Editorial: Turning the Tide

Whatever might be said about the Carter years and the 1970s in general, the sharp lurch to the Right represented by the new Reagan administration and the new Republican rule in the Senate must be seen for what it is: a serious setback for progressive forces throughout the country.

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Do economic fluctuations cause mental health problems? The answer is more complicated than was thought.

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When New York RNs struck last Fall, they were up against the City and the nurse's association.
In the area of health and health services, even the limited reforms that were being earnestly debated and advocated four years ago may now seem distant dreams: comprehensive national health insurance or a national health service; a safer, healthier workplace and environment; increased consumer involvement and community accountability; efforts to harness a runaway medical technology; women's right to abortion; community health centers and inner city hospitals; equal access to services and health careers for women, minorities, and working people as a whole; and a halt to U.S. medical, drug, and food/nutrition exports which bring super-profits to corporations here while inflicting death and repressive methods on the Third World.

There are certainly grounds for pessimism. Past Republican administrations have proven insensitive to needs for even modest social reform, and this administration will be backed not only by one house of Congress but by a much-hyped "swing to the Right" reading of American public opinion by most of the mass media. Reagan himself has long been the darling of conservatives, and Vice President Bush is a former CIA Director.

Meanwhile, the need for action to help the growing numbers of Americans without any means to pay for medical care (recently estimated to total 12.6 percent of the population, or 26.6 million persons) becomes if anything, more pressing. Directly related is the escalating destruction of inner city health services that medically abandons hundreds of thousands of additional poor and working poor persons each year. Existing environmental and workplace protections—meager at best after decades of struggle to strengthen them—are overwhelmed by the unceasing production of corporate injury and disease. Consumer and community involvement, more needed than ever, becomes increasingly difficult to achieve in practice. And, as Health/PAC's own studies have shown, two decades of affirmative action battles have yet to achieve real equality for women and minorities seeking health careers.

Despite what may seem adequate grounds, those of us who work and volunteer at

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THE SOUND OF THE RIGHT HAND CLAPPING

Graduates of American medical schools may be ashamed to know they have earned the only degree which qualifies them for every right-wing mailing list in Richard Viguerie's whirring computers. By raising the specter of Nationalized and Socialized Medicine as if it were hiding just around the corner, they appeal for money to fend off this hulking, bureaucratic mugger about to make red-tape hostages of us all. To read their literature is to discover the immanence of Socialized Medicine. Do they know something we don't know?

For those who do not receive these direct mail warnings or who recycle them without opening the envelopes, here is a brief listing. You can't tell the players without a scorecard!

From Shawnee, Oklahoma, comes the Doctors' Foundation Committee, Division of Americans Against Socialized Medicine. In a computer-typed letter which inserts the addressees name three times in the body of the letter, the Doctors' Foundation Committee attacks the radicals in the Carter Administration advocating catastrophic health insurance, while putting in a plug for the

seven major insurance companies which, they point out, can do the same job cheaper. "National health insurance, in any form, simply isn't needed, they argue, "You and I know this, Dr. _______. But do your patients?"

The Doctors' Foundation, interestingly, reminds the doctors that "every dollar you contribute can be deducted as a business expense."

Included with the letter is a press release from the Congress of County Medical Societies (an organization which exists largely to publish Private Practice, a magazine distributed

free to physicians), which attacks catastrophic health insurance and lists the seven insurance companies which can do it better. The president of the Private Medical Care Foundation, quoting statistics from US News & World Report, proves that catastrophic health insurance would benefit less than 2 per cent of the population, while taxing everyone. Truly catastrophic. All of this evidence is churned out of Oklahoma City.

In a followup letter, The Doctors' Foundation Committee complains that the AMA has capitulated to National Health Insurance, but gives the faithful hope by detailing how two county medical societies defeated a drug substitution bill before the Oklahoma legislature. Francis A. Davis, MD, president of the Committee, writes, "Armed with the facts we have here at the Foundation—the facts you know in your bones, Dr. _______... we doctors have the power to kill this thing if we will just get off the dime." Besides a pitch for money, the committee supplies a copy of "An Open Letter to My Patients About National Health Insurance" to distribute and instructions in its use.

What is not mentioned is the disappearance of Robert Barker, the appropriately named chairman of the Doctors' Foundation Committee, from one masthead to the next. Perhaps he had become too busy with his duties as chairman of the Private Medical Care Foundation mentioned in the Congress of County Medical Societies' news release and resigned. Or perhaps as a veterinarian he was not the most appropriate spokesman for these three interlocking groups. Or, perhaps, the committee decided he was more a barker than a biter.

Taking a less grassroots approach is the Committee for Responsible Health Care, which was assembled last summer in Washington, D.C. with funding from the Atlantic-Richfield Corporation. Taking a "star" approach to the corporate problem of rising health costs, the Committee has assembled a galaxy worthy of "Meet the Press." Their galaxy includes former Secretary of the Treasury William E. Simon, who sits on the boards of Xerox and

VITAL SIGNS

Senator Hatch warns that 'Labor and the ultra-liberals will have the government hiring thousands of new bureaucrats to regulate your health care'
Citcorp, and is currently president of the John M. Olin Corporation; Michael DeBakke, the nation’s foremost heart surgeon and president of Baylor Medical Center; Harry Kane, a former executive director of the American Public Health Association; and Elmo Zumwalt, the former chief of Naval Operations and member of the Joint Chiefs of Staff. Apparently, the main effort of the Committee has been to raise money for its own existence, an endemic problem of the "star" system.

From Senator Orrin Hatch and The Heritage Foundation you receive a free, simulated "National Health Identity Card" in which you are assigned to a government doctor and hospital by number. The card also gives you the waiting times for different kinds of surgery—four months for cataracts and cosmetic surgery and only two months for hernias and radical mastectomies.

The Heritage Foundation, writing before the euphoria of the Republican election victory, sounded the alarm with reports that "Big Labor’s # 1 goal for 1980 is to force you to join and pay for a government-run, compulsory Nationalized Medicine plan." The Foundation provides a scientific questionnaire to poll the public so that it can report its results to Congress and the media. Some of the questions include the following:

1. Do you believe if federal bureaucrats run a National Health Care System, it will result in an overall decline in the quality of health care standards for Americans?

2. Do you want the government bureaucrats to determine what kind of medicine and medical treatment you should have when you are sick?

3. Do you believe the price you pay for medical care under a National Health Care System should be set by the amount you earn—so that if you earn more, you pay more for these services?

The Foundation pits itself against the Brookings Institution and the AFL-CIO, claiming to be "America’s leading research/free enterprise institute," leaving the poor American Enterprise Institute in the cold and the Institute for Policy Studies in Siberia. Senator Hatch warns that
A San Francisco kidney specialist has set up his own non-profit foundation dedicated to showing ‘citizens the advantages of profit-making over non-profit health care delivery’

"Labor and the ultra-liberals will have the government hiring thousands of new bureaucrats to regulate your health care" in a plan that’s "a virtual carbon copy of England's." The price for their Campaign to Stop Nationalized Medicine: $185,000.

Rather than ask others for donations, Sajjan G. Dharnidharka, a San Francisco kidney specialist, is using $120,000 of his own money to found Taxpayers for Efficient Health Care. His "purely educational" foundation is dedicated to showing "citizens the advantages of profit-making over nonprofit health care delivery." Only 35 years old, Dr. Dharnidharka became aware that private for-profit facilities are the most efficient while establishing his own Artificial Kidney Clinic in Stockton, California. He is convinced that government is the leading villain causing soaring health costs. At the same time, he reports that he has maintained "healthy profits" despite legal mandates to reduce the charges for dialysis from between $200-$300 to $156 by "dialyzing more patients in less time through more efficient use of resources."

The philanthropic Dr. Dharnidharka would like to teach what he learned to others. Perhaps next he will teach citizens how to use tax-exempt foundations as both tax shelters and lobbies.

But Dr. Dharnidharka should know that San Francisco is not virgin territory. The Institute for Contemporary Studies and the Hoover Institution are already vying to be the Right’s foremost West Coast medical think tank. The Institute for Contemporary Studies has made a bold bid with New Directions in Public Health — A Prescription for the 1980s, a collection of essays edited by Harry Schwartz, who earned his credentials writing anti-Soviet diatribes at the New York Times. This stalwart anti-Stalinist Horatio at the bridge now bars the Communist Menace as editor of Private Practice.

—Hal Strelnick

Source: The U.S. Mail.

YOUR LIFE COULD BE WORTH $12.50

The following memorandum is reprinted in full.

As you know, the rate of post-mortem examinations at Montefiore Hospital and Medical Center has fallen to exceedingly low levels and is, at this moment, approximately 12% of all deaths occurring at the Hospital. This is inconsistent with the standing of a major teaching institution and a change is urgently needed. With the approval of the Medical Board, the Administration implemented two measures which should be helpful in this regard.

