this is "chicken feed" compared to the vast amounts of antibiotics now fed to livestock as part of standard feeds. About 40 percent of the 20 million pounds of antibiotics produced in the United States each year goes into animal feeds, according to the Office of Technology Assessment.

Low dosage, non-therapeutic antibiotics were first added to feeds in the early 1950s, when livestock producers began adding the nutrient broth in which antibiotics are made to animal feeds. The broth, which had been regarded until then as waste, contained low levels of antibiotics and was a by-product of their manufacture. The livestock producers soon recognized that their livestock being fed the broth were growing larger and faster. The demand for antibiotics in animal feed boomed. The drug companies quickly turned this waste product into a $50 million industry.

Livestock kept in clean, well-kept settings grow to optimum weight without the use of antibiotics. Only animals—cattle, chickens, or pigs—raised in unsanitary conditions benefit from the antibiotic-induced weight gains. Livestock producers contend that the latter course is cheaper. This results, according to OTA estimates, in 90 percent of pigs and veal calves, 60 percent of all cattle, and all poultry receiving low level antibiotics in their feeds.

Two theories are offered for the weight gain in antibiotic-fed animals. One argument asserts that the antibiotics help the animals defend against infectious diseases and keeps them healthy—an ounce of prevention is worth a pound of beef. The second argument maintains that the antibiotics alter the balance of bacteria which normally live in the animal's intestinal tracts, reducing the competition between animal and bacteria for vital nutrients, fattening the calf for less.

The widespread use of antibiotics has led to bacterial resistance to commonly used drugs, such as penicillin.

The wide-spread use of antibiotics has led to the widespread development of bacterial resistance to the commonly used drugs, penicillin and tetracycline. Through selective survival and transmission of resistance through genetic information passed in plasmids, increasing numbers of bacteria are growing immune to man's armamentarium of antibiotics. Strains of gonorrhea, typhoid, and meningitis, once susceptible to penicillin, have become resistant to conventional treatments. One specialist in resistant bacteria research predicted that "in 25 or 50 years the vast majority of antibiotics will be rendered useless" for human therapy by the spread of this resistance. Although it is difficult to establish the direct link between resistant bacteria causing human disease and the use of antibiotic-enriched feeds (especially with physician and lay misuse of antibiotics), epidemiological evidence exists. Several years ago Germany, the Netherlands, and other Common Market countries banned penicillin and tetracycline use in animal feeds and have since found a marked reduction in infections caused by bacteria resistant to these drugs.

In 1977 the Food and Drug Administration moved to follow the Common Market example and restrict the use of antibiotics in animal feed in order to reduce the population of resistant bacteria in the world. Pressed by the pharmaceutical giants—American Cyanamid, Pfizer, and Merck, Sharpe, and Dohme—Congress postponed any FDA action until a study could be completed by the National Academy of Science. The pharmaceutical industry also convinced farmers that a restriction on penicillin and tetracycline would mean a ban on all antibiotics in animal feeds, including those alternatives suggested by the FDA, bacitracin and tylosin, which are rarely used in human therapy and do not give rise to resistant plasmids.

Dr. Stanley Falkow, a professor of medicine and microbiology at the University of Washington, has claimed that the only reason why livestock producers have not switched to these alternatives is that "farmers have been getting bad information from the drug companies." He believes that the 5
drug companies have misled meat and poultry producers into thinking that they would not receive the same yield from the alternative drugs. Although the NAS report is not due until this spring, early reports have learned that the study will recommend more studies.

So the next time you hear the one about the travelling drug detail man and the farmer's daughter, you will know what he was selling the farmer. It ain't just chicken feed! It would serve him right if his dose were resistant to penicillin!

—Hal Strelnick


"Urology Today"—Enjoyable and Profitable

The Norwich - Eaton Television Network, a division of Norwich - Eaton Pharmaceuticals, which is in turn a division of MortonNorwich, a Chicago-based company that manufactures and sells salt (Morton salt—remember?), pharmaceutical, household, and specialty chemical products throughout the world, recently released the first of a series of television shows for doctors. The video-cassette shows will be offered on a free loan basis to physicians "for convenient viewing on home or office playback units," according to the press release announcing the show's release, "as well as to professional groups and hospitals. Additionally, NETVN will be distributed automatically to residency training programs at some 169 major teaching institutions."

Why didn't this rather obvious innovation come out of a medical school or other part of the non-profit sector? The problem is that the profit sector can be counted on to produce useful innovations, but then—and this will be recognized by theoretical buffs as the contradiction within private sector innovations—pervet them.

The first show released, "Urology Today," was produced with the help of 15 advisors from the American Urological Association who "carefully weighed and decided upon timely topics to be covered in the urology series." It probably would not have been done much differently in the Soviet Union, except it would then have to be approved by several more committees. This will be followed by three more shows on various aspects of urology over the coming year, all to be presented "in an interesting and enjoyable way."

So far so good. But the innovation's perversion doesn't take long to appear. One future "how-to NETVN show" will discuss running a cost-effective office practice. And after they have produced "Urology Today" type shows in all the other specialties, they will have to expand their market into additional shows on each specialty. After all, no self-respecting company can let a profitable product line lapse. So we can anticipate titles like: Urology and You; All You Ever Wanted To Know About Urology But Were Afraid to Ask In Medical School; The Coming Crisis in Urology; and How To Profit From the Coming Crisis in Urology.

—George Lowrey
Losing Patience

Continued from Page 2

Dr. X: When we received this report, we had not H.C. the man. There might be a case if the man were not H.C. and we needed the family doctor. I thought we should re-X-ray the man and then go through proper procedure. Fortunately it disappeared. He had been told nothing. It is a flexible situation.

Dr. Smith: No O.D. (Occupational Disease), no cancer, no TB. Re-X-ray in six months.

In the case of Patient A, the doctors actively suspected an infection or tumor, yet did not tell the patient of their suspicions — or take any other special action. In the case of Patient B, the doctors eliminated to their own satisfaction the possibility of cancer, but did not tell the patient of their observations or suspicions. To be sure, these medical decisions were made in the context of physician - patient relationships two decades ago. No doubt some doctors even today would argue for the wisdom of the decisions not to inform, especially in the latter case above. But in neither case did the affected worker know of his potentially grave condition, so that he might consult other specialists who might have performed additional tests, perhaps made a different diagnosis and possibly taken more aggressive medical action such as, for example, exploratory surgery. And since the doctors did not inform the workers, in neither case could they choose to leave their dusty job, to stop smoking or to exercise any other limited preventive measure. Throughout, the outside observer is left with the nagging question: Would these physicians have acted in the same manner with respect to these patients if they did not also have obligations to their employer, the Johns-Manville Corporation?

Unhealthy, Unwealthy and Unadvised

The occupational disease which these doctors encountered most often was asbestosis, a disabling, often fatal lung disease similar to coal miners' "Black Lung." Asbestosis is marked, many years after workers' first exposure to asbestos dust by breathlessness, coughing and scarring of the lung tissue, which can be seen on X-rays. Asbestosis is also one of a larger group of lung dust diseases called "pneumoconioses," a term the J-M doctors often used in their diagnoses.

The corporate medical strategy for asbestosis, as these medical conferences indicate, was initially not to tell workers that they had the disease. But as the disease progressed (upon continued exposure) and the worker became disabled, the company physician would reveal to the victim — slowly and in guarded terms — his or her true condition. This strategy was summed up in a now famous memo by Dr. Smith to his corporate superiors in February, 1949:

It must be remembered that although these men have the x-ray evidence of asbestosis, they are working today and definitely are not disabled from asbestosis. They have not been told of this
In some cases, company physicians simply decide to tell workers of known or suspected medical conditions. Workers then cannot choose to leave their dusty job, quit smoking or exercise any other limited preventive measures.

Thus six years elapsed between the physicians’ No Dust advisory restriction in 1948 and the “mention” of pneumoconiosis in 1954. Another two years elapsed before a full health counselling session was given. Such delay would hardly seem in the patient’s interest—and would most assuredly be in the company’s interest.

As indicated in Dr. Z’s last comment, these physicians were well aware of the extent and severity of the dust disease problem at least in the transite pipe division (where asbestos dust is added to a cement mixture to make a very strong type of water pipe). Yet three years before, in 1955, Dr. Smith, one of these participants, said in the *AMA Archives of Environmental Health* (p. 203), “Of all workers exposed to the fibers, very few develop asbestosis.” But in certain departments, it appears, the doctors were aware that the situation was not so rosy. This perception does not appear anywhere in the Smith paper.

Consider another patient conference on July 23, 1957:

**Patient D:** Male, 58 years old.

**Nurse W:** 5'9" tall, weighs 268 lbs. N.D. in 1947. 19 years in the coal mines.

**Dr. Z:** Hired in 1941. 6 years potential exposure to Portland Cement, asbestos fibre, and silica...In 1947, he went to R.G. as sweeper.

**Diagnosis:** Mixed Pneumoconiosis, moderately advanced.....

**Dr. Z:** 1. Tab
2. Advise the plant manager
3. No H.C.

So 10 years after the doctors proposed a No Dust restriction — which could explain the worker’s transfer to sweeper in 1947—and with a diagnosis of a “moderately advanced” pneumoconiosis, the company medical department was not ready to offer the man a health counselling session. A clue to the doctors’ reasons for *not* recommending a health counselling session is given in a later comment on this same patient by Dr. Smith, “I see no reason to bring a man in like this, it is...
dangerous." The danger is clearly to the company, not the man. As if to underscore this, Dr. X immediately responds, "Now take that woman, she is very nervous. If she is called in, she will get hysterical and I am sure you will have a claim on your hands." As a previous conference record showed, the woman referred to was diagnosed by the company physicians as having "Moderately Advanced Asbestosis." Based on these diagnoses and most state worker compensation laws at the time, both workers, of course, would appear entitled to compensation for these work-related illnesses.

Dust to Dust

These same doctors were equally parsimonious with their advice to transfer workers to non-dusty areas. Thus in their medical conference of April 9, 1958, the following interchange took place:

Patient E: Male, 53 years old.
Dr. Z: Records indicate Asbestosis in 2-51. Man was advised about dust in his lungs in 1-55. [Dr. A] reported on 2/1/57 'Original undated X-ray shows no abnormality.... In the absence of clinical or occupational data, it is not my belief that tuberculosis is a factor in this situation. It does not resemble any silicosis with which I am familiar. It seems to me to be one of the cases of pleural involvement you keep sending me, manifesting parenchymal elements after eighteen years. I would still advise occasional sputum examinations and X-rays at six month intervals.'

Diagnosis: Early to moderate Pneumoconiosis.
X-Ray: The right apex shows an area of increased density present in previous X-rays...
Dr. Z: 1. Tab
2. Notify plant manager
3. Do not transfer
4. Pending future changes indicated by the Medical Department.