The first measure is a new form which is appended on the reverse side of the Autopsy Consent Form and which must be completed for all patients dying at the Hospital, if an autopsy consent is not obtained.

The unit secretaries will place the form in the deceased patient’s chart for the responsible house officer to complete. The completed form will ultimately be reviewed by the Department of Pathology, which will monitor the autopsy rate for each clinical department and the reasons for the low rate of autopsies.

The second measure will provide additional incentives for the house officers: for every four autopsies obtained, he or she will receive a medical text or other publication of his or her choice up to a value of $50.00.

Would you please communicate these two measures to your staff and urge them to do their best to obtain authorizations for post-mortem examinations?

Your cooperation will be deeply appreciated.

From now on we’ll feel more secure as patients in hospitals with good lending libraries.
HALF AN EMPIRE IS BETTER THAN NONE

A recent article entitled "The New Medical-Industrial Complex" (Arnold S. Relman, "The New Medical-Industrial Complex," New England Journal of Medicine, v. 303, no. 17, Oct. 23, 1980, pp. 963-970) may seem like old hat to Health PAC readers but it has caused a mild storm in more established circles. In the article, Arnold Relman, the Journal's editor, noted that the growth of for-profit hospitals, nursing homes, laboratory services and renal dialysis centers threatened to distort the priorities of the health system and promote conflicts of interests among doctors and other health providers who might own stock in these businesses.

Of particular concern was the rapid growth of proprietary hospitals in the Western states. The editor was worried that such institutions, motivated by profits, would begin to "skim the cream" of profitable insured patients off the top of the patient pool, leaving the voluntaries and medical centers to care for the unprofitable, uninsured and more needy clients. Those patients who had "unprofitable" conditions—i.e. conditions for which reimbursement was inadequate or who lacked medical coverage — would be left without care.

While the article draws its analysis and even its very title from Health PAC's ten year old critique, most forcefully presented in The American Health Empire (New York: Random House, 1971), it should not be assumed that the Journal's editor shares our perspective.

The most significant difference lies in the distinction that Dr. Relman makes between the "old" and "new" medical-industrial complexes. The "old" medical-industrial complex, he says, included pharmaceutical and medical supply companies. In his view, these are not "particularly worrisome" because they "have been around for a long time and no one has seriously challenged their social usefulness." Besides, Dr. Relman maintains, "in a capitalistic society there are no practical alternatives" to them. The "new" medical-industrial complex, however, "is an unprecedented phenomenon with broad and potentially troubling implications for the future of our medical-care system." (p. 763).

In the editor's analysis, voluntary hospitals and medical centers and teaching institutions are also exempted from criticism. This should not be surprising; Dr. Relman is a medical educator. Nor is it surprising that the paper has attracted widespread attention from the popular press, most significantly on the editorial page of the New York Times. What is surprising is how completely the Health PAC ideas of ten years ago have permeated mainstream academic analysis and how thoroughly their meaning has been narrowed and di-

The term 'medical-industrial complex' refers to the crassest and most overt manipulators of the profit-motive in medicine. There is another name for the educators and medical centers which abuse the system in other ways—but that for later

David Rosner

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THE UNITED STATES OF AMERICA

THE DOLLAR
MAKING THE DEAN'S LIST

In biology, media are what infectious things grow on. Apparently, unsatisfied with lists of the Best Dressed, the Top Ten Movies of 1968, the Top Forty, and the Best Cheesecakes, the ranking of physicians in the media has been spreading. First there was John Pekkanen's *The Best Doctors in the United States*, a book that sold out its first printings and was serialized in the *National Enquirer* and other supermarket tabloids. Then came *New York Magazine*’s "Superdoctors: The Top M.D.’s in New York," which followed Pekkanen’s methodology by asking the specialists to name the super-specialists, ending up with a list of academic heavyweights (no general pediatrician was listed and only one general internist; family general practice, and community medicine did not even merit mention).

But what goes around, comes around. *Private Practice*, a journal distributed free to about 180,000 doctors by the Congress of County Medical Societies, decided to poll the deans of the nation’s medical schools to determine the best and the worst.

Before the Journal could harvest value judgements from all 200 deans and assistant deans at the nation’s 126 medical schools, Dr. John A.D. Cooper, president of the Association of American Medical Colleges, their trade organization, intervened, asking them not to respond. But *Private Practice* had already received the responses of 44 deans, and published their ranking of the 15 best and 10 worst schools.

What made news, however, was not the rankings themselves, but the *Washington Post* story of Dr. Cooper’s "gag order" by Daniel S. Greenberg, Washington columnist for the *New England Journal of Medicine*, who asserted that Cooper had violated the public’s right to know.

The survey results are a telling revelation of the values of academic medicine. Its top ten were the predictable paradigms of the post-Flexner era: 1) Johns Hopkins, 2) Harvard, 3) Duke, 4) Yale, 5) Columbia, 6) Chicago, 7) Washington (St. Louis), 8) Stanford, 9) UCLA, and 10) Michigan.

**Institutional racism can wear long white lab coats just as easily as it wears white hoods and white sheets**

Its ten worst medical schools, however, were either schools committed to training minority physicians or new schools committed to training primary care physicians: 1) Meharry, 2) Puerto Rico, 3) Howard, 4) New Jersey College of Medicine & Dentistry, 5) Southern Illinois, 6) Creighton, 7) Loyola, 8) Texas Tech, 9) Hahnemann, and 10) Medical College of Ohio. The three worst medical schools, by the dean’s list, are the three predominantly minority institutions in the country with long traditions of training physicians who often serve minority communities. Howard recently gave the *Washington Post* the scores of its students on the last pre-graduation part of the National Board Examination, which proved their pass rate was well above the national average. The New Jersey College of Medicine & Dentistry is one of the few predominantly white medical schools with a consistent commitment to affirmative action. Stanford is the only school among the dean’s list which can boast significant success in affirmative action, while Johns Hopkins has been among the worst schools in minority admissions.

Whether Dr. Cooper’s intervention was designed to protect academic medicine’s liberal image or to protect the dues-paying institutions in the trade association, it came too late to hide the naked truth. Institutional racism can wear long white lab coats just as easily as it wears hoods and white sheets.

—Hal Strelnick

Source: *Private Practice*.

SECOND OPINION

After debating the Detroit health services agency bed reduction plan (see Health/PAC Bulletin, October) a joint committee of the Michigan state legislature ordered the HSA to rewrite its proposal, demanding that hospitals be targeted. The joint committee also seriously questioned the value of shifting patients from low-cost community hospitals to high-cost tertiary hospitals. Heavy political pressure from the teaching facilities suppressed a staff recommendation that the giant teaching hospitals and the mid-size community hospitals share equally in reduction responsibility. The final outcome is unclear.

The Detroit HSA (CHPC-
Editorial: Turning the Tide

Continued from Page 2

Health/PAC are not sinking into despair. In fact, we see the Right's redux as an early warning and an opportunity.

The warning should be aimed at the 70s tendency to retreat — whether into nostalgia, fantasy, or the self — in the face of determined opposition. History will not inevitably bring progress towards a more humane society without our individual and collective efforts. As Frederick Douglass put it, "If there is not struggle, there can be no progress."

The opportunity is clear. The failure of a too-moderate liberalism to hold the economy together; to provide the impetus necessary to unite poor, working, and middle class Americans; or to sanely manage a declining US empire abroad, creates a vacuum of leadership as well as of ideas among progressive forces.

The concepts, issues, political movements, and leaders which will move and shake the 1980s can be progressive ones. But, rising to this opportunity requires close heed to the lessons of both the 1960s and the 1970s. Strategies and ideas from the past two decades are not necessarily adequate for the future. The success of the Right, for example, has been built upon not only immediate corporate/institutional bankrolling but on a newfound respect for coalition politics, a frightening instinct for the more perverse and confusing sides of everyday social, family, and personal "moralities" (do they favor a right-to-life after birth?), and a willingness to forsake ideological purity on all issues. At the same time, its publicists have succeeded in purveying the illusion that "private enterprise" and non-government-as-usual can provide economic growth and social improvement.

Can the Left similarly create practical coalitions of poor, working, and middle class groups around a progressive vision and issues that touch their everyday lives? Can we reconnect an understanding of how our communities, industries, and regions, as well as other parts of the world, are exploited in deadly ways by runaway and absolutely unaccountable transnational corporate investors?

In health, can we provide a vision of a society that is at once less involved in the production of disease and more equitable and accountable in its distribution of services and jobs? Can that vision be translated into practical actions which ordinary people can identify with and support?