So four years after the company medical department diagnosed asbestosis, the worker was advised about "dust in his lungs." By 1958 this person has progressed to "early to moderate asbestosis." Then, with no reasons given, the medical conference's firm advice is "no transfer" at that time. This sounds like the practice of the company's doctor, not the patient's.

The long delay between the medical observation of X-ray changes and notification of the workers was not exceptional, it was common practice. During the four reported medical conferences, a total of 20 workers had the dates both of the No Dust restriction and of their Health Counselling session recorded on their medical report. In only two of the 20 cases were workers counselled about their medical condition before the doctors recommended that management transfer them to a non-dusty job, as one would have expected to be done. In five of the 20 cases the workers were health counselled at the same time or within the same year that they were placed on a no-dust restriction. (See Table). But in 13 cases, that is for almost two-thirds of the group, the health counselling session took place years after the doctors had recommended a no-dust restriction. The delays for these 13 cases ranged from 2 to 10 years! And in some instances the person had not been health counselled by the time of the medical conference and it was further decided at the conference that they should not then be health counselled (see, for example, the case of Patient D). For these 13 cases, the average delay for counselling after the doctors had recommended that the workers be transferred was 3.6 years.

Affected workers, moreover, were not told that the doctors had recommended that they be placed on a No Dust restriction. In part we know this from interviews with Johns-Manville manufacturing workers, who told of being transferred and only years later finding out this was done by the company for medical reasons — see Health/PAC BULLETIN, No. 50, March 1973, p. 6. Also if the company physicians had promptly told the workers that they were recommending transfers, they obviously would have had to tell workers the medical reasons for this—in which case they would not have had to record years later that they told workers of "dust in the lungs" (Patient E), "mentioned" pneumoconiosis (Patient C), or "health counselled of X-ray changes" (Patients C and I).
A Rose by Any Other Name

When company physicians told workers of asbestos-related health problems they were consciously guarded in the words they chose. For example, they avoided such litigious words as “pneumoconiosis,” as in the following discussion at the July 10, 1957 medical conference:

Patient F: Male, 46 years old.
Nurse W: N.D. (No Dust restriction) in 1954, H.C. (Health Counselling) in 1956... Dr. Z: Hired in 8/12/29. 28 years potential exposure to asbestos fibre, diatomaceous earth (calcined and natural).
Nurse W: Advised of X-ray changes.
Dr. Y: When records say X-ray changes due to Pneumoconiosis, we would not use the term Pneumoconiosis to patient.
Dr. X: I spoke to this man and told him of the changes in his lungs. He said he is in a clean area.
Dr. Z: ... He says it is a clean area, I disagree with him—it is dusty.
Diagnosis: Early mixed Pneumoconiosis, plus old arrested TB in the right mid-lung field.

The doctors were also careful to keep certain information out of the medical files. For example, after a brief discussion about a patient at the July 10, 1957, conference the following interchange took place:

Patient G: Male, 41 years old.
Dr. Z: 1. Tab
2. Notify plant manager
3. AHS (Air Hygiene Survey)
3. We do not have many non-dusty areas.
   It has to be worked on.
Nurse W: Would you clarify — does the AHS report come to the Medical Department?
10 Dr. Z: I trust you do not put anything about the

AHS in the medical folders.
Nurse V: Do you recall at the first meeting, we decided to use initials to denote what has been done. We need something to show we did something about the changes when they were noted.
Dr. Z: Say referred to the Safety Department.
Nurse V: This is a change from what we decided at the first conference.
Dr. Smith: If we put in AHS, it means we have advised you to have a survey done but no reasons are recorded in the files. An attorney might say what did you do. They can answer we requested studies and they can then say they do not know the results of these studies.
Dr. X: But if it is requested and you do not get satisfaction?
Dr. Smith: That is not your responsibility. I think it good for you two doctors to know what the dust counts are but I do not think we should give any advice on that. Dust counts are not current. And with our present engineering changes, you would not have the latest changes. If anyone is worried about their work area, _________ will handle the whole thing.

Doctor/Lawyer?

Throughout these reports legal issues are inextricably interwoven with medical ones. Some physician concerns such as avoiding medical malpractice suits, are to some extent part of most doctors’ practice. But others, such as concern for protecting the company from compensation suits and their attendant costs, inevitably place the doctors in the adversarial role of advising the company and its lawyers how to fight workers’ claims. Then the conflict between the doctors’ (supposedly) primary concern for their patients and their allegiance and identification with the company breaks into the open.

Consider the case of Patient H, a woman of 49 years who was diagnosed by the company medical department as having “moderately advanced asbestosis, precipitated by earlier infection.” Dr. Smith said at that time: “She should not work in dust. She is moving fast. She should have no dust exposure.” Yet at the July 23, 1957 medical conference, discussion about her case focussed on how to help avoid her filing a compensation claim (to which, one assumes, she was entitled, based on the doctors’ diagnosis):

Dr. X: Now take that _________ woman, she is very nervous. If she is called in, she will get
hysterical and I am sure you will have a claim on your hands.

**Dr. Smith:** I will go along with that, but when you do X-rays, do a physical as well.

**Nurse V:** If she is transferred to another job, wouldn't that also precipitate something.

**Dr. X:** Mrs. __________ is working with no complaints. It is one year since she was H.C.

**Dr. Smith:** As a doctor, you cannot leave her where she is today.

**Nurse V:** If there are bad working conditions, she is to be transferred then?

**Dr. Smith:** You are precipitating the situation by transferring.

Despite the doctor's own beliefs that transfer to a non-dusty job was urgently necessary, they did not see their role as strong patient advocates for transfer within the company. On the contrary they discussed how to soften the blow to the sick woman if she was not transferred:

**Dr. X:** Will you explain the transfer to her?

**Dr. Z:** Either I or the plant manager will discuss this with her. I think we should tell her the reason we are transferring her to place her in a non-dusty area. If we cannot transfer her, I will come back to the conference and say—"What shall I do?"

**Dr. Smith:** We were going to explore, with the manager, the phases of transfer. If we cannot transfer, then we will come back to the conference and see what is what...

**Dr. X:** I will discuss this with her and soften this for her. I will say—we have recommended—etc.

**Dr. Z:** No, I do not want it to be said that you recommended. Say that we have discussed the possibility of a transfer and [Dr. Z] may contact her about this in the future. If you say you recommend and it is not done, she would get upset.

Similarly for:

**Patient I:** Female, 49 years old.

**Nurse W:** N.D. (No Dust restriction) in 1952 and H.C. (Health Counselled) 7-55.

**Dr. Z:** Hired in 1929. Prior to JM employment, she worked in a cigar factory. From 1941 to date she has been a spinner in A Building. 17 years potential exposure to asbestos fibre. In H.C. what was she told?

**Nurse W:** X-ray changes showing Pneumocionosis.

**Diagnosis:** First stage asbestosis...

**Dr. X:** You may precipitate something in the calling of the patient for examination. After all, they are producing and taking home a good pay, you may be creating a crisis. We may aggravate this into something decisive.

Whatever the "crisis" is that "you may be creating", it does not appear in the doctor's mind to be asbestosis, which the person already had at that time.

Or, in the April 9, 1958 conference:

**Patient J:** Male, 55 years old, 18 years of exposure to asbestos dust.

**Dr. Z:** The question is, third shift or come off the job?

**Dr. Smith:** We have to be practical. I would OK him for third shift, he is in a non-dusty area. Otherwise he may be out of a job, precipitate a claim and everybody is involved and in trouble.

**Diagnosis:** Early Asbestosis and arrested TB.

The apotheosis of the doctor's central concern with legal matters—heading off litigation against the company, protecting themselves from a malpractice suit and subjugating medical practice to company needs as opposed to patient's—comes in a revealing discussion during the March 5, 1958 medical conference:

**Patient K:** Male, 52 years old.

**Dr. Z:** He is working now. Was at Glen Gardner [TB Sanatorium] in 1950 for about 1½ years.

**Dr. X:** No change basically. SCTBA [Somerset County TB Association] is watching him and X-rayed him in February. They informed him through his family doctor that he has to go to the Sanatorium. He said we took X-rays in December and did not tell him there are more changes in 2-25-58. [Dr. A] agreed on this. The employee was upset and implied that we are trying to hide things from him. He came in this Monday and gave us a form letter requesting all our X-rays of him. I requested he give us authorization and that we would then be happy to send him the X-rays. We have to send these films to Glen Gardner but I wanted them for conference.

**Dr. Z:** I think there will be litigation. His brother has been talking litigation for a while. His brother was involved in a box car accident and there is a third party action...

**Dr. X:** I wonder if procedure-wise we could be criticized about our handling of this care, he knew we took X-rays and he was not told if
changes. Should we not change our procedure when TB is involved. We could tell the man that we are sending those X-rays to SCTBA and let them follow through.

**Dr. Smith:** They should follow up. They do sputum tests. We do not. It is their responsibility...

**Dr. Z:** 28 years employment and he is 52 years of age. What is the answer — Disability Retirement? He is getting VA benefits on the basis of TB... I foresee 100 percent total disability. They have us over a barrel... We have to outguess these people at this point, we do not know when or if they will file.

**Nurse V:** I do not think it is too wild a guess. His brother said, 'I told him never to go back to H Building with his chest, it will kill him.'

**Dr. Smith:** Even if he gets through this one, he will break down before he is 65 years old.

**Dr. X:** I think we should go back to our old system. Medically, as a doctor, I am responsible. SCTBA would carry on from there.

**Dr. Z:** I don’t think we raised any objection to SCTBA but only after conference.

**Dr. X:** But prior to that, we would send films to Dr. A on a routine basis. This is procedure around here. Two doctors — A and B — are on staff. They go to various institutions.

**Dr. Z:** If that is their function, should industry have to assume these responsibilities? Would they not be Dr. A’s functions?

**Dr. Smith:** *We take the X-rays for our own protection, not for social obligation.* There is no problem sending them out, but after conference.

**Strictly a Management Decision**

Not only do legal issues permeate the medical discussions described in these conference reports, these doctors also identify closely with management. In so doing, they make managerial-type decisions — decisions which seek to deflect (justified) worker suspicions of health hazards and advise that sick workers not be transferred. These latter decisions, especially, are clearly in the company’s managerial interests, but fly in the face of the workers’ health needs to limit or eliminate asbestos exposure.

From a conference on July 23, 1957:

**Patient L:** Male, 30 years old. Hired in 1943, No Dust restriction advised in 1954. Presently a packer and inspector in asbestos. 13-and-a-half years of potential exposure to asbestos, celite and silica.

**Diagnosis:** Early Pneumoconiosis, mixed.

**Dr. Z:** Has he been health counselled?

**Nurse V:** No.

**Dr. X:** Get deep inspiration on Re-X-ray.

**Dr. Smith:** Do not do anything for 6 months and bring up for conference then.

**Dr. X:** Do we do AHS (Air Hygiene Survey)

**Dr. Z:** If you take this man off, you will put another man on the same job. The area must be cleaned up.

**Dr. Smith:** That is a long-range idea.

**Dr. Z:** 1. Tab
   2. AHA
   3. Advise plant manager, to clean up area.
   4. Bring up in 3 months to conference after X-rays.