Health/PAC, like many of our activist supporters, begins the decade with meager resources and a sober disposition, but also with renewed dedication. Reagan has our adrenaline flowing, and that's great. We are, for example, now preparing a special March/April issue to coincide with the 10th anniversary of the Occupational Safety and Health Administrations and a national "corporate industrial diseases week." This effort will deepen our understanding of both the techniques of occupational-environmental "death-planners" and the work of their labor-based challengers. At the same time, the Bulletin will offer a self-critical strategic discussion of labor-based health politics.

We know health activists will play an important role in national and local efforts to unite all progressives around issues such as defense and development of services and economic well-being: occupational and environmental protection; and reducing the threat of nuclear catastrophe. The Caucus for Progressive Health Planning, for example, is working as part of the Planners Network (P.O. Box 4671, Berkeley, CA 94609) to organize a conference this spring to discuss joint strategies and political positions.

Of course, new ideas will not be enough. We have to build on basics — analysis, fundraising, organizing, staffing an office, and, yes, even getting our publications to the printer. The job can be done. It will be done if people continue to support one another. We'll be there.
Mental Health is Hard Work

How do the manic-depressive swings of the U.S. economy affect the physical and mental health of ordinary American citizens? Academics have long debated whether downturns and recessions bring rising rates of mental illness, or whether periodic runaway growth is actually the culprit (see "The Boom-Bust Debate" box).

In the following article the authors begin to unravel the complex relationships between the use of mental health services and economic activity, family, and personal life. Their study of mental health services in a small New England industrial area over a 25-year period finds evidence for both sides of the debate and highlights its complexity. They definitely conclude that economic fluctuations do affect mental health status, in ways influenced by the organization of particular families and communities. This serves as an important reminder to us all that community and family well-being are the most meaningful, yet most often neglected, measures of economic progress.
With three children, the youngest not yet in school, Peter and Debra Hansen (names and locale have been changed) were barely meeting day-to-day expenses with the income from Peter's job as foreman at a local company just outside Fitchburg, Massachusetts. The Hansens seemed to be a typical family in the area, and a reasonably stable one.

Suddenly Peter's shift at the company was cut from five days a week to four; his pay also dropped 20 percent. Money problems spread tension through the house. Debra was uncertain about looking for work with their smallest child still at home. Peter said it was out of the question. He began to hang out later on the nights he worked late and paced the floors during the days he was home. Debra had always kept the house immaculate, but Peter started complaining about her housekeeping.

Then the oldest Hansen child started bringing home reports of misbehavior in school. Each parent blamed the other. Family and friends seemed to stop coming by. Debra took a part-time job as a hospital ward-clerk over Peter's objections. Soon, almost nothing could be mentioned without a fight. Even when Debra brought up the possibility of counseling, there was a bitter quarrel. Finally, shaken by her threat to leave him if he didn't go with her, Peter agreed to counseling at the area's Community Mental Health Center (CMHC).

In this case study, a seemingly subtle change in the employment status of one member of a fairly typical American family had a profound impact on that family's emotional well-being. The result is contact with the formal system of mental health services, as well as changes in family roles.

Yet their social worker is convinced that personality problems and mental illness actually cause unemployment and the related upheavals in family life. One social worker at the Herbert Lipton CMHC in Fitchburg, Tom Dorrance, has said "About 15 percent of clients have job-related problems, such as conflict with their boss or co-workers. In most instances it is their marginal level of social skills and interpersonal competence that creates job-related problems."

According to Mike Sciabarrassi, an Intake Emergency Worker at the Herbert Lipton CMHC, "Very few clients ever come to the clinic with specifically employment related problems, even fewer as a result of unemployment," although some whose income loss made
medication unaffordable would turn to the clinic. Dr. Theodore Jellinek, Acting Director of the center, concurs with these staff opinions, "Very few people come to the Center on account of loss of employment," he said, "and I almost never meet them in my private practice."

What seems to have begun as an impersonal business decision is thus reinterpreted as an individual's chronic personal problem. But where is the truth?

The complex, and sometimes elusive, relations between individual behavior, family and community organization, and economic change have attracted the interest of numerous mental health professionals. Others, including community activists, social policy analysts and economists have also questioned whether time and resources are properly concentrated on individual treatment, or should be focused on strengthening the fabric of family and community life. Community mental health staff often find that the traditional exclusive emphasis on treating the individual, common in hospital-based practice, is no longer appropriate. They argue that the environment can bring on disability and dysfunction; therefore, "treating" the environment makes as much sense as treating the individual. Currently there exists a kind of ad hoc interdisciplinary exchange which finds community mental health workers venturing into the economic and social change arena, while economists pay greater attention to the "hidden" social costs of economic decisions.

The Community Context

The chicken-and-egg question of the relationship between individual stress or pathology and the disorganization of home, job and community life is obviously not simple. Nor is it only academic. The "line" of one scholar, Harvey Brenner, has been cited by the Joint Economic Committee of Congress as an important guide to national economic planning (see "The Boom-Bust Debate" box). When social and economic policy decisions are drawn from theoretical analyses, it becomes crucial to examine the factual basis of the analyses themselves.

To move beyond a simple cause and effect model of the stress-dysfunction relationship, the senior authors of this article carried out a detailed study of utilization of mental health services in the CMHC catchment area of Fitchburg-Leominster, an old industrial community in northeastern Massachusetts. The
Shifts in economic structure weaken the capacity of families and social networks to provide support and at the same time box individuals into increasingly distressed conditions.
DIANE LACEY TALKS ABOUT SYDENHAM

Attempting to save Sydenham Hospital has been a fulltime job, but Diane Lacey works at it in her spare time, which is hard to discern. When we arrived in her office at radio station WWRL on the day she had set a week in advance, she apologized for keeping us waiting. Her desk was piled high with papers, including a copy of Health/PAC's *The American Health Empire* — "I'm teaching a course," she explained. During the interview she referred to three meetings she had attended the day before; one of them was the monthly session of New York City's Health and Hospitals Corporation board, of which she is an embattled member.

How had she become involved in the Sydenham struggle? "A committee was established to save the hospital as far back as 1945, but my association began in 1976. At that time Sydenham was put on the hit list along with a number of other hospitals as part of the Beame Administration's response to the fiscal crisis. I was working in the Health and Hospitals Corporation, and tried to lobby from the inside to keep the hospital open. Unsuccessfully." Her lips formed the wry smile of someone who has been meticulous enough to prove the obvious.

"At that point I was also a Democratic district leader in the area where the hospital is located. I got together a broad-based group which put about 5000 people into 125th St. to protest the closing—the first march of that sort in Harlem since Adam Clayton Powell days. We were one of the early efforts in New York City, probably in the country, which rallied community people and others to save a public hospital. There was broad support, and after the politicians—both uptown and downtown — saw our determination, they joined in and we were able to defeat that move to close Sydenham. Of course," she added grimly, "since 1976 we've lost Philadelphia County Hospital and a number of others throughout the country.

"In June of 1979, when Mayor Koch demanded the hospital be closed and pushed a vote through the Health and Hospitals Cor-
poration, the Coalition to Save Sydenham Hospital came back together with essentially the same makeup; it’s just grown and developed in the past year.

“We’ve been working with a multilevel strategy. The Corporation vote was based on a task force report, which was supposedly written by Haskell Ward, then Koch’s black deputy mayor. So our first effort was to attack that report and all the errors of fact in it. We succeeded quite well, along with groups like the Coalition for a Rational Health Policy and the New York chapter of the American Public Health Association. Even the Health Systems Agency indicated that the report was full of holes and urged that the hospital stay open. So we thought that since the report was totally and completely discredited over three or four months, the Mayor would back down.” Again she smiled wryly. “Of course he did not, so our organizing efforts had to continue.

“With District Council 37 of the State, County, and Municipal Employees union; the Community Legal Action Service; and the NAACP — really led by the NAACP’s Manhattan Director, David Bryan—we went to court, charging that the closing of Sydenham represented a violation of the civil rights of the Black and Hispanic residents and hospital workers. We fought that battle for over a year and finally lost on the Appeals level in a two to one vote. That decision, we feel, was politically influenced, because the facts substantiated that the closing is very much a violation of civil rights. And we can point to the dissenting opinion, which was longer than the opinion of the original lower court judge.”

Diane Lacey’s voice, always clear and precise, became more animated. “We also worked with the citywide coalition to save municipal hospitals to raise the issue across the board in the city. We had hundreds of letter-writing and petition campaigns. We had demonstrations in front of Gracie Mansion, the mayor’s residence. We held speakouts and numerous community meetings with politicians and local leaders.”

Mayor Koch remained adamant, pugnaciously asserting Sydenham was a waste of money and Harlem residents could be better served elsewhere. Health activists argued in vain that all of the other northern Manhattan hospitals are suffering from budgetary constraints and reducing services. “The coalition began meeting pretty much non-stop about June, 1980, because the closing hovered over us but the date wasn’t set until August. At a variety of meetings and demonstrations in our own community and downtown, it was clear that our people were becoming very discouraged. After a while, it became clear that our people were becoming discouraged.”

“...still, Mayor Koch remained adamant, pugnaciously asserting that Sydenham was a waste of money and that Harlem residents could be better served elsewhere. After a while, it became clear that our people were becoming discouraged.”
city system, and had hired five or six extra people for the people around closing. But I think they were really lulled and did not believe that we would go that far.

"We had our meeting the night before, and more and more people came, and we took over the hospital. The trusted people had alerted some of their colleagues; people began to come. And the media were there that night—that is one success we can point to. In 1976 you could hardly get a murmur from the press about this issue, but we had gone to the well so many times, we had organized and been active on this issue so constantly, that whenever there was a rumor of closing, the media, including the TV people, would hang around. So they were there and got it right to the public and that helped us spread the word and make contact with a lot more people.

On September 16th of last year, Sydenham was set to be closed. Neighborhood residents began demonstrating and finally took over the facility to ensure that it remain open. The media was there . . .

"That Saturday, the picture of those police—who the mayor said operated with such restraint—brutally attacking demonstrators flashed all over the country and maybe all over the world—I've received copies of that photograph from the Caribbean. So the name of Sydenham and the struggle for Sydenham have become more nationally known."

When the subject of cooperation with people trying to save Harlem's North General Hospital was raised, Diane Lacey's eyes narrowed in a shrewd, thoughtful expression. "No, we haven't worked together much. The North General story is interesting. It started with the addition of a few Black members to the board of directors—with very little publicity. The white policy-makers at North General, which was then Joint Diseases, were very much involved in trying to defeat our efforts. Their position was that Joint Diseases had a much better facility, was a much stronger hospital, and should stay alive while Sydenham should close.

"We have since had many conversations and have agreed that it is not in the community's interest for either of the hospitals to close."

She paused with a small sigh which seemed to indicate both hope and exasperation. "So at least we are communicating. Of course since our dispute the Black and Hispanic executive staff and administrators there have had the rug pulled out from under them. Joint Diseases moved downtown in a manner which could best be described as the rape of North General. They even took partitions and walls—in addition to some of the cream of the staff. Secretly, and in violation of their commitments. They also pulled the rug out fiscally. Some of those people who were used to attack us in '79 have seen their chickens come home to roost."

How can a hospital which couldn't make it as a municipal survive as a voluntary? When this question came up, Diane Lacey's expression and voice took on a harder edge. This was, after all, the problem which was keeping her up nights at meetings, and no doubt when she tried to fall asleep as well. "First of all, for the last five years for sure and probably longer there has been a constant attrition policy in the Corporation, there has been bad management, and we have not had a system able to prove itself.

"Now, of the 17 municipal hospitals, Sydenham was able to generate the highest reimbursement rate, close to 90 percent of the operating budget. And we did that against tremendous odds. Many of our people had ideas about staffing which would have made our reimbursement even higher. So we have creative people, and we believe that without the burden of a system determined to fail, and a mayor who is publicly identified with the concept of closing municipal hospitals and giving them away to the private sector, we have a very good chance of surviving."
How long can Sydenham survive? 'We have a determined community. People are pledging their support to keeping the hospital. We are talking about self-determination in the Harlem community, and I’ve never seen this kind of energy and determination before'

“I’m going up to Lincoln Hospital in the Bronx to look again at their detox center, which has managed to stay alive through many administrations. Michael Smith is using acupuncture there, quite successfully, and they’re doing quite well with reimbursement. We think we can use similar artful measures to be financially viable.”

Will Sydenham have a drug program? “I’m not saying that,” she replied quickly, “I’m saying that we are looking at a successful program, and if they can do that, maybe we can do other things. We are unalterably opposed to the city’s plan for Sydenham, which is of course for detoxification, treatment for alcoholics, and for mental patients. There are plenty of other sites in Harlem suited for it. There are 200 detox beds at Harlem Hospital that were closed down a couple of years ago. There is the former Logan Hospital, which is being vandalized because it is not in use. There’s Metropolitan Hospital’s Mental Health Center, which has numerous beds available. We know that many of our patients who come to us with health problems also have drug problems, alcoholism problems, mental problems. But we have been treating them for their primary complaint, which is a health complaint, and will continue to do so.”

President Carter’s aides met with the Committee to Save Sydenham after the takeover and promised grants, but that was before the election. “We are raising money right now,” she said, “I can sell you tickets for our theatre benefit. And we have plans for major fund-raising, including a $100,000 weekend. We are going to be approaching foundations as well.”

How long can Sydenham survive? Her eyes widened. Her voice, still calm, repelled any thought of interruption or argument. “We have a determined community. We have people whom I could never get out before to support Sydenham pledging their resources and their time to make this hospital a reality, who are determined whether or not we get the federal grants which make starting up the hospital a little easier. We are talking about community ownership. We are talking about self-determination in the Harlem community, and I’ve never seen this kind of energy and determination before.

“In addition to being a health activist and health advocate, I consider myself a community organizer, so I think the major thing we’ve won is unity of the community around a single issue. We’ve been able to pull together not only Harlem but the Black leadership from around the city, and that’s been very exciting for me personally and for this effort. I believe this unity is going to be valuable not only for saving the hospital and focusing on the crisis in health care in northern Manhattan, but also for focusing on the problem of gentrification in Harlem, of our sad political state—we have been under attack by Ed Koch for the past three years—and hopefully give us the ability to pull people together around the 1981 mayoral elections.”

—Kate Pfordresher and Jon Steinberg

Errata

In the previous issue of the Bulletin, Kate Pfordresher should have been listed as Associate Editor. The photograph on page 10 of that issue was the work of Mel Rosenthal.
UNION BLUES

On Friday, October 17th, registered nurses in 14 of New York City's 17 municipal hospitals walked off their jobs to protest low pay and poor working conditions. Their contract had expired three months earlier, but the New York State Nursing Association had not been able to negotiate a new one.

Strike plans had been kept secret. The public first became aware of the walk out at 7:00 AM as morning shift nurses set up picket lines at the hospital gates. At noon Margaret Rooney of the NYSNA announced to the press that the Association did not endorse their members' action and urged nurses to return to work. The rank and file did not obey, defied a court-ordered injunction against the strike, and stayed out for five days.

Because there was no advance publicity, this wildcat strike seemed to appear out of thin air. It didn't.

Only five months before the strike, the NYSNA had avoided defeat in a decertification election involving the 5600 city hospital nurses. Receiving 36 percent, the NYSNA won by a narrow two percent margin over the combined total of the two challengers, the United Federation of Teachers (UFT) and the National Union of Hospital and Health Care Employees (District 1199).

During the last four years, city nurses have grown restive as their salary, benefits and working conditions fell behind those of nurses in the voluntary hospitals. Salary parity with nurses in New York's voluntary hospitals was suspended during the 1976 and 1978 contracts at the time of the New York City fiscal crisis. This discrepancy between private and public hospitals has created chronic nursing shortages in the City hospitals, since many RNs have been forced to transfer to maintain their living and working standards; periodic hiring freezes have slowed employment of replacements, creating a crushing workload for those who remain. The situation has become so desperate that the City has begun recruiting in the Philippines.

The NYSNA, which has represented the City RNs for over 20 years, has watched this erosion, powerless to stop it. Historically, the Association's main interests have been legislation, licensing requirements, and education; only recently has it turned to collective bargaining. The leadership of the organization is comprised of nursing administrators and educators, whose concerns at the bargaining table are often in conflict with the demands of rank and file nurses. The NYSNA's all out support for the 1985 Proposal to require a B.A. of all prospective RNs demonstrates this commitment to developing "nursing leaders" at the expense of working nurses and of patient care.

In the decertification battles, the NYSNA was challenged first by the UFT, which attracted many sincerely dissatisfied nurses. However, the teachers union campaign emphasized professionalism and attempted to draw a link between the needs of RNs and those of educators, a link many RNs did not see. Some were won over by the union's attempt to address bread and butter issues and to answer nurses' questions about their everyday needs.
District 1199, leaping into the fray several months after the UFT, also focused on the concerns of working nurses. Its union organizers, themselves RNs, emphasized 1199's successful representation of all health workers and its positive record on minority issues. Many nurses, however, questioned 1199's commitment to the City RNs, pointing to the union's belated and poorly funded entry into the contest.