**Dr. Smith:** I do not think the plant manager should be advised. There may be changes in the picture. We can give a better decision after a

---

**Time Intervals Between Recommended No Dust (N.D.) Restrictions and Health Counselling (H.C.) Sessions**

<table>
<thead>
<tr>
<th></th>
<th>Counselling before Job Restriction</th>
<th>Counselling at same time or within one year after Job Restriction</th>
<th>Counselling delayed one year or more after Job Restriction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Cases</td>
<td>2</td>
<td>5</td>
<td>13</td>
</tr>
<tr>
<td>Percent of Cases</td>
<td>10%</td>
<td>25%</td>
<td>65%</td>
</tr>
</tbody>
</table>

Average Delay between N.D. and H.C. = 3.6 years; Range of delays = 2 to 10 years.
short period of time.

**Dr. Z:** I think the plant manager should be told there is a potential liability. Also, here is a job that should be cleaned up. *I work all the building in the AHS not to make it too obvious.*

This coverup and concern for liability is managerial, not medical. Nevertheless its consequences pale in comparison to the potential human devastation of the doctors’ recommendations *not* to transfer workers known to have asbestosis or other pneumoconioses. It took a brief few moments, and no apparent agonizing on the doctors’ parts to decide in one such case, printed in full below, on July 10, 1957:

**Patient M:** Male, 53 years old.
**Dr. Z:** Hired in 1919. Was in Service. Has been in Textiles 39 years and had exposure to asbestos dust.
**Nurse W:** Mention of Pneumoconiosis in 1952. Advised of this in 1954.
**Diagnosis:** Early asbestosis.
**X-Ray:** Present film, compared with film of 1-17-57, there is now an increase in rib and cardiac shadow. Right hilar shadow also appears to be enlarged. Otherwise there is no change.
**Dr. Z:**
1. Tab
2. Notify plant manager
3. Do not transfer.

Similarly, brusquely, another ill person is kept on a very dusty job for seven more months, after having been diagnosed as having pneumoconiosis four years earlier:

**Patient N:** Male, 48 years old.
**Dr. Z:** Hired in 1940. 3 years in the Army. Presently a crane operator in Transite Pipe. 14 years potential exposure to silica, cement and asbestos.
**Nurse W:** H.C. about chest changes. Records indicate Pneumoconiosis in 1954.
**Diagnosis:** Early mixed Pneumoconiosis.
**X-Ray:** Diffuse linear exaggeration...No change since previous film.
**Dr. Z:**
1. Tab
2. Notify plant manager
3. Do not transfer
4. Watch carefully
5. Retire if necessary.

**Dr. Smith:** Leave him there until October.

Another serious case is discussed on March 5, 1958, and resolved in what can only be called cold-blooded terms. It is presented in full below:

**Patient O:** Male, 52 years old.
**Dr. Z:** Hired in 1933. 23 years potential exposure to Silica, Cement and Asbestos-Transite Pipe. Is presently shift foreman.
**Nurse W:** Worked as truck driver 1921-1933. Mention of Pneumoconiosis in 1952. Was H.C. in 12-54. P&S (Patch and Sputum tests—DK) were neg.
**Dr. Smith:** Advanced Pneumoconiosis.
**Dr. Z:** Should we change him?
**Dr. Smith:** Won’t make any difference.
**Dr. X:** If he hits 65 I will be surprised.
**Dr. Z:** He is to be watched carefully and retire on disability, if necessary.
1. Tab
2. Notify plant manager
3. Do not transfer
4. Watch carefully
5. Retire if necessary.

The above cases reveal a good deal about the practice of corporate physicians in the dominant company of one large industry over 20 years ago. But what light do these medical conferences shed on corporate medicine as practiced today?

First, they clearly reveal that corporate physicians often function in the multiple roles of personal physician, legal advisor and corporate manager — and that the demands of these roles are routinely in conflict.

The various roles company physicians play and the reasons that corporations hire the particular individuals they do have have not changed for decades. What has changed is not corporate interests, but the medical and social stage upon which these are acted out. The passage of the OSHA Act ten years ago and the growing worker and public awareness of occupational health hazards have significantly shifted this field of medicine out of private corporate and medical offices, onto the factory floor and into the public hearing chamber.

As a result of these changes, one would not expect physicians in large corporations today to speak as the doctors of Johns-Manville spoke in the late 1950s. But many corporate physicians today carry with them as direct personal experiences or through social tradition the values and relationships derived from that period. And one still sees quite clearly the old conflict between patient medical needs and corporate legal and managerial priorities. As they have been doing for decades, many corporate physicians continue to “resolve” this
conflict by opting to serve company interests before those of their worker / patients. Since outsiders to this day rarely see the "smoking gun" that reveals the doctors' choices between corporate and patient interests — and thus seldom consider the detailed implications for their medical practice of such choices—these Johns-Manville medical reports, despite their age, give us an important glimpse into this part of the corporate world.

The basic dilemma of corporate medicine remains today what it has been for decades: Who is the patient—the company or the worker?

—David Kotelchuck

### Names and Abbreviations Used in this Text

In the reports quoted in the text of this article, patient's and doctor's names are not used. While the documents are on the public record, the use of individual names does not seem warranted in this case. In particular, the affected workers and their families have a right not to have their medical conditions discussed or revealed publicly any more than was necessary in the legal suits for which they were originally gathered. Because however the reports reveal medical and social attitudes on the part of the company and its corporate physicians that are of broader interest and importance, conference discussions are reproduced in this article with the workers' names deleted so that others cannot identify them. The names of the corporate physicians are also not presented, not because we particularly wish to protect them (although the law does to some extent protect the confidentiality of doctor-patient relationships) but simply because publication of their names does not appear to serve any broader purpose here. The single exception is our use of the name of Dr. Kenneth W. Smith, who was Corporate Medical Director of Johns-Manville at the time of the conferences. Dr. Smith, who participated in all of the reported conferences, spoke with special authority as an officer of the corporation and did not appear in the reports to have personally examined or spoken with any of the affected workers. The same six doctors and nurses were listed as present at each of the four medical conferences reported and those other than Dr. Smith are consistently referred to as Nurses V and W, and Doctors X, Y and Z.

The reports of the medical conferences had a standard format: After reading the patient's name, department number and age, one medical staff person would discuss the patient's work record and exposure to potentially harmful dusts. Then the worker's X-ray films were described, as was his or her diagnosis by the company medical department as of the time of the conference. The collected staff then discussed the patient's medical situation and working conditions, then one of them made recommendations for the conference which included flagging the person's medical records ("Tab" or "No Tab"), notifying the plant manager, holding a medical conference with the worker ("H.C." or "No H.C."—that is, "Health Counselling" or "No Health Counselling"), conducting an air hygiene survey where the person works ("A.H.S." or "No A.H.S."), and transferring the worker to less dusty or non-dusty jobs. The industrial hygiene survey and job transfers were, according to the reports, clearly advisory recommendations to other departments of the corporation, which might or might not act upon them. The first three — tabbing the records, notifying the plant manager and holding a health counselling session with the workers—represented actions which were undertaken by the medical department itself.

Many abbreviations are used in these records, such as "O.D." for occupational disease and "T.B." for Tuberculosis. The abbreviations are presented as printed in the text of the reports, followed by their translation (according to the author) in brackets. Most abbreviations were obvious in the context of the few dozen case reports presented, although some uncertainty persists, especially in the abbreviations of department names.
PHILADELPHIA SANS PGH

"Tens of thousands of financially needy and/or medically underserved Philadelphians did not have their health needs met by the combined health services of public and private facilities before the closing of Philadelphia General Hospital (PGH) and their needs are still not being met today."

Thus begins the October 4, 1979 press release of the Fellowship Commission concluding its three year effort to document and understand the consequences of the closing of PGH. As significant as this statement is for a people-oriented view of the Philadelphia health scene, it, of course, begs the PGH question.

The PGH question has been around for several decades. During the first half of this century, however, the key role of PGH was unquestioned. It provided a quantity and range of services unmatched by any other hospital in the metropolitan area which includes the nation's fourth largest city. As with similar local public hospitals in urban areas with disproportionately large numbers of no- and low-income people, PGH provided both ordinary inpatient and outpatient services and an impressive number and quality of extraordinary services without hassling patients for payment. It was one of the nation's largest hospitals, having in its prime well over 2,000 beds. Its reputation in medical circles was excellent, attracting to its internships and residencies well qualified graduates of the best medical schools throughout the country.

In the 1950s and '60s, the city government sponsored several major studies of the city's proper role in the health field. Recommendations of the earlier studies were implemented including the closing of the physically separate infectious diseases hospital, the expansion of ambulatory services and district health centers, and the development of financial and professional relationships with Philadelphia's medical schools and voluntary hospitals. The later studies recommended, among other things, the construction of a $105 million general hospital building and the modernization of the concept and organization of PGH in keeping with the radical changes occurring in medical care financing and health field social policy. These recommendations were not implemented as they were made shortly before the start of the city's disastrous Rizzo Administration. In December, 1971, even before taking office as mayor, Frank Rizzo was reported in the daily press to believe that PGH should be closed.

From that time to the official announcement on February 15, 1976 that PGH would be phased out, PGH was plundered of its resources by the local academic institutions, and its staff and budget were mercilessly whit-
supplemental work undertaken by the Fellowship Commission's own staff in response to continuing severe criticism of JRB's study and later of the drafts of the Fellowship Commission's statement by several members of the study's advisory panel, including the author of this column.

Criticism of the Fellowship Commission's newly acquired sophistication about the Philadelphia health scene constitutes the first paragraph of the Rizzo administration's formal reaction to the Commission's press release: "the efforts of the Commission to assess these health needs [of the financially needy and medically underserved Philadelphians] and the provision of related medical services do appear to go beyond the scope of a study allegedly following up on the impact of the closing of the Philadelphia General Hospital...an obvious lack of intellectual integrity."

The Fellowship Commission is the nation's oldest private human rights agency but its PGH effort was its first major venture into the health field. The study was seriously handicapped from the beginning by grossly inadequate funds and by study staff who were complete strangers to the Philadelphia health scene.

The first fundamental deficiency of the design of the JRB study was that it was not a study of actual PGH users before and after the closing of PGH. Instead a variety of secondary date was to be used. However, the most relevant secondary date was often not available from the organizations which had them, the Philadelphia Department of Public Health and the hospitals which provided the alternative services after PGH closed.

The second fundamental deficiency of the study design was that the base of comparison was PGH in the period immediately preceding its closing when the predictable results of years of neglect and uncertainty as to its future were profound and visible. This deficiency is reflected in several statements in the study report implying that the problems of PGH in its terminal period were the cause of its death rather than the symptoms of its underlying neglected illness.

The study did include a small community survey which helped define some issues, in particular, the large percentage of an apparently well-informed group of low income people who did not know about Philadelphia's family medical care centers, the City's principal substitute for PGH's ambulatory services.

Because of the flaws in both study design and study execution, the data base is inadequate to draw conclusions responsive to the central study objective — "Are the previous users of PGH and those like them receiving the equivalent medical care which they require?"

This assessment is expressed by the Fellowship Commission in somewhat more refined language: "The Fellowship Commission cautions all those utilizing the JRB report to treat JRB's findings [and conclusions] as indicative not definitive...because they are based largely upon the availability [i.e. the existence of alternative services] and not upon documented information on the services actually received by traditional users of PGH."

The Fellowship Commission's three year effort has been the only structured attempt to evaluate the consequences of the closing of PGH. The City Administration of Mayor Frank Rizzo which delivered the coup de grâce to PGH, had no interest in evaluating the consequences of that action.

Thus, three years after the closing of PGH, the question is still asked in Philadelphia, as elsewhere, "What were the consequences?" The question will remain unanswered until a properly designed and executed study is completed.

—Walter J. Lear
(Walter J. Lear was a member of the Fellowship Commission's study advisory panel and currently is president of the Physician's Forum.)
RETURN OF THE OSHA CANCER POLICY

Question: How many OSHA employees does it take to change a light bulb?

Answer: Fifty. Forty nine to hold hearings and write a standard and one to change the bulb. If that light bulb is a carcinogen standard, the hearings and delays will drag on for years. Meanwhile, for every carcinogen removed from the workplace, a dozen new carcinogens will have been introduced.

In its first nine years, the Occupational Safety and Health Administration (OSHA) issued standards for only 18 workplace carcinogens. At the same time, OSHA recognizes over 500 workplace substances that might be candidates for regulation as carcinogens. The National Institute of Occupational Safety and Health (NIOSH) has compiled a list of over 2,000 potential cancer causing agents used by US workers. With 500 new toxic chemicals introduced to the workplace each year, the cancer problem threatens to move far beyond OSHA’s grasp.

Carcinogen standards typically came only after epidemiological studies have revealed a big body count in the past with many more victims to come. Without human victims, the regulatory wheels do not turn. Even in the face of major occupational tragedies, OSHA has been slow to act. A report prepared by three government research institutes estimates between 13-18 percent of all cancer deaths in the United States in the next 30-35 years will be asbestos related, but incredibly OSHA still has not moved to regulate asbestos as a carcinogen.

In October, 1977, OSHA proposed a new cancer policy to speed up and strengthen its regulatory process. (See Health/PAC BULLETIN, November-December, 1977.) On January 22, 1980 — some 250,000 pages later—OSHA finished reviewing a massive hearing record and issued its proposal. Scheduled to go into effect 90 days after the announcement, the policy faces inevitable court tests.

The OSHA cancer policy sets no timetable for regulating the backlog of workplace carcinogens; the policy does not require OSHA to regulate any minimum number each year. Dr. Eula Bingham, Assistant Secretary of Labor for Occupational Safety and Health, hesitantly predicts the new policy will allow OSHA to raise its average number of carcinogen standards from two to 10 per year.

Scientific Debate

The new OSHA policy takes the bold step of reaffirming the scientific basis for regulating carcinogens long advocated by organized labor and environmentalists. Industry had tried to shake the argument but failed to
provide any compelling data to prove its contentions that animal tests are unreliable, that there are safe threshold levels for carcinogens, that negative epidemiology studies are more important than positive animal studies, and that carcinogens can be ranked as "strong" or "weak" with existing research techniques. The OSHA policy offers industry the option of returning to prove its contentions if and when there is significant new evidence that warrants reopening the issue.

Meanwhile, the lengthy debate on the scientific grounding of carcinogen regulation will be closed in the interest of expediting new standards. Positive results in well conducted long term animal studies will be deemed sufficient to regulate when positive human epidemiological results are unavailable. Regulation will be based on the scientific principle that there is no safe level of exposure to a carcinogen. OSHA has decided that, at least as of now, industry has lost the scientific debate underlying carcinogen detection and control for lack of solid evidence to support its theories. Every three years OSHA will review the scientific basis of its position. Industry has termed OSHA's reluctance to regulate deadly chemicals on its own unsupported theories a "freeze on science."

Two Categories

At the heart of OSHA's new policy is the establishment of two categories: Category I and II carcinogens. A Category I carcinogen is one where positive results have been found in humans, or in a single mammalian species in a long term test where the results agree with some other scientific evidence of a carcinogenic hazard—such as short term tests, or in a single long term test in a mammalian species where OSHA feels the requirement for other evidence is not necessary. Exposures to Category I carcinogens are to be at the "lowest feasible level," primarily through the use of engineering and work practice controls. Where suitable substitutes exist, OSHA may order a "no occupational exposure level" set.

A Category II carcinogen is one where evidence of carcinogenicity is only suggestive or where it shows evidence of carcinogenicity in a single mammalian species without supporting evidence in other tests that OSHA deems necessary. Exposure levels will not be guided by the "lowest feasible level" test; instead, they will be set on a case by case basis. Most Category II substances will be there because of insufficient knowledge of their effects. OSHA hopes that such a classification will stimulate research to resolve the ambiguities.

Regulatory Process

At least twice a year OSHA will make a priority list of approximately ten candidates for regulation in each category, based on factors such as estimated numbers exposed and possible potency of the carcinogen. Inclusion on the list does not mean regulatory action must proceed. OSHA can also choose to regulate substances not on the list. When OSHA publishes a notice of proposed rule making for a Category I carcinogen, it can choose not to issue an emergency temporary standard, unlike the requirement for such a standard in the original proposal.

After OSHA issues a notice of proposed rulemaking on a suspected carcinogen, comments will be solicited and hearings begun. OSHA hopes to complete the whole process and issue a standard within a year. Hearings will consider such issues as feasible exposure levels, whether the carcinogen belongs in the proposed category, and various provisions of the model standard, such as medical surveillance procedures. The cancer policy does not require rate retention for workers medically removed from exposure to carcinogens.

Challenges Ahead

The AFL-CIO has sued in the District of Columbia Circuit Court to restore the automatic emergency temporary standard provision. They fear that without such a provision, and without responsive OSHA leadership such as that provided by Dr. Bingham, few standards would actually get implemented. Industry has run to its favorite Federal Court challenging the standard on numerous grounds.

If the policy survives the court test in recognizable form, the crucial question remains how forcefully OSHA will follow through to remove or limit carcinogens in the workplace. With its cancer policy, OSHA has put itself out front as a target of the well-financed industry-led efforts to curb regulation. Yet even with this new policy, OSHA is under no obligation to actually issue standards. Much depends on whether labor, environmentalists, and other groups can put together a political bloc that will push agencies such as OSHA into taking on industry, enforce the law, and save lives. The cancer policy gives OSHA a powerful new tool to do its job, but it is the outcome of the rapidly intensifying political struggle around regulation that will determine whether the job ever gets done.

—Tony Bale
HYDE AMENDMENT OVERTURNED: THINGS MAY GET MORE FAIR

In 1977, when asked if poor women should be refused abortions simply because they were poor, President Carter replied, "Well, as you know there are many things in life that are not fair, that wealthy people can afford and poor people can't..."

For those who believe that every woman should have the right to control her own body, life may become a bit fairer. The Hyde Amendment, which restricts federal funding for Medicaid abortions, has been declared unconstitutional by two Federal District Court judges in Illinois and New York. On February 19, 1980, the Supreme Court agreed to hear the two cases, _Zbaraz v. Quern_ and _McRae v. Harris_, together.

Congress passed the first Hyde Amendment as a rider to the HEW appropriations bill in 1976, specifically limiting federal Medicaid funding to abortion where "the life of the mother would be endangered if the fetus were carried to term." Though the precise wording changed slightly over the years (an exception for rape and incest victims who report promptly to law enforcement or public health officials was added in 1977), the effect of the Hyde Amendment, in all its forms, was to immediately reduce the federal funding for abortion by 99 percent.

Many law suits challenging state limitations have been filed and have been largely successful. However, only _Zbaraz v. Quern_ and _McRae v. Harris_ challenge the federal Hyde Amendment directly and would affect Medicaid funding for abortion throughout the entire country. At issue in the _McRae_ case is whether the Hyde Amendment makes a valid distinction between women who need an abortion for medical reasons and those who seek abortion out of convenience. If the law can't truly distinguish between "therapeutic" and "non-therapeutic" abortions, it is unequally harming some Medicaid recipients and violates their right to equal protection under the law. The second questions is whether the amendment, which was lobbied for by the Catholic Church from its particular religious viewpoint, constitutes a violation of a poor women's right to freedom of religion.

In _McRae v. Harris_, Judge Dooling found the Hyde Amendment restrictions to be unduly harsh. The amendment bars a woman and her physician from considering all health and relevant social factors in deciding for an abortion. It excludes nearly all the situations that were specifically noted in the Supreme Court's 1973 decisions that liberalized abortion. In fact, by restricting Medicaid abortions in cases of known fetal defect, the Hyde Amendment creates a situation even more restrictive than that which existed prior to 1973.

The evidence produced in the _McRae_ case also shows that the "life endangerment" standard does not work to separate "therapeutic" from "non-therapeutic" abortions in the real world. The medical providers who testified agreed that even in cases where the mother suffered from a disease that might meet the life endangerment standard, the outcome of the pregnancy depended greatly on the woman's psychological, physical, environmental and economic situation. Most severe and life-threatening conditions do not become obvious until late in pregnancy when the health risk of abortion is highest.

The evidence in the case carefully documents the exacerbating effects of poverty on the already low health status of poor women: high maternal and infant mortality (especially among adolescents), poor nutrition and lack of access to prenatal care.

When Medicaid funding is withdrawn, poor women have no where else to go. The average price of an abortion is equal...
to the average entire month's welfare benefit for a three person household. The only choices for a woman, then, are to carry the unwanted pregnancy to term, seek an unsafe, illegal abortion, or deprive herself and her children of what little money they do have to pay for the procedure. These restrictions recreate the inequality between poor and non-poor women's access to safe, legal abortions which was a consideration in the 1973 Supreme Court decision liberalizing abortion. For these reasons, Dooling concluded that the Hyde Amendment violates the poor woman's right to equal protection and privacy under the Fifth Amendment.

Only the staunchest fetal fanatics believe that a woman who is the victim of rape or incest should be forced to carry a resulting pregnancy to term. Given the general problem of underreportage of rape and incest, the 1977 and 1978 Hyde Amendments have not alleviated the suffering of these women. As the evidence showed, victims of rape and incest are most often denied Medicaid abortions because of the 60 day reporting requirement.