Once they were both involved, the UFT and 1199 spent most of their time fighting each other. Many nurses were completely turned off by the newcomers' claims and counterclaims. In contrast, the NYSNA's low profile campaign emphasized professionalism and the Association's traditional role in the municipal hospitals. It made no attempt to address the day-to-day needs of working nurses, thereby avoiding awkward questions about its neglect of these problems in the long years prior to the election.

When it came time to vote in the election, some nurses felt discouraged by their choice and did not vote. Some attribute this apathy to the "traditional" passivity of women workers in general and the predominantly female RNs in particular. But it can also be argued that their passivity has been encouraged by the NYSNA HIERARCHY. In addition to the Association's influence over the nursing hierarchy within each hospital and consequent control over information channels, supervisors dominate the local councils and are included in the bargaining unit. The influence—some say coercion—exercised by participating supervisors could have given NYSNA its slim victory margin.

Blaming the May decertification election for its slow start in renegotiating the RNs' contract, the NYSNA did not sit down with the City until early August, fully five weeks after the contract ran out. Despite its triumph, the Association was forced to acknowledge the feebleness of its support among working nurses. Since then it has changed its tactics and tried to look more like a union. Unfortunately, these efforts have been compromised by inexperience and internal conflicts.

Beginning in late August, the NYSNA authorized several job actions to draw public attention to the nurses' demands. Informational picket lines were held at Kings County Hospital, a sick-out was called at the Bellevue Hospital premie nursery, and nurses struck Harlem Hospital for 24 hours. All of these actions were poorly organized, received little publicity even among nurses at

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For desperate people willing to work long hours in poor conditions for substandard pay. Many American citizens have left their nursing jobs at New York City's municipal hospitals. The city is now actively recruiting in the Third World. A step down for Americans may be a step up for you.

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**WRITE TODAY!**
"The NYSNA's difficulty has been in recognizing that negotiations require intense political pressure to gain a good contract. Support needs to be mobilized from the community, trade unions and even political officials where possible."

The NYSNA's attempts to organize the nurses themselves were similarly compromised. Contract proposals addressed many issues raised during the decertification election, including salary parity, a 10 percent cost-of-living increase each year of the contract, day care, and full tuition reimbursement; but the NYSNA leadership refused to release the list of proposals to the membership, fearing the nurses might expect to get everything requested.

"The NYSNA's difficulty," explained a Nurses Network member, "has been in recognizing that negotiations, especially with the beleaguered City of New York, require intense political pressure to gain a good contract. Support needs to be mobilized from community groups, related trade unions, and even political officials where possible. These pressures were largely ignored by the NYSNA."

By the end of August, negotiations with the City were stalled and rumors of a strike were multiplying. At first it appeared that the lack of advanced planning for a job action might be attributable to NYSNA's political naivete. Nurses on the negotiating committee were reportedly surprised by the city's sudden hard-line position when negotiating began in earnest. But it soon became evident to many nurses that a split was developing between the NYSNA negotiating committee, which favored a job action, and the Executive Board, which was against it. This internal conflict destroyed any possibility of coordinated strike preparation.

Without explaining the details of the negotiations, the bargaining committee delegates in each hospital began taking preliminary strike votes in mid-September. Rank and file nurses voted unanimously for a strike, but they were still kept in the dark. Nurses at Kings County Hospitals had to take a vote to force their chairperson to reveal the contract proposals.

Sometime during the week of October 6th, the decision was made to call a strike. It was unclear at what level of the Association the decision was made. Local NYSNA representatives met with nurses at hospitals to explain the plan, but even then they would not say when the walk-out would begin.

On Thursday October 9th, the NYSNA called a strike to begin the next day. Notification was left to local representatives.
and was haphazard. Some nurses heard the announcement on the radio, others heard only rumours, and the rest found out when they reported to work and found picket lines. At Kings Country Hospital, nurses passed around a printed announcement but there was no way to ensure that everyone would see it.

Participation in the strike was high but the nurses were hampered by the lack of advance preparation or organized communication between their forces at different hospitals. Numerous attempts to set up communication networks between nurses on different shifts and units were only sporadically successful. Then came a crushing blow: capitulating to city government threats, the NYSNA announced to the press at noon that it did not support the strike and had agreed to binding arbitration. By evening, local NYSNA leaders and negotiating committee members were at the picket lines personally admonishing nurses to report to work the next day. Isolated from their colleagues, nurses at four municipal hospitals reluctantly returned to work the next day. However, at the majority of hospitals, the union's desertion only increased the nurses' frustration and anger; they voted to stay out.

On the second day of the walkout, striking nurses set up a communications center and hotline to counteract unsympathetic press coverage, conflicting signals from the NYSNA, and general misinformation at the hospitals. Up-to-date information from picket lines and hospital wards was communicated to nurses calling in. At the request of the nurses, the Committee of Interns and Residents (CIR), an independent union of house staff physicians, provided the necessary facilities in their offices. Although hastily put together,
An Organizer Tells How It Can Be Done

Last year registered nurses at St. Barnabas Medical Center, New Jersey's largest hospital, were up for a new contract. This wasn't a very happy prospect. Their bargaining agent was the Jersey Nurses Economic and Security Organization, the state nursing association, and the first JNESO contract had left much to be desired.

In the words of Gail Duffy, RN, "It was an embarrassing contract; rather than an improvement, it reflected losses in benefits."

"We never saw a representative," was a complaint expressed by Joanne Ferrante, an intensive care unit nurse. "There were no membership meetings; no one was informed. We had three delegates for 500 nurses, and the negotiating committee consisted of only four nurses."

The dissatisfied nurses didn't have to look far for an alternative, since the hospital's ancillary personnel had been in 1199, the National Union of Hospital and Health Care Employees, RWDSU/AFL-CIO, for 16 years. "Their benefits were far superior to ours," noted Marilyn Rauchenberg, RN, "and management respected their rights."

When St. Barnabas nurses contacted 1199, the union sent over fulltime organizers from its Nurses Division. They helped prepare a blitz of meetings, discussions and almost daily bulletins in the weeks before the decertification election last July. 1199 emerged victorious with 185 votes.

The winners were pleased, but anxious; they knew successful bargaining would require a much higher level of support. The new officers quickly held a nurses meeting to draw up contract proposals and elect a negotiating committee of 21, including nurses from every unit, for the September confrontation with management. After incorporating modifications suggested by 1199 staff, the chapter printed and distributed their own demands and the hospital administration's counterproposals.

The September negotiations quickly bogged down over key points. In a secret ballot, the nurses voted by a crushing 378-8 margin to authorize a ten day strike notice. Preparations for a walkout intensified.

"We met with doctors, practical nurses, private nursing registries, non-union employees, and the other 1199 members at SBMC," recalled Ellen Mooney, a member of the negotiating committee. "We also saw the labor council, congressmen, and majors."

In addition, the nurses inundated the local newspapers, the Board of Trustees, and patients' families, with letters and distributed 6000 leaflets in the community.

By the time the strike deadline came, the nurses had prepared headquarters equipped with bathrooms, food, provisions for emergency shelter, and an information hotline; they had also organized committees for food, media, emergency care, and communications. After a mass meeting voted overwhelmingly to strike—only 23 nurses opposed—all the RNs marched out to the picket line singing. "That overwhelming spirit of togetherness is something I won't forget," said Ellen Mooney later.

Ancillary workers refused to cross their union's picket line, and nurses and 1199 staff members were out there walking around the clock. On the third morning, the federal mediator came down to the sidewalk to say that management was ready to talk. A tentative agreement was reached before midnight and the nurses ratified it in a 6 a.m. mass meeting.

—Sondra Clark
(Sondra Clark is 1199's RN Division Director.)
A General Accepts M

Resisting the usual litany of threats from superiors, sixty houseofficers organized as the San Francisco Interns and Residents Association (SFIRA) walked off the job at San Francisco General on Tuesday, October 21. By Friday night, the standstill of close to a year of negotiations had been overcome. After several all-night negotiating sessions the city conceded almost all of the contract demands, including recognition as employees, guarantees of reasonable working hours, and specifications that the municipal hospital will be "adequately staffed" for the first time in several years.

The success was all the more remarkable because only about a third of the interns and residents at the hospital struck, and many of them continued to provide emergency and night coverage between shifts on the picket line.

A fiscal crisis in San Francisco has crunched the municipal hospital since California passed Proposition 13 in June 1978 (See Health/PAC July-August 1980). One consequence has been that only 1805 of 2055 budgeted staff positions were filled as of October 23. In the contract, the city agreed to an increase of 70 fulltime employees for the remainder of the current fiscal year and pledged to "maintain adequate staffing throughout the hospital," a statement that is grievable in court.

Other features of the contract include:

- A special staffing committee with representation from SFIRA and the Civil Service Association, SIEU Local 400, to review staffing every three months.
- The city agreed that the physicians need not "regularly and recurrently" perform the jobs of other hospital employees, such as making beds, pushing patients to x-ray or walking blood samples to the lab. While in one sense it seems doctors wish to get out of "shit-work" they feel beneath them, the "regularly and recurrently" clause is defended as forcing the city to improve staffing so that house officers have adequate time and energy to provide high quality medical care.
- The city agreed in principle to "reasonable" work hours for physicians, but the section is no stronger than "good-faith" language and it is unclear that goals of 24 consecutive hours off-duty per week and no more than 34 hours of continuous duty will be achieved.
- Full amnesty was granted for all strike participants.

The strike was unique in that salary was not an issue at all; concern about patient care dwarfed all other considerations.

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the Center became the focal point which enabled nurses to share news and strategies and to give each other support.

The nurses needed all the mutual support they could get. The city fought back quickly at the first announcement of a strike, obtaining a court injuction and authorizing enforcement of the state Taylor Law, which authorizes the City to withhold two days' pay for each day a government worker strikes. As the strike progressed, Mayor Koch publicly berated the nurses for "abandoning their patients and profession" and threatened to close the hospitals unless the nurses returned to work.

The attacks backfired. Directly following the mayor's announcement that Metropolitan Hospital would be the first to close, the proportion of nurses striking there rose from 63 percent to 97 percent and the city had to back down.

Nurses continued their strike for varying lengths of time at different hospitals; each voted independently on when to return to work. By Wednesday, October 15th, all the nurses were back at work, some wearing black armbands to demonstrate their dissatisfaction with the situation.

When the arbitrator's decision was announced on October 17th, all the nurses felt like wearing black: salary increases were limited to 8 per cent per year and the nurses were denied parity with their colleagues in voluntary hospitals—essentially the City's initial offer. An appeal filed by the NYSNA was denied.

By the usual measures of success in labor struggles, the city hospital nurses strike was a failure. The RNs did not win any significant concessions from the city, alienated the public and the press, and were assessed pay penalties. Neither the city nor the nurses give the NYSNA any credibility as an effective
Major Improvements

When it came time to walk off the job and staff the picket lines, only family practice, pediatrics and psychiatry were united behind the strike. A core group of medicine residents stood firm, but colleagues who had cast ballots for the strike stayed on the job. Surgery and obstetrics/gynecology residents largely opposed the walk-out on principle or bowed to threats of retaliation. Faculty offered little support. Given these divisions, the strength of the houseofficers seems inadequate to explain the city’s abrupt turnaround. Some organizers, while basking in the glow of victory, concede that pre-election politics, sympathetic press coverage and support from the Teamsters and the citywide labor council tilted the odds at the negotiating table. Indeed, Mayor Feinstein was out of town campaigning when the walk-out began, paralyzing the city’s response.

A skeptical minority of SFIRA members believes that the city has conceded much less than it appears. Health Department officials say that the 70 “additional” positions will be funded with savings achieved by understaffing the hospital still further for the first four months of the current fiscal year. It is unclear that funds for these positions will be allocated beyond July 1981.

The General provides city-wide emergency services but otherwise serves a largely indigent non-white population in one of the most overly-doctored cities in the country. Ward conditions are primitive compared to the university hospitals and plethora of private facilities. Indeed, private practitioners are said to favor phasing out of the hospital, since improvements would make it a competitive threat.

At the university hospital, for example, a male doctor usually performs a pelvic exam with a female nurse or chaperone in attendance. At San Francisco General, a “chaperoned” pelvic is virtually unheard of. Delays of several hours are common in obtaining “stat” chest x-rays for intensive care patients. The pharmacy is closed at night. Seriously ill patients have been known to wait for hours in the emergency room or admissions because no one has cleaned their rooms.

If the hospital care slips, there is greater force in arguments that patients could be better served elsewhere; even if the training program suffers. The victory at San Francisco General is very heartening, because the commitment of its doctors and other workers to quality public health care is reversing the emasculation of services by bureaucrats and private practitioners.

—Robert Steinbrook

(Robert Steinbrook is a resident in medicine at the University of California, San Francisco and a SFIRA member.)

bargaining agent. Many nurses, extremely embittered by the union’s desertion during the strike believe the NYSNA’s part in planning the job action was really an attempt to keep the nurses in line. As Edmund Kerns, a nurse at Bellevue Hospital told a New York Times reporter, “Our feeling is that we were sold out by the State Nurses Association. This was all preplanned: a one-day letting off of steam; then they expected us to return to work.” Following the strike, in what appears to many to be an attempt to deflect attention away from its own failure, the Association filed suit against the UFT and CIR for inciting and assisting the nurses in the wildcat strike.

Although they may have lost in the public arena, the nurses have gained an understanding of their own power and militancy. Instead of meekly filing back to their jobs at the bidding of the NYSNA, they overcame their initial disarray and continued the strike for five days, threatening to bring the entire municipal hospital system to a standstill.

The Communication Center is still functioning, bringing nurses together to discuss strategy and relaying information. The NYSNA Rank and File, an organization formed after the decertification election to press the concerns of working nurses, is continuing its work within the union. (Comprised of nurses from voluntary hospitals as well as municipal hospitals, so far it has had difficulty defining common priorities.)

It will be two years before the NYSNA can be challenged in another decertification vote. In the meantime, city hospital nurses cannot afford to ignore the existing NYSNA structures. Through informed, critical involvement, nurses feel they can make changes in both their workplace and the organization that represents them.

—Nurses Network
The Carcinogen Information Program of the Center for the Biology of Natural Systems is offering a free leaflet listing all human and animal carcinogens identified by U.S. Government agencies and the International Agency for Research on Cancer.

Copies are available from the CIP, Center for the Biology of Natural Systems, Washington University, St. Louis, MO 63130. You must include a stamped, self-addressed envelope with your request.

We’re Tired of Being Guinea Pigs!—A Handbook for Citizens on Environmental Health in Appalachia, has just been published by Highlander Research and Education Center. Written in clear, concise prose, this lavishly-illustrated 83-page handbook details the health problems attributable to conditions in the region’s major industries, including coal, nuclear power, and farming, and offers case histories of what communities have done to fight against their despoliation.

Single copies are sold for $6, including postage, by the Highlander Center, Route 3, Box 370, New Market, Tennessee 37820.

Stop Environmental Cancer, An Epidemic of the Petrochemical Age by Paul Blanc, MSPH, examines carcinogen dangers in California. Although this 180-page looseleaf-bound book is subtitled A Citizen’s Guide to Organizing, unlike the Highlander handbook it emphasizes working through regulatory agencies and pushing for stronger legislation; relevant ordinances are provided.

The Guide is a project of the Campaign for Economic Democracy Cancer Project, and is available from them for $11.25, which includes $1.25 for postage. The address is 409 Santa Monica Blvd., Room 214, Santa Monica, CA 90401.

Books Received

Ardell, Donald B. and John Y. James (Eds.), Author’s Guide to Journals in the Health Field (Binghamton, N.Y.: Hayworth Press, 1980) $16.00.


Mental Health

Continued from Page 12

metals have been partially offset by new ones in plastics and machinery at the low end of the wage scale. Like much of the region around Boston, Fitchburg is riding the boom in micro-circuit electronics. One resident, who claimed the area had “never recovered from the Depression,” remarked that Fitchburg had reached a “turning point for the better.” Still, it has been rough for the traditional workforce. Unemployment, already drearily above the national average since 1950, grew worse in the 1970s. Service and wholesale/retail positions account for most new jobs; women and minority workers have won many of them.

The Mental Health Context

The mental health services available to the 140,000 residents of the Fitchburg-Leominster CMHC catchment area are rated among the best in Massachusetts. Although there are paraprofessionals, most psychotherapy is provided by psychologists and social workers. Originally a child guidance center, the Herbert Lipton Community Mental Health Center now offers full counseling services, plus a day treatment program and other programs designed for the chronically impaired. It also has a unique history of coordinated services: Dr. Anthony Ferrante, the first director, also served as the superintendent of the Fitchburg-Leominster unit of the Gardner State Hospital and area programs Director and Mental Health Center Director. The CMHC is the main public resource for mental health services and maintains an affiliation with Burbank General Hospital and Worcester State Hospital as the main inpatient facilities.

Our study of the Fitchburg-Leominster CMHC catchment area surveyed the more than 10,000 encounters in the mental health system from 1950-1975, including inpatient and outpatient services at hospitals and clinics and office visits to private therapists.

Rather than attempting to measure the relation between events which could cause stress, e.g., unemployment, and individual dysfunction measured by application for mental health services only through first admissions as Harvey Brenner did, we tried to identify the factors which increase total utilization of these services, a more sensitive measure of the relationship between unemployment and emotional well-being.