Judge Dooling also found that a woman's right to religious freedom is restricted by the Hyde Amendment. The legislative initiative for passage of the amendment grew out of a moral conviction that abortion is murder — a conviction held by several, but certainly not all, religions (for example, Reform and Conservative Judaism, the United Methodists and American Baptist Churches). Though Dooling found as fact that the Catholic Church was directly involved in the Pro-Life political movement, he stopped short of ruling the amendment unconstitutional for this reason alone. He found the Hyde Amendment unconstitutional because it prevents a woman from choosing abortion in accordance with her own personal religious beliefs.

The Dooling decision in McRae v. Harris is a landmark decision. What emerges is a clear picture of the relationships among poverty, ill health and the decision to bear a child. By withholding abortion funding under Medicaid, society denies the right of a poor woman to control her own life and body, forcing her into mandatory child bearing and raising, without allowing her the means to deal successfully with it. Proponents of the Hyde Amendment and similar restrictions have not expressed the same enthusiasm for full employment, a guaranteed minimum annual income, adequate child care, decent housing, comprehensive health care, etc., that they have for restricting abortion. Although one has a right to life, one has no right to expect a secure, humane life.

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Should the Supreme Court agree with the decisions in the McRae and Zbaraz cases, Medicaid financing for abortions will be fully restored as a medically necessary service without further restriction. The only avenue then open to the anti-abortion lobby would be the proposed Right-to-Life Amendment to the Constitution. While this does not appear to be a political reality, it would be overly optimistic to believe that the 'Right-to-Life Movement' will cease to exist. Even if restrictions on Medicaid funding for abortions were illegal, anti-abortionists could still lobby for the restrictions which, if passed, will wreak havoc on poor women's lives before the courts can respond. The tactics of harassment and destruction (firebombings of clinics, anonymous phone calls to clients, sit-ins, etc.) that have been employed so effectively in the recent past will probably continue... and escalate.

Abortion is a fundamental component of any woman's freedom. Since there are no 100 percent effective (not to mention safe) methods of contraception, even the most diligently "careful" woman can become pregnant. Without the availability of safe and accessible abortions, women are forced into compulsory motherhood or genuine risk to their health and well-being. The decisions in McRae v. Harris and Zbaraz v. Quern are a hopeful sign that the right to abortion finally will be realized for all women.

— Marilyn Norinsky and Kate Pfordresher
In the last two months, RNs at many NYC voluntary hospitals have negotiated new contracts. The content of the new contracts has been as varied as the nature of the negotiations which led to the final settlements: three voluntary hospitals were struck — Maimonides, Kingsbrook and Columbia-Presbyterian Medical Center (CPMC); Beth Israel successfully negotiated after posting a strike notice; Mt. Sinai RNs were forced into interest arbitration.

Marching with picket signs reading “Nurses on Strike for Better Patient Care” and “Nurses have Rights Too,” over 2,000 RNs at three New York City voluntary hospitals went on strike during the week of February 1 to 8. The nurses, represented by the New York State Nurses’ Association (NYSNA), maintained a unified and militant presence during the strike actions. “We’re united: we’re fed up, and we’ll be out here until we get a decent contract,” stated one nurse on the picket line at Maimonides Hospital.

It was only two years ago that rank and file pressure forced NYSNA to remove a “no-strike” clause from its governing rules. These recent strikes were the first in NYSNA history and came at a time when the organization is facing a serious challenge to its representation of 6,000 City Hospital nurses from District 1199’s League of Registered Nurses and the United Federation of Teachers. Thus these strikes and the contracts they produced were an important proving ground for NYSNA. Perhaps these strikes can be considered a NYSNA warmup for the upcoming city elections which will decide who will be the collective bargaining agent for the city nurses.

Although wage increases were important in all the contract struggles due to the ever increasing rate of inflation, non-economic issues of working conditions and patient care were as important or of greater importance. These issues include: mandatory overtime, shift rotation, weekend scheduling, elimination of non-nursing duties, and job security. Although nurses have little experience in turning these issues into contract language, some progress was made in these contracts.

Recently, Beth Israel nurses have also negotiated a new contract, which has drawn much attention as more and more nurses have begun to compare contracts and explore collective bargaining alternatives. Beth Israel’s 600 RNs, who have recently joined District 1199’s
League of Registered Nurses, posted a ten day strike notice. The nurses were fully prepared to strike, but this proved unnecessary, due to the unity of the RNs and the support of the other hospital workers who are also represented by 1199. A new contract providing significant wage and benefit increases, every other weekend off and a decrease in shift rotation was won in down-to-the-wire negotiating sessions.

The determination of thousands of RNs on the picket lines and at the negotiating tables led to some gains being won with improvements in benefits and working conditions. Now the difficult task of enforcing these contracts on the job begins. In the past, NYSNA, with only 11 collective bargaining reps to service 30 hospitals, has had a real problem enforcing contracts and processing grievances. Nurses will be looking to see whether NYSNA’s commitment to the strike actions will lead to the correction of these problems.

It is also difficult to assess how these contract negotiations have affected the historical antagonisms between RNs and other hospital workers. In the past, RNs have been in the position of keeping the hospitals functioning during strikes by their fellow workers while at the same time benefiting from the strikes. Confused by the ideology of “professionalism”, often unorganized and fearful, motivated by concern for patients, nurses have worked long hours of overtime and actually prolonged strike situations. At the various institutions where there were NYSNA strikes, the strike committees spoke of having the support of some MDs, other workers and community members. However, no formal organizational support from the other unions involved was evident. On the other hand, at Beth Israel, where nurses are in the same union as the other hospital workers, plans for concrete mutual support were made. During the last week of negotiations, workers wore badges stating “We support our 1199 RNs,” and they visited the director of the hospital. The Hospital’s fear of concurrent job actions may have been a major factor in avoiding a strike at that institution.

Nurses must not wait for their collective bargaining representatives to lead the way. They themselves can take the steps to begin bridging the gaps and building the unity between themselves and the hospital workers. This will ultimately lead to an increase in strength for all involved in dealing with the hospital administration. Although these and other problems remain, the unity and activism of the nurses points the way to a potential change in Nursing. Nurses have become more active than in the past and must demand from their collective bargaining units an organization which provides for and encourages participation from the membership. Though administrators and educators would like us to change the labels without changing the basic power relationships, nurses are seeking real control over their working conditions and the ability to affect a real change in the delivery of patient care. As active participants in our unions and organizations, whatever they may be, in constantly seeking to democratize them and make them more responsive to our needs, we can go a long way toward achieving those goals of better patient care and more control over our working conditions.

—Nurses’ Network
TROUBLE AHEAD, TROUBLE BEHIND

The 1981 Health Budget

The Carter administration sent a tough, lean, and programatically conservative $61 billion budget to Congress. Although this represents a $5 billion increase over 1980, the rate of inflation in the economy means the budget actually represents a 3.2 percent cut in health expenditures over the current year. Worse yet, the looming economic crisis may well force further retrenchment. The ink had scarcely dried on the budget when the Administration began talking of a 10 percent across the board cut in all agency budgets—except the Department of Defense. The Carter version of “fiscal restraint” means “modest increases” which fail to keep pace with inflation for many programs, a few new areas of investment, and a few deep cuts, such as the proposed elimination of the federal capitation grant for medical schools and a major cut in money for nurse training.

The Carter budget is bounded by three demanding and equally contradictory political and economic realities: inflation, militarism, and the requirements of a political campaign. Carter is responding to inflation with a traditional Republican strategy of “cooling” the already paralyzed economy by curbing federal spending—especially in the area of social and human services. Even if Carter were not so inclined, he is being pushed in that direction by Congressional pressure. Resolutions have been introduced in the House and the Senate to limit the federal budget to a fixed percentage of the Gross National Product. If the House resolution is passed, Congress will have to hold the 1982 budget to 20 percent of the GNP—a cut of at least $57 billion. Ironically, the Senate version introduced by Warren Magnuson (D-Wash) would force even deeper cuts of $75 billion in the 1982 budget. These proposals amount to a federal Jarvis initiative. Carter strategists hope to head off such measures by demonstrating restraint in their own budget re-
## Health Care Financing Administration

(in millions of dollars)

<table>
<thead>
<tr>
<th></th>
<th>1979</th>
<th>1980</th>
<th>1981</th>
<th>% Change†</th>
</tr>
</thead>
<tbody>
<tr>
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<td>$33,542</td>
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<tr>
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<td>14,160</td>
<td>15,768</td>
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<tr>
<td>Quality Assurance</td>
<td>29</td>
<td>30</td>
<td>34</td>
<td>+ 13.3</td>
</tr>
<tr>
<td>Research and Demonstration</td>
<td>16</td>
<td>24</td>
<td>28</td>
<td>+ 16.7</td>
</tr>
<tr>
<td>All other HCFA</td>
<td>55</td>
<td>65</td>
<td>71</td>
<td>+ 9.2</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>$41,655</td>
<td>$47,821</td>
<td>$53,250</td>
<td>+ 11.4</td>
</tr>
</tbody>
</table>

Guests. Many analysts expect a federal budget cut of $20-40 billion.

That the “restraint” is limited to human and social services, and does not extend to the military budget, is so common that it shocks no one anymore. This is the “passive euthanasia” approach to federal health programs while MX missile systems, rapid deployment systems, and other mechanisms of international intervention abound.

Health advocates may take some comfort in the fact that the upcoming elections mean we will be spared the worst of the cuts, but the comfort should be small indeed. Carter cannot afford to risk angering the remnants of the old labor-civil rights-liberal coalition so long as there is the threat of a Kennedy candidacy, and so long as he sees a strong need to rally Democratic troops against a Republican challenge this fall. We may therefore expect that this year’s strategy of allowing inflation to eat away program funds will be replaced by a “slash and gouge” approach in 1982 that effects major attacks on important programs.

## Food and Drug Administration

(in thousands of dollars)

<table>
<thead>
<tr>
<th></th>
<th>1979</th>
<th>1980</th>
<th>1981</th>
<th>% Change†</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bureau of Foods</td>
<td>$ 87,907</td>
<td>$ 93,791</td>
<td>$ 96,507</td>
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</tr>
<tr>
<td>Bureau of Drugs and Devices</td>
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<td>150,286</td>
<td>154,962</td>
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</tr>
<tr>
<td>Bureau of Radiological Health</td>
<td>20,914</td>
<td>22,723</td>
<td>23,273</td>
<td>+ 2.4</td>
</tr>
<tr>
<td>Natl. Center for Toxicological Research</td>
<td>14,069</td>
<td>14,779</td>
<td>15,158</td>
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<tr>
<td>Program Management</td>
<td>39,729</td>
<td>42,381</td>
<td>42,899</td>
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</tr>
<tr>
<td>Building and Facilities</td>
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<td>4,372</td>
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</tr>
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<td><strong>TOTAL</strong></td>
<td>$312,126</td>
<td>$328,332</td>
<td>$362,462</td>
<td>+ 10.4</td>
</tr>
</tbody>
</table>

*New name for what remains of the Department of Health, Education and Welfare since the Department of Education was created.