Three groups of variables were identified as possible factors determining use of the center. The first, availability of services, includes the range of programs and how much access the community has to them; and these we termed supply factors. The second and third, population and stress, create situations in which people feel the need for help; we called these demand factors.

These are our five principal findings:

1. There were clear and reproducible relations between unemployment rates and use of mental health services. Although unemployment was not the only factor, it accounted for significant variation.
2. Trends and population changes tend to explain more of the variation in utilization rates than unemployment rates do. Use of mental health services has climbed steadily for more than a decade. It must be stressed that this trend, combined with gradual population growth, can account for most of the increase in visits to the Center. This suggests a steady growth of demand factors, reflecting, perhaps, generally increasing stress, eroding defenses against it, greater acceptance and desire for and availability of mental health services, or some combination (see Figure 3).
3. The relative importance of unemployment, trend factors, and population vary widely across various inpatient, outpatient, age and sex categories. The relative importance of trends vs. unemployment factors varies when different age or gender groups are examined. Perhaps surprisingly, this isn’t always related to participation in the labor force.
4. The time between unemployment and a request for treatment is very different for inpatient and outpatient services. As might have been expected, following economic changes it is much shorter for outpatient visits than for hospitalization.
5. Rising unemployment increases outpatient visits relatively quickly. But contrary to Brenner’s findings, when the economy improves inpatient treatment goes up, albeit more slowly. On the average, when other factors such as the availability of services and population changes were excluded, we found that a one percent increase in the unemployment rate pushes the Center’s traffic up eight percent over the next two years.

One way to reconcile the Fitchburg results with those of Brenner is to recognize that while
The community itself often becomes a source of stress, contributing heavily—if not completely—to the problems of emotional survival. The community’s sense of self-determination is destroyed as control of production and resources are drained away.

mental health-related hospitalizations may be increasing for the country as a whole, this is not necessarily the case in a small, discrete region. The unique nature of a regional economy may protect it from some of the deleterious effects which unemployment generally has elsewhere. In addition, Brenner completed his work in 1970—the beginning of the CMHC era.

Implications for Policy

Our Fitchburg-Leominster study challenges the notion that unemployment automatically produces the kind of stress and personal dysfunction which leads to hospitalization. We also learned that a community’s reaction to increased social stress such as unemployment may be affected by many factors.

Since the 1960s, a shift in public policy has created a national network of community mental health centers along with widespread deinstitutionalization. (See Health/PAC Bulletin 65; 11:4). As a result, mental health care providers today have a much wider range of therapeutic alternatives. Hospitalization, traditionally, has been the response when people are troubled by deep-seated problems; most mental health specialists believe one significant cause of such problems is cumulative stress. This is supported by the study’s finding that the unemployment rate affects the number of inpatients more slowly than the level of outpatient visits.

To the extent that CMHC outpatient therapy becomes a substitute for inpatient therapy and prevents hospitalization in the long run, it would also be reasonable to expect that the inpatient utilization will become less and less sensitive to community stress cycles.

Community support networks remain an important alternative and complement to services provided by the mental health system. Future research must investigate how changes in the economy alter these networks by reordering patterns of labor force participation or job demands. For example, when more women entered the labor force as the Fitchburg economy improved, disabled people cared for at home presumably lost an important support system. As a result, increasing job opportunities may have pushed vulnerable people into hospitalization—a hidden cost of economic growth.
Economy and Community

In the mid-19th century the locus of production effectively shifted from cottage craft to the factory. Since the factory is characterized by a mass of workers producing in a single location, the shift led to concentration of workers' families in the dark, fetid, overcrowded streets of city slums described so graphically by Charles Dickens. Asylums for the insane were one of many centralized institutions established during the late 18th century in response to this.

Figure 2

Employment by Major Industry, 1958-78, Fitchburg-Leominster Area

Note: Based on data from Standard Metropolitan Statistical Area (SMSA).

Source: Employment and Wages in Massachusetts. SMSA's and Labor Market Areas, Massachusetts Division of Employment Security.
There are clear relations between unemployment rates and use of mental health services. Although unemployment is not the only factor, it accounts for a significant variation in mental health service utilization. The wrenching pattern of industrialization, migration, and urbanization.

The community itself often became a source of stress, contributing heavily—if not completely—to the problems of emotional survival. The community's sense of determining its own destiny was destroyed as day-to-day control of production and resources for community building were drained away. Separate studies of Arvin, California (1), and Fall River, Massachusetts (2), have shown that the transfer of ownership of local business to urban financial centers was a hard blow to community vitality and re-investment.

In addition, expanding the size and scale of production generally wipes out skilled relatively high paying jobs and substitutes labor at the low end of the wage scale, increasing the sense of dependency and helplessness. Loss of a highly skilled 40-hour a week job often means that 60 to 80 hours of work must be found if people want to maintain their standard of living. The wage earner must take two jobs or, more likely, the family unit has to send someone else out into the labor market. Caring and Nurturing are shunted to the last hours.

The American tax system allows the local community virtually no chance of controlling any appreciable portion of the local surplus. The only business wealth it can effectively tax is what can't be easily sent somewhere else; in general this means real estate. Profits, on the other hand, are quite mobile and taxed, when at all, by the state. Cultural and philanthropic activity, meanwhile, is channeled through the hands of owners—where they live. As ownership centralizes, local communities lose even their token civic resources. Ironically, conservatives who rail against encroachment of the federal government on our lives are often enthusiastic boosters of the economic centralization which inevitably requires this governmental centralization.

Local communities desperate for more jobs increasingly compete to attract highly mobile corporations. Yet, absentee ownership frequently drags a community down to greater stagnation and an even more precarious economy. Muncie, Indiana, the subject of the "Middletown" studies, is a typical victim:

"One drastic difference from the 1920's is that Munsonians no longer control their own town. The Ball Corporation, now a diversified multi-national, has moved its important operations elsewhere, and the Ball family itself is scattered, with diminished clout in Muncie."
The local economy is now controlled from the out-of-town board rooms of large corporations — and from Washington." (3)

Caplow, one of the Middletown researchers, points out that if both the local public treasury and local philanthropy cannot support local needs, then the vacuum must be filled elsewhere if society is not to break apart. "The Federal Government has in effect taken over all the social welfare functions in Muncie," he elaborated, "The care of the sick, the poor, the aged and the delinquent is all controlled in Washington" (3).

Decreased demand for highly skilled labor and the need for additional family members to earn money often forces workers to travel greater distances to their job; some eventually will move away. Members of extended families and community social networks begin to find it difficult if not impossible to provide services for one another or mutual emotional support and attention. Families are strained by care for aging members; young families must seek out day care and other help outside the extended family so that both parents might work (4).

As family members become more wage dependent, they come to see their individual wages as the key to independence and survival; this often lessens the possibility of family or other collective action to improve the situation. (See "What Goes Around, Comes Around" box). Individual solutions are perceived as the only "realistic" possibility.

Overall, shifts in economic structure weaken the capacity of families and social networks to provide support and at the same time box individuals into increasingly distressed conditions. These communities, lacking many resources necessary to support their members,
Rising unemployment increases outpatient visits relatively quickly. There is a steady growth in demand, due to increased stress and eroded defenses. Some social workers, however, are convinced that personality problems and mental illness actually cause unemployment.

are the hometowns where deinstitutionalized patients are being returned for care.

Conclusions

Few mental health practitioners would link the Hansen family's problems to changes in the local economy. Their training and practice setting encourage them to localize problems and thus to treat the individual and occasionally his or her family. Often, well-meaning therapists such as those interviewed at the Fitchburg-Leominster CMHC inadvertently "blame the victims" when they draw conclusions about causal relations between their clients' mental health and the community's economic structure. Sound ecological theory, perception, and treatment would enable care providers and policymakers to identify and protect those most vulnerable to the emotional stress engendered by economic change. Unemployment rolls only tell the pebble's story, as the school problems of the Hansen's oldest child illustrate.

The picture of the individual and the community battered by economic change has important implications for economic and social policy, and for mental health and community activists as well.

"Growth" has long been the keystone of U.S. economic policy — the more, the better. But such accounting hasn't questioned whether the benefits are greater than the costs. Nor has it noted whether the costs and benefits are equitably distributed. The goal of maximizing the Gross National Product (GNP) fails to distinguish goods and services which truly add to the general well-being from those which merely repair the damage unbridled growth strews through the nation; it does not take into account how goods and services are distributed. The "growth" maximization we have experienced is much less productive in the long run than a policy of social cost minimization emphasizing community stability.

Apologists for the "private enterprise system" see this kind of local responsiveness as one of its key virtues. But as the history of communities such as Fitchburg-Leominster reveals that market forces have eliminated many local choices. Only a capital investment process more sensitive to community cohesiveness can ensure that mental health in the broadest sense of the term of a community is entered on the bottom line.

—Elliot Sclar
Peter Stathopolus
Hal Strelnick
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References


Figure 4

The Eyer Model Applied to American Mortality, 1870-1970

Note: Vertical lines mark peaks of the death rate.


Professor Brenner had reason to be pleased. The Committee report in which his paper was released had an introductory section in which JEC staff attempted to employ the Brenner model to estimate the social costs of small increases in the national unemployment rate.

Although Ralph Catalano, at the University of California, Munic, Public Policy Research Organizations, and others have noted that Brenner's work is "not yet at a stage to offer clear policy guidance," economist Jeanne Gordus of the Institute for Labor and Industrial Relations (co-sponsor of last year's conference on the economy and health with the National Institute of Mental Health) summed up the conference consensus with the comment that, "there was no doubt in anybody's mind that Brenner's correlations are correct. Discussions centered on trying to "pull apart" the data....to understand what they mean" (3).

The Debate

For more than a decade Brenner, a professor at the John Hopkins School of Hygiene and Public Health, has been developing a model relating economic indicators with measures of individual well-being. He began by showing the rate of first admissions to New York State mental hospitals was directly related to unemployment and downturns in the business cycle (4). This work was later expanded to include data for the entire U.S., including suicides and homicides, general mortality rates (according to ages, sex, and race) and specific mortality rates from cardiovascular disease and cirrhosis of the liver (5).

Brenner has since applied his methods to data from California and Massachusetts, as well as Sweden, England, and Wales (6) , each with appropriate lag times for various indicators. Others have found similar results for Australia (7). His initial studies emphasized the high correlation between unemployment and acute pathological disturbances (Figure 1). A similar relationship was found for rheumatic heart disease as early as 1944 (8).

Unfortunately, this assumption of cause and effect seems to be unsupported by the evidence. Studies of the physiological impact on workers laid off from jobs indicate that it varies greatly with the conditions of...
unemployment and reemployment (1). There is strong evidence that booms as well as busts can be bad for one's health (2). Recessions seem to result in illness most heavily among the retired and others not looking for work (3), suggesting that other, broader forces help determine the ultimate impact of economic change on personal behavior.

In 1977, Joseph Eyer of the University of Pennsylvania challenged Brenner's hypothesis with data demonstrating that death rates rise during business booms and decline during depressions—a conclusion reached as early as 1925 by D.G. Thomas in England (9). (Figure 4). Eyer argues that Brenner made his case by assuming that severe emotional distress which occurs a long time after job loss is related to it, but the studies don't really show a direct cause and effect relation between unemployment and illness. He proposes an alternative explanation for the variation of death rates with the business cycle, emphasizing the stress caused by hierarchical social relations.*

More recently, Brenner has tested Eyer's hypothesis without complete success, but he now adds rapid economic growth to recessions, as a source of increased mortality (10). Brenner also maintains that "It is the routine, daily economic activity of industry and government which have the most profound impact on the mental health of the nation."**

Both sides of this debate are weakened by their use of state or national data. For example, statistics from Ohio might indicate an unemployment—severe stress correlation when actually unemployment is rising in Toledo and citizens of Columbus are filling up their city's new hospital. Despite their current problems, refined versions of Brenner and Eyer models would be a valuable tool for evaluating primary and secondary prevention programs, indicating how well they have kept hospitalization below the level which would have been expected if they hadn't existed.

Predictive models can also forcast future resource needs and promote more efficient resource allocation to meet those needs, and, as in the JEC paper, help assess the social costs and benefits of national policy decisions. Similarly, communities could plug in one of these models to assess the impact of plant openings and/or closings and organize their public and social services agencies to cope with likely stress.


References

In 1974 the Colonial Press in Clinton, near Fitchburg, was acquired by Sheller-Globe, a manufacturer of auto parts, school buses, and ambulances. Almost immediately, Sheller-Globe installed its own management personnel at the Press; except for the new president, none of them had any experience in publishing. Not surprisingly, within three years the Press closed up shop and sent its 1,000 employees home.

The Road to Bankruptcy

On the road to this bankruptcy, Sheller-Globe charged management overhead of $900,000 a year, with some monthly charges reaching $200,000. Among the expenses piled up were elaborate security systems. Perhaps they had some logic in the conglomerate's auto parts division, but few print shop employees want to walk out with 10,000 copies of a Readers Digest condensed version of Shibumi. Yet workers regularly suffered the indignity of a search for stolen goods as they exited past 22 security guards and a shiny new wire-link fence.

Sheller-Globe believed there was little difference between producing a steering wheel and producing a book. Customer service was sacrificed in department mergers and computerized management information systems. Printing schedules became rigid, orders were misplaced, past practices essential to customers, such as free warehouse space and itemized cost estimates were eliminated; books were lost and misplaced. Important clients, including Reader's Digest and Random House, found new printers. According to testimony given before the Senate Judiciary Committee, "The publishing industry became alienated and sales declined...Decisions which were appropriate to the automotive industry proved disastrous in the book-printing industry."

After the plant closed, local officials, citizens groups, and unions mobilized to reopen it as a cooperative. Finally, in 1979, with the assistance of the Massachusetts Community Development Finance Corporation and the Industrial Cooperative Association, the press was sold to its workers as a full-scale cooperative. During the two-year hiatus the new Colonial Cooperative Press lost many old customers and now employs on-

In 1971 Magnolia's uncle died in Mississippi shortly after selling his run-down farm and left an unexpected inheritance of $1,500 to Magnolia and Calvin Waters. It was the first time in their lives that either Magnolia or Calvin had ever enjoyed a cash reserve. It was a moment of joy, a chance to put a down payment on a home.

Within three days of the check's arrival, the news had spread throughout their domestic network, and one of Magnolia's nieces had borrowed $25 to save her phone. Within a week the welfare office knew about the money. Magnolia's children were immediately cut off welfare, including medical coverage and food stamps, and she was told they would stay off until the money was used up—which had to be within four months.

When another uncle became very ill in the South, Magnolia and her older sister, Augusta, were called to sit by his side. Magnolia bought round-trip train tickets...
Table 1

<table>
<thead>
<tr>
<th>Causal Relations Accounting for the Business Cycle Variations of the Death Rate, 1949-1975 according to Eyer</th>
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<tbody>
<tr>
<td>Material Conditions (8%)</td>
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<tr>
<td>Housing (27%)</td>
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<tr>
<td>Nutrition (6%)</td>
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<tr>
<td>Social Relations in Class Struggle (89%)</td>
</tr>
<tr>
<td>Social Solidarity (19%)</td>
</tr>
<tr>
<td>Strikes (17%)</td>
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<tr>
<td>Marriage (2%)</td>
</tr>
<tr>
<td>Social Disintegration and Overwork (53%)</td>
</tr>
<tr>
<td>Overwork (34%)</td>
</tr>
<tr>
<td>Migration (9%)</td>
</tr>
<tr>
<td>Divorce (8%)</td>
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<td>Unemployment (2%)</td>
</tr>
<tr>
<td>Drug Consumption (17%)</td>
</tr>
<tr>
<td>Alcohol (11%)</td>
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<td>Tobacco (6%)</td>
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It is now more widely recognized that a community's mental health needs to be incorporated into the costs of a "runaway shop." The initial struggle will be over who picks up the tab. Maine passed a law in 1971 requiring a month's notice and severance pay for plant closures or relocations. Wisconsin followed suit in 1975. The list of states where similar legislation has been introduced reads like a roll call of the old Northeast industrial belt—Ohio, New Jersey, New York, Connecticut, Rhode Island, Michigan, Illinois, Pennsylvania—plus California (for farmworkers only), and Oregon; but in these states and in Congress vigorous business lobbying and threats of investment boycotts have buried even the most modest legislation. —Hal Strelnick


so that she and Augusta could attend the funeral. Soon after his death, Augusta's first "old man" died in The Flats and he had no kin to pay for the burial. Augusta asked Magnolia to help pay for digging the grave. Magnolia was unable to refuse. Another sister's rent was two months overdue and Magnolia feared that she would get evicted. This sister was seriously ill and had no source of income. Magnolia paid her rent.

Winter was cold and Magnolia's children and grandchildren began staying home from school because they did not have warm winter coats and adequate shoes or boots. She and Calvin decided to buy coats, hats, and shoes for all of the children—at least fifteen. Magnolia also bought a winter coat for herself and Calvin bought himself a pair of sturdy shoes.

Within a month and a half, all of the money was gone. —Carol Stack

All Our Kin: Strategies for Survival in a Black Community