†The percent change from 1980 to 1981 does not include an adjustment for the inflation rate of 14 percent. The actual increase or decrease is therefore understated in terms of 1981 dollars.

Within these limitations, the budget is still worth examining as a statement of federal intent. It tells something of programs the administration feels some commitment to and which programs are in deep trouble. The budget also tells us where in the health system some of the most critical stresses will be felt. (See box on Budgetary Highlights by Agency.)

**Budgetary Overview**

"As inflation forces expansion of uncontrol­lable entitlement programs, the health budget becomes more like a horse and rabbit stew," says Sherry Arnstein of the National Health Council. The Health Care Financing Administra­tion (HCFA) is the horse, and all the discretionary public health programs are the rabbit. Medicare and Medicaid account for some 86 percent of the federal health budget. Despite some small increases in Public Health Service programs, Administration budgeteers are shouting "hold that line" when reviewing most discretionary programs. The stew is being lightly seasoned with just enough increases to keep the beneficiaries of some categorical programs happy until the year's end. There are three major new outlays, and one major cut which telegraphs the Administration strategy.

**CHAP**

The Administration is pressing for enactment of the Child Health Assurance Program (CHAP) early enough to launch it this July. Over $400 million has been set aside for the program, which would mandate medical, dental, vision, hearing, pharmaceutical, and mental health benefits for 100,000 pregnant women and nearly two million low-income children. Yet the program itself is in trouble, as reported in last issue's *Washington* column. Far-reaching anti-abortion amendments have soured many women's groups on the bill, leaving a few women's and children's groups, and the low-income advocates to go it alone.

**Primary Care**

Required state coverage of comprehensive primary care in clinics would add another $52 million to Medicaid. The Public Health Service also plans to construct fourteen new community health centers (CHCs) and expand services at another fifty-one CHCs. The overall CHC budget will be upgraded by 14.3 percent, one of the few federal health programs to actually keep pace with inflation.

**NHSC**

The best news is the National Health Service Corps (NHSC) budget. NHSC is being slotted for a $52 million increase, a 43 percent improvement over 1980, even taking inflation into account. Current plans include a 61 percent increase in the present corps, to include 4,500 health care professionals. The Office of Management and Budget strongly opposes the Corps' growth, preferring to increase federal subsidies to the private sector via Medicare and Medicaid. In this area, at least, the public health advocates appear to have beaten the budgeteers—at least for this year.

**Professional Education**

The Administration once again will seek to eliminate capitation grants to medical schools entirely. Nurse training will also be cut 76 percent. The supply of physicians and nurses has doubled since 1960, and HEW believes that there are more than enough professionals to go around. This, of course, ignores the geographical and specialty maldistribution of physicians and the retention problem afflicting the nursing profession. HEW apparently believes that neither of these problems will be solved so long as a steady stream of federal dollars provides symptomatic relief. These cuts will be strongly opposed by the American Medical Association and the American Nurses' Association. The AMA's heavy campaign contributions guarantee stormy weather for at least this Carter-proposed cut.

Other cuts will likely be tolerated by the AMA, and will survive Congressional review. NHSC scholarships will be hiked 9.3 percent, which will be substantially less than anticipated tuition increases at most medical schools. Special scholarships for exceptionally needy medical students (i.e., anyone without $25,000 to put on the table) are being held at their present levels, which, given the 14 percent rate of inflation, is the equivalent of a 14 percent cut.

**Specific Programs**

The Health Care Financing Administration continues to sit atop a spiraling budget it has done little to control. Current HCFA strategy is to hold the line on major increases by pushing cost containment and increasingly aggressive regulatory approaches. The Alice-in-Wonderland mentality which pervades their policy-making can be seen in HCFA's list of...
<table>
<thead>
<tr>
<th>Category</th>
<th>1979</th>
<th>1980</th>
<th>1981</th>
<th>% Change†</th>
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<tr>
<td><strong>Health Promotion:</strong></td>
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<tr>
<td>Prevention Formula Grants</td>
<td></td>
<td></td>
<td>10</td>
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</tr>
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<td>Risk Reduction/Health Education</td>
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<td>14</td>
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<td>Total</td>
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<td>$14</td>
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<tr>
<td><strong>Preventive Services:</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Venereal Diseases</td>
<td>39</td>
<td>48</td>
<td>48</td>
<td>—</td>
</tr>
<tr>
<td>Immunization</td>
<td>47</td>
<td>30</td>
<td>30</td>
<td>—</td>
</tr>
<tr>
<td>Chronic Diseases</td>
<td>15</td>
<td>18</td>
<td>19</td>
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</tr>
<tr>
<td>Total</td>
<td>$101</td>
<td>$96</td>
<td>$97</td>
<td>+ 1.0</td>
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<td><strong>Health Protection:</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fluoridation</td>
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<td>7</td>
<td>10</td>
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<tr>
<td>Environmental Hazards</td>
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</tr>
<tr>
<td>Epidemic Services</td>
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<td>28</td>
<td>30</td>
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<tr>
<td>Occupational Safety and Health</td>
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<td>81</td>
<td>83</td>
<td>+ 2.5</td>
</tr>
<tr>
<td>Technology Development and Application</td>
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<td>27</td>
<td>27</td>
<td>—</td>
</tr>
<tr>
<td>Total</td>
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<td>$181</td>
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<td><strong>Other CDC:</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Buildings and Facilities</td>
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<td>11</td>
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<td>Health Incentive Grants</td>
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<tr>
<td>Total</td>
<td>$ 96</td>
<td>$ 83</td>
<td>$ 86</td>
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<tr>
<td><strong>TOTAL</strong></td>
<td>$351</td>
<td>$366</td>
<td>$391</td>
<td>+ 6.8</td>
</tr>
</tbody>
</table>

The proposed savings, which includes $780 million to be saved through the passage of a cost containment bill — the same bill which was defeated by more than a 2-1 vote in the House of Representatives! HCFA's inability to attack the true sources of medical inflation has led to a program which strikes the hardest at the weakest hospitals in the system—public and inner city community hospitals.

Despite Congressional hearings into the plight of distressed hospitals serving poor communities, HCFA has refused to develop a program to save these hospitals. HCFA officially believes that private hospitals will pick up the slack, Quentin Young, Medical Director of Chicago's beleaguered Cook County Hospital has decried HCFA's "Marie Antoinette Theory," as he calls it. In recent congressional testimony, Young wryly speculated whether poor patients unable to enjoy the simple fare of public health care would magically dine on escargot at voluntary hospitals. HCFA's true attitude was revealed in a private meeting when its chief, Leonard Schaeffer, reportedly belittled undocumented workers as "wetbacks," and denied that their care posed a problem.

There, at least, is agreement that screws are loose in HCFA, and that some form of screw-tightening is mandatory. HCFA plans to step up its Research and Demonstration projects to $58 million, an absolute increase of 8.3 percent, even taking inflation into account. HCFA's R & D programs are a mixed bag. Although $14 million went to bail out besieged Brooklyn Jewish Hospital last year (after intensive politicking and White House intervention), most of the money is earmarked for systems rationalization—often in the form of cutbacks and closures.

Other screw-tightening will be taking place in the long-term care area. HCFA has already attempted to hold all state nursing home reimbursement programs to a nationally-established median. This meat-axe approach will
### Health Services Administration

**(in millions of dollars)**

<table>
<thead>
<tr>
<th>Program</th>
<th>1979</th>
<th>1980</th>
<th>1981</th>
<th>% Change†</th>
</tr>
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<td>Community Health Centers</td>
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<td>$342</td>
<td>$391</td>
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<tr>
<td>National Health Service Corps</td>
<td>63</td>
<td>82</td>
<td>134</td>
<td>+63.4</td>
</tr>
<tr>
<td>Indian Health Service</td>
<td>492</td>
<td>549</td>
<td>602</td>
<td>+9.7</td>
</tr>
<tr>
<td>Indian Health Facilities</td>
<td>77</td>
<td>74</td>
<td>77</td>
<td>+4.1</td>
</tr>
<tr>
<td>Migrant Health</td>
<td>34</td>
<td>40</td>
<td>45</td>
<td>+12.5</td>
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<tr>
<td>PHS Hospitals</td>
<td>172</td>
<td>173</td>
<td>165</td>
<td>-4.6</td>
</tr>
<tr>
<td>Maternal and Child Health</td>
<td>381</td>
<td>380</td>
<td>394</td>
<td>+3.7</td>
</tr>
<tr>
<td>Family Planning</td>
<td>135</td>
<td>165</td>
<td>177</td>
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<tr>
<td>Hypertension</td>
<td>11</td>
<td>20</td>
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<td>—</td>
</tr>
<tr>
<td>Emergency Medical Services</td>
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<td>40</td>
<td>26</td>
<td>-35.0</td>
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<tr>
<td>Other HSA</td>
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<td>77</td>
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<td>+10.4</td>
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<td><strong>TOTAL</strong></td>
<td>$1,746</td>
<td>$1,942</td>
<td>$2,116</td>
<td>+9.0</td>
</tr>
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</table>

wreak havoc in states with costs significantly above the national average, such as New York and Massachusetts. It also undercut innovative reforms such as the Washington state effort to upgrade nursing home quality by bringing wage levels for nursing home aides up to 90 percent of parity with hospital aides. Washington’s increased reimbursement and required pass-through of wage increases would be undercut by these new regulations. Although a federal court has temporarily restrained HCFA from applying these regulations to state Medicaid programs the outcome remains uncertain.

HCFA’s general strategy relies on imposing a nation-wide rule, gracelessly conceived and witlessly executed. This appears to be administratively simpler than the politically touchy task of cracking down on fraudulent providers, as was recently done in New York, where New York’s Deputy Attorney General indicted, tried, and convicted over one hundred nursing home operators and administrators.

A few modest improvements in long-term care are anticipated from HCFA’s efforts to provide home health aids, to provide homemaker services, and to seek legislation eliminating the requirement that Medicare patients be hospitalized for three days before becoming eligible for nursing home care.

Long-term care is not the only area in which HCFA tacitly condones provider abuse. HCFA is planning to boost PSRO appropriations by a whopping 31 percent — after inflation. It continues to defend the effectiveness of the Professional Standards Review Organizations despite studies by the Congressional Budget Office and the General Accounting Office which suggest that PSROs spend at least as much, and possibly more, than they save. Meanwhile, in the other major area of Health and Human Services (HHS), Public Health Service programs do not fare nearly as well. The Food and Drug Administration is being slated for only a 2.3 percent increase (inflation included) in its program operations, with an additional $25 million for new laboratories. Significantly, the modest 2.6 percent increase for the FDA’s Bureau of Drugs and Devices cannot possibly allow it to establish its post-marketing surveillance system being widely touted as a replacement for extensive controls prior to the marketing of new drugs. The post-marketing system called for by Sen. Kennedy’s (D.-Mass) would substitute many current controls for a “downstream” approach that would presumably identify drug complication problems as they develop. No one is certain where the money is supposed to come from.

The Health Service Administration (HSA) represents a very mixed bag of increases and devastating cuts. The CHAP, NHSC, and CHC programs have already been described. Many other programs fared poorly.

The most alarming cuts are being faced by PHS’s eight general hospitals. The PHS hospitals rebounded from a Nixon attack in the 1970s to develop ways of more fully integrating
National Institutes of Health

(in millions of dollars)

<table>
<thead>
<tr>
<th>Institute</th>
<th>1979</th>
<th>1980</th>
<th>1981</th>
<th>% Change†</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Cancer Institute</td>
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<td>$1,008</td>
<td>+ 0</td>
</tr>
<tr>
<td>National Heart, Lung, and Blood Institute</td>
<td>506</td>
<td>528</td>
<td>548</td>
<td>+ 3</td>
</tr>
<tr>
<td>National Institute of Dental Research</td>
<td>65</td>
<td>69</td>
<td>70</td>
<td>+ 1</td>
</tr>
<tr>
<td>National Institute of Arthritis,</td>
<td>303</td>
<td>342</td>
<td>366</td>
<td>+ 7</td>
</tr>
<tr>
<td>Metabolism and Digestive Diseases</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Institute of Neurological and</td>
<td>212</td>
<td>242</td>
<td>250</td>
<td>+ 7</td>
</tr>
<tr>
<td>Communicative Disorders and Stroke</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>National Institute of Allergy and</td>
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<td>+ 5</td>
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<tr>
<td>Infectious Diseases</td>
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<td></td>
<td></td>
</tr>
<tr>
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<td>313</td>
<td>332</td>
<td>+ 6.1</td>
</tr>
<tr>
<td>National Institute of Child Health and</td>
<td>198</td>
<td>210</td>
<td>218</td>
<td>+ 3.8</td>
</tr>
<tr>
<td>Human Development</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Eye Institute</td>
<td>105</td>
<td>113</td>
<td>116</td>
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</tr>
<tr>
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<td>84</td>
<td>97</td>
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<tr>
<td>Sciences</td>
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<td></td>
</tr>
<tr>
<td>National Institute on Aging</td>
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<td>70</td>
<td>75</td>
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<td>Other NIH</td>
<td>257</td>
<td>255</td>
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<td>+ 7.4</td>
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<tr>
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<td>$3,186</td>
<td>$3,443</td>
<td>$3,582</td>
<td>+ 4.0</td>
</tr>
</tbody>
</table>

themselves into local delivery systems by providing support for primary care programs. Despite this, the hospitals face a $12 million cut. When inflation’s toll is added in, this represents a 16 percent decrease in support for the PHS hospitals.

Federal support for other primary care programs is also in doubt. Although the Community Health Centers are getting budget increases which will allow them to keep pace with inflation, the Maternal and Child Health (MCH) grants to states are receiving only a $15 million “increase,” which amounts to a 9 percent cut in the face of inflation. Family planning programs will sustain a similar 5 percent cut, despite their slightly increased appropriation over 1980. Even the desperately underfunded migrant health program is receiving only a $5 million increase.

Alcohol, Drug Abuse, and Mental Health Administration

(in millions of dollars)

<table>
<thead>
<tr>
<th>Institute</th>
<th>1979</th>
<th>1980</th>
<th>1981</th>
<th>% Change†</th>
</tr>
</thead>
<tbody>
<tr>
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<td>$620</td>
<td>$671</td>
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</tr>
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<td>190</td>
<td>201</td>
<td>+ 5.8</td>
</tr>
<tr>
<td>National Institute on Drug Abuse</td>
<td>272</td>
<td>274</td>
<td>274</td>
<td>—</td>
</tr>
<tr>
<td>St. Elizabeths Hospital</td>
<td>79</td>
<td>89</td>
<td>98</td>
<td>+ 10.1</td>
</tr>
<tr>
<td>Other</td>
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<td>$1,185</td>
<td>$1,261</td>
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boost, representing a 1.5 percent loss to inflation.

Inflation will also mean a 14 percent cut for HSA's hypertension screening, treatment, and referral programs. The academic researchers won a big battle with public health advocates when they won an additional $11.2 million for the Heart, Lung, and Blood Institute in the National Institutes of Health. Although the funds are targeted for demonstration and education projects on high blood pressure, advocates are complaining that many of NIH's programs in these areas maintain a comfortable "old boy's school" atmosphere that prefers academic conferences to service delivery. One such program in Georgia is spending over half a million dollars on "coordination" of hypertension programs without making any efforts to increase provider participation in Medicaid, the only source of payment for many black Georgians who suffer from hypertension.

The Center for Disease Control (CDC) is shifting money away from immunizations, chronic diseases, and venereal diseases (inflation is accomplishing an 11 percent cut) to health prevention and risk reduction programs, which are being stepped up from $14 to $27 million. Much of this money will be targeted for workplace, school, and other community settings. CDC is also requesting $25 million to enlarge its Appalachian Laboratory for Occupational Safety and Health in Morgantown, West Virginia.

Nearly all programs of the National Institutes of Health received modest "increases" which will fail to keep up with inflation. The most significant inflation-induced cuts hit the National Cancer Institute ($1 million increase, 12 percent cut), National Heart, Lung, and Blood Institute ($20 million increase, nine percent cut) and the National Institute of General Medical Sciences ($19 million increase, seven percent cut). These three institutes accounted for 53 percent of the NIH budget in 1980, and these cuts superficially suggest a weakening of the institutional research establishment. It is only when these small retrenchments are examined in the context of major cutbacks in other health and health-related programs that the staying power of NIH becomes clear.

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**Health Resources Administration**

(in millions of dollars)

<table>
<thead>
<tr>
<th></th>
<th>1979</th>
<th>1980</th>
<th>1981</th>
<th>% Change†</th>
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<tr>
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<td>10</td>
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<td>-</td>
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<td>$506</td>
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<tr>
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<td>24</td>
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<td>$633</td>
<td>$530</td>
<td>-16.3</td>
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Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA)

The ADAMHA budget with the National Institute of Mental Health sustained a five percent inflation-born cut despite a $51 million "increase". Although the Administration has also requested a $50 million supplemental appropriation to the 1980 budget to increase care to minorities and the chronically mentally ill, this request may fare poorly as the Congress approaches its self-imposed budget ceiling.

The Health Resources Administration has been targeted for the most extensive cuts of all the agencies in HHS. In addition to elimination of capitation grants ($116 million) and drastic cuts in support for nurse training ($77 million), HRA faces termination of its $45 million program to guarantee loans to medical facilities, the vestigial survivor of the old Hill-Burton program which fueled so much unnecessary expansion. Although there are strikingly sound arguments for each of these cuts, the overall impact on HRA itself may be alarming. When these cuts are added to inflation's toll, they represent a 27 percent cutback for this agency.

Cuts in Health Professions Education make the health planning program far more visible. As health planning's share of HRA's dwindling budget grows from 26 percent in 1980 to 33 percent in 1981, HRA may become increasingly threatened by HCFA's efforts to bring the planning program under its own control, effectively vivisecting HRA itself. This obscure bureaucratic infighting has alarming implications for the fate of inner city and other medically underserved areas. Although HRA has often ineptly allowed its planning agencies to ignore civil rights and access issues, the agency at least has an explicit policy of opposition to service cuts where there are no alternative sources of care for the underserved. HRA Chief Henry Foley's sensitivity to this issue stands in sharp contrast to the unremitting hostility HCFA's Leonard Schaeffer has exhibited toward minorities and the poor.

There is little joy in Mudville to leaven HRA's institutional woes. In addition to the cuts in professional education, the health planning program is slated for a meager $3 million increase. Inflation will effect a net 11 percent budget cut for the planning agencies. Similarly, HRA's once-ambitious program to help finance the conversion and closure costs of excess hospitals has been whittled down to a meager $10 million, scarcely enough to retire the long term debt at a single facility. HRA's intentions to slice this pie "equitably" will have the gloomy virtue of disappointing everyone fairly.

The virtual end to nurse education support will drastically reduce the flow of new RNs. Numerous studies have pointed to professional frustration and job dissatisfaction as the primary problems in retaining nurses. Shutting off the RN assembly lines will force hospitals to seek solutions to these problems. Yet they must seek them at precisely the point when fiscal pressures are the most intense ever, leaving facilities with very little room for discretionary innovation. Although throwing money at the

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Office of Assistance Secretary for Health

(in millions of dollars)

<table>
<thead>
<tr>
<th></th>
<th>1979</th>
<th>1980</th>
<th>1981</th>
<th>% Change</th>
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<td>42</td>
<td>- 6.7</td>
</tr>
<tr>
<td>National Center for Health Care Technology</td>
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<td>18</td>
<td>—</td>
</tr>
<tr>
<td>Smoking and Health</td>
<td>3</td>
<td>13</td>
<td>13</td>
<td>—</td>
</tr>
<tr>
<td>Health Promotion</td>
<td>3</td>
<td>3</td>
<td>6</td>
<td>+ 100.0</td>
</tr>
<tr>
<td>Other</td>
<td>104</td>
<td>110</td>
<td>120</td>
<td>+ 9.1</td>
</tr>
<tr>
<td>TOTAL</td>
<td>$218</td>
<td>$284</td>
<td>$311</td>
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problem of nurse retention will not solve it, it seems equally clear that bankrupting nurse training programs will only worsen the problem.

The Office of the Assistant Secretary for Health's (OASH) budget is set aside for programs heavily dependent on interagency cooperation (such as the National Center for Health Statistics or the National Center for Health Services Research) and for the Secretary of HEW's "showpiece" programs. Accordingly, no one was surprised to see former HEW Secretary Califano's anti-smoking program frozen at its current level. The Office of Health Maintenance Organizations (OHMO) received a hefty appropriations request outstripping inflation and allowing for a 2.6 percent increase in OHMO staffing and demonstration programs. OHMO may need all the help it can get when publicity is given to two reports HCFA sought to suppress which charge that even the best HMOs, including the consumer-owned Group Health Cooperative of Puget Sound, "skim" patients and seek to prevent poor and elderly persons from enrolling. The only other "winner" was the newly formed National Center for Health Care Technology, charged with the mission of evaluating the effectiveness of innovative medical technology relative to its costs. This office's budget was more than doubled, from $3 to $8 million, envisioning a growing federal involvement in questions of technology assessment.

**Health-Related Programs**

Many health-related programs are faring equally poorly. The Carter Administration plans to carve $817 million from child nutrition and food assistance programs by tightening eligibility standards for free and partially subsidized school lunches. These cuts stand in stark contrast to the Administration's bright promise of the CHAP bill. The Administration is also planning to curtail social security benefits for disabled workers, and is looking forward to even deeper cuts in the Social Security program after this fall's elections.

**Summary**

The 1981 health budget represents a major volley in the Administration's war of attrition against many public health programs. Federal failures to control the Medicare and Medicaid budgets virtually guarantee more of the same in the coming years. The only difference will be that the elections will be over, and there will be little to stand between needed public health care programs and devastating cuts.

Unlike his last Democratic predecessor, President Lyndon Johnson, Carter makes no pretense of being able to purchase guns and butter. Like Carter's other economic policies, he will doubtless say that the mounting toll of disease, degradation, and disability "suits me fine."

—Mark Kleiman

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E. Richard Brown

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One of the problems that advocates of professionalism in nursing must face is to define the specific content of that professionalism. While there has always been a vague sense of professionalism in nursing, and the form of nursing is changing in its upper echelon, there is still no unified and exclusive theoretical foundation for nursing.

Many nursing academics understand this theoretical deficiency and firmly believe that nursing will never be respected as a learned profession until it can find an empty peg to hang its hat on. Just what is it that nurses do that no other health practitioners can do?

One answer has come out of New York University — one of the vanguards of theoretical development. Taking off from nursing's historical "nurturing" role, Dolores Krieger has developed a distinct form of patient care called Therapeutic Touch (TT).

Krieger's Theory of the Concentration of Energy

The basic premises of Therapeutic Touch are simple.

Media Scan

Borrowing heavily from Eastern mysticism, TT maintains that the human organism is animated by a form of "energy" or *prana*. This energy is organized into specific pathways or foci called *chakras*. Symptoms of illness appear when the "flow" of *prana* is disrupted, depleted, or in imbalance — a somatic version of the energy crisis.

The healer, by a "knowledgeable" placement of her hands is supposed to be able to transfer her own energy to a depleted patient, or "unruffle" any "congestion" in the *chakras*. Knowledge on the part of the healer is less a product of scientific study than an inner almost voluntaristic, knowledge. "Conceive of the healer as an individual whose health gives him access to an overabundance of *prana* and whose strong sense of commitment and intention to help ill people gives him or her a certain control over the projection of this vital energy" (1).

The "Energy" of Nurses

"Transfer of energy" is not a new term of art in nursing. At least ten years ago the phrase came into vogue in relation to the care of patients suffering from debilitating diseases such as chronic obstructive pulmonary disease. On close analysis it becomes apparent that what "transfer of energy" means in that context is intelligently organized, patient, physical care which anticipates the patient's needs and improves his quality of life by relieving him of many physical burdens.

This, of course, is nothing new or mysterious, and merely exemplifies the inability of nursing theoreticians to use plain English.

In the institutional setting, the quality of nursing care given to patients is frequently directly proportional to the level of staffing determined by management. Nursing is a labor intensive field. Good nursing entails a heavy outlay of time to try to meet both the physical and psychological needs of patients. In addition, nurses should serve as a moderating force between patients and the rigid demands of institutionalized health care. Because of the centrality of the staffing question, rank-and-file or union input into decisions in this area is the most explosive non-economic issue being confronted by unionized nurses.

Hospitals, of course, do not share the same perspective. They only see that nurses are somehow able to take up the slack whenever hit by cutbacks.

In reality, what happens when nurses are speeded-up is that patients receive less and less direct care. The result is that patients take longer to get better, and staff morale plummets (except perhaps that of the hospital comptroller). Thus the real struggle for the "energy" of nurses is in getting the adequate staffing with which to spend the necessary time to have optimum effect.

Where does Krieger fit into this tug-of-war? While she carefully avoids any discussion...
of what TT would look like in the institutional setting, it would appear to be opposed to the labor intensive wholistic view of nursing. The “energy” put into patient care can be reduced to a simple mechanical technique which can be performed in a matter of minutes. This reductionist view of nursing may comfort both the fiscally-minded administrator and the harassed and overworked staff nurse.

“Science” and Therapeutic Touch

Krieger began developing her theory of healing by the laying on of hands by studying under lay healers. At first, she tried to give TT a scientific veneer. Between 1971 and 1974, she conducted a number of small studies which purport to demonstrate an elevation in the hemoglobin levels of patients treated by the technique (2). No similar attempted scientific approach is to be found in her book. Evidence of the effects of TT on the patient are exclusively limited now to testimonials and case studies—a practice which itself raises serious questions because of its use by quacks.

Krieger has shifted her scientific focus to the safer ground of the effects on the healer, which has in turn signalled a subtle shift toward an emphasis on the internalization of the healing role.

The turn toward focusing on the effects of Therapeutic Touch on the healer has appeared to accelerate Krieger’s adoption of mysticism. In her book, she now advocates the use of dream analysis, symbolic language, yoga and mandalas. The healer is to attain some ideal inner knowledge.

In a more scientific vein, Krieger has demonstrated the genuine state, as measured by the EEG and EMG (3). While this state may do wonders for the “head” of the healer, we are constrained to ask how all this is externalized? Krieger’s answer—”Kirilian” photography. The energy veritably leaps from her fingertips (4).

One on One

Incredibly, Krieger manages to avoid the debates around technology and priorities in health care. She refrains from explicitly counterposing Therapeutic Touch to Scientific Medicine, or presenting it as an adjunct to traditional medicine.
The approach of Health/PAC has been to criticize the misuse of technology, the misallocation of resources, and the skewed priorities of disease-treating medicine. Health and illness are fundamentally social issues; and refusal to accept that basic premise makes it impossible to analyze the problems in the system, let alone suggest progressive changes.

By contrast, Therapeutic Touch is individualistic to the core. The individual “healer” approaches the individual (ill) patient with no thought of where either fits into the system for better or worse. By its silence on the questions of technology, allocation, and priorities, it accepts the present arrangement as a given. Therapeutic Touch tries to be apolitical.

Therapeutic Touch does fit nicely into a health care system which rejects social responsibility for health. Cutbacks in services and appropriate technology become irrelevant. The success or failure of the system becomes dependent on the ability of nurses to throw themselves body and, more importantly, soul into their work. In this way, nurses are set-up to shoulder the failures of the health care system.

Technology and Health Care

There is a growing recognition that the latest technology may not be efficacious in all cases. For example, many terminal patients are better treated by supportive, rather than curative or even palliative, therapy. Doing “everything possible” can actually hasten death, and certainly increases the patient’s suffering and chances of iatrogenic disorders.

Krieger, however, makes no bid for the use of Therapeutic Touch when high technology is ineffective. In fact, nowhere does she explicitly address the question of which patient care situations are appropriate for TT and which may be less so.

Patient care situations in which technology is inappropriate because it is too little, too late, are precisely tailor-made for intensive, wholistic, traditional nursing care. The hospice movement is an explicit recognition of the value of nursing care over that of high technology in certain situations. A 10-minute “treatment” of TT is simply absurd and pathetic by comparison.

Counter-Culture and Health

Americans seem particularly fond of crackpot schemes (5). Next to general “life-style,” this mode of thought finds its strongest expression in matters of health. Does TT plug itself into any of these undercurrents in health?

Among the pop cultural approaches to sickness and health are religion, health food, physical culture (jogging against cancer), machine-breaking Illichism, and outright quackery. Objectively, TT should fit in along this continuum, if for no other reason than its blatant mysticism. All, with the exception of religion, preach individual reliance and responsibility for health. TT may be the penultimate “me generation” view of health by emphasizing the “power” of the individual.

Krieger makes no effort to place it there, or to identify with any of them. She has bigger fish to fry. Therapeutic Touch is not intended to be merely the latest health craze.

Content and Context

Therapeutic Touch is offered up as that unique body of knowledge which distinguishes nursing. Among unique bodies of knowledge, the selection is limited. Unfortunately for nursing, science is already spoken for.

Just how different is Therapeutic Touch from Scientific Medicine? In terms of actual knowledge base, they are polar opposites; but in terms of ideology, they are almost identical. Both propose an individual rather than social view of sickness and health. Both concentrate their efforts in cure rather than prevention. Both preserve a monopoly power over “health” in the healer (although Therapeutic Touch may do this more strongly), by mystifying, ritualizing and otherwise placing knowledge beyond the reach of the average individual. The healer remains the dispenser of magic.

Adoption of the medical model is no mistake. One of the hottest issues for the nursing elite is private practice for nurses. While many such schemes involve nurses remaining subordinate to medicine to some degree, Therapeutic Touch provides the wherewith-all to cut the cord.

The price of such independence, however, may be to make nursing the laughing stock of the health sciences. If private practice for doctors is tragedy, private practice for nurses, based on Therapeutic Touch, is farce (6).

TT and Nurse Practitioners

One of the movements which promises a far-reaching impact in the delivery of health care is specialization and nurse practitioners. As nurse practitioners, some nurses attain a measure of independence and receive the recognition due nursing. While there are serious problems of access and elitism among nurse practitioners, they are beginning to fill a need for cheaper middle-level health providers.
Frustration with the attempt to deliver quality nursing care is part of the social reality of which health care is a part. What is needed is not to 'balance' the inequities of the health care hierarchy but to destroy that hierarchy and to rehabilitate the handmaiden reputation of nurses.

Nurse practitioners have been able to gain a measure of success only by poaching on medicine's private preserve. It is unlikely that any alternative strategy would be attractive to most nurse practitioners so long as the epicenter of health care remains scientific medicine and its emphasis on diagnostics. By comparison, Therapeutic Touch is an eclectic form of therapeutics without diagnostics. Most nurse practitioners can be expected to shy away from any such attempt to funnel them out of the mainstream.

Therapeutic Touch can only appeal to a thin layer in nursing. It appeals most strongly to those who have grown disgusted with, or never intended to become involved with, institutional nursing (7). But this is an individual cop-out and diversion, coming just as nurses are beginning to flex their collective muscles.

Strategy for Change

The hundreds of thousands of working nurses have no need of Therapeutic Touch. The problems they face daily do not arise from deficiencies in their "heads," or in the inability of nursing to define itself beyond the borders of reality.

Frustration of the attempt to deliver quality nursing care is part of the social reality of which health care is a part. Much of what is done in the health care system comes through nurses. Nursing labor is central to the system's functioning. Nurses are in a position to realize the obvious deficiencies of understaffing and submersion of the importance of the role of nursing to the operation of the system. Because of their centrality, nurses can begin to affect change by using their collective strength.

What is needed is a struggle not to "balance" the inequities of the health care hierarchy a little more at the middle level by adding another individualistic, mystifying "science" but to destroy that hierarchy. Also challenged must be the hierarchy's systemic domination which prevents equity in effective care for all and obstructs a total public health approach to the social causes of illness.

Rather than looking for individual solutions among constructs, nurses should use their organized strength to demand an equal and collegial part of decision-making in a realigned health care system.

—Glenn Jenkins

References
